Olympic Area Agency on Aging

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SECTION A: AREA AGENCY PLANNING AND PRIORITIES

A-1 Introduction

The Olympic Area Agency on Aging (O3A) Area Plan was developed through broad-based community consultation, service data review, qualitative and quantitative fieldwork research, and public input. It describes O3A's priorities and provides an overall strategic framework to guide staffing and fiscal investments over the next four years. The area plan document serves as the foundation for workplans, funding priorities, and planning efforts to provide services for older adults, adults with disabilities, and family caregivers in Jefferson, Clallam, Grays Harbor, and Pacific Counties.

O3A has provided support to older adults in the four-county region since its inception in 1976. Designated by the Washington State Unit on Aging as one of 13 Area Agencies on Aging (AAAs) 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.

For additional information about our 2024-2027 Area Plan, please contact Laura Cepoi, Executive Director, at laura.cepoi@dshs.wa.gov or Michelle Fogus, Planner and Program Development Manager, at michelle.fogus@dshs.wa.gov or 360.538.8876.

A-2 Mission, Vision, Values

Mission

The Olympic Area Agency on Aging exists to help older adults, persons with disabilities, and their caregivers in leading independent, meaningful, and dignified lives in their own homes and communities.

We do this work through the federal Older Americans Act, which authorizes O3A to complete a wide range of functions related to advocacy, planning, coordination, inter-agency linkages, information sharing, contracting, and evaluation, designed to lead the development of comprehensive and coordinated community-based services.

Vision

O3A is committed to supporting a flexible range of options that are readily accessible to those we serve. Service delivery is effective, inclusive, and compassionate and is efficient with public resources, prioritizing those in greatest social and economic need.

Values

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

- Inclusion
- Respect
- Service Excellence
- Integrity
- Accountability

A-3 Planning and Review Process

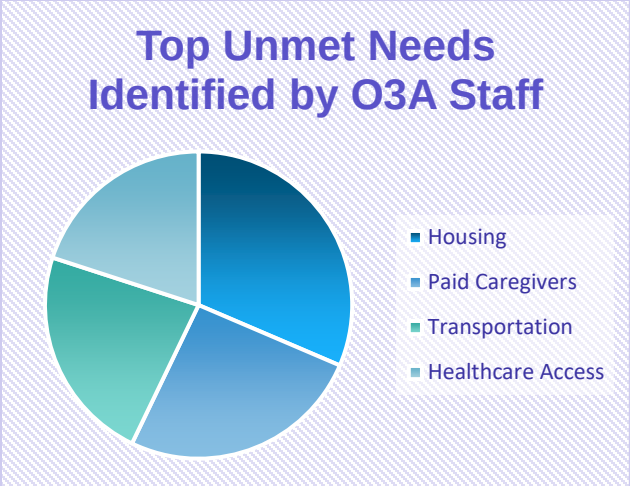
The 2024-2027 Area Plan is based on community input and data from multiple sources, including public and staff surveys, needs assessments, and population data. The plan is reviewed and approved by our Advisory Council and governing body, the Council of Governments.

Activity Timeline:

May-July 2023	Regional Survey distributed in paper/electronic formats and call-in
May-July 2023	Provider Survey Distributed through provider networks, contractor lists
September 2023	O3A Staff Survey - top needs
September 2023	Advisory Council review of Area Plan draft for public hearings
October 9,2023	Grays Harbor County Public Hearing
October 10, 2023	Jefferson County Public Hearing
October 10,2023	Clallam County Public Hearing
October 13, 2023	Pacific County Public Hearing
October 16, 2023	Advisory Council final review and recommendation for approval to submit to ALTSA
October 30, 2023	O3A All Staff review
November 2, 2023	Council of Governments approves Area Plan for submission

Staff Response:

Overall survey results identified the same unmet needs, but prioritization was different among respondent groups. For example, in the O3A staff survey, housing was identified as the most pressing unmet need, versus the general population survey results, which noted access to health care and maintenance of housing as priority unmet needs. O3A staff tend to work with Medicaid recipients who have limited incomes, in contrast to our general survey respondents who, overall, do not.



Community Input:

Area Plan surveys were distributed widely throughout the region. Two different surveys were created: one for clients/community members and one for service providers. They were distributed by staff and Advisory Council members in the following locations: community outreach events, health and information fairs, and senior centers. Surveys were sent to contractors and community partners via e-mail distribution lists and were available online at our website, o3a.org, and promoted via social media. Surveys were available in various formats, including paper, electronic, and a telephone option.

Survey results from these sources identified the following as the most significant needs:

- Healthcare (medical, dental, and mental health)
- Housing maintenance and upkeep, safety modifications
- Housing (availability, affordability, and stability)
- Transportation
- Food and assistance with meal preparation
- Social activities, including volunteer opportunities

Data Review:

Several data sources were reviewed to best understand the demographics of who we serve and how the population is expected to change, as well as how our current service delivery may need to be adapted. Primary sources included:

- O3A service data collected through CLC (Community Living Connection) to understand current service use and review year-over-year trends.

- Client satisfaction surveys (statewide survey of Long-Term Services and Supports recipients, local survey of Family Caregiver Support Program and Kinship Care Support Program recipients)
- Staff surveys from direct service staff
- Demographic data from the US Census, DSHS RDA (Research and Data Analysis), Washington State Department of Health, Elder Economic Index, and Social Vulnerability Index, Washington State Geospatial Open Data Portal

A-4 Prioritization of Discretionary Funding

Federal and State funds that are provided with the flexibility to be spent on local needs, determined at the local level, are referred to as discretionary funds. Services to be considered for discretionary funding were prioritized with the following criteria in mind:

- Does it serve our target populations (older adults, adults with disabilities, family caregivers, those with greatest social and economic needs, those at risk of institutional placement)?
- Address a service gap or equity gap?
- Reduce the need for higher cost services, especially long-term facility placement?
- Bring services to a Service Desert or Food Desert?
- Target social and geographic isolation?
- Provide support to a naturally occurring retirement community?

Prioritization of programs and services will be scored against the factors determined to be most urgent by funding and contractual source and obligation. A sample of scoring could include:

Level	Categories
1	High need and funding support
2	High need but no funding source
3	Lower need and /or less funding/or other organizations may be taking primary responsibility
4	O3A can play supportive role/advocacy

Discretionary funds typically come from Title IIIB, Senior Citizens Services Act (SCSA), and local sources. The public health emergency brought additional funds via the American Rescue Plan, which increased our capacity to address priority service needs in the area. These funds will expire in September of 2024.

There are minimum funding levels within the discretionary areas that must be met. These include Access Services (minimum 15%), Legal Services (minimum 11%), and In-Home services

(1%). O3A currently transfers about 26% of Title IIIC (Senior Nutrition) to Title IIIB (Support Services) to ensure that Information and Assistance services are available in all regions, including O3A offices, senior/community centers, and via mobile assistance in remote regions. The chart below summarizes O3A's planned allocations of discretionary funds:

LEGAL ASSISTANCE (OAA)	**$78,112**
ACCESS SERVICES	**$1,057,811**
Transportation (OAA)	78,000
Information & Assistance (OAA & SCSA)	979,811
IN-HOME SERVICES	**$30,000**
Minor Home Repair & Maintenance (OAA)	25,000
Senior Emergency Fund (SCSA)	5,000
Long Term Care Ombudsman (SCSA)	**$30,000**
Coordination	**$124,800**

Minor Home Repairs:

A 71-year-old woman living in a single-wide trailer broke her ankle. The trailer had ladder-like steps that made getting in or out of the home unsafe for her. O3A Minor Home Repair funds paid for materials for a new ramp which was installed by the client's friend. The ramp provided a permanent increase to home safety.

A low-income couple secured a lot in a mobile home park for their trailer. The trailer had stairs only for the front entrance, but park rules required stairs at both front and back doors. Because they had no funds, they used the front entrance only and ignored the lack of a second set of stairs until an eviction notice for failure to comply with park rules was received. Senior Emergency Funds paid for a set of trailer stairs for the back entrance, allowing them to continue to live in that park close to their medical providers.

Senior Emergency Funds

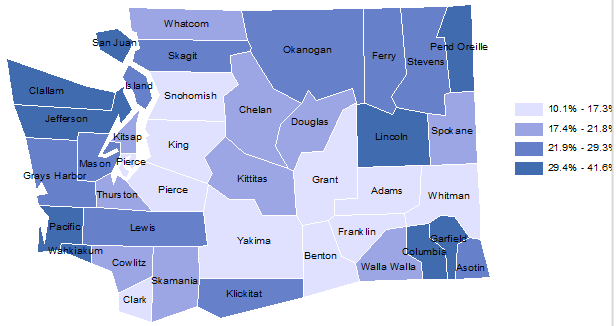
A very low-income older disabled woman was discharged home from an extended hospital stay. Home Delivered Meals were ordered but the woman had no way to heat the frozen meals, as both her microwave and stove were broken. Senior Emergency Funds purchased a new microwave oven, allowing her to prepare and eat her meals during recovery.

SECTION B: PLANNING AND SERVICE AREA PROFILE

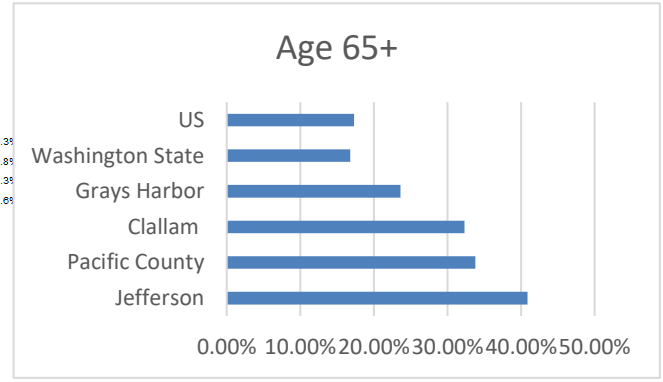
B-1 Target Population Profile

Planning and Service Area (PSA) 1 is comprised of Clallam, Grays Harbor, Jefferson, and Pacific counties. In 2023, there were 231,372[1] people living in O3A's four-county region, of whom 79,945 (34.6%)[2] were age 60 or over[3]. In 2024, there are projected to be 80,841 residents aged 60 or over, increasing to 82,415 by 2027. Jefferson, Pacific and Clallam counties have a median age higher than 50**,** and all three are within the top **five** oldest counties in Washington. Not only is Jefferson County the oldest county in the state, but it also ranks as **the sixth** oldest county in the nation.[1] The O3A service region is significantly older than both the state as a whole and the US.

Percent of Population Age 65 and older, 2020



Source: US Census Bureau 2022 QuickFacts



Source: Washington State Office of Financial Management

While the absolute number of people aged 60 and older is expected to increase slightly in the region over the next four years, the percentage (proportion of the population) is projected to decrease slightly. Target population numbers play a critical factor in interstate funding formulas, which apportion funding based on factors including age, poverty, minority status, English language proficiency and square miles in the service region.

Because of recent funding formula changes, O3A will be receiving about a 9% decrease in Older Americans Act funding as factors have shifted to meet the equity needs of the state. Even

[1] Seatle Times, WA's population is aging. The trend is most striking in these counties; May 31,2023, Gene Balk; https://www.seattletimes.com/seattle-news/data/was-population-is-aging-the-trend-is-most-striking-in-these-counties/

though we continue to see service needs increase and a significant number of our communities have evolved into "naturally occurring retirement communities,"[2] our regional population is not growing proportionately as fast as other regions. Regardless, the percentages of adults 65 and older is projected to increase, with the largest percentage increase for those oldest adults who are age 85 and older. When looking at the aggregate number of all unduplicated people served by all programs offered, O3A serves a little more than 10% of those eligible in the entire region.

Other trends include a large projected increase in the number of individuals with dementia and other cognitive impairments; increasing numbers of older adults in minority groups, including Native American elders and Alaska Natives; more people with limited English proficiency; and more people of all ages with disabilities.

Selected Population and Aging Service Utilization forecast, O3A for 2024[3]

Demographic	Total	Percentage
Total Population	210,407	
60 and over	81,398	39%
60 + and minority	6,312	7.8%
60 + and or below Poverty Level	5,813	7.1%
60+ and a minority at or below FPL	1,097	1.3%
60+ living in rural[3]	50,664[4]	62%
Adults with disabilities 18+	22,947	----
60+ with disabilities	17,580	22%
60+ with Limited English Proficiency	2,765	3.4%
Native American Elders 55+	1,757	2.2%
Number of persons aged 65 + with Dementia	6,505	8%
Number of persons 60+ at risk for institutional placement	17,605	22%
Number of Federally Recognized Tribe	8*	--
Tribal Nations (with Title VI (OAA) Programs): Chehalis Confederated Tribes, Hoh Tribe, Jamestonw S'Klallam Tribe, Lower Elwha Klallam Tribe, Quileute Nation, Makah Tribe, Quinault Nation, and Shoalwater Bay Tribe.		
*Note: While Chinook is not a federally recognized tribe, O3A works with the community of Bay Center to address needs of elders in that community.		

The regional data contained in the previous chart does not reflect the drastic differences in poverty rates between communities within the same county, which can range from a low of 4%

[2] "Naturally occurring retirement communities (NORCs) are neighborhoods where older adults make up a large share of the population, but which were not specifically designed or planned to meet the needs of older adults". https://www.jchs.harvard.edu/blog/naturally-occurring-retirement-communities-score-lower-livability.
[3] David Mancuso, PhD., Age Wave data for Olympic AAA, 6/3/21; date range from 2020-2030, data captured in above chart is from 2024 projections.
4 Washington State Department of Health, DOH 6090003 April 2017, designates all four counties as rural. Urban clusters are populations of at least 2,500 and less than 50,000 per the United States Census Bureau site.
5 Estimated by subtracting "urban clusters" from over age 60 population data; otherwise, 100% would be rural.

to a high of 49%. To understand current population needs, we must consider geography and the variance among cities within each county.

The following charts capture population data in cities by county for population numbers aged 60 and over, the percentage of the 60 and older population, and the poverty rate for people aged 65 and over. [5]

Clallam	**Population 77,805**	**Population 60 and older 32,678**	**% 60 and older 42%**	**Poverty rate for 65+ = 8%**
Port Angeles	*19,888*	*5,768*	*29%*	*10%*
Sequim	*7,896*	*3,553*	*45%*	*7%*
Forks[6]	*3,373*	*540*	*16%*	*20%*
Grays Harbor	**Population 77,038**	**Population 60 and older 23,882**	**% 60 and older 31%**	**Poverty rate for 65+ 13%**
Aberdeen	*16,842*	*3,537*	*21%*	*10%*
Copalis Beach	*437*	*153*	*35%*	*N/A*
Elma	*3,390*	*1,153*	*34%*	*15%*
Hoquiam	*8,700*	*2,697*	*31%*	*4%*
Montesano	*4,070*	*1,221*	*30%*	*6%*
Neilton	*299*	*102*	*34%*	*36%*
Ocean Shores	*6,637*	*3,983*	*60%*	*4%*
Westport	*2,199*	*814*	*37%*	*5%*

Jefferson	**Population 32,590**	**Population 60+ 15,317**	**% 60 and older 47%**	**Poverty rate for 65+ 7%**
Port Townsend	*10,002*	*4,701*	*47%*	*6%*
Port Hadlock/Irondale	*4,216*	*1,812*	*43%*	*4%*
Quilcene	*521*	*151*	*29%*	*10%*
Brinnon	*881*	*502*	*57%*	*11%*
Port Ludlow	*3,046*	*1,584*	*52%*	*3%*

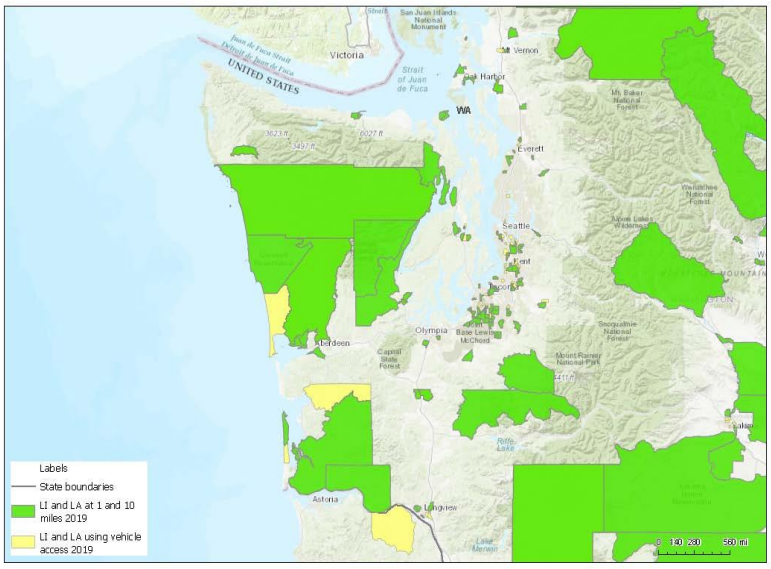
[5] Using data from the Census Reporter to capture city information, data ranges covered ages in 10-year spans thus allowing computation of the percentage of people aged 60 and over. Data sourced from, censusreporter.org/profiles; data from ACS 2021 5-year

[6] 20% of 65 and over are in poverty, this is double the rate of the Port Angeles area and WA state. https://censusreporter.org/profiles/16000US5324810-forks-wa/

Pacific	Population 22,974	Population 60+ 9,190	% 60 and older 40%	Poverty rate for 65+ 7%
Long Beach	*1,925*	*693*	*36%*	*9%*
Ilwaco	*1,725*	*552*	*32%*	*11%*
Ocean Park	*1,794*	*1,023*	*57%*	*4%*
Raymond	*3,035*	*941*	*31%*	*11%*
South Bend	*1,728*	*553*	*32%*	*19%*
Tokeland	*205*	*51*	*25%*	*49%*

The highest poverty rates (Tokeland 43%, South Bend 20%, Forks 26%) also correlate with the highest percentages of native and Hispanic populations. Understanding how our demographics interact with poverty and resources is an important element in how we allocate our resources, including our funding, staff time, and resource development.

The USDA compiles data that identifies those areas that have low income and low access to food, known as Food Deserts. These food deserts are areas that lack access to affordable and healthy foods that make up the full range of a healthy diet. In rural areas, full-service grocery stores can be many miles apart and only accessible by private transportation, as public transportation is not available. Whereas the term "food insecurity" is usually applied to a household's economic condition, the term "food desert" is a community issue. A majority portion of O3A's region is a "food desert," seen as the highlighted green areas, indicating that both access and income make it more challenging to access food.



O3A Food Deserts

Date: 9/30/2023 Source: USDA Economic Research Service, ESRI. For more information: https://www.ers.usda.gov/data-products/food-access-research-atlas/documentation

Access will be further impacted by climate change: risks include flooding, landslides, river channel migration, beach and bluff erosion and sea level rise[7]. Since this region is only accessible by two lane roads, the geographic isolation is magnified once roads are impacted by weather related events and roads become impassable or destroyed during severe storms.

[7] https://ecology.wa.gov/Air-Climate/Responding-to-climate-change/Sea-level-rise

Our service area includes nine tribes, many of which are in isolated coastal areas. Providing culturally relevant services is a priority for O3A, and as tribal populations age, developing the best services and supports for elders and tribal members with disabilities will require us to continue to strengthen our partnerships through increased outreach and providing more opportunities for tribal input into all aspects of service delivery.

O3A Staff and MAV Staff in La Push

One of the ways that we strengthen our tribal partnerships is to provide services through a Mobile Assistance Van (MAV) that provides resource connection, supplies, and groceries to those living along the rural coastal region. Continuing to find new ways to address the needs of older adults and adults with disabilities within our communities will be a major driver of O3A's activities in the next four years. We will focus on developing new programs and seeking creative and innovative ways to meet our communities' needs.

B-2 O3A Services and Partnerships

The Olympic Area Agency on Aging provides services to older adults, adults with disabilities and their families who live throughout the region through direct and contracted services.
O3A currently has 97 contracts in place for various services and supports. However, service provision in the region is constrained by a limited number of qualified providers; consequently, O3A provides many services directly in addition to core services.

O3A Direct and Contracted Services	Clallam	Grays Harbor	Jefferson	Pacific
Adult Day Care (Contracted)	**x**			
Care Transitions (Direct): Staff assist individuals after hospitalization to ensure supports are in place and to reduce the risk of rehospitalization.	x			x
Case Management (Direct): Oversight of services for individuals who qualify functionally for assistance through certain long-term care programs (Community First Choice, MAC/TSOA). Case Managers assess client needs and preferences, develop person-centered care plans, and authorize paid services.				
Medicaid CFC	x	x	x	x
MAC/TSOA	x	x	x	x

O3A Direct and Contracted Services	Clallam	Grays Harbor	Jefferson	Pacific
Dementia Action Program (in development, Direct) Provides education and training about dementia as well as partnerships that support dementia-friendly communities.	**x**	**x**	**x**	**x**
Elder Abuse Prevention - Long-Term Care Ombudsman (Direct): Staff and volunteers provide education and advocacy for individuals living in Adult Family Homes, Assisted Living, Skilled Nursing facilities.	x	x	x	x
ElliQ Pilot Project - Social Isolation (Contract)		x		x
Family Caregiver support Program - Unpaid caregiver support services (Direct) Provides a range of services to unpaid family caregivers, including assessment, caregiver training, respite services, financial assistance, and resource connection.				
Kinship Caregiver Support/Relatives as Parents	x	x	x	x
Caregiver training	x	x	x	x
Respite Services, Assessment & Coordination	x	x	x	x
Respite Care	x	x	x	x
MAC & TSOA services	x	x	x	x
Homeshare (Contract) Matches homeowners and home seekers on a secure platform to facilitate home sharing to help address housing availability and social isolation.	**x**	**x**	**x**	**x**
Information & Assistance(I&A) Services (Direct) Staff provide information and assistance with state and local resources, including referrals, eligibility screening, and advocacy.	x	x	x	x
Kinship Navigator (in development) (Direct) Staff provide assistance and resource connection to non-parental relatives raising children.	x	x	x	x
Legal Services - Senior Legal Advice Clinics (Contract): Provides free legal assistance to adults over 60, including landlord/tenant disputes, wills and Powers of Attorney, and other issues.	x	x	x	x
Minor Home Repairs/Senior Emergency (Direct) Assists with payment for one-time needs that are not covered by other payment sources.	x	x	x	x

O3A Direct and Contracted Services	Clallam	Grays Harbor	Jefferson	Pacific
Medicaid Waiver Services (Contract) Contracted services to meet the needs identified in an individual's CARE plan and eligible for Medicaid payment.				
• Personal care	x	x	x	x
• Adult Day	x			
• Home-Delivered Meals	x	x	x	x
• Community Choice Guiding	x	x	x	x
• Behavior Support Services	x	x	x	x
• Client Training	x	x	x	x
• Community Transition & Stabilization Svcs	x	x	x	x
• Environmental Modifications		x		x
• PERS (Personal Emergency Response System)	x	x	x	x
• Skilled Nursing	x		x	
Nursing Services (Direct): Consultation by Registered Nurses for long-term care clients.	x	x	x	x
Health Home Services (Direct): Health Home Services provide support for individuals with complex chronic care needs.	x	x	x	x
Nutrition/Food Security (OAA and Grant-Funded) (Contract): Addresses nutritional needs and food security with congregate and home-delivered meals, the Senior Farmers' Market program, and short-term grant funded projects through contracted services.				
Congregate Nutrition	x	x	x	x
Home-Delivered Meals	x	x	x	x
Senior Farmer's Market	X	X	X	x
MAV Mobile Food Delivery (grant funded)	x	x	x	x
Welcome Home Food Boxes (grant funded)	x		x	
Nourishing Neighbors (grant funded)	x		x	
Senior Drug Education Program (Contract) Education about medication safety and resources.	x	x	x	x
Statewide Health Insurance Benefits Advisors (SHIBA) (Direct): Staff & volunteers provide unbiased, confidential information about Medicare and related insurance plans.	x	x	x	x
Transportation (Contract) Contracted service for medical appointments and other essential trips for non-Medicaid clients.	x	x	x	x

PARTNERSHIPS:				
Services Provided	**Clallam**	**Grays Harbor**	**Jefferson**	**Pacific**
✓ **= Provided in County - = Not Provided in County**				
Accountable Communities of Health	✓	✓	✓	✓
Adult Day Care	✓	-	-	-
Alzheimer's / Dementia Services & Facilities	✓	✓	✓	✓
Behavioral Health Services				
Behavioral Health Centers & Providers	✓	✓	✓	✓
Substance Use Disorder Treatment Programs	✓	✓	✓	✓
Case Management Programs	✓	✓	✓	✓
City & County Fire / Paramedic Services	✓	✓	✓	✓
Community Action Programs	✓	✓	✓	✓
Councils on Aging or other significant senior organizations	✓	✓	✓	✓
Dental Health Programs & Services	✓	✓	✓	✓
Department of Social and Health Services (DSHS)	✓	✓	✓	✓
Adult Protective Services (APS)	✓	✓	✓	✓
Community Services Offices (CSO)	✓	✓	✓	---
Developmental Disabilities Offices (DD)	✓	✓	✓	✓
Special Nutrition Assistance Program	✓	✓	✓	✓
Home & Community Services (HCS)	✓	✓	✓	✓
Information & Referral	✓	✓		✓
Disability Access Programs	-	✓	✓	-
Disaster Planning				
County Emergency Management Departments	✓	✓	✓	✓
County and City Public Safety	✓	✓	✓	✓
Health & Medical Care			✓	✓
County Public Health Departments	✓	✓	✓	✓
Home Health Agencies	✓	✓	✓	✓
Home Care Agencies	✓	✓	✓	✓
Hospice Services	✓	✓	✓	✓
Hospitals	✓	✓	✓	✓
Community Health Clinics	✓	✓	✓	✓
Housing				
Public Housing Authority	✓	✓	✓	✓
Boarding Homes & Assisted Living Facilities	✓	✓	✓	✓
Adult Family Homes	✓	✓	✓	✓
Nursing Homes	✓	✓	✓	✓
Home Repair, Energy Assistance, Weatherization	✓	✓	✓	✓
Housing for the Homeless Services	✓	✓	✓	✓
Housing Coalitions	✓	✓	TBD	✓
Information & Referral Services (private/nonprofit, e.g., 211)	✓	✓	✓	✓
Legal Services	✓	✓	✓	✓

PARTNERSHIPS:				
Services Provided	**Clallam**	**Grays Harbor**	**Jefferson**	**Pacific**
✓ = Provided in County - = Not Provided in County				
Local Coalitions (Transportation, Affordable Housing/Homelessness Task Forces, etc.,)	✓	✓	✓	-
Native Elder & Minority Services				
OAA Title VI American Elder Nutrition & Cultural Programs	✓	✓	-	✓
Tribal Health Clinics	✓	✓	-	✓
Other	✓	✓	-	✓
Nutrition				
Food Banks (public)	✓	✓	✓	✓
Women-Infant-Children (WIC) Offices	✓	✓	✓	✓
Commodity Supplemental Food Program	✓	✓	✓	✓
Peer Counseling	✓	✓	-	-
Primary Care Physicians	✓	✓	✓	✓
Retired Senior Volunteer Program, other volunteer programs	✓	✓	✓	✓
Senior Centers	✓	✓	✓	✓
Senior Provider Networks	✓	✓	✓	✓
Senior Fitness and Social / Cultural Programs	✓	✓	✓	✓
Social Security Offices	✓	✓	-	-
Spiritual / Faith-Based Organizations (churches, synagogues)	✓	✓	✓	✓
Transportation (includes public transit and Para Transit)	✓	✓	✓	✓
Utility Providers	✓	✓	✓	✓

B-3 Focal Points

O3A has established six local offices that offer direct services throughout the service area. All offices are open to the public during business hours for drop in assistance. In addition, O3A staff provide outreach and services in various community venues, and we are thankful to our many partners who host our SHIBA, I&A and Family Caregiving program staff on their tribal lands, community centers, and food banks.

Port Angeles Senior Center-Coastal Community Action Program- Program Impact:

"It was one woman's first time to have a meal at the center, she is currently living at a shelter. She couldn't believe all the healthy food that was on her plate and that it tasted so good…she started crying. She said that this is her only meal for the day and wondered if she might have seconds. CCAP cook loaded up her second plate and gave her a little carry out box. "

Janis Housden, O3A Contracts Manager, upon return from Congregate site review

Focal Points

County	Office	Address	Phone	Services Offered
Clallam	O3A Senior Information & Assistance (I&A)	609 W. Washington Suite #16 Sequim WA 98382	360.452.3221 800.801.0070	I&A, Case Management, FCSP, KCSP, SHIBA, MAC/TSOA Health Homes
Clallam	O3A Senior Information & Assistance (I&A)	481 5th Ave. PO Box 1644 Forks WA 98331	360.374.9496 800.801.6559	I&A, Case Management, FCSP, KCSP, SHIBA, MAC/TSOA Health Homes
Clallam	Port Angeles Senior Center	328 East 7th St. Port Angeles WA 98362	360.457.7004	I&A, SHIBA, recreation, health & fitness, congregate meals
Grays Harbor	O3A Senior Information & Assistance (I&A)	2700 Simpson Ave. Suite 205 Aberdeen WA 98520	360-532.0520 800.801.0060	I&A, Case Management, FCSP, KCSP, SHIBA, SLAC, MAC/TSOA Health Homes
Grays Harbor	North Beach Senior Center	885 Ocean Shores Blvd NW Ocean Shores WA 98569	360.289.2801	I&A, SHIBA, Emergency food pantry
Grays Harbor	Senior Resource Center	557 Point Brown Ave NW, Ocean Shores WA 98569	360.289.3352	I&A, SHIBA
Grays Harbor	Montesano Community Center	314 S Main St, Montesano, WA 98563	360.249.4900	I&A, SHIBA, Congregate meals
Jefferson	O3A Senior Information & Assistance (I&A)	2500 W. Sims Way Suite 203 Port Townsend WA 98368	360.385.2552 800.801.0050	I&A, Case Management, FCSP, KCSP, SHIBA, MAC/TSOA, Health Homes
Pacific	O3A Senior I&A	430 3rd St. Raymond WA 98577	360.942.2177 888.571.6557	I&A, Case Management, FCSP KCSP, SHIBA, MAC/TSOA Health Homes
Pacific	Raymond Senior Center	324 Jackson Raymond WA 98577	360.942.5739	I&A, Congregate meals, Social activities
Pacific	O3A Senior Information & Assistance (I&A)	1715-A Pacific Ave. N., Long Beach, WA 98631	360.642.3634 888.571.6558	I&A, Case Management, FCSP, KCSP, SHIBA, MAC/TSOA, Health Homes

SECTION C: ISSUE AREA THEMES

This section assimilates the survey input, service data usage, and population demographics as part of the planning process to inform the goals and objectives, along with identifying areas of special focus and effort during the upcoming four-year plan period. These issue areas also correspond to ALTSA's state priority themes, which include:

- ✓ Promoting Healthy Aging
- ✓ Expanding and strengthening services and supports that prevent or delay entry into Medicaid funded Long Term Services and Supports
- ✓ Ensuring a network of person-centered home and community -based services
- ✓ Planning and coordination with Native American Tribes and Tribal Organizations
- ✓ Prepare for future risks, climate events, and emergencies through innovative practices used during the COVID-19 pandemic.

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

Unwinding the Public Health Emergency (PHE), Post-COVID rebuilding, and Funding Shifts

With the end of the public health emergency in May 2023, O3A was able to join community providers for in-person events on tribal reservations and at community centers, schools, and other venues. Community visibility increased through the multiple partnerships developed during the pandemic and funded by the American Rescue Plan Act Funding, CDC Rural Equity Covid- 19 Grant, and the Hunger Relief funding. O3A used these funds to augment existing services and to develop new services (including the Mobile Assistance Van, or MAV: see o3a.org/mav for more information).

The additional funding also allowed O3A to invest in projects that reduced social isolation for tribal members, and funded bilingual staff to conduct outreach and assistance to Spanish-speaking immigrant populations in our south counties who were experiencing food insecurity. Investments in technological innovations to reduce social isolation included piloting robotic companions (first on the West Coast) and distributing Robotic Pets to ease loneliness.

Poverty Reduction

The end of the PHE also signaled the end to the SNAP emergency allocation. SNAP is the nation's widest reaching anti-hunger program which also makes a significant difference in the health and

economic wellbeing of its older participants.[8] The average SNAP benefit, excluding the emergency allotment in 2020, was $110 for older adults living alone.[9] However, more than 50% who are eligible do not participate. Receiving the SNAP benefit reduces food insecurity by as much as 30%. [10] The benefits have dropped to about $30/month for older adults living alone. This has shifted the burden to the State, local agencies, and food banks to meet nutritional needs of those most in need.

By July 2024, O3A will need to identify additional funding streams to meet the senior nutrition demands that were newly identified and expanded in the region. In addition to pandemic era funding coming to closure, the new interstate funding formula used by the state to allocate funding will be funding O3A with a lower factor rate.

Current nutrition funding also does not address some of the gaps in access. The Older Americans Act (OAA) funds only congregate and home-delivered meals, neither of which are readily available in many of the most rural communities, which often have the highest need in terms of poverty level and lack of access to full-service grocery stores. O3A has used grant funds[11] to support food delivery through the Mobile Assistance Van (MAV) and to some homebound seniors; special dietary items for distribution at local food pantries; and boxes of food for individuals being released from hospitals.

> *"Jesse delivers to some 40 seniors in need and two of those on her route have terminal cancer, both ladies living alone. This week, we added canned soups and tuna in the produce boxes. When the ladies opened their boxes, Jesse said they both started crying because the soups and tuna were just what they needed!"*
> *Director, North Beach Senior Center- food delivery*

O3A recognizes the importance and value of the services provided by our local area food banks. Much of our region qualifies as a food desert, limiting resident's access to groceries. Local food banks are supporting families by filling in the food gaps created by the rising cost of groceries and fuel to get to the store, as well as providing information and resources on other programs to assist those families. O3A has partnered with both the Port Angeles Food Bank and Sequim Food Bank in the north, and North Beach Senior Center in the south on programs to improve health equity. Port Angeles Food Bank has developed a 'Nourishing Neighbors' program that allows community participants to help prepare meals for the food bank and take some home for their family. Sequim Food Bank's 'Welcome Home Food Boxes' provide nutritionally dense food boxes to people with chronic care conditions who are headed home after a stay in a care facility or hospital. North Beach Senior Center is a non-profit that also hosts a food pantry for residents and operates the Mobile Assistance Van which brings food and

[8] Get the Facts on Food Insecurity and Older Adults, NCOA, Aprl15,2022.
[9] U.S. Department of Agriculture, Food and Nutrition Service, Office of Policy Support, *Characteristics of Supplemental Nutrition Assistance Program Households: Fiscal Year 2020,* by Kathryn Cronquist and Brett Eiffes. Project Officer, Kameron Burt. Alexandria, VA, 2022
[10] https://www.ncoa.org/article/seniors-snap-5-myths-busted?utm_source=newsletter&utm_medium=email&utm_campaign=CBA
[11] including CDC Rural Equity Grant funds administered by the state Department of Health and one-time state Hunger Relief Funds

COVID supplies to 18 sites (most of which are at food banks that serve our most rural and isolated populations including tribes) throughout our region.

Trends in population access to nutrition assistance demonstrate that those who are 60-74 years old are more likely to use SNAP benefits, while those who are 75 years and older tend to use congregate nutrition sites based in the community and home delivered meals.[12] Helping older adults access SNAP may increase their usage. Expanding congregate meals to community centers may similarly help the younger adults feel comfortable participating in intergenerational meals. This would also encourage more social interaction among adults of all ages and children, making meal sites more accessible and family-friendly for grandparents raising grandchildren, family caregivers, and others in multigenerational households.

Program expansion in the following areas will allow us to deepen partnerships with healthcare, community services, and non-profit providers: Care Transitions Program (hospital transitions program to assist patients to return to their homes- 2022); Dementia Action Catalyst (2023) bringing education, training and supports to people with Alzheimer's and dementia in our region; and the Kinship Navigator Program (2023).

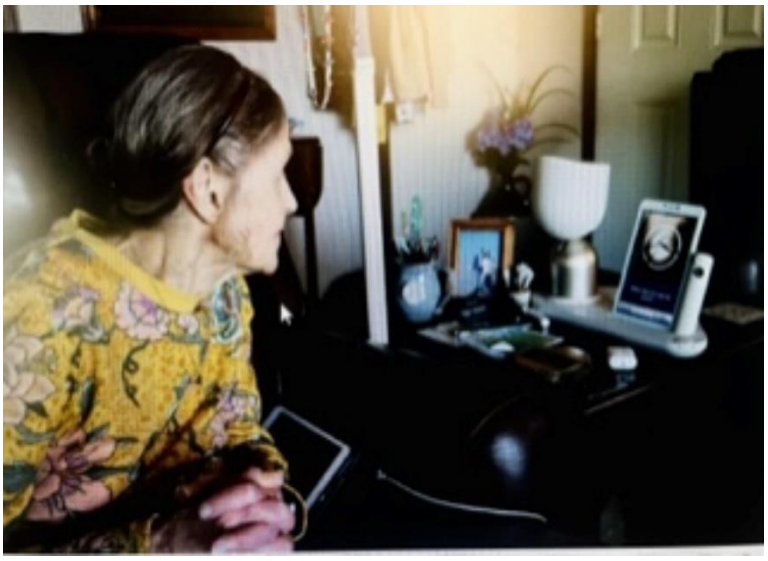
Federally, there are new Center for Medicare and Medicaid Services (CMS) rules requiring hospitals and physicians to screen Medicare patients starting January 2024 on the Health-Related Social Needs (HRSN). The screening tool can help providers find out patients' needs in 5 core domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help
- Safety

Effective health care partnerships will allow us to respond to an anticipated increase in referral volume to our I&A program. We anticipate the expansion of our Care Transitions program as the new requirements are implemented in Medicare patient screening.

We also recognize the growing importance of non-human supports. As the population ages and the projected shortage of both unpaid and paid caregivers continues to worsen, we need to explore new ways to support individuals to age in place. Advances in technology have opened doors for remote support; smart devices that can be operated by individuals with mobility issues, including those who are bedbound, to increase independence and reduce risks; artificial intelligence devices that can decrease loneliness and provide health and wellness benefits; and apps that allow for telehealth and communication with friends, family, and professionals.

[12] M50 Report, Mathematica Policy Research, 2018



Challenges to implementing technology include broadband access, digital literacy, and safety/privacy concerns. Some technology is not yet approved by Medicaid/Medicare. However, addressing these barriers and making new technologies available to those who want and need them will be crucial as we move forward.

Jan Worrell, 83, and her A-I powered companion robot named ElliQ, interact throughout the day at her home on the Long Beach Peninsula.

Photo: Tom Banse, NW News Network

To operationalize this Area Plan and the goals and objectives contained within it, O3A will emphasize:

- Prioritizing resources to reach those with the greatest social and economic need[13]
- Promoting equity, diversity, access, and inclusion practices
- Training/rededicating staff as funding, programs, and services change
- Building new partnerships with tribal, local, and regional service providers and state agencies

"Melanie contacted O3A after her husband suddenly died one week after a being diagnosed with a serious illness. She sold the family business that she and her husband had built together and was no longer getting out of the house. At age 71, she was alone. To help ease the loneliness, Melanie was offered a robotic pet. Melanie loves her robotic cat, so when she spoke with the I&A Specialist again they talked about O3A's ElliQ companion robot project. She is excited to try ElliQ, because it is even more interactive, encouraging her to maintain healthy habits as she works through her grief and sadness."
ElliQ Pilot Project Lead

[13] The term "greatest economic need" means the need resulting from an income level at or below the federal poverty line. The term "greatest social need" means the need caused by non-economic factors, including: (A) physical and mental disabilities; (B) language barriers; and (C) cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that-(i) restricts the ability of an individual to perform normal daily tasks; or (ii) threatens the capacity of the individual to live independently.

C-1 Healthy Aging

Healthy Aging is a continuous process of optimizing opportunities to maintain and improve mental and physical health, independence, and quality of life throughout our life course. O3A will provide services and programs designed to improve health and well-being and reduce disease and injury in older adults as this was the highest-ranking issue in our community survey. About 80% of rural America is medically underserved [14] , there are significant barriers to health care which include the necessity to travel longer distances for medical care, and a shortage of health care providers. On overage, rural residents live two years less than urban residents and have higher rates of dying from heart disease, cancer, and unintentional injury.[15]

Some factors that influence healthy aging in the community include:

- Exercise
- Access to healthy nutrition
- Regular medical care
- Economic security
- Mental health care
- Oral health
- Access to support services
- Social connections
- Safe and affordable home environment
- Access to transportation

O3A supports healthy aging by providing direct and contracted services that enable our aging community to live where they choose as they age and have the help they and their families need to do so.

Physical Health and Wellbeing

According to the National Council on Aging research, nearly 95% of adults 65 and older have at least one chronic condition, and nearly 80% have two or more. Aging increases the risk of chronic diseases such as dementia, heart disease, diabetes, arthritis, and cancer.[16] According to the Centers of Disease Control and Prevention (CDC), in 2021, health and long-term care costs associated with Alzheimer's and other dementia were $355 billion, making them some of the costliest conditions to society.

The pandemic exacerbated issues such as the lack of primary and specialty care providers, particularly in rural areas like O3A's service region. In addition, many providers do not accept Medicaid. Income also limits access for individuals who are not able to afford copays, deductibles, and prescription medications.

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[14] https://infogram.com/2023-rural-health-infographic-1hdw2jpo1vn8p2l: see Rural Health: Addressing Barriers to Care (nihcm.org)

[15] Rural Health: Addressing Barriers to Care, 10/25/23, NIHCM; https://infogram.com/2023-rural-health-infographic-1hdw2jpo1vn8p2l

[16] https://www.cdc.gov/chronicdisease/resources/publications/factsheets/promoting-health-for-older-adults.htm

Differences in vision, hearing, and any disability prevalence increase with age. Access to healthcare-including dental, vision, and hearing services - was identified as a primary concern in the 2023 Area Plan survey (see Appendix E). The percentage of Washington State population with disabilities: [17]

Age	Vision	Hearing	Any disability
Under 65	1.3%	1.7%	8.7%
65+	5.2%	14.9%	33.9%

Medical expenses for someone living in the service region[18] who is in poor health are estimated to be $799/month, whereas someone in excellent health is estimated to spend $548/month. Racial and ethnic minorities in underserved rural communities tend to experience the highest proportion of health disparities, according to The National Institute on Health, which is compounded by the additional costs and access to healthcare.

A couple talked to a SHIBA counselor about their Medicare coverage. It turned out that they are low income. They found out that they qualify for Medicaid. This qualification allowed them to drop private insurance and reduce their prescription costs. With these changes they saved approximately $4000 per year. In addition, their Part B premiums would be paid, saving them another $5400 per year!

In rural areas, transportation also limits access to medical and other services. Individuals without reliable personal transportation, or who are unable to drive the distances required to get care, often have no other options: minimal public transportation, the limitations of paratransit, and the 100-mile-per-month limit on caregiver mileage all inhibit people from getting the care they need. Transportation is also one of the most significant needs identified in the Area Plan survey and is frequently cited by tribes during the 7.01 process.

Food security, nutrition, and meal preparation are essential to healthy aging. O3A's service region has large food deserts, areas where a significant proportion of residents are low income and greater than 10 miles from a full-service grocery store. Congregate meal sites promote socialization and reduce social isolation, as well as providing a hot meal. These sites were closed during the pandemic, and we are working with our contractors to revive these services.

O3A used American Rescue Plan Funding, Covid-19 Rural Equity Grants and Hunger Relief Funding to develop food assistance along the coastal regions, expanding service to nearly 1,000 additional individuals per month through the Mobile Assistance Van (MAV), serving more individuals than all our

[17] U.S. Census Bureau, 2018 Community Survey 1 -year Estimates at https://data.census.gov/cedsci/advanced
[18] Elder Index. (2022). The Elder Index™ [Public Dataset]. Boston, MA: Gerontology Institute, University of Massachusetts Boston. Retrieved from ElderIndex.org

Older Americans Act Funded Senior Nutrition programs combined. The MAV was also able to bring services to six of the tribes in the region and four community/senior centers. A bilingual/ bicultural staff person was able to provide support to Spanish speaking immigrants in the area who needed support and assistance to access benefits. Our goal is to reduce food insecurity in these communities by exploring more robust service options, including restaurant vouchers, sustainable congregate meal sites, and home delivered meal options. We will continue to partner with the local food banks and other providers to address food insecurity in our region.

Brain Health and Dementia Support

Jefferson, Clallam, and Pacific Counties rank among the top five oldest counties in Washington. Jefferson County is the oldest county in Washington and ranks sixty nationwide. According to one community health needs assessment report,[19] there is a lack of gerontologists and Adult Family Homes to meet the needs of the elderly who suffer from Alzheimer's or dementia. As many people choose to retire to this region without family members nearby, it places more reliance on social service organizations in the absence of natural supports to assist with navigating care.

Data from WA State Department of Health- Chronic Disease Profile- 2017

County	Cognitive Decline (65+ health risks)	Over 65	Total population
Jefferson	10%	34%	31,090
Grays Harbor	9%	20%	72,820
Clallam	7%	28%	73,409
Pacific	7%	29%	21,183
WA State	9%	15%	7,267,491

Our four-county area has deep gaps in dementia services, which are exacerbated by the lack of access, information, and clinical support for identifying and diagnosing dementia in our region. Research shows that there is a significantly higher prevalence of mild cognitive impairment and dementia found in rural areas than in urban ones, especially for women.[20] In addition, individuals who live in metropolitan areas typically have longer survival after diagnosis. Alzheimer's disease is

[19] https://www.olympicmedical.org/wp-content/uploads/2019/12/2019-PRC-CHNA-Report-Clallam-County-WA.pdf
[20] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8277695/

the third leading age-adjusted cause of death in Washington State and is expected to grow by 15% from 2020-2025.[21]

O3A has an accepted proposal to offer additional services as a Dementia Resource Catalyst, and we plan on working alongside what is currently present and expand into areas with limited resources with class offerings, group teachings, handouts in private offices where community members may seek assistance for early stage and late-stage dementia, outreach with local emergency responders, and a pathway to the contracted specialist for individual training. The current barriers to a program such as this include overcoming stigma about dementia as a diagnosis. We hope to provide the education and support so that people can receive help sooner and develop a compassionate community response.

MAC/TSOA Program

An 83-year-old woman living alone called O3A for urgent help - rent and insurance used up her Social Security check, leaving no money as of the 3rd of the month for food or other bills.

Staff assisted with an application for SNAP benefits, food bank resources, incontinence supplies (saving $200/month alone), and getting her phone service reinstated.

Realizing that her rent was eating so much of her social security check, we put her name in the housing lottery opening in a few days in an effort to reduce housing costs.

At 83 she has outlived her entire family, including her son. She helps so many in her apartment complex that it was wonderful to help her. She was very thankful and appreciative, making it a great day at work!
O3A MAC/TSOA Specialist

Economic Wellbeing/Social Determinants of Health

Poverty and income limitations impact healthy aging. Financial limitations are especially common for those who live on fixed incomes. Most of O3A's service region is lower income than the state average, according to US Census figures. Many people are unaware of the programs and services available to them, and/or they lack access to services because of transportation or Internet issues. In addition to providing Senior Information & Assistance, O3A also participates in advocacy activities at both the state and federal levels. In 2022, the state increased the

SHIBA Program

"Christa is a 52-year-old single mother of a 17-year-old with special needs. She is on Social Security Disability Insurance and thought she had been thrown off Medicaid with the ending of the public health emergency. She was so concerned about paying for an upcoming MRI that she couldn't think about anything else. Her SHIBA counselor investigated her status and found that she had a $4,000 spenddown. Only one insurance plan could address her financial needs, so she signed up right away- relieved that she could get on with her life. She saved most of the $4,000 spenddown plus she will pay significantly less for her MRI than expected. "
O3A State Health Insurance Benefits Advisor-(SHIBA) Volunteer Coordinator

[21] Washington State Plan, ALTSA, DSHS May 2023

Personal Needs Allowance (PNA) significantly, providing more disposable income for many Social Security recipients. However, the increase did not affect individuals who receive Supplemental Security Income (SSI). Those on SSI are especially likely to experience negative health and safety consequences due to the inability to afford safe housing, adequate food, non-covered medical expenses, transportation, and other essentials. Programs like SHIBA, Case management, MAC/TSOA and Information and Assistance provide tangible assistance to reduce poverty in our communities.

<table>
<tr><th colspan="2">Issue Area C-1: Healthy Aging</th></tr>
<tr><td colspan="2">Profile of the Issue: Healthy Aging is a continuous process of optimizing opportunities to maintain and improve mental and physical health, independence, and quality of life throughout our life course. O3A will provide services and programs designed to improve health and well-being and reduce disease and injury in older adults. O3A's service region includes the highest percentage of older adults per capita in Washington State. Social determinants of health include income, safe housing, adequate nutrition, education, transportation and freedom from violence and exploitation. As a mostly rural service area, O3A will seek out ways to expand the network and variety of resources to meet individual client needs and will coordinate client services across systems.</td></tr>
<tr><td colspan="2">Goal/s: (1) Older adults and adults with disabilities are supported in their health-related social needs through direct and contracted services, partnerships, and advocacy. (2) Affected Individuals and their families will have access to Brain Health resources & Dementia Support. (3) Older adults and their families will have the knowledge and support to make informed choices about chronic disease prevention and management.</td></tr>
<tr><th>Major Objectives</th><th>Key Tasks and Benchmarks</th></tr>
<tr><td rowspan="6">Increase access to services and supports by contracted programs that will optimize health, ensuring those in greatest social need are prioritized.</td><td>Ensure O3A nutrition contracts are meeting targeted population service needs and prioritizing home delivered meal services that offer choices, consistency and meet nutritional standards.</td></tr>
<tr><td>Congregate meal services are supported and established based on community need and resources based at the local level.</td></tr>
<tr><td>Seniors Farmer Market program will be implemented by contractors/ O3A to ensure access to those with the greatest economic needs.</td></tr>
<tr><td>O3A will implement a restaurant voucher model in an area where congregate meals cannot be offered by Senior Nutrition Providers.</td></tr>
<tr><td>O3A will seek out funding to continue food distribution and assistance for the MAV.</td></tr>
<tr><td>Contract with volunteer transportation providers and advocate for additional transportation options in rural areas.</td></tr>
</table>

	Provide support and resources to low-income mobile home parks, long term RV campgrounds, etc. to support housing stability in transitory homes.
	Promote home sharing program to encourage the use of existing housing resources and reduce social isolation.
Establish Dementia Action Catalyst Program in region	Hire and train new Dementia Specialist position.
	Develop contracts with non-profit partners to provide services in all four counties.
	Identify dementia training modules for all O3A staff to complete.
	Coordinate dementia training for community partners, first responders, and health care providers.
	Establish early diagnosis support groups in all counties.
	Discuss dementia supports in all 7.01 plans and work with tribes to ensure culturally appropriate supports are in place.
Facilitate implementation of evidence based (Title IIID) programs.	Facilitate implementation of evidence-based programs, such as Chronic Disease Self-Management workshops; Staying Active and Independent for Life (SAIL) fitness programs for older adults; Powerful Tools for Caregiving; Tai Ji Quan Moving for Better Balance; Savvy Caregivers, and/or other evidence-based wellness programs in the service region.
	Evaluate interest to offer classes to special groups- LGBTQ, Spanish speaking, etc.
Reducing loneliness and Social Isolation	
	Ensure that Trending Healthy newsletter, Seniors Sunset Times, and website promote opportunities to join support groups and classes.
	Recruit and encourage volunteers to support SHIBA, Ombudsman, meal delivery and transportation as a means of connection and service.
	Analyze and review data from ElliQ pilot project, evaluate for efficacy in addressing loneliness and social isolation- prepare to disseminate findings via articles and conferences.

C-2 Expanding and strengthening services and supports that prevent or delay entry into Medicaid funded Long Term Services and Supports

Older adults and adults with disabilities need access to reliable information to understand the aging and long-term care system. Seventy percent of Americans over the age of 65 will likely need long-

term care, yet only 10% of them carry private long term care insurance.[22] Some individuals can't get help until they meet the financial qualifications for Medicaid long-term care, as there are few other options to pay for such care for those who are middle class. Medicaid's resource limit of $2,000 effectively means that individuals will spend their life savings on care until they qualify for Medicaid. For the publicly funded Medicare/Medicaid programs, the increased cost burden means the system will be strained even further. As of this writing, the Medicare hospital insurance fund under Part A, which covers 65 million people, is projected to become insolvent in 2031[23] Finding ways to delay or prevent people from having to enter the LTSS is central to protecting individuals' assets and to providing adequate coverage into the future for those who need it. Washington State has taken a first step in bridging the gap with the WA Cares fund, which will provide some flexible benefits beginning in 2026 to help individuals pay for some care expenses and prevent or prolong their need to enter the LTSS system. The following focus areas inform some of O3A's service delivery to delay entry into the LTSS system, supporting unpaid caregivers and reducing hospital and facility admissions.

Supporting Unpaid Caregivers

Nationwide, family members are the main source of caregiving for older adults and those with disabling conditions. According to a recent report from AARP [24] unpaid caregivers—most of whom are family members—provided care that was valued at approximately $600 billion last year. According to state data, there are over 820,000 unpaid caregivers providing services in Washington.

This caregiving is not "free" as it comes with substantial economic, physical, and psychological costs to those providing care in the form of lost wages, stress, exhaustion, and loss of free time. Supporting unpaid caregivers is crucial to helping people age in place as safely as possible, for as long as possible,

Case Management/MAC/TSOA

"A couple reached out to O3A for help after the husband became very ill with serious long term medical conditions that limited his mobility and accelerated cognitive decline. The wife, now finding herself caring for her husband full-time and managing his duties around the home on top of hers while dealing with the thought of losing the love of her life, was overwhelmed. She began to have suicidal thoughts. O3A has been able to help this couple get on SSI, food assistance, and the MAC Program, all of which helped to alleviate serious financial stresses. While on MAC program the husband got a raised toilet seat, and the wife is currently receiving monthly counseling and guidance with a contracted therapist who specializes in eldercare and supporting family caregivers. She states this has helped her immensely with an "expert" to talk to and help her sort through what the priorities are and where to ask for help. "

O3A MAC/TSOA Case Manager

[22] Urban Institute, "Who is Covered by Private Long-Term Care Insurance?" Richard W. Johnson, August 2016

[23] Healthcare Dive, 4/3/2023, citing Medicare Trustees 2023 Report to Congress

[24] New AARP Report Finds Family Caregivers Provide $600 Billion in Unpaid Care Across the U.S. 'Valuing the Invaluable' documents the increasing economic, physical and emotional costs of caregiving. 3/8/2023

with the best quality of life. This requires an array of supports, from information about various medical conditions to counseling and support groups to respite and more.

Reducing Hospital and Facility Admissions and Readmissions

ER visits, hospital admissions, and long-term care facility admissions are costly for both individuals and Medicare/Medicaid. Many ER visits and hospital admissions are preventable: Age-Friendly Public Health Systems examined data from Medicare on ER visits and noted the following for O3A's service area:

Percentage of preventable hospitalizations[25]	Preventable ***if*** patient had used preventative care	Preventable ***If*** patient accessed primary/urgent care before condition escalated,	Not emergent
38%-48%	7%-11%	14%-19%	16%-19%

ER visits and hospitalizations can be reduced by providing education and assistance with managing chronic conditions, medication management, fall prevention, specialized medical equipment, environmental modifications, assistance with medical transportation, and other services.

Supporting a Return to Home and Community-Based Settings

Issue Area C-2: Expanding and strengthening services and supports that prevent or delay entry into Medicaid funded long-term services and supports (LTSS)	
Profile of the Issue: Older adults and adults with disabilities need access to comprehensive, reliable information to understand the aging and long-term care system. Of the 820,000 unpaid caregivers in Washington, almost one-third of these unpaid caregivers help a person with memory loss. Most people cannot hire a private caregiver due to cost or availability. Requests for intermittent respite are hard to fulfill, as paid caregivers try to limit travel between multiple jobs in one day, leaving many unpaid family caregivers without a break. WA Cares benefits will be available to use in 2026, to pay for and support services that will delay entry into Medicaid LTSS system. O3A will support these efforts through outreach, capacity building, and advocacy for the program and expansion of the provider network.	
Goal/s: (1) Provide unpaid caregivers the opportunity to engage with healthy activities and benefit from community-based services and supports. (2) Reduce risks that lead to injuries and exacerbate medical conditions that require hospitalization and/or admission to short- and long-term facilities. (3) Ensure individuals can make informed choices about the care and supports they receive.	
Major Objectives Provide unpaid caregivers the opportunity to engage with healthy	**Key Tasks and Benchmarks**
	Conduct community program outreach in multiple venues in all counties via health fairs, county fairs, radio, print campaigns;

[25] Age-Friendly Public Health Systems Older Adult Health County Profiles for Clallam, Jefferson, Grays Harbor, and Pacific Counties, 2021

activities that support their wellbeing.	provide ongoing specific outreach to first responders, community partner organizations and Tribal nations.
	Enrolled clients receive needs assessment, program case management, and access to support groups; the family caregiver and care recipient are supported to remain in the home of choice with improved quality of life as reported by the clients and in accordance with funding entity program guidance and quality assurance review.
	Participate in workgroup with ALTSA to expand service and support options for unpaid caregiver programs
	Presentation to advisory group on progress, next steps, and/or outcomes from work group--semi-annually
	Outreach to providers and technical assistance with provider application and verification of qualifications to expand contracted services.
	Support advocacy efforts and pilot programs for spousal pay.
Reduce risks that lead to injuries that lead to hospital admissions.	Provide education and support around fall risk reduction and offer evidence-based programs.
	Expand MOUs for Care Transitions Program to hospitals in Grays Harbor and Jefferson County to reduce readmissions after the first 60 days of discharge.
Individuals can make informed choices about the care and services they receive.	I&A clients receive needs assessment and referral to programs and/or services to address their needs; assistance and support for program access is provided, including referral to and enrollment in Medicaid programs.
	Medicare beneficiaries are provided insurance counseling to make cost effective decisions with help from SHIBA program staff/volunteers.
	Health Home coordinators will aim for increased enrollments for Medicaid beneficiaries who want additional support to improve quality of life, including access to community benefits, assists with getting appointments, and post-hospital care.
Elder Abuse Prevention and Protection	Coordinate Senior Legal Advice Clinics staffed by attorneys who will also report/refer for potential abuse or neglect.
	Recruit Ombudsman volunteers to protect client rights for individuals residing in community care settings (i.e., AFH, Nursing homes, etc.)
	Promote WA Cares program outreach and benefits via articles, events, and public forums

Promote and support WA Cares access to prevent or delay entry into Medicaid enrollment.	Facilitate service access by contracting with providers and providing coordination and resource referral.

C-3 Person-centered home and community-based services

Most older adults choose to age in place—that is, to stay in their own homes and communities for as long as possible. Washington state is a national leader in offering home and community-based services (HCBS). Not only is in-home care the preferred option for most people, but it's also the most cost effective. Home care services are significantly less expensive than the $5,000-$10,000 per month for Adult Family Homes, Assisted Living Facilities, and Skilled Nursing Facilities. In-home care makes more efficient use of public funding than paying for 24-hour-a-day care in facilities by supplementing what individuals and families can do for themselves.

Increasing Numbers of Clients, Changing Demographics, and Clinical Complexity

As noted above, population changes include increasing numbers of older adults and increases in the number of adults with disabilities; minority populations, including those with limited English proficiency; and a particularly large increase in adults with dementia and other cognitive difficulties reflective of an aging population in the region.

Legislation in 2022 reduced caseloads for case managers serving long-term care clients to 75:1. This allows case managers to devote more time per client to help address increased needs due to clinical complexity (SUD, Behavioral Health, TBI, Dementia) and other factors (housing instability, workforce shortages, access to health services). Additionally, it allows case managers to devote more time to addressing individual needs and get solutions in place that protect an individual's choice and independence, preventing entry into institutional care.

Provider and Staff Availability

Nationwide caregiver shortages worsened during the pandemic and show little sign of improving. The shortage of primary and specialty healthcare providers, coupled with a lack of transportation options, means that many individuals cannot access preventive care or treatment. Some Medicaid contracted services are not available in parts of our service region; for example, there are no contractors available in our south counties for skilled nursing services or in our north counties for environmental

Family Caregiving Support Program- Support Group Impact:

Lana has experienced extreme emotional distress in the last few months watching the progression of her mother's dementia and its effect on her family. Her mother, husband, daughter, and granddaughter all lived with her under one roof. Mom went from mildly confused to paranoid to assaultive to self-harming. Having others to "talk and vent to," who knew just what she meant and had gone through some of the same things, saved her sanity and stabilized her household.

modifications (things such as ramps and grab bars). Finally, workforce shortages in our partner agencies have placed additional responsibilities on O3A staff to ensure that the needs of older vulnerable adults are met in a timely and compassionate manner.

Diversity, Equity, Access, and Inclusion (DEAI)

As our population becomes more diverse, we need to find new ways to reach out and partner with groups that serve various populations and ensure that our services are accessible, appropriate, and equitable to all.

<table>
<tr><th colspan="2">Issue Area C-3: Person-Centered Home and Community Based Services</th></tr>
<tr><td colspan="2">Profile of the Issue: Individuals should determine where they want to live and with whom they want to live with. Most older adults choose to stay in their own homes and communities. O3A provides a wide array of supports through both direct and contracted services within a person-centered planning process that honors individual choice to meet their needs.</td></tr>
<tr><td colspan="2">Goal/s: (1) Case Management services are person centered and provided by well trained staff. (2) Ensure that those with the greatest need have access to services that they can understand</td></tr>
<tr><th>Major Objectives</th><th>Key Tasks and Benchmarks</th></tr>
<tr><td rowspan="2">Case Management services are provided by well trained staff who support complex care needs through plans that are person centered, maximizing independence and the ability to engage in self-direction of services.</td><td>Ensure that case managers, I&A Staff, FCSP Staff, Health Home, and MAC/TSOA have access to additional training in topics such as dementia, substance use disorder, behavioral health, audiology effects on health, hospital induced delirium, etc. so that they can assist clients and caregivers with relevant, compassionate information and resources.</td></tr>
<tr><td>Case Management clients are supported by program staff to access the services, programs, and interventions necessary to promote quality of life and independence of choice, and that meet their individual needs assessment.</td></tr>
<tr><td rowspan="2">Increase access and equity</td><td>Ensure that written materials are available in alternative formats as needed.</td></tr>
<tr><td>Increase outreach to tribes, the Hispanic/Latinx community, the Southeast Asian community, the LGBTQ+ community, those with disabilities, and those with language barriers.</td></tr>
<tr><td>Provision of optional Health Homes care coordination to individuals.</td><td>Enrolled Health Homes clients will receive additional supports, program referrals, and individualized coordination with a goal of maximizing independent choice and improved health outcomes, with a minimum of at least once monthly contact.</td></tr>
</table>

C-4 7.01 Planning with Native American Tribes and Tribal Organizations

Issue Area C-4: Coordination of Community Service Access with Tribal Nations	
Profile of the Issue: O3A recognizes the sacred tribal lands that we share and is grateful for the many contributions Native Americans have made to our history and culture. We are committed to expanding our partnerships with the tribes in our service region to offer the best possible services to elders, adults with disabilities and family caregivers while acknowledging and respecting tribal sovereignty. There are eight federally recognized tribes within the O3A service region; while the Chinook are not a federally recognized tribe, O3A works with the community of Bay Center to address needs of elders in that community.	
Goal/s: (1) Ensure service access and coordination to Tribal members. (2) Support the development of Tribal service contracts to support Tribal Elders.	
Major Objectives	**Key Tasks and Benchmarks**
Strengthen partnerships and services to elders and adults with disabilities by increasing outreach and providing more opportunities for tribal input.	**Address Tribal Social Isolation via tribal specific grants to increase social connections via services, programing, and technology.**
	Expand services, including coordination of food and nutrition services, Home Care Services, Adult Day Care, and Health Homes
	Coordination of targeted staff outreach for Health Homes Program, FCSP, Kinship Navigator and Dementia Catalyst program- including scheduled staff visits to Tribal centers to provide on-site program access to members. Participation in Tribal Health Fairs.
	Offer support and services to Tribes who decline 7.01 planning process or are not federally recognized within service area.
Encourage participation in O3A opportunities	**Recruit a Regional Tribal Representative for Advisory Council Board**
	Invite Tribal participation in candidate review for positions that work with tribes.

Please see 7.01 plans below for specific goals developed with each tribe.

Policy 7.01 Plan and Progress Report

Timeframe: July 1, 2023, to June 30, 2024, Updated: March 2023

Administration/Division/AAA: Lewis Mason Thurston AAA (LMTAAA); Olympic AAA (O3A) **Region/Office:** 3

Tribe(s)/RAIOS(s): Chehalis 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, 2020
Discuss and implement Policy 7.01 Implementation Plan for 2023-2024 Biennium	Meet with representatives from Chehalis Tribe as requested. Discuss needs of the Chehalis tribal community and discuss challenges and successes of past coordination efforts. Meet with Chehalis Tribe at least annually for 7.01 planning, and more often, upon request.	Develop a Policy 7.01 Plan that represents a collaborative planning process with the Chehalis Tribe within LMTAAA and O3A service areas. Improve current and future coordination and collaboration between LMTAAA and Chehalis tribe, in order to improve services for elder tribal members.	LMTAAA: Donna Feddern, Community Supports Director O3A: Laura Cepoi, Executive Director Chehalis Tribe: Frances Pickernell Holli Gomes DSHS/OIP: Heather Hoyle, Region 3 Manager Review annually	Chehalis Tribe, LMTAAA and O3A met on March 16, 2023, to update the plan.
Ensure Chehalis tribal staff receive agendas and minutes from LMTAAA Advisory Council and Council of Governments	Include Chehalis tribal contacts in postal and email distribution lists. The main postal address should be	Increase Chehalis tribal awareness of LMTAAA and O3A and community activities, available funding, planning activities and training opportunities.	LMTAAA: Lisa Bachmann, Admin Coordinator John McBride, Access Services Supervisor	Contracts managers are sending the RFPs for LMTAAA & O3A funded programs and will send emails about caregiver services including

meetings, employment opportunities, RFP/RFQs for LMTAAA and O3A funded programs, notices of area planning, Family Caregiver Support Program newsletters and flyers, other relevant community event dates, training opportunities.	noted as: *Chehalis Tribal Headquarters* *PO Box 536* *Oakville, WA 98568*		Kristine Kane, Case Management Director Carrie Petit, Contracts Director O3A: CarolAnn Laase, Administrative Director Ann Peterson, Case Management Director Chehalis Tribe: Frances Pickernell Holli Gomes Information will be sent throughout the year on a monthly basis.	quarterly newsletters and online training opportunities. O3A sends employment opportunities and Advisory Council vacancies and information about relevant community event dates. Chehalis Tribe was invited to respond to O3A's Tribal RFP to address social isolation among tribal elders.
Continue individual and community awareness about emergency preparedness in the Chehalis Tribe and larger community.	Include the Chehalis Tribe in emergency preparedness efforts and messages. Inform and encourage Chehalis tribal representatives to participate in County specific emergency planning efforts. Coordinate and attend emergency	Individuals and the community at large will be better prepared in the event of an emergency Increased Tribal awareness of and participation in emergency planning efforts in the community Increased collaboration between LMTAAA, O3A and the Chehalis Tribe	LMTAAA: Jemma Williamson, Deputy Executive Director O3A: Ann Peterson, Case Management Director Chehalis Tribe: Clinton Davis, Emergency Management Director Kelly Edwards, Chief of Police Frances Pickernell	Chehalis Tribe has a new Emergency Management Director, Clinton Davis. Jemma Williamson is the new contact for LMTAAA and will start passing on emergency information going forward.

	preparedness meetings as requested by the Tribe.		Holli Gomes Annually and as new information becomes available throughout the year.	
Increase consumption of fruits and vegetables by Chehalis Elders in order to improve nutrition and overall health.	LMTAAA will provide Chehalis Tribe with a set-aside allocation of Senior Farmers Market Nutrition Program (SFMNP) cards. Tribal Elders Program will help with SFMNP applications and access to local Farmer's Markets and Farm Stands.	SFMNP checks will be available and easily accessible to Chehalis Elders. Access to affordable fruits and vegetables will be improved. Overall improvement in Chehalis Elders' health.	LMTAAA: Donna Feddern, Community Supports Director Valerie Aubertin, Contracts Manager O3A: Janis Housden, Contracts Manager Marki Lockhart, Community Programs Manager Chehalis Tribe: Frances Pickernell Holli Gomes Sam Boyd, Elders Coordinator Annually (June 1- Oct. 31)	Chehalis tribal members claimed 15 of the 25 vouchers Nutrition Program checks in 2022. Change in 2023: SFMNP vouchers will now be distributed in the form of benefit cards. Marki Lockhart will coordinate for the Tribe to receive vouchers and/or food boxes.
Continue collaboration between Family Caregiver Support Program (FCSP) and Chehalis tribal family caregiving programs.	Share ideas for programming and resources. Collaborate with Chehalis Tribe on family caregiving	Broaden the view and scope of both LMTAAA and Tribal Family Caregiver Support Programs.	LMTAAA: John McBride, Access Services Supervisor O3A: Renee Iverson, FCSP Supervisor	The LMTAAA Community Supports Team has been sending quarterly caregiver newsletters via email as well as notices about trainings.

	conferences and/or local trainings for Tribal members as opportunities arise. Dementia Conference will be held May 18, 2023, in Olympia. Provide outreach to families of the Chehalis Tribe. LMTAAA FCSP will send quarterly newsletter. LMTAAA: Advance Care Planning packets to be shared with tribe. These packets were developed by Providence. LMTAAA: Provide access to Trualta online family caregiver training as requested. O3A: Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs	Increase use of FCSP services by Chehalis tribal family caregivers. Increase training opportunities for Chehalis tribal family caregivers. Improve health and well-being of Chehalis tribal family caregivers. Increase the number of elders with an Advanced Care Plan in place. O3A: 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	<u>Chehalis Tribe</u>: Frances Pickernell Holli Gomes Quarterly updates will be provided. Advance Care Planning Packets to be sent by May 31, 2023	(O3A does not have newsletter) O3A will notify the Tribe when there are Evidenced Based Programs available online or in their area.

	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 individual provider or working for a home care agency. Chehalis Tribe: Chehalis Tribal Health Fair will be held Aug/Sept 2023.	Tribal members interested in becoming caregivers. Tribal caregivers are able to access training and potential employment in a timely manner. Improved caregiver services to elders; caregivers become more resilient Tribal staff gain knowledge about new caregiver support programs.		
Provide resources and information for Chehalis tribal kinship caregivers and Tribal Kinship Navigators	Kinship Navigator staff at Family Education and Support Services (FESS), LMTAAA subcontractor for kinship services, will provide outreach, information, resources	Continuation of collaborative relationships between FESS and the Chehalis tribe. Increased number of Chehalis members taking advantage of services for kinship caregivers.	LMTAAA: Alice Cunningham Kane, Contracts Director O3A: Renee Iverson, FCSP Supervisor	

	and direct services to Chehalis members and Tribal community service staff. (LMTAAA)Provide opportunity for FESS to meet with Chehalis Tribe staff to share kinship resources. (LMTAAA) Invite FESS to Chehalis Health Fair Aug/Sept. 2023 – LMTAAA will share info with FESS O3A: Increase outreach efforts, particularly for remote communities and Tribal reservations, to inform families of the resources available for relatives raising children. O3A staff contact biannually to check in; first due June 30, 2023	Improve health and well-being of Chehalis tribal kinship caregivers. Tribal grandparents & other elders raising children gain additional and often critical support through Relatives as Parents/Kinship Care Support programs.	FESS: Shelly Willis, Executive Director, Family Education and Support Services (LMTAAA subcontractor for kinship services) Chehalis Tribe: Frances Pickernell Holli Gomes Annually	
Increase awareness of Chehalis Elders about community services and resources, including	Maintain regular Information and Assistance visits to the Chehalis tribe for	Increased Chehalis member awareness and usage of community services and resources.	LMTAAA: John McBride, Access Services Supervisor O3A:	LMTAAA Aging & Disability Resource Center (ADRC) staff will begin regular visits again (were on hold during

long term care and supports, Medicaid services, legal assistance, living wills/POA, home modification assistance, transportation options, prescription drug coverage, etc.	education and outreach purposes. Provide written materials for Chehalis tribe. Set up and staff informational booths at Chehalis tribal Health/Community Fairs. Chehalis Tribe Health Fair will be held Aug/Sept 2023- Tribal staff will share info with AAAs		Ann Peterson, Case Management Director <u>Chehalis Tribe</u>: Frances Pickernell Holli Gomes Denise Walker, Clinic Director Twice a year.	pandemic) during Elders' lunches. O3A stopped Information and Assistance (I&A) and Statewide Health Insurance Benefits Advisors (SHIBA) staff visiting due to the pandemic; we are happy to restart these visits if the Tribe would like.
Increase community awareness of Chehalis tribal services and resources	List announcements specific to Chehalis tribal events on LMTAAA & O3A websites and social media. • Chehalis Tribe staff to send info to AAAs Inform Chehalis tribe of opportunities to attend and set up displays at health/community fairs and bazaars. • AAAs to send info to Chehalis Tribe	Increased community awareness of Chehalis tribal services, resources, and events.	<u>LMTAAA</u>: John McBride, Access Services Supervisor <u>O3A</u>: Marki Lockhart, Community Programs Manager Ann Peterson, Case Management Director <u>Chehalis Tribe</u>: Frances Pickernell Holli Gomes Denise Walker, Clinic Director Annually	Goal has not been met due to interruption of events, staffing, due to COVID pandemic. Will begin sharing information more regularly.

Coordinate Case Management (CM) services for tribal members. Increase awareness with tribal elders of Long-Term Care Services and Supports (LTCSS) options when receiving in-home care services. Be respectful of entering tribal lands.	Coordinate visits to tribal elders. Identify an LMTAAA CM liaison to the tribe. Contact Kelly Edwards (Chief of Police) with the client's consent to advise him of purpose of visit to tribe prior to coming onto the Reservation. Call, fax, or email. Phone #: 360-709-1608 Frances Pickernell or Holli Gomes may also be contacted for this purpose. (Contact first) AAA staff to attend Government to Government Training	Increased comfort levels and trust for tribal elders when using LTCSS. Tribal elders will receive assistance to enhance their ability to age in place successfully. Tribal authorities are aware of who is on tribal lands and for what purpose.	LMTAAA: Emily MacFarland, Case Management Supervisor O3A: Ann Peterson, Case Management Director Chehalis Tribe: Holli Gomes Frances Pickernell Denise Walker, Clinic Director Annually	LMTAAA liaison has been identified: Emily MacFarland, Case Management Supervisor. Donna Feddern and John McBride, LMTAAA attended Government to Government training in January 2022. New AAA Case Management staff complete the OIP-led training during Case Mgr Policy Training.
Completed Items (and date):				

Policy 7.01 Plan and Progress Report - DRAFT

Timeframe: July 1, 2023, to June 30, 2024, Updated: 2/3/2023

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 2023**
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	Status Update for the Fiscal Year starting last July 1.
Continue current outreach assistance to tribal members, both remotely and in-person.	Meet with tribal 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. Check-in quarterly on Tribal needs. O3A staff coordinate remote or in-person monthly visits. 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	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. ***Lead staff and contact information for both***	Laura Cepoi, O3A Executive Director September 30, 2023 Marki Lockhart, Community Programs Manager September 30, 2023 December 31, 2023 March 31, 2024 June 30, 2024 Michelle Fogus, Planner & Program Development Manager	O3A Staff attended the Hoh Health Fair on September 8, 2023.

	visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder. O3A staff will participate in Resource/Health Fairs and other tribal activities, as time permits to share resource information.	***organizations listed on the attached contact list.***	Marki Lockhart, Community Programs Manager <u>Tribal Staff</u> Britni Duncan, Director of Health Services	
Improved caregiver training and support options for unpaid family caregivers and paid caregivers serving tribal members (if interested/requested).	Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs Identify unpaid family caregivers through family caregiver support programs and tribal social service referrals and support caregivers to obtain respite, training, and other forms of support. Provide information and support for tribal members to access the Medicaid Alternative Care and Tailored Supports for Older Adults (MAC & TSOA) Programs With help from Hoh Tribe staff, identify tribal	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 can access training and	<u>Family Caregiver Support Program:</u> Renee Iverson, FCSP/KCSP Supervisor Susie Brandelius, Forks <u>Tribal Staff</u> Britni Duncan, Director of Health Services	O3A staff continues to provide support to tribal caregivers.

	members interested in becoming paid caregivers and provide referrals for training to become an individual provider or a home care agency worker.	potential employment in a timely manner. Unpaid family caregivers of elders receive additional support services 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.		
Enhanced services / support for Tribal grandparents/other relatives raising children.	Increase outreach efforts to inform families of the resources available for relatives raising children. Coordinate monthly outreach visit with O3A staff. Notify tribe of classes/training available to family caregivers by sending brochures/fliers to Family Service Director.	Tribal grandparents & other relatives raising children gain additional and often critical support through Relatives as Parents/Kinship Care Support programs.	<u>Kinship Caregiver Support Program:</u> Renee Iverson, FCSP/KCSP Supervisor Marki Lockhart, Community Programs Manager Susie Brandelius, Forks <u>Tribal Staff</u> Britni Duncan	O3A staff continues to provide support to tribal kinship caregivers.
Improve Hoh Tribe access to health and nutrition education and program services	Through nutrition contracts with local providers, promote inclusion of local tribal elders in nutrition education programs by	Tribal elders participate in programs implemented by local health / nutrition education providers.	Janis Housden, Contracts Manager	

to the extent resources allow.	sharing useful resources between Hoh Tribe and nutrition providers such as printed education material and 1/3rd RDA approved menus. Work to identify additional options for accessing Home Delivered or Congregate Meals by connecting Tribal staff with local Nutrition Services. Explore using other funds to support Tribe preparing meals for elders.	Capacity for Hoh Tribe and regional nutrition providers is increased by sharing ideas and material; more elders receive better information around health and nutrition.	Michelle Fogus, Planner/Program Development Manager <u>Tribal Staff</u> Britni Duncan, Director of Health Services	
Improved access to health and support services for Tribal elders.	Increase coordination between O3A and Tribal representatives to facilitate access to local services—especially health care-- for Tribal Elders. Notify Tribe, by email, of Title III-D wellness programs and classes. Invite the Hoh Tribe to engage in O3A Prevention programs- SAIL, Bingocize, 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. Tribal Elders /others gain knowledge planning options for Medicare / other insurance coverage.	Michelle Fogus, Planner/Program Development Manager Janis Housden, Contracts Manager Marki Lockhart, O3A Community Programs Manager	

	Explore options for scheduling a SHIBA Clinic for Hoh Elders in Fall of 2023.		Tribal Staff Britni Duncan, Director of Health Services	
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	Michelle Fogus, Planner & Program Development Manager Carol Ann Laase, Administrative Director Michelle Fogus, Planner & Program Development Manager Tribal Staff Britni Duncan	Hoh Tribe notified of Tribal Representative vacancy on O3A Advisory Council. O3A HR staff notify Hoh Tribe when posting positions.
Improved access to transportation for Tribal Elders with special needs. Volunteer Transportation program is accessible to all members over age 60.	Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions (RTPO & local transportation initiatives if known). O3A confirm with ALTSA if available to Tribal Elders at age 55. Volunteer transportation provider will complete a	Local planning efforts are responsive to transportation needs of the Hoh Tribe. Promote increased options for transportation for Tribal Elders with Special needs. Tribal volunteer drivers expand transportation capacity for Elders over 60. (Note that this age limitation is determined	Michelle Fogus, Planner & Program Development Manager Janis Housden, Contracts Manager Ingrid Henden, Contracts Manager 10/15/2023 Janis Housden, Contracts Manager Tribal Staff	

	resource presentation to the Tribe if requested. Hoh Tribe identifies tribal staff member or volunteer driver(s), to become a volunteer with the volunteer transportation program to be reimbursed per mile driven for qualified transportation services of elders 60 and over.	by fund source – Older Americans Act)	Britni Duncan, Director of Health Services	
Assist the Hoh Tribe, if interested, to develop contracts (for example, Adult Day 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 meeting to discuss Waiver 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.	Ingrid Henden, Contracts Manager Contact Britni by 9/30/2023 to schedule by 12/31/2023. <u>Tribal Staff</u> Britni Duncan, Director of Health Services	O3A staff attended a preliminary Health Homes meeting with ALTSA, HCA, and the Hoh Tribe on June 14, 2023. A copy of the health homes contract was provided. Ingrid emailed Britni on 9/22/2023 to coordinate a meeting date to discuss Medicaid contracts.

Policy 7.01 Plan and Progress Report - DRAFT

Timeframe: July 1, 2023, to June 30, 2024, Updated: October 20, 2022

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.	○ 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 Ann Peterson, Case Management Director ann.peterson@dshs.wa.gov 360.538.2449 Marki Lockhart, Community Programs Manager marki.lockhart@dshs.wa.gov 360.417.8553 I&A Offices–call for address: Sequim 360.452.3221 800.801.0070 O3A Advisory Council Tribal Representative – Open Position Brenda Francis Thomas, brenda.francis-thomas@dshs.wa.gov, 360.565.2203 Tribe:	A 7.01 planning meeting was not held with Jamestown S'Klallam Tribe in 2022.

	○ Ensure tribal issues are considered in agency planning, training, and project development.		Loni Greninger, 360.681.4660, lgreninger@amestowntribe.org Timeline: 7/1/2022 – 6/30/2023	
2. Improved caregiver training and support options for JST	○ Improve coordination between AAA Title III and Tribal Title VI Caregiver Support Programs ○ Assist unpaid Tribal caregivers to obtain training and support. ○ New Assist with CDWA transition as needed. ○ 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: Ann Peterson Marki Lockhart Fran Koski, Family Caregiver Support Program, 360.417.8549, koskiff@dshs.wa.gov Heather Patterson, (MAC/TSOA), 360.417.8551, heather.patterson@dshs.wa.gov Catholic Community Services – Local Training Partnership for caregiver training - Robin Gibson, robing@ccsww.org, 360.417.5420 Tribe: Loni Greninger Timeline: 7/1/2022 – 6/30/2023	
3. Enhanced services/support for Tribal grandparents /	○ Increase outreach efforts, O3A staff to introduce self to JST to	○ Kinship Care Support Program will benefit tribal grandparents and	State/AAA: Renee Iverson, FCSP Supervisor	

other Elders raising children	inform families of resources available for relatives raising children.	other Elders raising children.	renee.iverson@dshs.wa.gov Fran Koski, FCSP Heather Patterson (MAC/TSOA) Tribe: Loni Greninger Timeline: 7/1/2022 – 6/30/2023	
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: Janis Housden, Contracts Manager janis.housden@dshs.wa.gov 360.379.5064 MJ Baker Scott, OlyCAP (360) 452-4726, Ext. 6213 mjbakerscott@olycap.org Tribe: Loni Greninger Timeline: 7/1/2022 – 6/30/2023	
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	○ Tribal issues are represented in local community, county planning efforts. ○ Tribal needs are considered and addressed by local service providers,	State/AAA: Ann Peterson Marki Lockhart Tribe: Loni Greninger Timeline: 7/1/2022 – 6/30/2023	LTC Ombudsman visit to JST on 10/20/2022.

	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 ○ Explore options for contracting with Jamestown Clinic and/or JST Social Services for Health Homes Care Coordinating Organization (CCO) for eligible tribal Elders	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.		
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: CarolAnn, Administrative Director carolann.laase@dshs.wa.gov 360.379.5061 Ann Peterson Marki Lockhart Tribe: Loni Greninger Timeline: 7/1/2022 – 6/30/2023	

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 contracts Manager AC Tribal Representative Open Position Tribe: Rob Welch Loni Greninger Timeline: 7/1/2022 – 6/30/2023	JST was awarded $50,000 for activities to improve social isolation for elders.
9. Improved access to transportation for Tribal Elders with special needs.	○ Facilitate Tribal representation in local planning and coordination efforts and regional transportation coalitions ○ Explore options for developing a corps of tribal volunteers to help transport elders to activities/medical appointments as part of Catholic	○ Local planning efforts are responsive to transportation needs of the tribe. Promote increased options for transportation for Tribal Elders with Special needs. ○ Volunteer transportation provider can complete a resource presentation to the Tribe if requested.	State/AAA: Janis Housden Loni Greninger Clallam Teri Wensits, Volunteer Chore Services, TeriW@ccsww.org, 360.417.5640 Timeline: 7/1/2022 – 6/30/2023	

	Community Services Volunteer Transportation program	○ Tribal volunteer drivers expand transportation capacity for Elders over 60. (Note that this age limitation is determined by fund source – Older Americans Act)		

Policy 7.01 Plan and Progress Report - DRAFT

Timeframe: July 1, 2023, to June 30, 2024, Updated: 3/30/2023

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, both remotely and in-person.	Coordinate MIPPA outreach and/or events for elders, either in person or remotely. O3A staff can assist with Medicaid applications over the phone in local I&A office. Connect with Lower Elwha on quarterly basis. Ensure current outreach assistance is continued and explore expanding support and coordination assistance as available resources allow. Hold regular meetings with Lower Elwha to	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.	Marki Lockhart, Community Programs Manager Set meeting to follow-up and schedule Mid-Summer Marki Lockhart, Community Programs Manager	Follow-up visit to discuss MIPPA was scheduled for May 2023; LEKT staff had to postpone.

	discuss elder issues at least quarterly. 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. Identify any new elder issues emerging from the COVID19 Pandemic and work together to address needs.	***Lead staff and contact information for both organizations is listed on the attached document.***	Michelle Fogus, Planner & Program Development Manager Marki Lockhart, Community Programs Manager Michelle Fogus, Planner & Program Development Manager Michelle Fogus, Planner & Program Development Manager Michelle Fogus, Planner & Program Development Manager	

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, either in-person or remotely, 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.	<u>Renee Iverson, Family & Kinship Caregiver Support Programs Supervisor</u> <u>Marki Lockhart, Community Programs Manager</u> <u>Coordinate presentation in Fall 2023.</u> <u>Ingrid Henden, Contracts Manager</u> Coordinate with CCS for in person training for LEKT IPs in 2024. Set up follow-up meeting by 9/30/2023 to discuss home care agency possibility. <u>Tribal Staff</u> Becca Weed Lorinda Robideau	Family and Kinship Caregiver program brochures have been sent to the Tribe. O3A staff has been sending information and planning a presentation to elders. Follow-up meeting to discuss training was scheduled for May; LEKT staff had to postpone.

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. Fran joins Susie on outreach.	Kinship Care Support Program and Relatives as Parents will benefit tribal grandparents and other relatives raising children.	Renee Iverson, Family & Kinship Caregiver Support Programs Supervisor Coordinate O3A staff introductions and combined outreach by 12/1/2023. Tribal Staff Becca Weed Lorinda Robideau	
Improved 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 programs. LEKT has their own congregate site. Coordinate with OlyCAP to market Senior Farmers Market Nutrition Program to elders.	Tribal Elders may participate in programs implemented by local O3A contracted health/nutrition education providers. More elders access fresh local foods through the Senior Farmers Market Nutrition Program. Tribal elders have access to healthy, nutritious meals.	Janis Housden, Contracts Manager Coordinate with LEKT regarding additional resources in regard to SNAP funding reduction. Michelle Fogus, Planner & Program Development Manager Tribal Staff Becca Weed	

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).	Michelle Fogus, Planner & Program Development Manager Janis Housden, Contracts Manager Tribal Staff Becca Weed	
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.	Tribal issues are represented in local community, county planning efforts. Tribal needs are considered and addressed by local service providers,	Michelle Fogus, Planner & Program Development Manager	Health Homes contract implemented in 2021 and continues to serve eligible LEKT Tribal members.

	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.	resulting in increased access to services. Tribal elders with significant health impacts are supported to develop goals receive coordinated services improving health outcomes.	Janis Housden, Contracts Manager Notify Tribe of training/classes available, including Evidence-Based Programs as schedules are available. Tribe: Clinic staff Lorinda Robideau, LEKT Health Director	
Strengthen O3A and Lower Elwha Klallam Tribe's partnerships.	Notify LEKT staff when recruiting tribal representatives for Advisory Council. Notify LEKT when O3A positions are open. Train outreach staff in culturally appropriate communication.	Partnerships between O3A & LEKT result in responsive service / program development. LEKT members have opportunities for employment; O3A becomes more diverse. As schedules permit, Brenda or others will make Cultural Competency Training available to O3A.	Michelle Fogus, Planner & Program Development Manager Carol Ann Laase, Administrative Director Brenda Francis Thomas, DSHS Ingrid Henden, Contracts Manager	LEKT notified of Tribal Representative vacancy on O3A Advisory Council. O3A HR staff notifies LEKT when positing positions.

	O3A staff are undergoing Trauma Informed Training including historical trauma; this training is available to tribal staff if requested.		Coordinate follow-up meeting by 10/31/2023 to discuss Trauma Informed Care training. <u>Tribal Staff</u> Becca Weed Lorinda Robideau	Follow-up visit to discuss Trauma Informed Training was scheduled for May 2023; LEKT staff had to postpone.
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.	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.	<u>Ingrid Henden, Contracts Manager</u> Send link to Tribal waiver service contract applications. Schedule follow up visit to discuss contracts. <u>Tribal Staff</u> Becca Weed Lorinda Robideau	Information for Potential Indian Nation Medicaid Contractors sent to LEKT 9/7/2023. Follow-up visit to discuss homecare and O3A programs was scheduled for May 2023; LEKT staff had to postpone.

Policy 7.01 Plan and Progress Report - DRAFT

Timeframe: July 1, 2023, to June 30, 2024, Updated: October 20, 2022

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	○ 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 Ann Peterson, Case Management Director, 360.538.2449 ann.peterson@dshs.wa.gov Marki Lockhart, Community Programs Manager, 360.417.8553 marki.lockhart@dshs.wa.gov O3A Forks office staff: Char Carte - 360.374.9496 char.carte@dshs.wa.gov Susie Brandelius -360.374.9496 carolyn.brandelius@dshs.wa.gov O3A Advisory Council Tribal Rep - Open Position Brenda Francis Thomas, 360.584.3338 brenda.francis-thomas@dshs.wa.gov I&A Offices–call for address: Sequim 360.452.3221 800.801.0070	A 7.01 planning meeting was not held with Makah Tribe in 2022. Forks staff is currently scheduling outreach with Makah Tribe.

	Office; calls can be made by 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: 7/1/2022 – 6/3/2023	
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 ○ 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 identify 3-4 caregivers to support creating a course in Neah Bay.	○ 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	State/AAA: Renee Iverson, FCSP Supervisor renee.iverson@dshs.wa.gov Susie Brandelius Tribe: Maureen Woods Maureen.woods@makah.com 360-645-3027 Glenda Butler, Makah Wellness, Glenda.butler@makah.com Timeline: 7/1/2022 – 6/3/2023	

	○ New Assist with CDWA transition as needed.	potential employment in a timely manner. ○ 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: Renee Iverson 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: 7/1/2022 – 6/3/2023	
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.	○ Tribal elders participate in programs implemented by local health / nutrition education providers.	State/AAA: Janis Housden, Contracts Manager janis.housden@dshs.wa.gov 360.379.5064 Tribal Nutrition Providers Tribe:	

	○ Share useful resources between tribes and nutrition providers such as printed education material and 1/3 RDA approved menus.	○ Capacity for local tribes and regional nutrition providers is increased by sharing ideas and material; more elders receive better information around health and nutrition.	Maureen Woods Maureen.woods@makah.com 360-645-3027 Glenda Butler, Makah Wellness, Glenda.butler@makah.com Jessica Herndon, Makah Timeline: 7/1/2022 – 6/3/2023	
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.) ○ Support Makah Tribe Health Homes Care Coordinator and program.	○ 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: Ann Peterson Marki Lockhart Janis Housden, 360.379.5064 Janis.housden@dshs.wa.gov Tribe: Maureen Woods Glenda Butler Jessica Herndon, Makah Dorothy Aiken, Health Homes Dorothy.aiken@makah.com Timeline: 7/1/2022 – 6/3/2023	
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.	○ Partnerships between O3A and region tribes result in more responsive service and program development. ○ Tribal members have opportunities for employment; O3A becomes more diverse	State/AAA: AC Tribal Representative (open position) Designated O3A Contracts Management staff and Direct Service staff O3A leadership - Carol Ann Laase, O3A Administrative Director – 360.379.5064, lasseca@dshs.wa.gov Brenda Francis Thomas, DSHS	

	○ Notify tribes when O3A staff positions are open. ○ Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues.	and representative of the community we serve	Tribe: Maureen Woods Maureen.woods@makah.com 360-645-3027 Glenda Butler, Makah Wellness, Glenda.butler@makah.com Jessica Herndon, Makah Timeline: 7/1/2022 – 6/3/2023	
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	○ 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: Janis Housden Clallam Teri Wensits, Volunteer Chore Services, TeriW@ccsww.org, 360.417.5640 Tribe: Maureen Woods Maureen.woods@makah.com 360-645-3027 Glenda Butler, Makah Wellness, Glenda.butler@makah.com Jessica Herndon, Makah Timeline: 7/1/2022 – 6/3/2023	

	○ Support developing Transportation Contracts if tribe is interested			
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 through 2022) 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: 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: 7/1/2022 – 6/3/2023	
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: Designated O3A contracts staff Tribe: Maureen Woods Maureen.woods@makah.com 360-645-3027 Glenda Butler, Makah Wellness, Glenda.butler@makah.com Jessica Herndon, Makah Timeline: 7/1/2022 – 6/3/2023	Makah Tribe was awarded $21,098 for activities to improve social isolation for elders.

Policy 7.01 Plan and Progress Report - DRAFT

Timeframe: July 1, 2023, to June 30, 2024, Updated: 8/24/2023

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.
Continue current outreach assistance and work to develop a more tailored plan for the Quileute Tribe.	Meet with tribe's representatives to clarify/ update 7.01 policy plan. Ensure current outreach assistance is continued & explore expanding support and coordination assistance with Quileute Tribe as available O3A resources allow. Quarterly check-in with tribe by September 30, 2023. Coordinate on-site or remote visits from O3A staff. Ensure tribal issues are considered in agency planning, training, and project development. Ensure tribal elders and staff are aware of access	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. ***Lead staff and contact information for both***	Laura Cepoi, O3A Executive Director August 24, 2023 Marki Lockhart, O3A Community Programs Manager September 30, 2023 December 31, 2023 March 31, 2024 June 30, 2024 Michelle Fogus, O3A Planner & Program Development Manager Marki Lockhart, O3A Community Programs Manager Michelle Fogus, O3A Planner & Program Development Manager	O3A staff attended the Quileute Health Fair on May 25, 2023.

	to resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder. O3A to provide program brochures staff can share with elders Assist with development of an elder survey on request.	***organizations listed on the attached contact list.***	<u>Tribal Staff</u> Brittany Hutton, Human Services Director	O3A program brochures provided, will continue in 2023-2024. O3A is available to assist with a survey 2023-2024.
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. Notify Tribe of training/classes available, including Evidence-Based Programs. Support individuals to transition from long term care facilities back into the community if possible Schedule meeting to review Health Homes program with Tribe. Coordinate O3A services presentation. Provide a presentation to staff on	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.	Renee Iverson, Family & Kinship Caregiver Support Programs Susie Brandelius, Forks Janis Housden, Contracts Manager As schedules are available. Lori Lindley, Nursing Services Manager February 15, 2024 Marki Lockhart, O3A Community Programs Manager	

	Medicaid Alternative Care and Tailored Services for Older Adults (MAC & TSOA).		November 15, 2023	
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. Schedule Kinship Care Giver Training.	Relatives as Parents Support Program will benefit Tribal grandparents & other elders raising children	Renee Iverson, Family & Kinship Caregiver Support Programs Schedule training by March 31, 2024, to happen later in the year.	O3A staff does regular outreach for Kinship care. O3A will coordinate a training when the Quileute Tribe Kinship program opens.
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. Work with nutrition providers to ensure Tribal member inclusion. Assist Tribe with locating funding for nutrition programs (to go containers and food costs).	Tribal elders are able to participate in programs implemented by local nutrition providers. Tribal elders have access to health, nutrition meals.	Janis Housden, Contracts Manager Ongoing Janis Housden, Contracts Manager As schedules are available. Michelle Fogus, O3A Planner & Program Development Manager As requested,	O3A's Mobile Assistance Van visits the Tribal Senior Center once a month to distribute food, resource information, covid tests and prevention supplies, and other household products to Tribal members.

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. Coordinate options for non-will legally questions to be answered. 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 (<u>new</u> – errand services are available so driving to pick up and deliver groceries, prescriptions, etc. could be completed during pandemic) Notify	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. 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	Michelle Fogus, O3A Planner & Program Development Manager Schedule by Dec 31, 2023, to happen in early 2024. Janis Housden, Contracts Manager February 28, 2024 Janis Housden, Contracts Manager February 28, 2024 Janis Housden, Contracts Manager Follow-up by 10/31/2023.	A Tribal Will Clinic was held in May/June 2023 with 5 participants; Quileute Tribe would like to schedule another clinic this year.

	Tribe of EBP classes and trainings. 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.		Janis Housden, Contracts Manager As schedules are available. Michelle Fogus, O3A Planner & Program Development Manager Schedule by Dec 31, 2023, to happen in early 2024.	
Strengthen O3A and Quileute partnerships	Notify tribal staff when recruiting tribal representation on O3A Advisory Council. Notify tribes when O3A staff positions are open. Allow Tribe to participate upon request in the hiring process for select O3A positions working with Tribes. 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.	Laura Cepoi, Executive Director Carol Ann Laase, Administrative Director Michelle Fogus, O3A Planner & Program Development Manager Carol Ann Laase, Administrative Director Michelle Fogus, O3A Planner & Program Development Manager	Quileute Tribe notified of Tribal Representative vacancy on O3A Advisory Council. O3A HR staff notified Quileute Tribe when posting positions. Quileute Tribe is a recipient of an O3A Tribal Social Isolation contract for programs to improve social connections for elders.

	Quileute Tribe will notify O3A of elder and community events.			
Assist the Quileute Tribe to develop tribal service contracts with O3A, if interested.	Notify tribe of option to use O3A to help develop services/contracts. Send information on Waiver Service contracts Provide technical assistance as needed. Assist with first series of contract monitoring visits as needed. Schedule follow up visit to discuss contracts after O3A staff informational meeting.	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.	Ingrid Henden, Contracts Manager 8/31/2023. Schedule follow-ups visit after November 1, 2023.	Information for Potential Indian Nation Medicaid Contractors sent 9/7/2023.

Policy 7.01 Plan and Progress Report - DRAFT

Timeframe: July 1, 2023, to June 30, 2024, Updated: 8/24/2023

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.
Continue current outreach assistance and work to develop a more tailored plan for the Quileute Tribe.	Meet with tribe's representatives to clarify/ update 7.01 policy plan. Ensure current outreach assistance is continued & explore expanding support and coordination assistance with Quileute Tribe as available O3A resources allow. Quarterly check-in with tribe by September 30, 2023. Coordinate on-site or remote visits from O3A staff. Ensure tribal issues are considered in agency planning, training, and project development. Ensure tribal elders and staff are aware of access to	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. ***Lead staff and contact information for both***	Laura Cepoi, O3A Executive Director August 24, 2023 Marki Lockhart, O3A Community Programs Manager September 30, 2023 December 31, 2023 March 31, 2024 June 30, 2024 Michelle Fogus, O3A Planner & Program Development Manager Marki Lockhart, O3A Community Programs Manager Michelle Fogus, O3A Planner & Program Development Manager	O3A staff attended the Quileute Health Fair on May 25, 2023.

	resources and planning by visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder. O3A to provide program brochures staff can share with elders Assist with development of an elder survey on request.	***organizations listed on the attached contact list.***	<u>Tribal Staff</u> Brittany Hutton, Human Services Director	O3A program brochures provided, will continue in 2023-2024. O3A is available to assist with a survey 2023-2024.
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. Notify Tribe of training/classes available, including Evidence-Based Programs. Support individuals to transition from long term care facilities back into the community if possible Schedule meeting to review Health Homes program with Tribe. Coordinate O3A services presentation. Provide a presentation to staff on	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.	Renee Iverson, Family & Kinship Caregiver Support Programs Susie Brandelius, Forks Janis Housden, Contracts Manager As schedules are available. Lori Lindley, Nursing Services Manager February 15, 2024 Marki Lockhart, O3A Community Programs Manager	

	Medicaid Alternative Care and Tailored Services for Older Adults (MAC & TSOA).		November 15, 2023	
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. Schedule Kinship Care Giver Training.	Relatives as Parents Support Program will benefit Tribal grandparents & other elders raising children	Renee Iverson, Family & Kinship Caregiver Support Programs Schedule training by March 31, 2024, to happen later in the year.	O3A staff does regular outreach for Kinship care. O3A will coordinate a training when the Quileute Tribe Kinship program opens.
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. Work with nutrition providers to ensure Tribal member inclusion. Assist Tribe with locating funding for nutrition programs (to go containers and food costs).	Tribal elders are able to participate in programs implemented by local nutrition providers. Tribal elders have access to health, nutrition meals.	Janis Housden, Contracts Manager Ongoing Janis Housden, Contracts Manager As schedules are available. Michelle Fogus, O3A Planner & Program Development Manager As requested,	O3A's Mobile Assistance Van visits the Tribal Senior Center once a month to distribute food, resource information, covid tests and prevention supplies, and other household products to Tribal members.
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	Tribal issues are represented in local community, county planning efforts.	Michelle Fogus, O3A Planner & Program Development Manager Schedule by Dec 31, 2023, to happen in early 2024.	

	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. Coordinate options for non-will legally questions to be answered. 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 (<u>new</u> – errand services are available so driving to pick up and deliver groceries, prescriptions, etc. could be completed during pandemic) Notify Tribe of EBP classes and trainings. Engage Quileute Tribe in the prevention programs as funding permits, (e.g.,	Tribal elders receive legal services supporting their aging needs and goals Tribal elders have greater access to services and greater mobility. 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	Janis Housden, Contracts Manager February 28, 2024 Janis Housden, Contracts Manager February 28, 2024 Janis Housden, Contracts Manager Follow-up by 10/31/2023. Janis Housden, Contracts Manager As schedules are available.	A Tribal Will Clinic was held in May/June 2023 with 5 participants; Quileute Tribe would like to schedule another clinic this year.

	Powerful Tools for Caregivers, Savvy Caregivers, Wisdom Warriors) Connect tribe with Advanced Directives presentation to elders.		Michelle Fogus, O3A Planner & Program Development Manager Schedule by Dec 31, 2023, to happen in early 2024.	
Strengthen O3A and Quileute partnerships	Notify tribal staff when recruiting tribal representation on O3A Advisory Council. Notify tribes when O3A staff positions are open. Allow Tribe to participate upon request in the hiring process for select O3A positions working with Tribes. Routinely consult with tribal outreach (O3A direct service) staff re: O3A response to tribal issues. Quileute Tribe will notify O3A of elder and community events.	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.	Laura Cepoi, Executive Director Carol Ann Laase, Administrative Director Michelle Fogus, O3A Planner & Program Development Manager Carol Ann Laase, Administrative Director Michelle Fogus, O3A Planner & Program Development Manager	Quileute Tribe notified of Tribal Representative vacancy on O3A Advisory Council. O3A HR staff notified Quileute Tribe when posting positions. Quileute Tribe is a recipient of an O3A Tribal Social Isolation contract for programs to improve social connections for elders.

Assist the Quileute Tribe to develop tribal service contracts with O3A, if interested.	Notify tribe of option to use O3A to help develop services/contracts. Send information on Waiver Service contracts Provide technical assistance as needed. Assist with first series of contract monitoring visits as needed. Schedule follow up visit to discuss contracts after O3A staff informational meeting.	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.	Ingrid Henden, Contracts Manager 8/31/2023. Schedule follow-ups visit after November 1, 2023.	Information for Potential Indian Nation Medicaid Contractors sent 9/7/2023.

Policy 7.01 Plan and Progress Report - DRAFT

Timeframe: July 1, 2023, to June 30, 2024, Updated: October 20, 2022

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	○ 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	State/AAA: Laura Cepoi, Exec Director, O3A, laura.cepoi@dshs.wa.gov 360.379.5064 Ann Peterson, Case Management Director ann.peterson@dshs.wa.gov 360.538.2449 Marki Lockhart, Community Programs Manager marki.lockhart@dshs.wa.gov 360.417.8553 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:	A 7.01 planning meeting was not held with Shoalwater Bay Tribe in 2023.

	visiting or calling local O3A Information and Assistance Office; calls can be made by elder or others on behalf of elder.	plan more easily for elders' needs.	Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2022 – 6/30/2023	
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. ○ New Assist with CDWA transition as needed.	○ 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: Ann Peterson Renee Iverson, FCSP Supervisor renee.iverson@dshs.wa.gov 360.538.8894 *Bob Powell, Family Caregiver Support Program staff 360.214.9622, powelrm@dshs.wa.gov Catholic Community Services – Local Training Partnership for caregiver training - Robin Gibson, robing@ccsww.org, 360.417.5420 Tribe: Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2022 – 6/30/2023	

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: Renee Iverson 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: 7/1/2022 – 6/30/2023	
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: Janis Housden, Contracts Manager janis.housden@dshs.wa.gov 360.379.5064 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: 7/1/2022 – 6/30/2023	
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—	○ Tribal issues are represented in local community, county planning efforts.	State/AAA: Ann Peterson Marki Lockhart Janis Housden, Contracts Manager Tribe:	

	especially health care-- for Tribal Elders. ○ Engage tribe as local community partners in the prevention programs	○ Tribal needs are considered and addressed by local service providers, resulting in increased access to services.	Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2022 – 6/30/2023	
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: CarolAnn Laase, Administrative Director carolann.laase@dshs.wa.gov 360.379-5061 AC Tribal Representative Designated O3A Contracts Management staff O3A leadership Tribe: Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2022 – 6/30/2023	Shoalwater Bay Tribe will become a Mobile Assistance Van site for pop-up events providing food and resources to seniors and elders.
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).	○ 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	State/AAA: Janis Housden Grays Harbor Jennifer Madison, CCAP 360.500.4524 jenniferm@coastalcap.org Pacific Abbi Quigg Volunteer Services, CCS abbiq@ccsww.org, 360.637. 8563.ext113 Tribe:	

	○ Volunteer Transportation program is accessible to all members over age 60. ○ 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.	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)	Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2022 – 6/30/2023	
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 ○ 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 / Ingrid Henden, and O3A Community Programs Manager Tribe: Charlene Nelson, cnelson@shoalwaterbay-nsn.gov Kathirine Horne, khorne@shoalwaterbay-nsn.gov Timeline: 7/1/2022 – 6/30/2023	Shoalwater Bay Tribe was invited to participate in the O3A Tribal Social Isolation RFP in 2022.

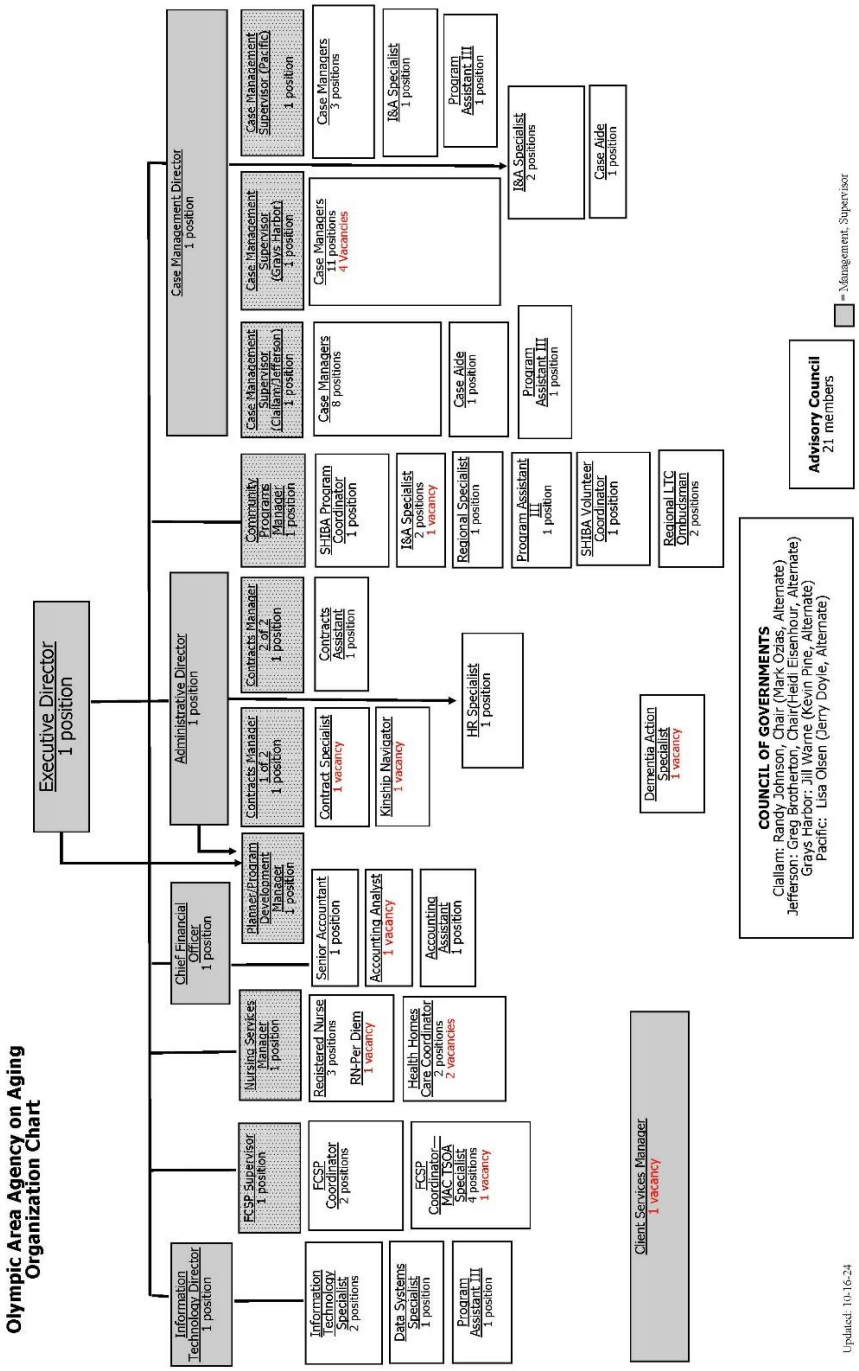
C-5 COVID-19 Response Services and Supports

Issue Area C-5: Preparing for future risks, climate events and emergencies through innovative practices used during the COVID-19 Pandemic	
Profile of the Issue: With the end of the public health emergency in May 2023, O3A was able to join community providers for in-person events on tribal reservations and at community centers, schools, and other venues. Community visibility increased through the multiple partnerships developed during the pandemic and funded by the American Rescue Plan Act Funding, CDC Rural Equity Covid-19 Grants, and state Hunger Relief funding. O3A used these funds to augment existing services and to develop new services. This same model can be used and applied to other public emergencies that would limit and impact how older adults receive necessary supplies and supports to survive an emergency.	
Goal/s: (1) Ensure that older adults have a connection to services and supports during an emergency (2) Encourage prevention and preparedness through education and person-centered counseling	
Major Objectives	**Key Tasks and Benchmarks**
Addressing Social Isolation	Multiple Social Isolation grant projects with Tribes were developed; coordination of programs is ongoing.
	Support continued outreach for ElliQ and Robotic Pets options to address isolation.
	Support congregate nutrition sites and/or restaurant voucher models that address food insecurity and social isolation that are based in remote communities that are hard to access.
Promoting Safety	Promote the importance of ongoing COVID vaccination through general community outreach and advocacy.

SECTION D: AREA PLAN BUDGET

APPENDICES

Appendix A – Organizational Chart



Appendix B – Staffing Plan

POSITION TITLE	TOTAL STAFF	POSITION DESCRIPTION
Accounting Analyst Vacancy	1 FTE	Accounting, audit assistance, payroll, and record-keeping duties including full charge responsibility for payroll. Enters and tracks Accounts receivable invoices and records transactions. Assists with budget preparation, year-end closing, audit preparation, and financial reporting and analyses.
Accounting Assistant V. Escene	1 FTE	Provides routine support to fiscal department staff, Processes Accounts Payable. Performs complex data entry and clerical tasks.
***Administrative Director** C. Laase	1 FTE	Ensures daily agency operations follow standard business processes. Provides advanced administrative support and coordination. Supervises or performs human resource functions. Supervises assigned staff. Oversight for agency contract administration, and advisory and governing board support.
Case Aide J. Rydman T. Smith	1 FTE 1 FTE	Assist Case Managers in carrying out their responsibilities.
***Case Management Director** A Peterson	1 FTE	Directs in-house case management program in all 4 counties of service area. Supervises Case Management Supervisors, and other staff as required (case managers, assistants, case aide staff etc.). Program development and improvement; planning; quality assurance; community leadership; state relations.
***Case Management Supervisor** R. McHugh S. Thurston T. Dixon	1 FTE 1 FTE 1 FTE	Assist the Case Management 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.
Case Manager R. Adams C. Bair D. Bradley C. Carte L. Culp R. Davis J. Dokter A. Ellis M. Garcia B. Hazeyama A. Hamm D. Henderson	1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE	Coordinate services & resources to meet long-term care/in-home care needs of older adults and people with disabilities.

B. Kyllonen C. Rowell M. Rushfeldt-Viada T. Rust S. Scott B. Shein R. Straughn C.Thompson C. Whiteman Vacancy	.75 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 4 FTE	
***Chief Financial Officer** C. Stern	1 FTE	Directs all the fiscal operations of the agency. Prepares all budgets, agency contract/grant billings, and financial statements.
***^Client Services Manager** Vacancy	1 FTE	Directs in-house direct services programs as assigned (i.e. FCSP, etc.); program development and improvement; planning; quality assurance; community leadership; state relations; supervises assigned program supervisors & staff.
Community Programs Manager M. Lockhart	1 FTE	Manages direct services programs as assigned (i.e. FCSP, I&A,etc.); program development and improvement; planning; quality assurance; community leadership; supervises assigned program staff.
Contracts Assistant K. Whipple	.63 FTE	Provides mid-level clerical and data entry support within contracts management and administrative departments.
***Contracts Manager** I. Henden J. Housden	1 FTE 1 FTE	Manage and monitor homecare agency, caregiver training, Older Americans Act, and COPES Ancillary, and other contracted services as assigned; Assist with subcontractor training & technical assistance. Supervise assigned staff. Guide assigned program development, planning and management.
Contract Specialist Vacancy	1 FTE	Manage and monitor homecare agency, caregiver training, Older Americans Act, and COPES Ancillary, and other contracted services as assigned; Assist with subcontractor training & technical assistance.
^*Data Systems Specialist N. Green	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.
Dementia Action Specialist Vacancy	1 FTE	Provides resource consultation, education, and advocacy for those living with dementia and their caregivers in our communities. Conducts needs consultations and service authorizations, coordinates services with contracted vendors and local supports, and provides outreach and community education.

***^Executive Director** L. Cepoi	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).
FCSP Coordinator B. Jacobs (MAC-TSOA) F. Koski E. Nessa (MAC-TSOA) H. Patterson (MAC-TSOA) R. Powell (MAC-TSOA) J. Svien Vacancy (MAC-TSOA)	 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE	Coordinate services & resources to meet needs of unpaid family caregivers of older adults and people with disabilities. Staff who work predominately with the MAC-TSOA program within the Family Caregiver Support Program (FCSP) department are marked. These staff persons may also provide general FCSP services to clients.
***^FCSP Supervisor** R. Iverson	1 FTE	Supervises FCSP staff coordinating services and resources to meet needs of unpaid family caregivers of older adults & people with disabilities. Works with Client Services Director to manage FCSP and MAC-TSOA program service delivery to meet requirements.
HH Care Coordinator P. Adams Y. Pearson Vacancy	 1 FTE 1 FTE 1.5 FTE	Assist Case Managers in carrying out their responsibilities; provides information and assistance/referral services to public; arranges supports for designated health home clients.
HR Specialist M. Busch	1 FTE	Provides general human resource functions; recruiting, onboarding, personnel file management, benefits enrollment, staff assistance for leave and benefit access, etc. Works with supervisor to ensure agency personnel functions are carried out appropriately. Provides confidential personnel matter support.
I&A Specialist A.M. Abbott H. Gregg N. Harris P. Idell C. Lee P. Reininger Vacancy	 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE .5 FTE	Provide information and assistance/referral services to public.

***^IT Director** K. Beard	1 FTE	Maintains and improves technology and communication systems; develops data management systems, provides training, works with other managers to create technology tools that better serve clients.
IT Specialist M. Koury-Covall R. Sletkolen	1 FTE 1 FTE	Collects and reports data for statistical reporting agency wide. Offers support and training on computerized tasks, troubleshoots and repairs problems, reporting results to IT Director.
Kinship Navigator Vacancy	1 FTE	Conducts needs and eligibility assessment, resource consultation, and enrollment assistance in public benefits programs to kinship caregivers. Conducts home visits and community education and outreach.
***Nurse Manager** L. Lindley	1 FTE	Supervises agency nursing staff. Manages agency's nurse services delivery to meet mandated Case Management requirements and provide Health Home services.
Planner/ Program Development Manager M. Fogus	1 FTE	Development of the agency's Area Plan; needs assessment and analysis; development and coordination of the agency's WA Cares outreach; coordinating Advisory Council activities; identifying and writing grants appropriate to agency goals; and management of assigned special projects / contracts.
Program Assistant III T. Akerlund M. Earley A. Crumb P. Gibeau K. McCarthy	1 FTE .75 FTE 1 FTE 1 FTE 1 FTE	Provides mid-level clerical support and data entry for direct services (I&A, CM, etc.); IP contract management. Provides clerical and client support
Regional Long Term Care Ombudsman A. Garrotte E. Guzman	1 FTE 1 FTE	Serves as Regional Long-Term Care Ombudsman in assigned area. Recruits, trains & supervises volunteers. Advocates for the well-being of long-term care residents. Assists in complaint resolution. May perform community education and legislative advocacy.
Regional Specialist C. Brandelius	1 FTE	Provides general and focused program outreach and access support to clients in a rural area with challenging geography. Provides MAC-TSOA programs services as a primary focus.
Registered Nurse K. Brennan-Labidi R. Kolodzie L. Lund	1 FTE 1 FTE .5 FTE	Per referrals, provides health-related consultation to case management, clients, and caregivers in the development and implementation of community-based long-term care services.
Reg. Nurse – Per Diem Vacancy	.25 FTE	Per referrals, provides health-related consultation to case management, clients, and caregivers in the development and implementation of community-based long-term care services.

Senior Accountant G. Pearson	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.
SHIBA Program Coordinator E. Bennett	.75 FTE	Provides senior-level clerical support for the case management and I&A department.
SHIBA Volunteer Coordinator D. Aldrich	1 FTE	Volunteer recruiter, coordinator and direct service provider for the Statewide Health Insurance Benefits Advisors (SHIBA) and Medicare Improvements for Patients and Providers Act (MIPPA) programs for assigned counties.

Number of full-time equivalents = 81.63 (FTE = 40 hours per week)
Number of Staff = 85
Number of Staff Over 60 = 33
Number of Staff Indicating a Disability = 8
Number of minority staff = 8

- Hispanic – 1
- Hispanic/Indian/Other - 1
- Indian/Native American – 1
- Asian/Pacific Islander – 2
- White/Native American – 1
- White/Alaskan Native -1
- Other – 1

*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.

Appendix C – Emergency Response Plan

Olympic Area Agency on Aging

2200 W Sims Way, Unit 100
Port Townsend WA 98368
www.o3a.org
Phone: 360-379-5064 or 1-866-720-4863 Fax: 360-379-5074

DRAFT

EMERGENCY MANAGEMENT PLAN FOR CLALLAM, GRAYS HARBOR, JEFFERSON AND PACIFIC COUNTIES

Table of Contents

OLYMPIC AREA AGENCY ON AGING EMERGENCY MANAGEMENT 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 occurred in 2007 when floods occurred in the south counties and the O3A building was damaged. **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.

- For any life-threatening emergencies contact 911
- We ask that all employees text and or call their supervisor and leave a message, including any disaster issues they may be facing
- Limited phone access – check in once phone access is available again, or if able, drive to work site to check in
- Employees are instructed NOT to enter a work site until the structural integrity has been verified (subject to the particular disaster)
- Managers should keep a contact list of all employees with them 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 – Our clients, given their fragile and more dependent status, are our immediate concern - it may be necessary to contact our most vulnerable clients to determine if they are safe and receiving essential support. O3A has determined that it is necessary to develop and keep monthly updated prioritized client lists in the event that we or the local County Department of Emergency Management need to contact our clients to determine their safety.

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 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

Low 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

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

The contact list includes the following:

Client Name
Physical Address
Phone Number(s)
Emergency Contact Name and Phone Number
Nearby Contact and Phone Number (preferably a neighbor)
Priority Designation (1, 2, or 3)
Home Care Agency and Work Contacts
Vendors' Contacts providing oxygen / nebulizers, other critical needs
Summary care needs/issues

Master List Process:

- O3A will maintain a master alphabetical list of clients by zip code and by priority designation.
- This list will be produced monthly using an applet with the Care Module, and Case managers/ others will review it marking the priority for each client, including changes in client priority status.
- Case managers /others will notify their supervisor that the update has been completed.
- Managers and or assigned staff from each unit will print master list on first of the month and store it in an assigned spot. Previous printed list will be shredded.

Client Contact Following Employee check-in after a Disaster:

- Case managers 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
- Case Managers will also contact vendors providing life sustaining equipment who may also be contacting clients.
- Case Managers may also contact care 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 Emergency Management to request a welfare check.**
- MOUS will be developed with the four County Emergency Management Offices identifying need for welfare checks to be completed for uncontacted or in need High Priority Clients.
- No one will have access to the list unless there is an emergency as declared by O3A Executive Director, O3A Direct Services Director or County Emergency Management Departments, and it will be used only to perform health and welfare checks on high priority clients.

When telephone communication is interrupted:

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

Business Continuity Plans

Check on Business Facilities – Depending on the disaster, it may be necessary to ascertain whether the business offices are fit for business activities.

- Determine if this can be done by supervising staff safely or if a professional (firefighter, structural engineer, or other professional) needs to be contacted.
- If building(s) is/are not fit for occupation, senior staff will make determination with FEMA assistance on alternatives for temporary business structures (either move or set up on site units.)
- Assess status of records and equipment necessary for ongoing minimal functioning of programs

- Track fund expenditures – set up mechanism for authorization

General Info

- Supervisors and Directors from other regions will attempt to travel to involved region to provide additional resources
- One employee will be assigned as key disaster lead for each O3A jurisdiction or office
- 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
- Units will conduct one practice drill each year and provide feedback to plan based on practice learnings
- Conduct an after-event feedback loop, adjust plan.
- Identify public disaster shelters and notify staff of each unit

Emergency Kits for Offices

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

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

- Case managers will review disaster planning with all clients that will include
- Encouraging development of a disaster kit
- Who will the client reach out to for help / who is nearby who can help
- A list of important contact numbers
- A useful tool developed by the American Red Cross is Disaster Preparedness for Seniors By Seniors: https://www.redcross.org/images/MEDIA_CustomProductCatalog/m4640086_Disaster_Preparedness_for_Srs-English.revised_7-09.pdf - Home care agencies are also encouraged to use this tool with their clients.

FIRST RESPONDERS

Emergency Management & Ambulance

Clallam County

Clallam County Emergency Management

223 E 4th St # 6,
Port Angeles, WA 98362
clallam.net/EmergencyManagement/emcontact.html
(360) 417-2483

Olympic Ambulance

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

Grays Harbor County

Grays Harbor Emergency Management

310 Spruce Ave W # 212,
Montesano, WA 98563
co.grays-harbor.wa.us
(360) 249-3911
E-mail: *ghcdem@co.grays-harbor.wa.us*
Twitter: http://twitter.com/ghcdem

Lifeline Emergency Response

915 Anderson Dr,
Aberdeen, WA 98520
(360) 537-5149

Ocean Shores Ambulance

800 Anchor Ave NW, Ocean Shores, WA 98569
(360) 289-1435 and
585 Point Brown Ave NE, Ocean Shores, WA 98569
(360) 289-3611

South Beach Ambulance Service

170 W Spokane Ave, Westport, WA 98595
(360) 268-9832

JEFFERSON COUNTY

Jefferson County Emergency Management

223 E 4th St # 6,
Port Angeles, WA 98362
clallam.net/EmergencyManagement/emcontact.html
360-385-9368
360-344-9779 (JeffCom)

EMS Training Coordinator Ambulance

Port Townsend, WA 98368
(360) 643-0776

PACIFIC COUNTY

Pacific County Emergency Management

Scott McDougal, Emergency Management
Director: smcdougall@co.pacific.wa.us
(360) 875-9338, cell – (360) 214-1046
Office Locations:
SOUTH BEND
300 Memorial Dr.
P O Box 27
South Bend, WA 98586
360-875-9340
Fax 360-875-9342
LONG BEACH
360-642-9340

FIRE DEPARTMENTS

CLALLAM COUNTY FIRE DEPT.

Port Angeles Fire Department

102 E 5th St, Port Angeles 98362
(360)417-4655 Fax: (360)417-4659
pafire@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: (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.....(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

Quileute

FDID: 05S03
Quileute Fire Department
PO Box 279, La Push 98350
(360)374-6605

U. S. Coast Guard Air Station

Sector Field Office, Port Angeles 98362
(360)417-5840

GRAYS HARBOR COUNTY FIRE DEPT.

Aberdeen

Aberdeen Fire Department
700 W Market St, Aberdeen 98520
(360)532-1254 Fax: (360)532-1255
www.aberdeenwa.gov

Cosmopolis

Cosmopolis Fire Department
111 D St, PO Box 2011
Cosmopolis 98537
(360)532-6429 Fax: (360)533-8192
cosifire@comcast.net

Elma

City of Elma Fire Department
112 N 2nd St, PO Box 3005, Elma 98541
(360)482-2812 Fax: (360)482-2813
www.cityofelma.com

Hoquiam

Hoquiam Fire Department
625 8th St, Hoquiam 98550
(360)532-5700 Ext 260
Fax: (360)532-3340

McCleary

Provides service to Grays Harbor 12
McCleary Fire Department
100 S 1st St, McCleary 98557
(360)495-3863

Montesano

Montesano Fire Department
310 E Pioneer, Montesano 98563
(360)249-4851 Fax: (360)249-4971
www.montesano.us

Ocean Shores

Ocean Shores Fire Department
585 Point Brown Ave NW
Ocean Shores 98569
(360)289-3611 Fax: (360)289-3709
www.osgov.com

Westport

Provides service to Grays Harbor 3
Westport Fire Department
170 W Spokane, PO Box 728
Westport 98595
(360)268-9235 Fax: (360)268-5565

FIRE PROTECTION DISTRICTS

Oakville: Grays Harbor FD 1

Provides service to City of Oakville
Grays Harbor County Fire District 1
108 E Main, PO Box 6, Oakville 98568
(360)273-6645 Fax: (360)273-3095
ghcfd1@comcast.net

Brady/Central Park/Wynoochee/Outlying Montesano Area: Grays Harbor FD 2

Grays Harbor County Fire District 2
6317 Olympic Hwy (Central Park)
Aberdeen 98520
(360)532-6050 Fax: (360)532-6075
ghfd2@ghfd2.org, www.ghfd2.org

Westport: Grays Harbor FD 3

Services provided by Westport Fire Dept
Grays Harbor County Fire District 3
506 Montesano St, PO Box 1327
Westport 98595

Quinault/Amanda Park/Neilton: GH FD 4

Grays Harbor County Fire District 4
Amanda Park, PO Box 8, Quinault 98575
(360)288-2611 Fax: (360)288-2707
ghcfd4@centurylink.net
Fire Chief **Brian Lines**..... (360)288-2611

Porter/Elma/Satsop/Bush Creek: GH FD 5

Grays Harbor County Fire District 5
428 Stamper Rd, PO Box 717, Elma 98541
(360)482-6266 Fax: (360)482-3152
ghfd5@ghfd5.org, www.ghfd5.org

North Hoquiam: Grays Harbor FD 6

Grays Harbor County Fire District 6
169 U S Hwy 101, Hoquiam 98550
(360)532-2996 Fax: (360)533-2086
ghfd6@comcast.net

Copalis Beach/Ocean City: Grays Harbor FD 7

Grays Harbor County Fire District 7
Administrative Office: 2670 SR 109
Ocean City 98569
Mailing: PO Box 322, Copalis Beach 98535
(360)289-4338 Fax: (360)289-4289
ghfd7@coastaccess.com
Fire Chief.....(360)580-3586

Pacific Beach: Grays Harbor FD 8

Grays Harbor County Fire District 8
4576 State Route 109, PO Box 357
Pacific Beach 98571
(360)276-4807 Fax: (360)276-8375
Fire Chief.....(360)276-8135

Wishkah/East Hoquiam: Grays Harbor FD 10

Grays Harbor County Fire District 10
4660 Wishkah Rd, Aberdeen 98520
(360)533-5773 Fax: (360)532-1607
Fire Chief.....(360)533-5447

Grayland: Grays Harbor FD 11

Grays Harbor County Fire District 11
1785 State Route 105, PO Box 276
Grayland 98547
(360)267-4126
graylandfire@outlook.com
Fire Chief..... (360)268-7243

McCleary: Grays Harbor FD 12

Services provided by McCleary Fire Dept
Grays Harbor County Fire District 12
PO Box 3338, McCleary 98557
graysharbor12@gmail.com

Markham/Ocosta/Bay City: Grays Harbor FD 14

Grays Harbor County Fire District 14
8 Market Ln, Aberdeen 98520
(360)648-2240 Fax: (360)648-2241
ocosta@ghfd14.comcastbiz.net
Fire Chief.....(360)648-2390

Artic: Grays Harbor FD 15

Grays Harbor/Pacific Fire District 15
PO Box 399, Cosmopolis 98537
ghpcfd15@gmail.com
Fire Chief.....(360)538-1597

Copalis Crossing: Grays Harbor FD 16

Grays Harbor County Fire District 16
1617 Ocean Beach Rd, PO Box 730
Copalis Crossing 98536
(360)289-3227 Fax: (360)289-4266
Fire Chief/District Secretary.....(360)589-8553

Humptulips/Axford: Grays Harbor FD 17

Grays Harbor County Fire District 17
3296 Hwy 101, PO Box 10
Humptulips 98552
graysharborfiredist17@gmail.com
Fire Chief.....(360)581-9168

JEFFERSON COUNTY FIRE DEPT.

FIRE PROTECTION DISTRICTS

Port Townsend: Jefferson FD 1

East Jefferson Fire-Rescue: No. 1

Provides service to City of Port Townsend
East Jefferson Fire-Rescue
24 Seton Rd, Port Townsend 98368
(360)385-2626 Fax: (360)344-4604
www.ejfr.org
Fire Chief..... (360)385-2626

Quilcene: Jefferson FD 2

Jefferson County Fire District 2
70 Herbert St, PO Box 433
Quilcene 98376
(360)765-3333 Fax: (360)765-0133
quilcenefire@qvfd.org
Fire Chief..... (360)765-3333

Port Ludlow Fire & Rescue: Jefferson FD 3

Port Ludlow Fire & Rescue
7650 Oak Bay Rd, Port Ludlow 98365
(360)437-2236 Fax: (866)367-2291
www.plfr.org
Fire Chief.....(360)437-2236

Brinnon: Jefferson FD 4

Jefferson County Fire District 4
272 Schoolhouse Rd, PO Box 42
Brinnon 98320
(360)796-4450 Fax: (360)796-3999
www.brinnonfire.org
Fire Chief.....(360)796-4450

Discovery Bay: Jefferson FD 5

Jefferson County Fire District 5
12 Bentley Pl, Port Townsend 98368
(360)379-6839 Fax: (360)379-6363
jcfd5@hughes.net
Fire Chief.....(360)379-6839

Clearwater: Jefferson FD 7

Jefferson County Fire District 7
W Jefferson Shop
Mailing: c/o 2503 Clearwater Rd
Forks 98331
Fire Chief.....(360)962-2500

FEDERAL, INDUSTRIAL, MUNICIPAL & PRIVATE FIRE DEPARTMENTS

Navy Region Northwest Fire & Emergency Services: Battalion 2

Indian Island Fire Department
(Naval Magazine Indian Island)
100 Indian Island Rd, Port Hadlock 98339
(360)396-5311 Fax: (360)396-5312

PACIFIC COUNTY

Ilwaco

Ilwaco Fire Department
301 SE Spruce St, PO Box 342
Ilwaco 98624
(360)642-3145 Fax: (360)642-3155
ilwacoch@willapabay.org

Long Beach

Long Beach Volunteer Fire Department
701 Washington Ave N, PO Box 310
Long Beach 98631
(360)642-2900 Fax: (360)642-8841

Raymond

Raymond Fire Department
212 Commercial St, Raymond 98577
(360)942-4144 Fax: (360)942-4139
www.raymondfire.org

South Bend

Provides service to Pacific 8
South Bend Fire Department
PO Box 228, South Bend 98586
(360)875-5571

FIRE PROTECTION DISTRICTS

Ocean Park: Pacific County FD 1

Pacific County Fire District 1
26110 Ridge Ave (District Office)
PO Box 890, Ocean Park 98640
(360)665-4451 Fax: (360)665-4909
www.pcfd1.org
Fire Chief..... (360)665-4451

Chinook Valley: Pacific County FD 2

Pacific County Fire District 2
Valley & Hwy 101, PO Box 235
Chinook 98614
Fire Chief.....(360)777-8373

Menlo: Pacific County FD 3

Pacific County Fire District 3
1006 State Route 6, Raymond 98577
Mailing: PO Box 187, Menlo 98561
(360)942-4144 Fax: (360)942-2531
Fire Chief.....(360)942-4144

Naselle: Pacific County FD. 4

Pacific County Fire District 4
Junction SR 4 & 401, PO Box 54
Naselle 98638
Fire Chief.....(360)484-3264

North Cove/Tokeland: Pacific County FD 5

Pacific County Fire District 5
2829 Hwy 105, PO Box 602
Tokeland 98590
(360)267-3970 Fax: (360)267-3855
pcfd5@comcast.net
Fire Chief.....(206)999-8362

Bay Center: Pacific County FD 6

Pacific County Fire District 6
6 Harrison St, PO Box 343
Bay Center 98527
(360)875-5356
baycenterfire@yahoo.com
Fire Chief.....(360)875-6669

Nemah: Pacific County FD 7

Pacific County Fire District 7
202 N Nemah Rd E, South Bend 98586
pcfpd7@reachone.com
Fire Chief..... (360)875-6069

Rural South Bend: Pacific County FD 8

Services provided by South Bend Fire Dept
Pacific County Fire District 8
PO Box 13, South Bend 98586
PO Box 130, Tokeland 98590
(360)267-6766 Fax: (360)267-6778

FEDERAL, INDUSTRIAL, MUNICIPAL & PRIVATE FIRE DEPARTMENTS

Shoalwater Bay Fire Department

LAW ENFORCEMENT

State Patrol

District 8 Headquarters/ Bremerton Detachment
4811 Werner Road
Bremerton, WA 98312
Phone: (360) 473-0300
Hoquiam Detachment Office: The Hoquiam VIN Lane is closed; call the Shelton or Chehalis offices for appointments. (Shelton Detachment Office - 360-432-7581)
Port Angeles Detachment Office: 360-417-1738

CLALLAM COUNTY

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, 360-374-2506 - Fax

Port Angeles Police Department

Port Angeles City Hall
321 E 5th St, Port Angeles
(360) 452-4545, 360-417-4556 - Fax

Sequim Police Department

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

JEFFERSON COUNTY

Jefferson County Sheriff's Office

79 Elkins Road, Port Hadlock, WA 98339
Telephone: (360) 385-3831 | FAX: (360) 379-051

Port Townsend Police Department

1925 Blaine St #100, Port Townsend
(360) 385-2322

GRAYS HARBOR

Aberdeen Police Department

210 East Market Street, Aberdeen, Washington, 98520
(360) 533-3180, (360) 533-4786 - Fax

Grays Harbor Sheriff's Office

100 W. Broadway, Suite 3, Montesano, WA
(360) 249-3711, (360) 532-3284, 1-800-562-8714
SOAdmin @Co.Grays-Harbor.WA.US

Hoquiam Police Department

215 10th Street, Hoquiam, Washington, 98550
(360) 532-0892, (360) 532-0899 - Fax

Cosmopolis Police Department

1101 1st Street, Cosmopolis, Washington, 98537
(360) 532-9237, (360) 532-9273 - Fax

Montesano Police Department

112 North Main Street, Montesano, Washington, 98563
(360) 249-1031, (360) 249-5492 – Fax

Ocean Shores Police Department

577 Point Brown Avenue Northwest, Ocean Shores, Washington, 98569
(360) 289-3331, (360) 289-3333 - Fax

Westport Police Department

506 North Montesano Street, Westport, Washington, 98595
(360) 268-9197, (360) 268-1363 - Fax

PACIFIC COUNTY

Long Beach Police Department

212 Pacific Avenue, Long Beach, Washington, 98631
(360) 642-3416
(360) 642-5273 - Fax

Raymond Police Department

233 2nd Street, Raymond, Washington, 98577
(360) 942-4120
(360) 942-4140 – Fax

South Bend Police Department

117 Willapa Avenue, South Bend, Washington 98586
(360) 875-5444
(360) 875-9447 – Fax

Elma Police Department

124 North 3rd Street, Elma, Washington 98541
(360) 482-3131
(360) 482-3717

Pacific County Sheriff's Department

318 2nd St NE · South Bend, WA
(360) 642-9404
360-875-9397 – North County
360-642-9397 – South County

SAMPLE MEMORANDUM OF UNDERSTANDING

BETWEEN

OLYMPIC AREA AGENCY ON AGING

AND

_____ 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 _____ County Department of Emergency Management, hereinafter referred to as DEM.

1. Purpose:
   The purpose of this agreement is to promote a partnership between O3A and DEM 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 DEM 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 communicate with the command centers of the counties including their names, titles, cell phones, email addresses, work phones, home phones, and any other means of communication with the _CDEM.

      _CDEM SHALL:
      a) Maintain and deliver current point of contact lists of the designated DEM 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 DEM 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 DEM 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 _____ 2016 until amended or terminated by written request of either party and the subsequent written concurrence of the other. Either O3A or DEM 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	**_____ County Department of Emergency Management**
Executive Director: Laura Cepoi laura.cepoi@dshs.wa.gov; (360) 379-5064 Mobile – (360) 301-5426	
Planner: Michelle Fogus michelle.fogus@dshs.wa.gov; (360) 538.8876 Mobile – (360) 580-6001	
Direct Services Director: Ann Peterson Ann.peterson@dshs.wa.gov; (360) 538-2449 Mobile: (360) 581-6945	
Case Management Supervisor: _____ _____	

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

THE PARTIES HERETO have executed this agreement.

_____ _____
Olympic Area Agency on Aging Date
Laura Cepoi, Executive Director

_____ _____
_____ County Emergency Management Department Date
Printed name: _____

Title: _____

ATTACHMENTS INCLUDED:

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

Attachment 1

PRIOTIZATION OF O3A CASE MANAGEMENT CLIENTS FOR USE IN DECLARED EMERGENCIES

Client Status – Our clients, given their fragile and more dependent status, are our immediate concern - it may be necessary to contact our most vulnerable clients to determine if they are safe and receiving essential support. O3A has determined that it is necessary to develop and keep monthly updated prioritized client lists in the event that we or the local County Department of Emergency Management need to contact our clients to determine their safety.

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 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

Low 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

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

The contact list includes the following:

Client Name
Physical Address
Phone Number(s)

Emergency Contact Name and Phone Number
Nearby Contact and Phone Number (preferably a neighbor)
Priority Designation (1, 2, or 3)
Home Care Agency and Work Contacts
Vendors' Contacts providing oxygen / nebulizers, other critical needs
Summary care needs/issues

O3A maintains a master list of clients by zip code and by priority designation. A master list is stored at _____, and county specific lists are stored at _____, _____ and _____. No one will have access to the list unless there is a Declared Emergency; lists will be used solely to perform health and welfare checks on high priority clients.

The master list will be produced monthly using an applet with the Care Module, and Case managers/ others will review it marking the priority for each client, including changes in client priority status. Case managers /others will notify their supervisor that the update has been completed. Managers and or assigned staff from each unit will print master list on first of the month and store it in an assigned spot. Previous printed list will be shredded.

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

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

If a client is in immediate danger, call 911.

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

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

Appendix D – Advisory Council

Member	Geographic Representation
Ronnie Meldrum	Clallam County
Elizabeth Pratt	Clallam County
Marsha Melnick	Clallam County
Joseph Sharkey	Clallam County
Ginny Adams	Jefferson County
Eileen Svoboda	Jefferson County
Vacant	Jefferson County
Margaret Taylor	Jefferson County
Pam Tuttle	Grays Harbor County
Jane Lauzon	Grays Harbor County
Vacant	Grays Harbor County
Susan Conniry--Chair	Grays Harbor County; State Council on Aging Rep./liaison, all counties
Beth Tripp	Pacific County
Nancy Gorshe	Pacific County
Jeannine Grey	Pacific County
Vacant	Pacific County
Vacant	Disability Representative
Vacant	Minority Representative
Vacant	Tribal Representative
Vacant	Elected Official Representative

Number of Advisory Council Members 60+years of age = 11
Number of Advisory Council Members self-indicating a disability = 0
Number of Advisory Council Members representing a minority = 0

Appendix E – Public Process

1. **A regional survey of older adults was distributed May-July 2023 in paper and electronic formats with a call-in option as well.**
2. **An online Provider Survey was sent to Senior Providers through the regular provider networks, contractor lists and O3A supervisors May -July 2023.**
3. **O3A direct service staff were surveyed in September 2023 to identify the top three needs observed for their clients.**
4. **After reviewing survey data and demographic data from a variety of sources (see below), the planning team developed goals and sought input from the leadership team.**
5. **The Advisory Council reviewed the draft plan in September 2023 and approved it for presentation at a series of public hearings.**
6. **Public Hearings were held in each of O3A's four service counties: Clallam, Jefferson, Grays Harbor, and Pacific counties in October 2023.**
7. **Suggestions from staff and the public were reviewed and incorporated into the plan in October 2023.**
8. **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 in October 2023.**
9. **The Council of Governments approved the plan on November 2, 2023, and it was submitted to ALTSA.**

COMMUNITY SURVEY

Highlights:

- **69.6% said life satisfaction is excellent or good**
- **87.25% have received or plan to receive COVID vaccines**
- **27.4% reported negative effects of social isolation in the past year**

Top unmet needs:

- **Housing (availability/affordability/safety and maintenance/upkeep)**
- **Medical care including dental, vision/hearing/ and mental health**
- **Transportation**
- **Food**

Preferred activities if available:

- **Volunteering**
- **In-person exercise or wellness**
- **Art/music/crafts**
- **Social activities**

Demographic information

- 254 respondents
- 70% female; 29% male; 1% nonbinary or no answer
- 4.5% self-identified as LGBTQ+
- 56.6% age 60-74; 29% 75-84; 18% under 60 and 18% over 85
- 42.5% live alone; 44.8% with spouse/partner; 12.7% other
- 35% Clallam; 33.8% Grays Harbor; 14.6% each Jefferson and Pacific
- 40.3% self-identified as someone with a disability

PROVIDER SURVEY

Highlights

Quality of life changes for clients

- Some are struggling 62%
- Most are struggling 27.6%
- No change observed 6.9%
- Most are doing ok 3.5%

Client depression/anxiety/sadness due to social isolation

- 35.7% intermittently
- 32.1% very depressed/anxious/sad
- 25% slightly
- 7.1% no obvious signs

Clients involved in social activities [adjusted percentages based on those who answered]

- 60% no
- 40% yes

Primary barriers

- Anxiety/fear (5/16) 31.3%
- Transportation (4/16) 25%

Housing issues (can choose more than one)

- 75% housing costs are challenging
- 57.1% upkeep and maintenance
- 50% need safety modifications
- 46.4% do not have stable housing
- 32.1% living in RVs or campers
- 28.6% living in temporary situations
- 17.9% at risk of foreclosure
- 14.3% living in shelters

Clients needing the most help with

- Transportation, social activities, MH treatment, dental services, food/meal preparation, healthcare; also medication, respite and substance use treatment

Changes in client needs since the pandemic: (could choose more than one)—top 3

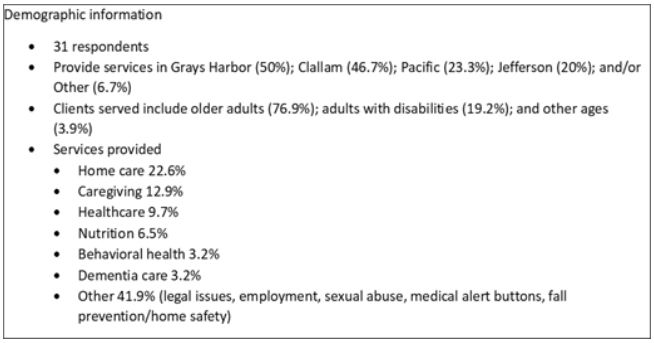
- Social isolation (6/21) 28.6%
- Mental health (5/21) 23.8%
- Food costs (3/21) 14.3%

Client difficulties purchasing items due to financial situation (could choose more than one)—top issues:

- 78.6% food
- 67.9% housing
- 64.3% utilities
- 60.7% transportation
- 50% medication
- 50% dental care

Most significant unmet client needs (could choose more than one)

- Housing/utilities (8/25 who answered) 32%
- Transportation (7/25) 28%
- Caregivers (6/25) 24%
- Food (5/25) 20%
- Socialization (5/25) 20%
- Home repair/mtc (3/25) 12%


Demographic information

- 31 respondents
- Provide services in Grays Harbor (50%); Clallam (46.7%); Pacific (23.3%); Jefferson (20%); and/or Other (6.7%)
- Clients served include older adults (76.9%); adults with disabilities (19.2%); and other ages (3.9%)
- Services provided
  - Home care 22.6%
  - Caregiving 12.9%
  - Healthcare 9.7%
  - Nutrition 6.5%
  - Behavioral health 3.2%
  - Dementia care 3.2%
  - Other 41.9% (legal issues, employment, sexual abuse, medical alert buttons, fall prevention/home safety)

Staff Survey

Top unmet needs their clients have: (3 responses allowed)

- Housing (availability/affordability/safety & maintenance/upkeep) -- 22
- Paid caregivers -- 18
- Transportation – 16
- Healthcare access -- 14

Demographic information
32 respondents
17 Medicaid LTC Case Managers, 2 MAC/TSOA Case Managers, 13 Other (I&A, supervisors, FCSP, KCSP)

Public Hearings

Clallam County- October 10th, 2023, 1-2:00pm
Clallam County Courthouse – Board of Commissioners Board Room 160
223 East 4th Street
Port Angeles, WA 98362

Grays Harbor County- October 9, 2023, 2-3:00pm (Hybrid: Zoom option)
Grays Harbor County – Small Commissioner Meeting Room
100 W. Broadway, Ste 1
Montesano, WA 98563

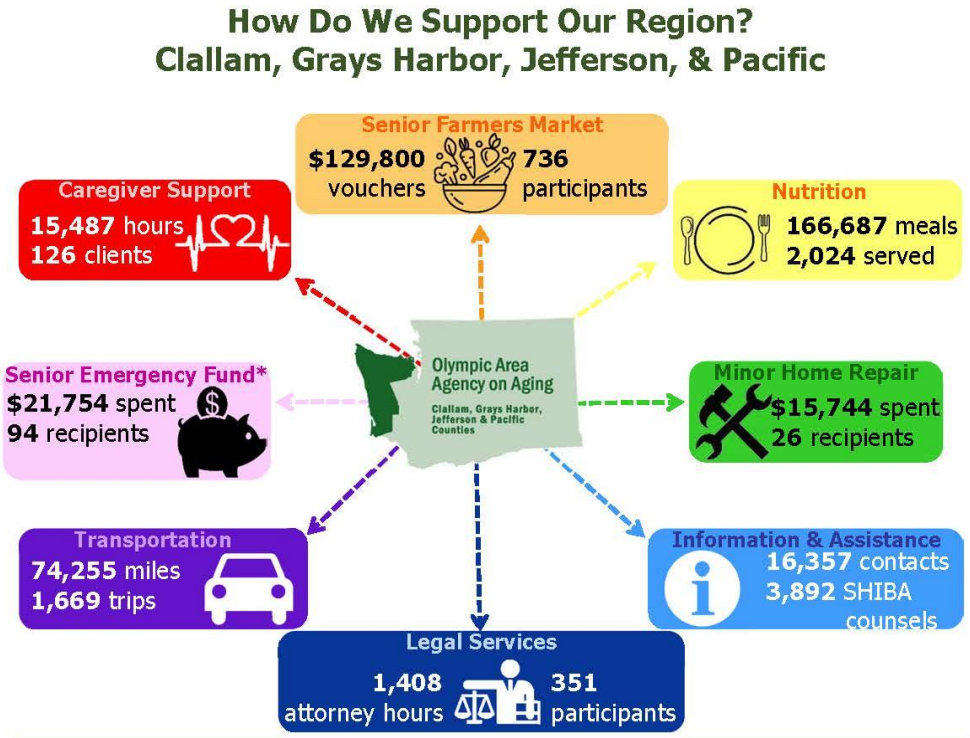
Jefferson County- October 10th, 2023, 10-11:00am
Jefferson County Courthouse – 1st Floor Conference Room
1820 Jefferson St,
Port Townsend, WA 98368

Pacific County-October 13, 2023, 2-3:00pm (Hybrid: Zoom option)
Pacific County Courthouse – Annex Comm. Meeting Room
1216 W Robert Bush Drive
South Bend, WA 98586
Data reviewed:

US Census Bureau state and county data
Washington State Office of Financial Management

Washington State Department of Health
DSHS Research and Data Analysis
Community Living Connections service data for select O3A programs
Internal service data

Appendix F - Report on Accomplishments from the 2022-2023 Area Plan Update



Long Term Care Ombudsman		
1,913 Hours	**over 4,000** Consultations/Complaint Resolutions	**22** Volunteers
Case Management		
1,700 Clients per month (approximate)	**21** Case Managers	**6** Local Offices
Nursing Services		
3,047 Contacts	**5,735** Hours	**253** Clients
Health Homes		
198 Clients	**$17 MILLION** saved annually statewide	**5** Care Coordination Org.

*including funding from the Grays Harbor Foundation

Services in 2022

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	Met- revising service delivery in Clallam and Jefferson counties so that more congregate sites can be operated on a continuous basis. Contracted with new HDM provider in Jefferson and Clallam. Have added one additional congregate site and have stabilized another site; a third site is anticipated to open soon in Port Townsend, this site was closed in 2011 and the community is excited to see it re-open.
	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 736 participants.

	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. Develop additional contracts as needed to serve remote areas, e.g., takeout restaurant contracts.	O3A Contracts Management staff	8/1/2021	12/31/2023	Created Mobile Assistance Van service that couples food and I&A along the coastal areas. Began service 11/2022- and are currently delivering services to 850 people per month. This program has a broader reach than our senior nutrition program.

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, and other essential services.	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	Met.

	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	Met- created taxi contracts in all four counties to assist with Vaccine access.
	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	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.

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	Met. Staff work with clients to assist with housing stability.
	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	Not met- multiple presentations to the Advisory Council on this topic; much interest in Home Sharing platform

					developed for O3A service area.
	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	Met- O3A staff participate in regional housing coalitions and collaboratives.
	d. Explore Shared Housing and other unique ways to address older adult housing issues.	O3A Planning and Program Development staff	6/1/2021	12/31/2023	Met- Silvernest began offering shared housing platform for O3A clients in May 2022. O3A pays for service fee to access the website to be explore matching home sharing requests.

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 Community Programs Manager	1/1/2020	12/31/2023 and continuing	Met- have hired an additional regional Ombudsman so that north and south counties have a dedicated position.

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 to medical specialty care services.	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	Met- Transportation contracts often travel extensive distances to urban areas for medical specialty appointments.
	~~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**	**Met- all client services staff are trained in Trauma Informed Care.**
	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**	**Met- staff are offered a variety of training to meet work needs.**
	~~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. Implement Social Isolation programs with clients, tribes and other interested partners, including education about the impacts of social	**Contracts Management Staff, Program Development staff, O3A Partners**	**1/1/2021**	**12/31/2023**	**Met- provided robotic pets, Tribal RFP for social isolation, and are funding and**

	isolation, and providing resources.				piloting ElliQ in WA.

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	Met- programs re-established after PHE was over; continue with remote classes as well.
	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	Met- articles are funded by Senior Drug Education for Living Well Magazine, Trending Healthy newsletter and Senior Resource Guide- articles include

					medication safety, addiction and seniors, safe storage and safe disposal articles.
	~~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	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.

and the general public.	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	a. Promote FCSP with appropriate local community organizations, and tribes via presentations &	FCSP Staff	1/1/2020	12/31/2023	Met.

family caregivers.	contacts to schools, medical service providers, discharge planners, churches, 7.01 plans and visits to tribes, etc.				
	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	Met.
	c. Provide T-CARE assessments & customized care plans for family caregivers.	FCSP Staff	1/1/2020	12/31/2023	Met.
	d. Provide services & supports to FCSP (e.g., respite, counseling, training, support groups).	FCSP Staff	1/1/2020	12/31/2023	Met.
	e. Identify and contract sufficient providers to facilitate efficient and timely service provision.	FCSP Staff & Contracts Management Staff	1/1/2020	12/31/2023	Partially met-continue to struggle with provider recruitment to serve remote regions.

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	Met.
	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	Met.

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	Unmet.
	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	Met- encouraging tribes to establish ADC.

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	a. In partnership with the local	Dir. Contracts Mgmt.	1/1/2020	12/31/2023	Unmet- just a few groups in

resources supporting families impacted by dementia.	Alzheimer's Association, facilitate increased training opportunities for support group leaders at community level.				the service area.
		Dir. Contracts Mgmt.	1/1/2020	12/31/2023	Unmet.
	c. Refer caregivers from MAC, TSOA and FCSP to Alzheimer's Disease support groups.	Direct Service staff	1/1/2020	12/31/2023	Partially met- Alzheimer's Disease support groups do not meet- but O3A has established 6 new support groups in 2023.
	d. Publicize dementia support groups through local, on-line and social media.	O3A staff	1/1/2020	12/31/2023	Unmet.
	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	Met- accepted proposal to become Dementia Action Catalyst in WA.

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	a. Develop/implement an annual outreach	Supervisor of MAC/TSOA/FCSP	1/1/2020	12/31/2023	Met.

outreach to community partners about these programs to encourage referrals.	plan, refine as needed.				

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	Partially met.
	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	Met.

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	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	Met.
	b. Support I&A services and staff with training to	Information and Assistance staff, Program	1/1/2020	12/31/2023	Met.

assistance to access.	maintain AIRS and CIR-S certification.	Development Manager			
	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	Met.
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	Met.
	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	Unmet- work with W4A to address home care agency coordination issues.
	c. Continue to support local Senior Provider meetings to share information.	Program Development Manager, I & A staff	1/1/2020	12/31/2023	Met.
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	Met.
	b. Enter local resources into Listing Manager.	Program Development Manager, Data Specialist, and support staff	1/1/2020	12/31/2023	Met.
	c. Data Manager will explore options for using CLC effectively.	Data Specialist	1/1/2020	12/31/2023	Met.
	d. Complete annual NAPIS report in a timely manner.	Data Specialist	1/1/2020	12/31/2023	Met.

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	
Objective 4: Promote volunteer opportunities throughout the region to increase available resources and outreach, and to improve quality of life for the recipient as	a. 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	SHIBA /LTCO Coordinators, Director Planning and Contracts Management, Contract Specialist	1/1/2022	12/31/2023	Met- volunteer recruitment activities for SHIBA and LTCOP

well as the volunteer.	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.				
	b. New - Provide quality volunteer experiences including evidence-based training and retention services.				Unmet

~~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.~~				Met- Executive Director serves as commissioner on behalf of W4A on the LTCSS Commission.
	~~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	~~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	Met.
	c. Procure contracted services that meet needs identified for	Contract Management Staff & Contractors	1/1/2020	12/31/2023	Met.

achieves service levels and high quality of service delivery.	Medicaid clients by case managers.				

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	Unmet-difficulty to expand program.
	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	Met.

~~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	Met. Mobile Assistance Van.
	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 communities, LGBTQ population and Latino populations.	Contracts Management and O3A Direct Service Staff	1/1/2020	12/31/2023	Met.

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~~				This role had been in process with ALTSA staff prior to onset of pandemic.

	~~program and develop partnerships for this program with Home Care Agencies and Home Care Referral Registry/Consumer Directed Employers.~~				
	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	Met, service is no longer offered.
	c. 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	Met.

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 particularly in	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	Met.

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**	**Met.**

Appendix G - Statement of Assurances and Verification of Intent