Proposed 2020 – 2023 Area Plan on Aging & Long Term Care for Planning and Service Area #11 - State of Washington

Individuals wishing to submit comments on this plan should contact Aging & Long Term Care of Eastern Washington's Planning Department at the physical address, phone number or email address listed below.

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AGING & LONG TERM CARE OF EASTERN WASHINGTON
2020 – 2023 AREA PLAN

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SECTION A – AREA AGENCY PLANNING AND PRIORITIES

Section A-1 Introduction

Aging & Long Term Care of Eastern Washington (ALTCEW) is a social service agency that helps older adults and people living with disabilities stay in their homes. ALTCEW provides services such as case management for people who need a caregiver, assistance accessing local resources to help people stay at home, and answers to questions about Medicare and Medicaid. Alone, we cannot fulfill our mission, so we work with local partners in the community to provide services such as home delivered meals, family caregiver support, transportation and information. Through community partners, ALTCEW provides funding for services to older adults and individuals living with a disability in our five-county area.

ALTCEW is the local Area Agency on Aging for Ferry, Pend Oreille, Spokane, Stevens and Whitman counties. Area Agencies on Aging were established by the 1973 amendments to the 1965 Older Americans Act. There are approximately 700 of these agencies across the nation. They are part of what is known as the "Aging Network." This network includes the Administration for Community Living at the federal level, State Units on Aging in each state, Area Agencies on Aging (AAA) at the local level and other public and private agencies, such as senior centers and nutrition project sites, all working together to serve the nation's elderly.

The organizational and funding flow to the Agency begins with Congress, who enacted the Older Americans Act, the Social Security Act and other laws impacting older persons and others in need of long term care. These Acts are amended periodically, and Congress appropriates federal funds. The Washington State Legislature enacted the Senior Citizens Services Act and appropriates state funds for various senior programs. The Department of Health and Human Services and the Administration on Community Living (federal) develop regulations and procedures for implementing the Older Americans Act and awarding funds to the states. The Washington State Department of Social and Health Services Aging and Long Term Support Administration administers federal funds on behalf of the State, and prepares a state plan on aging. They develop policies and procedures for implementing the federal Older Americans Act, the State Senior Citizens Services Act and other programs. They review and approve Area Agency on Aging Area Plans, award funds and monitor and evaluate Area Agencies on Aging.

Every four years, ALTCEW develops an Area Plan. The Area Plan is a document that describes:

- How we prioritize discretionary funding.
- The programs we will fund in our service area using the discretionary funding formula.
- The areas of work we will accomplish to address the needs of older adults and people living with disabilities in our region over the next four years.

ALTCEW is responsible for performing the following activities in the region for older persons and people with disabilities needing long term care:

1. Determining the needs;

2. Planning services to meet the needs;

3. Coordinating the delivery of services, which are already operating in the area;

4. Searching for new sources of funds to pay for the development and continuance of needed services;

5. Providing leadership and advocacy;

6. Administering the federal and state dollars available for services in the community, including providing direct services and contracting with local agencies to provide services;

7. Providing technical assistance to service providers and other agencies;

8. Developing community education programs to keep the community informed as to what programs and services are available.

ALTCEW was established as a regional public corporation in 1978 under the provisions of the Older Americans Act. The parties to the Interlocal Governmental Agreement under which the Agency was created include the City of Spokane, the City of Spokane Valley, and the five counties of Ferry, Pend Oreille, Spokane, Stevens and Whitman. The agency's service area includes all of the above counties except for the Colville Indian Reservation located in the southern portion of Ferry County.

ALTCEW's agency structure includes the following groups:

1. Governing Board - made up of one county commissioner from each county, one City of Spokane council member, the Director of Community Housing and Human Services at City of Spokane, one City of Spokane Valley council member, and the Planning and Management Council's Chairperson; and

2. Planning and Management Council – an advisory council made up of 35 volunteers broadly representative of older persons and the community served by the Agency; and

3. Staff - deliver agency programs, monitor contracted providers, plan for community needs, provide technical assistance, and ensure funding is spent in compliance with federal and state guidelines.

Section A-2 Mission, Vision, Values

AGING & LONG TERM CARE OF EASTERN WASHINGTON

MISSION STATEMENT

The mission of Aging & Long Term Care of Eastern Washington is to promote well-being, independence, dignity, and choice for all older persons and for individuals needing long term care in Ferry, Stevens, Pend Oreille, Spokane, and Whitman counties.

Our mission will be achieved by:

- Collaborating with others to create coordinated and comprehensive service delivery systems; and
- Providing planning, program development and administration, public information, advocacy, and direct service; and
- Emphasizing that the above functions and services are targeted on those with greatest social, economic and health needs and on culturally diverse individuals; and
- Promoting a long term care system through integrating acute and chronic care services; and
- Creating innovative outreach and information mechanisms to reach isolated vulnerable individuals.

VISION STATEMENT

Our vision is to provide the best home and community based services to support healthy living and aging in place.

We Listen… to our community to understand individual needs.
We Adapt… to our changing world.
We Provide Solutions...using innovative services to improve quality of life.

Section A-3 Planning and Review Process

PLANNING PROCESS:

Aging & Long Term Care of Eastern Washington's process for developing the 2020-2023 Area Plan on Aging and Long Term Care for PSA #11 flows directly out of a series of policy directions established by the Planning and Management Council (PMC) and Governing Board. The following elements went into the process for planning and developing the 2020-2023 Area Plan on Aging and Long Term Care for PSA #11:

1. The Planning and Resources Committee and PMC established the scope, timelines, methods, principles and guidelines for conducting the Proposed 2020-2023 Area Plan on Aging and Long Term Care planning process for PSA #11.

2. The staff and Planning and Resources Committee conducted a series of activities to gather information on available resources and needs of older persons and individuals with disabilities living in PSA #11. This included seventeen focus groups to receive and gather information on available resources and needs of older persons and individuals with disabilities living in PSA #11. A variety of diverse and underserved audiences were invited to participate in focus groups including the LGBTQ+ community, the interfaith community, racial and ethnically diverse older adults, long term care ombudsmen and Aging & Long Term Care case managers that reported on the experiences of homebound older adults and adults living with a disability. Additionally, three focus groups were held with individuals experiencing memory loss, their care partners and providers. These focus groups were used to inform draft goals and work objectives presented at the community planning meetings.

3. The Planning and Resources Committee and PMC held a series of community planning meetings in PSA #11 to receive information and comments on issues that may impact development of the 2020-2023 Area Plan on Aging and Long Term Care. Input gathered from the community planning meetings was used to draft the proposed plan presented at the public hearings. The following community planning meetings were held:

   a. Ferry County - Date: April 2, 2019
      Time: 10:00 AM to 12:00 PM
      Place: Republic Senior Center
      Republic, WA 99201

   b. Pend Oreille County: - Date: April 4, 2019
      Time: 11:00 AM to 12:45 PM
      Place: Hospitality House
      212 S Washington Ave
      Newport, WA 99156

c. Stevens County: - Date: April 8, 2019
Time: 1:30 PM to 3:35 PM
Place: The Hub
The Flex Room
231 W. Elep Ave
Colville, WA 99114

d. Spokane County - Date: April 9, 2019
Time: 2:00 PM to 3:30 PM
Place: ALTCEW – Conference Room B&C
1222 North Post Street
Spokane, WA 99201

e. Whitman County - Date April 10, 2019
Time 1:00 PM to 2:30 PM
Place Colfax Pantry
121 North Main St.
Colfax, WA 99111

4. The Planning and Resources Committee and PMC held a series of public hearings in PSA #11 to receive formal information and comments on the Proposed 2020-2023 Area Plan on Aging and Long Term Care. The schedule for the public hearing was:

a. Spokane County - Date: July 1, 2019
Time: 1:30 PM to 3:00 PM
Place: Corbin Senior Activity Center
827 W. Cleveland
Spokane, WA 99205

b. Tri-County Area: - Date: July 8, 2019
Time: 1:30 PM to 3:00 PM
Place: The Hub Senior Center
231 W. Elep Ave.
Colville, WA 99114

c. Whitman County Area

Date: July 15, 2019
Time: 1:30 PM to 3:00 PM
Place: Pullman Senior Center
325 SE Paradise St.
Pullman, WA 99163

5. The Planning and Resources Committee and PMC reviewed, modified and accepted sections of the Proposed 2020-2023 Area Plan on Aging and Long Term Care based on public comments and information received at the public hearings at their meeting on July 26, 2019. The PMC made recommendations to ALTCEW's Governing Board on acceptance of the Proposed 2020-2023 Area Plan on Aging and Long Term Care for PSA #11.

6. At its meeting on August 9, 2019, ALTCEW's Governing Board reviewed, modified and/ or accepted sections of the Proposed 2020 - 2023 Area Plan on Aging and Long Term Care based on recommendations from the PMC.

7. ALTCEW's Proposed 2020 - 2023 Area Plan on Aging and Long Term Care for PSA #11 will be submitted to Aging and Long Term Support Administration on October 4, 2019.

Section A-4 Prioritization of Discretionary Funds

PRIORITIZATION OF DISCRETIONARY FUNDS

Under Section A – 4, Prioritization of Discretionary Funds, the Area Plan instructions require the Area Agencies on Aging to describe their priorities for services for which there is discretionary funding. ALTCEW must describe its process for determining priority services, including the criteria established, the basis for the criteria, factors influencing the prioritization, and the methods employed in weighting individual elements.

ALTCEW must also describe how it would implement these priorities in the event of reductions or increases. The instructions state that discretionary funds are normally those that come from Older Americans Act Title IIIB, Senior Citizen Act and local sources.

2020 – 2023 PRIORITIZATION PROCESS CONSIDERATIONS:

For the 2020-2023 Prioritization Process we are recommending the following questions be considered when prioritizing discretionary funded services in each area:

1. Does the program/service reach: (a) those with greatest economic and/or social need, (b) those with severe disabilities, (c) those with limited English-speaking ability, (d) those residing in rural areas, (e) those with dementia disease and related disorders (and caretakers of such individuals), (f) those at risk of institutional placement and/or (g) racially or culturally diverse individuals?

2. What is the impact of the program or service to the larger network of services?

3. Is the community need one that can be met through community collaboration, if internal resources are not sufficient?

PROPOSED PRIORITIZATION MATRIX
SPOKANE COUNTY SUBREGION DISCRETIONARY FUNDS

PROPOSED 2020-2023 SERVICE PRIORITIES

Priority	Status	Service Objective
1	Continue	Community Living Connections
2	Continue	Home Delivered Meals
3	Continue	Adult Day Services / Fee Subsidy Transportation
4	Continue	Bathing Assistance/Limited Home Care
5	Continue	Congregate Meals / Fee Subsidy Transportation
6	Continue	Matter of Balance
7	Continue	Long Term Care Ombudsman
8	Continue	Minor Home Repair
9	Start	Dementia Support and Education

2018-2019 SERVICE PRIORITIES

Priority	Status	Service Objective
1	Continue	Community Living Connections
2	Continue	Home Delivered Meals
3	Continue	Adult Day Care / Fee Subsidy Transportation
4	Continue	Bathing Assistance/Limited Home Care
5	Continue	Congregate Meals / Fee Subsidy Transportation
6	Continue	Matter of Balance
7	Continue	Long Term Care Ombudsman
8	Continue	Minor Home Repair

Based on feedback of focus groups and the prioritization criteria, we are proposing to keep the same list of prioritized services as in years past. In addition we would like to add the following areas for consideration if increased funding is available and discretionary funding could be used to leverage outside funds:

- Senior Van and Volunteer Transportation
- Support for hospital transitions
- Evidence based health programs

TRI-COUNTY SUBREGION DISCRETIONARY FUNDS

PROPOSED 2020-2023 SERVICE PRIORITIES

(Northern Ferry, Pend Oreille and Stevens counties)

Priority	Status	Service Objective
1	Continue	Community Living Connections
2	Continue	Senior Van/Volunteer Transportation
3	Continue	Home Delivered Meals
4	Continue	Congregate Meals
5	Continue	Long Term Care Ombudsman

2018-2019 SERVICE PRIORITIES

(Northern Ferry, Pend Oreille and Stevens counties)

Priority	Status	Service Objective
1	Continue	Community Living Connections
2	Continue	Senior Van/Volunteer Transportation
3	Continue	Home Delivered Meals
4	Continue	Congregate Meals
5	Continue	Long Term Care Ombudsman

Based on feedback on focus groups and the prioritization criteria, we are proposing to keep the same list of prioritized services as in years past. In addition we would like to add the following areas for consideration if increased funding is available and discretionary funding could be used to leverage outside funds:

- Support for hospital transitions
- Evidence based health programs

WHITMAN COUNTY DISCRETIONARY FUNDS

PROPOSED 2020-2023 SERVICE PRIORITIES*

Priority	Status	Service Objective
1	Continue	Community Living Connections
2	Continue	Senior Van and Volunteer Transportation
3	Continue	Home Delivered Meals
4	Continue	Congregate Meals
5	Continue	Long Term Care Ombudsman

2018-2019 SERVICE PRIORITIES

Priority	Status	Service Objective
1	Continue	Community Living Connections
2	Continue	Home Delivered Meals
3	Continue	Senior Van and Volunteer Transportation
4	Continue	Congregate Meals
5	Continue	Long Term Care Ombudsman

Based on feedback on focus groups and the prioritization criteria, we are proposing to reprioritize services as noted above. In addition we would like to add the following areas for consideration if increased funding is available and discretionary funding could be used to leverage outside funds:

- Evidence based health programs
- Family Caregiver Support Program

SECTION B – Planning and Service Area Profile

Section B-1 Target Population Profile

PLANNING AND SERVICE AREA #11:

Aging & Long Term Care of Eastern Washington's (ALTCEW) service area is the third largest geographic area in the state of Washington, totaling approximately 8,900 square miles. This area, called Public Service Area #11 (PSA#11) is located in the northeast corner of the state. PSA#11 is comprised of three distinct geographic and economic sub-regions: (1) Spokane County subregion, which is comprised of the City of Spokane, City of Spokane Valley, and several smaller outlying communities; (2) Whitman County subregion, located at the northeastern edge of the Palouse agricultural area; and (3) Tri-County subregion (including Ferry, Pend Oreille and Stevens Counties), which is a mountainous, rural, and frontier area.

The population in ALTCEW's service area has grown significantly over the years, from 446,297 persons in 1990 to 580,080 persons in 2010. The U.S. Census Bureau estimates the ALTCEW service area's population to be 630,933 as of July 1, 2018. The number of persons 60 and older has also grown during that period from 74,806 persons, or 16.76% of the population in 1990, to 110,543 persons, or 19.06% of the population in 2010. American Community Survey (ACS) data estimated the number of persons 60 and older to be 145,128, or 23% of the population in 2018. The State of Washington Office of Financial Management estimates the number of persons 60 and older will be 153,934 persons, or 26.31% of the population in 2020.

Following is a brief description of each area, or sub region, in PSA #11.

SPOKANE COUNTY SUBREGION:

Spokane County covers 1,764 square miles. Of all the forces that shaped the Spokane County economy, none is more powerful than Spokane's historic role as a regional center of services for the surrounding rural populations of Eastern Washington and Northern Idaho. Regional services include government and higher education, medical services, retail trade and finance.

Fairchild Air Force Base is the county's largest employer. In addition, manufacturing has had a solid base due to the nexus of the Bonneville dam power generation, rail systems and the interstate highway system. Spokane is competitive with other urban centers in attracting national and international investment in the form of tourism and conventions, the military and research. These investments in turn support the creation and expansion of still other complementary businesses, creating a well-rounded and diversified economy.

The topography of Spokane County, for the most part, does not present any significant geographic barriers to the delivery of services to older persons and individuals living with disabilities. Public transportation services for the City of Spokane, Spokane Valley, Airway Heights, Medical Lake and Cheney, are provided by the Spokane Transit Authority. Interstate-90 serves as the major transportation corridor for east-west traffic and State Highway 395 serves as the access for traffic flowing north-south. The southeast section of Spokane County is likely the most isolated of the rural areas in the county. This remote area, bordering western Idaho and northern Whitman County, makes up less than one percent of Spokane County's population but contains nearly one-fifth of the total land area of the county.

WHITMAN COUNTY SUBREGION:

Whitman County occupies approximately 2,159 square miles. The county seat is located in the east central portion of the county in Colfax. The elevation within the county ranges from 740 to 4,000 feet above sea level. The elevation increases about 25 feet in height per mile from the southwest to the northeast. Deep soil, rolling hills and relatively moderate weather combine to make Whitman County well suited for dry land farming of barley, wheat, dry peas and lentils.

Whitman County borders seven Washington counties and three Idaho counties. Additionally, Whitman County is unique in that it has such a large number of small communities interspersed throughout the county. Only two communities, Colfax and Pullman, have populations above 2,000, with 67% of the county's total population residing in the Pullman area. Pullman, the largest city in the county, is the home of Washington State University.

TRI-COUNTY SUBREGION:

The Tri-County Subregion consists of Ferry, Pend Oreille and Stevens counties and is located in the northeastern corner of Washington State. This sub-region covers 6,082 square miles. The Tri-County Subregion is bordered by British Columbia on the north, and by Idaho on the east.

Generally described as mountainous, the subregion is characterized by five primary mountain ranges extending in a north-south direction. Elevations range from 2,000 feet in the valleys to the state's highest navigable mountain pass in Ferry County at 5,575 feet.

More than fifty-percent of the Tri-County Subregion is public land administered by the U.S. Forest Service, the Department of Natural Resources and three Indian tribes (the Colville, Kalispel and Spokane Tribes) that are within the subregion's boundaries. Since much of the land is classified as public, the tax base is limited. There is only one east-west highway linking the counties. Weather in the Tri-County Subregion is moderate with the exception of winter, which brings snow and freezing conditions that make travel and access difficult. The subregion's economy is resource-based, with timber, agriculture and mining as major forces. Unemployment and poverty rates have been high for the past 30 years.

DEMOGRAPHIC CHARACTERISTICS

2018 Data	Ferry County	Pend Oreille County	Spokane County	Stevens County	Whitman County	PSA #11
Total Population	7,532	13,115	492,581	43,286	47,878	604,392
Persons 60+	2,850	4,988	115,218	15,040	7,519	145,615
Persons 60+ and Minority	515	318	8,214	1,347	573	10,967
Persons 60+ Below 100% Poverty Level[1]	288	423	7,343	1,357	457	9,868
Persons 60+ Below 100% Poverty Level and minority	97	59	1,002	239	89	1,486
Persons 60+ in Rural Areas	2,850	4,988	28,113	15,040	7,519	58,510
Persons 18+ with Disabilities	859	1,422	38,544	4,523	3,590	48,940
Persons 60+ with Disabilities	604	1,021	23,838	3,087	1,651	30,201
Limited English Speaking 60+	101	171	3,937	543	340	5,091
Persons 18+ with cognitive impairment	522	830	25,963	2,731	3,119	33,165
Persons 60+ with cognitive impairment	281	461	14,664	1,409	757	13,688
Persons 60+ at Risk for Institutional Placement	295	614	14,664	1,858	1,030	18,461
Native American Elders 60+	297	114	567	498	21	1,477
Native American Tribes	N/A	Kalispel Tribe	N/A	Spokane Tribe[2]	N/A	

Sources: Washington State Office of Financial Management, Department of Social and Health Services

[1] The Federal Poverty Level was $12,140 for a single person household in 2018.

[2] The Spokane Tribe has Title VI programs.

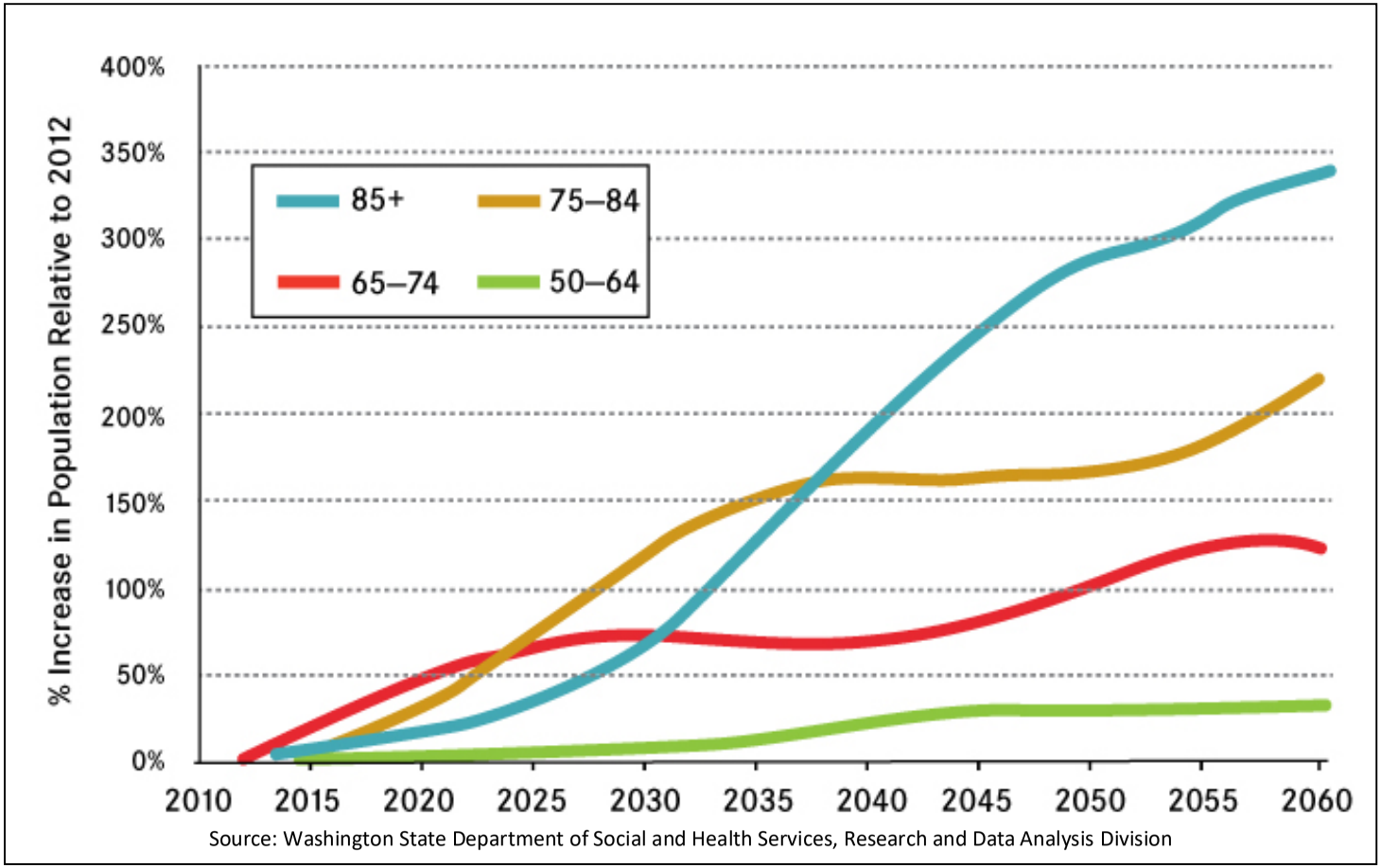
2025 Estimates	Ferry County	Pend Oreille County	Spokane County	Stevens County	Whitman County	PSA #11
Total Population	7,881	14,367	539,818	47,338	50,125	659,529
Persons 60+	2,598	5,781	138,315	17,322	8,530	172,546
Persons 75+	1,131	2,197	46,896	6,084	3,063	59.371
Persons 85+	282	478	11,748	1,441	803	14,752
Persons 60+ and Minority	337	422	11,287	1,726	776	14,860
Persons 60+ Below 100% Poverty Level	209	462	8,865	1,447	534	11,607
Persons 60+ Below 100% Poverty Level and minority	42	77	1,324	285	136	1,935
Persons 60+ in Rural Areas	2,598	5,781	33,749	17,322	8,530	68,645
Adults 18+ with Disabilities	744	1,665	44,262	5,194	3,855	55,939
Persons 60+ with Disabilities	588	1,307	29,542	3,846	1,925	37,355
Limited English Speaking 60+	104	217	5,116	667	424	6,545
Persons 18+ with cognitive impairment	425	936	28,679	3,043	3,202	36,430
Persons 60+ with cognitive impairment	270	588	13,229	1,749	688	13,286
Persons 60+ at Risk for Institutional Placement	369	815	18,255	2,398	1,205	23,042
Native American Elders 60+	86	140	683	590	24	1,802
Native American Tribes	N/A	Kalispel Tribe	N/A	Spokane Tribe	N/A	

Sources: Washington State Office of Financial Management, Department of Social and Health Services

2030 Forecast	Ferry County	Pend Oreille County	Spokane County	Stevens County	Whitman County	PSA #11
Total Population	7,953	14,494	564,538	48,443	51,218	686,646
Persons 60+	2,566	5,867	149,341	17,562	9,019	184,949
Persons 75+	1,390	2,710	59,738	7,362	3,709	74,909
Persons 85+	358	675	14,881	1,963	1,069	18,946
Persons 60+ and Minority	411	474	13,398	1,966	933	17,509
Persons 60+ Below 100% Poverty Level	190	434	9,641	1,379	563	12,291
Persons 60+ Below 100% Poverty Level and minority	47	84	1,558	292	160	2,211
Persons 60+ in Rural Areas	2,566	5,867	36,439	17,562	9,019	71,453
Adults 18+ with Disabilities	801	1,800	49,551	5,582	4,151	62,125
Persons 60+ with Disabilities	643	1,451	34,131	4,232	2,155	42,774
Limited English Speaking 60+	111	230	5,883	721	478	7,440
Adults 18+ with cognitive impairments	458	1,009	31,488	3,260	3,365	39,735
Persons 60+ with cognitive impairments	299	661	15,383	1,943	982	19,348
Persons 60+ at Risk for Institutional Placement	422	951	21,743	2,744	1,387	27,247
Native American Elders 60+	386	145	747	635	26	1,939
Native American Tribes	N/A	Kalispel Tribe	N/A	Spokane Tribe	N/A	

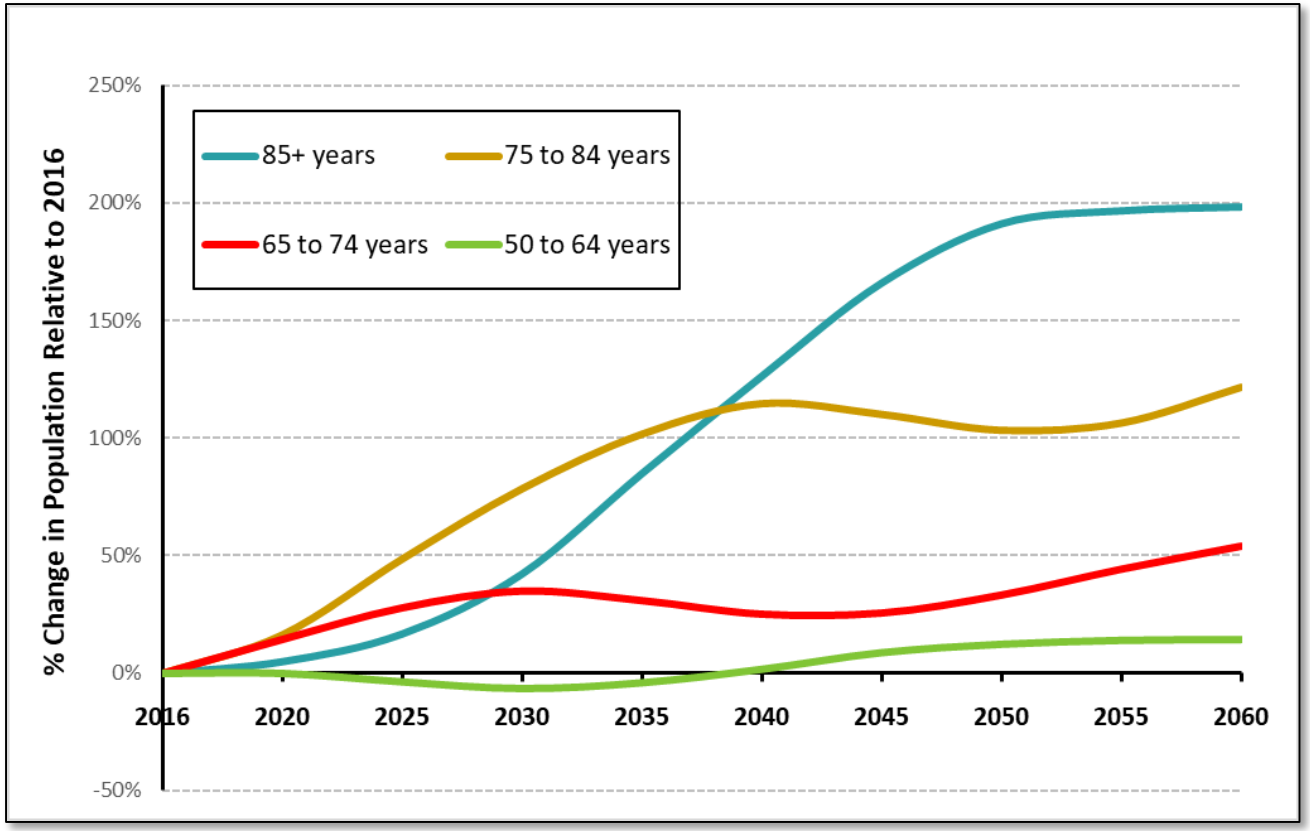
Sources: Washington State Office of Financial Management, Department of Social and Health Services

The US Population is Aging - original



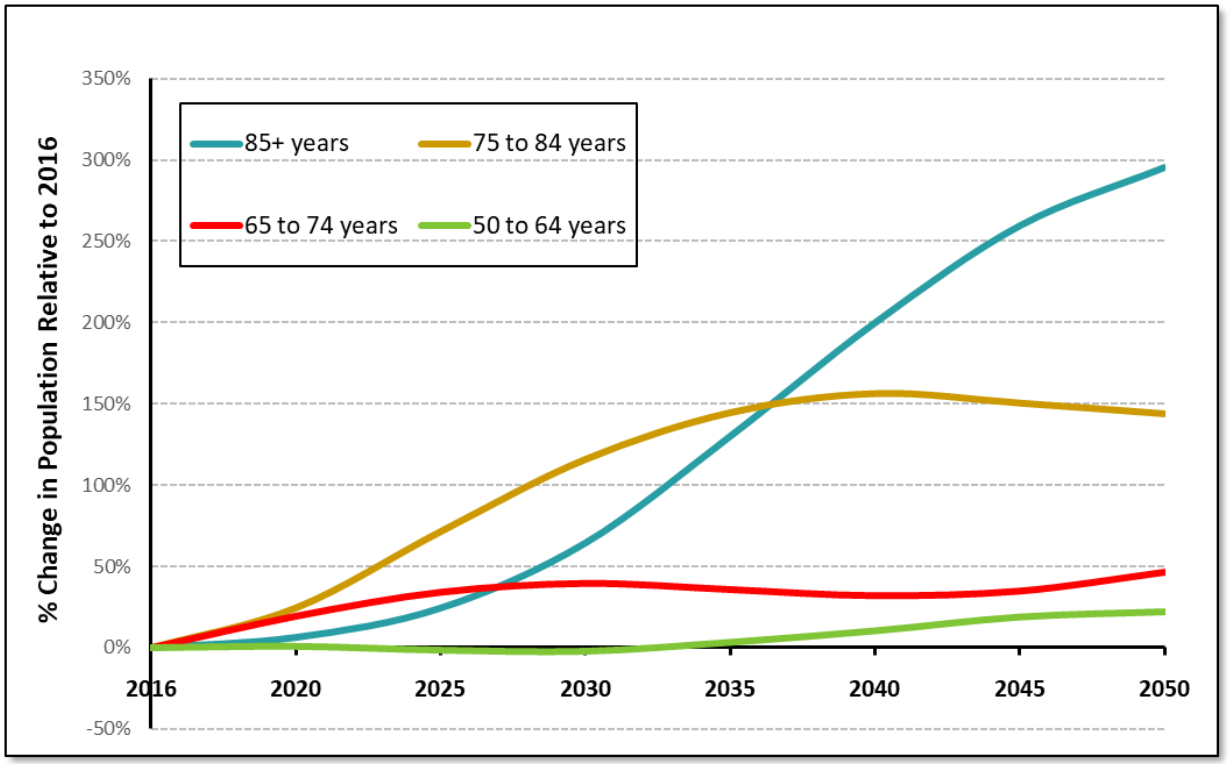
Source: Washington State Department of Social and Health Services, Research and Data Analysis Division

The US Population is Aging – Updated 2016-2060



SOURCE: Projected 5-Year Age Groups and Sex Composition: Main Projections Series for the United States, 2017-2060. U.S. Census Bureau, Population Division: Washington, DC. Revised Release Date: September 2018 https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html, Accessed Oct 30, 2018

The WA Population is Aging: 2016-2050



SOURCE: State of Washington Office of Financial Management Forecasting & Research Division (August 2018). 2017 Projections, County Growth Management Population Projections by Age and Sex: 2010–40. https://ofm.wa.gov/washington-data-research/population-demographics/population-forecasts-and-projections/growth-management-act-county-projections/growth-management-act-population-projections-counties-2010-2040-0, Accessed Oct 25, 2018

Section B-2 AAA Services and Partnerships

Community Living Connections: Provides seamless access to information, referral, assistance, decision support, and person centered planning on long- term services and support options in local communities. Services include benefits counseling and assistance applying for public benefits.

Family Caregiver Support Program: Provides a multifaceted system of support services to respond to the needs of family and other unpaid caregivers. Counseling, respite care, support groups and other supportive services available based on assessment.

Medicaid Alternative Care (MAC): Provides caregiver support services to unpaid caregivers of individuals currently eligible for Medicaid long term care, but choosing to receive caregiver support services in lieu of personal care. Counseling, respite care, support groups and other supportive services available based on assessment for both caregiver and care receiver.

Tailored Supports for Older Adults (TSOA): Provides caregiver support services to unpaid caregivers of individuals who need assistance with personal care that are not financially eligible for Medicaid long term care. Counseling, respite care, support groups and other supportive services available based on assessment for both caregiver and care receiver. Limited personal care is also available to individuals who do not have an unpaid caregiver.

Kinship Navigator: Connects grandparents and relatives who are raising children to community resources, such as health, financial and legal services, support groups, and emergency funds.

Kinship Caregiver Support Program: Provides support services to grandparents and other relative caregivers, over the age of 18, who are raising minor children, and who are at the greatest risk of not being able to maintain their caregiving role.

Senior Van and Volunteer Transportation: Provides transportation using volunteer or paid drivers, owned vans or vehicles, or volunteer vehicles to older persons who have no other means of transportation or are unable to use existing transportation.

Case Management: Case managers assist clients to develop and monitor a plan of care to enable them to reside in the setting of their choice. Case managers support the client's independence by coordinating and offering assistance to access needed services. Case management is provided to clients receiving Medicaid Personal Care, COPES, and Community First Choice.

Medicaid Personal Care (MPC): Provides personal care and household assistance to individuals 18 years of age or older, to enable them to remain in the community. Program serves people who meet functional and financial eligibility. Clients are low income and need assistance with activities of daily living.

Community Options Program Entry System (COPES): Provides similar services to Medicaid Personal Care and Community First Choice, but case managers can authorize additional services such as home modifications, specialized medical equipment, adult day care or day health, and many others. Clients must meet nursing facility level of care or be at risk of institutionalization within 30 days. Can have a higher income than persons on Medicaid Personal Care.

Community First Choice (CFC): Is a Medicaid State Plan program. CFC eligibility includes clients who, in the absence of the caregiver services provided under CFC, would otherwise need to be in a hospital or Nursing Facility. CFC pays for personal care and if eligible, for Relief Care, Nurse Delegation, Skills Acquisition Training, Personal Emergency Response Systems (PERS), Assistive Technology, Community Transition Services and Caregiver Management Training. Clients may need other services which are available from the waiver (COPES) in addition to their CFC services. If they qualify for CFC, and are both functionally and financially eligible for waiver services, they can be on both programs simultaneously in order to access additional needed COPES services (CFC+COPES).

Nursing Consultation Services: Registered Nurses provide nursing assessment, skin observation, care coordination, evaluation, and education to caregivers and clients on health related issues. Serve Medicaid Personal Care, COPES, Community First Choice, Developmental Disabilities Administration, and Home and Community Services clients.

Personal Care Services: In-home assistance provided by Home Care Aides to clients in the Medicaid Personal Care, COPES, or Community First Choice programs. Services include assistance with locomotion, bed mobility, bathing, toileting, dressing, transferring, eating, meal preparation, personal hygiene, positioning, and assistance in medication management, essential shopping, housework, and travel to medical services. Personal care services may be provided by a contracted Independent Provider, or through an approved Home Care Agency.

Bath Assistance and Limited Home Care: Assistance provided in bathing and personal hygiene to persons age 60 and over who need these services to remain in their own homes, and are not eligible for, or have exhausted other sources of payment.

Home Delivered Meals: Provides nutritious meals and other nutrition services to persons age 60 and over who are homebound by reason of illness, incapacitating disability, or otherwise isolated. Meals are delivered to the person's home, usually by a volunteer.

Congregate Meals: Provides nutritious meals and other nutrition services, including nutrition outreach and nutrition education, in a group setting.

Fee Subsidy Transportation: Provides transportation to and from specific services, including Adult Day Services and Congregate Meals, for persons age 60 and older. A fee is provided to an eligible transportation provider, which can include paratransit or bus service.

Senior Farmer's Market Nutrition Program: Provides eligible seniors with vouchers that can be used to purchase fresh fruits and vegetables from certified farmers markets.

Minor Home Repair: Provides repairs or modifications to the homes of older adults that are essential for their health and safety.

Adult Day Care: A structured day program where older adults are provided core services such as: basic health monitoring with consultation from a registered nurse; therapeutic activities; supervision or protection; provision of a meal, not replacing or substituting for a full day's nutritional regimen; and programming and activities designed to meet the client's physical, social, and emotional needs.

Adult Day Health: In addition to the core services provided in Adult Day Care, Adult Day Health offers routine clinical services including skilled nursing and skilled therapy including occupational and physical therapy. Psychological services are also provided including assessing psychosocial needs, presence of dementia, abuse or neglect, and alcohol and/or drug misuse. Intermittent supportive counseling is also available.

Legal Assistance: Provide access to the system of justice by offering representation by a legal provider who acts as an advocate for the socially and economically needy older individual who is experiencing legal problems.

Long Term Care Ombudsman Program: The ombudsman is an impartial mediator working with families, residents and staff of long term care facilities in Spokane, Whitman, Stevens, Pend Oreille, and northern Ferry counties. Certified volunteer ombudsman receive, investigate and resolve complaints and concerns about the quality of life in long term care facilities including nursing homes, boarding homes, and adult family homes.

Home Care Referral Registry: A web-based database of individual in-home providers who are ready and available to work. Services can only be accessed by clients served through Medicaid Personal Care, COPES, Community First Choice, Developmental Disabilities Administration, and Home and Community Services. Also provides contracting and training services for individuals interested in becoming Independent Providers, as well as training for consumers on hiring and managing in-home workers. The program also assists providers and clients in accessing Carina, an online platform that assists clients and Independent Providers in connecting.

Statewide Health Insurance Benefit Advisors (SHIBA): Provides free, unbiased counseling to consumers regarding all aspects of publicly funded health insurance and health care access in Spokane and Whitman counties. Counseling is provided by staff and volunteers trained by the Washington State Office of the Insurance Commissioner.

MIPPA (Medicare Improvement for Patients and Providers Act): Provides targeted outreach and assistance to eligible individuals applying for the Medicaid Part D Low-Income Subsidy and Medicare Savings Programs.

Senior Drug Education: Provides education to older adults on the safe and appropriate use of prescription and non-prescription drugs.

Senior Medicare Patrol: Provides education to Medicare and Medicaid beneficiaries, family members and caregivers on how to actively protect themselves against health care fraud, waste and abuse. Volunteers also coordinate reports of expected abuse and forward them to Medicare for resolution.

Care Coordination (Health Homes): Provides comprehensive care transitions, coordination of medical and social service supports, and assistance to individuals in identifying and reaching their health goals. The care coordinator meets monthly one on one with clients to assist them in identifying and achieving their health goals. Services are provided to high-risk Medicaid only and dually eligible (Medicaid/Medicare) clients.

Supportive Housing: Provides assistance to Medicaid clients with complex health needs in obtaining and maintaining housing. Supportive Housing Specialists work collaboratively with clients and landlords to obtain housing benefits, secure housing, and support tenancy.

A Matter of Balance: An evidence based falls prevention program, for people who are 65 or older, provided in a workshop format. Participants who have sustained a fall or have a fear of falling learn fall prevention techniques and participate in exercises from the National Institute on Health. Workshops are led by volunteers who are often peers who have sustained falls.

Aging Network Services by Provider

Aging and Long Term Care (ALTCEW)

- Community Living Connections
- Case Management
- Medicaid Personal Care
- Community First Choice
- Community Options Program Entry System (COPES)
- Nursing Consultation Services
- Home Care Referral Registry
- SHIBA
- MIPPA
- A Matter of Balance
- Senior Drug Education
- Senior Medicare Patrol
- Care Coordination
- Supportive Housing

Elder Services

- Family Caregiver Support Program
- Medicaid Alternative Care (MAC)
- Tailored Supports for Older Adults (TSOA)
- Kinship Navigator
- Kinship Caregiver Support Program
- Case Management
- Medicaid Personal Care
- Community Options Program Entry System (COPES)
- Community First Choice

SNAP (Spokane Neighborhood Action Programs)

- Long Term Care Ombudsman
- Minor Home Repair

Council on Aging and Human Services

- Senior Van and Volunteer Transportation
- Home Delivered Meals
- Congregate Meals
- Senior Farmer's Market Nutrition Program

Rural Resources Community Action

- Community Living Connections
- Family Caregiver Support Program
- Medicaid Alternative Care (MAC)
- Tailored Supports for Older Adults (TSOA)
- Kinship Navigator
- Kinship Caregiver Support Program
- Senior Van and Volunteer Transportation
- Case Management
- Medicaid Personal Care
- Community Options Program Entry System (COPES)
- Community First Choice
- Home Care Referral Registry
- Legal Assistance
- Home Delivered Meals
- Congregate Meals
- Senior Farmer's Market Nutrition Program

Providence Adult Day Health

- Adult Day Care
- Adult Day Health
- Fee Subsidy Transportation

University Legal Assistance

- Legal Assistance

Family Resource Home Care

- Bath Assistance and Limited Home Care

Catholic Charities

- Senior Farmer's Market Nutrition Program

Greater Spokane County Meals on Wheels

- Home Delivered Meals
- Congregate Meals
- Fee Subsidy Transportation

Approved Medicaid Home Care Agencies:

- Aging Better In-Home Care
- Addus Healthcare
- Alternative Nursing Services
- Angel Senior Care
- Beneficial In-Home Care
- Chesterfield Services
- Providence DominiCare
- Havenwood Caregiver Services
- Family Resource Home Care
- ResCare HomeCare
- Spokane Tribe of Indians

Programs / Services by Sub-Region

SUB-REGION	PROVIDER	PROGRAM/SERVICE
Spokane County	Aging & Long Term Care of Eastern Washington	Community Living Connections SHIBA / MIPPA Senior Drug Education Senior Medicare Patrol A Matter of Balance Case Management Nursing Consultation Services Medicaid Personal Care Community First Choice Community Options Program Entry System (COPES) Home Care Referral Registry Care Coordination Supportive Housing
	Catholic Charities of Eastern Washington	Senior Farmers Market Nutrition Program
	Elder Services	Case Management Family Caregiver Support Medicaid Alternative Care Tailored Support for Older Adults Kinship Navigator Kinship Caregiver Support
	Greater Spokane County Meals on Wheels	Senior Nutrition (*Congregate Meals/Home Delivered Meals*) and Fee Subsidy Transportation
	Spokane Neighborhood Action Programs (SNAP)	Minor Home Repair Long Term Care Ombudsman
	University Legal Assistance	Senior Legal Assistance

SUB-REGION	PROVIDER	PROGRAM/SERVICE
Spokane County	Providence Adult Day Health	Adult Day Services (Day Health and Day Care)
	Family Home Care	Bathing Assistance and Limited Home Care
Tri-County (Stevens, Ferry, Pend Oreille)	Rural Resources Community Action (RRCA)	Community Living Connections Case Management Family Caregiver Support Medicaid Alternative Care Tailored Support for Older Adults Kinship Navigator Kinship Caregiver Support Senior Nutrition (*Congregate Meals/ Home Delivered Meals*) and Fee Subsidy Transportation Van and Volunteer Transportation Home Care Referral Registry Legal Assistance
	SNAP	Long Term Care Ombudsman
Whitman County	Rural Resources Community Action (RRCA)	Community Living Connections Case Management Family Caregiver Support Medicaid Alternative Care Tailored Support for Older Adults Kinship Navigator Kinship Caregiver Support
	Council on Aging & Human Services	Transportation (Van & Volunteer) Senior Nutrition (*Congregate Meals/ Home Delivered Meals*) and Fee Subsidy Transportation
	SNAP	Long Term Care Ombudsman

Section B – 3 Focal Points

Throughout ALTCEW's service area, the Aging & Disability Resource Center (ADRC), known as Community Living Connections (CLC) in Washington, will serve as the Focal Point in each county. Specific information, by county, follows.

Spokane County
Aging & Long Term Care of Eastern Washington
Community Living Connections
1222 N Post St
Spokane, WA 99201
509-960-7281

Ferry County
Rural Resources Community Action
Community Living Connections
42 Klondike Rd
Republic, WA 99116
509-775-0912
1-800-873-5889

Pend Oreille County
Rural Resources Community Action
Community Living Connections
333211 Highway 2, Suite 200
Newport, WA 99156
509-447-9997
1-800-873-5889

Stevens County
Rural Resources Community Action
Community Living Connections
956 S Main St
Colville, WA 99114
509-684-8421
1-800-873-5889

Whitman County
Rural Resources Community Action
Community Living Connections
1300 NE Henley Court, Suite 1
Pullman, WA 99163
509-332-0365
1-800-873-5889

Section C - Issue Area Themes, Goals and Objectives

Aging & Long Term Care of Eastern Washington has provided services in PSA #11 since 1973 and targets services to individuals with the greatest economic and social need. While continuing to meet the needs of individuals in our service area remains central to ALTCEW's mission, planning for the additional impacts the aging baby boom population brings to the aging network represents significant emerging work. Additionally, the experience of memory loss in its various forms and the associated devastating long-term challenges and losses for individuals, families and communities calls for yet further engagement and action.

As Americans live longer, growth in the number of older adults is unprecedented. The "age wave" refers to a massive population shift resulting from the aging of the baby boom generation, increased life expectancy and declining birth rates.

In a March 13, 2018 publication, "Older People Projected to Outnumber Children for First Time in U.S. History," the U.S. Census Bureau describes this dramatic change.

> The year 2030 marks an important demographic turning point in U.S. history according to the U.S. Census Bureau's 2017 National Population Projections. By 2030, all baby boomers will be older than age 65. This will expand the size of the older population so that 1 in every 5 residents will be retirement age.
>
> "The aging of baby boomers means that within just a couple of decades, older people are projected to outnumber children for the first time in U.S. history," said Jonathan Vespa, a demographer with the U.S. Census Bureau. "By 2035, there will be 78.0 million people 65 years and older compared to 76.7 million (previously 76.4 million) under the age of 18."[1]

To highlight the multifaceted and sweeping impacts that memory loss will bring, the Alzheimer's Association provides these 2019 facts and figures:

- 5.8 million Americans are living with Alzheimer's. By 2050, this number is projected to rise to nearly 14 million.
- Every 65 seconds, someone in the United States develops the disease.
- 1 in 3 seniors dies with Alzheimer's or another dementia
- Alzheimer's disease is the 6th leading cause of death in the United States. It kills more than breast cancer and prostate cancer combined.

[1] United States Census Bureau. [Internet]. Washington, D.C. [cited 2018 September 6]. Available from: https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html

- By 2019, Alzheimer's and other dementias will cost the nation $290 billion. In 2050, these costs could rise as high as $1.1 trillion
- More than 16 million Americans provide unpaid care for people with Alzheimer's or other dementias. These caregivers provided an estimated 18.5 billion hours of care valued at over $234 billion.[2]

To continue to address the direct service needs of individuals in our service area and to advocate for current and emerging community needs, during the planning period of 2020 – 2023, ALTCEW will focus on the following Issue Areas.

ISSUE AREA: Healthy Aging

GOAL: Improve health and wellbeing of older adults by increasing the array of affordable health, prevention and wellness service options for older persons and individuals living with disabilities.

PROFILE: The topic of Healthy Aging encompasses a wide variety of practices that have the capacity to improve health and well-being and reduce disease and injury in older adults. The quality of life improves for individuals and communities as significant investments are made in personal and public health. As people adopt healthy habits and behaviors, stay involved in their community, use preventive services, manage health conditions and understand all their medications, these practices can contribute to healthier living and a longer life.

Within PSA #11 and beyond, ALTCEW plays an active leadership role as advocate, collaborator and convener of conversations in a wide variety of areas that affect older adults and adults living with a disability.

Objectives within this issue area address falls prevention, nutrition, housing and transportation. Individually and collectively, these building blocks of healthy aging have the capacity to transform lives.

One in three Washington residents over age 65 fall each year. From 2011 – 2016, Washington State had the 14th highest rate of fall-related deaths of adults age 65 and older in the United States, and the 5th highest rate of self-reported falls. This rate has increased 28 percent since 2000 and was 82.6 per 100,000 in 2016.[3] Within Spokane County, the fall mortality rate is 56

[2] Alzheimer's Association website [Internet]. Available from: https://www.alz.org/alzheimers-dementia/facts-figures

[3] Washington State Department of Health [Internet]. Available from: https://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/OlderAdultFalls

percent higher than the rate for Washington State, resulting in an average of 133 people who die from a fall in Spokane County each year.[4]

In September 2019, ALTCEW begins its fifth year as a Master Training Site for the evidence-based falls prevention workshop, A Matter of Balance, proven to help older adults reduce their fear of falling and to increase physical activity.

Adequate nutrition and access to transportation remain critical needs for older adults and adults with disabilities throughout PSA #11. Through contracted services and advocacy, ALTCEW maintains a continuous presence throughout our service area for these basic needs of older adults and adults living with a disability.

Specific housing needs are as varied as the diverse communities that form the rich tapestry that is PSA #11. ALTCEW remains an active presence in community conversations and advocacy on a variety of levels of government with the goal of ensuring that all older adults and adults living with a disability have access to accessible, affordable and safe housing.

Objective A: Between January 1, 2020 and December 31, 2023, ALTCEW will expand the use of Evidence Based Programming, specifically A Matter of Balance, to support prevention and wellness options for older persons and individuals living with disabilities.

Objective B: Between January 1, 2020 and December 31, 2023, ALTCEW will continue to advocate for additional funds to continue the Senior Farmers Market Nutrition Program (SFMNP) voucher process and continue efforts to increase awareness of the SFMNP through flyers, public service announcements and other media opportunities.

Objective C: Between January 1, 2020 and December 31, 2023, ALTCEW will elevate the housing issue within the greater community, advocating for universal design methodology, retrofitting of older housing structures and highlighting the need for larger numbers of accessible units within new multi-housing construction. Advocate for and assist local housing providers in creating additional affordable, accessible housing units for older adults.

Objective D: Between January 1, 2020 and December 31, 2023, ALTCEW will continue to advocate for awareness of the transportation needs of older adults and individuals living with disabilities through staff participation in coalitions and committees within the ALTCEW Service Area.

[4] Spokane Regional Health District [Internet]. Available from: https://srhd.org/programs-and-services/falls-prevention

ISSUE AREA: Mental Health and Aging

GOAL: Improve the cognitive, emotional and behavioral wellbeing of older adults, disabled adults and their families.

PROFILE: The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[5] Because mental health is essential to overall health and well-being, it must be recognized and treated in all Americans, including older adults, with the same urgency as physical health.

The National Coalition on Mental Health and Aging provides the following Quick Facts:

- Most older people have good mental health. However, approximately 20 – 22% of older adults may meet criteria for some form of mental disorder, including dementia.
- Fewer than 40% of older adults with mental health and/or substance use disorders get treatment.
- The prevalence of dementia increases dramatically with age, with approximately 5% of the population between ages 71 and 79 and 37% of the population above age 90 suffering with this condition.
- Emergency room visits by older adults with opioid misuse increased over 220% from 2006 to 2014.
- If the prevalence of mental health disorders among older adults remains unchanged, the number of older adults with mental health and/or substance disorders could reach 14 million people by the year 2030.
- Older adults have one of the highest suicide rates in the nation. White males 85+ complete suicide at 4 times the rate of the general population.
- Mental health disorders, particularly depression and anxiety, are major contributors to – and are exacerbated by – social isolation, which results in diminished quality of life, further barriers to intervention and premature institutionalization.
- By 2020, an estimated 5 million older adults will have substance abuse problems.[6]

Objective A: Between January 1, 2020 and December 31 2023, ALTCEW will collaborate and promote partnership with the Spokane Alzheimer's Association office and additional community

[5] World Health Organization (1948) [Internet}. Available from: http:/www.who.int/governance/eb/who_constitution_en.pdf

[6] National Coalition on Mental Health and Aging [Internet]. Available from: http://www.ncmha.org/

partners to offer "Staying Connected," an Early Stage Memory Loss for individuals with early stage memory loss and their care partners.

Objective B: Between January 1, 2020 and December 31, 2023, ALTCEW will collaborate and promote partnership with local government, home care entities, hospitals and the medical community, community services and supports, the business community, local universities and first responders to facilitate the development of Spokane County as the first Dementia Friendly Community in the State of Washington.

Objective C: Between January 1, 2020 and December 31, 2023, ALTCEW will continue to advocate regarding the mental health needs of older adults through coordination efforts with providers of mental health services and community educational events.

ISSUE AREA: Community Based Supports

GOAL: Address basic needs of individuals living in the community by increasing access to information and assistance to services and supports that prevent or delay entry into Medicaid funded long-term services and supports (LTSS).

PROFILE: Community Living Connections (CLC) and Statewide Health Insurance Benefits Advisors (SHIBA) create a comprehensive and solid foundation to enable older adults and adults living with a disability to address their basic needs, preventing or delaying their entry into Medicaid funded long-term services and supports. The Family Caregiver Support Program (FCSP), Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) provide a multifaceted system of support services to respond to the needs of family and other unpaid caregivers.

Washington State's Community Living Connections (CLC) is part of a national collaborative effort of the U.S. Department of Health and Human Services, the Veterans Administration and the Centers for Medicare & Medicaid Services designed to help individuals of all ages, disabilities and income levels, their caregivers, legal representatives and families get the right home and community-based supports and services at the right time, in the right place.

Finding the right services can be a daunting task, Washington State's CLC network will help individuals, their caregivers, legal representatives, and families navigate and connect with information and access to long-term and home or community-based service and supports system.

By linking consumers with services and supports that match their individualized priorities and preferences, CLC network partners have the ability to assist individuals to remain at home or in their communities.

CLCs provide four key services to consumers: Information, Referral, and Awareness; Options Counseling and Assistance; Streamlined Eligibility Assistance for Public Programs; and Person-Centered Care Transitions Supports. The CLC program aims to promote well-being, independence, dignity and choice for all individuals we serve. ALTCEW provides these services through a dedicated team of Information and Referral (I&R) staff who assist with referrals to; In Home Care, Medicare Counseling, Medicaid and Qualified Health Plans (Affordable Care Act), Caregiver Support, and Options Counseling. An essential component of Options Counseling is a personal interview to discuss available options; facilitate a decision process; choosing options based on strengths, preferences, and values.

Information, Referral, and Awareness – Aging and Disability Resource Centers (ADRCs) serve as highly visible and trusted places where people of all ages, disabilities and income levels know they can turn for objective information on the full range of home and community supports and service options.
The ADRC's information, referral, and awareness services are designed to help consumers navigate the variety of agencies and organizations offering services and supports with differing eligibility criteria, application processes, and cost sharing requirements for public pay, private pay, and local community or faith-based resources.

CLC's Options Counseling and Assistance function provides person-centered counseling and support with decision making, including one-on-one assistance with individuals, caregivers, legal representatives and families to navigate long term services and supports in their local community.

Streamlined Eligibility Assistance for Public Programs begins with screening for eligibility. When someone appears eligible and wants to go forward with the process, CLC staff guide and assist the individual through the eligibility determination process. While the details may be complex, CLC staff endeavor to make the eligibility determination process as seamless as possible, for programs funded by Medicaid, the Older Americans Act, and other state and federal dollars.

Person-Centered Care Transitions supports movements of individuals between health care settings require some coordination. The Person-Centered Care Transitions component of the CLC

assists individuals to coordinate care needs for people transitioning from one setting of care to another.[7]

The Statewide Health Insurance Benefits Advisors (SHIBA) program is a statewide network of trained volunteers who educate and advocate for people of all ages who have Medicare. SHIBA volunteer counselors help individuals understand their rights and Medicare insurance choices. SHIBA staff and volunteers do not sell anything. As part of the Washington State Office of the Insurance Commissioner, SHIBA staff and volunteers and their services are unbiased.

The Family Caregiver Support Program (FCSP) provides a multifaceted system of support services to respond to the needs of family and other unpaid caregivers. Counseling, respite care, support groups and other supportive services are available based on assessment.

Medicaid Alternative Care (MAC) provides caregiver support services to unpaid caregivers of individuals currently eligible for Medicaid long term care, but choosing to receive caregiver support services in lieu of personal care. Counseling, respite care, support groups and other supportive services are available based on assessment for both the caregiver and care receiver.

Tailored Supports for Older Adults (TSOA) provides caregiver support services to unpaid caregivers of individuals who need assistance with personal care that are not financially eligible for Medicaid long term care. Counseling, respite care, support groups and other supportive services are available based on assessment for both caregiver and care receiver. Limited personal care is also available to individuals who do not have an unpaid caregiver.

ALTCEW continues to develop public awareness campaigns to familiarize further those living within PSA #11 with an understanding of available services and programs and to expand access for those that will benefit from these services and programs. Additionally, ALTCEW continues to collaborate with providers to ensure successful transitions from hospital to home, minimizing the possibility of re-hospitalization.

Objective A: Between January 1, 2020 and December 31, 2023, ALTCEW will continue to develop a public awareness campaign to enhance access to resources and information of the services available within the ALTCEW Service Area.

Objective B: Between January 1, 2020 and December 31, 2023, for Community Living Connections, ALTCEW will conduct quality assurance cycles that examine and improve 1) content

[7] Community Living Connections (CLC) [Internet] Available from: https://www.waclc.org/consite/connect/about_community_living_connections.php

of electronic resource directory, 2) services to provide information and referral, and 3) services to provide options counseling.

Objective C: Between January 1, 2020 and December 31, 2023, ALTCEW will continue providing benefits counseling and enrollment assistance to Medicare and Medicaid beneficiaries and assist low-income individuals with the application process for other types of cost-saving benefits.

Objective D: Between January 1, 2020 and December 31, 2023, ALTCEW will collaborate with providers for more thorough and effective hospital discharge planning to insure a successful transition to home and to minimize the possibility of re-hospitalization.

Objective E: Between January 1, 2020 and December 31, 2023, ALTCEW will assist subcontractors in promoting the Family Caregiver Support Program and the Medicaid Transformation Demonstration (MAC and TSOA) to address needs, also reducing or delaying the need for more costly services.

ISSUE AREA: Medicaid Supported Services

GOAL: Work across systems to ensure access to planned and coordinated care for older persons and individuals with disabilities.

PROFILE: Medicaid Supported Services include a variety of long-term services and supports available to eligible participants as determined by a functional and financial assessment. By direct service and through contracts, ALTCEW enables older adults and adults living with a disability to receive home and community based services, affording the option of living in the setting of their choosing.

Title XIX Case Managers authorize a variety of services that can help people to live at home, including services such as assistive technology, environmental modifications, home delivered meals, supportive housing, supported employment and transportation. Services can be offered to support a primary unpaid caregiver, such as a spouse or adult child, while other individuals may qualify for an Individual Provider who is authorized a specific number of paid caregiver hours each week.

Washington State is leading strategic changes within Medicaid, allowing the state to move forward in its pursuit of better health, better care and lower costs. The goals of this demonstration enable communities to improve health system performance at the local level through Accountable Communities of Health and to broaden the array of service options that enable additional individuals to stay at home and delay or avoid the need for more intensive care. Additionally, targeted foundational community supports (in housing and employment) can

promote stability and positive health outcomes while preventing homelessness and dependence on costly medical and behavioral health care.

Finally, Health Home Care Coordinators support eligible clients to develop a person-centered health action plan, improve self-management of chronic conditions, ensure care coordination, and care transitions. A partnership between the Washington State Health Care Authority, the Centers for Medicare and Medicaid Services and the Department of Social and Health Services, the Health Home program helps older adults and adults living with a disability reach their health goals.

Objective A: Between January 1, 2020 and December 31, 2023, ALTCEW will collaborate with Home and Community Service and Managed Care Organizations to ensure successful care transitions.

Objective B: Between January 1 2020 and December 31, 2023, ALTCEW will collaborate with local behavioral health providers to improve access to appropriate care.

Objective C: Between January 1, 2020 and December 31, 2023, ALTCEW will advocate for enhanced access to translation services to support communication, involving languages encountered less frequently.

Objective D: Between January 1, 2020 and December 31, 2023, ALTCEW will evaluate the level of mental health training needed for Title XIX Case Managers and research and plan to provide training to Case Management Staff.

Objective E: Between January 1, 2020 and December 31, 2023, ALTCEW will continue with the expansion of the Health Home Program to include dual eligible, Medicaid/Medicare and Medicaid clients to reduce care costs and promote client wellness. Additionally, ALTCEW will include increasing its ability to refer to community and social supports, as new needs arise that are beyond the traditional Medicaid or Medicare benefit packages.

Objective F: Between January 1, 2020 and December 31, 2023, through the Supportive Housing Program, ALTCEW will collaborate and promote partnership with public agencies and private sectors to assist in identifying and securing housing resources for clients in need of assistance to prepare for and transition to housing in Spokane County. ALTCEW will continue to provide services to support individuals to maintain tenancy once housing is secured.

Objective G: Between January 1, 2020 and December 31, 2023, ALTCEW will advocate with Aging and Long Term Support Administration (ALTSA) and the state legislature to increase funding for Title XIX Case Management.

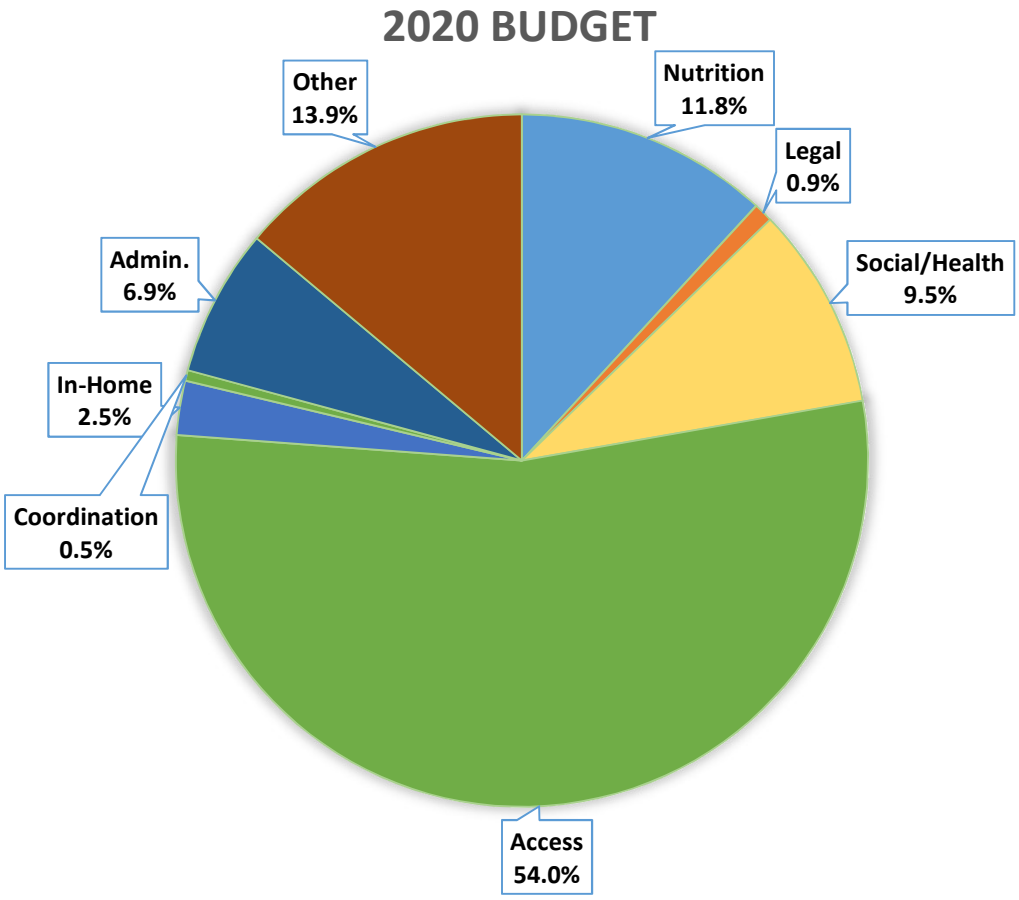
ISSUE AREA: 7.01 Planning with Native American Tribes and Tribal Organizations

GOAL: ALTCEW will consult and collaborate with representatives from the Kalispel Tribe, the Spokane Tribe, and the Native Project, in order to ensure quality and comprehensive planning and service delivery to all American Indians and Alaskan Natives in Planning and Service Area #11.

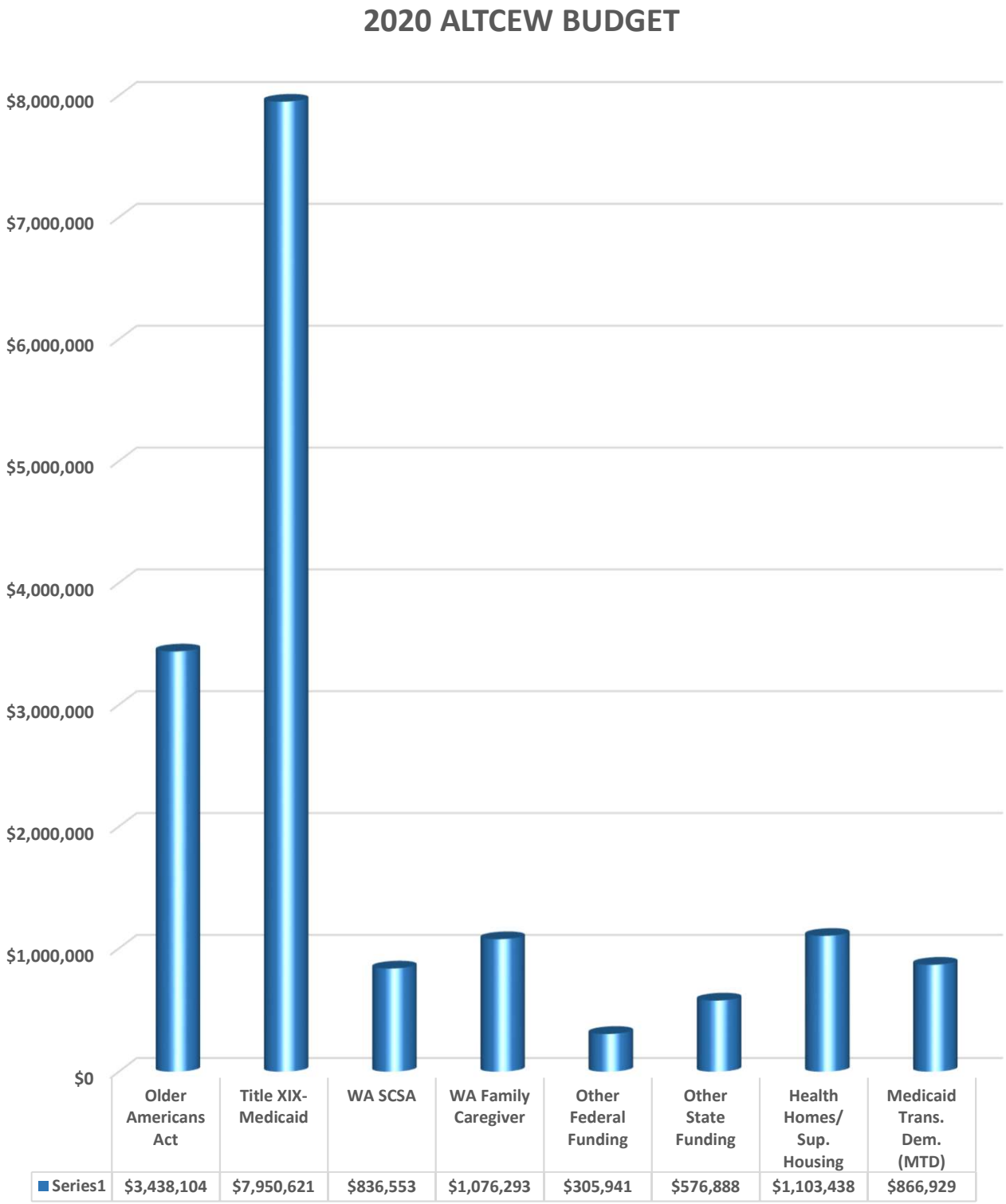
PROFILE: The purpose of Title VI of the Older American's Act is to promote the delivery of supportive services, including nutrition services to American Indians, Alaskan Natives and Native Hawaiians that are comparable to services provided under Title III.

Objective A: Between January 1, 2020 and December 31, 2023, ALTCEW will develop and implement 7.01 Plans in collaboration with local Tribes and Urban Indian Organizations. ALTCEW will meet with Tribes and Urban Indian Organizations as requested to update plans.

SECTION D - AREA PLAN BUDGET



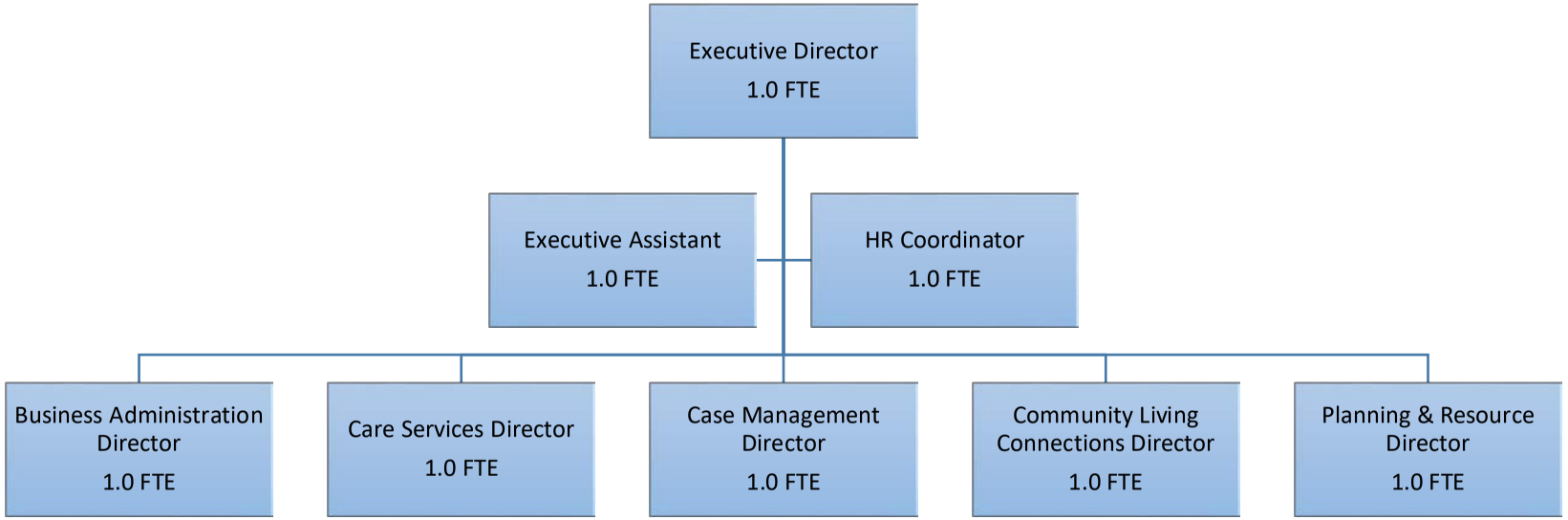
Nutrition Services	$1,912,737
Legal Assistance	$145,300
Social and Health Services	$1,532,629
Access Services	$8,715,497
In-Home Services	$409,348
Coordination	$80,000
Administration	$1,114,795
Other Activities	$2,244,461
Total 2020 Budget	$16,154,767



Total 2020 Budget $16,154,767

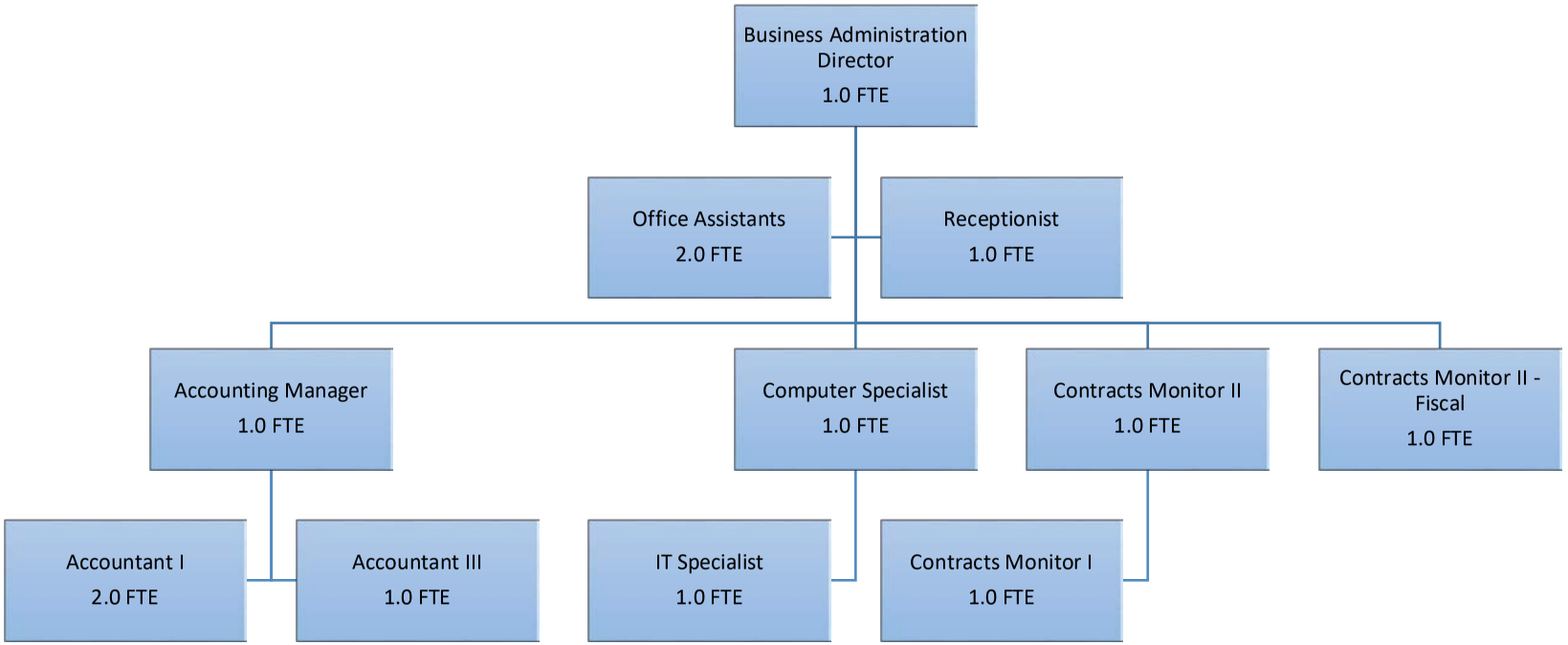
Appendix A

Aging & Long Term Care of Eastern Washington
Lead Staff Organization – July 2019



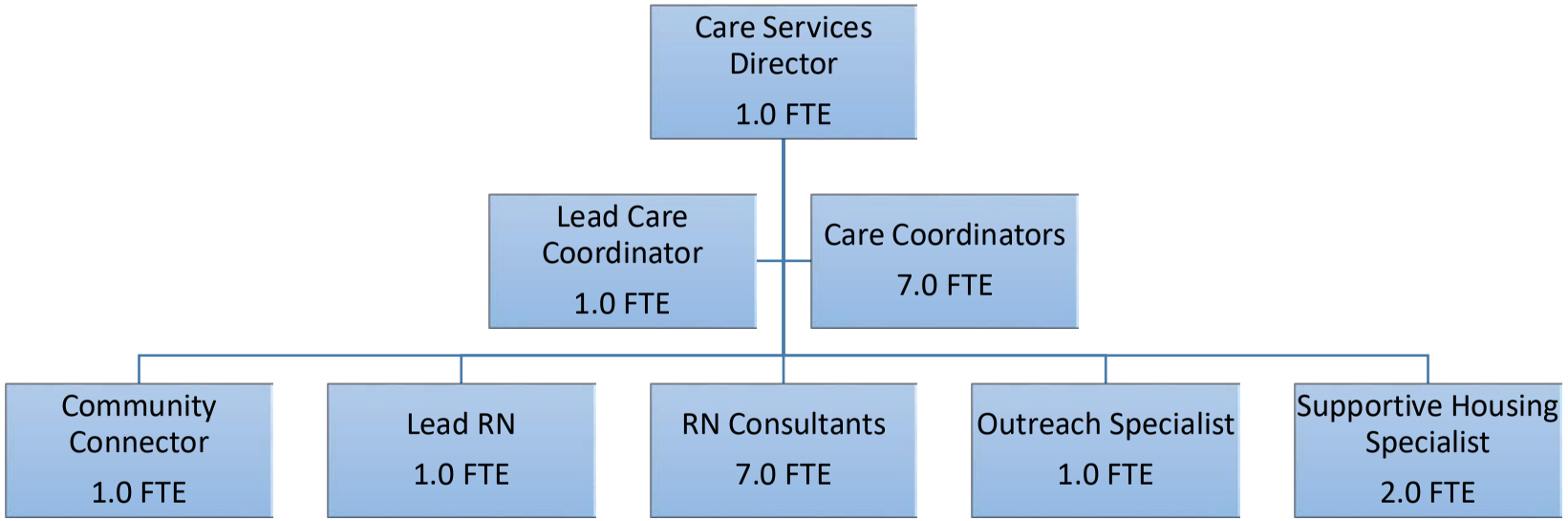
Aging & Long Term Care of Eastern Washington

Business Administration Organization – July 2019



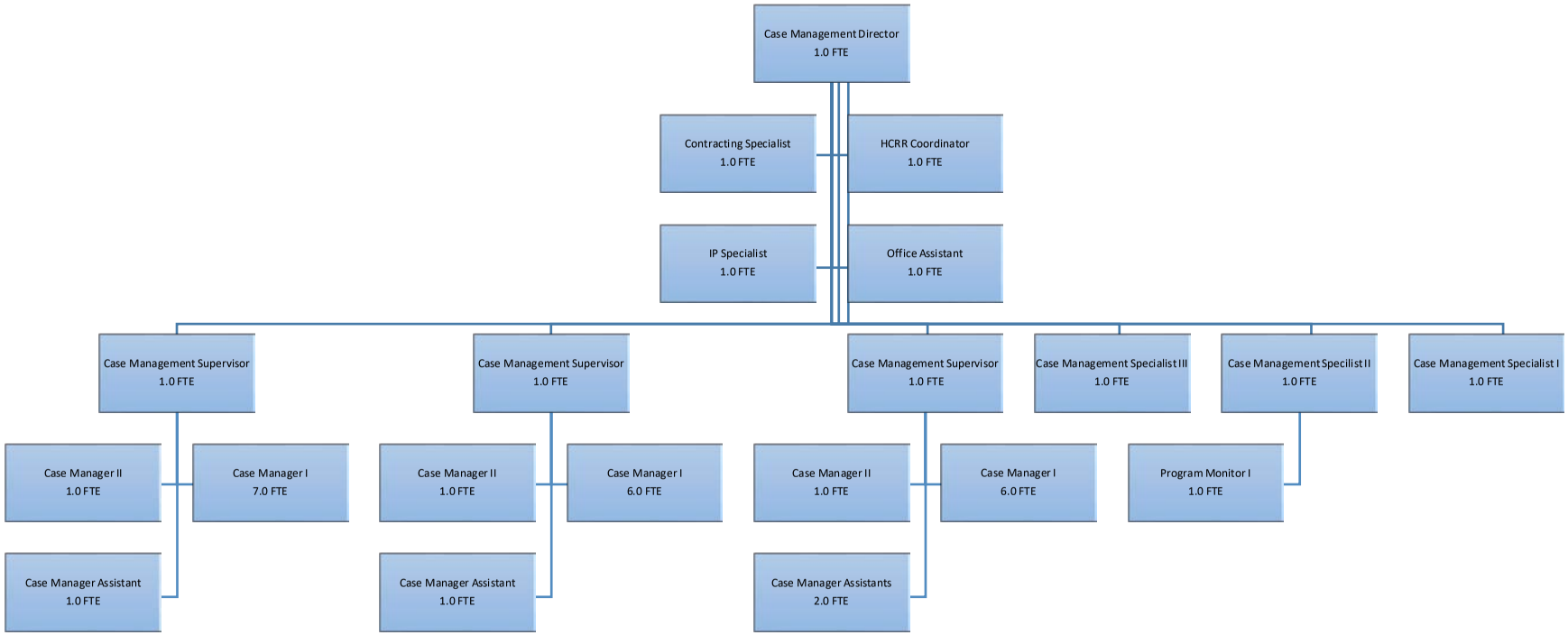
Aging & Long Term Care of Eastern Washington

Care Services Organization – July 2019



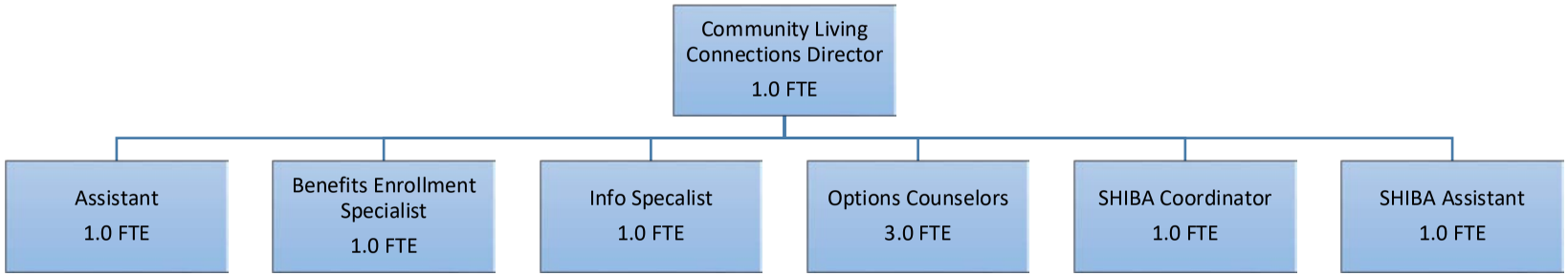
Aging & Long Term Care of Eastern Washington

Case Management Organization – July 2019

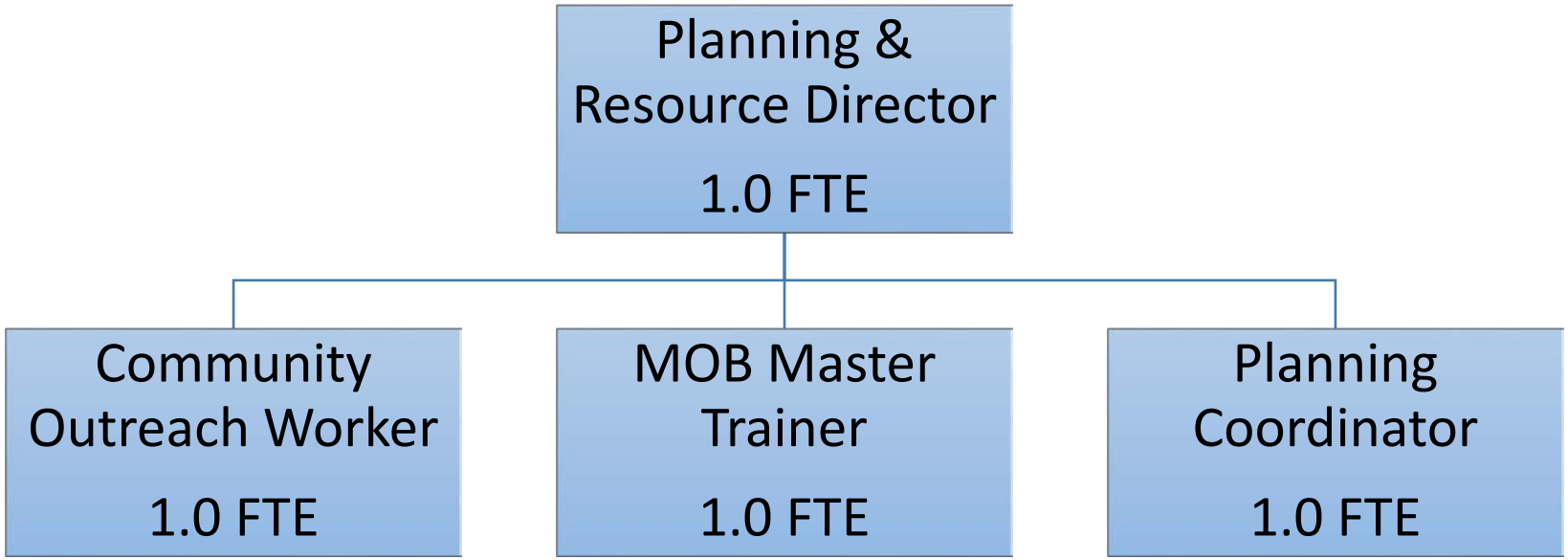


Aging & Long Term Care of Eastern Washington

Community Living Connections (CLC) Organization – July 2019



Aging & Long Term Care of Eastern Washington
Planning & Resource Organization – July 2019



APPENDIX B – STAFFING PLAN (2019)

Position Title	Name	Total Staff	Position Description
Executive Director	Kimball, Lynn	1 FTE	AAA Administration; Coordination; Staff Support to Board and Council
Executive Assistant	Scheideler, Khristina	1 FTE	Assistant to the Executive Director
Human Resource Coordinator	Chapel, Peggy	1 FTE	Provides Generalist Human Resources expertise, support and advisement to Agency management and staff
Care Services Director/RN Supervisor	Michielli, Teresa	1 FTE	Health Homes, Supportive Housing, RN Supervisor
Case Management Specialist III	Rollins, Pam	1 FTE	Program Monitoring/QA; Administrative Hearings Coordination; CARE TA; Nurse Delegation TA
Case Management Specialist II	Eppinger, Kristi	1 FTE	Supervisor/program oversight, COPES waiver vendors, Quality assurance assessment and administration, Public Disclosure officer
Program Monitor I	Wavra, Emily	1 FTE	Program Monitoring/QA, ETR Review
Program Monitor II	Leppert, Rhiannon	1 FTE	Compliance, contracting/monitoring, Medicaid Transformation Demonstration Contractor Specialist
Contract Monitor II/Acct-Metrics	Faran Soheili -Richards	1 FTE	Monitors contractor accounting and data reporting. Metrics for Agency programs
Case Management Specialist I	McFarlen, Jacki	1 FTE	In-Home Medicaid Programs, ProviderOne/IPOne state payment system
Contracting Specialist	Potapenko, Vladimir	1 FTE	IP Contracting
IP Program Assistant	Winter, Tina	1 FTE	Monitors I.P. qualification
TXIX Specialist	Katie Mesaros	1 FTE	Contract/Waiver Compliance
Case Manager Assistant	Dhital, Kamal	4 FTE	Case Manager Assistance

	Dumbrava, Svetlana Miles, Maxine Santiago, Sara		
Title XIX Case Management Director	Lichorobiec, Jennifer	1 FTE	Title XIX Case Management supervision oversight, HCRR Administration
Case Manager Supervisor	Mercer, Amy Spencer, Steve Leslie Whalen	3 FTE	Case Manager Supervisor
Case Manager II	Andrews, Ron Smith, Terresa Scott, Brenda	3 FTE	Case Management/Lead Trainer
Care Coordinator	Donally, David French, Halina Guerrero, Cassandra Hernandez, Jenna Johnson, Meagan Njoku, Nnebueze Pointer, Melena Robbins, Beverly	8 FTE	Health Homes Care Coordination
Housing Specialist	Robinson, Jeannie Putnam, Rose	2 FTE	Case management and supportive housing services
Outreach & Engagement Coordinator	Macario-Rumsey, Paloma	1 FTE	Coordinates services to patients referred.
Community Connector	Brown, Theresa	1 FTE	Patient enrollment, admin support, finds community resources

Case Manager I	Bond, Becky Boulter-Reed, Katrina Cordova, Kayla Dunlap, Wendi Fisher, LeeAnne Grandinetti, Sarah Greene, Ashley Grisso, Megan Kenoyer, Molly Koski, Teri Mauger, Justin Miller, Kylie Montgomery, Angie Moore, Brittany Prouty, Jessica Ruiz-Ferreyra, Emilia Sellers, Keith Trammell, Petra Vacant Position	19 FTE	Case Management
Home Care Referral Registry Coordinator	Riehl, Sheri	1 FTE	Recruit and screen individual providers for Referral Registry
Business Administration Director	Beck, John	1 FTE	AAA Fiscal Management; Staff Support to Board and Council; Building Maintenance; State Fiscal Taskforce; Employee Benefits; Accounts Receivable; Accounts Payable; Cash flow; Payroll; Support Staff Supervision
Accounting Manager	Gottsch, Diane	1 FTE	State Billings; Financial Statements; General Ledger

Accountant III	Pereira, Christine	1 FTE	Billing/Reconciliation Support/Payroll
Accountant I	Martin, Darlene Willey, Joanna	2 FTE	Accounts payable; agency and Provider Billing; OFR Payment Process Billing/Payroll Assistance
Receptionist	Cunningham, Marilyn	1 FTE	Front Desk Reception
Office Assistant II	Lehman, Jessica Reams-Taylor, Savannah	2 FTE	Administrative Support
CLC Director	Phillips, Lola	1 FTE	Community Living Connections program supervision.
CLC Options Counselor	Crawford, Josette Stokes, Susan Wright, Michelle	3 FTE	Assessment, counseling, referral.
CLC Assistant	Shepard, Mary	1 FTE	Information and referral
CLC Benefit Enrollment Specialist	Votaw, Karen	1 FTE	Medicaid/other Enrollment Assistance and referral
CLC Information Specialist	Peterson, Delynn	1 FTE	Referral intake assistance, screens for type of service needed
I.T. Manager	Ehr, Russ	1 FTE	MIS Services; Computer Technical Assistance
I.T. Specialist	Skinner, Joel	1 FTE	Computer Support, end-user training
Planning & Resource Director	Haberman, Mark	1 FTE	Planning; Special Studies and Data TA; Staff Support to Board and Council
MOB Master Trainer	Vacant Position	1 FTE	MOB Program Development (Grant)
Planning Coordinator	Fine, Cindy	1 FTE	Planner; Staff for Disaster Preparedness Planning; A Matter of Balance Master Trainer
Community Outreach Specialist	Vacant Position	1 FTE	Marketing and coordination of outreach for Agency services.
SHIBA Coordinator	Kudrna, Monica	1 FTE	SHIBA/MIPPA Coordinator; Agency Contact for Client/Public Complaints on Subcontracted Services

SHIBA Customer Service Specialist	Ball, Mike	1 FTE	Consumer education of Medicare/Medicaid and other insurances.
Lead RN	Sinclair, Anne	1 FTE	RN Coordination, supervision
RN Consultant	Edmunds, Dominique Garpestad, Terri Havercroft, Beth Morris, Jodi Parsons, Anne Prugh, Sheila Vacant Position	7 FTE	RN Consultation Services/Care Coordination

Total number of full-time equivalents = 88 FTE = 37.5 hours/week

Total number of staff = 88

Total number of Hispanic, Latino, or Spanish origin staff = 4

Total number of American Indian or Alaska Native staff = 1

Total number of Asian staff = 1

Total number of Northern European, Arabic, Basque staff = 1

Total number of staff over age 60 = 14

Total number of staff self-indicating a disability = 8

Disaster and Business Continuity Plan

9-2019 update

*The **mission** of Aging & Long Term Care of Eastern Washington (ALTCEW) is to promote well-being, independence, dignity, and choice for all older persons and for individuals needing long term care in Ferry, Stevens, Pend Oreille, Spokane, and Whitman counties.*

I. Purpose

The mission of ALTCEW is to promote well-being, independence, dignity, and choice for all older persons and for individuals needing long term care in Ferry, Stevens, Pend Oreille, Spokane, and Whitman counties. Language contained in the Older Americans Act, Section 306 requires Area Agencies on Aging to include information on how they will coordinate activities with other agencies and to develop long-term preparedness plans in preparation for an emergency. The State of Washington's Aging and Long Term Support Administration (ALTSA) requires all Area Agencies on Aging (AAA) to have disaster plans in place. This plan is to be used as a tool by ALTCEW to address the requirements of Older Americans Act and as well as a proactive approach to carrying out the organization's mission.

Major provisions within this plan identify the disasters that occur in our service areas, demographics, command structure, potential partner agencies, business continuity, and the major roles that ALTCEW will play in the event of a disaster. This plan is to be reviewed and updated every two years in congruence with the update of the county emergency plans or as needed.

II. Scope

This disaster plan is in reference to the services provided by ALTCEW and its subcontractors in Spokane, Ferry, Pend Oreille, Stevens and Whitman counties.

III. Limitations

This plan is limited to the staff of and clients served by ALTCEW and its subcontractors. Significant events may affect ALTCEW and its subcontractors' ability to respond, yet this plan cannot anticipate all events that may occur.

IV. Types of Disasters/Emergencies prevalent in ALTCEW's Service Area and their Probability of Affecting ALTCEW Services

Type of Disaster	Description	Probability
Flood	A flood is an inundation of dry land with water. Types of floods in Spokane City/County are primarily river, surface water, and flash.	Medium to High
Wildfire	Wild land fires are the uncontrolled destruction of forests, brush, field crops and grasslands caused by nature or humans.	Medium to High
Volcano	A volcano is a vent in the earth's crust through which molten rock, rock fragments, gases, and ashes are ejected from the earth's interior. A volcano creates a mountain when magma erupts from the earth's interior through a vent in the earth's crust and lava flows onto the earth's surface.	Low to Medium
Severe Local Storm	Severe local storms are atmospheric disturbances manifested in strong winds accompanied by rain, snow, or other precipitation, and often by thunder or lightning.	Medium to High
Earthquake	An earthquake is the shaking of the ground caused by an abrupt shift of rock along a fracture in the earth, called a fault.	Medium
Drought	Drought is a condition of climatic dryness that is severe enough to reduce soil moisture and water and snow levels below the minimum necessary for sustaining plant, animal, and economic systems.	Low to Medium
Urban Fire	Urban fire occurs primarily in cities or towns with the potential to spread rapidly to adjoining structures. These fires damage and destroy homes, schools, commercial buildings, and vehicles.	Medium
Hazardous Material	Hazardous materials are materials, which, because of their chemical, physical, or biological nature, pose a potential risk to life, health, or property when released. A release may occur by spilling, leaking, emitting toxic vapors, or any other process that enables the material to escape its container, enter the environment, and create a potential hazard. The hazard can be explosive, flammable, combustible, corrosive, reactive, poisonous or radioactive. It may consist of toxic materials or biological agents.	Low to Medium
Terrorism	Terrorism is the unlawful use of force or violence against persons or property to intimidate or coerce a government or civilian population, in furtherance of political or social objectives.	Medium
Civil Disturbance	Any incident that disrupts a community where intervention is required to maintain public safety is a civil disturbance. Examples are demonstrations, riots, strikes, public nuisance, and criminal	Low to Medium

	activities. The hazard can surface in any community and be sparked by racial, ethnic, religious, political, social, or economic reasons.	
Landslide	Landslide is the sliding movement of masses of loosened rock and soil down a hillside or slope. Landslide causes depend on rock type, precipitation, seismic shaking, land development and zoning practices, soil composition, moisture, and slope steepness.	Low

Chart from Greater Spokane Emergency Management's *Description of Types of Hazards (2015)*

If clients are in danger and are unable to get necessary assistance, ALTCEW staff will contact Greater Spokane Emergency Management Duty Officer at 509-477-4209 x0822 or CountyDEMDutyOfficer@spokanecounty.org.

V. Community Coordination/Planning

ALTCEW participates in on-going cooperative disaster response planning in the community and has taken the following steps to become recognized as an integral part of the community's emergency preparedness response network:

A. Community Organizations Active in Disasters (COAD)

COAD is an organization, based within the Eastern Washington and North Idaho areas. The COAD's purpose is to bring together organizations, agencies and businesses to promote mitigation and preparedness activities and to efficiently respond to disasters and recover therefrom. The COAD is a coordinating organization and does not assume direct operational responsibility in any disaster situation. The COAD meets the first Tuesday of each month (except July) at the Salvation Army (222 E. Indiana Avenue).

B. Greater Spokane Emergency Management Planning Committees for ESF's (Emergency Support Functions). The ESF's in Spokane City/County Emergency Plan are updated regularly.

Emergency Support Function # 6 Committee - This committee is made up of agencies such as Frontier Behavioral Health, regional hospitals, Spokane Regional Health District, churches, schools, the Red Cross, and the Salvation Army. The purpose of the committee is to support the efforts to address the non-medical mass care, emergency assistance, housing and human services needs of individuals and families impacted by disasters and emergencies in Spokane County.
https://www.spokanecounty.org/DocumentCenter/View/4749/ESF-6---Mass-Care-Housing-and-Human-Services-PDF

Emergency Support Function # 8 Committee - This committee is made up of agencies such as regional health, dental associations, mortuary services, hospitals, ambulance, fire

departments, mental health, service professionals, and volunteer groups. The purpose of this committee is to ensure that provisions have been made to coordinate the organization and mobilization of public health, medical, and mortuary services for emergencies and disasters in Spokane County.
https://www.spokanecounty.org/DocumentCenter/View/4751/ESF-8---Public-Health-Medical-and-Mortuary-Services-PDF

Emergency Support Function #14 Committee - This committee is made up of agencies such as Frontier Behavioral Health, ALTCEW, the American Red Cross, Department of Social and Health Services, the Salvation Army, Volunteer Organizations Active During Disasters (VOADs), local governments, county government and the Spokane Regional Health District. The purpose of this committee is to provide a framework to enable the community to recover from a disaster in the short and long term.

C. REDi Healthcare Coalition (Spokane Regional Health District) – Formerly Washington State Region 7, Region 8 and Region 9 Healthcare Coalitions, the Regional Emergency and Disaster (Redi) Healthcare Coalition is the healthcare coalition serving the 19 counties and 4 tribes of Eastern Washington. The REDi Healthcare Coalition's mission is to prepare for, respond to and recover from crisis using all available resources to provide patient care at the appropriate level and in the most efficient manner. In all their work, the coalition strives to build emergency preparedness across the healthcare system to create resilient communities across the region.

VI. Command/Control Structure

A. Government Command/Control Structure: In General

1. Following the response to a hazardous event, the county Emergency Coordination Center (ECC) will become activated to coordinate initial response, recovery and restoration activities. The ECC will remain activated until its coordinating functions are no longer needed. The ECC may be reactivated on a temporary basis to meet developing needs.

2. Depending on the nature of the disaster, a Disaster Recovery Team may be established by the ECC command to coordinate the county's recovery and restoration activities.

3. Both the ECC staff and the Disaster Recovery Team will support countywide activities. Coordination will be maintained with federal, state, city, and town officials, the American Red Cross, and other volunteer organizations. The Director of Emergency Management or Chair of the Disaster Recovery Team will determine the priority of the tasks.

4. During the response phase, ECC staff will document the damage throughout the county, evaluating community needs, and commence planning for recovery and restoration.

Resources and services will be arranged, as necessary, for meeting urgent community needs.

5. The resources and services of county organizations will be used to the extent practicable. Additional services or resources, or those not normally part of the county inventory, may be procured from private sources, requested through the state Emergency Management Division (EMD), or provided by the community at large.

6. Individuals, families, and the business community seeking financial or housing assistance will be referred to state, federal, or volunteer program coordinators, as applicable.

B. ALTCEW: In General

In the event of an emergency within the ALTCEW service area the Executive Director or their delegated person from the Lead Staff will make decisions. The Executive Director's role is to ensure that ALTCEW works with local emergency responders, community partners and staff to carry out the requirements within the Disaster and Business Continuity Plans.

C. Community Disaster Emergency Exercises/Events

ALTCEW will participate (when appropriate) in local community disaster preparedness exercises and events when they are provided within our service area. ALTCEW will also participate in planning and exercise events that relate to the appropriate ESF's within our service area.

VIII. Formal Agreements in Place

A. Subcontractor Contract Language:

All contracts will include the following language regarding Disaster/Emergency Planning in the General Terms and Conditions:

A. The Contractor agrees to maintain a business continuity plan and develop criteria to identify high risk clients in the community and maintain a list of these clients that can be easily accessed during an emergency or disaster. The Long Term Care Ombudsman Program and Senior Legal Assistance Program are exempt from this requirement. Case Management agencies, as part of the annual assessment and/or significant change process, will educate new clients on how to be prepared for emergencies and disasters. Case Managers will use ALTCEW's Home Emergency Preparedness Plan and FEMA handouts.

B. Memorandums of Understanding (MOU)

The purpose of the MOU is to describe how ALTCEW will coordinate activities with other governmental agencies in the event of a disaster. MOUs have been developed with appropriate emergency management organizations within PSA # 11.

IX. ALTCEW's Role During Specific Phases of Disasters/Emergencies

1. Organization

ALTCEW has developed written emergency evacuation procedures and a Business Continuity Plan. The emergency procedures designate exits, an assembly area and include provisions for ensuring everyone has left the building. Special arrangements for helping staff and visitors with a disability to exit the building is also addressed.

ALTCEW's Business Continuity Plan addresses how ALTCEW will continue its operations in the event of an emergency or loss of ALTCEW property. The Business Continuity Plan includes procedures for maintaining service delivery during and after an emergency. It also provides information regarding the roles and responsibilities of managers and staff before, during and after a disaster or emergency.

ALTCEW has developed agreements with county governments to provide support services under specific emergency support functions. ALTCEW will continue to represent older adults and people living with disabilities and participate in ongoing cooperative planning of the community's emergency preparedness and response network.

2. Staff

Staff will be educated on being prepared at an All Staff meeting or by email at least once per year. This educational overview may include information, but is not limited to, information on:

- Types of disasters possible in our service area
- ALTCEW's role during the specific phases of a disaster
- Federal, state and local response plans and resources
- How to prepare yourself and family
- When to and when not to come into work
- Continuing services to clients

3. Clients

A. Case managers will educate clients during their assessment on how to be prepared for emergencies. This will be completed using ALTCEW's Personal *Emergency Preparedness Document* and a discussion about evacuation. Case Managers will distribute preparedness information to clients during annual assessments and/or significant change assessments.

B. ALTCEW's Case Management Program has developed the following Vulnerable Adult Criteria that is used to identify the most at-risk clients on the caseload:

Vulnerable Adult Criteria

1. Individuals who live alone or without reliable support (like living with young children), and/or lack family or informal support with ONE of the following conditions:
    a. Severe Dementia
    b. Coma
    c. Stroke with Hemiplegia
    d. Quadriplegia (with skin problems)
    e. Multiple Sclerosis
    f. COPD with Emphysema
    g. Congestive Heart Failure
    h. Diabetes of Insulin dependence
    i. Inability to transfer without assistance,
    j. Condition of being bedfast/chair fast
    k. Complex medical regime
    l. Dialysis dependent
    m. Inability to propel wheelchair
    n. Need for medications to be Administered or Self Directed
    o. Possess CPS score of 4, 5, or 6 as generated by the CARE Assessment Tool.
    p. Technologically dependent

2. Technologically dependent (Respirator/ventilator, Peritoneal Dialysis Machine, IV nutritional support, Oxygen).

3. Geographically remote (meaning living more than 45 minutes from essential services).

C. The process for identifying the most vulnerable clients utilizing the Vulnerable Adult Criteria is as follows:

Case Managers review clients in CARE to identify clients with the Vulnerable Adult Criteria and provide the name to the CM Supervisor. Case Managers will keep the contact information up to date by reporting changes to the Case Management Assistant.

Case Management Assistants will update the Agency Client Management (ACM) Database. This will be recorded in a column in the ACM Database, which is titled Priority or Vulnerable. A check mark or X will be placed in this column for those meeting the criteria.

Criteria will be reviewed for each new client transfer by the Case Management Director or Case Management Supervisor and they will be flagged on the ACM database. The ACM client list will be printed monthly and distributed to designated staff keep in secure locations in case of emergency or disaster. The list will also be kept at the office with Case Management Director and Disaster Preparedness Coordinator.

4. Response

During the response phase of an emergency or disaster, ALTCEW leadership will execute the emergency plan and engage in activities to continue operations and provide service to clients. Depending on the event, activities may include:

- Communicating with the state (ALTSA) and with Emergency Coordination Center (ECC) regarding the needs of the population served by ALTCEW.

- ALTCEW's Business Continuity Plan establishes alternative worksites. If necessary ALTCEW will continue operations from an alternative site.

- ALTCEW will coordinate with its contractors and other community partners to locate and obtain assistance for clients that need immediate assistance.

- Sharing information from the Emergency Coordination Committee (ECC) with staff, contractors and website during disasters.

- Identifying high-risk clients (case managed by ALTCEW), using criteria listed under preparedness, contracting them using the following procedure and referring them to first responders as necessary.

  Procedure for contacting the most vulnerable and at-risk clients:

If clients are in danger and are unable to get necessary assistance, ALTCEW staff will contact Greater Spokane Emergency Management Duty Officer at 509-477-4209 x0822 or CountyDEMDutyOfficer@spokanecounty.org.

5. ALTCEW Internal Coordination

Disasters of varying severity can happen. As an agency, it is important to have an internal plan in place for response to smaller scale, regional disasters.

In the event of a smaller scale disaster, the Case Management Director and Disaster Preparedness Coordinator will be responsible for coordinating internal ALTCEW disaster response activities, in consultation with the ALTCEW Executive Director, as appropriate. Together, the Case Management Director and Disaster Preparedness Coordinator will be responsible for sharing information and coordination activities with case management service providers in PSA#11. The Disaster Preparedness Coordinator and Title XIX Manager will function as the liaison with Aging and Long Term Support Administration (ALTSA) and other partner organizations.

LEVEL 1 (Ready): Conditions are severe. Prepare to leave your current location.

LEVEL 2 (Set): Be prepared to leave at a moment's notice. Dangerous conditions threaten your residence or business. Hazards severely limit emergency services protection. If you or anyone at your location has special needs, pets or livestock, you should leave at this time.

LEVEL 3 (Go): Leave immediately. This may be your only notice. Current conditions present an immediate threat to your life and safety, and emergency services may not be able to assist you. You will not be allowed to return until conditions are safe.

In the event that the Case Management Director is not available, the Care Services Director will cover. If the Disaster Preparedness Coordinator is not available, the Planning and Resource Director will cover designated responsibilities.

A. Evacuations

Department of Natural Resources (DNR) evacuation level definitions

Based on the Department of Natural Resources (DNR) declaration, information will be disseminated to vulnerable clients accordingly. Prioritization of contact will occur based on the geographic areas most significantly impacted.

Response to Activation of DNR Evacuations

If a Level 1 evacuation is issued, vulnerable clients in the affected geographic area will be notified. During the contact, Case Managers (CM) will:

- Advise client to Shelter in Place-ensure that client is aware of the current disaster, and has a plan get them through anticipated duration of event.
- Let them know that they can get up to date information through the local media (list specific site if available).

If a Level 2 evacuation is issued, vulnerable clients in the affected geographic area will be notified. During the contact, CMs will:

- Advise client to Shelter in Place with preparation to leave if needed- ensure that client is aware of the current disaster, and has a plan get them through anticipated duration of event.
- Let them know that they can get up to date information through the local media (list specific site if available).

If a Level 3 evacuation is issued, vulnerable clients in the affected geographic area will be notified. During the contact, CMs will:

- Direct the client to evacuate their residence.
- Advise of location of area shelter.
- Advise Case Management Director if client is unable or unwilling to evacuate.
- Case Management Director will contact Greater Spokane Emergency Management Duty officer.

Response to Large Scale Power Outages

In the event of an ongoing, large-scale power outage, ALTCEW CMI's will target technology dependent clients on the vulnerable clients list. A good faith effort of contact will be made, either telephonically or in person, within 24 business hours of the power outage. During the contact, CMI's will:

- Ensure that the client has a plan to get them through anticipated date of power restoration. If available, advise of anticipated date and time service will be restore, as determined by utilities providers (i.e. Avista, Inland Power).
- If applicable, advise of local shelter resources (i.e. Riverside High School, nurse on site to assist as needed).
- Let them know that they can get up to date information through the local media (list specific site if available).

Emergencies outside of business hours

In the event that a disaster occurs when the ALTCEW office is closed, the ALTCEW Executive Director will delegate when to activate the ALTCEW disaster response and business continuity plan. If the Executive Director is not available, the Lead Staff in charge will be the Responsible Staff.

After activating the ALTCEW disaster plan, the Responsible Staff will work with the Case Management Director and Case Management Supervisors to contact clients.

- Case Management Supervisors and Health Homes Supervisors will divide the list of vulnerable clients and contact them, from home or the office. They will work with the ALTCEW Director to direct clients to the appropriate Emergency Services in the community as needed.

- ALTCEW will communicate with staff, media, volunteers and clients to assist with the dissemination of information.

6. Recovery

During the recovery phase of a disaster or emergency, ALTCEW will provide services as possible to assist clients in re-establishing their lives. ALTCEW will engage in long-range planning and coordination activities. ALTCEW will meet with other community organizations to establish needs and resources. Information will be communicated to Aging and Long Term Support Administration (ALTSA) regarding problems and need in the community. ALTCEW will obtain additional resources from ALTSA if needed and possible.

ALTCEW and its contractors will coordinate the delivery of services to clients in the community.

7. Evaluation Component/Debriefing

Following a disaster or emergency, ALTCEW's Lead Staff will meet and review the incident and details of the response. They will make recommendations for improvement to the plan and/or procedures based on lessons learned.

8. Emergency Expenditures

Emergency expenditures are available under the Older Americans Act, Title III, Sec. 310. The Older Americans Act helps assure that AAA's will be reimbursed for extra services they may provide

during a disaster. In the event of a disaster, steps will need to be taken for ALTCEW to receive reimbursement under this Act.

1. Determination of a need and the development of a plan of response to the need shall be developed. This may include the number of persons affected, aging facilities damaged, and the characteristics of the disaster impact. This is then to be submitted to ALTSA, who will then contact the regional office(s) and other state agencies.

2. A skeleton plan will need to be developed with an estimate of the fiscal resources that will be needed to implement the plan. ALTCEW will share this with ALTSA, the state and federal emergency management agencies, and is forwarded to the regional office(s).

3. As ALTCEW is responding to an emergency, staff will be responsible for maintaining diaries of expenditures and the amount of time they have spent working on the disaster. These receipts and documentation will need to be kept on file for reimbursement later.

   Currently ALTCEW has a Line Item in its budget for emergency expenditures. This allows for expenses and reimbursements to occur without a public hearing.

XI. Business Continuity Plan

This plan is an acknowledgement that disasters can happen at any time. Having a plan in place to ensure agency operation during a crisis ensures that ALTCEW will continue to be able to provide quality client care and operations essential to ALTCEW's mission. This plan addresses internal ALTCEW operations and Direct Services. ALTCEW's subcontractors are contractually responsible for developing their own internal business continuity plan and disaster preparedness plan.

A. Decision Making

Responsible Staff
Decision making during a large-scale emergency will be done by the Executive Director. If the Executive Director is not available, the Lead Staff in charge will be responsible for decision-making and signing documents. Hereafter, the person responsible for decision making during a disaster will be referred to as Responsible Staff. See E – Communication for procedure to determine the Responsible Staff. The Responsible Staff will coordinate with emergency responders and disaster response agencies, as well as coordinate intra-agency and inter-agency disaster response. This includes determining if ALTCEW's subcontracted service providers are able to function after the disaster.

Disaster Preparedness Coordinator
The Responsible Staff will receive technical support during and after a disaster from the Disaster Preparedness Coordinator.

Supervision
Supervision will follow the normal chain of command unless choosing an alternate supervisor within the department will allow for a smoother transition of services during a crisis. Supervisors will work closely with the Responsible Staff to coordinate services and carry out the emergency response plan.

Planning and Management Council
In the case of an emergency the Planning and Management Council (PMC) will be temporarily suspended until conditions improve to the extent that a meeting can be facilitated. ALTCEW values the PMC volunteers and ensuring their safety is important. As soon as feasible after a disaster a conference call with the PMC Executive Committee will be facilitated to brief members on agency operations and disaster response.

Governing Board
Governing board meetings, if scheduled during or after a disaster, will attempt to be facilitated by conference call. This will be to ensure the safety of our governing board members. As soon as feasible after a disaster a conference call with the Governing Board will be facilitated to brief members on agency operations and disaster response.

B. Personnel

Internal management of personnel functions is critical to recovering from a disaster in a timely and organized manner. ALTCEW is a complex organization made up of diverse departments. The criticality, roles, and responsibilities of each department will vary depending on the type, length, and severity of the disaster. The Responsible Staff will make the determination of which departments will continue to operate in what capacity. Supervisors will follow the direction of the Responsible Staff.

ALTCEW acknowledges that not all staff may be available in the case of an emergency or area-wide disaster. Taking care of family and property is usually our first priority, but client care cannot fall by the wayside. Staff will work with their supervisors and the Responsible Staff to ensure that there is enough staffing to cover workload during a crisis. As Staff, we are here to support each other as well as our clients during a disaster.

During a disaster, several ALTCEW direct services can be suspended temporarily. In certain cases, the responsibilities for these direct services programs can be transferred to Aging and Long Term Support Administration (ALTSA) or another agency in our service network. Below is a list of ALTCEW direct services programs and guidelines for disaster response.

Case Management

Case Managers will follow the Case Management Client Contact Plan in the event of a disaster, as appropriate. The Case Management Director will work with the Responsible Staff and case managers to determine appropriate staffing levels to ensure quality client care.

Nursing Consultants

During a disaster, non-urgent nursing services may be temporarily suspended or nursing staff reduced under the direction of the Responsible Staff. The Care Services Director and Lead RN will follow the direction of the Responsible Staff and work closely with the Case Management Director to coordinate client services.

Accounting

The accounting department will be responsible for tracking expenditures during a disaster. Disaster expenses should be accounted for in detail to allow for the application for disaster-relief funding from multiple sources. This department will work with the Planning & Resource Director to apply for disaster relief funding. The accounting department will also ensure the continuity of payroll, accounts receivable, and accounts payable. Accounting staff will work closely with the MIS department before, during, and after a disaster to ensure that the proper software and files are available.

Information Technology (IT)

During and after a disaster, IT plays an important role in recovery since so many mission-critical functions are technology dependent. The IT department will be responsible for server maintenance and backup procedures, restoring the server, establishing necessary technology at an alternate site, and procuring needed technology after the significant loss of technology during a disaster. The IT department will work closely with the Responsible Staff to ensure that the appropriate systems are in place to ensure agency operations can continue. If no IT staff is available, ALTCEW will seek support from Washington Technology Solutions (WaTech), Aging and Long Term Support Administration (ALTSA), or the local Home and Community Services (HCS) office.

Contract Monitoring/Quality Assurance

Ongoing monitoring duties can be suspended temporarily during a disaster. In the case of an area-wide disaster, the Business Administration Director and Contract Monitors will pay special attention to the disaster response and management of Senior Nutrition and Personal Care Services contractors and supply technical assistance as needed.

Case Management Administration

Case Management Administration staff will support the case management subcontractors as needed during the disaster. All monitoring and quality assurance staff should remain aware of the higher potential for Medicaid/Medicare fraud and financial exploitation of seniors and individuals with disabilities during and after an area-wide disaster. As information becomes available about local scams and fraudulent practices targeting seniors, information and educational materials will be shared with case management and nursing staff.

Community Living Connections (CLC)
CLC services can be suspended in the event of an emergency. CLC may be temporarily relocated in order to assist customers if their primary workspace is not accessible due to disaster.

Health Home/Supportive Housing
The Health Home and Supportive Housing programs can be suspended in the event of an emergency. All closures will be coordinated with lead agencies.

Home Care Referral Registry (HCRR)
The HCRR can be temporarily suspended during an emergency. If needed, functions can be transferred to Aging and Long Term Support Administration (ALSTA). The HCRR and Carina tools are available online, allowing for an easy transition of services to an alternate agency.

State Health Insurance Benefits Advisory (SHIBA)
SHIBA can be suspended in the event of an emergency. If necessary, functions can be temporarily transferred to other SHIBA providers or the Office of Insurance Commissioner (OIC).

Planning & Resource Department
Staff functions can be temporarily suspended, except as needed to ensure adequate supervision of staff and application for aid during a disaster.

Support Staff
Support staff functions can be temporarily suspended. Calls to the main office can be rerouted to another partner in the case of a temporary office closure. If an alternate location is secured, ALTCEW will coordinate with the partner involved to determine if support staff is necessary to assist with workflow control.

C. Technology

Though many mission-critical applications are available from Washington Technology Solutions (WaTech) wide area network (WAN) and WaTech and DSHS Servers, many functions rely on the integrity of the ALTCEW servers. When backing up the ALTCEW servers, IT will create daily backups of critical data using a method that will provide at least three copies. Backups shall be encrypted and stored off site in a secure location at the Rock Pointe Office located at 316 W. Boone Avenue, Suite 258. Monthly a full backup will be transferred to another secure off-site location. Having a second off-site location will ensure that in the case of a total loss of both facilities, back-up of the server will still be available. Backups shall include user access control information as required to maintain data security and prevent unauthorized access when data is restored.

IT staff will be responsible for the **relocation of reusable IT equipment** as well as the coordination, purchasing, and setting up of technology if operations move to an alternate location (see D – Facilities).

IT staff will be responsible for providing technical assistance in case the Virtual Private Network (VPN) must be used to facilitate telecommuting for essential staff with personal broadband access and VPN accounts. Essential staff with VPN accounts will test their accounts at least once per month to ensure familiarity with using the VPN in case of a disaster.

D. Facilities

In the event of a disaster, one or more facilities may be entirely lost or temporarily vacated. Following are alternative locations for ALTCEW operations:

Alternative for ALTCEW Main Office: Rock Pointe, 1330 North Washington
Alternative for Rock Pointe: ALTCEW Main Office, 1222 N Post

If alternate facilities are impractical due to the disaster situation, the Responsible Staff will determine if essential staff with personal broadband access should telecommute using the Virtual Private Network (VPN). ALTCEW staff will work with Aging and Long Term Support Administration (ALTSA) and community partners to find an alternative location for operations if needed.

E. Communication

In the case of a temporary office closure, the agency's outgoing voicemail message will include information about other helpful resources. In the case critical personnel are moved to alternate facility, all calls will be rerouted to the alternate site.

If phone lines are lost temporarily due to a disaster, essential calls will be made using ALTCEW cell phones and personal cell phones. The accounting department with work with the Responsible Staff to determine guidelines for reimbursing staff if personal cell phones must be used in a disaster situation.

A "phone tree" will be used to contact staff during temporary office closures or after an area-wide disaster occurs. A phone list of all staff is maintained by the HR Coordinator and Executive Assistant, and is accessible by supervisors to use in the case of an emergency. Upon the occurrence of a disaster situation, lead staff will contact one another and determine who is available to be the Responsible Staff. Once the next course of action is determined, lead staff will contact all supervisors and direct reports. Supervisors will contact their staff . If a staff person is unable to be reached, the Responsible Staff will be notified, and a good faith effort to contact them will be made until all staff is accounted for. If a supervisor or lead staff member is

unavailable or does not respond, the Responsible Staff will contact all of their direct reports to ensure all staff receive instructions.

If phone lines and cell phone towers are down in the case of an area-wide disaster, a good faith effort will be made by lead staff to ensure that the names of clients at risk will be turned over to emergency management personnel.

F. Transportation

Transportation can be challenging in Spokane and surrounding areas during the winter, or during summer storms. Staff will use discretion when transporting themselves to a client's home or to the office during inclement weather. Services may be temporarily suspended in the case of a short-term weather crisis due to heavy snow, icy roads, wind storms, or ice storms. This determination shall be made by the Responsible Staff. The Responsible Staff will notify supervisors of office closure or travel advisories. Supervisors are responsible for notifying their staff of office closure during poor weather.

In the case of prolonged inclement weather, staff will work together to ensure all critical staff are able to get to and from the office or alternate site. Carpooling is encouraged and may be coordinated by supervisors during extended weather occurrences.

If transportation is not safe or viable, the Responsible Staff will determine if telecommuting via VPN access will be used for essential staff.

G. Other

ALTCEW will continue to use multiple suppliers for office and technology materials to ensure that in the case of a disaster there will be a way to secure essential supplies. Vendor account numbers and the names of staff on the accounts will be backed up and stored in a secure off-site location for emergencies.

APPENDIX D Advisory Council and Governing Board

2019 Governing Board Membership

Ken Smith
Planning and Management Council Chair

Mike Blankenship
Ferry County Commissioner

Don Dashiell
Stevens County Commissioner

Mike Fagan, Vice Chair
Spokane City Council

Josh Kerns
Spokane County Commissioner

Karen Skoog
Pend Oreille Commissioner

Rod Higgins
Spokane Valley City Council

Arthur D. Swannack, Chair
Whitman County Commissioner

Michael J. Piccolo
Governing Board Legal Counsel

Kelly Keenan
City of Spokane Appointee

Advisory Council

Planning and Management Council
2019 Membership

Spokane County Residents
Jan Abrams
Aruna Bhuta
Sandra Boudreaux
Allan Cory
Carol Delaney
Justin Eisenstadt
Margaret Ennis
Martha Haynes
Mary Giannini
Carol Irion
Connie Jay
Marty Johnston
Jean Kindem
Ana Matthews
Arlene Nowak
Mary Wilkinson-Orvik
Beverly Parker
Cy Parker
Arlene Patton
Maria Hernandez-Peck
Marie Raschko
Bob Scarfo
Marian Sheafor

Ferry County Residents
Ron Bacon

Pend Oreille County Residents
Beryl Pielli
Ken Smith

Stevens County Residents
Hal Balzert
Fran Bessermin
Barry Lamont

Planning and Management Council Membership[1]
Total number of members age 60 and over: 30
Total number of members self-identifying minority status: 3
Total number of members self-identifying a disability: 3
Total number of members who are elected officials: 1

[1] Additional information regarding ethnicity of the Advisory Council is not available at this time. It will be collected in connection with future surveys.

Appendix E – Public Process

Appendix E includes the following documentation describing planning activities undergirding the development of this area plan.

- Focus Group Locations
- Focus Group Questions
- Community Survey
- Community Survey Results
- Community Planning Meetings Advertisement
- Community Planning Meeting Flyer
- Public Hearing Meeting Notice
- Public Hearing Meeting Flyer

Information included below illustrates the numbers of community members that participated in the Public Process.

- Focus Group Participants (Seventeen Focus Groups) – 176 persons
- Community Survey Respondents – 182 persons
- Community Planning Meetings Participants (Five Community Planning Meetings) – 87 persons
- Public Hearings Participants (Three Public Hearings) – 32 persons

Aging & Long Term Care of Eastern Washington
Area Plan 2020 – 2023
Focus Groups

Spokane County

Target Group or Constituency	Host Organization	Date
Individuals and Care Partners Impacted by Early Stage Dementia	Alzheimer's Association	January 18, 2019
Russian Speaking Refugee Elders	Pilgrim Slavic Baptist Church	February 4, 2019
Racially and Ethnically Diverse Older Adults	Martin Luther King Center	February 7, 2019
LGBTQ+ Community	Spokane Unitarian Universalist Church	February 11, 2019
Targeted Zip Codes (with high percentages of older adults) – Southside	Southside Senior & Community Center	February 19, 2019
Adults with Disabilities	Access4All (at St. Luke's)	February 20, 2019
Adults with Disabilities	Access4All (at St. Lukes)	March 1, 2019
Interfaith Community	ALTCEW (Spokane Interfaith Council)	March 4, 2019
Dementia Focus Group – affected persons and care partners	ALTCEW	March 5, 2019
Long Term Care Ombudsmen	SNAP	March 6, 2019
Care Partners and Others (Professionals) - Mid to Later Stage Dementia	ALTCEW	March 11, 2019
Homebound Adults with Disabilities	ALTCEW – Case Managers	March 14, 2019

Tri-County Region and Whitman Counties

County	Host Organization	Date
Whitman County	Pullman Senior Center	February 4, 2019
Stevens County	Columbia Apts Meal Site - Hunters	February 25, 2019
Ferry County	Ferry County Memorial Hospital	March 21, 2019
Pend Oreille County	Camas Center (with Kalispel Tribe)	March 27, 2019

Tribal Organizations

Tribe	Host Organization	Date
Spokane Tribe	Senior Center at Wellpinit	March 11, 2019
Kalispel Tribe	Camas Center (w/ Pend Oreille County)	March 27, 2019

Aging & Long Term Care of Eastern Washington
Area Plan 2020 – 2023

Focus Group Questions

Top Ranked Areas from the Washington State Plan

Affordable Housing, Accessible Housing

1. What kind of affordable housing is needed in our community for older adults and disabled adults?
2. What do you see happening to housing that is currently affordable?
3. Who would be parties to work with to solve affordable housing challenges (how do we "move the needle on this")?
4. Thinking of existing housing programs, how can we support them and help them operate more efficiently and effectively?

Information and Assistance (ADRC functions)

A starter question could be: "If you noticed a family member or neighbor having a hard time keeping up with daily activities, where would you turn for helpful information?"

Then move to:

1. What suggestions do you have that would improve your search for information?
2. What is your opinion of any (printed) resource guides you have used?
3. When situations get complicated, how could a knowledgeable person be engaged to help the situation? (This question would get at the service of options counseling).

In-Home Care Services

Begin with the primary question (for clients receiving In-Home Care Services: "What is your top issue or need with regard to your In-Home Care Services?" In their focus group, Case Managers could be given a number of small Post It notes on which to write responses. The conversation could expand from there.

Additional questions can encourage focus group participants to describe non-skilled (non-medical) services where individual supports are needed (eating, dressing and help with errands are examples).

Help returning from hospital with support of remaining at home

1. What challenges have you faced when returning to your home upon discharge from the hospital?
2. What specific kinds of help have you needed when returning to your home upon discharge from the hospital?
3. What additional tasks have any disabilities added to your transition to home upon discharge from the hospital?

Family Caregiver Support Program

Depending on context, begin with a general question: "Who is a caregiver?" Immediate family members (spouse or partner, sibling, child), friends and neighbors may see themselves as a loving part of a person's circle. As those supports are offered, that individual is fulfilling a caregiving role.

1. What are your greatest challenges as a caregiver?

2. Has your quality of life changed since becoming an informal family caregiver?
3. How have your other family relationships been impacted by your current caregiving relationship (i.e. stress on marriage due to taking care of in laws)?
4. If enrolled in the Family Caregiver Support Program (FCSP), what has been the most helpful services(s) provided to you/your family through the FCSP program?

Transportation

1. For what types of activities or errands do you need to get around in your community?
2. How do you get around in your community?
3. How do you get around when your usual transportation is not available?
4. What is your most significant unmet need for transportation in your community?

Dementia Supports and Services

Individuals with dementia and their families attending the Spokane County Dementia Friendly Community Forum held at the Providence Auditorium in October 2018 shared the following needs, in priority order.

- A local memory, brain and wellness center for Spokane
- Create an educational program to ease stigma
- Affordable caring communities for those not able to stay at home
- Programs that address the needs of people with dementia under the age of 65 who are still physically healthy
- Strategies for families to support their family member patient

Additional questions may be:

1. "We have heard that "a local memory, brain and wellness center" is a priority within a dementia friendly community. Can you describe the services you could anticipate to receive from such a center and how those would benefit you?
2. We have heard that "affordable caring communities for those not able to stay at home" is a priority within a dementia friendly community. Can you describe the features of such a community that would be important to you?
3. We have heard that "programs that address the needs of people with dementia under the age of 65 who are still physically healthy" is a priority within a dementia friendly community. Can you describe some of the specific needs of these persons?
4. We have heard that "strategies for families to support their family member patient" is a priority within a dementia friendly community. Can you describe some of the types of support that are particularly important?"
5. What have we missed?

Other

What other gaps do you see in the community?
What other support services do you deem a priority?

Aging & Long Term Care of Eastern Washington
Area Plan 2020 – 2023

Community Survey

A Community Survey was distributed electronically to ALTCEW staff, Governing Board and Planning and Management Council members and ALTCEW volunteers. Additionally, the survey was distributed to community partners and other interested parties. A rack card was created and distributed widely and contained a simple URL that would lead interested persons to the survey.

One hundred eighty-two people responded.

The survey contents are shown below.

Aging & Long Term Care of Eastern Washington
Area Plan Survey

Every four years Aging & Long Term Care of Eastern Washington seeks community feedback to help determine how it will prioritize a portion of the federal and state funding it receives. Your feedback will help Aging & Long Term Care to more fully understand community need and how it can better serve people in your area. Your feedback is anonymous.

To learn more about Aging and Long Term Care,
visit our website at www.altcew.org

Age (please check one):

18 – 59 years ___ 60 – 74 years ___ 75 – 84 years ___ 85 years and older ___

Are you answering on behalf of an organization? Yes ___ No ___

If yes, please list organization: _____

County of Residence (please select one):

Ferry County _____ Pend Oreille County _____ Stevens County _____

Whitman County _____ Spokane County_____ Other (please list): _____

1. **Think about the question, "Can you get the help you need when you need it?"**

   Please check the three support services you think are the most important for:

   - Adults (18 and older) living with disabilities in your community
   - People 60 years of age and older living in your community

Help Most Needed	**Adults (18 and older) living with a disability** (Please choose three)	**People 60 years of age and older** (Please choose three)
Affordable Food and Healthy Meals		
Affordable Health Care		
Affordable Housing and Utilities		
Connecting to Community Resources		
Transportation		
Dementia Supports and Services		
Counseling and Emotional Support		

Other _____ _____		

2. **Are there needs of individuals, 60 years of age and older, within your community that are not being addressed?**

   Yes _____ No _____

   If yes, please explain below.

3. **Are you or others you know receiving the proper support to stay at home in these situations?**

   - **After hospital discharge (to prevent being admitted again)**

     Yes_____ No_____ N/A _____

   - **Living at home with one or more chronic health conditions**

     Yes_____ No_____ N/A _____

Once completed, please return to: **Aging & Long Term Care of Eastern Washington**
1222 North Post Street
Spokane, WA 99201

Or

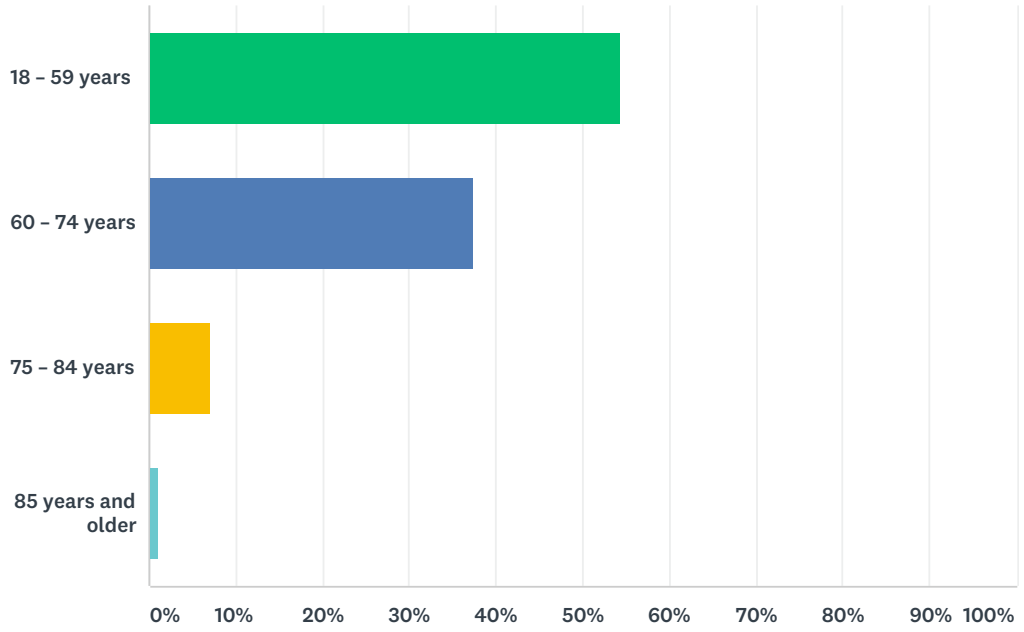
action@altcew.org

Please return by March 31, 2019

Thank you!

Q1 Age (please select one):

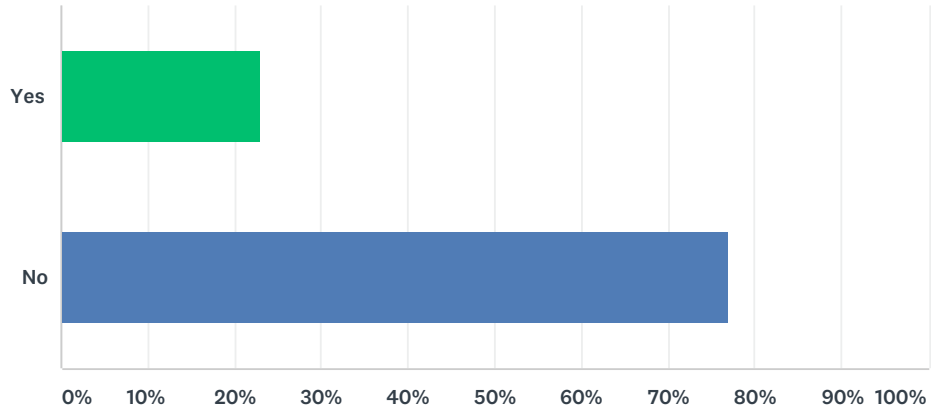
Answered: 182 Skipped: 0



ANSWER CHOICES	RESPONSES	
18 – 59 years	54.40%	99
60 – 74 years	37.36%	68
75 – 84 years	7.14%	13
85 years and older	1.10%	2
TOTAL		182

Q2 Are you answering on behalf of an organization?

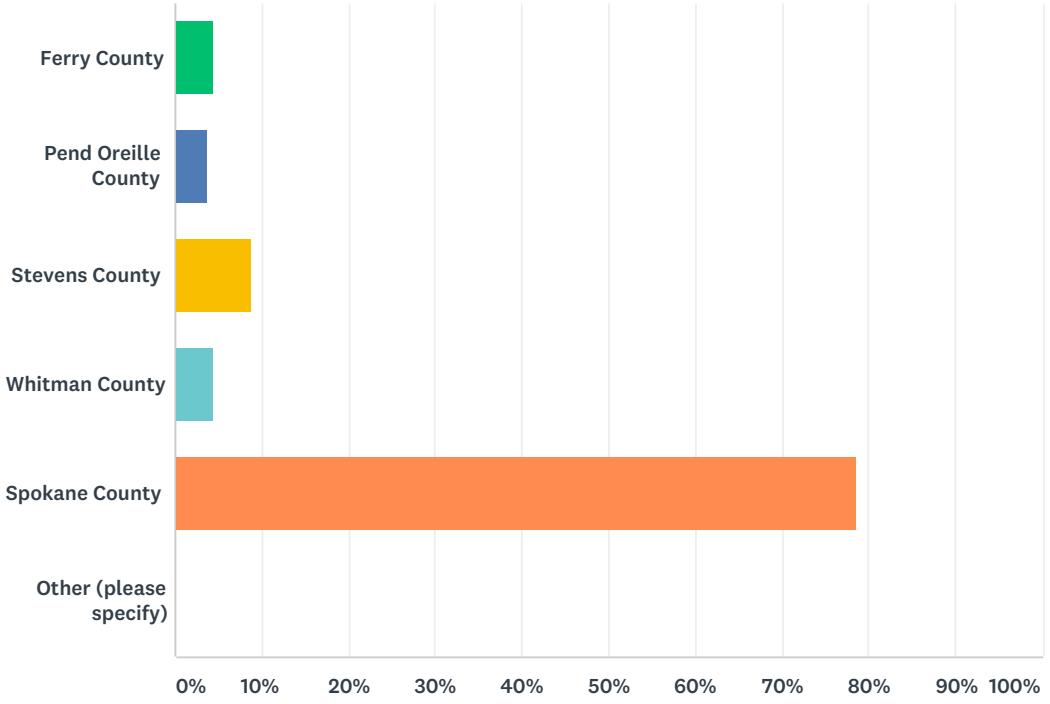
Answered: 182 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	23.08%	42
No	76.92%	140
TOTAL		182

Q3 County of Residence (please select one):

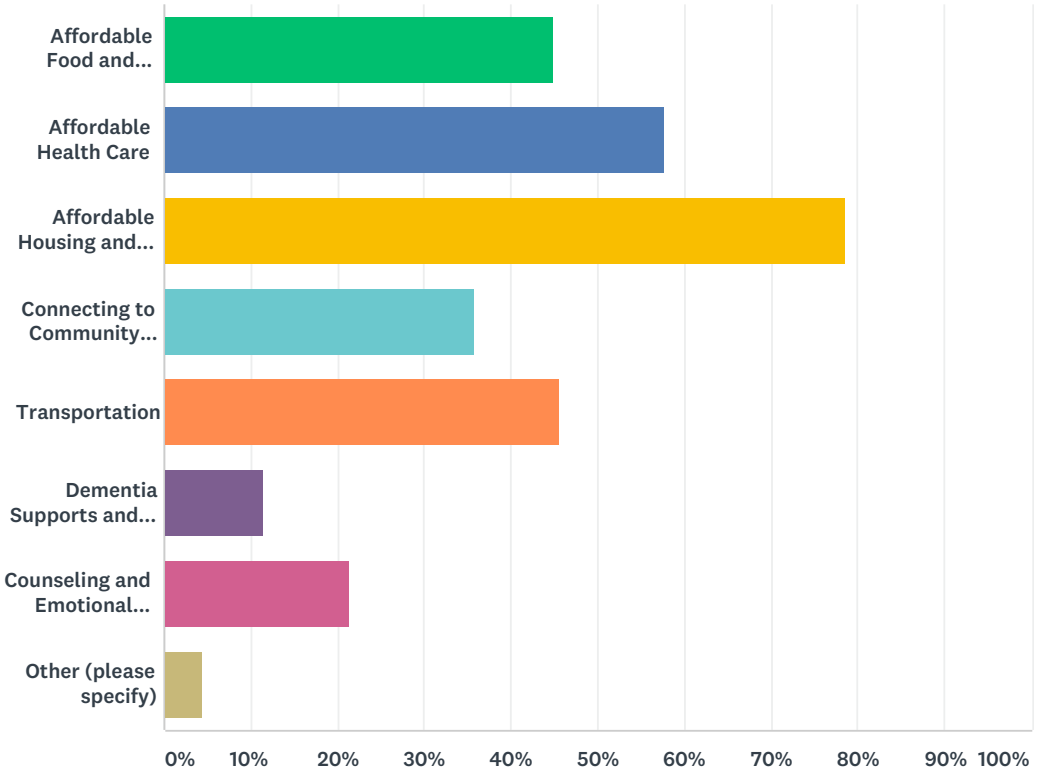
Answered: 182 Skipped: 0



ANSWER CHOICES	RESPONSES	
Ferry County	4.40%	8
Pend Oreille County	3.85%	7
Stevens County	8.79%	16
Whitman County	4.40%	8
Spokane County	78.57%	143
Other (please specify)	0.00%	0
TOTAL		182

Q4 Think about the question, “Can you get the help you need when you need it?” Please check the three support services you think are the most important for adults (18 and older) living with disabilities in your community. Select 3 from the list below.

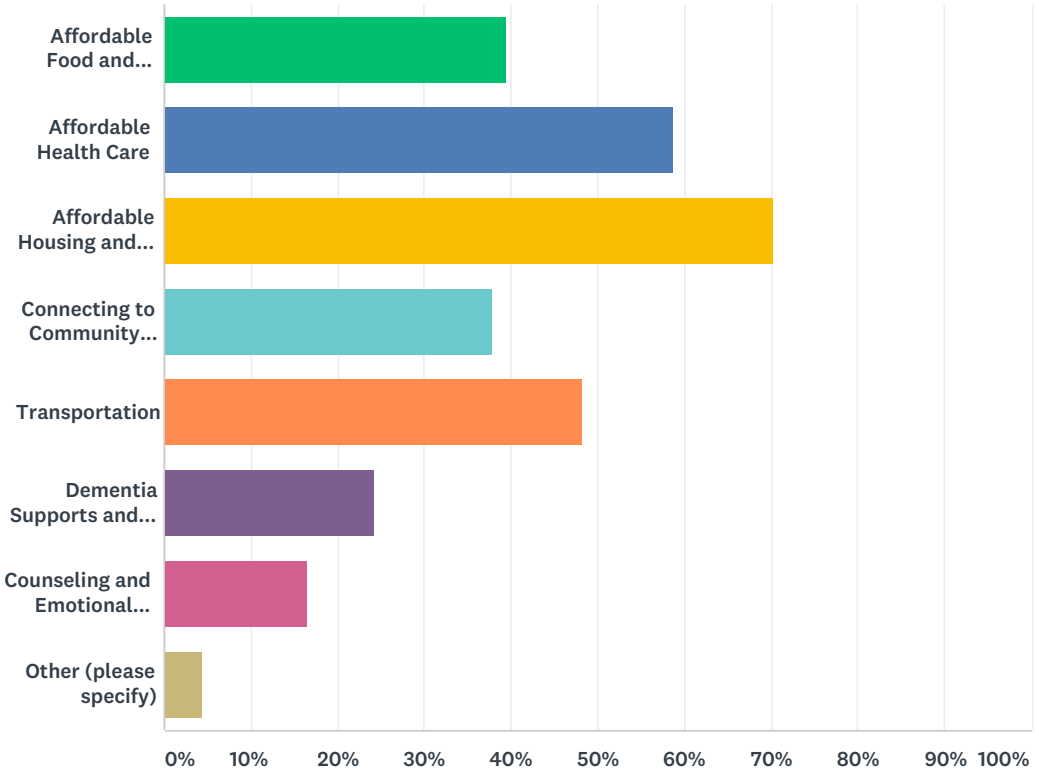
Answered: 182 Skipped: 0



ANSWER CHOICES	RESPONSES	
Affordable Food and Healthy Meals	45.05%	82
Affordable Health Care	57.69%	105
Affordable Housing and Utilities	78.57%	143
Connecting to Community Resources	35.71%	65
Transportation	45.60%	83
Dementia Supports and Services	11.54%	21
Counseling and Emotional Support	21.43%	39
Other (please specify)	4.40%	8
Total Respondents: 182		

Q5 Think about the question, “Can you get the help you need when you need it?” Please check the three support services you think are the most important for people 60 years of age and older living in your community. Select 3 from the list below.

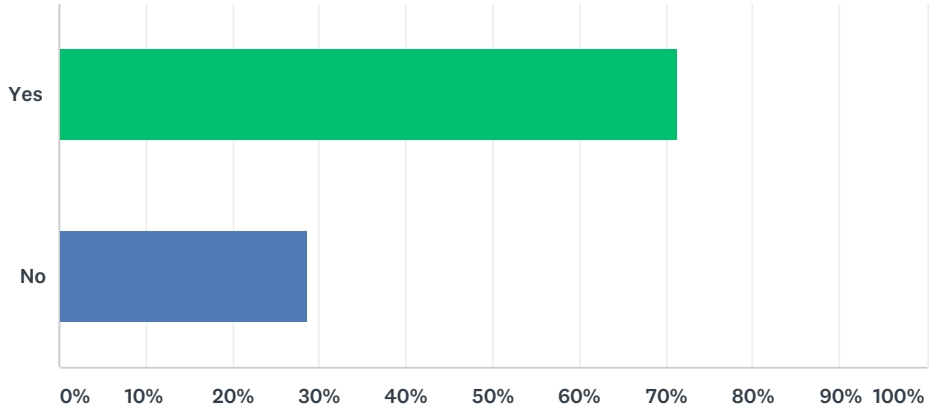
Answered: 182 Skipped: 0



ANSWER CHOICES	RESPONSES	
Affordable Food and Healthy Meals	39.56%	72
Affordable Health Care	58.79%	107
Affordable Housing and Utilities	70.33%	128
Connecting to Community Resources	37.91%	69
Transportation	48.35%	88
Dementia Supports and Services	24.18%	44
Counseling and Emotional Support	16.48%	30
Other (please specify)	4.40%	8
Total Respondents: 182		

Q6 Are there needs of individuals, 60 years of age and older, within your community that are not being addressed?

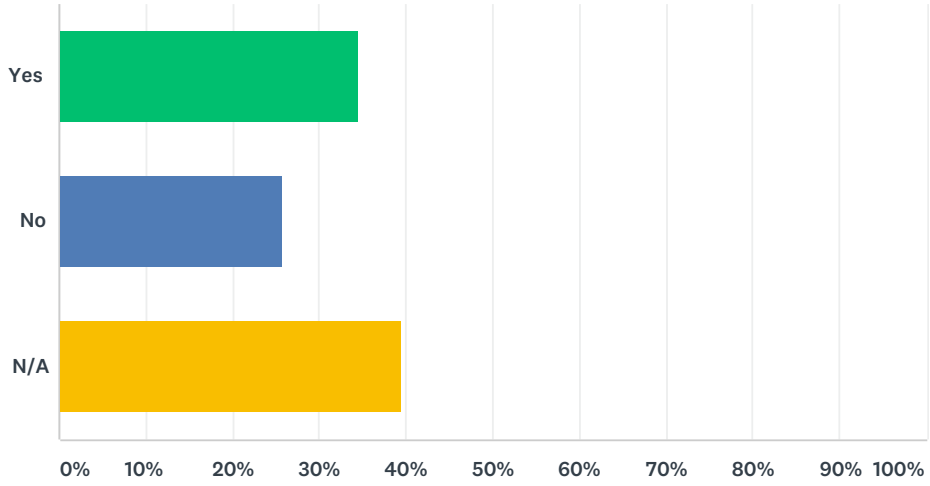
Answered: 182 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	71.43%	130
No	28.57%	52
TOTAL		182

Q7 Are you or others you know receiving the proper support to stay at home after hospital discharge (to prevent being admitted again)?

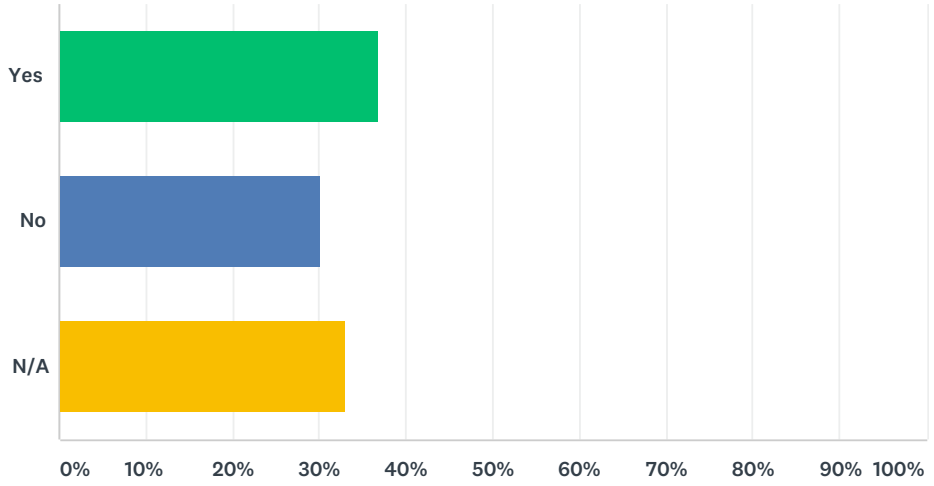
Answered: 182 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	34.62%	63
No	25.82%	47
N/A	39.56%	72
TOTAL		182

Q8 Are you or others you know receiving the proper support to stay living at home with one or more chronic health conditions?

Answered: 182 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	36.81%	67
No	30.22%	55
N/A	32.97%	60
TOTAL		182

Responses – All

Q3 – County of Residence ("Other" Responses)

King

Okanogan

Lincoln

Garfield

Kootenai

Q4 - Think about the question, "Can you get the help you need when you need it?" Please check the three support services you think are the most important for adults (18 and older) living with disabilities in your community.

Other

Addiction

Dental coverage

Deaf and latent deaf support such as devices, access to sign language, and qualified interpreters. Education of deafness and deaf culture for medical personnel.

Respite for caregivers

Legal

Need for disability friendly communities that provide higher wages, transportation, and mobility choices. Increased personal safety and financial resiliency.

Employer sick leave for chronic or serious treatment care

Access to medical equipment and supplies

Q5 - Think about the question, "Can you get the help you need when you need it?" Please check the three support services you think are the most important for people 60 years of age and older living in your community.

Other

Dental

Access to safe, affordable, and appropriate durable medical equipment

Deaf and latent deaf support such as devices, access to sign language, and qualified interpreters. Education of deafness and deaf culture for medical personnel.

Information for soon to be retirees

Respite

Legal services

Access to medicine, supplies, and equipment not provided.

Q6 - Are there needs of individuals, 60 years of age and older, within your community that are not being addressed?

Mental health

Substance abuse treatment while living at home

Education and support for families to assist older adults to stay at home

Keep people active and engaged in the community

Shortage of licensed caregivers

ALZ and dementia resources and educational outreach for rural areas

Education for public to know who to call

Affordable rent/housing

Access to providers, including specialists, in rural areas

Affordable memory care

Transportation

Affordable in-home care AND/OR group home, assisted living, or skilled care for those w private insurance but do not qualify for Medicaid

Intergenerational programs

Energy/heat assistance

Access to healthy food

Affordable prescription drugs

Multi-culture resources printed in multi-language

LGBT friendly resources, services and/or providers

Homeless and low-income shelter

Support to provide care for pets

Affordable dental care, especially in emergencies

Aging & Long Term Care of Eastern Washington
Area Plan 2020 – 2023

Community Planning Meeting Advertisement

Below is a copy of a Community Planning Meeting Advertisement that appeared in *The Spokesman Review*. Similar notices also ran in the *Ferry County View*, *Statesman Examiner, Newport Miner* and *Whitman County Gazette*.

The Community Planning Meeting Flyer on the following page was distributed to those attending Focus Groups as well as with ALTCEW's community partners. County-specific flyers were also produced and distributed.

Community Planning Meeting

Aging & Long Term Care invites you to attend one of our upcoming community planning meetings. At this meeting we will discuss services available and gather public input about what services are needed. Please join us and share what issues are impacting older adults and people receiving long term care in your community!

Ferry County

April 2, 2019
10:00—11:30 AM
Republic Senior Center
3 Klondike Road
Republic, WA 99166

Stevens County

April 8, 2019
1:30—3:00 PM
The Hub
231 W. Elep Ave
Colville, WA 99114

Pend Oreille County

April 4, 2019
Time 11:00 AM—12:30 PM
Hospitality House
216 S Washington Ave
Newport, WA 99156

Spokane County

April 9, 2019
2:00 PM—3:30 PM
Aging & Long Term Care
1222 N. Post St.

Whitman County

April 10, 2019
1:00—2:30 PM
Colfax Pantry
121 North Main St.
Colfax, WA 99111

Questions?

509-458-2509
www.altcew.org
action@altcew.org

AMERICANS WITH DISABILITIES ACT (ADA) INFORMATION: Aging & Long Term Care is committed to providing equal access to its facilities, programs and services for persons with disabilities. Individuals requesting reasonable accommodations or further information may contact Khristina Scheideler, ADA Coordinator, at least 5 days before the meeting date, at (509) 458-2509 or at action@altcew.org. Persons who are deaf or hard of hearing may contact the Washington Relay Service at 7-1-1.

The following Public Notice was placed in the Spokesman Review notifying the public of the Public Hearing. Similar notices were placed in The Statesman Examiner, the Newport Miner and the Whitman County Gazette.

Date: June 6, 2019

To: Spokesman Review

From: Aging & Long Term Care of Eastern Washington

RE: Public Hearing

Public Hearing Notice

Aging & Long Term Care of Eastern Washington (ALTCEW) is holding a Public Hearing to receive comments on the proposed 2020 – 2023 Area Plan and budget for providing services in Ferry, Stevens, Pend Oreille, Spokane and Whitman counties.

The hearing will be held on July 1, 2019 from 1:30 PM – 3:00 PM at Corbin Senior Activity Center, 827 W Cleveland, Spokane, WA 99205

This meeting is open to the public. AMERICANS WITH DISABILITIES ACT (ADA) INFORMATION: ALTCEW is committed to providing equal access to its facilities, programs and services for persons with disabilities. Individuals requesting reasonable accommodations or further information may contact Khristina Scheideler, ADA Coordinator, at least 5 days before the meeting date, at (509) 458-2509 or at action@altcew.org. Persons who are deaf or hard of hearing may contact the Washington Relay Service at 7-1-1.

Public Hearings

Aging & Long Term Care of Eastern Washington (ALTCEW) invites you to attend our upcoming Public Hearings on the proposed 2020 -2023 Area Plan on Aging and Long Term Care. At this meeting we will discuss our plan for providing services for older adults and individuals needing long term care, in addition to Aging & Long Term Care's proposed 2020 budget. Please join us and share your feedback!

Materials will be presented at the hearings and are available upon request. To request by mail, please call 509-458-2509. Information is also available on our website at www.atcew.org

Spokane County

July 1, 2019
1:30 — 3:00 PM
Corbin Senior Activity Center
827 W Cleveland
Spokane, WA 99205

Tri-County Area

July 8, 2019
1:30 — 3:00 PM
The Hub Senior Center
231 W. Elep Ave
Colville, WA 99114

Whitman County Area

July 15, 2019
1:30 — 3:00 PM
Pullman Senior Center
325 SE Paradise St
Pullman, WA 99163
New date & location

Questions?

509-458-2509

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Appendix F Report on Accomplishments from the 2018-2019 Area Plan Update

Aging & Long Term Care of Eastern Washington (ALTCEW) has provided services in PSA #11 since 1973 and targets services to individuals with the greatest economic and social need. In 2016, our network helped almost 40,000 people living in PSA #11. To continue to address the needs of individuals in our service area, during the planning period of 2016-2019, ALTCEW will focus on the following Older American Act and Statewide Issue Areas:

ISSUE AREA: Long Term Services and Supports

GOAL: Address basic needs of individuals living in the community by increasing access to information and assistance to long term care services and support options.

Objective A: Between January 1, 2016 and December 31, 2019 Aging & Long Term Care of Eastern Washington (ALTCEW) will advocate with Aging and Long Term Support Administration (ALTSA) and the state legislature to match required tasks (e.g. frequency of client contact) for Medicaid case management with available Medicaid case management resources (ongoing). ALTCEW will support activities that assess the adequacy of state funding level for coordination of statewide long term care services, support activities, planning efforts, monitoring and evaluating processes.

Outcome: Ongoing advocacy and sufficient funding to meet program expectations as evidenced by participation in W4A, senior lobby, staff participation in legislative calls, and sponsor and/or support participation in local and state and legislative forums in PSA#11.

Accomplishments: ALTCEW's Planning and Management Council engaged in advocacy in partnership with the Washington Association of Area Agencies on Aging (W4A), the Senior Citizen's Lobby, and the State Council on Aging, and local partners in the 2016-2019 sessions. This included Age Wave Forums for candidates in October 2016 and September 2018 held in Spokane in collaboration with the Age Wave Coalition. ALTCEW was actively involved in the W4A legislative committee and discussions about joint policy goals with ALTSA. As a result of PMC participation in statewide advocacy, for the 2017-2019 biennium Area Agencies on Aging received a 2% vendor rate increase, health home incentive payments, senior nutrition bill and funding for home delivered meals, increased funding for the long term care ombudsman program, and vendor rate increases for other AAA partners. Several bills the PMC engaged in advocacy and support also passed during the 2016 and 2017 sessions, including the CARE Act (SB 6327) Vulnerable Adult Bill (HB 1153), and Senior Nutrition Bill (SB 5736). 2018 session outcomes included increased resources for health homes care coordination for high risk Medicaid clients, but no increase to case

management. In 2019 advocacy achieved a $1.7 million increase for Medicaid in-home care case management for the 2019-2021 biennium.

Objective B: Between January 1, 2016 and December 31, 2019**,** ALTCEW will support the reauthorization for all titles of the Older Americans Act.

Outcome: Reauthorization of the Older Americans Act.

Accomplishments: Nearly five years after it expired, legislation to reauthorize the Act was passed by Congress with unanimous, bipartisan support. The bill was signed into law by the President on April 19, 2016.

Objective C: Between January 1, 2016 and December 31, 2019 ALTCEW will develop a public awareness campaign to enhance access to resources and information of the services available within the ALTCEW Service Area, Public Service Area (PSA) #11. The campaign will include public forums, outreach and engagement.

Outcome: Dissemination of information on services provided by ALTCEW through two public forums, development of a community outreach and engagement plan, and the development of a communication plan. ALTCEW will enhance awareness of its services via the use of media, including local and regional news sources.

Accomplishments: In 2016 ALTCEW continued its agency-wide task force to examine and improve outreach and engagement methods. The following mediums for outreach were utilized: new staff and volunteer welcome booklet and orientation, ALTCEW website, ALTCEW Insider, Facebook, external meetings and display booths, advertising, elevator speech, and resource brochures. The website experienced a 3% increase in unique visitors compared to 2015; we established a Facebook presence setting a standard for three postings per week; more than 5,000 copies of the Community Living Connections (CLC) resource directories were distributed. We established a new baseline of 6,302 individuals contacting our CLC providers; the new baseline was established due to a new CLC contractor in Spokane County. Our Training Center served 1,592 individuals, which was 91% of 2015 total. With our Referral Registry effort, we met activity targets: 65% of the time for new and reactivated IPs and 100% of the time for number of consumers served. Carina is a new online tool for clients and families to find Individual Providers. We are seeing success with matching clients with Individual Providers.

In 2017 ALTCEW continued the use of its Welcome Booklet and Orientation, bringing new people up to speed quickly when communicating with family and friends. Early in the calendar year, the website was updated to bring the Referral Registry more prominence on the site. A tab for Independent Provider was

designated, a separate page for the Registry was created, and the number of "hits" from people looking for this information increased by 155% comparing the first three quarters of 2016 (582) to first three quarters of 2017 (1,479). A review of all links within the site was conducted with many updated. With implementation of the Medicaid Transformation Demonstration, we updated the ALTCEW website page on family caregivers and language is now consistent with the messaging on rack cards developed for Frontier Behavioral Health and Rural Resources. The Insider completed its fourth year. In response to readers' request for more articles about co-workers and the work they perform, Khristina Scheideler created a new "column" entitled "Mission Impact". Our administrator and several staff members posted 185 times to Facebook. The three most popular postings in order were 1) story on A Matter of Balance presentation to the Planning & Management Council, 2) story on SHIBA volunteer recognition, and 3) notification of Daylight Savings. By year's end friends to our Facebook totaled 141, representing a growth of 115%. We shared guidelines for external meetings with staff members participating in external meetings and representing ALTCEW. Special attention was given to build their awareness and understanding regarding the Medicaid Transformation Demonstration and how best to promote that new service. ALTCEW had a regular presence in the Boomer section of the Spokesman Review, Fig Tree, and Black Lens. A list of topics for 2017 included A Matter of Balance, diabetes, stroke, age wave, caregivers, and Medicare Open Enrollment. We advertised for the first time in the Cheney Gazette and Spokane Valley News Herald. The Journal of Business published a story on new services for unpaid caregivers and the update issue of the Senior Directory included several articles and listings. The resource brochures (Spokane County, Tri-Counties, and Whitman County) remain very popular with wide distribution occurring. More than 5,000 copies of the Spokane County edition were printed, 400 for Tri Counties, and 285 for Whitman County. A new brochure was developed for nursing services with distribution primarily to home care agencies and physicians. The number of individuals contacting CLC area wide was 7,760.

In 2018, recognizing that Family Caregiver and Community Living Connections would be the major push for outreach, and because mediums and procedures had been developed in previous years, the agency-wide Outreach Task Force was dis-banned. Selected strategies to build public awareness were the use of billboards, ongoing newspaper advertisements, and Facebook postings. Billboards ran for two months and were located at Sprague and Carnahan, Market and Francis, Evergreen and Riverside, and Lincoln and Broadway. (See Objective F for Facebook data.) Additional outreach efforts were targeted to medical providers and associations, pharmacies, libraries, faith communities with a total of 182 individuals informed. The number of individuals contacting CLC area wide was 6,328.

Objective D: Between January 1, 2016 and December 31, 2019, expand partnerships with the Veteran's Administration, Centers for Independent Living, senior centers and retirement communities to support their role in providing up-to-date information to their participants and residents.

Outcome: Eight new enhanced partnerships will be established. Partner agencies will have staff who provide information, referral, and assistance regarding long term services and supports provided through the ALTCEW service network. ALTCEW will pursue contractual arrangements with the Veteran's Administration on the VA home care initiative.

Accomplishments: In 2016, ALTCEW staff attended the "Veteran Community Partnerships" meeting at Mann-Grandstaff VAMC, establishing contacts between VA social workers and CLC staff. In March of 2017, ALTCEW held training for CLC partners entitled Veterans Administration Services.

In 2018, a memorandum of understanding was signed between ALTCEW and CHAS with three purposes in mind: 1) offer support on site for ALTCEW to conduct Medicare enrollment and health insurance education; 2) train CHAS personnel to serve as coaches for the MOB program and offer classes on-site. In Sept/Oct 2019 CHAS personnel coached their first MOB class with patients referred by CHAS providers; and 3) screen targeted populations of older patients for services available at ALTCEW.

Objective E: Between January 1, 2016 and December 31, 2016 build content and increase reliability of information in the electronic resource directory of Community Living Connection (CLC) GetCare. Thereafter, update content on a 12 month cycle to assure accuracy.

Outcome: Public access to accurate, web-based information linking them to personalized care and support options in the long-term care network.

Accomplishments: A total of 248 listings for PSA #11 have been entered into the GetCare database with an average quality ranking of 16 on a scale of 1 – 19. In 2017 staff began cycling through listings on a monthly basis to achieve annual updates on all 248 listings.

By the end of 2018 a total of 484 listings were housed in the database. Quality rankings ranged between 16 and 19, with 19 being the highest available ranking. Rankings are based on number of required fields completed. We continue to strive toward annual updates.

Objective F: Between January 1, 2016 and December 31, 2019, market ALTCEW and CLC partners as the organizations who link individuals to personalized care and support options.

Outcome: Increased awareness of how to access needed information about local long-term services and supports via web resources, media outlets and public forums. Increase number of Information and Referral/Assistance contacts by 2% each year, as determined by recordings in the CLC GetCare database.

Accomplishments: In 2016 a total of 24,039 unique individuals visited the ALTCEW website: www.altcew.org, which represented a 3% increase compared to 2015. In July 2016 we initiated a Facebook presence with 66 posting in the year; SHIBA's open enrollment photo was the most popular posting reaching 356 individuals. I&A contacts area wide for 2016 equaled 9745.

In 2017, 14,859 individuals visited the ALTCEW website and in 2018, 16,144 visited. In 2017 we started "boosting" Facebook postings. The 2018 Facebook postings totaled 140 and a caregiving post that was boosted had the highest number of viewings at 1,063.

I&A contacts area-wide in 2017 equaled 16,377 and in 2018 equaled 13,829. Individuals utilizing options counseling in 2017 equaled 306 and in 2018, 318; this represents a 4% increase in the use of options counseling.

Objective G: Between January 1, 2016 and December 31, 2019, ALTCEW will increase benefits counseling in Statewide Health Insurance Benefits Advisors (SHIBA), and enrollments through the Washington Health Plan Finder (WHPF) and Washington Connections by 5% each year.

Outcome: Individuals transitioning from one source of health care coverage to another get the answers and assistance needed.

Accomplishments: ALTCEW/Spokane and Whitman counties compiled the following 2016 baseline data: SHIBA 4,597 counseling sessions; Washington Health Plan Finder 52 enrollment assists; WA Connection 63 enrollment assists. Baseline data supports meeting the 5% projection.

SHIBA counseling sessions in 2017 totaled 5,682 and in 2018 totaled 3,722; Washington Health Plan Finder 2017, 30 enrollment assists and 2018, 25 assists; WA Connection (Medicaid) 2017, 88 enrollment assists and in 2018, 172 assists. Although collectively 2017 increased by 23%, we saw a significant decline (17%) in 2018.

Objective H: Between January 1, 2016 and December 31, 2019, ALTCEW will conduct quality assurance cycles for Information, Referral, and Assistance (I&R/A).

Outcome: Consumer input is provided to I&R/A staff that improves the interactions between callers and I&R/A staff and the value received by the consumer.

Accomplishments: In 2016, ALTCEW conducted a satisfaction survey with a total of 149 surveys completed in PSA #11.

Survey Findings

- 91% agreed the person they talked with responded quickly with the information they asked for.
- 99% agreed the person they talked with was courteous.
- 93% agreed the person they talked with paid close attention to what they were saying.
- 91% agreed the person they talked with was knowledgeable.
- 78% agreed the information received was helpful.
- 40% people referred to services received the service they were seeking.
- 97% would contact Community Living Connections again.
- 97% would recommend Community Living Connections to others.

In 2017 special attention was given to improving I&A staff understanding of the reasons for and procedures to record follow-up in the GetCare database. A detailed Quality Improvement Work Plan was developed and specific criteria for follow-up established.

Survey Findings 2019 for Spokane County

- 93% agreed the person they talked with was attentive to their needs.
- 95% agreed the person they talked with was courteous.
- 96% agreed the person they talked with paid close attention to what they were saying.
- 93% agreed the person they talked to was knowledgeable.
- 91% agreed the information received was helpful.
- 52% stated they received the services they were seeking.
- 95% stated they would contact Community Living Connections again.
- 98% stated they would recommend Community Living Connections to others.

Survey Findings 2019 for Tri-Counties

- 100% agreed the person they talked with was attentive to their needs.
- 100% agreed the person they talked with was courteous.
- 100% agreed the person they talked with paid close attention to what they were saying.
- 100% agreed the person they talked with was knowledgeable.
- 95% agreed the information received was helpful.

- 74% received the services they were seeking.
- 100% would contact Community Living Connections again.
- 100% would recommend Community Living Connections to other.

Survey Findings 2019 for Whitman County

- 100% agreed the person they talked with was attentive to your needs.
- 100% agreed the person they talked with was courteous.
- 100% agreed the person they talked with paid close attention to what they were saying.
- 100% agreed the person they talked with was knowledgeable.
- 83% agreed the information received was helpful.
- 50% received the services they were seeking.
- 83% would contact Community Living Connections again.
- 100% would recommend Community Living Connections to others.

Objective I: Between January 1, 2016 and December 31, 2019 ALTCEW staff will continue advocate for awareness of the transportation needs of older adults and individuals living with disabilities through staff participation in coalitions and committees including Spokane Regional Transportation Council, Spokane Transit Authority, and other transportation planning organizations in the ALTCEW Service Area. ALTCEW staff will support and advocate for partners to coordinate with Regional Transportation Planning organizations in the rural counties in PSA#11.

Outcome: Increased advocacy, education and awareness of transportation needs and availability of appropriate services for older adults and individuals living with disabilities who reside in PSA #11.

Accomplishments: During the 2016 - 2017 period, ALTCEW staff was appointed to the Spokane Regional Transportation Council and participates in regular council meetings and advocacy events. In 2018 staff participated in a coalition of local social service providers advocating with Spokane Transit Authority to provide options to low income customers to mitigate the impact of fare increases. In 2018 staff participated in updating the Human Services Transportation Plan with Spokane Regional Transportation Council. In 2019 the agency participated in a regional transportation workgroup focusing on improving senior and disabled transportation options with regional partners.

Objective J: Between January 1, 2016 and December 31, 2019, partner with Home and Community Services, and local housing providers to advocate for secure affordable and accessible housing for older adults and people living with disabilities in the ALTCEW service area.

Outcome: Support the utilization of subsidized housing services for older adults and people living with disabilities and increasing number of clients in stable and safe housing. Increase in advocacy, education, and awareness on housing needs for older adults and people living with disabilities.

Accomplishments: During the 2016 to 2017 period, ALTCEW staff organized a Regional Housing Consortium in coordination with Home and Community Services. ALTCEW staff were appointed to serve on the Continuum of Care Board that addresses housing and homelessness in Spokane County. In addition, ALTCEW was represented on a Senior Housing Forum produced by a local community production team and broadcast in mid-2017.

During the 2018 to 2019 period ALTCEW staff were represented in the Spokane Homeless Coalition. Planning staff will also be at the table for the Spokane City Comprehensive Plan, which coordinates affordable housing funding. The Planning and Management Council joined in housing advocacy for the 2019 session, advocating for increased resources to the Housing Trust Fund and supportive housing services. The agency became contracted in late 2018 with Amerigroup to provide Supportive Housing under the Foundational Community Supports Program, and employed two staff members to work with Health Homes and Case Management clients with significant housing needs. Since implementing the program in September 2018, the ALTCEW Supportive Housing team has a 60% success rate stabilizing clients housing within 6 months.

Objective K: Between January 1, 2016 and December 31, 2019, ALTCEW will support staff development and training to address the ongoing needs of older adults and individuals with disabilities who reside in PSA#11.

Outcome: Ongoing quarterly training opportunities for ALTCEW staff and community partners as appropriate.

Accomplishments: During the 2016 -2019 period, ALTCEW provided numerous training opportunities for staff, contractors and the public in partnership with the Senior Assistance Fund of Eastern Washington including Reaching LGBT Elders, Senior Falls Prevention, Suicide Prevention, Motivational Interviewing, and Trauma and Older Adults. ALTCEW promoted and shared multiple training opportunities including mental health first aide, Alzheimer's disease & dementia, diabetes management, assistive technology, medication management, motivational interviewing, coaching, and cultural sensitivity.

ISSUE AREA: Family Caregivers and Kinship Caregivers

GOAL: Increase the number of family and other non-paid caregivers that receive information and support in providing care for older persons and individuals living with disabilities.

Objective A: Between January 1, 2016 and December 31, 2019 ALTCEW will assist subcontractors in promoting the Family Caregiver Support Program and support groups in rural communities.

Outcome: Increased awareness of the Family Caregiver Support Program and associated services and supports as evidenced by a 5% increase in program participation.

Accomplishments: During the 2016 - 2019 contract period, ALTCEW assisted Elder Services (ES), Rural Resources Tri-County (RRCA Tri), and Rural Resources Whitman County (RRCA WC) in promoting the FCSP. Elder Services and Rural Resources Community Action have continued outreach and targeting family and unpaid caregivers that are age 55 and older, caring for persons under age 19, or over the age of 60, with severe disabilities. Outreach efforts stretched further throughout rural areas of PSA 11, positively affecting those in need of services and support that were largely unaware of the FCSP.

During the 2016 – 2017 contract period there was a 73% increase in group presentations, and a 37% increase in dissemination of publications.

During the 2018 – 2019 contract period, as of June 11, 2019, there have been a total of 63 group presentations and meetings. Additionally, during the same timeframe there has been a 96% increase in dissemination of publications, reaching 16,129 FCSP contacts.

Objective B: Between January 1, 2016 and December 31, 2019, ALTCEW will collaborate with the Alzheimer's Association in support of the dementia enhanced caregiver support program. Activities will include promotion and dissemination of information on the development of a Washington State Alzheimer's Plan.

Outcome: Increased awareness of the enhanced caregiver support program and the Washington State Alzheimer's Plan.

Accomplishments: During the 2016 -2019 period, ALTCEW staff has supported the Alzheimer's Association's early stage support group. Early Stage Groups have been offered in Whitman and Spokane County. In addition, ALTCEW staff was appointed to the Dementia Action Collaborative for the Washington State Alzheimer's Plan and are involved in the workgroup addressing Long Term Services and Supports.

The special grant for development of dementia capable systems and Early Stage Groups ended in 2018. Through the course of the project 2 leaders were trained in Whitman County and 7 in Spokane County; 49 staff were trained in recognizing dementia and knowing what to do in such cases; a total of 13 Early

Stage Group sessions were conducted in Spokane County with 59 dyads participating and 3 sessions in Whitman County with 10 dyads participating.

Objective C: Between January 1, 2016 and December 31, 2019, ALTCEW will promote the work of the Family Caregiver Specialist with community partners in continuing and enhancing the support provided to unpaid caregivers.

Outcome: Increased awareness and access to the Family Caregiver Support Specialist (FCSS) and associated benefits of the FCSP resources.

Accomplishments: The FCSS position was eliminated at ALTCEW due to budget constraints. ALTCEW Contracts Monitoring staff provided Technical Assistance to the contractors of the FCSP, as well as regular desk monitoring of service delivery. ALTCEW continued to focus on increased awareness of the FCSP, and outreach in the rural communities, to positively impact relative caregivers who might otherwise be unaware of available services, administering support to recipients of services offered through the FCSP.

Objective D: Between January 1, 2016 and December 31, 2019, ALTCEW will support increased resources and coordination of caregiver support services that help people who are not eligible for Medicaid in home services.

Outcome: Support coordination and improved community capacity for volunteer chore services and other programs that provide caregiving support outside of the Medicaid system.

Accomplishments: ALTCEW successfully implemented the 1115 Medicaid Waiver, referred to as the Medicaid Transformation Demonstration (MTD), to support family caregivers not currently financially eligible for Medicaid long-term care.

ISSUE AREA: Delay of Medicaid-funded Long Term Services and Supports, Health Promotion and Disease Prevention (aka Pre-Medicaid Services)

GOAL: Improve health and well-being of older adults by increasing the array of affordable health, prevention and wellness service options for older persons and individuals living with disabilities.

Objective A: Between January 1, 2016 and December 31, 2019, ALTCEW will expand on the use of Evidence Based Programming to support prevention and wellness options for older persons and individuals living with disabilities.

Outcome: ALTCEW will increase the clients served through expanding to additional evidence based programs to meet currently unmet community needs.

Accomplishments: During the 2016 - 2019 period, ALTCEW staff has implemented A Matter of Balance, an Evidence Based Falls Prevention Program in throughout PSA#11. We offered 9 Coach Training sessions and trained 55 volunteer coaches. We have held 48 MOB classes and have confirmed an additional 4 for the remaining of 2019. Across PSA#11, 488 older adults have enrolled in these classes and 387 have completed 5 or more of the 8 class sessions, earning the designation of a "completer." This completion rate of 79.3% is in line with national completion rates.

Objective B: Between January 1, 2016 and December 31, 2019, ALTCEW will expand partnerships with Federally Qualified Health Centers (FQHC), hospitals, and facilities providing long-term services and supports to older adults and individuals living with disabilities to promote chronic care management.

Outcome: Care Transitions Intervention (CTI) or health home projections (I.e. Increased coordination of services will reduce readmissions of individuals living with chronic conditions by 5%).

Accomplishments: During the 2016-2017 period ALTCEW engaged in numerous services supporting older adults and people with disabilities with targeted partners. ALTCEW's contract for Care Transitions with Centers for Medicare and Medicaid Services ended on February 29, 2016. As a result of the contract, ALTCEW provided 4,377 older adults on Fee for Service Medicare care transition services between February 1, 2013 and February 29, 2016. Readmission rates, emergency department visits, 60 and 90 day readmissions were lower for program participants than other patients. The program resulted in a savings to Medicare of $1.4 million.

ALTCEW integrated care transition services and skill sets into the Health Home program and refocused on Health Home expansion. CMS reports the first 42 months of the Health Home program services provided statewide saved Medicare $107 million. In addition, ALTCEW concluded the National Institute on Aging study on chronic care management for high risk individuals served by Federally Qualified Health Centers, in partnership with Washington State University College of Nursing and Community Health Association of Spokane (CHAS). In 2017-2018 ALTCEW began a care coordination pilot in partnership with Empire Health Foundation and CHAS in north Spokane County, with the goal of improving medication and health outcomes for high-risk older adults.

In 2018, a memorandum of understanding was signed between ALTCEW and CHAS with three purposes in mind: 1) offer support on site for ALTCEW to conduct Medicare enrollment and health insurance education; 2) train CHAS personnel to serve as coaches for the MOB program and offer classes on-site;

and 3) screen targeted populations of older patients for services available at ALTCEW.

Objective C: Between January 1, 2016 and December 31, 2019, ALTCEW will collaborate and promote partnership with the local Centers for Independent Living (CILS) to facilitate outreach and transitional services to individuals living with disabilities in rural areas of PSA 11.

Outcome: Increased coordination of services and utilization for individuals living with disabilities in rural communities.

Accomplishments: In 2016 ALTCEW collaborated closely with the local Center for Independent Living in a technical assistance collaborative for developing business acumen. ALTCEW continues to collaborate with the CIL and other local disability advocacy organizations to support resources for persons with disabilities throughout the region. ALTCEW has contracted with the CIL to provide Community Transition and Training Specialist services through the Medicaid waiver for PSA 11 up until January 2019 when Spokane Center for Independent Living chose to end their contract for convenience.

Objective D: Between January 1, 2016 and December 31, 2019 ALTCEW will continue to advocate for additional funds to continue the Senior Farmers Market Nutrition Program (SFMNP) voucher process and continue efforts to increase awareness of the SFMNP through flyers, public service announcements and other media opportunities.

Outcome: Increased market vendors who participate in the SFMNP.

Accomplishments: ALTCEW has continued to support the Senior Farmers Market Nutrition Program (SFMNP). The vouchers are currently offered in Spokane County through Catholic Community Services and in bulk delivery by Greater Spokane County Meals on Wheels. Rural Resources Community Action administers the funding in the Tri-County service area, and Council on Aging distributes vouchers in Whitman County. In 2017, ALTCEW received authorization from the state to provide allow vouchers to be used by WA state residents in Moscow, Idaho. In 2019 ALTCEW added $10,000 of unallocated SCSA administrative funding to purchase an additional 250 packets of checks. This is close to the unserved wait list experienced in 2018 in Spokane County.

Objective E: Between January 1, 2016 and December 31, 2019 ALTCEW will continue to provide advocacy regarding the mental health needs of older adults through coordination efforts with local providers of mental health services and community educational events.

Outcome: Documentation supporting efforts to enhance the public awareness and increase levels of care for persons who require both aging network and mental health services living in PSA #11.

Accomplishments: ALTCEW has provided advocacy for the mental health needs of older adults through direct client advocacy, through coordination with providers, and local advocacy and planning activities. Both the Health Homes Program and the In-Home Care Case Management Program provided direct client advocacy, helping clients in need of mental health services access treatment, connect with local providers, and troubleshoot issues with insurance coverage affecting mental health benefits. A significant issue identified has been the loss of mental health care for individuals who age out of the Medicaid expansion and transition to Medicare – they are losing both their care coordination benefits as well as access to mental health care. On the broader community level, ALTCEW has been engaged in the local Accountable Community of Health, providing advocacy and voice for the mental health needs of older adults and younger persons with a disability. ALTCEW has also increased involvement in the Spokane Dementia Action Collaborative, as well as participated in the statewide Dementia Action Collaborative. ALTCEW staff also coordinated with local MCOs and other providers for continuity of care for case management clients funded through behavioral health, with the integration of physical and behavioral health for Medicaid in January 2019.

Objective F: Between January 1, 2016 and December 31, 2019, ALTCEW will, conduct advocacy activities and support other efforts that provide additional resources for dental, vision, hearing and other related health services in PSA #11.

Outcome: Participation with the Washington Dental Society, and Access for All to advocate for adequate supports for health related services in PSA#11.

Accomplishments: ALTCEW partnered with the Washington Dental Society in coordinating and providing presentations on dental access. ALTCEW had representation on the Access for All Committee advocating for the needs of older adults and individuals living with disability in PSA # 11.
In 2018 ALTCEW signed an agreement with the ARCORA Foundation to test the effectiveness of enhanced Medicaid dental benefits, with care coordination as the anchor strategy. The target population is adults between the ages of 18 and 64 receiving Medicaid benefits and diagnosed with diabetes. Systems development and dentist recruitment was the main focus in 2018.

Issue Area: Service Integration & Systems Coordination

Goal: Work across systems to ensure access to planned and coordinated care for older persons and individuals with disabilities.

Objective A: Between January 1, 2016 and December 31, 2019 ALTCEW will continue with the expansion of the Health Home Program to include dual eligible, Medicaid/Medicare and Medicaid clients to reduce care costs and promote client wellness. ALTCEW will work toward a twenty-eight percent (28%) increase in participation in the Health Home Program.

Outcome: Increase in Health Home Participants.

Accomplishments: Between January 1, 2016 and May 31, 2019, ALTCEW achieved a 52% increase in health home monthly participation. The active caseload in January 2016 was 233 clients, and in May 2019 it was 355 clients. The agency has steadily served 600 clients per year in the health homes program.

Objective B: Between January 1, 2016 and December 31, 2019 ALTCEW will develop partnerships with hospitals and facilities that provide services to older adults and individuals living with disabilities to facilitate transitions in care and create infrastructure for ongoing transitions.

Outcome: Increased coordination and support as people transition between levels of care.

Accomplishments: During the 2016-2017 period ALTCEW engaged in numerous services supporting older adults and people with disabilities with targeted partners. ALTCEW's contract for Care Transitions with Centers for Medicare and Medicaid Services ended on February 29, 2016. As a result of the contract, ALTCEW provided 4,377 older adults on FFS Medicare care transition services between February 1, 2013 and February 29, 2016. Readmission rates, emergency department visits, 60 and 90 day readmissions were lower for program participants than other patients. The program resulted in a savings to Medicare of $1.4 million. ALTCEW integrated care transition services and skill sets into the Health Home program and refocused on Health Home expansion. CMS reports the first two years of the Health Home program services provided statewide saved Medicare $67 million. Currently, ALTCEW provides care transitions services in conjunction with health homes, but not with any other service. ALTCEW participated in a Hospital Transitions Summit with area hospitals, DSHS, Long Term Care Facilities and Managed Care Organizations to improve communication and collaboration across systems. This partnership continues as a member of a workgroup for complex hospital discharges and clients with long lengths of stay in the Spokane Area hospitals.

Objective C: Between January 1, 2016 and December 31, 2019, ALTCEW will continue product knowledge and education with faculty and staff at hospitals and nursing facilities

to increase Care Transitions Intervention program awareness and improve outcomes.

Outcome: Increase in client participation in the Care Transitions Intervention program.

Accomplishments: ALTCEW's contract for Care Transitions with Centers for Medicare and Medicaid Services ended on February 29, 2016. As a result of the contract, ALTCEW provided 4,377 older adults on FFS Medicare care transition services between February 1, 2013 and February 29, 2016. Readmission rates, emergency department visits, 60 and 90 day readmissions were lower for program participants than other patients. The program resulted in a savings to Medicare of $1.4 million.

Objective D: Between January 1, 2016 and December 31, 2019 ALTCEW will foster collaborative relationships with the local Accountability Communities of Health (ACH) to ensure coordinated access to care for older adults and individuals with disabilities.

Outcome: Increased coordination resulting in strategically meeting the needs of older adults and people living with disabilities in PSA#11.

Accomplishments: ALTCEW actively participates in the Accountable Community of Health, Better Health Together. The agency has actively participated in the Governing Board, Leadership Council, Spokane Collaborative, and the HUB Council.

Objective E: Between January 1, 2016 and December 31, 2019, ALTCEW will support the development of an 1115 Waiver designed to target long-term services and supports to address needs, while also reducing or delaying the need for more costly services.

Outcome: Creation of targeted Family Caregiver Support and pre-Medicaid services via the 1115 Waiver administered by Aging and Long Term Support Administration.

Accomplishments: ALTCEW has continued to work with its subcontractors, successfully implementing the 1115 Medicaid Waiver, referred to as MTD, since September 2017. MTD is a five-year pilot program in the State of Washington that serves caregivers and care receivers that might not otherwise be able to access alternative services. The Warm Hand-Off (WHO) protocol was developed and implemented as a means of clear communication between Home and Community Services, ALTCEW, and its subcontractors. Clear communication allows clients to move through the intake, prescreen, presumptive eligibility,

screening, assessment, and care plan development steps efficiently. Currently, 174 individuals and 72 dyads are actively served through MTD services. MTD enrollments continue to increase monthly. Because MTD clients are not required to pay a copay or succumb to estate recovery, more individuals and dyads are seeking out resources provided by MTD. Further, FCSP Case Managers offer MTD services when the level of need meets the service capability of MTD.

In April 2019, ALTCEW unveiled its marketing campaign through a contract awarded to marketing company Blue541. This campaign increased exposure to MTD through the use of billboards, radio advertisements, newspaper advertisements, local magazine publications, and Facebook advertisements. All included forms of media were designed to educate viewers and listeners through clear messages about how to identify one's self as an unpaid caregiver.

In addition to ALTCEW's marketing campaign, ALTSA launched its own global marketing campaign across the State. ALTCEW's marketing campaign acts as a companion to the State's marketing efforts, directing people locally to ALTCEW and its subcontractors for information about MTD. The front door contact when calling the number listed on ALTCEW's advertisements is the Community Living Connections team, providing Information and Assistance/Referral, as well as Options Counseling (when necessary), where callers are able to describe their needs and be directed to appropriate resources.

Regarding MTD services, via mutual agreement between ALTSA, ALTCEW, and ALTCEW's subcontractors, a target service goal for MTD dyads was set at 40%, meaning 40% of MTD clients served will be dyads in 2019. Currently, ALTCEW's subcontractors are serving 29% dyads, though new dyads are being identified and enrolled in MTD services regularly. This goal will be re-evaluated for 2020 and beyond, with the expectation that 40% will be met and eventually exceeded. The MTD program focuses on helping care receivers and caregivers, and was designed to reduce caregiver burnout and prevent care receivers from entering facilities until it is determined through assessment that they are no longer able to remain safely in their own homes.

Finally, marketing efforts are being expanded in the Tri – and Whitman County areas, to include electronic advertisements in medical offices and billboards in key locations of high traffic. Getting unpaid caregivers to identify themselves as such can be a challenge at times, which makes this campaign especially valuable.

Objective F: Between January 1, 2016 and December 31, 2019, ALTCEW will support staff development, training and education regarding the Affordable Care Act, Healthier Washington, and other health initiatives that impact the lives of older adults and individuals with disabilities who reside in PSA 11.

Outcome: Enhanced understanding of the initiatives and a greater understanding of the implications of the initiatives as evidenced by the ability to articulate an understanding of these initiatives.

Accomplishments: ALTCEW actively participates in the Accountable Community of Health, Better Health Together and has provided consistent updates to staff and the Planning and Management Council on issues and developments that impact the lives of older adults and individuals with disabilities who reside in PSA 11.

Issue Area: Older Native Americans

GOAL: ALTCEW will consult and collaborate with representatives from the Kalispel Tribe of Indians, the Spokane Tribe of Indians and urban Indian community organizations, in order to ensure quality and comprehensive planning and service delivery to all American Indians and Alaskan Natives in Planning and Service Area #11.

Objective A: Develop the 7.01 plan in collaboration with local Native American Tribes and Urban Indian Organizations.

Outcome: Coordination of services with local Native American tribes in PSA#11.

Accomplishments: ALTCEW has successfully developed formalized 7.01 plans with the Spokane Tribe, Kalispel Tribe, and Native Project.

Aging & Long Term Care of Eastern Washington

Appendix G Statement of Assurances and Verification of Intent

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

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

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

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

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

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

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

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

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

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

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

8/9/19
Date

Lynn Kimball
Executive Director

8/9/19
Date

Ken Smith
Chair, Planning and Management Council

8/9/19
Date

Art Swannack
Chair, Governing Board

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