Olympic Area Agency on Aging

Area Plan Update
2022 – 2023

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

Olympic Area Agency on Aging

2022 West Sims Way, Unit 100
Port Townsend, WA 98368
www.o3a.org
Phone: 360-379-5064 or 1-866-720-4863 Fax: 360-379-5074

September 30, 2021

Dear Friend:

Rarely has an Area Plan Update been more revised than the Olympic Area Agency on Aging 2022 - 2023 Area Plan Update. The COVID 19 pandemic had an impact on all areas of services offered as well as our internal operations. The resiliency of our staff, service provider network and communities are reflected in this plan in how we innovated and adapted to pandemic restrictions.

We are grateful for the opportunity to evolve services in response to the public health emergency to cement new partnerships and expand our reach to those with the most social vulnerability. By reviewing our data and trends during this pandemic we were able to identify new service needs and make decisions on program allocations which reflect current need.

Updated goals related to supporting older adults, adults with disabilities, and their families include:

- Reducing Social Isolation
- Expanding nutrition services in food deserts via non-profits and local restaurants
- Providing equity in funding with a targeted RFP for Tribes addressing social isolation
- Programing and resources to address housing issues
- Addressing the Impacts of the COVID-19 pandemic
- Recovering our volunteer workforce

Preparation of the Area Plan Update is a statutory requirement and represents considerable time and effort on the part of our Contracts and Planning Director, Jody Moss, we are grateful for her work. 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:

- Lisa Olsen, 2021 Chair, Pacific
- Randy Johnson, 2021, Vice Chair, Clallam
- Greg Brotherton, 2021, Jefferson
- Jill Warne, 2021, Grays Harbor

And To:

- Elizabeth Pratt, Advisory Council Chair
- Rebecca Knievel, Advisory Council Vice-Chair
- The Advisory Council

We are looking forward to resuming in person direct and contracted services throughout the Olympic Peninsula. If you would like some additional information, please do not hesitate to telephone or email me at laura.cepoi@dshs.wa.gov, or visit our agency website: www.o3a.org.

Best,

Laura Cepoi
Laura Cepoi
Executive Director

CONTENTS

Acronyms

AAA	Area Agency on Aging
AC (O3A)	Advisory Council
ACH	Accountable Community of Health
AD	Alzheimer's Disease
ADA	Americans Disability Act
ADRC	Aging & Disability Resource Center
ALTSA	Aging & Long Term Services and Supports Administration
ADC	Adult Day Care
ADH	Adult Day Health
AFH	Adult Family Homes
ALF	Assisted Living Facility
ALTSA	Aging & Long Term Services Administration
AIRS	Association of Information & Referral Specialists
AOA	Administration on Aging
APS	Adult Protective Services
BH	Behavioral Health
CCM	Chronic Care Management
CCO	Care Coordination Organization
CDC	Center for Disease Control
CDE	Consumer Directed Employment
CDSMP	Chronic Disease Self Management Program
CE	Continuing Education (Unit)
CFC	Community First Choice
CG	Caregiver
CGT	Caregiver Training
CLEAR	Coordinated Legal Education, Advice and Referral System
CM	Case Management (Care Management)
CLC	Community Living Connections
CMS	Centers for Medicare& Medicaid Services
COG	Council of Governments
COPES	Community Options Program Entry System
COVID-19	Corona Virus Disease 2019, also knowns as SARS-CoV-2
CSO	Community Services Office
CT	Care Transition
DCAP	Dental Care Access Program
DD	Developmental Disability
DDD	Developmental Disability Division of DSHS
DOH	Department of Health
DOT	Department of Transportation
DSHS	Department of Social & Health Services
EVV	Electronic Visit Verification
FCSP	Family Caregiver Support Program
FEMA	Federal Emergency Management Assistance
HAP	Health Action Plan
HC/HCA	Home Care / Home Care Aide
HCS	Home and Community Services
HCRR	Home Care Referral Registry
HH	Health Homes
HIPAA	Health Insurance Portability Accounting Act
HUD	Department of Housing & Urban Development
I&A	(Senior) Information & Assistance
ILC	Independent Living Center
IP	Individual Provider
IPA	In Person Assister
IRC	Internal Revenue Code
IRS	Internal Revenue Service

INS	Immigration & Naturalization Service
KCSP	Kinship Caregiver Support Program
LGBTQ	Lesbian, Gay, Bisexual/ Binary Transgender, Questioning
LIS	Low Income Subsidy Program
LTC	Long Term Care
LTCOP	Long Term Care Ombudsman Program
MAC	Medicaid Alternative Care
MB	Management Bulletin
MCO	Managed Care Organization
MTPD	Medicaid Transformation Project Demonstration
MH	Mental Health (preferred terminology today is Behavioral Health)
MIPPA	Medicare Improvements for Patients and Providers Act
MPC	Medicaid Personal Care
N4A	National Association of Area Agencies on Aging
NCOA	National Council on Aging
NICOA	National Indian Council on Aging
NS	Nursing Services
NSIP	Nutrition Services Incentive Program
OAA	Older Americans Act
O3A	Olympic Area Agency on Aging (OAAA)
PERS	Personal Emergency Response System
PSA	Planning and Service Area
RCW	Revised Code of Washington
RFI	Request for Information
RFOC	Revised Fundamentals of Caregiving
RFQ	Request for Qualifications
RFP	Request for Proposals
RSVP	Retired Senior Volunteer Program
SAIL	Stay Active & Independent for Life
SARS-CoV2	Severe Acute Respiratory Syndrome Corona Virus 2
SCOA	State Council on Aging
SCSA	Senior Citizens Service Act
SCSEP	Senior Community Service Employment Program
SFMNP	Senior Farmers Market Nutrition Program
SHIBA	Statewide Health Insurance Benefit Advisors
SLAC	Senior Legal Advice Clinic
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSPS	Social Service Payment System
SSA	Social Security Administration
TJQMBB	Tai Ji Quan Moving for Better Balance
T-CARE	Family caregiver assessment tool
TSOA	Tailored Services for Older Adults
USDA	United States Department of Agriculture
WAC	Washington Administrative Code
W4A	Washington Association of Area Agencies on Aging

SECTION A – AREA AGENCY PLANNING AND PRIORITIES

A – 1 INTRODUCTION:

The Olympic Area Agency on Aging, Area Plan Update 2022-2023

The Olympic Area Agency on Aging is pleased to present our Area Plan Update for 2022 through 2023. The plan supports O3A's mandate to develop a comprehensive and coordinated system of home and community-based services for older adults and people with disabilities. It describes O3A's priorities and provides an overall framework to guide financial and staffing investments for the four years, and was developed through broad based community consultation, qualitative and quantitative field research, and public input. The Area Plan document serves as the foundation for work plans, funding priorities and planning efforts to provide services for persons who are older or need long-term care in Clallam, Grays Harbor, Jefferson, and Pacific Counties.

O3A has provided support to older adults in Clallam, Grays Harbor, Jefferson, and Pacific counties since its inception in 1976. Designated by the Washington State Unit on Aging as one of 13 area agencies on aging in our state, O3A is mandated to coordinate services and advocate on behalf of older adults and others in need of long-term care throughout its service region. This plan outlines the needs of older adults and adults with disabilities in each local region and proposes goals and objectives as well as specific programs to address those needs.

Service Region: O3A's primarily rural service area comprises **212,908**[1] people (approximately a 4% increase in population since 2020), dispersed over 8,301 square miles of rugged mountainous terrain, forests and farmland, small rural cities, towns, and small villages on the Olympic Peninsula, and extends the entire length of Washington's west coast. The region is generally considered economically distressed, with higher unemployment and lower wages than many areas in the state.

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

The service population within this region includes **78,115[2] adults over the age of 60 with a predicted increase to 83,973 by 2030** – this is termed the Age Wave**.** There are adults age 18 and older with disabilities **- 22,073 growing to 25,055 by 2030**, native elders from eight Tribes **2,207 growing to 2,425,** and a 60+ minority population **(5,968 growing to 7,201**), of which the majority of individuals are Hispanic from a variety of North & Central American countries.

O3A's Approach to Aging in Place

To support people to age in place and live independently in their own homes, O3A has developed a multidimensional approach that includes direct and contracted service delivery; community outreach with information and assistance; disease prevention and health promotion; strategies to increase access to health care, and supportive services; and advocacy with the public and legislators on issues affecting older adults and adults with disabilities.

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

O3A direct service staff provided nursing, case management, and other services to **2,277** Medicaid eligible adults age 18 and older in 2020, with that number continuing to grow each year. O3A's Information & Assistance (I&A) program provides community outreach with information about health insurance, legal issues, options for planning for aging and for long-term care, and other senior service programs and benefits to thousands of local residents each year.

Governance

O3A is governed by a Council of Governments, with membership comprising one county commissioner from each of the four service region counties. In addition, O3A is guided by an active Advisory Council that includes 21 consumers, providers, health and social service specialists, community representatives, tribal and minority population advocates. The member council includes representatives from each of the four counties in O3A's service area (16 total); plus five regional members in the positions of a disability representative, an elected official, a representative for the 8 tribes in our region, and a representative from minority/ethnic populations in the service area. The remaining position is a regional State Council on Aging

[2] David Mancuso, PhD., Jingping Xing, PhD., Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2030 in Washington State; Office of Financial Management, WA State, 2021

Representative, appointed by the Governor's office as a liaison between the State Council on Aging and the region.

Operational Capacity

Approximately 80 direct service, technical, and administrative personnel are based in seven offices - one in Grays Harbor, and two in each of Clallam, Jefferson, and Pacific counties. An administrative office, located in Port Townsend, houses executive, financial, human resources, planning, and contract management staff. Two larger offices in Aberdeen, (Grays Harbor) and Sequim (Clallam) comprise direct service provision staff, and management for Information and Assistance, Case management, Family Caregiver Support including MAC & TSOA, Nursing Services and Information Technology.

Two offices in Pacific County (Raymond & Long Beach), one in the West End of Clallam County (Forks), and one in Jefferson County, (Port Townsend) serve as satellite offices for I&A, Case Management Program, and FCSP staff with other staff traveling to serve remote areas as required.

O3A receives federal and state funding to administer over 20 programs, as well as foundation grants and local resources and has an average annual operating budget of $10 million. For fiscal years 2022 and 2023 the operating budget is anticipated to increase due to additional spending related to the pandemic.

O3A also authorized Medicaid services in the amount of $1,417,003.62 last year to 2,277 unique clients. While this may appear to be a significant investment, the annual cost of nursing facility care for the current 1,770 O3A clients receiving case management services in their

homes would be $168,830,512. Thus, our Area Agency on Aging alone is reducing potential expenses to the state and federal government by more than $100 million annually.

O3A supports its direct and contracted service provision with contract management, technical assistance and monitoring, financial oversight, and IT support. O3A maintains a website (www.o3a.org) and access to media publicity through radio programs and columns in local newspapers. These two outreach efforts have the potential to reach significant numbers of the population in the 4-county region, listed below (likely reach). In addition, O3A has increasingly used Facebook, a Constant Contact Newsletter, and to a lesser extent Pinterest and Twitter for outreach.

Media Organization	Distribution	Region	Likely numbers of readers/ listenership**	Online Monthly hits**
Chinook Observer*	Weekly	GH P	11 2,062	W-14,603 for GH & P
Willapa Harbor Herald*	Weekly	P	3,442	W – 45,414 FB – 3,173
Daily World	3 X/Week	GH	1,538	W – 93,132
Daily World Saturday Events Column*	1/week	GH	1,520	W – 93,132
Peninsula Daily News	Daily	C J	2,583 680	W – 155,916
Forks Forum	Weekly	C	386	W – 8,454
Sequim Gazette	Weekly	C	1,292	W – 30,947
Port Townsend Leader	Weekly	J	2,978	W – 37,471
Senior Sunset Times*	Monthly	C/J GH/P	3,119 4,469	W – 16,855 C/J/GH/P Combined
Living Well Magazine* (Resource Guide)	Annually	PSA Request	38,000	1,100
Constant Contact* Newsletter (Trending Healthy)	Monthly	C/J GH/P	800	
Ocean Observer*	Monthly	G	2,944	No online presence
Radio Program	**NA**	**Region**	**# of listeners / quarter hour**	
KANY		GH	95	
KBKW*		GH	95	
KJET		GH P	165 6	
KONP		C	4,542 (per hour)	
KPTZ*		J/CL	20,000 (estimate)	
KSQM*		C	3,244	
KSWW		GH	259	
KXRO		GH	2,354	
Possible Total Reader/Listenership (Reach)			**98,522**	

*Note: Regular articles/radio shows appear in/on these media outlets. Periodic articles/programs and ads are in/on the others. **All figures have been corrected with percentages of population >60 from 2020 Census. Radio audience surveys have not been performed for several years by stations/corporations.

Contact: For more information about this plan, please contact: Laura Cepoi, Executive Director, at 360-379-5064, or 1-866-720-4863; 2200 West Sims Way, Unit 100, Port Townsend, WA 98368; laura.cepoi@dshs.wa.gov. For information about the Olympic Area Agency on Aging; please consult O3A's website at www.o3a.org.

A – 2 MISSION, VISION AND VALUES:

Mission

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

We do this work through the federal Older Americans Act which provides O3A with the authority to deploy six broad operational strategies to advance its mission. These strategies include:

- **Advocacy,** which encompasses O3A's responsibility to represent the needs and concerns of older people in the policy, program, and budget development processes at the local, state, and federal levels, as well as their needs and concerns arising from service delivery
- The dissemination of **consumer information** and the conduct of **public education** activities
- **Procurement of local services** through performance-based contract mechanisms
- **Provision of coordination and technical assistance** to community-based and other stakeholder organizations that affect aging services, policies, and programs throughout the service region
- **Planning and program development,** based on local community assessment and including the application of evidence-based program and service models that improve the quality of life and enhance the delivery of health and human services at the community level
- **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
- 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 87.5% is considered "nondiscretionary" and is designated for specific services like Medicaid Title XIX Case Management and Home Care.

The O3A annual budget also includes about 12.5% in discretionary funds from the Federal Older American Act (OAA) and the Washington State Senior Citizens Services Act (SCSA), and several other small funding sources. "Discretionary" funding is more flexible and can be used to meet O3A identified priority needs within a range of allowable services and criteria in the O3A service region.

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

Resource Allocation Guidelines for Discretionary Funds

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

Funding Guidelines

Funds must be allocated in accordance with the mandates from each funding source.

Services/support must be responsive to the current operating environment. Critical elements to focus on for 2022-2023:

- Identifying the ongoing impacts of the COVID-19 pandemic on older adults and adults with disabilities and implementing suitable responses
- Assuring that older adults and adults with disabilities have simple, no wrong door access to help them with planning and to identify resources they may need as they age
- Strengthening the safety net for vulnerable adults through support for traditional (e.g., professional and family caregivers) and non-traditional stakeholders, (e.g., engaging

businesses, community-based organizations, faith-based organizations, and local coalitions in developing services and supports)

- Prevention services and health promotion programs aimed at reducing the burden of chronic disease and injury in at risk populations and improving unpaid family caregiver resilience
- Ensuring O3A maintains the capacity to respond to emerging local needs through O3A programs, for example, O3A's I&A, Medicaid Alternative Care, Tailored Services for Older Adults (MAC & TSOA) and Health Homes Lead work
- Greater coordination and support for local service delivery at the community, county, and at regional levels (e.g., strengthening partnerships with agencies serving the same population and addressing social determinants of health and leveraging with health providers for opportunities within the current Accountable Communities of Health)
- Engaging consumers in creating solutions, through technology and development of an integrated service model that supports consumer choice and reflects our diverse and rural communities
- Discretionary funding for those services/supports which are a high priority and which cannot reasonably expect to be funded by other entities
- Services will be funded at a level sufficient to make the program viable and responsive to consumer needs. O3A will encourage providers to "leverage" additional funding for services and may assist providers to secure funds from grants and other sources
- O3A will generally avoid allocating funding of services in which the O3A contribution is less than 15% of the total for that particular service, and/or if it appears likely that other funding, or fundraising, could be used to cover the service cost
- In the case of new services and/or initiatives for which other funding sources may be anticipated, O3A funding may be allocated and considered "seed" money, for a time period
- Consideration will be given to the needs, resources, and proportion of the target population in each county in developing funding allocations

Staff Allocation Guidelines

- Staff time must be allocated in accordance with mandates from each funding source and to assure compliance with requirements of each program/ service.
- Staff resources will be for program development, quality initiatives, training, coordination, and advocacy efforts that support the agency mission and statement of values and vision for 2022-2023.
- Staff resources will be allocated first for those activities that are necessary to support and improve the quality of service funded directly by O3A.
- Staff resources will be allocated next for those efforts for which the agency can expect to have a high level of impact and likelihood of success in achieving the agency's mission, vision, and objectives.

- Staff resources will be allocated to take advantage of opportunities that arise during the next two 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 may be needed for the Health Homes program, MAC & TSOA, Case Management, the Long Term Ombudsman Program, and to develop more robust community outreach – these needs will be assessed over time and added incrementally.

Prioritization of Programs & Services

Services planned for 2022-2023 are prioritized according to the following scale, with Level One being highest priority. Please note that the services listed below include both mandated and discretionary services and are not broken out by fund source. Changes in the fund source may lead to reductions or enhancements to the designated service. Enhancements or reductions will be considered based on these priorities and the funding source requirements.

Level One	Level Two	Level Three
Case Management Services	Congregate Meals	Advance Care Planning
COVID-19 Response	Dementia Planning	Evidence Based Programs
Family Caregivers Support	Information & Assistance	Health Care Access Issues
Housing Issues	Falls Prevention	Suicide Prevention
Home Delivered Meals	Health Homes Services	
In-Home Personal Care	Home Repair & Maintenance	
Nursing Services	Kinship Caregiver Support	
Social Isolation	LTC Ombudsman	
Transportation	Senior Legal Services	
	Statewide Health Insurance Benefits Advisors (SHIBA)	

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

The chart below summarizes O3A's planned allocations of Discretionary funds:

Service Category	Based on 2020/21 Allocations*
LEGAL ASSISTANCE	**$ 77,117**
ACCESS SERVICES	**$952,606**
Transportation	72,001
Information & Assistance	880,605
IN-HOME SERVICES	**$17,000**
Minor Home Repair & Maintenance (OAA)	7,000
Senior Emergency Fund (SCSA)	10,000
NUTRITION SERVICES	**$609,000**
Congregate Meals	225,000
Home Delivered Meals	290,000
Senior Farmers Market Nutrition Program	62,000
NSIP Funds	$32,000
SOCIAL & HEALTH SERVICES	**$980,455**
Medication Management for Older Adults	12,612
Disease Prevention/Health Promotion	33,557
Family Caregiver Support Program	**$791,911**
Information Services	3,200
Access Assistance	349,314
Support Services	6,000
Respite Care Services	367,000
Supplemental Service	13,500
Services to Grandparents/Relatives	52,897
Kinship Caregiver Support Program	41,296
Long Term Care Ombudsman	134,636
OTHER ACTIVITIES	**$301,864**
Outreach	900
Coordination	156,000
Covid Other Emergency Response / Vaccine	144,964
TOTAL	**$2,938,042**
**American Rescue Plan Act	$1,500,000

Should additional funds become available, O3A plans to invest in additional nutrition services, outreach to remote communities, social isolation, services to tribes & housing resources.

This chart represents some but not all service areas and funding streams. Fund sources have limits but allow for discretion on how they are allocated. The chart excludes grants and contracts with required use of the funds. **The newest COVID Relief funds from the America Rescue Plan Act will be allocated based on need over the next three years. *Funding Sources include:

Older Americans Act	Senior Drug Education Program	Expanded Nutrition (SB5736)
Senior Citizens Service Act	Nutrition Services Incentive	ADRC Vaccine Outreach & Asst.
State Family Care Giver Support	Program (NSIP)	CARES Act
Kinship Caregiver Support Program	Senior Farmer's Market (SFMNP)	Consolidated Appropriations Act

SECTION B - PLANNING AND SERVICE AREA PROFILE

B – 1 POPULATION PROFILE:

O3A's service area is home to approximately **205,264** people widely dispersed over the rugged mountainous terrain of the Olympic Peninsula. Of these, close to **38.7% or 79,374** are 60 years old and over. The entire service region is considered to be rural, and in some regions "Frontier and Remote"[3] with an average of 30 people per square mile[4]. This is significant in relationship to access to health and social services, food resources, socialization opportunities, etc. To travel from one end of the region to the other, one must circle impenetrable mountains often using one accessible highway between regions.

The Olympic Peninsula has become a significant retirement destination, owing to a beautiful, unspoiled, 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 dropped during the COVID-19 pandemic. However, thanks to improvements in education, medicine, nutrition and general living standards, many individuals who reach the age of 60 today can expect to live 20 more years.

As life expectancy has lengthened, the number of "older old" and "oldest old" adults increases. For this reason, programs and policies directed to the 60 and over population must consider the needs of up to three generations of older adults.

In addition to generational differences, the older population is extremely diverse in health, social status, and economic status. While most of the older adults between the ages of 60 to 74 are active, healthy, and independent, those who are 85 years and older are more likely to face problems of ill health, loss of independence, and difficulty accessing services, further straining an already overburdened rural health and long-term care system.

Retirees with the means to do so tend to relocate closer to children, grandchildren, or services once they become frail. Those who cannot relocate close to children/grandchildren or do not have families may be faced with aging without natural supports, and with fewer economic supports.

For elders in the region, as well as for people with disabilities, residence in a rural setting such as the Olympic Peninsula can contribute to social isolation and an increased risk to well-being. Social Isolation has increased further because of the pandemic with most older adults taking extra care to isolate themselves from others. 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

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

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

COVID-19 Impact: The COVID-19 pandemic has created an increased shortage of caregivers as workers left the workforce to take care of children at home; some older workers left their positions because they were part of the high risk category.

The pandemic also had an impact on volunteerism throughout the service region as the majority of volunteers have been older adults who went into isolation at the onset of the pandemic. Many of those volunteers have now returned to their previous role, but volunteerism lags behind pre-pandemic levels. Volunteers deliver meals to the homebound, provide transportation services and support many other services and programs addressing senior needs. In addition, just the act of volunteering in this manner can reduce social isolation.

Surveys

From April through July 2021, the Advisory Council and O3A staff provided outreach to distribute online surveys for older adults and adults with disabilities and their caregivers, and a second survey for Key Informants to learn what has changed for community members and service providers during the pandemic. Many of the answers and challenges facing seniors are similar to the survey results conducted in 2019. Common themes are listed below:

2019 – had 434 Respondents	2021 – had 262 Respondents
50% Live with a spouse or partner	45% Live with a spouse or partner ↓
40% of respondents live alone	45% of respondents live alone ↑
40% have problems with housing	50% have problems with housing ↑
25% were having problems with upkeep and maintenance	37% are having problems with upkeep and maintenance ↑
16% were having challenges keeping up with the cost of housing (rent, mortgage, utilities. taxes)	18% are having challenges keeping up with the cost of housing (rent, mortgage, utilities, taxes) ↑
8% said their home needs modifications to improve safety like a ramp or accessible bath	18% say their home needs modifications to improve safety like a ramp or accessible bath ↑
New question not asked in 2019	2% are living in a mobile home

24% are serving as a caregiver for a family member or friend	34% are serving as a caregiver for a family member or friend. ↑
People responded that they had occasionally skipped paying for:	People responded that they had occasionally skipped paying for:
Housing 1%	Housing 3% ↑
Transportation 5%	Transportation 7% ↑
Insurance 10%	Insurance 7% ↓
Utilities 9%	Utilities 7% ↓
Food 13%	Food 7% ↓
Medicine 9%	Medicine 7% ↓
Dental Care 29%	Dental Care 28% ↓
Vision or Glasses 29%	Vision or Glasses 26% ↓
Pets (care or food) 7%	Pets (care or food) 7% =
Internet 10%	Internet 11% ↑
Cell Phone 9%	Cell Phone 5% ↓
No financial stress 57%	No financial stress 52% ↓

In this survey, we also asked a series of COVID-19 questions:

- 93.75% have gotten or plan to get the COVID-19 vaccine
- 3.5% or 9 people had been infected with the virus
- 38 respondents lost weight during the pandemic, 89 people gained weight, and 131 stayed the same
- Most people stayed at home or limited the time they were in public – 92.67%
- 90 people said they have been intermittently or very depressed, anxious, or sad because of the social isolation; 169 said that they have been only slightly or have not experienced depression, anxiety, or sadness.
- Some people reported needing help with cooking meals, transportation services, and accessing dental and health care services.

The majority indicated that they either did not need help or had access to help. But many respondents wrote comments which described a different story. People related heartbreaking stories of struggling with care giving, having a parent move in due to the pandemic and adjusting to that, struggling with paying for and remaining in their home and anxieties about the pandemic, being alone and lonely.

Probably most telling are these two word clouds for the 2019 survey and the 2021 survey, which clearly identifies social isolation as a major issue:

2019

2021

Key Informant Survey: A second survey was conducted in April through July 2021 of Key Informants, people who work with seniors and adults with disabilities. While a very small number responded, they highlighted many similar issues with some unique responses. People with dementia deteriorated during the pandemic. The lack of interactions with others really heightened confusion and distress. Housing was highlighted as an issue impacting older clients, caring for their own housing, or encountering difficulty in locating adequate housing.

Key Informant Survey

Demographic Summary

Demographic	Total	
Total Population	**205,264**[5]	**% of Total over 60**
60+	**79,374**	**38.7%*↑**
60+ and a minority	**5,968**	**7.5% ↓**
60+ at or Below Poverty Level	**5,854**	**7.8%↓**
60+ and a minority at or Below Poverty	**1,094**	**1.4% ↓**
60+ at or below the Elder Economic Security Index	**15,790**	**20.2%↑**
60+ Living in Rural Areas[6]	**30,876**[7] *(estimated)*	**40% =**
Adults w/ Disabilities (age 18+)	**22,073**	**10.3%*↑**
60+ w/ Disabilities	**16,403**	**21%↑**
60+ Limited English Proficiency	**2,604**	**3.3%↓**
Tribal Elders (55+)	**2,085**	**2.6% ↑**
Individuals with Cognitive Impairment	**12,879**	**6%*↑**
65+ w Alzheimer's Dementia, Cognitive	**5,815**	**7.4%↑**
60+ at Risk of Institutional Placement[8]	**10,254**	**13%↑**
Number of Tribes	**8**	
Tribal Nations (with Title VI (OAA) Programs†): †Chehalis Confederated Tribes, Hoh Tribe, †Jamestown S'Klallam Tribe, †Lower Elwha Klallam Tribe, †Makah Tribe, †Quileute Nation, †Quinault Nation, and †Shoalwater Bay Tribe.		
*Percentage of total population. ↑↓ arrows indicate higher or lower than the state percentage Unless otherwise footnoted, totals are derived from David Mancuso, PhD., WA St Office of Financial Management = means the value is unchanged or current information is not available		

[5] David Mancuso, PhD., Jingping Xing, PhD., Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2030 in Washington State; Office of Financial Management, WA State, 2021

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

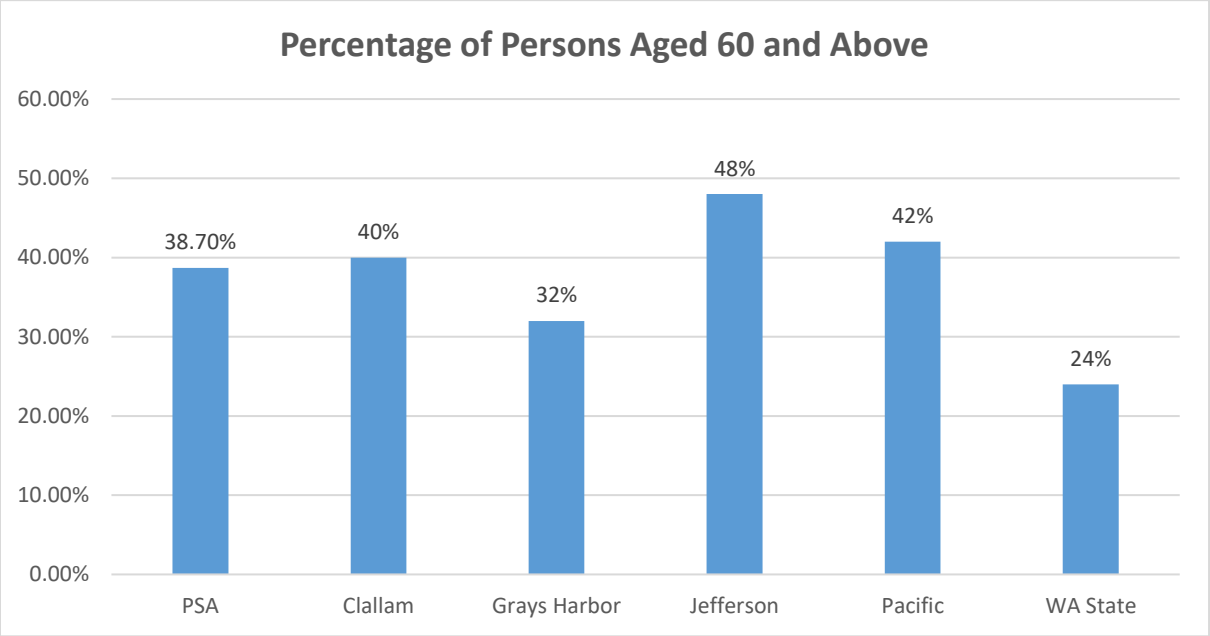
[7] https://www2.census.gov/geo/docs/reference/ua/County_Rural_Lookup.xlsx estimated using 60+ percentage of total population data.

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

Number of Persons Aged 60 or Above

Throughout the O3A service region, 38.7% of the population is 60 or older, compared to Washington State as a whole, with 24%. All counties exceed the state averages. Most percentages have increased since the 2020-2023 Area Plan was written two years ago, and this trend is expected to continue for the next decade.

The 60+ age group already represents over a third of the population in three of the four O3A service counties and very close to a third in the fourth county. As adults continue to age in place and arrive on retirement to the Peninsula, growth in the number of 60+ residents will continue to outpace the rest of the state and nation.



Elders Living Alone

In a recent O3A survey of the region, 44.6% of respondents reported living alone; 44.6% reported living with a spouse or partner, and 9.3% reported living with a friend or relative.[9] This percentage is borne out by Senior Report in the American Health Rankings.

In the United States 28% of older adults live alone; 21% of older men and 34% of older women.[10] These percentages increase with age, especially for women; 44% of women over the age of 75 live alone. Men tend die before their wives and if widowed or divorced are more likely to remarry (69% of older men are married compared to 47% of older women. Older adults who live alone are more likely to be poor, experience loneliness and social isolation. They are more likely to miss cues on deteriorating health changes and because eating is a social experience, often do not prepare healthy meals for themselves resulting in poor nutrition.

[9] O3A Area Plan Survey, Conducted April – July 2021, N=262

[10] https://www.merckmanuals.com/professional/geriatrics/social-issues-in-older-adults/older-adults-living-alone

A single elder living alone is also at risk of being priced out of housing while on a fixed income as prices continue to rise. The Elder Index,[11] which measures how much income a retired older adult requires to meet his or her basic needs—without public or private assistance, documents that within our 4 counties single elder renters must have an income of between $26,544 and $28,101, a base 20% increase in just 2 years. For homeowners with a mortgage, earnings must be between $33,084 and $36,132 and for owners with no mortgage, between $23,868 and $24,648; for both categories, costs have increased by 13%. The Elder Index measures basic expenses for elders, age 65+ living in the community, not in institutions.

Unfortunately, seniors, especially women have become the fastest growing population entering homelessness. Increased poverty among older adults, the loss of a spouse and income, increasing rent, lack of affordable housing options are all contributing to this emerging and pressing problem.

Minority Populations

Within the O3A service region, 88.8% of the total population is Caucasian. Persons identifying themselves as Hispanic or Latino amounted to 7.7% of the population, the largest minority in the region recorded by updated 2018 Census data.[12] American Indian/Alaskan Natives comprise the second largest 'minority' community at 4.1% of total population.

According to the Williams Institute at UCLA, approximately 5.2% of Washingtonians identify as gay, lesbian, bisexual, transgender, or queer (LGBTQ). If the same percentage holds true locally, 3,107 seniors in our region identify as LGBTQ. (1,225 - Clallam, 871 in Grays Harbor, 636 in Jefferson, and 376 in Pacific County)[13]

Washington State is one of ten U.S. States with the highest number of LGBTQ identifying adults.

O3A PSA: White, Native American and Hispanic Populations

County	Caucasian	American Indian/Alaskan Native	Hispanic or Latino
Clallam	87.1%	5.6%	6.6%
Grays Harbor	87.1%	5.6%	10.3%
Jefferson	91.1%	2.2%	3.8%
Pacific	90.0%	2.8%	10.1%
PSA Average	**88.8%**	**4.1%**	**7.7%**
Some people identify as from two or more races so numbers can add up to more than 100%			

Adults with Disabilities

The percent of adults age 18 and above with disabilities (10.3%) exceeds the state percentage of 7%. In 2020 only 17.9% of adults with disabilities over the age of 18 are employed in our

[11] http://www.elderindex.org

[12] Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2010 to July 1, 2019 (CC-EST2019-ALLDATA) for Washington State; https://www.census.gov/data/tables/time-series/demo/popest/2010s-counties-detail.html

[13] https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=53#density

country.[14] Adults with disabilities experience higher rates of poverty, obesity, diabetes, and heart disease. Adults with disabilities who are receiving long-term care services will spend significantly more time requiring services than an older adult. For example, with advances in health care supports, an adult who has a motorcycle accident at 28 and becomes a quadriplegic, can expect a long life, and will require a variety of supports and case management for the rest of their life.

Seniors with Disabilities

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

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

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

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

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

Service provision in the region is constrained by a limited number of qualified providers; consequently, O3A provides many services directly. Other services are provided by a network of community- based organizations located throughout the service region, which contract with O3A to provide services. In addition, O3A provides case management to approximately **2,200 clients each year,** (carrying an average caseload of 1,770), **and this volume is steadily**

[14] https://www.bls.gov/news.release/pdf/disabl.pdf

increasing. The following table indicates current services being provided and the geographic location of each. Service descriptions follow.

O3A Direct and Contracted Services	Clallam	Grays Harbor	Jefferson	Pacific
Adult Day Care Services	X	X		
Case Management ❖ COPES / Medicaid Personal Care	X	X	X	X
Elder Abuse Prevention - Long-Term Care Ombudsmen	X	X	X	X
Family Caregiver Support Program - Unpaid caregiver support services ❖ Kinship Caregiver Support/Relatives as Parents ❖ Caregiver training ❖ Respite Services, Assessment & Coordination ❖ Respite Care	X X X X X	X X X X X	X X X X X	X X X X X
Home Care Referral Registry (to be replaced by CDE by April 2022)	X	X	X	X
Information & Referral Services	X	X	X	X
Legal Services - Senior Legal Advice Clinics	X	X	X	X
Minor Home Repairs	X	X	X	X
Nursing Services ❖ Core Nursing Services ❖ Health Home Services	X	X	X	X
Nutrition ❖ Congregate Nutrition ❖ Home Delivered Meals ❖ Senior Farmers' Market	X X X	X X X	X X X	X X X
Transportation	X	X	X	X
Senior Drug Education Program	X	X	X	X
Statewide Health Insurance Benefits Advisors (SHIBA)	X	X	X	X

O3A Direct and Contracted Services: O3A currently has 88 contracts in place for various services and supports. *(Direct means that the services are provided by O3A staff or volunteers.)*

Adult Day Services (Contracted)

Adult Day Services are provided to adults with medical or disabling conditions to prevent or delay the need for institutional care. Case management authorized participants attend contracted 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 of the following programs: *Olympic Community Action Programs Encore* and *Brighter Days* are the *Adult Day Care Service* programs available to participants in the O3A service region. *Encore* is located in Clallam County, and *Brighter Days* has sites in Mason and Thurston counties. Both programs provide 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. While the *Brighter Days* sites are not located in the O3A service area, they are close enough for participants in east Grays Harbor and southeast Jefferson counties to attend. O3A has also been coordinating with Jefferson Healthcare Medical Center about a possible Adult Day site in Jefferson County. While still in the planning stages, O3A is fully supportive of this option.

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

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

Caregiver support focuses on both the individual caregiver and the system that supports the caregiver. It includes in-home and out-of-home respite care services for family and other unpaid caregivers who provide the daily services required when caring for adults with functional disabilities. Unpaid Family Caregivers can receive help with information, training, respite care, translation/ interpretation, counseling, massage, specialized transportation, and other supports. Services are also provided to grandparents and tribal elders (age 55+) caring for relatives and for caregivers of persons age 18 and over. Paid caregivers, known as *Individual Providers*, receive support with training and continuing education, as well as placement with the Homecare Referral Registry. In 2022, some management functions for *Individual Providers* will be assumed by *Consumer Direct Care Network Washington.*

Case Management (Direct)

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

Case managers have regular follow-up contact with clients and service providers to ensure that clients obtain and can effectively use necessary supports, crisis intervention, and follow-up after termination from services. Screening and referral for case management services are provided through the O3A Information & Assistance program, and DSHS Home & Community Services.

COVID-19 Impacts: Case Management services were immediately retooled to be delivered remotely to the majority of O3A's clients. The majority of these services were delivered telephonically. O34A is assessing how to accomplish face to face services in a safe way and what markers would trigger a need to return to remote services. Clients have been remarkably responsive to this new mode of delivering services but both case managers and clients miss the interactions, and many key indicators of a person's needs and environment can only be assessed in person. In addition, we know that O3A clients are experiencing high levels of social isolation imposed on them by this pandemic.

Community First Choice (CFC)/Community Options Program Entry System (COPES)/Medicaid Personal Care (MPC)(Contracted)

Community First Choice (CFC)/ Community Options Program Entry System (COPES)/Medicaid Personal Care are all Medicaid services and are provided to low income, disabled Medicaid clients who often live alone. Services can also be provided to multiple qualifying family members in the same home, to an aging frail couple, for example. These services include:

- In-home assistance with activities of daily living provided by a trained homecare aide
- Behavior Support Services are provided by licensed professionals to support individuals transitioning with mild anxiety or depression,
- Client training by a skilled professional, such as a pharmacist, registered nurse, or dietician
- Community Choice Guiding to assist clients in transitioning out of a facility to sustainable housing in the community
- Community Transition or Sustainability Services to facilitate goods or services necessary for a client to transition out of a facility or maintain housing in the community
- Environmental modifications by licensed, bonded construction companies that build or install minor physical adaptations and devices in the home of clients
- Home-delivered meals for housebound clients who lack the ability to prepare meals and do not have help
- PERS (Personal Emergency Response Systems), which include the installation of devices and in-home monitoring and response to personal emergency requests for help
- Professional Supports are all geared towards providing services to help a person remain in the community setting and include three types of services:
    - Behavior Consultation and Technical Assistance which includes services addressing a range of behavioral health problems including a comprehensive plan to address challenging behaviors. Technical assistance can include training and support for family, and staff

- Communication Therapy addressing speech, language and audiology support – at this time O3A does not presently have a communication contract
- Dietician/Nutritionist includes nutritional assessments, nutrition education, nutritional consultation, and medical nutrition therapy.

- Skilled in-home nursing services to meet needs that are beyond the capacity of non-licensed staff
- The Department of Social and Health Services has contracts for Durable Medical Equipment and Specialized Equipment & Supplies which allow the client to function better in the home and community (such as wheel-chairs, special shoes, flashing light doorbells, and aids to assist with standing, specialized communication devices, etc.).

Elder Abuse Prevention (Direct)

The Long Term Care Ombudsman Program (LTCOP) is designed to ensure the rights, dignity and wellbeing of residents living in nursing homes, congregate care facilities, assisted living facilities and adult family homes. With the assistance of trained and certified volunteers, the Regional Ombudsman investigates and advocates to resolve complaints made by or on behalf of residents and identifies facility issues and/or potential issues that affect facility residents and their rights. The Regional LTCOP also monitors and promotes changes in relevant federal, state, and local legislation as well as participates in Senior Lobby Day at the Capital.

COVID-19 Impacts: When the COVID-19 pandemic began, it severely restricted Long Term Care Facilities and the onsite work of the LTCOP program. The Regional LTCOP Advocate and the volunteers immediately shifted to a telephonic/electronic model, using email/zoom and snail mail to communicate and advocate with residents and their loved ones. The LTCOP volunteers are continuing to advocate for the residents within their means, but the barriers created when long term care facilities shut down continues to create challenges in advocacy. In addition, the onset of the pandemic coincided with the planned retirements of several ombudsman volunteers creating an enormous gap in advocacy availability in all 4 counties.

Evidence Based Programs (Contracted)

Evidence Based Programs (EBP) offer proven ways to promote health and prevent disease among older adults. They are based on research and provide documented health benefits and should be delivered with fidelity to the model to be effective. The percentage of older individuals in the population has increased with each decade, and the proportion of persons 75 years and older has grown even faster. As a result, chronic diseases and falls have increased and are now the leading cause of death and disability among older Americans. Fortunately, both chronic diseases and falls are highly preventable. Older adults who participate in EBPs can lower their risk of chronic diseases, improve their health if they have one or more diseases, lower their risk of falls, or minimize the impact of a fall.

Some evidence based programs are designed to support caregivers in their difficult, demanding work. Most programs are offered as multisession workshops and help caregivers to manage their stress and improve their own quality of life while caring for a loved one. O3A attempts to

recruit providers in all parts of the PSA to deliver all National Council on Aging (NCOA) approved EBPs, online and in-person.

COVID-19 Impacts: All programs offered by O3A were immediately discontinued as a result of the pandemic. It took time for the Administration on Community Living and the NCOA to develop guidelines for virtual delivery of a few EBP. Grand round meetings were held nationwide by the NCOA as they worked with EB Program Administrators to develop the guidelines to deliver programs virtually, while maintaining program fidelity and assuring safety for older adults to participate from their own home. The rollout of virtual EBPs was very slow, and only a few qualified to be offered virtually, while maintaining the fidelity of the program. The O3A Contract Specialist responsible for these programs promptly developed a Remote Evidence Based Program Request for Proposals RFP (which has been shared statewide and nationally), and thus far has 2 contractors who are conducting programs. O3A's goal is to continue to expand this work throughout the region. O3A is also researching how to create safe in-person Evidence Based programs should pandemic infection rates and variants allow for this. Because of the very rural communities in our region, if the NCOA allows for the delivery of virtual EBPs, O3A will endeavor to RFP for both virtual and in-person (when in-person can resume safely).

Information and Assistance (Direct)

Information and Assistance (I&A) connects older adults and their families with the services and information they need. Information is provided over the telephone and in-person, by trained and certified specialists who maintain a current comprehensive data base of local, state, and federal resources for older adults and their families. Assistance in contacting and accessing services is also provided for clients who are unable to do so themselves. AIR-S certified and trained in Person Centers Counseling and Trauma Informed Care, O3A I&A specialists screen clients to determine their need for more extensive services, which are provided by the case management or caregiver support staff. Staff also provide outreach with information, outreach and education via newspaper and radio media, conduct fairs and seminars, e.g., legal will clinics, Medicare Part D presentations, and other activities designed to reach out to older persons who need services and link them with the most appropriate resources.

COVID-19 Impacts: In Mid-March 2020, all offices closed, and I&A staff no longer met with clients in person though were able to continue to offer the same level of response to callers. I&A staff assisted with well check calls to clients, and to help with many other activities involved in transitioning the agency to a remote workforce. They assisted case managers working remotely and were key in providing COVID Vaccination resources to all clients who needed help with access.

Legal Services (Contracted), also known as Senior Legal Advice Clinics

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

groups and bar associations through lectures, group discussions, and the media. There are also legal services specific to the unique needs of tribal elders.

COVID-19 Impacts: When the pandemic began, this program transitioned to a remote service, managed mostly by telephone with in-person, masked and distanced meetings only for signing documents. As Washington State reopens, this program will continue in a mixed model based on client and attorney preferences.

Minor Home Repair and Maintenance (Contracted)

This service provides limited repair or modification of eligible, client-occupied structures that are essential for health and safety of the client, on a first-come, first-served basis. Projects most frequently include installing ramps and grab bars.

COVID-19 Impacts: Many clients declined to receive these services due to fears about an outsider coming into their home. This has resulted in some clients living with suboptimal housing features (lacking grab bars, ramps, etc.). It has also resulted in decreased frequency of services provided by contractors which may translate into difficulty securing services for this pent up need when clients feel safe to receive them.

Nursing Services (Direct)

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

Medication Management (Contracted)

Medication management training is provided by a pharmacist who may review a client's medication list, educate the client about their medications and when to take or not take certain medications and under what circumstances (with food, with extra liquids, not to take certain medications at the same time), review supplements and talk about interactions with other medications, etc.

Nutrition Services (Contracted)

The *Congregate Nutrition* program helps meet dietary needs of older people by providing nutritionally sound meals in a group setting, along with nutrition education. Socialization opportunities are a benefit of this program. Two contracted agencies manage nutrition sites located throughout the service region, with settings in senior and community centers, churches and assisted living facilities. One Diner's Choice voucher model is in place where clients sign up and can eat a meal in a restaurant using a voucher system and the restaurant is reimbursed by the contractor.

COVID-19 Impacts: During the pandemic congregate meals immediately transitioned to a drive by / pick up meal model. The contractors will reopen congregate meal sites once direction is provided by state and public health guidance.

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

- Meals are provided 4 days per week in Chimacum and Port Angeles due to program and fiscal and facility availability constraints.

Home Delivered Meals, often referred to as "Meals on Wheels", provides meals to older people who are homebound and unable to prepare meals for themselves. Adults with disabilities age 18 and older enrolled in Medicaid long-term care service may also receive meals delivered at home. Clients may receive hot or frozen meals delivered to their homes, as well as frozen meals for weekends and days that are not scheduled for meal delivery. This program also includes a socialization and gatekeeper component where the delivery staff or volunteer checks on the client and makes referrals for additional services if the need becomes apparent. Often, Home Delivered Meals are the first supportive services offered to an aging individual, so this gatekeeper function serves a critical function in identifying growing unmet needs.

COVID-19 Impacts: COVID has resulted in some changes to this program as the drivers delivering the meals maintain distance from the client and drop the meals at the door. For some frail clients who need assistance, drivers will provide that with masks and gloves, still trying to maintain a safe distance from the client. Both contractors also lost some older volunteer drivers during the pandemic. Volunteers are slowly returning.

Many pandemic flexibilities were granted so contractors were able to offer additional numbers of home delivered meals per day to any senior trying to isolate at home. Some healthy seniors took advantage of this option, but most have discontinued the additional meals or have returned to shopping and cooking for themselves.

The Senior Farmers Market Nutrition Program provides fresh, locally grown fruits and vegetables to eligible low income seniors in Jefferson, Clallam, Grays Harbor and Pacific Counties to improve nutrition; also provides nutrition education. Fresh produce is available through a voucher exchange at local farmers markets in Clallam and Jefferson Counties, as well as through bulk purchase and distribution in areas with no participating farmers markets in Grays Harbor and Pacific Counties. Clients may also receive this fresh produce delivered to their homes along with home delivered meals or during congregate meals. This program is limited in scope and is offered on a first come first serve basis to qualified older adults.

COVID-19 Impact: The contractors were unable to make as much outreach as in a normal season and delivered produce or vouchers to fewer people. During the 2021 season, one contractor has noted that many seniors are already receiving fresh produce from other types of

donations (Northwest Harvest, local farmers, food banks), and there was a decrease in the numbers who have signed up for the Farmers Market programs.

Respite Services (Contracted)

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

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

COVID-19 Impact: There has been a significant drop in requests for respite services. This in combination with a shortage of paid care providers, has made staffing respite requests difficult.

Senior Drug Education Program (Direct & Contracted)

Senior Drug Education (RCW 74.09.660) provides adults age 60 and over education and information on safe and effective use of medication (prescription drugs, vitamins, and herbs) through articles on prescription herbal supplement safety; medication and falls prevention; safe prescription disposal; pain management, opiate use and addiction issues affecting seniors; and other topics. Articles are written by pharmacists or other professionals and are included in the annual Senior Resource Guide and in the monthly online O3A Trending Healthy newsletter.

Statewide Health Insurance Benefits Advisors (SHIBA) (Direct)

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

COVID-19 Impacts: During the pandemic limited face to face meetings were scheduled. Plexiglass screens were installed in all meeting offices to be able to meet safely with masks. Some volunteers retired during the pandemic and have not returned to support this function.

Volunteer Transportation (Contracted)

Contracted volunteer transportation services are designed to transport older persons who do not drive, and who cannot access or utilize public transportation, to and from medical, health care and social services, meal programs, senior centers, shopping, and recreational activities. This is an area where additional resources beyond volunteer transportation programs are

needed. While the volunteer program is an excellent option, it is often under-resourced, and generally available only with advance planning; last minute transportation requests are more difficult to accommodate.

COVID-19 Impacts: During the pandemic volunteers (mostly older) retired from the program, although many have now returned. Contractors received additional funds to support errands for clients, with the client not in the vehicle. Contractors were also able to assist with home delivered meals although this proved unnecessary. Initially, client requests for transportation dropped dramatically and has slowly been resuming previous usage rates. O3A also contracted with taxi services in 3 counties to assist with transportation for vaccine purposes.

Volunteer Opportunities

O3A offers many safe volunteer opportunities through our own services or by referring people to our partners; one opportunity can even be done from home on a weekly basis. Volunteering not only expands the services available to older adults, it also expands knowledge of O3A resources available to older adults. Volunteer research has demonstrated that volunteering increases your confidence, decreases depression, helps you stay physically healthy, kindles happiness, advances your career, provides valuable career experience and job skills. Volunteer opportunities include:

- Becoming an Alzheimer's / Dementia Trainer or Support Group leader with the Alzheimer's Association
- Home Delivered Meals Drivers with an O3A contractor
- Long Term Care Ombudsman (O3A)
- Statewide Health Insurance Benefits Advisors (SHIBA) (O3A)
- Social Call Volunteers – making a call once a week to an elder to talk about anything and everything
- Volunteer Transportation – with an O3A contractor taking elders to medical appointments and grocery shopping
- Other opportunities occasionally become available, including Advisory Council representation, Special Projects, Advocacy, etc.

Olympic Area Agency on Aging Coordination Services

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

Partnerships

Partnerships and collaboration are the processes by which all work not directly delivered or funded by O3A is accomplished, and even some of that work requires strong partnership to ensure excellent service delivery. For example, O3A collaborates with a variety of resources (Public Utilities, St. Vincent de Paul, Community Action, other social service nonprofit agencies, faith communities, etc.,) to help a client with outstanding utility bills.

Partnerships can be loosely developed, as simply a referral network that works to arrange needed services or resources. It can also become a formalized, more closely defined process, with outlined responsibilities and deliverables. The primary types of partnerships in this region are the former, where in the rural environment, the benefits of knowing one another well and working together over years of partnering come successfully to the forefront.

The more formal method is used as needed if O3A or the partnering agency encounter problems, or the partnering agency is required to have such agreements in place. Below is a chart listing just a few of the partners/collaborators O3A has worked with or would consider developing partnerships with as needs arise. (For example, O3A does not partner with all faith communities, but might develop a plan for a particular client need.)

PARTNERSHIPS				
Services Provided	**Clallam**	**Grays Harbor**	**Jefferson**	**Pacific**
X = Provided in County - = Not Provided in County				
Accountable Communities of Health	X	X	X	X
Adult Day Care	X	X*	X*	-
Alzheimer's / Dementia Services & Facilities	X	X	X	X
Case Management Programs	X	-	X	X
City & County Paramedic Services	X	X	X	X
Community Action Programs	X	X	X	X
Councils on Aging or other significant senior organizations	X	X	X	X
County Emergency Management	X	X	X	X
Dental Health Programs & Services	X	X	X	X
Department of Social and Health Services (DSHS)	X	X	X	X
• Adult Protective Services (APS) (aka Elder Abuse)	X	X	X	X
• Community Services Offices (CSO)	X	X	X	X
• Developmental Disabilities Offices (DD)	X	X	X	X
• Special Nutrition Assistance Program	X	X	X	X
• Home & Community Services (HCS)	X	X	X	X
• Information & Referral	X	X	X	X
Disability Access Programs	-	X	X	-
Disaster Planning				
○ County Emergency Management Departments	X	X	X	X
○ County & City Fire Districts & Paramedic Programs	X	X	X	X
○ County and City Public Safety	X	X	X	X
○ Home Care Agencies & Individual Providers				
Health & Medical Care				
• County Health Departments	X	X	X	X
• Home Health Agencies	X	X	X	X
• Home Care Agencies	X	X	X	X
• Hospice Services	X	X	X	X
• Hospitals	X	X	X	X
• Community Health Clinics	X	X	X	X
Housing				
• Public Housing Authority	X	X	X	X
• Boarding Homes & Assisted Living Facilities	X	X	X	X
• Adult Family Homes	X	X	-	X
• Nursing Homes	X	X	X	X
• Home Repair, Energy Assistance, Weatherization Services	X	X	X	X
• Housing for the Homeless Services	X	X	X	-
• Housing Coalitions	X	X	TBD	TBD

Services Provided	Clallam	Grays Harbor	Jefferson	Pacific
Information & Referral Services (private/nonprofit, e.g., 211)	X	X	X	X
Legal Services	X	X	X	X
Local Coalitions (Transportation, Affordable Housing/Homelessness Task Forces, Accountable Communities of Health, etc.,)	X	X	X	-
Behavioral Health Services				
• Behavioral Health Centers & Providers	X	X	X	X
• Substance Use Disorder Treatment Programs	X	X	X	X
Native Elder & Minority Services				
○ OAA Title VI American Elder Nutrition & Cultural Programs	X	X	-	X
○ Tribal Health Clinics	X	X	-	X
○ Other	X	X	-	X
Nutrition				
○ Food Banks (public)	X	X	X	X
○ Women-Infant-Children (WIC) Offices	X	X	X	X
○ Commodity Supplemental Food Program	X	X		
Peer Counseling	-	-	-	-
Primary Care Physicians	X	X	X	X
Retired Senior Volunteer Program, other volunteer programs	X	X	X	X
Senior Centers	X	X	X	X
Senior Provider Networks	X	X	X	X
Senior Fitness and Social / Cultural Programs	X	X	X	X
Social Security Offices	X	X	-	-
Spiritual / Faith-Based Organizations (churches, synagogues)	X	X	X	X
Transportation (includes public transit and Para Transit)	X	X	X	X
Utility Providers	X	X	X	X

*Adult Day Care Services located in Mason and Thurston Counties are available to east Grays Harbor and southeast Jefferson clients

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

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

Olympic Area Agency on Aging Focal Points				
County	**Office**	**Focal Point Address**	**Public Phone Number & E-Mail* Address**	**Services Coordinated at this Site (Optional)**
Clallam	Sequim Information & Assistance (I&A)	609 W. Washington Suite #16 Sequim, WA 98382	360.452.3221 800.801.0070	All I&A Offices provide: LTCOP I&A Case Management HCRR FCSP KCSP SHIBA MAC/TSOA Health Homes
Clallam	Forks I&A	481 5th Ave. P.O. Box 1644 Forks, WA 98331	360.374.9496 800.801.6559	
Grays Harbor	Aberdeen I&A	2700 Simpson Ave. Suite 205 Aberdeen, WA 98520	360-532.0520 800.801.0060	
Jefferson	Port Townsend I&A	2500 W. Sims Way Suite 203 Port Townsend, WA 98368	360.385.2552 800.801.0050	
Pacific	Raymond I&A	430 3rd St. Raymond, WA 98577	360.942.2177 888.571.6557	
Pacific	Long Beach I&A	1715-A Pacific Ave. N., Long Beach, WA 98631	360.642.3634 888.571.6558	
Jefferson	Administration Office	2200 W Sims Way, Unit 100 Port Townsend, WA 98368	360.379.5064 866-720-4863 *jody.moss@dshs.wa.gov	Administrative, HR, Fiscal, Planning, Contracts Management

SECTION C - ISSUE AREAS, GOALS, AND OBJECTIVES

C – 1 HEALTHY AGING

O3A Healthy Aging Programs and Services

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

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

Employment and Economic Security

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

As the population ages, older Americans play an increasingly important role in our economy and America's leadership in the world marketplace. In 2020, 24.3% of Americans work force was aged 55+ and by 2024, 25% of the U.S. labor force will be an elder population.[15]

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

Although the rate of unemployment among mature workers is lower than younger population, older workers who do become unemployed spend more time searching for work. In 2014, 8.9% of the unemployed population were older workers. Nearly half a million older adults aged 55-64 and 168,000 aged 65+ who wanted to work in 2014 were unemployed 27 weeks or longer.[16]

Senior Community Services Employment Program (SCSEP)

This program, formerly a program of O3A, is now managed by the AARP Foundation, which works to match unemployed seniors 55 and older with nonprofits and public organizations so they can gain job skills. In order to assure that this resource remains viable in our region, O3A asks local agencies hosting SCSEP employees to continue to encourage the AARP Foundation to actively support this senior employment program in rural areas.

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

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

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

Food insecurity in older adults can result in:

- Poor intakes of protein, carbohydrate, niacin, riboflavin, vitamins B6 and B12, magnesium, iron and zinc
- Poor overall health status and compromised ability to resist infections
- Deteriorating mental and physical health
- Greater incidence of hospitalizations and extended hospital stays and
- Increasing care-giving demands and health care expenditures.

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

Senior Nutrition program---Congregate and Home Delivered Meals

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

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

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

COVID-19 Impact: Congregate meal sites closed their doors across the region around March 16th, 2019 and began distributing meals through a drive by pick up method. Home delivered meals were delivered with care – i.e., dropped at doorstep for client to pick up to allow for social distancing. If assistance is needed, driver will wear a mask, gloves, and maintain as much distance from the client as possible.

Senior Farmers Market Nutrition Program

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

Lack of Transportation options Affects Access to Services

It is not surprising given the impressive growth in the older population in the O3A service region that a growing number of vulnerable adults lack access to public or private transportation. This has historically registered as a high need in the O3A Area Plan Survey. This includes older adults and adults with disabilities who do not drive; do not have access to a private vehicle; and either cannot afford or may be too frail to access public transportation. Other access issues, such as lack of access to medical specialty care may also be driven by the inability to get to and from distant specialist offices.

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

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

Linking older people with goods, supports, and activities in the community becomes a greater challenge as people routinely outlive their ability to drive. On average, men will live an average of six years and women an average of 11 years after they stop driving[17]. Furthermore, only 3% of older people use public transit[18] due to concerns about safety, schedules, and connections to needed destinations.

"Currently, there are about 8.4 million senior citizens who depend on others for their transportation. Shortly, the number of older drivers will more than double, making the issue of senior transportation even more critical. In fact, according to the Administration on Aging, by the year 2030 the number of drivers over age 85 will be 4–5 times what it is today.[19]" Some older drivers may continue driving beyond when safety deems they should stop, out of necessity, and a desire to maintain independence.

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

Preventing Elder Abuse & Exploitation

Elder abuse refers to intentional or neglectful acts by a caregiver or "trusted" individual that leads to or may lead to harm of a vulnerable elder. According to the Centers for Disease Control (CDC) 1 in 10 or 10% percent of Americans over the age of 60 reported some form of elder

[17] 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.
[18] 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.
[19] http://www.caregiverslibrary.org/caregivers-resources/grp-transportation/transportation-and-the-elderly-article.aspx

abuse in 2008.[20] Many cases go unreported--for every single case elder abuse, neglect, exploitation, or self-neglect reported to authorities, at least five more go unreported. In almost 90% of the elder abuse and neglect incidents with a known perpetrators are adult children or spouses.

Financial abuse is the most common, yet only 1 out of 25 cases is reported.[21] 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. For those elders who have been mistreated, the risk of death is 300 times greater than those who have not been. And an extremely troubling study showed that 47% of patients struggling with dementia have experienced some form of abuse.[22]

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

Neglect can be defined as the failure of a caretaker, which includes facilities, to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness, (for example abandonment, denial of food or health related services).

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

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

All O3A employees and most contractors are mandatory reporters of abuse.

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

Long-Term Care Ombudsman

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

An Ombudsman:

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

The following people can use the Ombudsman Program:

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

Safe and Affordable Housing

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

- Nationally, 37% of seniors over 80 years old are paying over 30 percent of their monthly income on housing. Unfortunately, that housing might not even meet their needs for accessibility, comfort, or safety.[23]

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

- This affects younger seniors as well, as more than one-third of seniors over 50 are spending 30% or more a month on housing.[23]
- Even more shocking is that 23% of senior homeowners, as well as 30% of renters, are spending more than half of their monthly income on housing costs[25]
- The population of sheltered homeless seniors, age 62 and older, in the U.S. population rose from 2.9 percent to 4.7 percent from 2007 to 2016.[24]
- In 2016, adults with disabilities were about four times more likely to be experiencing sheltered homelessness than were adults without disabilities.
- Older adults experiencing homelessness have medical ages that far exceed their biological ages and are frequent users of health care and emergent care. Research has shown increased rates of cognitive and mobility decline exceeding their housed counter parts by 20 years.[25]
- Analysis data from 3 decennial censuses has revealed that homelessness among older adults affects people born in the latter half of the Baby Boom generation (between 1955 and 1965) and the period following. This is due to a crowded labor market and housing market, pressure because of decreased wages, especially for those with a high school degree or less. Some members of this cohort group have struggled with homelessness from the 1980's to the present day.[25]
- Anecdotally, housing advocates in our region have noted that seniors, especially senior women, are the fastest growing population sector falling into homelessness.

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

The increasing costs of owning and maintaining a home, even one with no mortgage commitment, will continue to present seniors with a lower income and even modest income growing challenges. At the same time, increasing maintenance costs surpass the ability for many elders on fixed incomes to keep their properties safe and functional. In the 2019 and 2021 Area Plan surveys, seniors noted that help with yard work and housework is an ongoing unmet need. As seniors age, their housing ages, and their ability to maintain the property concurrently decreases.

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

[24] https://files.hudexchange.info/resources/documents/2016-AHAR-Part-2.pdf
[25] https://www.aisp.upenn.edu/wp-content/uploads/2019/01/Emerging-Crisis-of-Aged-Homelessness-1.pdf

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

In addition to affordability, home safety is an issue as we age, and as physical and cognitive abilities diminish. Stairs, doorways bathtubs, and ovens can present barriers and safety risks not anticipated by people until their specific and special needs increase.

Many times, people have to move because their homes are no longer safe or user-friendly. Homes that use universal designed features intended for all ages and designed for a lifetime, can go a long way in allowing people to live independently for as long as possible.

It is possible to make the home environment safer with relatively simple modifications, such as wheelchair ramps, grab bars and raised toilets. Home modifications can be expensive, however, and many people over the age of 60 with disabilities cannot afford and have not made the modifications they may need to remain safely in their chosen environment.

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

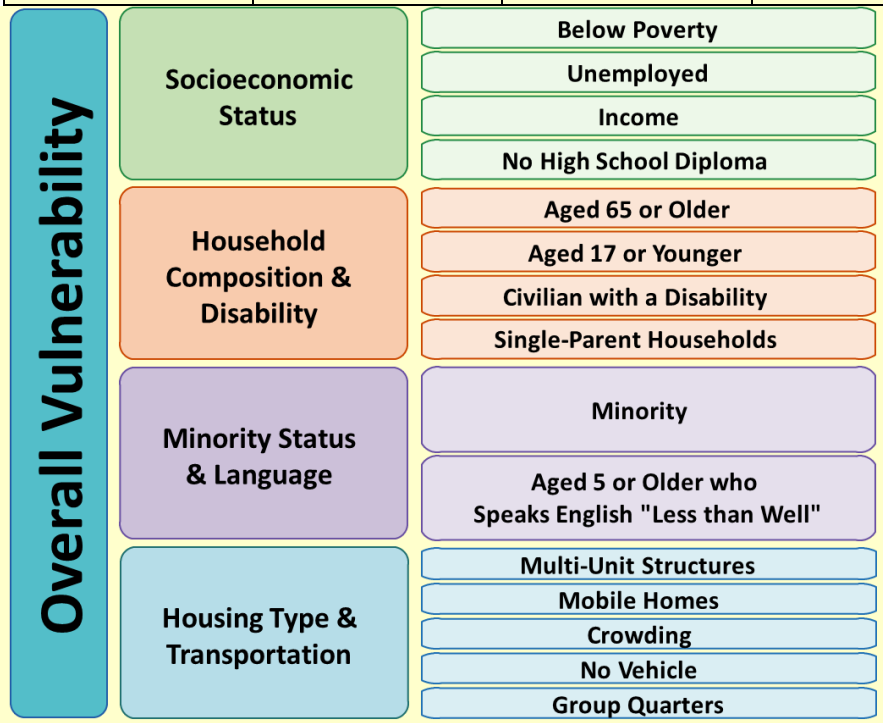
O3A Social Vulnerability Data

What is Social Vulnerability? Every community must prepare for and respond to hazardous events, whether a natural disaster like a tsunami or disease outbreak. A number of factors, including poverty, lack of access to transportation, and crowded housing may weaken a community's ability to prevent human suffering and financial loss in a disaster. These factors are known as **social vulnerability**.

The following chart has some Social Vulnerability data that have a direct effect on the O3A service population. This index is a customized version of the Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry Social Vulnerability Index (CDC/ATSDR SVI). Minority Health SVI uses data from the United States Census Bureau and other public sources to help identify communities that may need support before, during, and after disasters, with a focus on minority racial, ethnic, and language groups as well as medical vulnerability.

O3A Social Vulnerability Index – based on ACL 2014-2018 data

	Grays Harbor	Pacific	Jefferson	Clallam
65+	20.3%	29.3%	34.2%	28%
American Indian	4.4%	1.4%	2.1%	4.7%
Ethnic/Racial	9.9% (Latinx) 1.6% (Asian), 1% (Black)	9.4% (Latinx)1.8% (Asian), 0.3 % Black	3.6% (Latinx), 1.7% (Asian), 0.8% (Black)	6.2%, (Latinx), 1.5% (Asian), 1.1% (Black)
Below Poverty	15.9%	17.4%	13.3%	15.9%
Mobile Home	12%	18.4%	12.5%	12.6%
Disability	19.8%	26.6%	17.2%	19.9%
Without Internet	16.3%	19.3%	9.9%	14.3%



While the issues described in the chart above can affect a community's resiliency during any sort of disaster, residents of the Olympic Peninsula are generally familiar with emergency situations caused by severe weather storms, including prolonged power outages, road and bridge closures and damage to buildings caused by flooding and fallen trees. Local county governments and emergency response agencies are increasingly actively engaged in community-wide planning to improve readiness especially in major emergencies.

Emergency Preparedness

O3A is a natural community partner for the dissemination of information. Designated O3A staff participate to inform local emergency operations leadership about the needs of older adults and adults with disabilities in emergencies, and to obtain current information on resources and recommendations on steps local seniors can take to improve their own readiness. O3A communicates information on individual and household emergency preparedness via the media (newspaper columns and radio broadcasts), and in pamphlets.

O3A also ensures its contractors, e.g., home care agencies, have plans in place with staff designated to check on the welfare of vulnerable clients in an emergency. In addition, O3A has developed a process to identify the highest priority clients, and in the event of a disaster, work with all home care agencies to be able to find home care workers able to reach clients to check on them or provide critical services.

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

The O3A Emergency Management Plan is aligned with "*Standards for professional information and referral"* These standards require AAA's to:

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

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

COVID-19 Impact: The pandemic identified a specific type of disaster which may not be adequately addressed in O3A's current Disaster Planning. However, through the pandemic, new partnerships with Local Health Jurisdictions and Emergency Management were formed

and strengthened. These partnerships will serve O3A clients well in the event of another major disaster.

Health Care in the Region

Although more residents have been able to obtain health insurance through Washington State's Health Benefit Exchange, local medical care practices are constrained to meet the increasing demands of an older population, and people of any age moving to region have experienced long wait times to establish a relationship with a primary care provider.

In particular, residents in Grays Harbor, (with 1 provider for every 2,960 residents[26]), and Pacific Counties, (with 1 provider for every 3,670 residents[28]), face a significant lack of primary care providers. These ratios compared poorly with the Washington State and US average of 1,180 residents to every provider. As a result, residents without a local primary care provider tend to delay seeking treatment, visit an emergency room and/or call 911, contributing to an overuse of local EMS services for non-emergency care.

Access to Behavioral Health Care

Accessing comprehensive behavioral healthcare in smaller, rural communities like those in the O3A region, is a challenge for older adults. On average, at least 37% of the population in O3A's service region is 60 or better. According to the World Health Organization, 15% of adults aged 60 and over suffer from a diagnosed mental disorder.[27] Because these are only those who have been seen and diagnosed the actual number is likely significantly higher. In our four-county region, this data point translates to more than 11,700 older adults have a diagnosed mental health condition, predicted to grow to 12,200 in the next 3 years.

According to Jeanette Semke, MSW, PhD, at the Washington Institute for Mental Illness Research & Training, University of Washington, older adults also have the highest rates of suicide compared to any other age group.

Additional factors contribute to the pressure for availability of behavioral health care in our region. In 2018, Western State Hospital lost their federal funding (over $50 million). Western State Hospital had up to 850 beds and included serving patients who were involuntarily committed due to psychiatric disorders (many older adults). Since then, many Western State residents have been discharged to care in Home & Community settings with Area Agencies on Aging providing case management services. By 2023, "nearly all of the roughly 560 civilly committed patients at Western State Hospital would be placed in community beds"[28]. Washington State has long struggled with inpatient behavioral health bed availability.

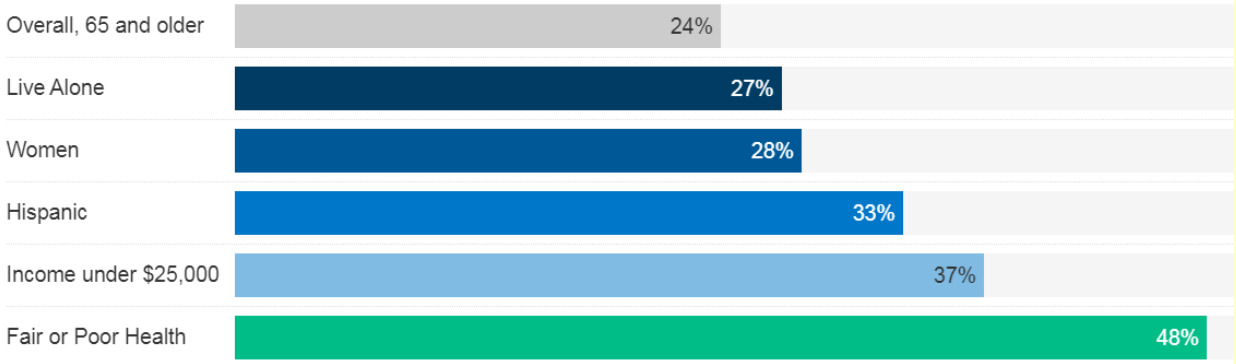
Fortunately, in 2017 the 1115 Waiver created new options and eligibilities for long-term services and supports (LTSS). This included a significant move to care for older adults in their own homes, by transitioning older adults who lived in nursing facilities for 3 months or longer (and on Medicaid) to "in-home" care. Due to this transition of adults with behavioral health

[26] https://www.countyhealthrankings.org/
[27] https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults
[28] "Western State Hospital loses $53 million in federal funding after failing inspection", The Seattle Times, published 6.25.2018.

problems, additional resources have been allocated to behavioral health care services. However, provider shortages in all rural regions hamper access.

COVID-19 Impacts: Research done during the pandemic has indicated that while older adults may be more resilient when faced with prolonged social isolation than younger people, 1 in 4 older adults have reported anxiety and depression related to the pandemic, which is a significant increase of the previous statistic of 1 in 10 from a 2018 Medicare Beneficiary study.[29] One positive impact from the pandemic is the acceptance of telemedicine which can expand access to remote services. Lack of broadband and lack of comfort with technology still presents a barrier.

Figure 1. A Quarter of Older Adults Reported Anxiety or Depression Amid the Coronavirus Pandemic, while Some Groups Reported Higher Rates



NOTE: Analysis is among adults age 65 and older. Self-reported health status. Adults of Hispanic origin may be of any race, but are categorized as Hispanic for this analysis; All other groups are non-Hispanic.
SOURCE: KFF analysis of U.S. Census Bureau's Household Pulse Survey, August 19-31, 2020.

KFF

Access to Specialty Care

Access to Specialty Care was highlighted repeatedly by respondents to the 2019 Area Plan Survey. 32% of the 407 respondents reported no access or difficulty accessing specialty care. Reasons may include lack of transportation, lack of insurance, or lack of the provider for a particular specialty service available within what individuals consider a reasonable distance. Due to some shortages of specialty care, some individuals may have to wait months to be seen by a specialist. In rural areas many types of specialty care can only be accessed by traveling to an urban area or by having a partnership

[29] https://www.kff.org/medicare/issue-brief/one-in-four-older-adults-report-anxiety-or-depression-amid-the-covid-19-pandemic/

with a larger specialty group that contracts to provide visiting specialty services periodically in some of the smaller rural cities.

Oral Health Care is increasingly more difficult to find in our communities

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

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

Substance use disorders in older adults often goes undetected, and effective treatment for alcohol and drug addiction in older adults has not been well-studied. Older adults experience many changes, both physically and emotionally, as they progress through the aging experience. Some will choose to self-medicate in attempts to cope with loss, physical disability, and loneliness. Those with chronic, painful diseases such as arthritis, osteoporosis and cancer, or psychiatric disorders such as depression or anxiety are more likely to drink or take substances[30]. About one third of all older people with a substance use disorder began taking substances after the age of sixty. Half of emergency room visits by older adults are related to consequences of alcohol or substance use.

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

- 57.8% increase among 50-64 year olds from 2006-2013[31]
- 250% increase among 65+ year olds from 2006-2013
- Smoking cannabis can cause airway injury and bronchitis, increased heart rate, cardiac output, supine blood pressure; possible risk of heart attack, orthostatic hypotension, may affect blood sugar, may cause drug-drug interactions
- Seniors with complex or sensitive medication regimens could be at risk of adverse reactions
- Some evidence cannabis can increase bleeding risk in those using anticoagulant, antiplatelet drugs
- Using cannabis with anticholinergics or stimulants can magnify its cardiovascular effects
- THC can enhance effects of CNS depressant drugs and alcohol – major concern for accident/fall risk

[30] Widlitz, Michelle and Marin, Deborah B. 2002. Substance abuse in older adul10ts. Geriatrics, Vol 57 (12), p 29-34.
[31] Demographic Trends Among Older Cannabis Users in the United States, Addiction Research Report, Society for the Study of Addiction, dol 10.1111/add.1 3670.

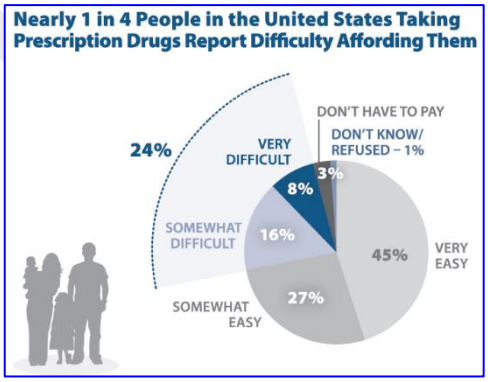
- Unknown how cognitive effects of cannabis may interact with cognitive effects of aging[32]

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

COVID-19 Impact: The pandemic has increased the use of drugs and alcohol as a means of coping with the impacts of isolation. The authors of an article titled "Poll finds risky drinking patterns in older adults during the pandemic noted that drinking in this population was rising faster than in the general population even before the pandemic started. This poll of 2,000 older adults from age 50 to 80 was based at the University of Michigan's Institute for Healthcare Policy and Innovation. In the poll, 23% reporting that they routinely had 3 or more drinks in one sitting (considered signs of problematic drinking), and 10% of those who drink reported using other recreational drugs while drinking. 14% of those polled reported increased drinking since the pandemic began.[33]

Access to Prescription Drugs and Assistive Devices

Reference for chart[34]



Many older adults lack medical insurance with sufficient drug coverage; this is true even for adults age 65 and older with Medicare. Medicare prescription drug coverage (Medicare Part D) still includes a prescription drug coverage gap and different Medicare Part D plans manage this differently, often leaving the older person with significant out-of-pocket expenses during the latter part of the year. This is also true for adults under 65 with disabilities. Gaps in being able to afford prescriptions still affects many. According to the Kaiser Family Foundation, nearly 3 million Medicare Part D enrollees had out-of-pocket prescription drug spending above the catastrophic threshold between 2015 and 2019, spending $7.4 billion to cover their prescription expenses.[35]

In just the last several years, the cost of many commonly prescribed medications has skyrocketed. The high cost of medications, coupled with the large number of medications taken by older adults, make appropriate use of prescribed medications extremely challenging and frequently unmet. 19% of the respondents to the 2019 O3A Area Plan survey reported that they sometimes skip purchasing medication, (or perhaps take medication intermittently to stretch it further).

Assistive devices such as glasses, walkers, hearing aids, are unaffordable to many older adults. Medicare has only recently begun paying for hearing aids but not all types are covered.

[32] Susan Stoner, PhD., Licensed Psychologist, Research Consultant, Alcohol and Drug Abuse Institute, University of Washington; Presentation to O3A Advisory Council, November, 2018
[33] https://healthblog.uofmhealth.org/wellness-prevention/poll-finds-risky-drinking-patterns-older-adults-during-pandemic
[34] https://jamanetwork.com/journals/jama/fullarticle/2510894
[35] https://www.kff.org/medicare/

Medicaid covers some but not all the devices needed and older adults who are ineligible for Medicaid simply do not have access.

Skipping Care because of Affordability

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

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

Palliative Care & Hospice

Palliative care is specialized care for people with serious illnesses. It is focused on addressing what curative treatment may not, including providing people with relief from pain symptoms and stress of a serious illness---whatever the diagnosis. The goal is to support the patient and family with guidance to make informed decisions about difficult or complex treatment and care options and improve the quality of life for both the patient and the family. In 2021 the Palliative Care Road Map was released by the State Hospice and Palliative Care board, working with the State Joint Legislative Executive Committee on Aging and Disability, and the Washington State Department of Health (also available by searching for Palliative Care Road Map).

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, such as pain, fatigue or medication side effects may not be adequately addressed. The care team works with the patient and their family and the patient's physicians to provide symptom management, extra time for communication, and help navigating the healthcare system. In addition, the care team provides the patient and family the opportunity and guidance to initiate often difficult conversations about end-of-life concerns related to the prognosis of the patient's illness.

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

Hospice Care is similar in that it is a team approach towards addressing comfort measures for the patient and family with the difference being that it is provided at the end of life, typically when the person is expected to live for 6 months or less. Many people think accepting hospice is something not to be considered, that it is "giving up". Yet research shows that palliative care,

hospice care, and advanced care planning (described several sections below), can contribute to increased patient and family satisfaction with care and a sense of peace in difficult circumstances, reduced costs to the family, and even increased medical provider satisfaction.

Palliative Care for Dementia

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

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

This approach focuses on:

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

Advance Care Planning

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

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

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

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

Advance care planning includes:

- Getting information on the types of life-sustaining treatments that are available.
- Deciding what types of treatments, you would or would not want should you be diagnosed with a life-limiting illness.
- Sharing your personal values with your loved ones.
- Completing advance directives to put into writing what types of treatment you would or would not want – and who you chose to speak for you – should you be unable to speak for yourself.
- In 2017, the O3A Advisory Council and staff completed a list of Advanced Directive documents that can be accessed here: https://www.o3a.org/files/2019/03/AD_Information.pdf

Death with Dignity Act

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

Aging and Chronic Illness

Although life spans are increasing, many older adults are affected by disability or activity limitations due to physical, mental, or emotional conditions. The Centers for Disease Control and Prevention (CDC) estimates that nationally about 60% of all adults have 1 chronic condition and 40% have 2 or more[36]. The situation on the Peninsula, with 37% of the population age 60 and better, is made worse by the shortage of primary care, specialty care (and particularly geriatrics), dental and behavioral health providers as well as inadequate transportation options.

[36] https://www.cdc.gov/chronicdisease/pdf/infographics/chronic-disease-H.pdf

Evidence Based Programs

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

O3A has taken a proactive approach to assisting older adults to prevent and manage illness and improve their health, with targeted interventions related to chronic disease management, falls prevention, and increasing physical activity. Falls for an older adult can be a life-ending experience, causing harm to the individual, their families, and costing millions both to the family, private insurance, and in public Medicaid / Medicare / VA tax funded dollars. As older adults age, they may become less active or may be limited by chronic disease or even one illness which impacts overall fitness.

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

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

- Chronic Disease Self-Management Program (CDSM) also known as *Living Well with Chronic Conditions."* The program features a six week workshop for older adults who wish to learn to better manage their chronic illness, and for caregivers of people with chronic illness. These programs include a variety of alternatives such as Wisdom Warriors – a Native American adaptation, which is culturally relevant, Diabetes Self Management, Chronic Pain Self-Management, etc.

[37] https://www.ncoa.org/center-for-healthy-aging/basics-of-evidence-based-programs/about-evidence-based-programs/
[38] https://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/OlderAdultFalls

- Staying Active and Independent for Life (SAIL) is a strength, balance, and fitness program for adults 65 and older. Performing exercises that improve strength, balance and fitness are the single most important activity that adults can do to stay active and reduce their chance of falling. The entire curriculum of activities in the SAIL program can help improve strength and balance, if done regularly. SAIL is offered 3 times a week in a one hour class. SAIL exercises can be done standing or sitting.[39]
- Tai Ji Quan Moving for Better Balance is a research-based balance training regimen designed for older adults at risk of falling and people with balance disorders. Fuzhong Li, Ph.D., a Senior Scientist at Oregon Research Institute, developed the program. Although its origin can be traced to the contemporary simplified 24-form Tai Ji Quan routine, TJQMBB represents a significant paradigm shift in the application of Tai Ji Quan, moving the focus from its historical use as a martial art or recreational activity to propagating health by addressing common, but potentially debilitating, functional impairments/ deficits. This unique training approach is the culmination of a systematic series of scientific studies to improve efficacy, utility, and community and clinical relevance.[40]
- Powerful Tools for Caregivers (PTC) provide classes which help caregivers take care of themselves while caring for a friend or relative. Research shows that these programs help improve self-care behaviors with increased exercise, relaxation and medical checkups; emotional management with reduced anger, guilt and depression; increased self-confidence in coping with caregiving demands; and increased knowledge about and use of community resources so the caregiver is not so isolated.[41]
- Stress Busting Program (SBP) for Family Caregivers is a multi-component program where two facilitators meet with a small group of family caregivers for 1 ½ hours once a week for 9 consecutive weeks to facilitate education, support, problem solving, and stress management. It takes a holistic approach addressing the emotional, physical, spiritual, and cognitive needs of family caregivers. Content includes the topics of (1) stress and relaxation, (2) grief, loss, and depression, (3) dealing with challenging behaviors of people with dementia, (4) coping with stress, (5) positive thinking, (6) taking time for yourself, and (7) choosing a path of wellness. Stress management techniques are taught including (1) relaxation breathing, (2) meditation, (3) imagery, (4) art, (5) music, (6) journaling, and (7) aromatherapy.[42]
- Savvy Caregiver is another caregiver support program with a special focus for tribal caregivers, introducing family caregivers to the caregiving role, providing them with the knowledge, skills, and attitudes needed to carry out that role and alerting them to self-care issues, and resulting in improved caregiving as well as a healthier caregiver. https://www.caregiver.org/savvy-caregiver-program[43]

O3A also partners at the state level to promote a systematic and sustainable approach towards funding and delivery of evidence-based programs throughout the state, with a goal of

[39] https://www.ncoa.org/wp-content/uploads/SAIL-Summary-2016.pdf
[40] https://tjqmbb.org/
[41] https://www.powerfultoolsforcaregivers.org/
[42] https://fsrtc.ahslabs.uic.edu/promising-practices/stress-busting/
[43] https://www.caregiver.org/savvy-caregiver-program

increasing funding, program capacity and consumer engagement in these life changing programs.

Social Isolation (New Section)

Social isolation, which previously was seen to be an issue mostly affecting aging seniors, is now recognized as a serious issue due to the pandemic. Social isolation has been found to contribute to greater incidence and worsening of chronic conditions, a weakened immune system, addiction, depression, anxiety, suicide, dementia, including Alzheimer's Disease, and increased mortality. It has been classified as "worse than smoking a pack of cigarettes a day." And it probably doesn't need to be overstated that the pandemic has imposed increased isolation for all adults, and children as well. The Area Plan Survey and the Survey update reflect the impact this has had on seniors. One Key Informant commented that seniors had told them, "They would rather die of COVID-19 than loneliness." Loneliness within the first month of COVID-19 reportedly increased by 20-30% and emotional distress increased by 30%.[44]

Social isolation has long-term impacts with observed increases in alcohol and drug use, domestic violence, poorer sleep, and potential increased risk of suicide. Social isolation is made worse in the older adult population by the digital divide and lack of access to internet connections, computer use, etc. Even with access to digital resources, recent data suggests that Zoom interactions are not as effective in reducing social isolation in the older population.

During the pandemic, O3A working with staff and partners, implemented check in calls, and several programs, including:

- Well Connected – a Senior Center programing modeled on accessibility by phone or by computer with over 100 programs including a fully Spanish model – available to those 60 and better.
- Social Call – a program which connects a trained and vetted volunteer over 18 with an adult 60 or better for a weekly phone call. This is not a check in call, but one based on building a relationship.
- GetSetUp – is a program that just recently began partnering with the state Aging and Long Term Care Supports to deliver online courses to adults 50 and older and their caregivers.

O3A is also working in partnership with any interested Olympic Community of Health partners to conduct a short social isolation survey of their clients, using a tool that produces a personalized client report with suggested actions the client can take to improve social connections.

[44] https://www.healthaffairs.org/do/10.1377/hblog20200609.53823

C – 1: Goals & Objectives – Healthy Aging

Problem/Needs Statement:

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

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

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

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

  Complete by 12/2023

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

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

  Complete by 12/2023

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

- Share information about and help older adults to access programs to reduce costs associated with housing (e.g., property tax relief, utility subsidies, maintenance, and safety modifications).
- Develop and implement a homelessness / affordable housing advocacy plan for O3A.
- Partner with other housing advocates to promote resources for senior housing needs.

- New: Explore Shared Housing and other unique ways to address older adult housing issues.

  Complete by 12/2023

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

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

  Complete by 12/2023

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

~~**Objective 1:** Advocate for resources to fund dental, hearing and vision services for both the Medicare and Medicaid populations.~~
~~**Key Activities:**~~

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

~~**Complete by 12/2023**~~ *Made the decision to delete these goals due to inadequate capacity.*

Objective 1: Support increased access to medical specialty care services.
Key Activities:

- Support volunteer and other transportation services to distant communities where specialty care is located.
- ~~Partner with local medical institutions to develop local solutions for accessing specialty care.~~ *Local medical organizations are already working on increasing access for specialty care with partnerships with regional larger healthcare networks.*

  Complete by 12/2023

Objective 2: Support increased access to behavioral health services.
Key Activities:

- Implement Trauma Informed Care Training for entire O3A staff; inviting community partners as staffing allows.
- Consider / Implement other trainings for staff and /or community partners e.g., Mental Health First Aid, SAFEtalk, self-protection training for O3A direct service staff.
- ~~Develop community resources / partnerships to address emerging behavioral health issues.~~ *We have been able to contract with sufficient behavioral health contractors to address O3A clients' needs but lack capacity to take on a larger effort currently.*
- New: Implement Social Isolation programs with clients, tribes, and other interested partners, including education about the impacts of social isolation, and providing resources.

  Complete by 12/2023

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

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

Key Activities:

- As funding and willing contractors allow, facilitate implementation of evidence-based programs, such as Chronic Disease Self-Management workshops; Staying Active and Independent for Life (SAIL) fitness program for older adults; Powerful Tools for Caregiving, Stress Busting for Caregivers, Tai Ji Quan Moving for Better Balance, Savvy Caregivers and/or other evidence-based wellness programs in the service region.
- Provide information to older adults on medication management through Senior Drug Education Program.
- ~~Advocate for additional funding and partnerships to support evidence-based programs.~~ *Made the decision to discontinue this effort due to lack of capacity.*

  Complete by 12/2023

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

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

~~**Key Activities:**~~

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

  Completed on 3/2021

Objective 1: Promote awareness of the benefits of palliative care, hospice, and advance care planning to providers and the general public.

Key Activities:

- New/Moved from above: Promote the Palliative Care Road Map to the senior providers, medical groups, and the general public.
- Partner with local organizations like Olympic Medical Center to promote palliative care, hospice, and advanced care planning.
- ~~Identify whether other medical centers in PSA are similarly focused and encourage engagement in this work.~~ *Made the decision to discontinue this effort due to lack of capacity. Once we able to travel more, this may become a viable goal once again.*

  Complete by 12/2023

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

Older Adults and Adults with Disabilities

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

Family Caregivers and Kinship Caregivers

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

Millions of caregivers are spouses, siblings, or children, some of whom are in their seventies and eighties themselves. Grandparents, and even great-grandparents, may also find themselves as the primary caregivers to their grandchildren. Caregivers do not often identify themselves as such – they are doing what any loving relative would do for their loved ones. Yet, caregiving can take a heavy toll on the caregivers, jeopardizing their health and emotional well-being. The physical demands, emotional stress, and often advanced age increases the caregiver's risk for health problems.

As a result, it is important to support the caregiver as well as the care receiver. Since caregivers often do not seek medical care, health, and wellness activities, they are often unaware that services exist, or only seek help when a crisis occurs.

COVID-19 Impact: Almost all services for family caregivers shifted to telephonic and or by remote video conferencing if available and the client preferred this. Initially there were fewer calls for services but since then, service volume has returned to normal. A big area of impact for caregiver support has been the shortage of home care aides, thus making respite services difficult to access. FCSP staff are exploring other services like housework and errands, or massage therapy while family caregivers are waiting for a paid caregiver to be available for intermittent respite services.

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

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

- Alzheimer's Disease (AD) is the 6th leading cause of death in the United States.

- 82% of seniors report that it is important to have their thinking or memory checked, yet only 16% report regular cognitive assessments.
- Every 65 seconds someone in the US is diagnosed with some form of dementia.
- 5.8 million Americans are living with some form of dementia - by 2050 that number (above) is expected to rise to 14 million.
- More than 16 million Americans provide unpaid care to someone with dementia.
- In 2019, dementia will cost the nation $290 billion – by 2050 - **$1.1 TRILLION!!!!**[45]

There are currently 125,517 people aged 65 and older in Washington State living with some form of dementia. **The number of persons in the O3A region aged 65 and older with any type of dementia is estimated at 5,815.**

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

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

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

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

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

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

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

COVID-19 Impacts: People with Alzheimer's and other forms of dementia have been acutely impacted by the pandemic. Survey respondents reported that many people with dementia don't understand masking and social distancing and not seeing their families. Some caregivers have reported concerns about their loved ones' ability to rejoin social activities due to deterioration that has occurred during social isolation. Some data suggests that social isolation, disrupted routines, a lack of structure, and decreased access to respite care have contributed to increased loneliness, depression, and anxiety for people with dementia as well as their caregivers. In addition, other impacts are new or worsening safety issues related to interpersonal violence and hygiene have all surfaced during the pandemic. Most notably, caregivers have reported an acute worsening of clinical symptoms including reduced cognitive functioning, an aggravation of behavioral symptoms, and increases in their own depression and anxiety.[46]

Particularly Vulnerable Caregivers

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

- Limited English-speaking and ethnic caregivers.
- Native American caregivers.
- Caregivers who are in the greatest economic and social need.
- Caregivers who provide care to persons (any age but those over 60 are high priority) with Alzheimer's Disease and other dementias.
- Caregivers who provide care to persons at risk for institutionalization.
- Non-traditional family caregivers who may not be recognized as family; LGBTQ (Lesbian, Gay, Bisexual, Transgender or Questioning) partners and individuals who are not legally married.
- Grandparents and relatives, age 55 and older, and relatives over the age of 18 raising children who are not their own children.
- Older individuals caring for people, including children (of all ages), with severe disabilities (including developmental disabilities).
- Caregivers providing care to adults under the age of 60.

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

- For immigrants, even if legally in the country, the caregiver may not seek help out of fear for themselves or family members and put themselves, their own health, and the health of their loved one at risk.

[46] https://www.frontiersin.org/articles/10.3389/fnagi.2020.625781/full?utm_source=S-TWT&utm_medium=SNET&utm_campaign=ECO_FNINS_XXXXXXXX_auto-dlvrit

- Caregivers with fewer financial resources may be at risk for losing housing, living in inadequate, unsafe housing, having utilities shut off, or living with food instability.
- Caring for individuals with dementia carries a huge array of risks, including a loved one who becomes angry, combative, fearful, not recognizing their care provider. The experience can include lack of sleep due to nighttime wandering, inability or unwillingness to recognize the point where additional supports and potentially the need for placement in a long-term care facility has become necessary, etc.
- When a caregiver is a member of a marginalized population, they themselves may not be recognized and supported in their role, for example an LGBTQ spouse, may not be recognized or valued in this role, and potentially could even be barred from serving in the role by non-accepting family members.

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

Caregivers Statistics[47]

- Approximately 43.5 million caregivers have provided unpaid care to an adult or child in the last 12 months.
- About 34.2 million Americans have provided unpaid care to an adult age 50 or older in the last 12 months. The majority of caregivers (82%) care for one other adult, while 15% care for 2 adults, and 3% for 3 or more adults.
- Approximately 39.8 million caregivers provide care to adults (aged 18+) with a disability or illness or 16.6% of Americans.
- About 15.7 million adult family caregivers care for someone who has Alzheimer's disease or other dementia.
- The value of services provided by informal caregivers has steadily increased over the last decade, with an estimated economic value of $470 billion in 2013, up from $450 billion in 2009 and $375 billion in 2007.
- At $470 billion in 2013, the value of unpaid caregiving exceeded the value of paid home care and total Medicaid spending in the same year, and nearly matched the value of the sales of the world's largest company, Wal-Mart ($477 billion).
- The economic value of the care provided by unpaid caregivers of those with Alzheimer's disease or other dementias was $217.7 billion in 2014.
- 9% of caregivers self-identify as LGBTQ.
- There are at least 3 million LGBTQ persons aged 55+ in the U.S. This number is expected to double in the next two decades.
- LGBTQ male caregivers report providing more hours of care than female caregivers. The average weekly hours of care provided by females from both the LGBTQ and general

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

population samples is similar—26 vs. 28 hours—but LGBTQ males provide far more hours of care than males from the comparison sample (41 hours vs. 29). This reflects that about 14% of gay males indicate that they are full-time caregivers, spending over 150 hours per week in this capacity, compared to 3% of lesbian and 2% of bisexual respondents.

Other issues related to the LGBTQ aging population:

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

State and National Family and Kinship Caregiver Support Programs

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

O3A's Family Caregiver Support and Relatives Programs

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

The T-CARE program helps FSCP coordinators understand the caregiving experience and guides the design and targeting of support services for caregivers. Caregivers' receptiveness to services shifts as they move through seven caregiving stages

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

Outreach to Vulnerable Caregivers

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

- Health and hospital fairs, including O3A-sponsored events. Tribal health fairs and outreach to Native Americans.
- News media, including newspaper columns, and radio.
- Outreach to and referrals from local physicians' offices (builds awareness in other providers in practices).
- Outreach to local schools resulting in referrals for the Relatives As Parents services.
- Word of mouth - caregivers who have received assistance spread the word to their friends and family.
- Outreach to churches.
- Presentations to providers.

COVID-19 Impact: Almost all public, non-remote outreach work has been curtailed during the pandemic. O3A continues to write articles about services for publication in local and social media. We also relayed services to Local Health Jurisdictions and Emergency Management and to other partners.

Core Family Caregiver Support Services

Family Caregiver Support services available in each county include:
- Information about long-term care and caregiver support.
- Assistance in gaining access to supportive services.
- Evidence-based assessment of caregivers' needs and care planning.
- Caregiver support groups.
- Caregiver training, consultation, and education (increasing skill building and self-care).
- Counseling services to cope with challenges.
- Massage Therapy.
- Respite care services (in and out-of-home settings, e.g., Memory Care and Wellness Services) to provide breaks.
- Supplemental Services such as assistive technology, home safety features like grab bars incontinence supplies, etc.
- Health and wellness referrals to cope with depression and medical issues.

Information Services are provided by:
- O3A FSCP coordinators, in person and by telephone (including a toll free number).
- Information & Assistance staff, who provide information on legal services and benefits.
- Written materials, including brochures and pamphlets created by O3A and other agencies, such as the Family Caregiver Alliance[48], specifically written for family caregivers; materials from Alzheimer's and dementia support agencies; videos; books, web resources, many of which are linked on the O3A website.
- Newspaper columns, articles, and radio presentations by O3A staff.
- O3A social networking and websites.

Group Activities with outreach to Caregivers include:

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

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

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

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

Counseling

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

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

Massage Therapy

Massage therapy is available to provide caregivers stress management as well as help address body mechanic issues caregivers may encounter.

Training

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

Referral to other training opportunities

FCSP staff also refer caregivers to local training opportunities offered by O3A and other community providers, such as training in caring for persons with Alzheimer's Disease and other dementias.

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

Support Groups

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

COVID-19 Impact: Most Caregiver Support Groups were discontinued during the pandemic and caregivers were mostly not interested in remote options, although one support group has reconvened remotely in Clallam County. Some caregiving evidence-based programs have continued but can only support 10-15 participants at any one time.

Respite Care Services (both in-home and out-of-home)

Respite care is the most frequently accessed service to provide the unpaid caregiver with regular breaks from caregiving responsibilities. In-home care is provided through O3A – contracted home care providers in each county; out-of-home respite care is available in Clallam County from "'Encore," a program of OlyCAP, and for eastern Grays County, from Brighter Days. Jefferson Healthcare has been planning for an Adult Day Service but is seeking partners outside of the hospital to be a co-leader. The two Adult Day Care programs are unable to serve persons with dementia who are at-risk of wandering, or persons with incontinence.

The need for safe, out-of-home respite options is largely unmet in the service region. O3A is always exploring options with other long-term care providers.

Supplemental Services

The O3A FCSP also provides durable medical equipment & assistive technology, as well as minor and limited home modifications; "wander guard" technology, such as Lifeline and legal aid from O3A Senior Legal Advice Clinics. All these services are interventions listed on T-Care.

Core Services Available to Kinship Caregivers

The O3A Kinship Caregiver Program (KCSP), serving adult caregivers (age 18+) to children, and the Relatives as Parents (RAP) program serving older adults age 55 and better, serving older relatives raising children sometimes without notice and often lacking the resources to meet even basic needs for the children in their care. Unfortunately, both fund sources are fairly limited, which limits the number of clients O3A is able to serve.

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

- **Information** on support and services available locally, frequently including referral to Legal Services.
- **Support group** (in Grays Harbor County and in Jefferson County).
- **Supplemental Services** provided directly by FCSP coordinators to help caregivers with urgent basic needs such as housing, food, clothing, and essential supplies.
- The need for these services generally exceeds O3A's capacity to meet it.

Medicaid Transformation Project Demonstration – Medicaid Alternative Care & Tailored Supports for Older Adults[49]

Washington State has already created a rebalanced system where more individuals receive Long-Term Services and Supports (LTSS) in their homes than in long-term care facilities. Our LTSS system has been ranked 1st and 2nd in the nation by AARP (trading spots with Minnesota) for its high performance while at the same time ranking 34th in cost. **Washington is building on the successes of our current system and create a "next generation" system of care** focused on outcomes supporting families in caring for loved ones, delaying, or avoiding the need for more intensive Medicaid-funded LTSS where possible and creating better linkage to a reformed healthcare system and continuing its commitment to a robust Medicaid LTSS system for those that need it. The demonstration project has two main LTSS components:

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

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

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

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

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

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

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

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

Network adequacy similarly presents challenges in small, rural areas where providers may be hesitant to embrace a program which includes the complexity of Medicaid contracting and billing. O3A Contract Specialists continue working to expand the network of providers, both locally and with the assistance of Home and Community Services Resource Development Program Managers. This work benefits MAC & TSOA, FCSP, and TXIX[50] clients as well.

[50] Title XIX of the federal social security act offers valuable opportunities to increase federal funds available to provide community-based long-term care services to **functionally disabled persons in** their homes, and in noninstitutional residential facilities, such as adult family homes and congregate care facilities.

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

1. Access to in-home respite services - There is a national paid caregiver shortage[51] that has been made worse by COVID-19. It is difficult for home care agencies to staff shorter respite hours when clients with greater needs do not have an assigned caregiver.
2. Out-of-home respite services - O3A has spent the last 6 years exploring options for expanding Adult Day Services with few solutions surfacing. To utilize limited resources wisely, the development focus in this area must be to increase the number of Adult Day Care programs which are the most economical.
3. Need for additional FCSP and Kinship Care funding.

Quality Assurance

O3A supports quality assurance through several mechanisms:

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

Long-Term Care Trust Act

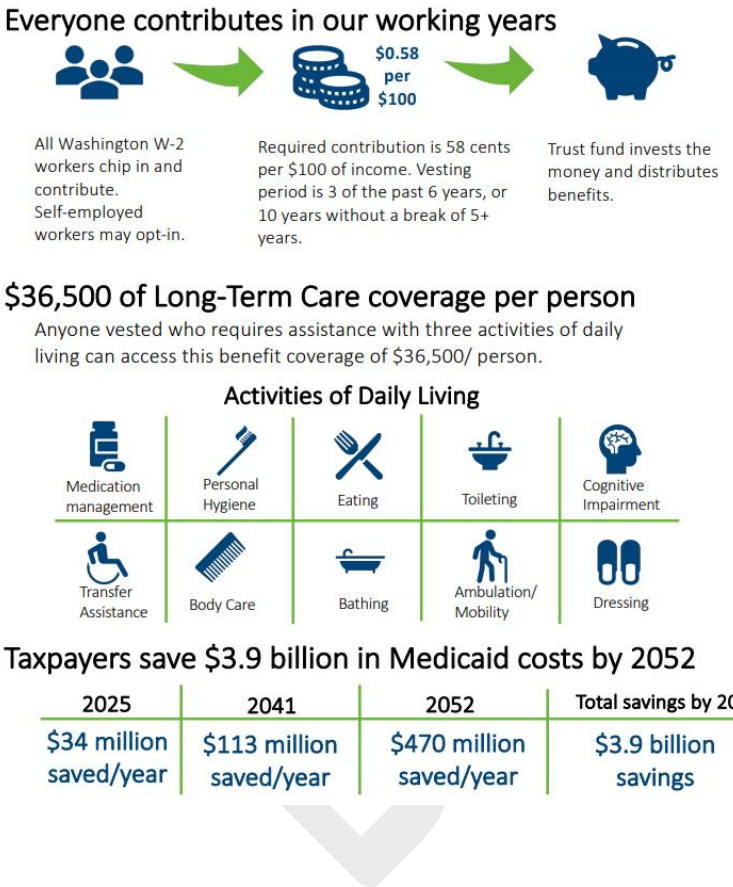
Fewer than 1 in 10 people have long-term care insurance. Most people do not think they will need this and furthermore, cannot afford it. However, 7 out of 10 will need long-term care. Currently, without insurance, each person pays for these long-term care services themselves, until they can no longer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

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

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

In 2019, Washington State passed groundbreaking legislation to create the first Long Term Care Trust Act (LTCTA), now called the WA Cares Fund, in the nation. This legislation had a majority of voter support of all ages even as a taxing initiative.

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



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

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

C – 2: Goals and Objectives – Access to Resources

Problem/ Need(s) Statement:

As aging occurs, older adults, and adults with disabilities are at risk of losing their ability to live independently. Unpaid Family and Kinship Caregivers are at continuous risk of being unable to

continue their loving and important work. To strengthen services and support to unpaid family and kinship caregivers in the O3A service region, O3A needs to conduct outreach, expand referral relationships, and provide targeted services responsive to the needs of family and kinship caregivers; expand options for training and group support for caregivers; and develop options for in-home and out-of-home respite care.

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

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

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

  Complete by 12/2023

Objective 2: Provide support and services to kinship caregivers.
Key Activities:

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

  Complete by 12/2023

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

Key Activities:

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

  Complete by 12/2023

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

- In partnership with the local Alzheimer's Association, facilitate increased training opportunities for support group leaders at community level.

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

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

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

Key Activities

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

Objective 2: Continue to develop network adequacy.

Key Activities

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

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

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

Key Activities:

- Offer ongoing, high quality Information and Assistance (I&A) programs throughout the region according to standards.
- Support I&A services and staff with training to maintain AIRS and CIR-S certification.
- Coordinate with local community partners to provide coverage with responsive services and current information on alternatives.
  Complete by 12/2023

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

Key Activities:

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

  Complete by 12/2023

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

Key Activities:

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

  Complete by 12/2023

New Objective 4*: Promote volunteer opportunities throughout the region to increase available resources and outreach, and to improve quality of life for the recipient as well as the volunteer.*

Key Activities:

- *Market the following volunteer opportunities throughout the PSA*
  - Becoming an Alzheimer's / Dementia Trainer or Support Group leader with the Alzheimer's Association
  - Home Delivered Meals Drivers with an O3A contractor
  - Long Term Care Ombudsman
  - Statewide Health Insurance Benefits Advisors (SHIBA)
  - Social Call Volunteers – making a call once a week to an elder to talk about anything and everything
  - Volunteer Transportation – with an O3A contractor taking elders to medical appointments and grocery shopping
  - Other opportunities occasionally become available, including Advisory Council representation, Special Projects, Advocacy, etc.
- *Provide quality volunteer experiences including evidence based training and retention services.*

~~**Objective 4:** Collaborate on developing the Long Term Care Trust Act Implementation Plan~~

~~**Key Activities:**~~

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

- ~~Participate on subcommittees as requested.~~ *At this time there is little work to be done by O3A staff. Advocacy for investing LTCTA funds will re-emerge in the future and O3A will engage our Advisory Council in advocacy efforts.*

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

Supporting People to Age in Place in their Homes[52]

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

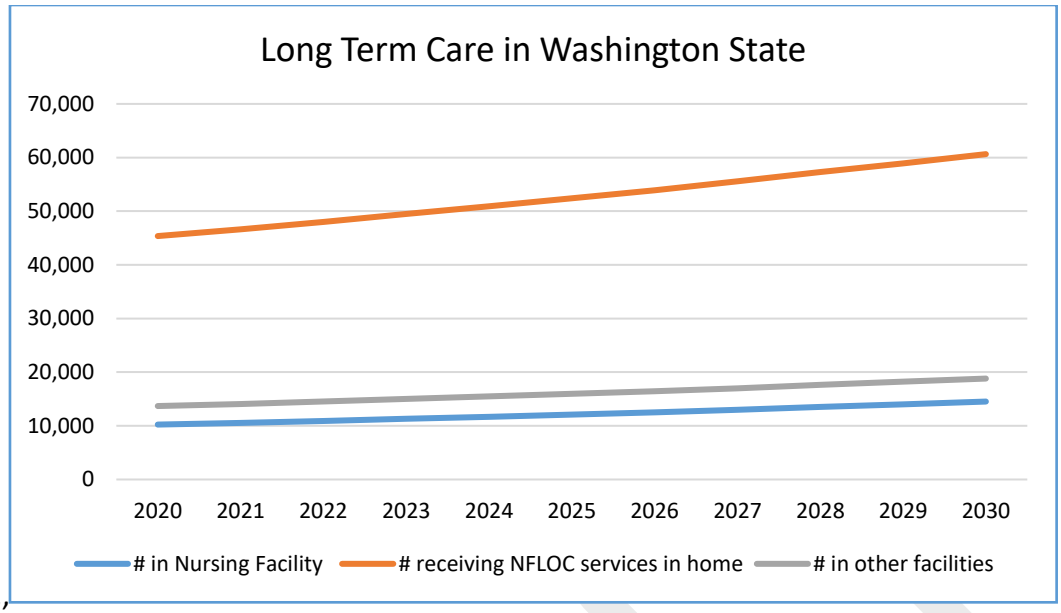
Not only is in-home care the preferred LTSS option, it is the most cost-effective. There is a wide range of services and hours of service authorized for individuals receiving care in their homes. However, the costs for home care services are significantly lower compared to over $5,000 to $9,000 or more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

As the following chart demonstrates, statewide there are over 46,000 people in the in-home and community-based portion of Washington's Medicaid LTSS system who face a broad range of challenges to their health and independence. All need assistance to accomplish daily activities such as bathing, dressing, preparing meals, personal hygiene, and moving around the home.

In the O3A service region, there are approximately 2,200 people receiving services through the Medicaid LTSS system. Of these, approximately 1,770 receive services in their homes; 350 are receiving services in a skilled nursing facility, and 280 in other community residential facilities.

Medicaid reimburses all providers of services at a much lower rate, much less that the actual cost of providing services. Because of this, the number of facilities in the O3A region that accept Medicaid clients is limited, which in turn limits the option for people who wish to remain in their communities when their need for services cannot be met through in-home care.

[52] David Mancuso, PhD., Jingping Xing, PhD., Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2030 in Washington State; Office of Financial Management, WA State, 2021 (includes chart on next page).



,,

Washington State Long-Term Care Assessment by Setting and Acuity

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

In-Home Care

Community-based in-home care services effectively support people with disabilities and self-care limitations, regardless of income, who wish to remain in their own homes. Approximately 80% of care provided in the home is performed by family members who need support and respite themselves. Approximately 20% of those who need ongoing care to stay at home do not have family members to care for them completely. These people often receive additional home care from paid home care workers.

On a monthly basis, O3A manages Medicaid LTSS services for about 1,770 people receiving in-home care. On an annual basis, with turnover, O3A supports about 2,277 people over the course of a year. After assessment, they receive an individual plan that authorizes personal care help with activities of daily living, including tasks such as bathing, toileting, and personal hygiene, mobility, encouragement walking, transferring from bed to wheelchair, housekeeping, laundry, and meal preparation, and trips to the doctor or for essential shopping.

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

Once the client has received an assessment and the case manager has authorized services, home care workers are engaged to support clients in their homes with the activities of daily living. Some qualified home care workers are trained to perform medical tasks such as insulin

injection or wound care under the supervision of a registered nurse. In addition, clients may receive other supportive services, such as nutritional counseling to help a diabetic client learn to make better food choices; or a walker to support safer ambulation. Multiple other resources are available to support an individual being able to remain successfully in their home

Within the O3A service region, paid home care is available from about 1,766 caregivers employed as individual providers (1,091) or as an agency home care workers (over 675) from seven agencies. This is a decrease of 434 care givers since 2020. Individual providers are contracted by O3A on behalf of the state, though the O3A Home Care Referral Registries, which recruit and support paid caregivers to receive health insurance benefits, training, and certification. Referral Registries also provide support for family caregivers who wish to transition to a paid career in caregiving.

In 2022, Consumer Direct Washington will assume many of the human resource management activities currently handled by the Home Care Referral Registries for Individual Providers.

COVID-19 Impact: The paid caregiver shortage, already a problem pre-pandemic, has been heightened by those leaving their caregiving positions for various reasons, and is now at the point where clients may have to wait for a caregiver to be assigned and/or may not receive all hours of service authorized.

Increasing caseloads & impact on the case management system

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

Within the O3A Medicaid caseload, the number of younger adults with disabilities (aged 18 and over) is similarly increasing. Younger clients tend to need more support from the case manager

to deal with "quality of life" needs such as increased mobility and communication needs. In addition, younger clients rely on LTSS for longer periods due to increased longevity.

Increasing clients' clinical complexity

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

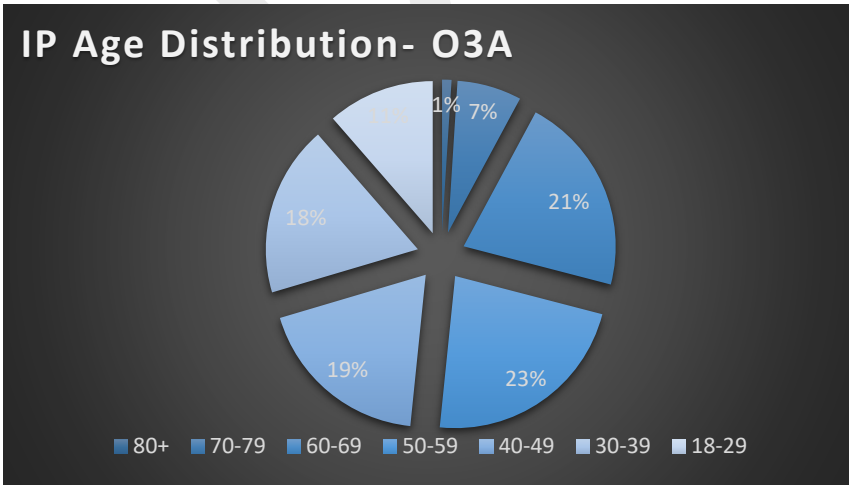
Especially for younger case managed clients with disabilities, there is a need to integrate other types of services, such as those provided through I&A and SHIBA, as well as other agencies, to support a substantial increase in client-directed service provision.

The proportion of people with disabilities who also have self-care limitations increases in the 65-plus age groups, and the prevalence of these limitations increases sharply for people who are 75-and older. People in this group are more likely to have physical or sensory limitations or to be unable to get out of the house. Although the rates of disabilities for older adults have declined overall, the older adult population with less education and lower income generally has not yet experienced these improvements.

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

Workforce and Provider Constraints

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



O3A completed a point-in-time assessment of Individual Provider age

distribution after hearing of a home care aide who could not drive at night because of their advanced age. The chart to the left represents the breakdown in age distribution of this workforce. This chart further highlights the fragility of the care system where 52% of the care providers are over the age of 50 themselves. Older workers are not a negative and are often very positively received by clients. Caregiving can be physically demanding, and older workers may not have access to accommodation for some of the tasks, thereby being at risk for injury. And an older workforce, paired with a workforce shortage, is a significant issue with future consequences.

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 and as mentioned this shortage has been magnified and worsened during the pandemic with a total loss of almost 500 qualified home care workers in the past 2 years. Agencies often struggle with having enough staff available, plus finding staff who will drive to distant rural areas. The small volume of clients in these remote areas makes it costly for agencies to provide the required supervision and to ensure that sufficient substitute caregivers are available when needed. The O3A home care contract requires agencies to serve at least a two-county region, for example an agency cannot elect to just provide service in Grays Harbor, with a higher client volume, but must also serve clients in Pacific County, with a lower number of clients. It is difficult, however, for agencies to serve an area if they cannot get workers there.

Individual Providers

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

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

Agency Providers

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

- The dramatic increase in transportation costs for service providers, especially in our rural region, where it is not unusual for clients to have to travel 100 miles or more in a month for services and medical appointments.

- Changes in federal regulations and state payment systems are making it difficult for smaller agencies and providers to afford the contract requirements, thus further limiting client choice.
- Lack of economies of scale (e.g., caseload size in large rural areas in relation to required administrative structure).
- The high costs to develop and support a decentralized, local structure to meet the needs of frail elders and adults with disabilities living in remote service areas.
- Insurance coverage for service providers has become more expensive as insurance. companies have associated higher risks with providing services to an aging population.

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

DSHS Home and Community Services staff may not be applying this reapplication process as frequently due to the pandemic-related caregiver shortage.

Contracting for Home Care Services

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

O3A contract managers work with case management personnel from Home and Community Services (HCS) and within O3A's region to recruit and contract with providers for services. O3A contract specialists and case management staff meet regularly to discuss concerns, issues, or questions regarding home care and other services. O3A meets at least annually with home care agencies throughout the region to discuss issues affecting service to clients. O3A Contract staff meet monthly with all contract managers and with ALTS staff across the state to discuss emerging issues and problems. Results of these meetings are provided to the Washington Association of Area Agencies on Aging (W4A) for any significant action.

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

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

Ensuring Compliance

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

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

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

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

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

Community First Choice

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

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

Health Homes

With funding from the centers for Medicare and Medicaid Services (CMS), Washington State implemented a plan that integrated care for beneficiaries who are eligible for both Medicaid and Medicare services, often referred to as ‘dual eligible’ or ‘duals’. The program is designed to reduce the fragmentation and complexity of the current system for people with two or more

chronic conditions, to streamline the process for eligible clients to access appropriate health care as needed, to set their own personal health goals and to be coached to reach those goals.

The Washington Health Homes 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 the community social service supports, and used patient education and behavior changing techniques such as motivational interviewing to empower clients to take charge of their health and use of healthcare series.

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

Health Homes Coordination

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

Health Home Services

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

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

The Health Home program emphasizes person-centered care that places the beneficiary in a pivotal role. The beneficiary is involved in improving their health through the development of an individualized Health Action Plan (HAP). Beneficiaries may choose to include their families, caregivers, or others as part of their Health Team. Each beneficiary is assigned a Care Coordinator (CC) who provides health coaching, community and health care service referral assistance, and care coordination to link efforts of the medical, behavioral health, substance abuse, long-term services and supports, and bring community social service delivery systems together to meet the beneficiary's identified healthcare needs in a coordinated manner. CCs

help the beneficiary to establish health goals and then work with them to assume greater levels of responsibility and confidence in the management of their own healthcare conditions which is critically important for individuals with chronic illness.

Health Homes Lead

The Health Homes program is an important building block in Washington State for innovation models promoting health, preventing and managing chronic disease, and controlling health care costs. As a Health Homes Care Coordinating Organization, O3A coordinates services for individual clients including community resources and medical resources.

In February 2019, O3A became a Health Homes Lead to both provide care coordination for eligible long-term care clients within the O3A service region; in 2021, the region was expanded to include Lewis, Mason, and Thurston. Now O3A recruits and contracts with other organizations willing to serve as a Health Homes Care Coordination Organizations (CCOs) throughout an eight county region. As a Health Homes Lead entity, O3A has the responsibility to expand this program to other high medical need populations such as those with substance use disorders and those with Behavioral Health Disorders. As of August 2021, O3A has contracts with 5 organizations, 2 of which are tribes, with two more organizations interested in developing contracts for this work.

C – 3: Goals and Objectives – Aging in Place

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

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

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

Key Activities:

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

Objective 2: Expand the Health Homes program.
Key Activities

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

Duplicate Objective of Goal C.1.2 a & b: ~~**Objective 3:** Implement training for O3A staff and community partners to promote better understanding for personalized (person-centered) services.~~
~~**Key Activities:**~~

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

~~**Completed by 12/2023**~~

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

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

- Advocate for adequate resources and programs in remote rural areas and for at risk populations, e.g., west coastal areas and regions outside of small cities.
- Identify at risk populations and effective mechanisms to reach them, share information about O3A with them, and remove barriers in serving them, e.g., working with 8 tribal communities, LGBTQ population and Latino populations.
  Completed by 12/2023

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

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

- ~~Contact local high schools and community colleges to encourage implementation of Home Care Aide (HCA) training/certification program and develop partnerships for this program with Home Care Agencies and Home Care Referral Registry/Consumer Directed Employers.~~ *This role had been in process with ALTSA staff prior to onset of pandemic.*
- *Until the Consumer Directed Employer (CDE) program is launched, continue to recruit and contract with individual providers through the O3A Home Care Referral Registries; ensure caregiver requirements are met, including certification and training.*
- New: Educate local community members about home care aide shortages and impacts and support ALTSA efforts to develop local high school/community college HCA programs.

  Completed by 12/2023

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

Key Activities:

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

  Completed by 12/2023

C – 4: PARTNERSHIPS WITH TRIBES

Within the O3A region, there are 8 federally recognized tribes.

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

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

Over the past several years two tribes have developed Health Homes contracts with O3A. One tribe has developed an Environmental Modification contract with O3A. We hope to expand contracts with tribes in the future so tribes can deliver more services to their own members. O3A has contracted with Northwest Justice's Native Unit to be able to offer legal clinics, most frequently to develop tribal wills.

Our goal always is to become a trusted resource so staff and elders can easily reach out and be connected to services and resources.

COVID Impacts: During the pandemic all tribes closed to outsiders to focus on the needs of tribal members to keep them safe and to keep tribal staff members safe. O3A maintained remote and telephone contact with the tribes seeking to understand evolving issues and connect staff and individuals to needed services. In some conversations we heard about some tribes' unique efforts to address social isolation which has been rampant in tribal communities, where family relationships and friendships and gathering are an inherent part of tribal culture. Other tribes delivered food to as many families as possible with their CARES Act funds, adding extra frozen meals for weekends. Services continued to be provided to elders as needed throughout 2020, and 2021, although many individuals receiving case management and personal care services opted to limit their exposure to caregivers.

The eight most current 7.01 plans for each tribe in the O3A region appear on the following pages.

Policy 7.01 Plan and Progress Report *(Draft)*

Timeframe: July 1, 2021 to June 30, 2022 Updated 12/04/2020

AAA: Olympic Area Agency on Aging **Region 3 / South** **Tribe(s)/RAIOs: Chehalis Confederated Tribes**

Annual Due Date: April 2 (Submit Regional Plan to the Assistant Secretary) and April 30 (submit Assistant Secretary's Plan to OIP).

Implementation Plan				**Progress Report**
Goals/Objectives	Activities	Goals/Objectives	Activities	Goals/Objectives
1. Continue outreach to the Chehalis Tribe	○ Meet with tribe's representatives to develop / update 7.01 policy plan. ○ Ensure current outreach assistance is continued & explore expanding support and coordination assistance with the Chehalis Tribe as available O3A resources allow. ○ Meet with tribal representatives to discuss elder issues as requested. ○ Ensure tribal issues are considered in agency planning, training, and project development. ○ Ensure tribal elders and staff are aware of access to resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder.	○ Tailored updated 7.01 plan in place between O3A and Chehalis Tribe ○ Enhanced access to culturally relevant services for tribal elders. ○ Increased collaboration with local tribes and community partners to assure access to appropriate services. ○ Elders, family members and staff are able to identify resources and plan more easily for elders' needs. ○ New pandemic related elder issues are identified and addressed.	State/AAA: Laura Cepoi, Executive Director, 360.379.5064 laura.cepoi@dshs.wa.gov Jaci Hoyle, Regional Director, 360.301.1052 jaci.hoyle@dshs.wa.gov Jody Moss, Contracts Management & Planning Director, 360.379.5064 jody.moss@dshs.wa.gov O3A Advisory Council (AC) Tribal Rep I&A Offices–call for address: Aberdeen 360.532.0520 800.801.0060 Marietta Bobba, 360.438.8633, Marietta.bobba@dshs.wa.gov Brenda Francis Thomas, francBD@dshs.wa.gov, 360.565.2203 Tribe: Frances Pickernell, Chehalis Social Services Director, fpickernell@chehalistribe.org, 360.709.1745	

	○ Identify any new elder issues emerging from the COVID19 Pandemic and work together to address needs.		Holli R. Gomes, Chehalis APS Caseworker hgomes@chehalistribe.org 360.810.1350 (C) 360.709.1745 Timeline: 7/1/2021 – 6/30/ 2022	
2. Improved caregiver training and support options for unpaid family caregivers and for paid caregivers serving tribal members for interested tribes. Note: In 2019, the Chehalis Tribe sponsored Savvy Caregiver training, so staff have been engaged in this work.	○ Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs ○ Identify unpaid family caregivers through family caregiver support programs* and tribal social service referrals and support Tribal caregivers to obtain respite, training, and other forms of support. ○ Through partnerships with tribal staff, identify tribal members interested in becoming paid caregivers and provide referrals for training** and becoming an independent provider or for working for a home care agency. ○ Include Tribal caregivers in Home Care Referral Registry (HCRR)*** training and referral activities. ○ As needed, support Chehalis' Savvy Caregiver efforts	○ Coordinated Title III and VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing and provision of technical assistance. ○ Increased resources for and capacity of family caregivers to support their loved ones in their homes for as long as possible. ○ Tribal capacity for accessing and/or providing training to Tribal members interested in becoming caregivers. Tribal caregivers are able to access training and potential employment in a timely manner. ○ Increased number of Tribal caregivers	State/AAA: Laura Cepoi, Executive Director, 360.379.5064 laura.cepoi@dshs.wa.gov Jaci Hoyle, Regional Director, 360.301.1052 jaci.hoyle@dshs.wa.gov Jody Moss, Contracts Management & Planning Director, 360.379.5064 jody.moss@dshs.wa.gov O3A Advisory Council (AC) Tribal Rep I&A Offices–call for address: Aberdeen 360.532.0520 800.801.0060 Marietta Bobba, 360.438.8633, Marietta.bobba@dshs.wa.gov Brenda Francis Thomas, francBD@dshs.wa.gov, 360.565.2203 Tribe: Frances Pickernell, Chehalis Social Services Director, Holli R. Gomes, Chehalis APS Caseworker Timeline: 7/1/2021 – 6/30/ 2022	

	○ Provide a presentation to staff on Medicaid Alternative Care and Tailored Services for Older Adults (MAC & TSOA)	○ Improved caregiver services to elders; caregivers become more resilient ○ Tribal staff gain knowledge about new caregiver support programs.		
3. Enhanced services / support for Tribal grandparents / other elders raising children	○ Increase outreach efforts, particularly for remote communities and Tribal reservations, to inform families of the resources available for relatives raising children.	○ a. Tribal grandparents & other elders raising children gain additional and often critical support through Relatives as Parents/Kinship Care Support programs.	State/AAA: Jaci Hoyle Eric Nessa, O3A Kinship Care Support Program and Relatives as Parents Delivery staff Tribe: Frances Pickernell, Chehalis Social Services Director, Holli R. Gomes, Chehalis APS Caseworker Timeline: 7/1/2021 – 6/30/ 2022	
4. Improved Tribal access to health and nutrition education and program services to the extent resources allow.	○ Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition education programs. ○ Share useful resources between tribes and nutrition providers such as printed education material and 1/3 RDA approved menus.	○ Tribal elders participate in programs implemented by local health / nutrition education providers. ○ Capacity for local tribes and regional nutrition providers is increased by sharing ideas and material; more elders receive better	State/AAA: O3A Planning & Program Mgmt. staff Coastal Community Action Program, Nutrition Services, Annette Glodowski - 360.500.4530, annetteg@coastalcap.org Tribe: Frances Pickernell, Chehalis Social Services Director,	

		information around health and nutrition.	Holli R. Gomes, Chehalis APS Caseworker Tribal Nutrition Providers Timeline: 7/1/2021 – 6/30/ 2022	
5. Improved access to health and support services for Tribal elders.	○ Increase coordination between the Area Agency on Aging and Tribal representatives to facilitate access to local services for Tribal Elders. ○ As funding opportunities permits, Janis Housden will coordinate with Chehalis staff to access to prevention program funding (Savvy Caregivers, Powerful Tools for Caregivers, Wisdom Warriors, fall prevention programs), etc. for elders.	○ Tribal issues are represented in local community, county, and regional planning efforts. ○ Tribal needs are considered and addressed by local service providers, resulting in increased access to services.	State/AAA: Jaci Hoyle, Regional Director Jody Moss, Planning Director Janis Housden, Contract Specialist Tribe: Frances Pickernell, Chehalis Social Services Director, Holli R. Gomes, Chehalis APS Caseworker Timeline: 7/1/2021 – 6/30/ 2022	
6. Strengthened O3A and tribal partnerships.	○ Notify tribal staff when recruiting tribal representation on O3A Advisory Council. ○ Notify tribes when O3A staff positions are open. ○ Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues. ○ Ensure contracting mechanisms support productive tribal partnerships.	○ Partnerships between O3A and region tribes result in more responsive service and program development. ○ Tribal members have opportunities for employment; O3A becomes more diverse and representative of the community we serve	State/AAA: AC Tribal Representative TBD Designated O3A Contracts Management staff and Direct Service staff O3A leadership Tribe: Frances Pickernell, Chehalis Social Services Director, Holli R. Gomes, Chehalis APS Caseworker Timeline: 7/1/2021 – 6/30/ 2022	

		○ Contract instruments are responsive to tribal administration capacity.		
7. Improved access to transportation for Tribal Elders with special needs.	○ Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions (RTPO & local transportation initiatives if known). ○ Volunteer Transportation program is accessible to all members over age 60. ○ Tribes can identify a tribal volunteer driver(s) if they wish who would become a volunteer with the volunteer transportation program and could be reimbursed per mile driven for qualified transport services.	○ Local planning efforts are responsive to transportation needs of Tribes. Promote increased options for transportation for Tribal Elders with Special needs. ○ Volunteer transportation provider will complete a resource presentation to the Tribe if requested. ○ Tribal volunteer drivers expand transportation capacity for Elders over 60. (Note that this age limitation is determined by fund source – Older Americans Act)	State/AAA: Jody Moss – O3A Contracts Mgmt. & Planning Director Grays Harbor Amanda Farrar, CCAP 360.500.4524 amandaf@coastalcap.org Pacific Abbi Quigg Volunteer Services, CCS abbiq@ccsww.org, 360.637. 8563.ext113 Tribe: Frances Pickernell, Chehalis Social Services Director, Holli R. Gomes, Chehalis APS Caseworker Tribal Social Services Director Tribal Elders Liaison Timeline: 7/1/2021 – 6/30/ 2022	
8. Assist Chehalis Tribe if interested, to develop contracts available in 2018 (for example, Adult Days Services, Home Care Agency, Environmental Modification, Transportation, and others).	○ Notify tribe of option to contact O3A to help develop services/contracts ○ Provide technical assistance as needed ○ Assist with first series of contract monitoring visits as needed. ○ Tribe is interested in Transportation and will work	○ Communication between O3A and tribe results in awareness of new service options, and strengthens O3A's relationship with Chehalis Tribe ○ Expands culturally relevant services to tribal elders	AC Tribal Representative Jody Moss Jaci Hoyle Designated O3 Program Manager, and O3A Direct Service staff, Marietta Bobba, 360.438.8633, Marietta.bobba@dshs.wa.gov Ingrid Henden, O3A Program Manager, Environmental Modification Contracts,	

Note: Since Chehalis Members live and receive services in both Grays Harbor (O3A's region) and Lewis County – Lewis Mason Thurston Area Agency on Aging (LMTAAA) – we will work closely with LMTAAA staff to develop contracts in both regions if they need to cross county lines	with Marietta Bobba to determine if a contract is a solution. ○ They may be interested in an Environmental Modification Contract as well.	○ Strengthens and improves the quality and cultural relevancy of services provided through tribal contracts.	Ingrid.henden@dshs.wa.gov, 360.379.5064. Tribe: Frances Pickernell, Chehalis Social Services Director Holli R. Gomes, Chehalis APS Caseworker Timeline: 7/1/2021 – 6/30/ 2022	

Note: Because tribal members live and/or seek services in both Grays Harbor and Lewis Counties, O3A and Lewis Mason Thurston Area Agency on Aging (LMTAAA) developed the following check sheet for meeting needs of tribal members in each region.

Type of Service	O3A	LMTAAA	Service definition
Case Management	X	X	Authorizes services on Medicaid in-home care programs, works with client to obtain care, coordinates care, brings on new services as needed – predominant service includes Home Care services from an agency or individual provider
Contact	Jaci Hoyle (360) 301-1052 jaci.hoyle@dshs.wa.gov	Buong Le 360-664-3162 x140 buong.le@dshs.wa.gov	
Information & Assistance	X	x	Helps clients work through problems/questions, find resources, connects to services available from other organizations, connects clients to other internal services
Contact	Aberdeen Office: 800-801-0060 360-532-0530	John McBride 360-664-3162 x 139 John.mcbride@dshs.wa.gov	
Family Caregiver Support	X	X	Support for the unpaid caregiver including respite caregiving services, training, equipment, counseling, massage, etc.
Contact	Jaci Hoyle	John McBride	

MAC & TSOA	X	X	Medicaid Alternative Care / Tailored Services for Older Adults - Provides similar services as above for unpaid caregivers and in-home care for adults who do not have a caregiver through a new Medicaid program which has more relaxed financial requirements and does not include estate recovery
Contact	Jaci Hoyle	John McBride	
Kinship Caregiver Support, Relatives as Parents	X	X	Resources for non-parental relatives who are caring for children under the age of 18; example include clothes, cribs, car seats, school fees, etc. LMTAAA subcontracts kinship support to the local non-profit Family Education and Support Services (1-877-813-2828) who provide support groups, Kinship Navigator services and emergency goods and services.
Contact	Jaci Hoyle	Carrie Petit 360-664-3162 x 115 Carrie.petit@dshs.wa.gov (Subcontracted service)	
Evidence Based Program Funding	X	X	Funding that you can apply for to fund training and workshops for a variety of programs focused on preventing problems and strengthening individuals. Examples are Falls Prevention programs like SAIL & Tai Ji Quan Moving for Better Balance, Wisdom Warriors & Chronic Disease Self Management, Powerful Tools for Caregivers, Savvy Caregivers, and many others
Contact	Janis Housden 360-379-5064 janis.housden@dshs.wa.gov	Donna Feddern 360-664-3162 x142 Donna.feddern@dshs.wa.gov Alison Lord 360-664-3162 x137 Alison.Lord@dshs.wa.gov	
Senior Legal Advice/ Clinics	X	X	Lawyers will meet with individuals over 60 for 30 minute slots to answer legal questions and help with civil legal problems. For O3A, Elders call our Information and Assistance offices for an appointment.
Contact	Jaci Hoyle	Carrie Petit	

		(Subcontracted Service)	LMTAAA subcontracts legal services with Northwest Justice Project. Elders can call the Northwest Justice Project at 1-888-387-7111.
Long Term Care Ombudsman	X	X	Volunteer Ombudsman visits individuals in nursing homes, assisted living and adult family home facilities, and serve as their advocate and watch dog.
Contact	Jaci Hoyle	State Long Term Care Ombudsman Program Office 1-800-562-6078	
SHIBA Help Line and SHIBA Clinics	X	X	State Health Insurance Benefits Advisors – Volunteers provide information and help with questions about Medicare, Medicare Part D, and other insurance plans. They help compare plans for the client to make informed decisions.
Contact	State Helpline: 800-562-6900 O3A SHIBA Help: 360-538-2444, or 800-801-0060	State Helpline – 800-562-6900	
Home Care Referral Registry	X	X	
Contact	Jaci Hoyle	Emily MacFarland 360-664-3162 x 104 emily.macfarland@dshs.wa.gov	Helps connect clients to Individual Providers, and contract with Individual Providers giving them direction on how to obtain their Home Care Aide Certification
Adult Day Care		X	
Contact	Currently not available in Grays Harbor	Carrie Petit (Subcontracted Service – Thurston & Mason County locations)	A community-based supervised daytime program providing personal care and social day care services for adults with disabilities not requiring skilled nursing care, while offering respite to family caregivers.

Nutrition Services	X	X	
Contact	Subcontracted through Coastal Community Action Programs 360-533-5100	Valerie Aubertin 360-664-3162 x146 Valerie.aubertin@dshs.wa.gov (Subcontracted Service)	Congregate and home delivered meals for seniors age 60 and older (OAA).
Other services we contract with outside agencies for clients	X	X	
PERS	X	X	Personal Emergency Response System
Counseling	X	X	Counseling
Environmental Modification	X	X	Fixing a client's home with a ramp, grab bars,
Community Transition and Training Services	X	X	Services that help individuals transition back to the community from a nursing home
Volunteer Transportation	X	X	Transportation to medical appointments and other critical services
Senior Farmers Market Nutrition Program	X	X	Bulk Food program in Grays Harbor – sign up each spring for weekly or biweekly delivery or pick up. LMTAAA uses a voucher program to access fresh fruit and vegetables at authorized farmers' markets and roadside stands.
Assistive Technology	X	X	Technology that helps a client stay at home (exclude hearing aids)
Client Training	X	X	Based on client need
And many other services			
Assistive Technology	X		Technology that helps a client stay at home (exclude hearing aids)
Client Training	X	X	Based on client need
And many other services			

Policy 7.01 Plan and Progress Report *(Draft)*

Timeframe: July 1, 2021, to June 30, 2022 Updated: June 2020

AAA: Olympic Area Agency on Aging **Region 3 / North** **Tribe(s)/RAIOs: Hoh Tribe**

Annual Due Date: April 2 (Submit Regional Plan to the Assistant Secretary) and April 30 (submit Assistant Secretary's Plan to OIP)

Implementation Plan				**Progress Report October 2020**
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	Status Update for the Fiscal Year starting last July 1.
1. Continue current outreach assistance to tribal members.	○ Meet with tribe's representatives to clarify/ update Administrative Policy 7.01 plan. ○ Ensure current outreach assistance is continued & explore expanding support and coordination assistance with Hoh Tribe as available O3A resources allow. ○ Meet with tribal representatives to discuss elder issues as requested. ○ Ensure tribal issues are considered in agency planning, training, and project development. ○ Ensure tribal elders and staff are aware of access to resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made by	○ O3A and Hoh Tribe's relationship is strengthened leading to better communication and more opportunities for partnerships. ○ Enhanced access to culturally relevant services for tribal elders. ○ Increased collaboration with the Hoh Tribe and community partners to assure access to appropriate services. ○ Elders, family members and staff are able to identify resources and plan more easily for elders' needs.	State/AAA: Laura Cepoi, Executive Director, 360.379.5064 laura.cepot@dshs.wa.gov Jaci Hoyle, Regional Director, 360.301.1052, jaci.hoyle@dshs.wa.gov Jody Moss, Contracts Management & Planning Director, 360.379.5064 jody.moss@dshs.wa.gov O3A Forks office staff: Char Carte - 360.374.9496 carteci@dshs.wa.gov, Susie Brandelius -360.374.9496, brandcs@dshs.wa.gov O3A Advisory Council Tribal Rep (open position) Brenda Francis Thomas, francBD@dshs.wa.gov, 360.565.2203 I&A Offices–call for address: Sequim 360.452.3221 800.801.0070 Forks 360.374.9496 888.571.6559	

	elder or others on behalf of elder. ○ Arrange a Meeting between Felicia Leitka and O3A Forks staff, to facilitate better linkages. ○ O3A staff will participate in Resource/Health Fairs and other tribal activities, as time permits to share resource information.		Tribe: Hoh Tribe Representatives: Open Position, Family Services Dir. open@hohtribe-nsn.org, 360.374.5423 Sharon Millett, DBHR / Librarian, Sharon.millett@hohtribe-nsn.org, 360-374-5288 Bob Smith, ED, bob.smith@hohtribe-nsn.org, 360.374.6501, 360.780.0280-c Timeline: 7/1/2021 through 6/30/2022	
2. Improved caregiver training and support options for unpaid family caregivers and for paid caregivers serving tribal members (if interested/requested).	○ Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs ○ Identify unpaid family caregivers through family caregiver support programs and tribal social service referrals and support caregivers to obtain respite, training, and other forms of support. ○ Provide information and support for tribal members to access the Medicaid Alternative Care and Tailored Supports for Older	○ Coordinated Title III and VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing and provision of technical assistance. ○ Increased resources for and capacity of family caregivers to support their loved ones in their homes for as long as possible. ○ Hoh Tribe capacity for accessing and/or providing training to Tribal members interested in becoming caregivers. Hoh Tribe caregivers are able to	State/AAA: Jody Moss Jaci Hoyle Susie Brandelius HCRR Coordinators – Aida Crumb, 360.417.8553, aida.crumb@dshs.wa.gov Tribe: Hoh Tribe Representatives: Open Position, Family Services Dir. Sharon Millett, DBHR / Librarian, Bob Smith, ED, Timeline: 7/1/2021 through 6/30/2022	

	Adults (MAC & TSOA) Programs ○ With help from Hoh Tribe staff, identify tribal members interested in becoming paid caregivers and provide referrals for training to become an independent provider or a home care agency worker. ○ Include Tribal Individual Providers in Home Care Referral Registry training and referral activities.	access training and potential employment in a timely manner. ○ Unpaid family caregivers of elders receive additional services to support them in caregiving and help sustain services in the home for as long as possible. ○ Increased number of Tribal caregivers available to deliver home care services to elders		
3. Enhanced services / support for Tribal grandparents / other relatives raising children	○ Increase outreach efforts to inform families of the resources available for relatives raising children.	○ Tribal grandparents & other relatives raising children gain additional and often critical support through Relatives as Parents/Kinship Care Support programs.	State/AAA: O3A Kinship Care Support Program and Relatives as Parents program staff: Susie Brandelius Hoh Tribe Representatives: Open Position, Family Services Dir. Sharon Millett, DBHR / Librarian, Bob Smith, ED, Timeline: 7/1/2021 through 6/30/2022	
4. Improved Hoh Tribe access to health and nutrition education and program services to the extent resources allow.	○ Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition education programs.	○ Tribal elders participate in programs implemented by local health / nutrition education providers. ○ Capacity for Hoh Tribe and regional nutrition providers is increased by	State/AAA: Jody Moss or designated O3 Program Manager, and O3A Services Delivery staff Kathy Sculley, OlyCAP – (360) 452-4726 , Ext. 6213 ksculley@olycap.org	

	○ Work to identify additional options for accessing Home Delivered or Congregate Meals – Connect Tribal staff with OlyCAP Nutrition program manager ○ Schedule a meeting with Marietta Bobba and tribe to explore tribal home delivered meal funds ○ Share useful resources between Hoh Tribe and nutrition providers such as printed education material and 1/3 RDA approved menus.	sharing ideas and material; more elders receive better information around health and nutrition.	Marietta Bobba, 360.438.8633, Marietta.bobba@dshs.wa.gov Hoh Tribe Representatives: Open Position, Family Services Dir. Sharon Millett, DBHR / Librarian, Bob Smith, ED, Timeline: 7/1/2021 through 6/30/2022	
5. Improved access to health and support services for Tribal elders.	○ Increase coordination between the Area Agency on Aging and Tribal representatives to facilitate access to local services—especially health care-- for Tribal Elders. ○ Invite the Hoh Tribe to engage in the O3A Prevention programs ○ *New:* Explore options for scheduling a SHIBA Clinic for Hoh Elders	○ Tribal issues are represented in local community, county planning efforts. ○ Tribal needs are considered and addressed by local service providers, resulting in increased access to services. ○ Tribal Elders /others gain knowledge planning options for Medicare / other insurance coverage.	State/AAA: Jaci Hoyle, Regional Director Jody Moss, Dir, Contracts Management & Planning Hoh Tribe Representatives: Open Position, Family Services Dir. Sharon Millett, DBHR / Librarian, Bob Smith, ED, Timeline: 7/1/2021 through 6/30/2022	

6. Strengthen O3A and tribal partnerships.	○ Notify tribal staff when recruiting tribal representation on O3A Advisory Council. ○ Notify the Hoh Tribe when O3A staff positions are open. ○ Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues.	○ Partnerships between O3A and the Hoh Tribe results in more responsive service and program development. ○ Tribal members have opportunities for employment; O3A becomes more diverse and representative of the community we serve	State/AAA: AC Tribal Representative - TBD Jody Moss or designated O3 Contracts Management staff, and O3A Direct Services staff Carol Ann Laase, O3A Human Resources – 360.379.5064, Lasseca@dshs.wa.gov Brenda Francis Thomas, DSHS Hoh Tribe Representatives: Open Position, Family Services Dir. Sharon Millett, DBHR / Librarian, Bob Smith, ED, Timeline: 7/1/2021 through 6/30/2022	
7. Improved access to transportation for Tribal Elders with special needs.	○ Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions (RTPO & local transportation initiatives if known). ○ Volunteer Transportation program is accessible to all members over age 60. ○ If the Hoh Tribe is able to identify a tribal staff member or volunteer driver(s), they can become a volunteer with the volunteer transportation	○ Local planning efforts are responsive to transportation needs of The Hoh Tribe. Promote increased options for transportation for Tribal Elders with Special needs. ○ Volunteer transportation provider will complete a resource presentation to the Tribe if requested. ○ Tribal volunteer drivers expand transportation capacity for Elders over 60. (Note that this age limitation is determined	State/AAA: Jody Moss or designated O3 Program Manager, and O3A Services Delivery staff Clallam Teri Wensits, Volunteer Chore Services, TeriW@ccsww.org, 360.417.5640 Hoh Tribe Representatives: Open Position, Family Services Dir. Sharon Millett, DBHR / Librarian, Bob Smith, ED, Timeline: 7/1/2021 through 6/30/2022	

	program and could be reimbursed per mile driven for qualified transportation services of elders 60 and over.	by fund source – Older Americans Act)		
8. Assist the Hoh Tribe, if interested, to develop contracts (for example, Adult Days Services, Home Care Agency, Environmental Modification Transportation Health Homes and others).	○ Notify Hoh Tribe of options to contact O3A to help develop services/contracts ○ Schedule a separate meeting to discuss possible contracts ○ Provide technical assistance as needed ○ Assist with first series of contract monitoring visits as needed.	○ Communication between O3A and the Hoh Tribe results in awareness of new service options, and strengthens O3A's relationship with the Hoh Tribe ○ Expands culturally relevant services to tribal elders ○ Strengthens and improves the quality and cultural relevancy of services provided through tribal contracts.	State/AAA: Jody Moss or designated O3 Program Manager, and O3A Services Delivery staff Marietta Bobba, ALTSA Tribal Affairs Administrator, 360.725.2618, marietta.bobba@dshs.wa.gov AC Tribal Representative Hoh Tribe Representatives: Open Position, Family Services Dir. Sharon Millett, DBHR / Librarian, Bob Smith, ED, Timeline: 7/1/2021 through 6/30/2022	The onset of COVID-19 stopped further outreach around this goal in 2020, as both the tribe and O3A dealt with critical pandemic issues. The option for tribal contracts, remains available should the tribe be interested in the future.

Policy 7.01 Plan and Progress Report *(Draft)*

Timeframe: July 1, 2021, to June 30, 2022 Updated: January 2020

AAA: Olympic Area Agency on Aging **Region 3 / North** **Tribe(s)/RAIOs: Jamestown S'Klallam Tribe**

Annual Due Date: April 2 (Submit Regional Plan to the Assistant Secretary) and April 30 (submit Assistant Secretary's Plan to OIP).

Implementation Plan				**Progress Report**
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for Fiscal Year starting last July 1.
1. Jamestown S'Klallam Tribe (JST) and Olympic Area Agency on Aging (O3A) representatives work together to develop an effective outreach plan	○ Representatives from JST and O3A meet together to develop / refine tailored 7.01 plan ○ Ensure outreach assistance is provided & explore expanding support and coordination assistance as available resources allow. ○ O3A and I & A staff meet with JST tribal representatives to discuss elder issues as requested/give presentations to elders on services available and how to access them as requested. ○ Ensure tribal issues are considered in agency planning, training, and project development.	○ Plan guides activities and coordination between JST and O3A. ○ Enhanced access to culturally relevant services for tribal elders. ○ Increased collaboration and communication with JST and community partners to assure access with appropriate services. ○ Elders, family members and staff are able to identify resources and plan more easily for elders' needs.	State/AAA: Laura Cepoi, Exec Director, O3A, laura.cepoi@dshs.wa.gov 360.379.5064 Jaci Hoyle, Regional Director, 360.301.1052, jaci.hoyle@dshs.wa.gov Jody Moss, O3A Contracts Mgmt. & Planning Director, 360.379.5064 jody.moss@dshs.wa.gov, I&A Offices–call for address: Sequim 360.452.3221 800.801.0070 O3A Advisory Council Tribal Representative – Open Position Brenda Francis Thomas, francBD@dshs.wa.gov, 360.565.2203 Marietta Bobba, Tribal Planning & Program Development Manager, (360) 725-2618 marietta.bobba@dshs.wa.gov Tribe: Rob Welch, 360.582.4868 rwelch@jamestowntribe.org,	

			Loni Greninger, 360.681.4660, lgreninger@amestowntribe.org Timeline: 7/1/2021 – 6/30/2022	
2. Improved caregiver training and support options for JST	○ Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs ○ Assist paid and unpaid Tribal caregivers to obtain training and support. ○ Provide a presentation to staff on Medicaid Alternative Care and Tailored Services for Older Adults (MAC & TSOA) ○ Connect JST staff and caregivers with Savvy Caregiving Training opportunities	○ Coordinated Title III & VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing, and provision of technical assistance. ○ Tribal caregivers are able to access training. ○ Increased number of tribal caregivers. ○ Tribal staff gain knowledge about new caregiver support programs.	State/AAA: Jaci Hoyle Jody Moss Fran Koski, Family Caregiver Support Program, 360.3417.8549, koskiff@dshs.wa.gov Renee Worthey, (MAC/TSOA), 360.406.0091, renee.worthey@dshs.wa.gov Catholic Community Services – Local Training Partnership for caregiver training - Robin Gibson, robing@ccsww.org, 360.417.5420 Aida Crumb, 360.417.8553, crumbaf@dshs.wa.gov – works with Individual Providers Marietta Bobba, Tribal Planning & Program Development Manager (Savvy Caregivers) (360) 725-2618 marietta.bobba@dshs.wa.gov Tribe: Rob Welch Loni Greninger Timeline: 7/1/2021 – 6/30/2022	
3. Enhanced services/support for Tribal grandparents / other Elders raising children	○ Increase outreach efforts, Fran Koski to introduce self to JST to inform families of resources available for relatives raising children.	○ Kinship Care Support Program will benefit tribal grandparents and other Elders raising children.	State/AAA: Jaci Hoyle, Fran Koski, Renee Worthey (MAC/TSOA) Tribe: Rob Welch	

			Loni Greninger Timeline: 7/1/2021 – 6/30/2022	
4. Improved access to health and nutrition education and program services to the extent resources allow.	○ Through nutrition contracts with OlyCAP, promote inclusion of local Tribal Elders in nutrition programs. ○ Coordinate with OlyCAP to contact JST and market program to elders. ○ Explore tribal access to new state home delivered meals expansion funds.	○ Tribal Elders may participate in programs implemented by OlyCAP, the health/nutrition education contractors. ○ More elders access fresh local foods through the Senior Farmers Market Nutrition Program. ○ Tribal elders have access to healthy, nutritious meals.	State/AAA: Jody Moss Kathy Sculley, OlyCAP (360) 452-4726, Ext. 6213 ksculley@olycap.org Tribe: Rob Welch Loni Greninger Timeline: 7/1/2021 – 6/30/2022	
5. Improved access to health and support services for Tribal Elders.	○ Increase coordination between the O3A and tribal representatives to facilitate access to local services for Tribal Elders. ○ As funding opportunities permit, coordinate with JST staff to access to prevention program funding (Powerful Tools for Caregivers, Wisdom Warriors, Falls Prevention programs), etc. ○ Explore options for a Tribal Legal Clinic, and/or Senior Legal Advice Clinic ○ Connect tribe with Advanced Directives & Estate Planning presentations to elders	○ Tribal issues are represented in local community, county planning efforts. ○ Tribal needs are considered and addressed by local service providers, resulting in increased access to services. ○ Tribal Elders' civil legal needs are addressed ○ Elders learn about advance directives and are able to develop plans for themselves and families ○ High need tribal elders' health improves based on their own goals.	State/AAA: Jaci Hoyle, Jody Moss Sandy Ulf, Olympic Medical Center Honoring Choices program, sulf@olympicmedical.org (Advanced Directives) (retiring in 2021) Tribe: Rob Welch Loni Greninger Timeline: 7/1/2021 – 6/30/2022	

	○ Explore options for contracting with Jamestown Clinic and/or JST Social Services for Health Homes Care Coordinating Organization (CCO) for eligible tribal Elders			
6. Strengthen O3A and JST partnerships.	○ Notify JST staff when recruiting tribal representatives for Advisory Council. ○ Notify JST when O3A positions are open. ○ Explore options for O3A staff visiting elders' lunches	○ Partnerships between O3A & JST result in responsive service / program development. ○ JST members have opportunities for employment; O3A becomes more diverse.	State/AAA: Jody Moss Jaci Hoyle Tribe: Rob Welch Loni Greninger Timeline: 7/1/2021 – 6/30/2022	
8. Help the Jamestown Tribe if they are interested, to develop contracts.	○ Notify tribe of option to use O3A to help develop services/contracts ○ Provide technical assistance as needed ○ Assist with first series of contract monitoring visits as needed. ○ During 7.01 planning meetings, interest was expressed in Environmental modification, Adult Day Care, Health Homes – Schedule follow up session	○ Communication between O3A and the Jamestown S'Klallam Tribe results in awareness of some options, and strengthens O3A's relationships with tribe ○ Expands services available to tribal elders ○ Strengthens and improves the quality of services provided through tribal contracts	State/AAA: Designated O3 Program Manager, and O3A Services Delivery staff Jody Moss AC Tribal Representative Open Position Tribe: Rob Welch Loni Greninger Timeline: 7/1/2021 – 6/30/2022	
9. Improved access to transportation for Tribal Elders with special needs.	○ Facilitate Tribal representation in local planning and coordination efforts and	○ Local planning efforts are responsive to transportation needs of the tribe. Promote increased options for transportation	State/AAA: Jody Moss Loni Greninger Clallam	

	regional transportation coalitions ○ Explore options for developing a corps of tribal volunteers to help transport elders to activities/medical appointments as part of Catholic Community Services Volunteer Transportation program	for Tribal Elders with Special needs. ○ Volunteer transportation provider can complete a resource presentation to the Tribe if requested. ○ Tribal volunteer drivers expand transportation capacity for Elders over 60. (Note that this age limitation is determined by fund source – Older Americans Act)	Teri Wensits, Volunteer Chore Services, TeriW@ccsww.org, 360.417.5640 Timeline: January 1, 2020 – December 31, 2022	

Policy 7.01 Plan and Progress Report (*Draft)*

Timeframe: July 1 2021 to June 30, 2022 Updated: 11/5/2020

AAA: Olympic Area Agency on Aging **Region: 3 North Office** **Tribe(s)/RAIOs: Lower Elwha Klallam Tribe**

Annual Due Date: April 2 (Submit Regional Plan to the Assistant Secretary) and April 30 (submit Assistant Secretary's Plan to OIP).

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.
Continue current outreach assistance to the Lower Elwha Klallam Tribe.	Ensure current outreach assistance is continued and explore expanding support and coordination assistance as available resources allow. Hold regular meetings with Lower Elwha to discuss elder issues at least biannually. Expand activities in this area through grants available. Include Tribal Outreach staff agency planning, training and project development, and regular emails related to programs. Ensure tribal elders and staff are aware of access to resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder.	Enhanced access to culturally relevant services for Tribal Elders Increased collaboration with Lower Elwha and community partners to assure appropriate services for tribal elders. Elders, family members and staff are able to identify resources and plan more easily for elders' needs.	State/AAA: Laura Cepoi, Executive Director, 360.379.5064 Laura.Cepoi@dshs.wa.gov Jaci Hoyle, Regional Direct Services Director, 360.301.1052 jaci.hoyle@dshs.wa.gov Jody Moss, Contracts Management & Planning Director, 360.379.5064 jody.moss@dshs.wa.gov I&A Offices–call for address: Sequim 360.452.3221 800.801.0070 Forks 360.374.9496 888.571.6559 Pt Townsend 360.385.2552 800.801.0050 Tribal Staff Becca Weed, LEKT Social Services Director / Elders 360.461.7033 Becca.Weed@elwha.org Lorinda Robideau, Lorinda Robideau, LEKT Health Director, Lorinda.Robideau@elwha.org Timeline: 7/1/2021 to 6/20/2022	

	Identify any new elder issues emerging from the COVID19 Pandemic and work together to address needs.			
Improved caregiver training and support options for unpaid family caregivers and for paid caregivers serving tribal members for interested tribes	Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs Assist paid and unpaid Tribal caregivers to obtain training and support. Provide a presentation to staff on Medicaid Alternative Care and Tailored Services for Older Adults (MAC & TSOA)	Coordinated Title III & VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing, and provision of technical assistance. Tribal caregivers are able to access training. Increased number of tribal caregivers. Tribal staff gain knowledge about new caregiver support programs.	State/AAA: Jaci Hoyle Jody Moss Becca Weed Fran Koski, Family Caregiver Support Program, 360.3417.8549, koskiff@dshs.wa.gov Renee Worthey, (MAC/TSOA), 360.406.0091, renee.worthey@dshs.wa.gov Catholic Community Services – Local Training Partnership for caregiver training - Robin Gibson, robing@ccsww.org, 360.417.5420 Aida Crumb, 360.417.8553, crumbaf@dshs.wa.gov – works with Individual Providers Timeline: July 1, 2020 to December 31, 2021	
Enhanced services/support for Tribal grandparents / other relatives raising children	Increase outreach efforts, Fran Koski to introduce herself to Lower Elwha to inform families of resources available for relatives raising children.	Kinship Care Support Program and Relatives As Parents will benefit tribal grandparents and other relatives raising children.	State/AAA: Jaci Hoyle Fran Koski, Kinship Care Coordinator, 360.417.8559 koskiff@dshs.wa.gov Tribe: Becca Weed Lorinda Robideau	

			Timeline: 7/1/2021 – 6/30/2022	
Improved access to health and nutrition education and program services to the extent resources allow.	Through nutrition contracts with OlyCAP, promote inclusion of local Tribal Elders in nutrition programs. Coordinate with OlyCAP to contact market Senior Farmers Market Nutrition Program to elders. Explore tribal access to new state home delivered meals expansion funds.	Tribal Elders may participate in programs implemented by OlyCAP, the O3A contracted health/nutrition education provider. More elders access fresh local foods through the Senior Farmers Market Nutrition Program. Tribal elders have access to healthy, nutritious meals.	State/AAA: Jody Moss Kathy Sculley, OlyCAP – (360) 452-4726 , Ext. 6213 ksculley@olycap.org Tribe: Becca Weed Timeline: 7/1/2021 – 6/30/2022	
Improved access to transportation for Tribal Elders with special needs.	Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions – currently inactive. Volunteer Chore Transportation program is accessible to all members over age 60. Tribes can identify a tribal volunteer driver(s) if they wish who would become a volunteer with the Volunteer Chore program and could be reimbursed per mile driven for qualified transport services.	Local planning efforts are responsive to transportation needs of Tribes. Promote increased options for transportation for Tribal Elders with Special needs. CCS Volunteer Chore Transportation will complete a resource presentation to the Tribe if requested. Tribal volunteer drivers expand Lower Elwha transportation capacity for Elders over 60. (Note that this age limitation is determined by fund source – Older Americans Act).	State/AAA: Jody Moss Teri Wensits, Volunteer Chore Services, 360.417.5640 TeriW@ccsww.org, Tribe: Becca Weed Timeline: 7/1/2021 – 6/30/2022	

Improved access to health and support services for Tribal Elders.	Increase coordination between the Area Agency on Aging and tribal representatives to facilitate access to local services – especially health care—for Tribal Elders. As funding opportunities permit, coordinate with LEKT staff to access to prevention program funding (Powerful Tools for Caregivers, Wisdom Warriors, falls prevention programs), etc. for elders. New: Assist Lower to Implement Health Homes Contract	Tribal issues are represented in local community, county planning efforts. Tribal needs are considered and addressed by local service providers, resulting in increased access to services. Tribal elders with significant health impacts are supported to develop goals receive coordinated services improving health outcomes.	State/AAA: Jaci Hoyle, Jody Moss Janis Housden, Evidence Based Programs, 360-379-5064 Janis.housden@dshs.wa.gov Tribe: Clinic staff Lorinda Robideau, LEKT Health Director Timeline: 7/1/2021 – 6/30/2022	
Strengthen O3A and Lower Elwha Klallam Tribe's partnerships.	Notify LEKT staff when recruiting tribal representatives for Advisory Council. Notify LEKT when O3A positions are open. Train outreach staff in culturally appropriate communication. New O3A staff are undergoing Trauma Informed Training including historical trauma; this training may be available to share with tribal staff if requested.	Partnerships between O3A & LEKT result in responsive service / program development. LEKT members have opportunities for employment; O3A becomes more diverse. As schedules permit, Brenda or others will make Cultural Competency Training available to O3A.	State/AAA: Designated O3A Leadership, Contracts Management and Direct Services staff Jody Moss Jaci Hoyle Carol Ann Laase, O3A Human Resources – 360.379.5064, Lasseca@dshs.wa.gov Ingrid Henden, Trauma Informed Care Ingrid.henden@dshs.wa.gov Brenda Francis Thomas, DSHS Tribal Staff Becca Weed Lorinda Robideau	

			Timeline: 7/1/2021 to 6/20/2022	
Assist the Lower Elwha Klallam Tribe if they are interested, in developing tribal Medicaid contracts with O3A. - Environmental Modification contract - Personal Emergency Response provider - Caregiver & Client Support Services - Community Transition & Training Specialist - COPES Home Delivered Meals - Professional Services - Specialized Equipment & Supplies - Non-Medical Transportation Services - Nurse Delegation (A. Dahl) - Wellness Programs	Notify tribe of option to use O3A to help develop services/contracts Provide technical assistance as needed Assist with first series of contract monitoring visits as needed. Schedule follow up visit to discuss contracts	Communication between O3A and the Lower Elwha Tribe results in awareness of some options, and strengthens O3A's relationships with tribe Expands services available to tribal elders Strengthens and improves the quality of services provided through tribal contracts.	State/AAA: AC Tribal Representative Designated O3 Contracts Management staff (Jody Moss) O3A Direct Services (Jaci Hoyle) Marietta Bobba (Savvy Caregivers) (360) 725-2618 marietta.bobba@dshs.wa.gov Tribal Staff Becca Weed Lorinda Robideau Timeline: 7/1/2021 to 6/20/2022	

Policy 7.01 Plan and Progress Report (*Draft)*

Timeframe: July 1, 2021 to June 30, 2022 Updated: October 8, 2021

AAA: Olympic Area Agency on Aging **Region 3 - North Office** **Tribe(s)/RAIOs: Makah Tribe**

Annual Due Date: April 2 (Submit Regional Plan to the Assistant Secretary) and April 30 (submit Assistant Secretary's Plan to OIP).

Implementation Plan				**Progress Report**
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for Fiscal year starting last July 1
1. Continue current outreach assistance with staff and tribal members	○ Meet with tribe's representatives to develop / update 7.01 policy plan. ○ Ensure current outreach assistance is continued & explore expanding support & coordination assistance with Makah Tribe as available O3A resources allow. ○ Meet with Makah tribal representatives to discuss elder issues as requested. ○ Ensure tribal issues are considered in agency planning, training, and project development. ○ Ensure tribal elders and staff are aware of access to resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made by	○ Enhanced access to culturally relevant services for tribal elders. ○ Increased collaboration with the Makah Tribe and community partners to assure access to appropriate services. ○ Elders, family members and staff are able to identify resources and plan more easily for elders' needs.	State/AAA: Laura Cepoi, Executive Director, 360.379.5064 Laura.Cepoi@dshs.wa.gov Jaci Hoyle, Regional Direct Services Director, 360.301.1052 jaci.hoyle@dshs.wa.gov Jody Moss, Contracts Management & Planning Director, 360.379.5064 jody.moss@dshs.wa.gov O3A Forks office staff: Char Carte - 360.374.9496 carteci@dshs.wa.gov, Susie Brandelius -360.374.9496 brandcs@dshs.wa.gov O3A Advisory Council Tribal Rep - Open Position Brenda Francis Thomas, 360.584.3338 francBD@dshs.wa.gov Marietta Bobba, 360.725.2618 marietta.bobba@dshs.wa.gov I&A Offices–call for address: Sequim 360.452.3221 800.801.0070	

	elder or others on behalf of elder.		Forks 360.374.9496 888.571.6559 Tribal staff: Maureen Woods Maureen.woods@makah.com 360-645-3027 Glenda Butler, Makah Wellness, Glenda.butler@makah.com Dorothy Aiken, Health Homes Dorothy.aiken@makah.com Timeline: 7/1/2021 – 6/3/2022	
2. Improve caregiver training and support options for unpaid family caregivers and for paid caregivers serving tribal members.	○ Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs ○ Support development of a high school Home Care Aid program ○ Include Tribal caregivers in Home Care Referral Registry* training and referral activities. ○ Provide information and support for tribal members to access the Medicaid Alternative Care and Tailored Supports for Older Adults (MAC & TSOA) Programs ○ New Support providing caregiver training in-person and online – Maureen can	○ Coordinated Title III and VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing and provision of technical assistance. ○ Increased resources for and capacity of family caregivers to support their loved ones in their homes for as long as possible. ○ The Makah Tribe capacity for accessing and/or providing training to Tribal members interested in becoming caregivers. Tribal caregivers are able to access training and potential employment in a timely manner.	State/AAA: Jody Moss / Ingrid Henden Jaci Hoyle Susie Brandelius *Aida Crumb 360-417-8583 crumbaf@dshs.wa.gov Tribe: Maureen Woods Maureen.woods@makah.com 360-645-3027 Glenda Butler, Makah Wellness, Glenda.butler@makah.com Timeline: 7/1/2021 – 6/3/2022	

	identify 3-4 caregivers to support creating a course in Neah Bay.	○ Increased number of Tribal caregivers available to deliver home care services to elders. Help with advocacy for local training		
3. Enhanced services / support for Tribal grandparents / other relatives raising children	○ Increase outreach efforts to inform families of the resources available for relatives raising children.	○ Tribal grandparents & other relatives raising children gain additional and often critical support through Relatives as Parents/Kinship Care Support programs.	State/AAA: Jaci Hoyle O3A Kinship Care Support Program and Relatives as Parents Delivery staff: Susie Brandelius Tribe: Maureen Woods Maureen.woods@makah.com 360-645-3027 Maria Secor, Kinship Navigator Maria.secor@makah.com Glenda Butler, Makah Wellness, Glenda.butler@makah.com Timeline: 7/1/2021 – 6/3/2022	
4. Improved Tribal access to health and nutrition education and program services to the extent resources allow.	○ Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition education programs. ○ Share useful resources between tribes and nutrition providers such as printed education material and 1/3 RDA approved menus.	○ Tribal elders participate in programs implemented by local health / nutrition education providers. ○ Capacity for local tribes and regional nutrition providers is increased by sharing ideas and material; more elders receive better	State/AAA: Jody Moss Tribal Nutrition Providers Kathy Sculley, OlyCAP (360) 452-4726, Ext. 6213 ksculley@olycap.org Tribe: Maureen Woods Maureen.woods@makah.com 360-645-3027	

		information around health and nutrition.	Glenda Butler, Makah Wellness, Glenda.butler@makah.com Jessica Herndon, Makah Timeline: 7/1/2021 – 6/3/2022 Timeline: 1/1/2018 – 12/31/2022	
5. Improved access to health and support services for Tribal elders.	○ Engage Makah Tribe in the prevention programs (Areas of interest include Stress Busters for Caregivers, Powerful Tools for Caregivers, Savvy Caregivers, Wisdom Warriors, etc.)	○ Tribal issues are represented in local community, county planning efforts. ○ Tribal needs are considered and addressed by local service providers, resulting in increased access to services.	State/AAA: Jaci Hoyle, Jody Moss Janis Housden, 360.379.5064 Janis.housden@dshs.wa.gov Tribe: Maureen Woods Glenda Butler Jessica Herndon, Makah Timeline: 7/1/2021 – 6/3/2022	
6. Strengthened O3A and tribal partnerships.	○ Notify tribal staff when recruiting tribal representation on O3A Advisory Council. ○ New: Send minutes of the Advisory Council meetings to tribe along with the AC application to help with AC Tribal rep recruitment. ○ Notify tribes when O3A staff positions are open. ○ Routinely consult with tribal outreach (O3A direct	○ Partnerships between O3A and region tribes result in more responsive service and program development. ○ Tribal members have opportunities for employment; O3A becomes more diverse and representative of the community we serve	State/AAA: AC Tribal Representative (open position) Designated O3A Contracts Management staff (Jody Moss) and Direct Service staff (Jaci Hoyle) O3A leadership - Carol Ann Laase, O3A Human Resources – 360.379.5064, Lasseca@dshs.wa.gov Brenda Francis Thomas, DSHS Tribe: Maureen Woods	

	service) staff re: O3A response to tribal issues.		Maureen.woods@makah.com 360-645-3027 Glenda Butler, Makah Wellness, Glenda.butler@makah.com Jessica Herndon, Makah Timeline: 7/1/2021 – 6/3/2022	
7. Improved access to transportation for Tribal Elders with special needs.	○ Volunteer Transportation program is accessible to all members over age 60. ○ If Makah Tribe can identify tribal volunteer driver(s), coordinate training with the Catholic Community Services Volunteer Transportation program so drivers can support elder transportation needs and can be reimbursed per mile driven for qualified transport services. *New – Contact Glenda Butler to discuss volunteer recruitment.* ○ Facilitate communication between Clallam Connect and Makah Tribe ○ Support developing Transportation Contracts if tribe is interested	○ Local planning efforts are responsive to transportation needs of Tribes. Promote increased options for transportation for Tribal Elders with Special needs. ○ Volunteer transportation provider will complete a resource presentation to the Tribe if requested. ○ Tribal volunteer drivers expand transportation capacity for Elders over 60. (Note that this age limitation is determined by fund source – Older Americans Act)	State/AAA: Jody Moss – O3A Planning Director Clallam Teri Wensits, Volunteer Chore Services, TeriW@ccsww.org, 360.417.5640 Marietta Bobba (Savvy Caregivers) (360) 725-2618 marietta.bobba@dshs.wa.gov Tribe: Maureen Woods Maureen.woods@makah.com 360-645-3027 Glenda Butler, Makah Wellness, Glenda.butler@makah.com Jessica Herndon, Makah Timeline: 7/1/2021 – 6/3/2022	

8. Assist Makah Tribe as interested, to develop contracts. Areas of interest include Transportation, Home Care, Community Choice Guiding, Client Training and Transition Services; *Environmental Modification (2020), and Health Homes Contracts (2019) completed.* *See notes at end for full list of available contracts.*	○ Notify tribes of option to contact O3A to help develop services/contracts ○ Provide technical assistance as needed ○ Assist with first series of contract monitoring visits as needed.	○ Communication between O3A and tribes results in awareness of new service options, and strengthens O3A's relationship with tribes ○ Expands culturally relevant services to tribal elders ○ Strengthens and improves the quality and cultural relevancy of services provided through tribal contracts.	State/AAA: Jody Moss/Ingrid Henden Designated O3A Contracts Manager, and O3A Direct Services staff Tribe: Maureen Woods Maureen.woods@makah.com 360-645-3027 Glenda Butler, Makah Wellness, Glenda.butler@makah.com Dorothy Aiken, Health Homes Staff dorothy.aiken@makah.com Jessica Herndon, Makah Timeline: 7/1/2021 – 6/3/2022	
9. Assist Makah Tribe to be able to access more grant resources	○ Notify Makah Tribe about grant opportunities for Tribe only funds. ○ New: Provide Tribe with RFP for Social Isolation services and assist with technical assistance as needed.	○ Tribe enabled to expand capacity for providing services to members.	State/AAA: Jody Moss, O3A staff Tribe: Maureen Woods Maureen.woods@makah.com 360-645-3027 Glenda Butler, Makah Wellness, Glenda.butler@makah.com Jessica Herndon, Makah Timeline: 7/1/2021 – 6/3/2022	

Additional notes from 10/8/21 Meeting:

- Makah has issued a mandatory vaccine requirement for staff.
- Developed a local Resource Manual (copies provided to O3A staff)
- Developed a veteran's program with an accredited service officer
- Home Delivered meals have tripled due to COVID and have been expanded to supplies, grocery delivery etc.
- Maureen suggested we send the Advisory Council minutes out to tribes which may help with recruiting a tribal representative.
- Maureen has appreciated the Senior Nutrition education materials and hopes they can continue. She shares this material with both the Home Delivered Meals clients and the Health Homes clients.

- Maureen mentioned issues with cleaning up clients' homes and pest issues – these services are av available through COPES if the client qualifies – talk to the Case Manager (Char).
- Other available contracts that tribes can develop include: Adult Day Services (Adult Day Care, Adult Day Health), Caregiver and Client Support Services, Client Training, Environmental Modification, Home Care, Home Delivered Meals – COPES, Personal Emergency Response Systems, Professional Support Specialist, Transportation, Wellness Programs and Activities (Massage, Acupuncture, Chiropractic, Fitness and Exercise), Evidence Based Programs (exercise programs, Wisdom Warriors, Savvy Caregivers, caregiver support programs)
- Discussed Housing issues and the possibility of using some funds from a Rural Health Equity grant that O3A has been awarded to support these kinds of issues. Maureen mentioned that currently, there are a number of people who are homeless and able to be housed and or quarantined as needed in unused rental cabins. This will change once the reservation opens again.

Policy 7.01 Plan and Progress Report (*Draft)*

Timeframe: July 1, 2021 to June 30, 2022 Updated: 1/20/2021

AAA: Olympic Area Agency on Aging **Region 3 North Office** **Tribe(s)/RAIOs: Quileute Nation**

Annual Due Date: April 2 (Submit Regional Plan to the Assistant Secretary) and April 30 (submit Assistant Secretary's Plan to OIP).

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 and work to develop a more tailored plan for the Quileute Nation	○ Meet with tribe's representatives to clarify/ update 7.01 policy plan. ○ Ensure current outreach assistance is continued & explore expanding support and coordination assistance with Quileute Nation as available O3A resources allow. ○ Meet with tribal representatives to discuss elder issues as requested. ○ Ensure tribal issues are considered in agency planning, training, and project development. ○ Ensure tribal elders and staff are aware of access to resources and	○ O3A and Quileute Nations' relationship is strengthened leading to better communication and more opportunities for partnerships. ○ Enhanced access to culturally relevant services for tribal elders. ○ Increased collaboration with the Quileute Nation and community partners to assure access to appropriate services. ○ Elders, family members and staff are able to identify resources and plan more easily for elders' needs. ○ Expanded knowledge of elders' needs.	State/AAA: Laura Cepoi, Executive Director, 360.379.5064 **laura.cepoi@dshs.wa.gov** Jaci Hoyle, Regional Director, 360. 301.1052 jaci.hoyle@dshs.wa.gov Jody Moss, Contracts Management & Planning Director, 360.379.5064 **jody.moss@dshs.wa.gov** O3A Forks office staff: Susie Brandelius – Information & Assistance, Family and Caregiver Support, MAC & TSOA - 360.374.9496, **brandcs@dshs.wa.gov** Char Carte – Case Manager - 360.374.9496 **carteci@dshs.wa.gov** Survey – Jody Moss Tribal Contacts	

	planning by visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder. ○ (New) Provide brochures of O3A programs so staff can share with elders in their homes. ○ (New) Have Susie Brandelius contact Regina Williams to review programs ○ (New) Assist with development of an elder survey on request		Regina Williams, Human Services Program Manager, 360-374-0336 **regina.williams@qu**ileute.org Lisa Hohman-Penn, Senior Cook, Lisa.hohman@quileutenation.org, 360.374.6040 Timeline: 7/1/2021 – 6/30/2021	
2. Support caregiver training and support options as requested by the Quileute Nation.	○ Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs ○ Support Tribal caregivers to obtain training and support. ○ Support individuals to transition from long term care facilities back into the community if possible.	○ Coordinated Title III and VI resources result in support for family caregivers and Individual Providers as requested by the Quileute Nation. ○ Tribal caregivers are able to access training ○ Tribal elders are able to age in or closer to their own communities. ○ Tribal staff gain knowledge elders learn about new caregiver support program.	State/AAA: Jaci Hoyle Susie Brandelius Tribal Contacts Regina Williams, Human Services Program Manager, 360-374-0336 **regina.williams@quileute.org** Lisa Hohman-Penn, Senior Cook, **Lisa.hohman@quileutenation.org**, 360.374.6040 Timeline: 7/1/2021 – 6/30/2021	○

	○ Provide a presentation to staff on Medicaid Alternative Care and Tailored Services for Older Adults (MAC & TSOA)			
3. Enhanced services / support for Tribal grandparents / other elders raising children	○ Increase outreach efforts, particularly with remote communities and Tribal reservations, to inform families of the resources now available for relatives raising children.	○ Relatives as Parents Support Program will benefit Tribal grandparents & other elders raising children.	State/AAA: Jaci Hoyle Susie Brandelius Tribal Contacts Regina Williams, Human Services Program Manager, 360-374-0336 regina.williams@quileute.org Lisa Hohman-Penn, Senior Cook, Lisa.hohman@quileutenation.org, 360.374.6040 Timeline: 7/1/2021 – 6/30/2021	○
4. Improved Tribal access to nutrition program services (such as Senior Nutrition, Meals on Wheels and Senior Farmers Market) through coordination with local nutrition providers.	○ Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition programs. ○ Explore tribal access to new state home delivered meals expansion funds. ○ New: Link OlyCAP Program Director with Quileute staff to coordinate as resources allow. Share	○ Tribal elders are able to participate in programs implemented by local nutrition providers. ○ Tribal elders have access to healthy, nutrition meals.	State/AAA: Jody Moss Kathy Sculley, OlyCAP – (360) 452-4726, Ext. 6213 ksculley@olycap.org Tribal Contacts Regina Williams, Human Services Program Manager, 360-374-0336 regina.williams@quileute.org Lisa Hohman-Penn, Senior Cook, Lisa.hohman@quileutenation.org, 360.374.6040 Timeline: 7/1/2021 – 6/30/2021	○

	information and answer questions on how Spoons Café program works. ○ New: Consider tribal needs in allocating COVID funds			
5. Promote access to health and support services for Tribal elders.	○ Increase coordination between the Area Agency on Aging and Tribal representatives to advocate increased access to local services—especially health care-- for Tribal Elders. ○ Continue to support Tribal Wills Clinic and/or Senior Legal Advice Clinics for more general civic legal needs ○ Explore options for developing a corps of tribal volunteers to help transport elders to activities/medical appointments as part of Catholic Community Services Volunteer Transportation program (new –	○ Tribal issues are represented in local community, county planning efforts. ○ Tribal elders receive legal services supporting their aging needs and goals ○ Tribal elders have greater access to services and greater mobility.	State/AAA: Jaci Hoyle Jody Moss Janis Housden 360-379-5064, Evidence Based Programs, Tribal Estate Planning janis.housden@dshs.wa.gov Teri Wensits, Volunteer Chore Services, *Transportation Services)* 360.417.5640, TeriW@ccsww.org Sandy Ulf, Olympic Medical Center Honoring Choices program, sulf@olympicmedical.org (Advanced Directives) retired 2021 Jody Moss Marietta Bobba, 360.438.8633, Marietta.bobba@dshs.wa.gov Tribal Contacts Regina Williams, Human Services Program Manager, 360-374-0336 regina.williams@quileute.org	○

	errand services are available so driving to pick up and deliver groceries, prescriptions, etc. could be completed during pandemic) ○ Engage Quileute Tribe in the prevention programs as funding permits, (e.g., Powerful Tools for Caregivers, Savvy Caregivers, Wisdom Warriors) ○ Connect tribe with Advanced Directives presentation to elders ○ <u>New:</u> Follow up with staff on Health Homes Programs	○ Quileute Tribal members gain access to prevention programs and healthy activities for elders ○ Elders learn about advance directives and are able to develop plans for themselves and families ○ Quileute Tribal Members with significant health risk develop goals and improvement in health outcomes	Lisa Hohman-Penn, Senior Cook, Lisa.hohman@quileutenation.org, 360.374.6040 Darlene Zimmerman, Quileute Health Center, 360.374.4318, qhc.director@quileutenation.org <u>Timeline</u>: 7/1/2021 – 6/30/2022	
6. Strengthened O3A and Quileute partnerships	○ Notify tribal staff when recruiting tribal representation on O3A Advisory Council. ○ Notify tribes when O3A staff positions are open. ○ Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues.	○ Partnerships between O3A and region tribes result in more responsive service and program development. ○ Tribal members have opportunities for employment; O3A becomes more diverse and representative of the communities O3A serves.	<u>State/AAA:</u> AC Tribal Representative TBD Jody Moss – to connect with designated O3A Program Management and Service Delivery staff O3A leadership <u>Tribal Contacts</u> Regina Williams, Human Services Program Manager, 360-374-0336 regina.williams@quileute.org	○

			Lisa Hohman-Penn, Senior Cook, Lisa.hohman@quileutenation.org, 360.374.6040 Darlene Zimmerman, Quileute Health Center, 360.374.4318, qhc.director@quileutenation.org Timeline: 7/1/2021 – 6/30/2022	
7. Assist the Quileute Nation develop tribal service contracts with O3A, if interested.	○ Notify tribe of option to use O3A to help develop services/contracts ○ Provide technical assistance as needed ○ Assist with first series of contract monitoring visits as needed. ○ Schedule follow up visit to discuss contracts, especially Health Homes contracting	○ Communication between O3A and the Quileute Nation results in awareness of some options, and strengthens O3A's relationships with tribe ○ Expands services available to tribal elders ○ Strengthens and improves the quality of services provided through tribal contracts.	State/AAA: AC Tribal Representative Jody Moss Lori Lindley, Health Homes 360.530.1052, lori.indley@dshs.wa.gov Designated O3 Program Manager, and O3A Services Delivery staff Marietta Bobba, 360.438.8633, Marietta.bobba@dshs.wa.gov Tribal Contacts Regina Williams, Human Services Program Manager, 360-374-0336 regina.williams@quileute.org Lisa Hohman-Penn, Senior Cook, Lisa.hohman@quileutenation.org, 360.374.6040 Darlene Zimmerman, Quileute Health Center, 360.374.4318, qhc.director@quileutenation.org Miss Ann Penn Timeline: 7/1/2021 – 6/30/2022	○

Policy 7.01 Plan and Progress Report (*Draft)*

Timeframe: July 1, 2021 to June 30, 2022 Updated: September 2019

AAA: Olympic Area Agency on Aging **Region 3. South Office** **Tribe(s)/RAIOs: Quinault Nation**

Annual Due Date: April 2 (Submit Regional Plan to the Assistant Secretary) and April 30 (submit Assistant Secretary's Plan to OIP).

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. Quinault Nation and O3A representatives work together to develop/refine 7.01 policy implementation plan.	○ Representatives from Quinault Nation and O3A meet to develop/refine 7.01 policy implementation plans. ○ Ensure current O3A outreach assistance is continued & explore expanding support and coordination assistance as available O3A resources allow. ○ O3A Information & Assistance (Grays Harbor) staff schedule meeting(s) with tribal representatives to discuss elder issues in Taholah. ○ Ensure tribal issues are considered in agency planning, training, and project development. ○ Ensure tribal elders and staff are aware of access to resources and planning by	○ 7.01 plan guides activities and coordination between O3A and the Quinault Nation. ○ Enhanced access to culturally relevant services for tribal elders. ○ Increased communication with Quinault Nation and community partners to improve access to appropriate services. ○ Elders, family members and staff are able to identify resources and plan more easily for elders' needs.	State/AAA: Laura Cepoi, Exec Director, O3A laura.cepoi@dshs.wa.gov 360-379-5064 Jaci Hoyle, Regional Director I&A/CM 360. 301.1052, jaci.hoyle@dshs.wa.gov Jody Moss, O3A Planner, 360-379-5064, mossjm1@dshs.wa.gov I&A Offices–call for address: Aberdeen 360.532.0520, 800.801.0060 Raymond 360.942.2177, 888.571.6557 O3A Advisory Council Tribal Representative – Open Position Heather Hoyle,, DSHS Office of Indian Policy, heather.hoyle@dshs.wa.gov, (360) 480-9052 Marietta Bobba, Tribal Planning & Program Development Manager, (360) 725-2618 marietta.bobba@dshs.wa.gov Tribe: Amelia Delacruz, Quinault Nation Social Services Manager, 360-276-8215, Amelia.Delacruz@quinault.org	

	visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder		Lanada Mail-Brown, Quinault Nation Elder Programs, 360.276.8211 x8221, LANDERSON@quinault.org Timeline: 7/1/2021 – 6/30/2022	
2. Improved caregiver training and support options for unpaid family caregivers and for paid caregivers serving tribal members as requested by the Quinault Nation.	○ Improve coordination between AAA Title III and Quinault Nation Title VI Caregiver Support Programs. ○ Identify unpaid family caregivers through family caregiver support programs and tribal social service referrals and support unpaid family caregivers to obtain respite, training, and other forms of support. ○ Tribal staff, identify tribal members interested in becoming paid caregivers and provide referrals for training and becoming an independent provider or for working for a home care agency. ○ Include Tribal caregivers in Home Care Referral Registry* training and referral activities. ○ *New:* Perform introductions & a meeting between staff and Eric Nessa and Renee Iverson to facilitate	○ Coordinated Title III and VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing and provision of technical assistance. ○ Increased resources for and capacity of family caregivers to support their loved ones in their homes for as long as possible. ○ Tribal capacity for accessing and/or providing training to Tribal members interested in becoming caregivers. Tribal caregivers are able to access training and potential employment in a timely manner. ○ Increased number of Tribal caregivers available to care for elders.	State/AAA: Jaci Hoyle, Regional Director I&A/CM Eric Nessa, Family Care Giver Support Program Support Staff, 360.538.2458 or 866.582.1485, NessaEM@dshs.wa.gov Ann Peterson, O3A Aberdeen Direct Services Supervisor, 360-538-2449, 866.582.1482, peteram@dshs.wa.gov Tribe: Amelia Delacruz, Quinault Nation Social Services Manager, 360-276-8215, Amelia.Delacruz@quinault.org Lanada Mail-Brown, Quinault Nation Elder Programs, 360.276.8211 x8221, LANDERSON@quinault.org Timeline: 7/1/2021 – 6/30/2022	

	improved communication and an understanding of programs.			
3. Enhanced services / support for Tribal grandparents / other elders raising children	○ Increase outreach efforts, particularly with remote communities and Tribal reservations, to inform families of the resources now available for relatives raising children.	○ Relatives as Parents Support Program will benefit Tribal grandparents & other elders raising children.	State/AAA: Jaci Hoyle, Regional Director I&A/CM Eric Nessa, Kinship Care / Relatives as Parents Support Staff Tribe: Amelia Delacruz, Quinault staff Lanada Mail-Brown, Quinault staff Timeline: 7/1/2021 – 6/30/2022	
4. Improved Tribal access to nutrition program services (such as Senior Nutrition, Meals on Wheels and Senior Farmers Market) through coordination with local nutrition providers.	○ Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition programs. ○ *New:* Lanada is interested in expanding Home Delivered Meals	○ Tribal elders are able to participate in programs implemented by local nutrition providers.	State/AAA: Jody Moss, O3A Planner Rosemary Biggins, ALTSA Nutrition Program Manager, 360.725.2466 *retiring 2021* rosemary.biggins@dshs.wa.gov, Annette Glodowski, Coastal Community Action Programs (CCAP) - (360) 500-4540, annetteg@coastalcap.org Tribe: Amelia Delacruz, Quinault staff Lanada Mail-Brown, Quinault staff Timeline: 7/1/2021 – 6/30/2022	
5. Promote access to health and support services for Tribal elders	○ Increase coordination between tO3A and Tribal representatives to advocate access to local services - especially health care - for Tribal Elders. ○ Increase coordination with volunteer transportation program in Grays Harbor County.	○ Tribal issues are represented in local community, county planning efforts.	State/AAA: Jaci Hoyle, Regional Director I&A/CM Jody Moss, O3A Planner Tribe: Amelia Delacruz, Quinault staff Lanada Mail-Brown, Quinault staff Timeline: 7/1/2021 – 6/30/2022	

6. Strengthened O3A and Quinault tribal partnerships.	○ Notify Quinault staff when recruiting tribal representation on O3A Advisory Council. ○ Notify Quinault staff when O3A staff positions are open. ○ Routinely consult with O3A direct service staff and Quinault staff re: O3A response to tribal issues. ○ Ensure contracting mechanisms support productive tribal partnerships.	○ Partnerships between O3A and region tribes result in more responsive service and program development. ○ Tribal members have opportunities for employment; O3A becomes more diverse and representative of the community we serve ○ Contract instruments are responsive to tribal administration capacity.	State/AAA: AC Tribal Representative – open position Jody Moss/Designated O3A Contracts Management and Jaci Hoyle/Direct Service staff O3A leadership Tribe: Amelia Delacruz, Quinault Nation Social Services Manager, 360-276-8215, Amelia.Delacruz@quinault.org Lanada Mail-Brown, Quinault Nation Elder Programs, 360.276.8211 x8221, LANDERSON@quinault.org Timeline: 7/1/2021 – 6/30/2022	
7. Improved access to transportation for Tribal Elders with special needs.	○ Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions (RTPO & local transportation initiatives if known). ○ Volunteer Transportation program is accessible to all members over age 60. ○ Quinault Tribe can identify a tribal volunteer driver(s) if they wish who would become a volunteer with the volunteer transportation program and could be reimbursed per mile driven for qualified transport services.	○ Local planning efforts are responsive to transportation needs of Tribes. Promote increased options for transportation for Tribal Elders with Special needs. ○ Volunteer transportation provider will complete a resource presentation to the Tribe if requested. ○ Tribal volunteer drivers expand transportation capacity for Elders over 60. (Note that this age limitation is determined by fund source – Older Americans Act)	State/AAA: Jody Moss – O3A Planning Director Grays Harbor - Coastal Community Action Programs, Amanda Farrar, amandad@coastalcap.org or 360.500.4524 Tribe: Amelia Delacruz, Quinault Nation Social Services Manager, 360-276-8215, Amelia.Delacruz@quinault.org Lanada Mail-Brown, Quinault Nation Elder Programs, 360.276.8211 x8221, LANDERSON@quinault.org Timeline: 7/1/2021 – 6/30/2022	

8. Help the Quinault Nation if they are interested, to develop contracts available in 2018, (e.g., Adult Days Services, Home Care / Respite Contracting, Environmental Modification and others).	○ Notify Quinault Nation of option to use O3A to help develop services/contracts ○ Provide technical assistance as needed ○ Assist with first series of contract monitoring visits as needed. ○ *New* – Lanada and Amelia expressed interest in a possible Transportation contract, and eventually / once new building is completed, an Adult Day Care program.	○ Communication between O3A and the Quinault Nation results in awareness of new service options and strengthens O3A's and Quinault Nation's relationships. ○ Expands services available to tribal elders ○ Strengthens and improves the quality of services provided through tribal contracts.	State/AAA: AC Tribal Representative, Designated O3 Program Manager, and O3A Services Delivery staff (contact Jody.moss@dshs.wa.gov Marietta Bobba, ALTSA Tribal Affairs Administrator, 360.725.2618, Marietta.bobba@dshs.wa.gov Tribe: Amelia Delacruz, Quinault Nation Social Services Manager, 360-276-8215, Amelia.Delacruz@quinault.org Lanada Mail-Brown, Quinault Nation Elder Programs, 360.276.8211 x8221, LANDERSON@quinault.org Timeline: 7/1/2021 – 6/30/2022	

Policy 7.01 Plan and Progress Report (*Draft)*

Timeframe: July 1, 2021 to June 30, 2022 Updated: March 2018

AAA: / Olympic Area Agency on Aging **Region 3, South Office** **Tribe(s)/RAIOs: Shoalwater Bay Tribe**

Annual Due Date: April 2 (Submit Regional Plan to the Assistant Secretary) and April 30 (submit Assistant Secretary's Plan to OIP).

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 and work to develop and improve the tailored plan for the Shoalwater Bay Tribe.	○ Meet with tribe's representatives to develop / update 7.01 policy plan. ○ Ensure current outreach assistance is continued & explore expanding support and coordination assistance with Shoalwater Bay Tribe as available O3A resources allow. ○ Meet with tribal representatives to discuss elder issues as requested. ○ Ensure tribal issues are considered in agency planning, training, and project development. ○ Ensure tribal elders and staff are aware of access to resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made	○ Tailored 7.01 plan in place between O3A and each individual Tribe within O3A service region. ○ Enhanced access to culturally relevant services for tribal elders. ○ Increased collaboration with local tribes and community partners to assure access to appropriate services. ○ Elders, family members and staff are able to identify resources and plan more easily for elders' needs.	State/AAA: Laura Cepoi, Executive Director, 360.379.5064 laua.cepoi@dshs.wa.gov Jaci Hoyle, Regional Director, 360.301.1052 jaci.hoyle@dshs.wa.gov Jody Moss, Contracts Management & Planning Director, 360.379.5064 jody.moss@dshs.wa.gov Heather Hoyle, DSHS Office of Indian Policy, 360 480-9052 heather.hoyle@dshs.wa.gov, O3A Advisory Council Tribal Rep – Open position I&A Offices–call for address: Aberdeen 360.532.0520 800.801.0060 Raymond 360.942.2177 888.571.6557 Long Beach 360.642.3634 888.571.6558 Tribe:	

	by elder or others on behalf of elder.		Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2021 – 6/30/2022	
2. Improved caregiver training and support options for unpaid family caregivers and for paid caregivers serving tribal members for interested tribes.	○ Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs ○ Identify unpaid family caregivers through family caregiver support programs* and tribal social service referrals and support Tribal caregivers to obtain respite, training, and other forms of support. ○ Through partnerships with tribal staff, identify tribal members interested in becoming paid caregivers and provide referrals for training** and becoming an independent provider or for working for a home care agency. ○ Include Tribal caregivers in Home Care Referral Registry training and referral activities.	○ Coordinated Title III and VI resources are maximized, resulting in improved dissemination of best practices, available resources, information sharing and provision of technical assistance. ○ Increased resources for and capacity of family caregivers to support their loved ones in their homes for as long as possible. ○ Tribal capacity for accessing and/or providing training to Tribal members interested in becoming caregivers. Tribal caregivers are able to access training and potential employment in a timely manner. ○ Increased number of Tribal caregivers	State/AAA: O3A Planning & Program Mgmt. staff Jaci Hoyle Jody Moss *Bob Powell, Family Caregiver Support Program staff360.214.9622, powelrm@dshs.wa.gov Catholic Community Services – Local Training Partnership for caregiver training - Robin Gibson, robing@ccsww.org, 360.417.5420 Ann Peterson, Supervisor, Home Care Referral Registry, peteram@dshs.wa.gov, 360-538-2449 Tribe: Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2021 – 6/30/2022	

3. Enhanced services / support for Tribal grandparents / other elders raising children	○ Increase outreach efforts, particularly for remote communities and Tribal reservations, to inform families of the resources available for relatives raising children.	○ a. Tribal grandparents & other elders raising children gain additional and often critical support through Relatives as Parents/Kinship Care Support programs.	State/AAA: Bob Powell, O3A Kinship Care Support Program & Relatives as Parents Delivery staff, 360.214.9622, powelrm@dshs.wa.gov Tribe: Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2021 – 6/30/2022	
4. Improved Tribal access to health and nutrition education and program services to the extent resources allow.	○ Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition education programs. ○ Share useful resources between tribes and nutrition providers such as printed education material and 1/3 RDA approved menus.	○ Tribal elders participate in programs implemented by local health / nutrition education providers. ○ Capacity for local tribes and regional nutrition providers is increased by sharing ideas and material; more elders receive better information around health and nutrition.	State/AAA: O3A Planning & Program Mgmt. staff Annette Glodowski, Coastal Community Action Programs (CCAP) - (360) 500-4540, annetteg@coastalcap.org Tribe: Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2021 – 6/30/2022	
5. Improved access to health and support services for Tribal elders.	○ Increase coordination between the Area Agency on Aging and Tribal representatives to facilitate access to local services—especially	○ Tribal issues are represented in local community, county planning efforts. ○ Tribal needs are considered and addressed	State/AAA: Jaci Hoyle, Regional Director Jody Moss, Planning Director Janis Housden, Program Manager Tribe:	

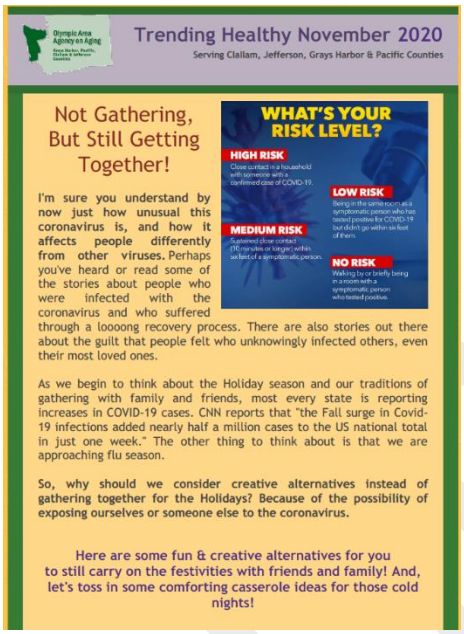
	health care-- for Tribal Elders. ○ Engage tribe as local community partners in the prevention programs	by local service providers, resulting in increased access to services.	Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2021 – 6/30/2022	
6. Strengthened O3A and tribal partnerships.	○ Notify tribal staff when recruiting tribal representation on O3A Advisory Council. ○ Notify tribe when O3A staff positions are open. ○ Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues. ○ Ensure contracting mechanisms support productive tribal partnerships.	○ Partnerships between O3A and Shoalwater Bay Tribe results in more responsive service and program development. ○ Tribal members have opportunities for employment; O3A becomes more diverse and representative of the community we serve ○ Contract instruments are responsive to tribal administration capacity.	State/AAA: AC Tribal Representative Designated O3A Contracts Management staff / Jody Moss and Direct Service Staff / Jaci Hoyle O3A leadership Tribe: Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2021 – 6/30/2022	
7. Improved access to transportation for Tribal Elders with special needs.	○ Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions (RTPO & local transportation initiatives if known). ○ Volunteer Transportation program is accessible to all members over age 60.	○ Local planning efforts are responsive to transportation needs of Tribe. Promote increased options for transportation for Tribal Elders with Special needs. ○ Volunteer transportation provider will complete a resource presentation to the Tribe if requested.	State/AAA: Jody Moss – O3A Planning Director Grays Harbor Amanda Farrar, CCAP 360.500.4524 amandaf@coastalcap.org Pacific Abbi Quigg Volunteer Services, CCS abbiq@ccsww.org, 360.637. 8563.ext113 Tribe:	

	○ Tribe can identify a tribal volunteer driver(s) if they wish who would become a volunteer with the volunteer transportation program and could be reimbursed per mile driven for qualified transport services.	○ Tribal volunteer drivers expand transportation capacity for Elders over 60. (Note that this age limitation is determined by fund source – Older Americans Act)	Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2021 – 6/30/2022	
8. Assist Shoalwater Bay Tribe if interested, to develop contracts to deliver services to elders.	○ Notify tribe of option to contact O3A to help develop services/contracts ○ Provide technical assistance as needed ○ c. Assist with first series of contract monitoring visits as needed.	○ Communication between O3A and tribe results in awareness of new service options, and strengthens O3A's relationship with Shoalwater Bay Tribe ○ Expands culturally relevant services to tribal elders ○ Strengthens and improves the quality and cultural relevancy of services provided through tribal contracts.	State/AAA: AC Tribal Representative Designated O3 Contracts Manager / Jody Moss, and O3A Direct Services staff/ Jaci Hoyle Tribe: Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2021 – 6/30/2022	

C – 5: COVID-19 Response Services And Supports

O3A's Pandemic Response

On March 16, 2020, like many organizations around the State of Washington, O3A offices closed to the public and most employees began to work remotely. Some essential staff remained in the offices or came in only as necessary. Services to clients shifted to remote care to the extent possible with extra caution, social distancing, hand washing and sanitizing surfaces. O3A participated in weekly local Public Health/ Emergency Management planning efforts in all four counties and participated in weekly meetings (sometimes more often) with ALTSA. O3A provided technical assistance to contractors throughout the pandemic to meet shifting requirements. O3A Leadership and Management Team initially sent out updated procedures via email to all staff. Later the Leadership and the Management Team developed pandemic related policies and procedures which were updated as needed (included in the end of the Emergency Response Plan in the Appendices).


Trending Healthy November 2020

Serving Clallam, Jefferson, Grays Harbor & Pacific Counties

Not Gathering, But Still Getting Together!

WHAT'S YOUR RISK LEVEL?

HIGH RISK

LOW RISK

MEDIUM RISK

NO RISK

I'm sure you understand by now just how unusual this coronavirus is, and how it affects people differently from other viruses. Perhaps you've heard or read some of the stories about people who were infected with the coronavirus and who suffered through a loooong recovery process. There are also stories out there about the guilt that people felt who unknowingly infected others, even their most loved ones.

As we begin to think about the Holiday season and our traditions of gathering with family and friends, most every state is reporting increases in COVID-19 cases. CNN reports that "the Fall surge in Covid-19 infections added nearly half a million cases to the US national total in just one week." The other thing to think about is that we are approaching flu season.

So, why should we consider creative alternatives instead of gathering together for the Holidays? Because of the possibility of exposing ourselves or someone else to the coronavirus.

Here are some fun & creative alternatives for you to still carry on the festivities with friends and family! And, let's toss in some comforting casserole ideas for those cold nights!

Signs were posted related to masking and safety in all offices. Personal Protective Equipment was secured for all offices and staff with client interactions. O3A Management Team has surveyed employees several times during the intervening year and held several brown bag lunches to support employees as we figured out how to manage in this new environment.

Advisory Council (AC) meetings (along with all other meetings) shifted to the Zoom platform and after some initial struggles have become effective for the most part. For AC members who were challenged by the Zoom platform, we leased GrandPads.

In our region, COVID-19 was slow to have an impact. There were few infections in any of our counties initially, and after infections began to increase, there were thankfully few deaths. As the pandemic continued, we have observed outbreaks in some counties worse than others.

The most immediate issue O3A dealt with was how to deliver home care in this environment. O3A and ALTSA worked closely with home care agencies throughout the spring, summer and into the fall, assuring continuity of services for frail elders and adults with disabilities needing face to face services provided in as safe a manner as possible. Many clients preferred to not have anyone coming into their homes in the initial stages of the pandemic. We accommodated everyone's wishes while working to maintain their safety with an appropriate level of care.


Trending Healthy SPECIAL ISSUE

Serving Clallam, Jefferson, Grays Harbor & Pacific Counties

STUCK AT HOME!

The laundry is caught up, books are read, light bulbs dusted, the puzzle is complete,

NOW WHAT!

Senior Nutrition services also became an immediate issue, and quickly shifted to drive by - pick up meals and remote home delivered drop off meals for as many clients as possible. Contracts were issued using FFCRA and

CARES Act funding which allowed for additional pandemic flexibilities. Contractors were urged to reach out to additional community members who may be in need. One contractor lost volunteer drivers and funds were allocated to pay for temporary paid drivers. Technical assistance has been provided throughout the pandemic.

Senior Nutrition has continued to be of concern because while contractors are serving more meals, they may not be reaching a significant number of additional clients or reaching remote areas in our region. The O3A Executive Director located some neighborhoods with limited meal access because of inability to store a volume of frozen meals in small freezers. O3A is exploring some additional options for meal provision by restaurants in that local region. The Executive Director and Administrative Director also worked with a Senior Center in Ocean Shores which has been delivering food (not meals), up and down the coast in Grays Harbor and even into Western Jefferson and even Clallam County. O3A helped this agency submit a grant to build their infrastructure so that they are better able to continue to serve people, many of whom are seniors, and may eventually be able to qualify as a provider of Older Americans Act funded meals.

Legal services continued but shifted immediately to a telephonic / social distancing model using masks and hand sanitizer for signing documents. This has become a preferred method for some clients and attorneys.

Evidence based programs shifted to remote services as soon as this mode was approved by the Administration for Community Living. Unfortunately, some contractors were not comfortable or did not have the expertise to shift to a remote model. Two programs continued in this remote mode – one supporting caregivers and the other Tai Ji Quan Moving for Better Balance. O3A Contract Management staff developed an Evidence Based request for proposals for remote programs which has been shared across the country and the state for others to use.

Errand contracts were issued with O3A's three Volunteer Transportation providers, so they could shop for clients, and pick up prescriptions without the client in the vehicle.

Social Isolation of clients quickly became a concern. O3A staff made check-in calls with all clients. Our contractors made check-in calls with clients. Smart phones and flip phones provided by the state were distributed to clients. O3A partnered with an agency out of California which offered two programs, Well Connected, offering remote Senior Center programing, and Social Call, which matches seniors with a volunteer for weekly phone calls premised on developing a relationship, not just a check-in. O3A served on the committee developing a project using robotic pets with family caregivers of clients with dementia. In mid-2021, O3A developed a project in partnership with Olympic Community of Health to screen clients for social isolation and provide feedback to agencies of the results. The project will also provide a personalized report to each client of actions they can take to improve social connection.

COVID education material was shared prodigiously with staff and community members through newspaper articles, through our monthly online newsletter, Trending Healthy, through staff, and from material sent directly by ALTSA. Around November, we began sharing a weekly updated status report of infection rates by county with the O3A staff and the Advisory Council.

O3A has reached out to the tribes several times during the pandemic to identify emerging issues they may be experiencing. Social isolation is a big issue in tribal communities right now and O3A is developing a Request for Proposals to fund all applicants for social isolation projects using American Rescue Plan funding, hopefully for the full three year cycle which these funds will be available.

In January, when vaccines became available to older adults, O3A was already involved in the two counties which had early success. We were able to share information with I&A staff about processes within each county, and they become key to supporting community members to get signed up for vaccines, arrange transportation, and we began working on how to get vaccinations to homebound clients. By the time O3A received funding to support vaccine efforts, many seniors in our region were already immunized. We continued our efforts to outreach to those who had barriers to getting vaccines in many ways:

a) O3A/I&A worked with all 4 County LHJs and Emergency Management Departments to serve Homebound clients.
b) O3A called every O3A client to determine their need for assistance and if client needs a home vaccine visit, O3A coordinated with LHJs to deliver the vaccine.
c) Grays Harbor I&A coordinated with LHJ for seven micro-vaccine clinics at Housing Authority sites for seniors and adults with disabilities. I&A Staff provided resources and staffing at these clinics.
d) Developed a series of four vaccine messages that had been researched as effective with thousands of people across the country to address vaccine hesitancy. These were used as ads in two series – the first series included a message to call O3A for assistance with scheduling vaccines. A repeat series included a message to call O3A for help with transportation to vaccination sites or if homebound for in-home vaccination.
e) Vaccine hesitancy messaging also appeared in social media, in the Senior Resource Guide (38,000 copies), in an online O3A newsletter, and on O3A website landing page (www.o3a.org), and distributed by Advisory Council members as flyers, to their own email networks and on their social media pages.
f) Distributed flyers to all Congregate and Home Delivered Meal Clients with vaccine hesitancy messages offering assistance with scheduling, transportation, and homebound vaccine assistance.
g) Shared vaccine hesitancy messaging widely with other agencies in the region and partnered with Olympic Community of Health to share ads widely with other partners who might wish to use them.
h) Shared Vaccine ads with other AAAs with permission to use in their own regions.
i) O3A Contracts Management developed contracts with taxi services in three counties to drive clients to and from vaccines.
j) O3A Contracts Management had previously allocated CARES Act funds for errands to Volunteer Transportation providers – amendment issued to use funds for vaccinations as well.
k) Created and placed an ad in all local papers seeking volunteer drivers to work with Volunteer Transportation to drive older adults to vaccine appointments.
l) Developed numerous educational articles addressing vaccine hesitancy and vaccine safety in newspapers and in online newsletters.
m) One O3A Staff member who has been a longtime Emergency Management volunteer worked with the first vaccine mass clinic in our region and distributed O3A Materials from beginning of public vaccine provision

in January through early June when mass vaccine clinics converted to pop up and physician offices/pharmacy vaccine services. While the beginning of her experience preceded the ADRC Vaccine contract, it informed much of our work around vaccine clinics. O3A has been able to share with other county LHJ about experiences and encourage best practices.

n) O3A staff consistently shared COVID vaccine best practices learned from attending webinars with all county partners and Emergency Management Departments.

o) Emergency Management Situation Reports for all counties referenced O3A supportive services and vaccine efforts and publicized them via their extended email lists.

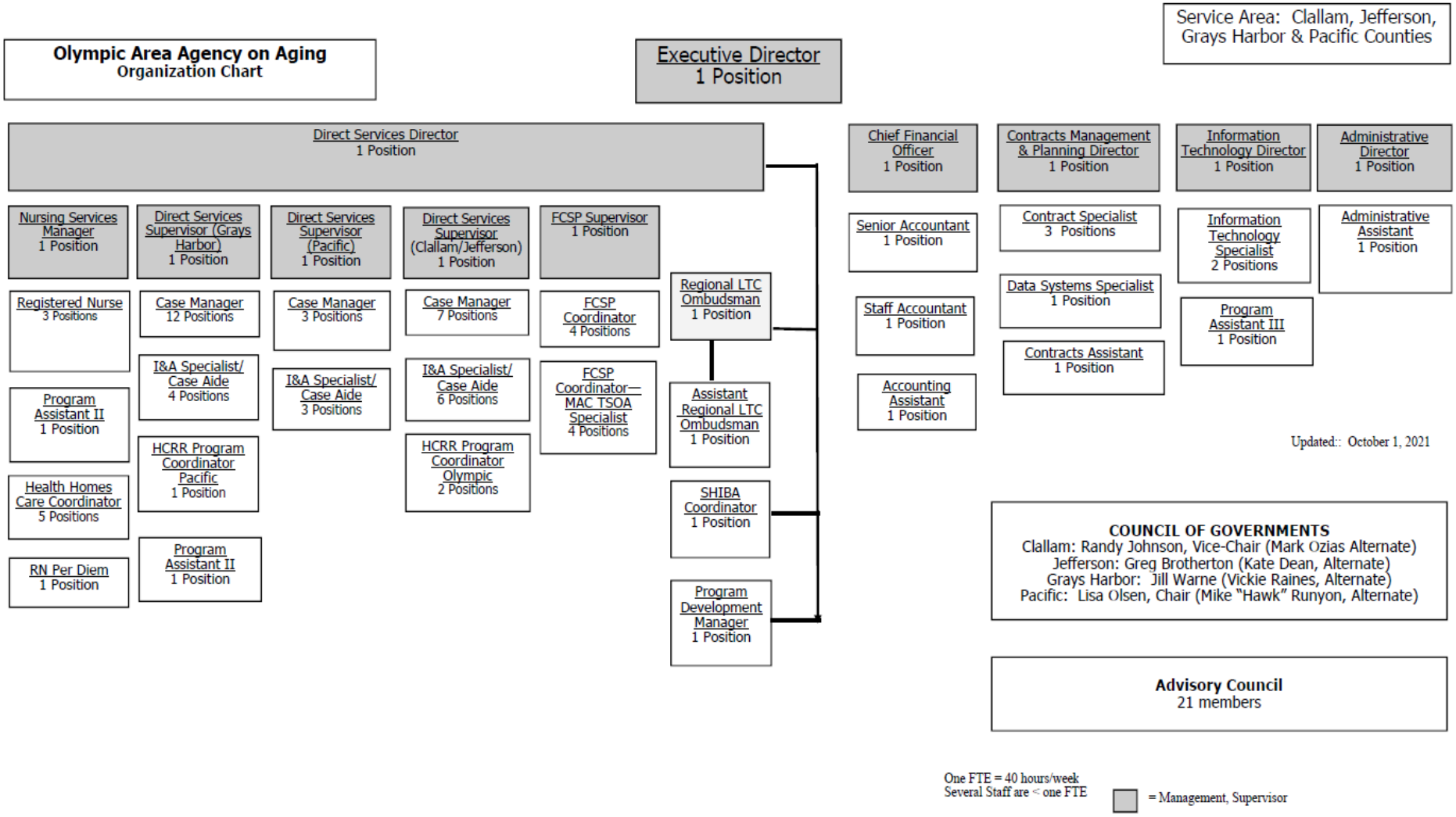
p) Applied for and received CDC Rural COVID -19 Equity Grant for Grays Harbor and Clallam County, each award was $350,000 for a total of $700,000. These grants will be used for a variety of programs to reduce the impact of the pandemic on rural areas.

SECTION D – AREA PLAN BUDGET & COST ALLOCATION PLAN

Submitted as a separate attachment

APPENDICES

APPENDIX A – OLYMPIC AREA AGENCY ON AGING ORGANIZATION CHART *UPDATED FOR 2021*



Olympic Area Agency on Aging

2022 Staffing Plan

POSITION TITLE	TOTAL STAFF	POSITION DESCRIPTION
*^Executive Director 1 Position	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 1 Position	1 FTE	Directs in-house direct services programs in all four counties; program development and improvement; planning; quality assurance; community leadership; state relations; supervises CM/I&A Supervisors, Nurse Manager, designated direct service personnel.
*^Information Technology Director 1 Position	1 FTE	Maintains and improves technology and communication systems; develops data management systems, provides training, works with other managers to create technology tools that better serve clients.
*Chief Financial Officer 1 Position	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 1 Position	1 FTE	Supervises planning & contract management activities. Coordinates community-based planning/needs assessment process, monitors progress toward plan goals. Coordinates Advisory Council activities. Develop community & tribal partnerships. Lead on subcontract management & monitoring; subcontractor training & technical assistance. Grant preparation; program development.
*^Contract Specialist 3 Positions	3 FTE	Manage and monitor homecare agency, caregiver training, Older Americans Act, and COPES Ancillary, and other contracted services as assigned; Assist with subcontractor training & technical assistance.
*Administrative Director 1 Position	1 FTE	Ensures daily agency operations follow standard business processes. Provides advanced administrative support and coordination. Maintains personnel files; performs or oversees all general human resource functions. Assists with agency contract administration and oversight. Provides governing board support.
*Direct Services Supervisor 3 Positions	3 FTE	Assist the Direct Services Director in supervising and managing the department; supervise direct service staff in coordinating services & resources to meet long-

		term care/in-home care needs of older adults & adults with disabilities.
*Nursing Services Manager 1 Position	1 FTE	Supervises agency nursing staff. Works with Direct Services Director to manage agency's nurse services delivery to meet mandated requirements and provide Health Home services.

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

*^FCSP Supervisor 1 Position	1 FTE	Supervises FCSP staff coordinating services and resources to meet needs of unpaid family care-givers of older adults & people with disabilities. Works with Direct Services Director to manage FCSP and MAC-TSOA program service delivery to meet requirements.
Case Manager 22 Positions	22 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 13 Positions	13 FTE	Assist Case Managers in carrying out their responsibilities; provides information and assistance/referral services to public.
Care Coordinator 5 Positions	5 FTE	Assist Case Managers in carrying out their responsibilities; provides information and assistance/referral services to public; arranges supports for designated health home clients.
Senior Accountant 1 Position	1 FTE	Prepares complex agency billings. Responsible for general ledger & bank reconciliations. Assists CFO with budgeting, financial reports, & annual audit. Helps CFO coordinate department workflow & functions.
Staff Accountant 1 Position	1 FTE	Works with fiscal team to manage accounting functions & automated accounting system. Primary on payroll functions. Assists with sub-contractor monitoring.
Accounting Assistant 1 Position	1 FTE	Provides routine support to fiscal department staff; Processes Accounts Payable. Performs complex data entry and clerical tasks.

^*Data Systems Specialist 1 Position	1 FTE	Ensures varied program data base program entries are accurate, performs reporting and review functions. Technical assistance to staff and contractors for data base platform usage. Coordinate service reporting.
Information Technology Specialist 2 Positions	2 FTE	Collects and reports data for statistical reporting agency-wide. Offers support and training on computerized tasks, troubleshoots and repairs problems, reporting results to IT Director.
Contracts Assistant 1 Position	.75 FTE	Provides mid-level clerical and data entry support within contracts management and administrative departments.
Program Assistant III 1 Position	.75	Provides mid-level clerical support and data entry for direct services (I&A, CM, etc.); IP contract management.
Administrative Assistant 1 Position	1 FTE	Provides mid-level support in the administrative office; supports Administrative & Executive Director; general office management and human resource support.
Program Assistant II 2 Positions	1.88 FTE	Provides clerical support for the agency.
SHIBA Coordinator 1 Position	.75 FTE	Provides senior-level clerical support for the case management and I&A department.
*Program Development Manager 1 Position	1 FTE	Performs all levels of administrative support to direct services; emphasis on special projects & program administration for case management and I&A. May assist with subcontractor training & technical assistance.
Registered Nurse 3 Positions	2.75 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 1 Position	.25 FTE	Per referrals, provides health-related consultation to case management, clients, and caregivers in the development and implementation of community-based long-term care services.

Family Caregiver Support Program Coordinator 4 FCSP Positions 4 FCSP / MAC-TSOA Positions	4 FTE 4 FTE	Coordinate services & resources to meet needs of unpaid family caregivers of older adults and people with disabilities. Staff who work predominately with the MAC-TSOA program within the Family Caregiver Support Program (FCSP) department are marked. These staff persons may also provide general FCSP services to clients.
Regional Long Term Care Ombudsman 1 Position	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.
Assistant Regional Long Term Care Ombudsman 1 Position	1 FTE	Functions as lead Regional Long-Term Care Ombudsman in assigned area (North Counties) supervised by RLTC Ombudsman. Supports recruiting, training & supervision of Certified Volunteer Long term Care Ombudsmen region-wide. Data entry and record keeping for service area. Helps advocate for long-term care residents, assists in complaint resolution.
HCRR Coordinator 3 Positions	3 FTE	Work in HCRR operation in accordance with ALTSA guidelines. Trained & skilled in use of the HCRR database. Provide support to consumers and IP workers.

Number of full-time equivalents = 82.13 (FTE = 40 hours per week)

Number of Staff = 84

Number of Staff Over 60 = 35

Number of Staff Indicating a Disability = 6

Number of minority staff = 8

- Hispanic – 1
- White/Native American – 2
- White/Alaska Native American – 1
- Pacific Islander – 2
- Other - 2

APPENDIX C - EMERGENCY RESPONSE PLAN

(The following is the Clallam County Plan – each plan is specific to the County)

OLYMPIC AREA AGENCY ON AGING DISASTER PLAN

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

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

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

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

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

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

Criteria for Assessing Client Risk/Frailty

Following are guidelines for assessing client risk:

The High Priority Client

Solely:

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

-OR-

Two or more:

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

The Lower Priority Client

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

Assessing Priority

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

The Client Contact List

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

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

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

Master List Process

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

Client Contact Following Employee check-in after a Disaster:

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

When Telephone Communication is Interrupted:

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

Emergency Kits for Offices

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

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

CMs will review disaster planning with all clients including:

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

Business Continuity Policy

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

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

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

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

the Information Technology Coordinator. DSHS/ALTSA, HIPPA, and O3A policies shall be the guidelines for offsite records retention. A duplicate of critical electronic records shall be stored offsite as described in the Business Continuity Policy procedures.

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

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

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

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

General Info

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

FIRST RESPONDERS

Emergency Management & Ambulance

Clallam County Emergency Management

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

Olympic Ambulance

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

FIRE DEPARTMENTS

Port Angeles Fire Department

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

Forks: Clallam County Fire District 1

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

Port Angeles: Clallam County FD 2

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

Sequim: Clallam FD 3

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

Joyce: Clallam County FD 4

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

Clallam Bay/Sekiu: Clallam County FD 5

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

La Push/Three Rivers: Clallam County FD 6

Three Rivers Fire Station
PO Box 2385, Forks 98331
360.374.2266

FEDERAL, INDUSTRIAL, MUNICIPAL & PRIVATE FIRE DEPARTMENTS

Neah Bay

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

Quileute

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

U. S. Coast Guard Air Station

Sector Field Office, Ediz Hook, Port Angeles 98362
360.417.5840

LAW ENFORCEMENT

State Patrol

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

Clallam County Sheriff's Office

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

Forks Police Department

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

Port Angeles Police Department

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

Sequim Police Department

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

O3A / CCEM MEMORANDUM OF UNDERSTANDING

BETWEEN

OLYMPIC AREA AGENCY ON AGING

AND

CLALLAM COUNTY DEPARTMENT OF EMERGENCY MANAGEMENT

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

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

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

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

      O3A SHALL:

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

      CCDEM SHALL:

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

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

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

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

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

6. Principal Contacts. The principal contacts for this agreement are:	
Olympic Area Agency on Aging	**Clallam County Department of Emergency Management**
Executive Director: Laura Cepoi laura.cepoi@dshs.wa.gov; (360) 379-5064 Mobile – (360) 301-1506	
Planning Unit Director: Jody Moss jody.moss@dshs.wa.gov; (360) 379-5064 Mobile – (360) 301-0568	
Direct Services Director: Jaci Hoyle Jaci.hoyle@dshs.wa.gov; Mobile: (360) 301-1052	
Case Management Director: Jaci Hoyle Jaci.hoyle@dshs.wa.gov; Mobile: (360) 301-1052	

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

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

ATTACHMENTS INCLUDED:

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

Attachment 1: O3A PRIORITIZATION of CLIENTS IN DECLARED EMERGENCIES

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

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

High Priority Client Lists

Solely:

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

-OR-

Two or more:

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

Lower Priority Client for Contact

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

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

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

Contact Process

- O3A will make every attempt to contact frail clients first followed by all other clients.
- If unable to reach high priority client, O3A staff will contact supervisor followed by Emergency Management to request a welfare check.

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

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

Purpose:

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

Problem:

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

Rules:

HCAs SHALL:

a) Immediately contact 911 if client is experiencing life threatening problems (realizing that in the event of a large scale natural disaster, first responders may not be able to respond quickly to these situations).
b) Encourage clients to develop a personal disaster plan. A useful tool developed by the American Red Cross is Disaster Preparedness for Seniors By Seniors: https://www.redcross.org/images/MEDIA_CustomProductCatalog/m4640086_Disaster_Preparedness_for_Srs-English.revised_7-09.pdf.
c) Previously secured client authorization to release records will suffice during disasters
d) Maintain contact lists of the designated HCA lead staff to communicate with one another during disasters.
e) Commit to help one another's clients during disasters.
f) Respond to all requests received by email, phone or SMS text as follows:
    1. Respond that message has been received.
    2. Check to determine if a care giver is in the area and can perform a welfare check/deliver service.

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

O3A SHALL:

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

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

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

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

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

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

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

Responsibilities of the parties:

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

Commencement/Expiration/Termination:

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

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

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

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

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

Attachment #1
HCA Process for Disaster Cross Agency Collaboration

Scenario

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

Agreements

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

Actions

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

After Actions

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

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

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

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

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

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

O3A COVID-19 POLICIES

The following policies COVID-19 related policies were developed in response to the Public Health Emergency and to address post pandemic work concerns, they include:

- **Temporary Work Station Assignments and remote work document-March 2020**
- **O3A Direct Service Office Protocol During Pandemic** - June 30, 2020: Describes updated protocol for workplace procedures.
- **O3a Procedure Policy On Workplace Covid Exposure Response For Management And Supervisors:** November 20, 2020, Updated 12-11-2020 – Revision 1
- **Temporary Covid-19 Personnel Policy:** 11/20, Updated 12/2020 Revision 1, Updated 5-6-2021 – Revision 2: Policy defining and addressing COVID-19 exposure, isolating before returning to work, associated leave procedures, remote work, inclement weather during remote work, home visiting protocols, in-office protocols.
- **Remote Work Policy:** 8/1/2021: Developed a permanent remote work policy.
- **Home Visitation Procedure:** 8/1/2021, includes prescreening questionnaire, PPE Equipment training attestation, COVID mitigation training attestation, and minimum requirements.

APPENDIX D - ADVISORY COUNCIL

O3A ADVISORY COUNCIL MEMBERSHIP

Membe	Geographic Representation
Vacant	Clallam County
Elizabeth Pratt – 2021 Chair	Clallam County
Charla Wright	Clallam County
Joseph Sharkey	Clallam County; State Council on Aging Rep./liaison, all counties
Sandy Goodwick	Clallam County, Disability Representative
Ginny Adams	Jefferson County
Karen Sturnick	Jefferson County, Minority Representative
Rebecca Knievel – 2021 Vice Chair	Jefferson County
Marti Anthony	Jefferson County
Margaret Taylor	Jefferson County
Vacant	Grays Harbor County
Jane Lauzon	Grays Harbor County
Laura Morris	Grays Harbor County
Tom Edwards	Grays Harbor County
Susan Conniry	Grays Harbor County, Elected Representative
Denny Evans	Pacific County
Connie King	Pacific County
Dale Jacobson	Pacific County
Vacant	Tribal Representative - all counties.

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

APPENDIX E - PUBLIC PROCESS

Description of the O3A 2020 -2023 Area Plan & 2022-2023 Update Work and Activities:

1. A Customer Satisfaction Telephone Survey was conducted in March and April, 2019 by Advisory Council Members
2. A regional survey of older adults was distributed via O3A's website, Advisory Council Members, stakeholder, and provider network, via a newsletter, Trending Health and advertised in local media in May – July 2019.
3. An online Provider Survey was marketed to all Senior Providers through the regular provider networks, contractor lists and O3A supervisors – in May to July 2019.
4. A regional re-survey of older adults was distributed via O3A's website, Advisory Council Members, stakeholder, and provider network, via a newsletter, Trending Health and advertised in social and local media between April and July 2021.
5. A Key Informant Survey was marketed to all Senior Providers through the regular provider networks, contractor lists and O3A staff between April and July 2021.
6. O3A staff organized a conference call and conferred with colleagues across the state to share ideas, research sources, and other pertinent information, 2019.
7. O3A staff reviewed current research on aging issues; recent information published by various local sectors (civic planners, public health, hospitals, transportation, social services, community action programs, etc.); national data sources (census, county health rankings, family caregiver data sources, etc.), and county and regional demographic projections, 2019 and 2021.
8. Planning meetings occurred with ALTSA, with the Advisory Council to review the Area Plan requirements, last Area Plan goals and accomplishments, and changes in requirements from ALTSA, 2019.
9. Developed goals and sought input from Direct Service leadership staff, Advisory Council, and through Public Hearing process, 2019 and 2021.
10. The Advisory Council reviewed the draft plan and approved the draft copy for presentation at a series of public hearings, 2019 and 2021.
11. Public Hearings were held in each of O3A's four service counties: Clallam, Jefferson, Grays Harbor, and Pacific counties, 2019 and 2021.
12. A Senior Provider Forum and a O3A Staff Forum were held in September, 2019.
13. The Advisory Council accepted the plan and recommended that the Council of Governments approve the plan for submission to the Aging and Long Term Support Administration on September 17, 2019.
14. The Council of Governments approved the plan on October 3, 2019, and updates were approved on October 7, 2021.

Area Plan Update, 2021:

1. Conducted a Community Survey and a Key Informant Survey between April and July 2021.
2. Conducted research on updated numbers and data in July – August 2021.
3. Reviewed Survey feedback with Advisory Council July, 2021.
4. Reviewed Area Plan updates and sought input from the O3A Advisory Council throughout the August to September.
5. The Advisory Council accepted the plan and recommended that the Council of Governments approve the plan for submission to the Aging and Long Term Support Administration on September 21, 2021.
6. Public Hearing were conducted by remote means on September 14th in Pacific County, September 15th in Jefferson County, September 16th in Grays Harbor County and on September 17th in Clallam County.
7. The 2022 – 2023 Area Plan was submitted to Aging and Long Term Support Administration on October 4, 2019, and the update was submitted on October 29, 2021

Surveys:

2019 Area Plan Survey →

Number of respondents – 433

← **2019 Client Satisfaction Phone Survey**

2019 Senior Provider Survey →

2021 Survey results and word clouds reported on pages 17 through 19 of this Update.

Senior Provider Forum, 2019:

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

Topics discussed following the presentation included:

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

- Noted that most funded services are delivered by a combination of direct service staff and contracted agencies. Non-funded goals will be responsibility of Contracts Management & Planning staff.

O3A Staff Forum, 2019: Port Townsend & Sequim staff requested a presentation on the draft Area Plan on September 17, with 25 present. Staff was interested in how the plan was developed, what the goals were, and particularly interested in some of the data presented. They noted that the Prioritization page omitted SHIBA, which has since been added in.

O3A Staff Input, 2021: Shared the Draft of Area Plan Update with all of O3A staff on September 1st, 2021 with a request from Laura Cepoi that all staff read the update and welcoming feedback.

Public Hearings:

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

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

Public Hearings were held in:

c. Pacific County on August 22, 2019, 10:00 p.m., at the Pacific County Courthouse Annex in South Bend.
d. Grays Harbor County on August 22, 2019, at 2:00 a.m., at the Grays Harbor County Administration Building in Montesano.
e. Clallam County on August 28, 2019, 10:00 a.m., at the Clallam County Courthouse in Port Angeles.
f. Jefferson County on August 29, 2019, 9:00 a.m., at the Jefferson County Courthouse in Port Townsend.

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

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

A summary of each Public Hearing follows:

Clallam County Public Hearing

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

Commissioner: Randy Johnson, 2019 Council of Governments Vice Chair

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

O3A Staff: Roy Walker, Jody Moss

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

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

- Recognition of the large geographic area and the challenges presented in delivering services, combined with the lack of recognition of these challenges in the I5 Corridor.
- Differences even within other rural areas for example comparing Kitsap to Clallam.
- Rural addresses may be poorly signed and unmarked, and lack of connectivity makes way finding challenging "turn right at the big rock and into the dirt track by the large cedar tree."
- Question was voiced on whether O3A is finding many Health Home clients with behavioral health issues. Explained the 3 sectors being served with Health Homes and that O3A is recruiting / contracting with other Care Coordinating Organizations for Behavioral Health and Substance Use Disorder Health Home Clients. In addition, O3A is general seeing increases in behavioral health issues in the population.
- Lack of specialty care services and limited numbers of gerontologists in region is a big issue.
- Providers are not familiar with the frail elder's experience in a long term care facility or in their home is so that the provider's treatment recommendations may be unrealistic.
- There is a need to address issues for the middle income individual facing the same challenges in aging and the high costs of long term care services. Information was shared on what is available to this middle income population.
- Cost of care is significant – Tammy mentioned the benefits of a Health Savings Plan.
- Discussion on housing and increase in homelessness for elderly women; there is an increase in the number of women living in their cars. Cathy Morgan noted shelter residents include several elderly women no longer able to support themselves in housing once a spouse passes away.
- Commissioner Johnson described an affordable housing strategy he is pursuing using a public private partnership and may ask for support for the strategy in the future.
- Generally, participants agreed that we cannot build our way out of housing issues and will need a new paradigm, for example Naturally Occurring Retirement Communities where individuals share housing; or building housing with shared kitchen / bathroom facilities. All these options will need a culture shift in acceptance that it is honorable to live in a more shared social way.
- Noted that these options do address social isolation which is a significant elder issue.
- The need for oral health care access is critical as well as vision and hearing access for elders in the future. Discussed options for midlevel practitioners perhaps addressing the oral health care, but this is an issue the oral health care providers will need to embrace.
- Need for legislative advocacy for Medicare to cover oral, vision and hearing services.
- Need for advance care planning with entire family. Discussed work Olympic Medical Center is doing with Honoring Choices.
- Other issues – lack of adult day care and transportation options, abandonment of elders by their families.

Jefferson County Public Hearing

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

Commissioners: David Sullivan

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

O3A Staff: Roy Walker, Jody Moss

Members of the Public: Brian Jackson, Home Instead

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

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

Grays Harbor Public Hearing

August 22, 2019: Grays Harbor County Courthouse, Montesano

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

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

O3A Staff: Roy Walker, Jody Moss

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

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

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

Pacific County Public Hearing,

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

Commissioner: Lisa Olsen

O3A Advisory Council: Dale Jacobsen, Long Beach

O3A Staff: Roy Walker, Jody Moss

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

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

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

Advisory Council Meeting, 2019:

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

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

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

Second was made by Rebecca Knievel. Motion carried.

Council of Governments, 2019

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

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

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

PUBLIC HEARINGS ON AREA PLAN UPDATE, 2021

Pacific County Public Hearing:

September 14, 2021: Remote Hearing Due to COVID-19

Commissioner: Lisa Olsen

O3A Advisory Council: Elizabeth Pratt

O3A Staff: Laura Cepoi, Jody Moss, Jaci Hoyle, Doug Sheaffer

Members of the Public: None

Summary: Presented summary of plan and changes and new goals and tasks Questions/Discussion:

- Adult Day Services – significant need in Pacific County. Former PACE space may be an option.
- Outreach has been challenging due to lack of public opportunities, cancelled radio programing due to small office space at station and lack of technology.
- Work Force issues: There was some movement pre-COVID-19 with Grays Harbor College in Raymond on creating a home care aide program but this was stalled because of the pandemic. Work Source may be an interested partner.
- Discussed exploring Oregon residents working in Washington as home care aids.
- Suggested adding a goal around volunteers.

Jefferson County Public Hearing:

September 15, 2021: Remote Hearing Due to COVID-19

Commissioner: Greg Brotherton

O3A Advisory Council: Ginny Adams, Rebecca Knievel, Karen Sturnick

O3A Staff: Laura Cepoi, Jody Moss

Members of the Public: None

Summary: Presented summary of plan and changes and new goals and tasks Questions/Discussion:

- Housing – Shared Housing presents opportunities for younger renters to become paid caregivers for their housemate, and for shared caregiving – one paid caregiver providing client services to two residents who are sharing the same house.
- Advocacy – Commissioner Brotherton asked if there were any advocacy goals. Advocacy is part of O3A's mission and is part of the ED's job description. It is also the responsibility of W4A and the Advisory Council. While there may not be detailed goals, this happens on an annual and formal basis with a statewide agenda and local issues do get highlighted. It also occurs at the federal

level.

- Do tribal members receive services provided by O3A on tribal land? Laura pointed out that Native Americans represent 4% of the population and receive 7% of the services. Tribes also can now become contractors with O3A to deliver services directly to eligible tribal members.
- Laura mentioned that O3A is considering a tribal liaison staff role and a Housing Coordinator role.

Grays Harbor County Public Hearing:

September 16, 2021: Remote Hearing Due to COVID-19

Commissioner: Jill Warne

O3A Advisory Council: Elizabeth Pratt, Susan Conniry, Tom Edwards, Laura Morris

O3A Staff: Laura Cepoi, Jody Moss, Ann Peterson

Members of the Public: None

Summary: Presented summary of plan and changes and new goals and tasks Questions/Discussion:

- One member asked questions about how the Senior Farmers Market might work if CCAP adopts a voucher model and whether an Ocean Shores Coop could potentially participate.

Clallam County Public Hearing:

September 17, 2021: Remote Hearing Due to COVID-19

Commissioner: Randy Johnson

O3A Advisory Council: Sandy Goodwick, Charla Wright

O3A Staff: Jody Moss

Members of the Public: None

Summary: Presented summary of plan and changes and new goals and tasks Questions/Discussion:

- Housing issues: A question was voiced about helping a friend who is in the hospital with the former Adult Family Home refusing to accept her return. (Will provide feedback on this issue after following up.
- Housing continued – Commissioner Johnson has encountered homeless senior women living in vehicles who will not contact housing provider out of embarrassment, fear and concern for safety. Safe parking was mentioned but this group would be uncomfortable even using that resource.
- Commissioner Johnson suggested that the Shared Housing coordinator be an inhouse staff member to be able to more closely address and control senior housing issues for safety and security reasons.
- Network Adequacy – Sandy mentioned WATAP Assistive Technology resources – these include not just information technology devices but also things like spoons that are easier for people with tremors to hold for example. Some time ago a suitcase of assistive technology equipment was sent to O3A. Sandy has volunteered that once the pandemic is less of a problem, she will provide local assistance to locate and distribute as well as educate staff about this resource.
- Commissioner Johnson mentioned that it would be helpful to have a more specific section in the

Area Plan on marketing goals. He agreed with a previously mentioned statement that few people know about O3A services. He suggested also educating our legislators about the amount of funding saved by supporting people to age in place in their homes and the many services we coordinate to do so. I mentioned future goals to have a community outreach position.

Advisory Council, 2021

The Advisory Council met on September 21, 221 to conduct a final review of the Area Plan, Goals, and Public Hearing details. During that meeting the following discussions took place:

- Assistance with Prescription costs – one AC member mentioned Good Rx and suggested marketing these resources to community members and that this be added as a strategy/task, including annual check-ins with SHIBA – This is already contracted, so not added as a new goal.
- It was suggested these resources be added to the Living Well Resource Magazine.
- Marketing and wide distribution using the Living Well Resource Magazine should also be added as a goal – this is also already contracted work and not added as part of Area Plan.
- AC members asked how they could help fill the AC Tribal representative role.
- One member suggested using the FEMA Tribal Liaison job description as a resource tool for serving tribes, which they will provide top the staff.

Dale Jacobs made the following motion: The Olympic Area Agency on Aging Advisory Council recommends that the Council of Governments approve the Olympic Area Agency on Aging 2022-2023 Area Plan Update draft to be presented to the Aging and Long-Term Support Administration as required.

Second was made by Tom Edwards. Motion carried.

Council of Governments, 2021

The Council of Governments met on October 7, 2021 and reviewed final changes to the Area Plan.

Clallam County Commissioner, Mark Ozias (Alternate Council of Government representative) made a motion: The Olympic Area Agency on Aging Council of Governments approves the Olympic Area Agency on Aging 2022-2023 Area Plan to be presented to the Aging and Long-Term Support Administration as required.

Second was made by Grays Harbor County Commissioner, Jill Warne. Motion carried.

APPENDIX E - PUBLIC PROCESS

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

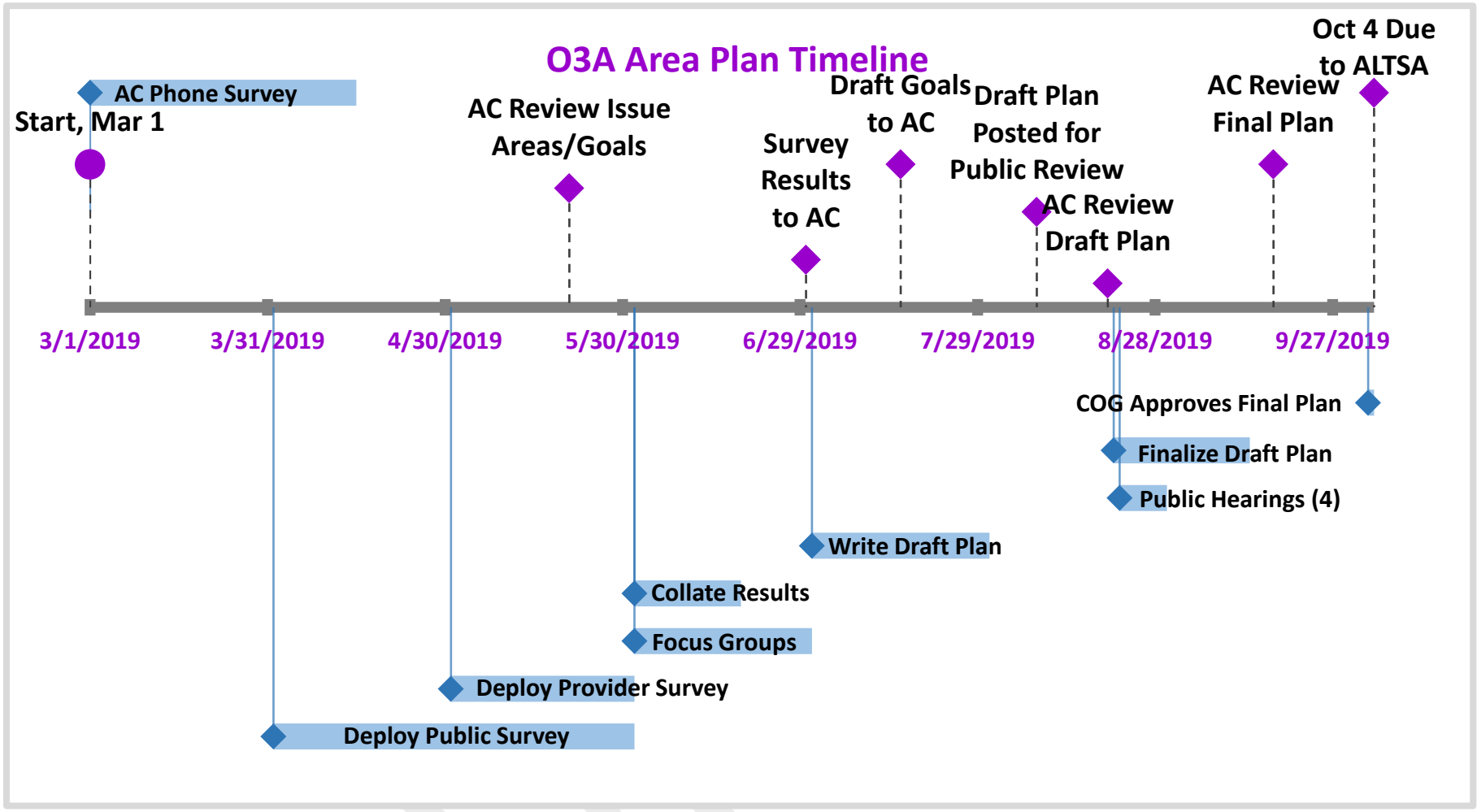
Key:

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

Actions	Person Responsible	Timeline[53]
ALTSA Issues AP instructions – See Attached	ALTSA	April ✓
7.01 Meetings	Jody, Roy, Mark	Jan-Apr✓
Issue Areas & Background Narrative Review		
Develop 2016-2019 Plan Review PowerPoint and present to AC	Jody & staff	Sept 18 ✓
Instructions / Issue Areas Goals / Objectives / Targets Reviewed w/AC	Jody & staff, AC	5/21
Discuss Issue Areas, Goals, Objectives & Activities with AC and seek input	JM, IH, JH, RW, AC	5/21
Present draft very preliminary goals to AC	Jody, AC	7/16
Refine goals based on local data/survey/focus groups/other community input	JM, IH, JH, CH	July Aug
Profile Research		
Search web sites for county and regional data	Carrie	May-Jun
Field Research		May/June
Phone Survey by AC	Jody, AC	3-4/19 ✓
Deploy Public Survey	Jody & staff, AC	4/16✓
Deploy Provider Survey	JM, Janet, Heaven, Shane, Karna, JH, IH	5/1
Collate results	Carrie, Brenda	6/30
Feedback on all survey results to AC	Jody	July
Share instructions with AC	Jody	May
Write and Edit Area Plan		

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

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


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

APPENDIX F - 2021 AREA PLAN UPDATE GOAL SUMMARY SHEET

Issue Area: Healthy Aging					
Goal C – 1.1: Older adults and adults with disabilities are able to meet basic needs for food, transportation, and housing.					
Measurable Objectives	**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2020-2023 (By Month & Year)**		**Accomplishment or Update**
			Start Date	**End Date**	
1. Provide OAA Senior Nutrition and Senior Farmer's Market Nutrition Programs.	a. Ensure OAA service contracts prioritize home delivered meals, and that Senior Nutrition providers offer congregate meals services that are within their capacity to sustain.	O3A Contract Specialist & Contractors	1/1/2020	12/31/2023 & continuing	Two contractors are delivering Home Delivered Meals and Pick up Congregate Meals as well as fresh produce donated to programs to over 494 HDM and 521 CM people.
	b. Continue contracting for Senior Farmers Market program with existing Senior Nutrition providers.	O3A Contract Specialist & Contractors	6/1/2020	10/31/2023 & continuing	Two Nutrition contractors are delivering the SFMNP through vouchers and bulk food to between 730 and 1,000 clients. It has been more difficult during the pandemic, with lower numbers signing up.
	c. Encourage contractors to connect with local food networks.	O3A Contract Specialist & Contractors	1/1/2020	12/31/2023	Both contractors work closely with other food resources, make referrals and help clients sign up for SNAP program and partner with farmers and food banks.
	d. New: Develop additional contracts as needed to serve remote areas, e.g., takeout restaurant contracts.	O3A Contracts Management staff	8/1/2021	12/31/2023	New - Exploring this option currently.
Goal C – 1.1: Older adults and adults with disabilities are able to meet basic needs for food, transportation, and housing.					
Measurable Objectives	**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2020-2023 (By Month & Year)**		**Accomplishment or Update**
			Start Date	**End Date**	
2. Support Volunteer Transportation options for older adults to access health, shopping,	a. Procure local volunteer transportation services through O3A contracts with local agencies to provide transport for medical services and essential shopping.	O3A Contract Specialist & Contractors	1/1/2020	12/31/2023 & continuing	2021 marked the year for procurement of Transportation Contractors. All 3 previous contractors were the sole applicants and wee all approved to continue their work.

and other essential services.	b. Advocate at state and local levels to improve coordination of transportation services.	O3A Executive Director, Contract Management staff, Advisory Council and Contractors	1/1/2020	12/31/2023 & continuing	This is an ongoing issue and always part of our advocacy work. The pandemic may have helped to highlight this issue as older adults needed more transportation assistance to get vaccines.
	c. Work to expand transportation resources, especially with tribes and in remote rural areas.	O3A Contract Management staff, Contractors, Tribes, others	1/1/2020	12/31/2023 & continuing	In 2022, the 3 Volunteer Transportation contractors will be able to serve clients in multiple counties if they have the capacity to do so allowing direct service staff & clients more options than just one contractor per county. Additional help has been provided to recruit additional volunteers. Encouraged each tribe to seek volunteer drivers to work with contractors to drive tribal members.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
3. Advocate for housing options for homeless and at-risk seniors.	a. Share information about, and help older adults to access programs to reduce costs associated with housing (e.g., property tax relief, utility subsidies, maintenance, and safety modifications).	O3A Direct Service Staff	1/1/2020	12/31/2023 & continuing	Staff routinely share resources with clients who call with housing issues. As the housing market tightens, this has become more important, and more difficult.
	b. Develop and implement a homelessness / affordable housing advocacy plan for O3A.	O3A Leadership, Planning staff, and Advisory Council	1/1/2021	12/31/2022	Advisory Council is learning about housing issues affecting seniors and will develop some advocacy points to work from following.
	c. Partner with other housing advocates to promote resources for senior housing needs.	O3A Leadership, Planning staff, and community organizations/housing coalitions	1/1/2020	12/31/2023	O3A is already engaged loosely with some housing efforts in the 4 county region. We plan to engage more directly as staff and volunteers can be identified in each area to represent O3A and senior issues.

	d. New: Explore Shared Housing and other unique ways to address older adult housing issues.	O3A Planning and Program Development staff	6/1/2021	12/31/2021	O3A is engaged in learning about Shared Housing and other options to address senior housing shortages and senior affordable housing issues and are considering offering an RFP to local contractors for a Shared Housing program specifically focused on seniors and their needs.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
4. Maintain regional coverage in Long-Term Care Ombudsman Program.	a. Ensure current level of effort/staff/volunteer capacity is maintained, and as capacity allows, expanded.	O3A LTCOP Manager	1/1/2020	12/31/2023 and continuing	LTCOP continues although was encumbered by the pandemic. Recruitment of new volunteers will be important in the future.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
~~1. Advocate for resources to fund dental, hearing and vision services for both the Medicare and Medicaid populations.~~	~~a. Develop/implement an advocacy plan for oral, hearing and vision care access~~				Made the decision to discontinue this effort due to lack of capacity.
	~~b. Continue to refer clients to known resources for oral health services.~~				Made the decision to discontinue this effort due to lack of capacity.
	~~c. Partner on local oral health coalition efforts.~~				Made the decision to discontinue this effort due to lack of capacity.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
1. Support increased access	a. Support volunteer and other transportation services to distant communities where specialty care is located.	Contracts Management Staff and Contractors	1/1/2020	12/31/2023	Transportation contracts often travel extensive distances to urban areas for medical specialty appointments.

to medical specialty care services.	~~b. Partner with local medical institutions to develop local solutions for accessing specialty care.~~				Discontinued as local healthcare providers are already working on increasing access for specialty care with partnerships with larger regional healthcare networks.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
2. Support increased access to behavioral health services	a. Implement Trauma Informed Care Training for entire O3A staff; inviting community partners as staffing allows.	Contracts Management Staff	1/1/2020	12/31/2023	Over 50% of O3A staff has been through this training, which is considered mandatory by O3A Direct Services Director. Will continue to train staff and work to get Training Partnership and ALTSA to approve this as a continuing education opportunity for IPs and Home Care Aides.
	b. Consider / Implement other trainings for staff and /or community partners e.g., Mental Health First Aid, SAFEtalk, self-protection training for O3A direct service staff.	O3A Leadership-Executive Director	1/1/2020	12/31/2023	Staff were offered the opportunity to take Mental Health First Aid. Planning all staff implicit bias or equity training by HR Consultant.
	~~c. Develop community resources / partnerships to address emerging behavioral health issues.~~				We have been able to contract with sufficient behavioral health contractors to address O3A clients' needs, but lack capacity to take on a larger role currently.
	c. New: Implement Social Isolation programs with clients, tribes and other interested partners, including education about the impacts of social isolation, and providing resources.	Contracts Management Staff, Program Development staff, O3A Partners	1/1/2021	12/31/2023	Developed new resources, Social Call, Well Connected, Acquaint, as well as state resource, GetSetUp. Marketing same to the public. Working on Robotic Pet Project. In planning stage for a social isolation project with Olympic Community of Health partners.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)	Accomplishment or Update

			Start Date	End Date	
1. Facilitate implementation of evidence-based wellness programs in communities throughout the PSA.	a. As funding and willing contractors allow, facilitate implementation of evidence-based programs, such as Chronic Disease Self-Management workshops; Staying Active and Independent for Life (SAIL) fitness program for older adults; Powerful Tools for Caregiving, Stress Busting for Caregivers, Tai Ji Quan Moving for Better Balance, Savvy Caregivers and/or other evidence-based wellness programs in the service region.	O3A Contract Management Staff and Contractors	1/1/2020	12/31/2023	In 2020, programs shifted to remote services. Currently only 2 programs are in place. Goal is to expand to all 4 counties and to support contractors to shift back to in person services if desired and when safe to do so.
	b. Provide information to older adults on medication management through Senior Drug Education Program.	O3A Contract Management Staff and Contractors	1/1/2020	12/31/2023	Monthly Trending Healthy newsletters, media articles and Senior Resource guide are all include medication safety, addiction and seniors, safe storage and safe disposal articles. These articles have much greater reach for educating seniors & caregivers.
	~~c. Advocate for additional funding and partnerships to support evidence-based programs.~~				Made the decision to discontinue this effort due to lack of capacity. Wait and see mode.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
~~1. Coordinate with state-level palliative care committee and with local advance care planning efforts.~~	~~a. Work with Advisory Council member serving on this newly forming Palliative Care committee.~~		1/1/2020	3/1/2021	Completed
	~~b. When produced, market the Palliative Care Roadmap to the community at large.~~		1/1/2020	3/1/2021	Completed - continuing to distribute material.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	

2. Promote awareness of the benefits of palliative care, hospice, and advance care planning (ACP) to providers and the general public.	a. Moved / New: Promote the Palliative Care Road Map to the senior providers, medical groups and the general public.	O3A staff	1/1/2021	12/31/2023 & continuing	O3A staff now has copies of the Palliative Care Road Map in their offices and shares this with clients as need arises.
	b. Partner with local organizations like Olympic Medical Center to promote palliative care, hospice, and advanced care planning.	Contracts Management Staff, Advisory Council, other partners	1/1/2020	12/31/2023	Presentation of Olympic Medical Center Advance Care Planning staff made to Advisory Council. Material on ACP posted on O3A website. Made connections between OMC staff and other facilities for broadening reach of presentations on Advance Care Planning.
	~~c. Identify whether other medical centers in PSA are similarly focused and encourage engagement in this work.~~				Made the decision to discontinue this effort due to lack of capacity. Once we are able to travel more, this may become a viable goal once again.

Issue Area: ACCESS TO RESOURCES (DELAY ENTRY INTO LONG TERM SERVICES AND SUPPORT SYSTEM)

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
1. Conduct outreach and provide support and services to family caregivers.	a. Promote FCSP with appropriate local community organizations, and tribes via presentations & contacts to schools, medical service providers, discharge planners, churches, 7.01 plans and visits to tribes, etc.	FCSP Staff	1/1/2020	12/31/2023	This is an ongoing effort for staff, and while made more difficult by the pandemic, staff continued to outreach to the community with remote presentations, participating in community events when invited and sharing resources through various print, radio and social media posts.
	b. Support/facilitate referrals from hospitals, discharge planners, physicians' offices, schools, churches, etc. Develop new referral resources as they are identified in each county.	FCSP Staff	1/1/2020	12/31/2023	O3A has relationships with all many steady referral sources through discharge planners and provider's offices and is continually seeking new opportunities to share information on resources available.

	c. Provide T-CARE assessments & customized care plans for family caregivers.	FCSP Staff	1/1/2020	12/31/2023	This is ongoing work performed daily by FCSP staff.
	d. Provide services & supports to FCSP (e.g., respite, counseling, training, support groups).	FCSP Staff	1/1/2020	12/31/2023	This is ongoing work performed daily by FCSP staff.
	e. Identify and contract sufficient providers to facilitate efficient and timely service provision.	FCSP Staff & Contracts Management Staff	1/1/2020	12/31/2023	FCSP staff has worked closely with Contracts Management staff to identify gaps in services - i.e., contracts staff is currently working to secure additional housework and errands and massage contracts (albeit for MAC & TSOA caregivers) that can be used to offer some supports while clients wait for a respite caregiver to become available.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
2. Provide support and services to kinship caregivers.	a. Share information about KCSP & RAP (as limited KCSP/RAP resources allow).	FCSP Staff	1/1/2020	12/31/2023	On going work by FCSP staff for as long as each fund source allows. O3A is often able to use unused KCSP and RAP funds from other AAA, and many relatives raising grandchildren benefit. This program also has great outreach in the tribal communities in our region.
	b. Provide services & supports to Kinship / RAP caregivers (e.g., help with emergent supplies, car seats, cribs, children's school supplies, etc.).		1/1/2020	12/31/2023	On going work by FCSP staff for as long as each fund source allows. O3A is often able to use unused KCSP and RAP funds from other AAA, and many relatives raising grandchildren benefit. This program also has great outreach in the tribal communities in our region.

Goal C – 2.1: Family Caregiver Support (FCSP), Kinship Caregiver Support (KCSP) and Relatives as Parents (RAP) programs support more family & kinship caregivers to care for their family members.					
Measurable Objectives	**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2020-2023 (By Month & Year)**		**Accomplishment or Update**
			Start Date	**End Date**	
3. Work towards expansion of out-of-home respite options for caregivers	a. Survey local facilities to ascertain their interest / capacity to provide out-of-home respite through an O3A contract.	Contract Specialist, Contracts Management	1/1/2020	12/31/2023	With few respite options available in our region, this is an ongoing work effort, but was discontinued during the pandemic due to other pressing issues.
	b. Provide technical support and assistance to facilities interested in contracting to provide out-of-home respite care.	Contract Specialist, Contracts Management, Director	1/1/2020	12/31/2023	Introduced partners who want to work on establishing an adult day program in Jefferson County. Will provide technical assistance and possibly some start up funds if available.

Goal C – 2.1: Family Caregiver Support (FCSP), Kinship Caregiver Support (KCSP) and Relatives as Parents (RAP) programs support more family & kinship caregivers to care for their family members.					
Measurable Objectives	**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2020-2023 (By Month & Year)**		**Accomplishment or Update**
			Start Date	**End Date**	
4. Develop more local resources supporting families impacted by dementia.	a. In partnership with the local Alzheimer's Association, facilitate increased training opportunities for support group leaders at community level.	Dir. Contracts Mgmt.	1/1/2020	12/31/2023	Very little has been accomplished in this goal because of the pandemic. The Alzheimer's Assoc. has been in touch about recruiting community training volunteers as community trainers and as support group leaders.
	b. In partnership with the local Alzheimer's Association, facilitate increased training opportunities to help O3A staff recognize dementia and appropriately assist clients and their families.	Dir. Contracts Mgmt.	1/1/2020	12/31/2023	As above - considering partnership with Alzheimer's Association to train staff for support groups and to assist families and clients.
	c. Refer caregivers from MAC, TSOA and FCSP to Alzheimer's Disease support groups.	Direct Service staff	1/1/2020	12/31/2023	Clients have been referred to MAC & TSOA. Unfortunately all support groups in region have been discontinued due to the pandemic.

	d. Publicize dementia support groups through local, on-line and social media.	O3A staff	1/1/2020	12/31/2023	Unfortunately all support groups in region have been discontinued due to the pandemic.
	e. Explore methods/strategies to encourage our region to become a Dementia Friendly PSA, including supporting expansion of the Memory Café model, and "Meet me at the Movies".	Dir. Contracts Management	1/1/2020	12/31/2023	Prior to the pandemic we had these programs and were marketing them but, again, all have been disbanded at this time.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
1. Conduct robust outreach to community partners about these programs to encourage referrals.	a. Develop/implement an annual outreach plan, refine as needed.	Supervisor of MAC/TSOA/FCSP	1/1/2020	12/31/2023	Outreach Plan developed annually. Again, outreach has been difficult during the pandemic since it is all being accomplished remotely.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
2. Continue to develop network adequacy.	a. Develop a network adequacy profile each year.	Contracts Management	1/1/2020	12/31/2023	Network Adequacy reviewed and updated. Working to add new housework and errands contractors and Massage contractors.
	b. Identify potential contractors and provide technical support throughout the Medicaid enrollment process, the initial client service period and beyond.	Contracts Management and Direct Services	1/1/2020	12/31/2023	The relationship between those delivering Direct services to clients and contracting staff is important to help maintain a robust network and knowledge of resources in each community. Contract staff try to meet with direct service staff regularly to build that relationship and find out current needs on the

					ground and to encourage use of new contractors.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
1. Inform older adults, families, other consumers about existing health and long-term care options and provide assistance to access.	a. Offer ongoing, high quality Information and Assistance (I&A) programs throughout the region according to standards.	Information and Assistance staff, Dir. Services Director	1/1/2020	12/31/2023	Ongoing work of I&A staff. Calls and visits to offices dropped initially and are slowly returning to previous levels.
	b. Support I&A services and staff with training to maintain AIRS and CIR-S certification.	Information and Assistance staff, Program Development Manager	1/1/2020	12/31/2023	New staff continued with AIRS and CIR-S training and recently became certified.
	c. Coordinate with local community partners to provide coverage with responsive services and current information on alternatives.	Information and Assistance staff, Direct Services Director, Program Development Manager	1/1/2020	12/31/2023	Information and Assistance, and management of direct services. Research is often provided on new alternatives for resources. O3A works closely with Community Living Connections and 211 to help them keep their resource and referrals systems updated. O3A also produces an annually updated resource guide which is widely sought after.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	

2. Participate in local and regional community coordination activities leading to stronger service networks for vulnerable clients.	a. Continue participation in Accountable Communities of Health regional networks.	Executive Director, Contracts Management Director	1/1/2020	12/31/2023	Serve as an alternate on the northern ACH board, continue with numerous projects and collaborations, one of which is a social isolation project. Thanks to our work, the Olympic Community of Health has agreed to expand the eligibility pool to include dually eligible adults of any age in the coming years.
	b. Continue participation in local and regional program coordination efforts, e.g., regional transportation providers organizations; regional home care agency coordination meetings.	Executive Director, Contracts Management Director	1/1/2020	12/31/2023	Most groups have disbanded or meet by zoom. We continue to participate if we have time. O3A regularly participates with the subcommittees that W4A sponsors to assure the long term care system remains viable
	c. Continue to support local Senior Provider meetings to share information.	Program Development Manager, I & A staff	1/1/2020	12/31/2023	Senior Provider meetings have continued with varying degrees of participations as everyone deals with Zoom fatigue. But we very much look forward

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
3. Increase utilization of Community Living Connections program for support services, resources, and data.	a. Train and support staff in utilization of CLC tracking options.	Program Development Manager, I & A staff,	1/1/2020	12/31/2023	Ongoing training occurs with all contractors and staff on using CLC.
	b. Enter local resources into Listing Manager.	Program Development Manager, Data Specialist, and support staff	1/1/2020	12/31/2023	Staff verify that listings are still accurate and add new resources annually. This is also done in preparation for printing the annual Senior Resource Guide.

	c. Data Manager will explore options for using CLC effectively.	Data Specialist	1/1/2020	12/31/2023	Data Specialist prepares quarterly service reports, and produces ad hoc reports as requested by staff. DS also assists other staff to identify data needs and determine if they can be fulfilled by CLC or other data sources.
	d. Complete annual NAPIS report in a timely manner.	Data Specialist	1/1/2020	12/31/2023	Data Specialist completed the NAPIS report annually and will continue to do so with OAAPS after this year.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
New Objective 4: Promote volunteer opportunities throughout the region to increase available resources and outreach, and to improve quality of life for the recipient as well as the volunteer.	**a. New Market the following volunteer opportunities throughout the PSA** ○ **Becoming an Alzheimer's / Dementia Trainer or Support Group leader with the Alzheimer's Association** ○ **Home Delivered Meals Drivers with an O3A contractor** ○ **Long Term Care Ombudsman** ○ **Statewide Health Insurance Benefits Advisors (SHIBA)** ○ **Social Call Volunteers – making a call once a week to an elder to talk about anything and everything** ○ **Volunteer Transportation – with an O3A contractor taking elders to medical appointments and grocery shopping** ○ **Other opportunities occasionally become available, including Advisory Council representation, Special Projects, Advocacy, etc.**	SHIBA /LTCO Coordinators, Director Planning and Contracts Management, Contract Specialist	1/1/2022	12/31/2023	

	b. **New -** Provide quality volunteer experiences including evidence based training and retention services.				
~~4. Collaborate on developing the Long Term Care Trust Act implementation Plan~~	~~b. Work with Washington Association for the Area Agencies on Aging (W4A) to provide feedback on ideas which emerge from the Planning Commission.~~				At this time there is little work to be done by O3A staff. Advocacy for investing LTCTA funds will re-emerge in the future and O3A will engage our Advisory Council in advocacy efforts.
	~~b. Work with Washington Association for the Area Agencies on Aging (W4A) to provide feedback on ideas which emerge from the Planning Commission.~~				
	~~c. Participate on subcommittees as requested.~~				

Issue Area: AGING IN PLACE (PERSON-CENTERED HOME AND COMMUNITY-BASED SERVICES)

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
1. Maintain O3A staffing and service capacity to provide a personally designed (person-centered) care plan and care coordination services to clients throughout the region that achieves service levels and high quality of service delivery.	~~a. Recruit and contract local agencies & providers to meet client needs for Medicaid-funded services identified by case managers.~~				Duplicate of 3.1.1.C
	b. Implement all staff training programs required during 4 year cycle.	Direct Service Director & Staff	1/1/2020	12/31/2023	Staff training up to date. Two additional I&A staff met their AIRS certification.
	c. Procure contracted services that meet needs identified for Medicaid clients by case managers.	Contract Management Staff & Contractors	1/1/2020	12/31/2023	Contracting is an ongoing effort. Currently at 88 contracts, soon to be 89.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)	Accomplishment or Update

			Start Date	End Date	
2. Expand the Health Homes program.	a. Deliver quality services as a CCO to long-term care clients, including expanding program.	Direct Service Director, Nurse Manager	1/1/2020	12/31/2023	In process of hiring additional care coordinators with a goal of expanding numbers of clients served.
	b. Develop expanded Care Coordinating Organization network contracts for improved network adequacy.	Direct Service Director, Contracts Management Director, Nurse Manager, Contracted Agencies	1/1/2020	12/31/2023	Contract with an additional 3 CCOs, 2 tribes, and expanding 1 CCO to additional counties. 2 other potential agencies have expressed interest in contracting.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
~~3. Implement training for O3A staff and community partners to promote better understanding for personalized (person-centered) services~~	~~a. Implement Trauma Informed Care Training for entire O3A staff and potentially community partners as staffing allows.~~				This is a duplication of Goal C.1.2 a & b
	~~b. Consider / implement other trainings for staff and /or community partners e.g., Mental Health First Aid, SAFEtalk, maintaining personal safety with higher risk clients.~~				
	~~c. Provide logistics and coordination for training venues.~~				

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
1. Promote access to services in remote areas.	a. Advocate for adequate resources and programs in rural areas and for at risk populations, e.g., west coastal areas and regions outside of small cities.	Executive Director, Contracts Management Staff	1/1/2020	12/31/2023	Working with current contractors to outreach to underserved areas. Working to secure additional contractors in remote regions. Securing additional funding for rural community program development. ,
	b. Identify at risk populations and effective mechanisms to reach them, share information about O3A with them, and remove barriers in serving them, e.g., working with 8 tribal	Contracts Management and O3A Direct Service Staff	1/1/2020	12/31/2023	Working with tribal communities to identify gaps, develop new contracts, and share ways to help elders access services.

	communities, LGBTQ population and Latino populations.				

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
1. Advocate for training programs in local educational institutions.	~~a. Contact local high schools and community colleges to encourage implementation of Home Care Aide (HCA) training/certification program, and develop partnerships for this program with Home Care Agencies and Home Care Referral Registry/Consumer Directed Employers.~~				This role had been in process with ALTSA staff prior to onset of pandemic.
	b. Until the Consumer Directed Employer (CDE) program is launched, continue to recruit and contract with individual providers through the O3A Home Care Referral Registries; ensure caregiver requirements are met, including certification and training.	Home Care Referral Registry Staff	1/1/2020	12/31/2022	HCRR continues work to recruit, support training and licensing for IPs.
	c. New: Educate local community leaders about home care aide shortages and impacts and support ALTSA efforts to develop local high school/community college HCA programs.	Contracts Management Staff	7/1/2021	12/31/2023	Have had conversations with Peninsula College President. Have discussed HCA shortage with health care and community based organizations within the Olympic Community of Health.

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

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2020-2023 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
2. Continue to advocate for sufficient support for provision of services across the AAA network in the state and	a. Advocate for issues affecting rural areas related to new initiatives on the horizon and emerging issues in the future including Electronic Visit Verification and Consumer Directed Employer.	Executive Director and Director of Direct Services	1/1/2020	12/31/2023	Contracts Management staff working on EVV subcommittee and with contractors; O3A Director and Direct Services Director working with CDWA to convey issues of lack of connectivity, rurality, etc. in region.

particularly in the remote, rural areas.	b. Ensure that revenue from case management and care coordination contracts adequately supports O3A level of effort.	O3A Leadership	1/1/2020	12/31/2023	Financial review of services and claiming procedures completed, realignment of some staff roles for better financial management, salary survey completed and adjustments made to improve recruitment efforts.

APPENDIX G - STATEMENT OF ASSURANCES AND VERIFICATION OF INTENT

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

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

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

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

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

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

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

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

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

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

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

Date	Laura Cepoi, Executive Director Olympic Area Agency on Aging
Date	Elizabeth Pratt, Advisory Council Chair Olympic Area Agency on Aging
Date	Lisa Olsen, Pacific County Commissioner Chair, Council of Governments Olympic Area Agency on Aging Legal Contractor Authority