PROPOSED 2016-2019 AREA PLAN ON AGING AND 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 Unit at the physical address, phone number or email address listed below.

Aging & Long Term Care of Eastern Washington
1222 North Post Street
Spokane, Washington 99201-2518
(509) 458-2509
www.altcew.org action@altcew.org

AGING AND LONG TERM CARE OF EASTERN WASHINGTON
2016-2019 AREA PLAN

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SECTION A – AREA AGENCY PLANNING AND PRIORITIES

Section A-1 Introduction

HISTORICAL PERSPECTIVE

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 on Aging (AoA) 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 Aging (federal) develops 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. The Aging and Disability Services Administration 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.

Aging & Long Term Care of Eastern Washington (ALTCEW) pursues the development of a comprehensive and coordinated services system for older persons and other individuals in need of long term care in a 4-1/2 county Planning and Service Area (PSA). ALTCEW develops an Area Plan on Aging and Long Term Care, awards funds to service providers, and monitors and evaluates service providers. Under contract to ALTCEW are our service providers who provide a variety of direct services within specific geographic areas.

ALTCEW is responsible for performing the following activities in the PSA for older persons and others in need of 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 contracting with subcontractors to provide services;

7. Providing technical assistance to subcontractors (providers of services) 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. From that date through 1994, the Agency was known as Eastern Washington Area Agency on Aging. The change in name in 1994, to Aging and Long Term Care of Eastern Washington (ALTCEW), signified a recognition of how its services and clientele have changed over the past 10 years and the direction the Agency needed to move toward in the future. Revisions to the Agency mission were also completed at this time.

The parties to the Interlocal Governmental Agreement under which the Agency was created include the City of Spokane and the five counties of Ferry, Pend Oreille, Spokane, Stevens and Whitman. The geographic area assigned to ALTCEW encompasses 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, two City of Spokane council members, one staff representative and the Planning and Management Council's Chairperson; and

2. Planning and Management Council – an advisory council made up of no more than 35 volunteers broadly representative of older persons and the community served by the Agency; and

3. Staff - skilled in the areas of planning; data collection and analysis; contract development, administration, and evaluation; advocacy and community education; administration and fiscal management of multiple federal, state and local funding sources.

A-2 Mission and Vision

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.

A-3 Planning and Review Process

PLANNING PROCESS:

Aging & Long Term Care of Eastern Washington's process for developing the 2016-2019 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 2016-2019 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 2016-2019 Area Plan on Aging and Long Term Care planning process for PSA #11.

2. The members of the Planning and Resources Committee, Service Quality Assurance Committee and PMC established, reviewed and approved the service specifications and procurement policies for services out to bid for 2012.

3. 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 twelve focus groups to receive and gather information on available resources and needs of older persons and individuals with disabilities living in PSA #11. These focus groups were used to inform draft goals and work objectives presented at the community planning meetings.

4. 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 2016-2019 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. Spokane County - Date: April 7, 2015
      Time: 1:00 PM to 2:0 PM
      Place: ALTCEW – Conference Room B&C
      1222 North Post Street
      Spokane, WA 99201

   b. Whitman County - Date April 1, 2015
      Time 1:00 PM to 3:00 PM
      Place Pullman Senior Center
      325 SE Paradise St
      Pullman, WA 99163

c. Ferry County - Date: March 31, 2015
Time: 1:30 PM to 2:30 PM
Place: Republic Senior Center
Republic, WA 99201

d. Stevens County: - Date: April 7, 2015
Time: 1:00 PM to 2:00 PM
Place: The Hub
The Flex Room
231 W. Elep Ave
Colville, WA 99114

e. Pend Oreille County: - Date: April 2, 2015
Time: 11:00 AM to 12:00 PM
Place: Hospitality House
212 S Washington Ave
Newport, WA 99156

5. 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 2016-2019 Area Plan on Aging and Long Term Care. The following public hearings were held:

a. Spokane County - Date: July 15, 2015
Time: 1:00 PM to 2:30 PM
Place: ALTCEW – Conference Rooms B&C
1222 North Post Street
Spokane, WA 99201

b. Whitman County - Date: July 10, 2015
Time: 1:00 PM to 2:30 PM
Place: Public Service Building
310 N. Main
Colfax, WA 991111

c. Ferry County: - Date: July 12, 2015
Time: 1:00 PM to 2:30 PM
Place: Republic Senior Center
Republic, WA 99201

d. Stevens County Date: July 14, 2015
Time: 1:30 PM to 3:00 PM
Place: Ambulance Center

		Conference Room 425 North Highway Colville, WA 99114
e. Pend Oreille	Date: Time: Place:	July 9, 2015 11:00 AM to 12:30 PM Hospitality House 216 S Washington Ave Newport, WA 99114

6. The Planning and Resources Committee, Service Quality Assurance Committees and PMC reviewed, modified and accepted sections of the Proposed 2016-2019 Area Plan on Aging and Long Term Care based on public comments and information received at the public hearings at their meeting on July 29, 2015. The PMC made recommendations to ALTCEW's Governing Board on acceptance of the Proposed 2016-2019 Area Plan on Aging and Long Term Care for PSA #11.

7. At its meeting on August 7, 2015, ALTCEW's Governing Board reviewed, modified and accepted sections of the Proposed 2016-2019 Area Plan on Aging and Long Term Care based on recommendations from the PMC.

8. ALTCEW's Proposed 2016-2019 Area Plan on Aging and Long Term Care for PSA #11 was submitted to Aging and Long Term Support Administration on October 9, 2015.

A-4 Prioritization of Discretionary Funding

PRIORITIZATION OF DISCRETIONARY FUNDING

Under Section A-4: Prioritization of Discretionary Funding, the Area Plan instructions require 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 weighing 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 III-B, Senior Citizen Services Act and local sources.

For the 2016-2019 Prioritization Process, the following questions were considered when prioritizing discretionary funded services in each subregion:

1. Does this service target vulnerable adults?
2. Does this service help maintain persons in their home or living situation of choice?
3. Does this service improve or maintain individual health outcomes?
4. Does this service address an unmet community need?
5. If this service is not provided, will it create unmet need(s) for vulnerable adults?
6. Does this service prevent isolation or promote socialization?

PROPOSED SERVICE AND PRIORITIZATION PRINCIPLES:

1. ALTCEW should use its discretion in transferring funds up to the maximum amount allowed.

2. As a priority, the current targeting principles from the Older Americans Act (OAA) and Senior Citizen Services Act (SCSA) should be maintained using updated census data for special populations including:
   - Older individuals residing in rural areas
   - Older individuals with the greatest economic need
   - Older individuals with the greatest social need

3. Continue Community Living Connections (CLC) as the top priority for each subregion as the focal point and hub of the service delivery network in PSA #11.

4. Utilize the regional allocation formula, which includes a base amount for each subregion, plus a percentage that is based on population figures and other factors. The percentages will be based on the 2010 U.S. Census population data for each of the subregions in PSA #11 until more recent data becomes available.

5. Any increase or decrease in revenue should be shared equitably by administration and direct and contracted services. If ALTCEW should lose the support of units of government, the burden of the loss would be shared equitably by AAA administration and the service network.

6. ALTCEW will implement a Prioritization Process a minimum of once every four years to prioritize discretionary funded services for the implementation of necessary reductions or increases in revenues. The Prioritization Process will include adoption of a series of questions to be used to rank individual services in each subregion. The ranking process will be completed by PMC members. The resulting matrix will be revised through discussion, debate and public testimony. The resulting prioritization matrix for each subregion will be revisited for possible additions, modifications and deletions when conducting Area Plan Updates.

7. New service priorities will be considered based on unmet needs, community resource analysis, information received from the focus groups, public perception survey, public hearings and other sources of information or research. Consideration should be given to service gaps within current services, shrinking or eliminating waiting lists for existing services or opportunities to leverage other community resources.

SPOKANE COUNTY DISCRETIONARY FUNDS
2015-2017

PROPOSED 2016-2017 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	Medication Management (Health Promotion Disease Prevention)
7	Continue	Long Term Care Ombudsman
8	Continue	Minor Home Repair
9	**	

2015 SERVICE PRIORITIES

Priority	Status	Service Objective
1	Continue	Information & Assistance/ General Case Management
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	Health Promotion/Disease Prevention
7	Continue	Long Term Care Ombudsman
8	Continue	Minor Home Repair
9	Start**	Chore-Like Services

* Proposed 2016-2017 Service Priorities based on the Prioritization Process completed by the ALTCEW Planning and Management Council on June 26, 2015.

** The Planning and Management Council recommends removing “Start” activities from prioritization matrix and including in Area Plan objective goals for additional funding opportunities. This is due to historical record of additional discretionary funding allocations throughout PSA#11.

WHITMAN COUNTY DISCRETIONARY FUNDS
2015-2017

PROPOSED 2016-2017 SERVICE PRIORITIES*

Priority	Status	Service Objective
1	Continue	Community Living Connections
2	Continue	Home Delivered Meals
3	Continue	Van/Volunteer Escort Transportation
4	Continue	Congregate Meals
5	Continue	Long Term Care Ombudsman
6	**	
7	**	

2015 SERVICE PRIORITIES

Priority	Status	Service Objective
1	Continue	Information & Assistance / General Case Management
2	Continue	Home Delivered Meals
3	Continue	Van/Volunteer Escort Transportation
4	Continue	Congregate Meals
5	Continue	Long Term Care Ombudsman
6	Start**	Health Appliances & Limited Health Care
7	Start**	Chore-Like Services

* Proposed 2016-2017 Service Priorities based on the Prioritization Process completed by the ALTCEW Planning and Management Council on June 26, 2015.

** The Planning and Management Council recommends removing “Start” activities from prioritization matrix and including in Area Plan objective goals for additional funding opportunities. This is due to historical record of additional discretionary funding allocations throughout PSA#11.

TRI-COUNTY SUBREGION DISCRETIONARY FUNDS
2015-2017

PROPOSED 2016-2017 SERVICE PRIORITIES*

(northern Ferry, Pend Oreille and Stevens counties)

Priority	Status	Service Objective
1	Continue	Community Living Connections
2	Continue	Van/Volunteer Escort Transportation
3	Continue	Home Delivered Meals
4	Continue	Congregate Meals
5	Continue	Long Term Care Ombudsman
6	**	
7	**	
8	**	

2015 SERVICE PRIORITIES

(northern Ferry, Pend Oreille and Stevens counties)

Priority	Status	Service Objective
1	Continue	Information & Assistance / General Case Management
2	Continue	Van/Volunteer Escort Transportation
3	Continue	Home Delivered Meals
4	Continue	Congregate Meals
5	Continue	Long Term Care Ombudsman
6	Start**	Minor Home Repair
7	Start**	Chore-Like Services
8	Start**	Bathing Assistance/limited Home Care

*Proposed 2016-2017 Service Priorities based on the Prioritization Process completed by the ALTCEW Planning and Management Council on June 26, 2015.

** The Planning and Management Council recommends removing “Start” activities from prioritization matrix and including in Area Plan objective goals for additional funding opportunities. This is due to historical record of additional discretionary funding allocations throughout PSA#11.

NON-DISCRETIONARY FUNDS
PLANNING AND SERVICE AREA #11

The instruction for completing the 2016-2019 Area Plan on Aging and Long Term Care require that the area agency on aging also list services provided through non-discretionary sources. This includes sources from the State's general fund, waiver services provided through Title XIX of the Social Security Act and any other local, foundation or private sources.

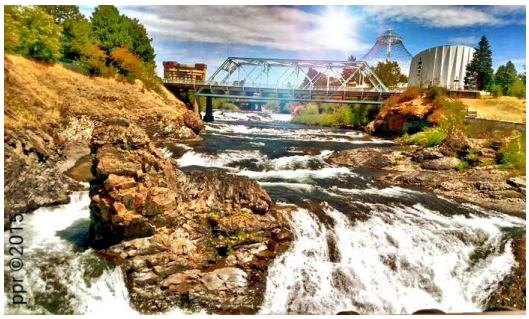
Non-Discretionary Funded Service
Title XIX Medicaid (MPC / COPES / CFC) ➢ Case Management ➢ Personal Care Services ➢ Nursing Services ➢ Core Services Contract Management
Community Living Connections/ Information & Assistance (formerly ADRC)
Bridging Care (Community Based Care Transitions)
Care Coordination (Health Homes)
Caregiver Training
Dementia Capable Systems
Dental Outreach Program
Family Caregiver Support Program
Home Care Referral Registry
Kinship Caregiver Support Program
Kinship Navigator Program
National Institute of Health Chronic Care Intervention Study (in partnership with WSU College of Nursing)
Nutrition Services Incentives Program
Senior Drug Education
Senior Farmer's Market Nutrition Program
Senior Legal Services
Senior Medicare Fraud Patrol
State Health Insurance Benefits Advisors (SHIBA)
Veterans Directed Home Services
Title V – Senior Community Service Employment Program

SECTION B – Planning and Service Area Profile

B-1 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 and 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, 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 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. Following is a brief description of each area, or subregion, in PSA #11.



SPOKANE COUNTY SUBREGION:

Spokane County covers 1,764 square miles. The area's economy is based primarily on retail, manufacturing, medical and government services. The retail sales and services industries employ the largest number of people.

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 wheat, peas, lentils and barley.

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 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

2010 Data	Ferry County	Pend Oreille County	Spokane County	Stevens County	Whitman County	PSA #11
Total Population	7,551	13,001	471,221	43,531	44,776	580,080
Persons 60+	2,018	3,647	82,450	10,856	5,661	104,632
Persons 75+	528	944	28,804	2,802	2,029	35,106
Persons 85+	153	257	9,369	750	729	11,258
Persons Below 100% Poverty Level[1]	1,415	2,392	61,231	6,228	10,573	81,839
Persons 60+ Below 100% Poverty Level	282	449	8,406	1,191	596	10,924
Persons 60+ Below EESI[2]	575	886	14,352	2,364	1,202	19,379
Minority	1,793	1,094	50,946	4,608	6,910	65,351
Minority 60+	459	332	4,436	1,185	375	6,788
Low Income Minority 60+	106	114	779	310	122	1,431
Native American Elders 60+	231	107	235	419	102	1,095
Limited English Speaking 60+	85	152	2,644	411	176	3,467
Rural	7,551	13,001	172,550	43,531	14,977	251,610
Square Miles	2,204	1,400	1,764	2,478	2,159	10,005
Persons Per Square Mile	3.4	9.3	267.1	17.6	20.7	58
Native American Tribes	N/A	Kalispel Tribe	N/A	Spokane Tribe	N/A	

Sources: 2010 Census, 2009 American Community Survey 5-year estimates, Washington State Office of Financial Management, *Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2020 in Washington State*, David Mancuso, PhD.

[1] The Federal Poverty Level was $10,830 for a single person household in 2010.

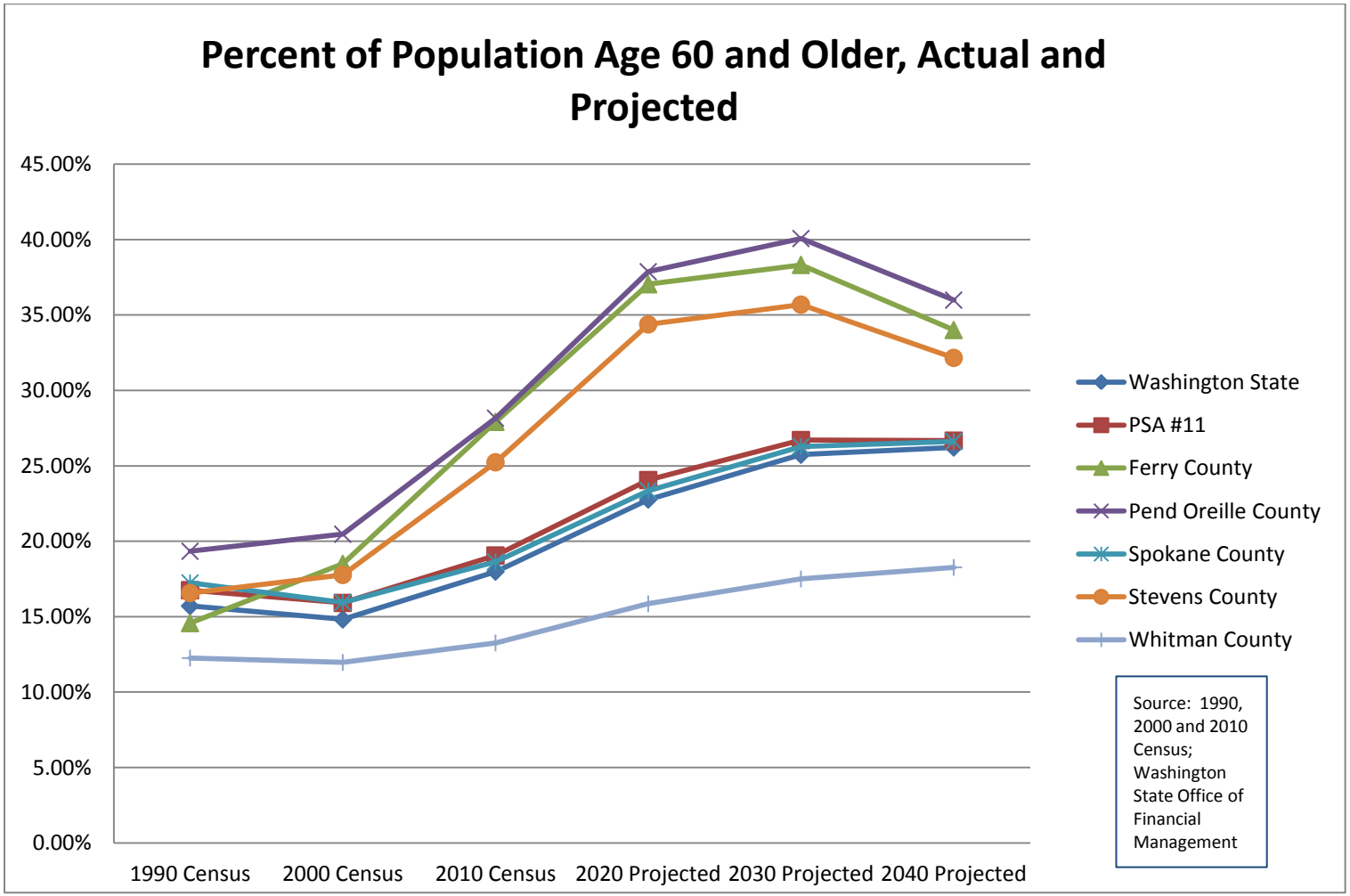
[2] EESI – Elder Economic Security Index, a realistic measure of how much it costs to live in Washington State, $18,336 for a single elder homeowner without a mortgage in 2010. Please see page 60 for additional details.

Forecast- 2016	Ferry County	Pend Oreille County	Spokane County	Stevens County	Whitman County	PSA #11
Persons 60+	2,667	4,710	108,556	14,118	6,936	136,987
Persons 60+ at or Below 100% Poverty Level	281	398	8,083	1,256	1,019	11,037
Minority 60+	453	277	6,576	1,206	672	9,184
Low Income Minority, 60+	88	29	623	219	185	1,144
Native American Elders 60+	234	107	1,025	456	71	1,893
Limited English Speaking 60+	104	171	3,694	514	361	4,844
18+ living with disabilities	857	1,423	38,826	4,468	3,609	49,183

Sources: Washington State Office of Financial Management *Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2020 in Washington State*, DSHS Research and Data Analysis Division, David Mancuso, PhD. June 2015.

On the next page is a graph that shows the past, current, and projected growth of persons 60 and older as a percentage of the total population in PSA #11, Washington State, and each county in PSA #11. This graph illustrates the dramatic growth in the number of persons 60 and older in the next ten and twenty years as the baby boom generation ages.

Growth of population ages 60 and above as percent of total population: Past, Current and Projected



Source: 1990, 2000 and 2010 Census; Washington OFM 2007 county projections by age: 5-year age groupings & 5-year intervals only

B - 2 Target Population

Aging & Long Term Care of Eastern Washington (ALTCEW) targets services to individuals with the greatest economic and social need. Contracts are designed to encourage subcontractors to serve targeted populations including minorities, low-income, limited-English-speaking, isolated individuals (single, widowed, separated, and/or living alone),individuals aged 75 and over, older Lesbian , Gay, Bisexual, and Transgender (LGBT) and people 60 and under living with disabilities. Special emphasis are efforts to identify and provide services to Native American elders living in PSA #11. ALTCEW performs regular desk monitoring activities designed to measure effectiveness and ensure compliance with the special conditions contained in each subcontractor's service agreement.

To serve individuals living in the ALTCEW service area, ALTCEW subcontracts with agencies throughout each sub region to provide locally based services in each community. Community Living Connections, Title XIX Case Management, Family Caregiver Support Program, and Kinship Caregiver Support Program and Kinship Navigator Programs are all administered by local agencies in each of the ALTCEW sub regions (Rural Resources Community Action in Tri-County and Whitman County areas, Elder Services in Spokane). Family Caregiver Support Program, Kinship Caregiver Support and Kinship Navigator, as like programs, are provided by the same agency in each sub region. This makes it possible to tailor services to the unique needs of those needing these services in both rural and urban areas. Rural areas also provide numerous other services tailored to the local needs of their communities. In order to better serve rural counties, ALTCEW allocates a base amount of funding to rural counties so that they receive equitable funding versus if allocation was based on population alone.

As a state requirement, ALTCEW targets limited-English-speaking and minority individuals in the same proportion as occurs in the population. All agencies are required to serve minority and limited-English-speaking elders in a proportional percentage as they occur in the total elder population in the respective counties. The Community Living Connections (CLC) subcontractor in Spokane County is required to target and serve minority and limited-English proficient elders at twice the percentage levels of minority and limited-English proficient age 60 and older individuals living in the Spokane County. To better serve limited English-speaking individuals, ALTCEW also promotes the translation of forms and informational materials into other languages, as well as the use of interpreters.

ALTCEW and its subcontractors have also developed, and will continue to implement a plan of action for addressing outreach and linkages with minority and limited-English-speaking populations in PSA #11. Contact with these populations will be realized through ongoing linkages with other segments of the aging network, public presentations, and multimedia outreach efforts. As part of these ongoing outreach efforts, close contact will be maintained with ethnic and minority groups in PSA #11.

Spokane hosts a significant number of recent and former refugee elders. Refugees often arrive having experienced extreme stress and duress, to a foreign land with a completely different

culture and limited English skills. Due to the increasing number and recognition of refugee elders that receive ALTCEW-sponsored services, ALTCEW continues to coordinate with World Relief, Refugee Connections, and other organizations in order to improve and coordinate services to refugee elders.

ALTCEW is working with Eastern Washington University (EWU) School of Social Work to continue the development of partnerships with organizations serving LGBT elders. ALTCEW and EWU are in the final stages of development of a staff and subcontractor training that will address the unique needs of older adults in the LGBT community.

Persons at risk of institutional placement are targeted several ways. First, they are targeted by outreach and service to persons with the greatest social and economic need. Also, persons at risk of institutional placement are targeted by the choice of services provided in each subregion. For example, in Spokane County several services are targeted to at-risk individuals such as Bathing Assistance, and Adult Day Care. The Family Caregiver Support Program, available in all subregions, is designed to support family caregivers in their caregiving role in order to prevent the care recipient from being institutionalized or placed in a higher cost of care setting.

B-3 AAA Services

SERVICES PROVIDED THROUGH SUBCONTRACTS

ACCESS SERVICES:

Community Living Connections (Information & Assistance)

Community Living Connections are a nationwide effort led by the Administration for Community Living and the Centers for Medicare and Medicaid Services to restructure services and supports for older adults and persons 18 and older with disabilities. Washington State has re-branded the national efforts with the name Community Living Connections (CLC). CLCs serve as integrated points of entry into the long-term care system that are designed to address many of the frustrations consumers and their families experience when trying to access needed information, services, and supports. They are essentially a "one-stop-shop" for long-term care information, referral, and assistance. ALTCEW utilizes a network approach to accomplish these goals and currently involves ten partners in the network.

Part of the Community Living Connections is Information & Assistance (I&A). This service is the focal point, the hub of the aging and long term care service delivery system. I&A/ Options Counseling provides the link to community resources. Services may include information, referral, short term assistance, advocacy and screening to determine if an in-home assessment is needed. It also actively seeks out at-risk adults, assesses their needs, and through person-centered interventions, develops and implements a plan for insuring supports are in place to maintain independence as long as possible.

Rural Resources Community Action
1345 NE Terre View Drive
Pullman, WA 99163
(509) 332-0365
Whitman County

Elder Services/Frontier Behavioral Health
5125 North Market Street
Spokane, WA 99207
(509) 458-7450
Spokane County

Rural Resources Community Action
956 South Main Street
Colville, WA 99114-2505
(509) 684-3932
Pend Oreille, Stevens and northern Ferry counties

Family Caregiver Support Program

The Family Caregiver Support Program provides a multifaceted system of support services to respond to the needs of family and other unpaid caregivers. These services include providing information about public and private long term care support services; providing assistance in gaining access to an array of caregiver services; individual counseling and consultation; promotion and implementation of support groups; training to assist the unpaid caregiver in making decisions and solving challenges related to the Caregiving role; respite care services; and supplemental services that include additional supportive services for the unpaid caregiver such as transportation, purchasing of needed supplies, durable goods or equipment, and other support services necessary to assist and maintain the unpaid Caregiving role.

The federal monies for this program also allow up to 10% to be spent on services to grandparents and other relatives raising relatives, who are over age 60 and caring for a relative 18 years or younger. The purpose of these funds is to support and empower these relatives raising relatives and provide them with the information and resources they need to be successful caregivers.

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1345 NE Terre View Drive
Pullman, WA 99163
(509) 332-0365
Whitman County

Elder Services/Frontier Behavioral Health
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Spokane, WA 99207
(509) 458-7450
Spokane County

Rural Resources Community Action
956 South Main Street
Colville, WA 99114
(509) 684-8421
Stevens, Pend Oreille and northern Ferry counties

Kinship Caregiver Support Program

The Kinship Caregiver Support Program uses state monies to provide 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.

Rural Resources Community Action
1345 NE Terre View Drive

Pullman, WA 99163
(509) 332-0365
Whitman County

Elder Services/Frontier Behavioral Health
5125 North Market Street
Spokane, WA 99207
(509) 458-7450
Spokane County

Rural Resources Community Action
956 South Main Street
Colville, WA 99114
(509) 684-8421
Stevens, Pend Oreille and northern Ferry counties

Kinship Navigator Program

The Kinship Navigator Program connects grandparents and relatives who are raising children to community resources, such as health, financial and legal services, support groups, and emergency funds. These crucial links, between kinship caregivers and services, help families create healthier environments and establish the self-sufficiency and long-term stability needed to keep their children out of foster care.

Rural Resources Community Action
1345 NE Terre View Drive
Pullman, WA 99163
(509) 332-0365
Whitman County

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5125 North Market Street
Spokane, WA 99207
(509) 458-7450
Spokane County

Rural Resources Community Action
956 South Main Street
Colville, WA 99114
(509) 684-8421
Stevens, Pend Oreille and northern Ferry counties

Transportation

This program provides transportation services to older persons who have no other means of transportation or are unable to use existing transportation. ALTCEW priorities include transportation to and from medical and health care services, social services, and meal programs. In special circumstances transportation may be provided to senior centers, shopping, and/or recreational activities. Personal assistance for those with limited physical mobility is also provided. Transportation may be provided by van or by volunteers using their own private vehicles, depending on the local service design, and the person's needs and abilities.

Council on Aging and Human Services
210 South Main Street
Colfax, WA 99111
(509) 397-4611
Whitman County

Rural Resources Community Action
956 South Main Street
Colville, WA 99114
(509) 684-8421
Stevens, Pend Oreille, and northern Ferry counties

IN-HOME SERVICES:

Personal Care Services

Chore Personal Care (Case Management / Nursing Services-Core Service)

Pursuant to WAC 388-106-0610 Chore services are no longer available to new clients.

Title XIX Medicaid Personal Care Program (Case Management / Nursing Services-Core Service)

The Title XIX (Medicaid) Personal Care program, known as MPC, provides personal care and household assistance to individuals 18 years of age or older, to enable them to remain in the community through the provision of semi-skilled maintenance or supportive services.

Individuals must be assessed as having an unmet or partially met need or the activity did not occur (because they are unable or no provider is available) with at least 1) three or more tasks, as defined in WAC 388-106-0210 if supervision, set up, or assistance is needed or 2) one or more tasks as defined in WAC 388-106-0210 if extensive or limited assistance plus one person physical assist is needed. The Department of Social and Health Services division Home and Community Services conduct the initial assessment of the individual's needs. Individuals must also meet financial eligibility requirements. Services are then performed by qualified and

trained Personal Care Aides in the client's home or community-based residence. Medicaid Personal Care services include such tasks as: 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. Title XIX (Medicaid) Personal Care services exclude tasks which clearly should be provided by certified medical professionals, such as a registered nurse, licensed practical nurse or therapist. The target population for the program is persons who have been certified as Title XIX Medicaid eligible "categorically needy" medical assistance clients. Personal Care clients must live in their own home or an adult family home, a licensed boarding home under contract to DSHS or children's foster family home.

Personal care services may be provided by a contracted Independent Provider, or through a Home Care Agency contracted by the Area Agency on Aging.

Elder Services/Frontier Behavioral Health
5125 North Market Street
Spokane, WA 99207
(509) 458-7450
Spokane County

Rural Resources Community Action
1345 NE Terre View Drive
Pullman, WA 99163
(509) 332-0365
Whitman County

Rural Resources Community Action
956 South Main Street
Colville, WA 99114
(509) 684-8421
Stevens, Pend Oreille, and northern Ferry counties

Community First Choice (Case Management / Nursing Services-Core Service)

Community First Choice (CFC) is a Medicaid state plan program authorized under RCW 74.39A.400. Clients eligible for this program may receive services in their own home or in a residential setting, as defined in WAC 388-110-0020 and show that they need the level of care provided in a Nursing Facility. CFC works with the client to create a person centered service plan to help them decide which services and supports they wish to receive. They have a choice about where they want to live and what services they receive. The services offered under the CFC program include personal care services, as defined in WAC 388-106-0010, Relief care, which provides personal care services by a second individual or agency provider as a back-up to primary paid personal care provider, Skills acquisition training which is defined as training that allows clients to acquire, maintain, and enhance skills necessary to accomplish ADLs, IADLs, or

health related tasks more independently, Personal emergency response systems (PERS), Assistive technology which is an item which increases independence or substitutes for human assistance.

To qualify for CFC services an individual must be assessed as having an unmet or partially met need as defined in WAC 388-106-0310 and 388-106-0355. The client must require assistance in a minimum of two tasks to qualify. The Department of Social and Health Services (DSHS) division Home and Community Services (HCS) conduct the initial assessment of the individual's needs. Individuals must also meet financial eligibility requirements.

Personal care services may be provided by a contracted Independent Provider, or through a Home Care Agency contracted by the Area Agency on Aging.

Elder Services/Frontier Behavioral Health
5125 North Market Street
Spokane, WA 99207
(509) 458-7450
Spokane County

Rural Resources Community Action
1345 NE Terre View Drive
Pullman, WA 99163
(509) 332-0365
Whitman County

Rural Resources Community Action
956 South Main Street
Colville, WA 99114
(509) 684-8421
Stevens, Pend Oreille, and northern Ferry counties

COPES Personal Care Program (Case Management / Nursing Services-Core Service)

The Community Options Program Entry System, known as COPES, provides personal care and household assistance to persons 18 years of age or older and blind or disabled, as defined in WAC 388-475-0050; or are 65 or older who reside in their own homes, adult family homes, congregate care facilities, or assisted living facilities. Clients must be functionally or clinically eligible for nursing facility level of care. COPES is part of the Medicaid program, which also covers nursing home care and other medical services.

Individuals must be assessed as having an unmet or partially met need, or the activity did not occur (because they were unable or no provider was available) with at least 1) three or more tasks, as defined in WAC 388-106-0310 and 388-106-0355, if supervision, set up or assistance is needed or 2) one or more tasks as defined in WAC 388-106-0310 and 388-106-0355, if

extensive or limited assistance plus one person physical assist is needed. The DSHS division Home and Community Services conducts the initial assessment of the individual's needs. Services are then performed by qualified and trained Personal Care Aides in the client's home or community-based residence. Personal Care services include such tasks as: locomotion, bed mobility, bathing, toileting, dressing, transfer, eating, meal preparation, personal hygiene, positioning, and assistance in medication management, essential shopping, housework, and travel to medical services. COPES Personal Care services exclude tasks which clearly should be provided by certified medical professionals, such as a registered nurse, licensed practical nurse or therapist.

Personal care services may be provided by a contracted Independent Provider, or through a Home Care Agency contracted by the Area Agency on Aging.

Elder Services/Frontier Behavioral Health
5125 North Market Street
Spokane, WA 99207
(509) 458-7450
Spokane County

Rural Resources Community Action
1345 NE Terre View Drive
Pullman, WA 99163
(509) 332-0365
Whitman County

Rural Resources Community Action
956 South Main Street
Colville, WA 99114
(509) 684-8421
Stevens, Pend Oreille, and northern Ferry counties

Veteran Directed Home Services

The Veteran Directed Home Services (VDHS) Program began at ALTCEW in July 2015. The Veterans on this program are not on Medicaid; they have higher income and do not have the same financial eligibility as other clients. The Case Managers/Care Consultant does an assessment using the states Comprehensive Assessment Reporting Evaluation Tool (CARE) to identify the needs and preferences of the participant. An individual budget and spending plan is developed based on the Veteran's needs and includes goods and services (including hiring and managing employees) that will best meet the identified needs. Public Partnerships, LLC. (PPL) provides financial management services to Veterans participating in VDHS. While PPL provides procurement, contracting and bill paying services, Veterans have complete control over what services and/or goods are purchased as part of their spending plans as long as there is consistency between the services/goods and assessed needs.

Personal care services may be provided by a contracted Independent Provider, or through a Home Care Agency contracted by the Area Agency on Aging.

Rural Resources Community Action
956 South Main Street
Colville, WA 99114
(509) 684-8421
Stevens, Pend Oreille, and northern Ferry counties

Other In-Home Services

Bath Assistance/Limited Home Care (Bath Assistance)

Bath Assistance/Limited Home Care Program services are furnished to older persons in their own homes on a visiting basis. Services include Bathing and Personal Hygiene as the primary service. Additional allowable services that can occur during the same home visit as the primary service include Transfer, Body Care, Dressing, Housework, and Laundry. A maximum of two in-home visits can be provided per week.

The target population is persons age 60 and over who need Bathing Assistance/Limited Home Care services to remain in their own homes, and are not eligible for, or have exhausted other sources of payment (such as Medicare, Medicaid, private insurance, etc.), for similar services or similar services are not available.

Family Home Care Corporation
22820 E Appleway Ave
Liberty Lake, WA 99019-9514
(509) 473-4900
Spokane County

Home-Delivered Meals

The Home Delivered Nutrition Services Program 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. Services are intended to maintain or improve the health status of these individuals, support their independence, prevent premature institutionalization and allow earlier discharge from hospitals, nursing homes, or other residential care facilities. Each meal served contains at least one-third of the current recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences National Research Council. Meals may be delivered hot each day, up to five days a week. Frozen, liquid, or shelf stable meals may be delivered up to four weeks of meals at a time depending on the locale and client storage space.

Council on Aging and Human Services
210 South Main Street
Colfax, WA 99111
(509) 397-4611
Whitman County

Greater Spokane County Meals on Wheels
12101 E Sprague Ave
Spokane Valley, WA 99206
(509) 924-6976
Spokane County

Rural Resources Community Action
956 South Main Street
Colville, WA 99114
(509) 684-8421
Stevens, Pend Oreille, and northern Ferry counties

Minor Home Repair and Maintenance

Minor Home Repair services consist of those repairs or modifications to client-occupied structures which are essential for the health and safety of older occupants. There is a limit of $1,000 of repairs per year for state-funded service or $150 for federal-funded service.

Spokane Neighborhood Action Programs
Housing Improvements Division
212 West Second Ave, Suite 100
Spokane, WA 99201-3606
(509) 744-3370
Spokane County

COMMUNITY SERVICES:

Adult Day Care

Adult Day Care Services are provided in a center certified as a Medicaid Title XIX provider where the client requires adult day care or day health services including the provision of personal care, as defined under WAC 388-71-0702; 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.

Providence Adult Day Health
6018 N. Astor

Spokane, WA
(509) 482-2475
Spokane County

Congregate Nutrition (Congregate Meals)

The Congregate Nutrition Services programs help meet the complex nutritional needs of persons age 60 or over who do not eat adequately by providing nutritionally sound and satisfying meals and other nutrition services, including nutrition outreach and nutrition education, in a group setting. Each meal served contains at least one-third of the current recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences National Research Council. Related support services, such as transportation to congregate meal sites, personal escorts, nutrition counseling, and health education are also available.

Council on Aging and Human Services
210 South Main Street
Colfax, WA 99111
(509) 397-4611
Whitman County

Greater Spokane County Meals on Wheels
12101 E Sprague Ave
Spokane Valley, WA 99206
(509) 924-6976
Spokane County

Diner's Choice is a nutrition program where seniors have the opportunity to try different restaurants located throughout Ferry, Pend Oreille and Stevens counties. Any person that is 60 years of age and older is eligible. Participating restaurants honor Diner's Choice coupons for any approved menu choice. Coupons are honored for the month that they are issued and each coupon features a clearly marked expiration date. Most menus include several breakfast, lunch and dinner options.

There are two ways to become a Diner's Choice participant. First, contact any Rural Resources Community Action office and ask for an application. Second, each Diner's Choice restaurant can provide an application and temporary coupon(s) while the application is being processed. After signing-up, a representative from the Senior Nutrition Program will contact the applicant. They will assist the applicant in completing a five-minute nutrition evaluation. The nutrition evaluation is used to determine the applicant's level of participation in the program.

Rural Resources Community Action
956 South Main Street

Colville, WA 99114
(509) 684-8421
Stevens, Pend Oreille, and northern Ferry counties

Legal Assistance

Legal Assistance services 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 (60 years of age or older) who is experiencing legal problems. Priority issues are established to reflect local needs. Programs are to foster cost-effective high quality services that are integrated in the aging services network and accessible throughout each planning and service area, and develop and maximize the use of other resources.

University Legal Assistance / Senior Citizens Law Project
721 N. Cincinnati St. #101
Spokane, WA 9902-2021
(509) 313-5791
Spokane County

Rural Resources Community Action
956 South Main Street
Colville, WA 99114
(509) 684-8421
Stevens, Pend Oreille, and northern Ferry counties

Long Term Care Ombudsman

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.

Spokane Neighborhood Action Programs
Long Term Care Ombudsman
500 South Stone
Spokane, WA 99201
(509) 456-7106
All counties

Home Care Referral Registry

The Home Care Referral Registry is a web-based database of individual in-home providers who are ready and available to work. Home Care Referral Registry services are available to

consumers who use publicly funded in-home care services (Aging Services, Developmental Disabilities, and Children's Services). Consumers and case managers can access the Home Care Referral Registry to find qualified individual providers. Clients can interview providers referred by the registry and hire the ones that best suit their needs. Along with referrals, the Registry provides contracting and training services for individuals interested in becoming Independent Providers, as well as information for consumers on hiring and managing in-home workers.

Home Care Referral Registry services are available in Spokane, Whitman, Pend Oreille and Stevens counties. Consumers can call 1-800-970-5456, call their Case Manager, or visit the Home Care Referral Registry website at www.hcrr.wa.gov for more information about the Home Care Referral Registry.

Aging & Long Term Care of Eastern Washington
1222 N. Post Street
Spokane, WA 99201
(509) 458-2509
Spokane and Whitman counties

Rural Resources Community Action
301 W. Spruce Street, Suite D
Newport, WA 99156
(509) 447-5614
Pend Oreille and Stevens County

Senior Farmers Market Nutrition Program (SFMNP)

The Senior Farmers Market Nutrition Program is designed to improve the diets of low income senior citizens in ALTCEW's Planning and Service Area. Vouchers can be used throughout Washington State, regardless of where the consumer lives. This is to be accomplished by providing eligible seniors with vouchers that can be used to purchase fresh fruits and vegetables from the following Farm Season certified farmers markets: Spokane Farmers Market, Airway Heights Farmers Market, Cheney Farmers Market, Liberty Lake Farmers Market, Millwood Farmers Market, South Perry Farmers Market, Hillyard Farmers Market, Colville Farmers Market, Pend Oreille Valley Farmers Market, Deer Park Farmers Market, West Central Marketplace, and Chewelah Farmers Market. Bags of fresh fruits and vegetables from these markets may also be provided directly to seniors during delivery of home delivered meals.

Vouchers provided by (Spokane County only):

Catholic Charities
12 E. 5th Ave
Spokane, WA 99202
Spokane County

Distributed by:

Greater Spokane County Meals on Wheels
12101 E Sprague Ave
Spokane Valley, WA 99206
(509) 924-6976
Spokane County

Vouchers provided by:

Rural Resources Community Action
956 South Main Street
Colville, WA 99114
(509) 684-8421
Ferry and Stevens counties

Council on Aging and Human Services
210 S Main St
Colfax, WA 99111
(509) 397-4611
Whitman County

Bulk produce is provided to Home Delivered Meal recipients by:

Greater Spokane County Meals on Wheels
12101 E Sprague Ave
Spokane Valley, WA 99206
(509) 924-6976
Spokane County

SERVICES PROVIDED DIRECTLY BY ALTCEW

Aging & Long Term Care of Eastern Washington
1222 North Post Street
Spokane, WA 99201
(509) 458-2509
Spokane, Whitman, Stevens, Pend Oreille, and northern Ferry counties (except as noted)

ACCESS SERVICES:

Community Living Connections (Information & Assistance)

Community Living Connections are a nationwide effort led by the Administration for Community Living and the Centers for Medicare and Medicaid Services to restructure services and supports for older adults and persons 18 and older with disabilities. Washington State has re-branded the national efforts with the name Community Living Connections (CLC). CLCs serve as integrated points of entry into the long-term care system that are designed to address many of the frustrations consumers and their families experience when trying to access needed information, services, and supports. They are essentially a "one-stop-shop" for long-term care information, referral, and assistance. ALTCEW utilizes a network approach to accomplish these goals and currently involves ten partners in the network.

Part of the Community Living Connections in Information & Assistance (I&A). This service is the focal point, the hub of the aging and long term care service delivery system. I&A/ Options Counseling provides the link to community resources. Services may include information, referral, short term assistance, advocacy and screening to determine if an in-home assessment is needed. It also actively seeks out at-risk adults, assesses their needs, and through person-centered interventions, develops and implements a plan for insuring supports are in place to maintain independence as long as possible.

IN-HOME SERVICES:

Nursing Services

Upon referral from Home and Community Services, Developmental Disabilities Administration, ALTCEW or its subcontracted case management organizations, the Registered Nurse Consultants will provide the following services for Medicaid Personal Care, COPES Personal Care and other eligible clients which may include the following: nursing assessment and reassessment, instructions to care providers, care coordination, and evaluation.

Veteran Directed Home Services

The Veteran Directed Home Services (VDHS) Program began at ALTCEW in July 2015. The Veterans on this program are not on Medicaid; they have higher income and do not have the same financial eligibility as other clients. The Case Managers/Care Consultant does an assessment using the states Comprehensive Assessment Reporting Evaluation Tool (CARE) to identify the needs and preferences of the participant. An individual budget and spending plan is developed based on the Veteran's needs and includes goods and services (including hiring and managing employees) that will best meet the identified needs. Public Partnerships, LLC. (PPL) provides financial management services to Veterans participating in VDHS. While PPL provides procurement, contracting and bill paying services, Veterans have complete control over what services and/or goods are purchased as part of their spending plans as long as there is consistency between the services/goods and assessed needs.

Personal care services may be provided by a contracted Independent Provider, or through a Home Care Agency contracted by the Area Agency on Aging.

Service available in Spokane, Ferry, Pend Oreille and Stevens counties.

COMMUNITY SERVICES:

Senior Community Service Employment Program

The Senior Community Service Employment Program (SCSEP, also known as Title V) is a program sponsored by ALTCEW with funding by Title V of the Older Americans Act. It is designed to provide, foster and promote useful part-time work activities for economically disadvantaged persons who are 55 years of age or older. It provides on-the-job training in community service or non-profit organizations. Enrollees are expected to seek unsubsidized employment while in a subsidized workplace. Service available in Spokane, Ferry, Pend Oreille and Whitman counties.

To be eligible for this program, applicants must:

- Want to work;
- Be at least 55 years of age;
- Be unemployed;
- Be a resident of the State of Washington;
- Not have income exceeding 125% of the Federal Poverty Guidelines.

Dental Outreach Program

Washington State Dental Association (WSDA) Outreach Program is a reduced fee dental care program for low-income elderly, disabled, and Alzheimer's patients. Dental services and laboratory charges are discounted by 25% and provided by participating members of the WSDA

and the Washington State Dental Laboratory Association. As the local Area Agency on Aging, ALTCEW determines the eligibility of seniors and Alzheimer's patients. The Washington Oral Health Foundation determines the eligibility for patients living with disabilities.

Home Care Referral Registry

The Home Care Referral Registry is a web-based database of individual in-home providers who are ready and available to work. Home Care Referral Registry services are available to consumers who use publicly funded in-home care services (Aging Services, Developmental Disabilities, and Children's Services). Consumers and case managers can access the Home Care Referral Registry to find qualified individual providers. Clients can interview providers referred by the registry and hire the ones that best suit their needs. Along with referrals, the Registry provides contracting and training services for individuals interested in becoming Independent Providers, as well as information for consumers on hiring and managing in-home workers.

Home Care Referral Registry services are available in Spokane, Whitman, Pend Oreille and Stevens counties. Consumers can call 1-800-970-5456, call their Case Manager, or visit the Home Care Referral Registry website at www.hcrr.wa.gov for more information about the Home Care Referral Registry.

Statewide Health Insurance Benefits Advisors Help Line (SHIBA/ Senior Medicare Patrol)

Statewide Health Insurance Benefits Advisors (SHIBA) Help Line is a program funded through the Office of the Washington State Insurance Commissioner with funding from the Administration on Aging. SHIBA volunteers are trained by the Office of the Washington State Insurance Commissioner to provide free, unbiased counseling to consumers regarding all aspects of health insurance and health care access in Spokane and Whitman counties. Counseling specialties include Medicare and its programs (Medicare Supplements, Medicare Advantage Plans, Medicare Part D and Part D's Low Income Subsidy), Medicaid, Individual Coverage, Apple Health for Kids, and Washington Basic Health.

Senior Medicare Patrol (SHIBA/ Senior Medicare Patrol)

The Senior Medicare Patrol is a program funded through the Office of the Washington State Insurance Commissioner with funding from the Administration on Aging. Trained volunteers work in their communities, senior centers, and elsewhere to educate Medicare and Medicaid beneficiaries, family members and caregivers 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.

Senior Drug Education Program

The goal of the Senior Drug Education Program is to increase knowledge of individuals 65 years of age and older in the safe and appropriate use of prescription and non-prescription drugs.

This is done by conducting the following activities: (a) Gathering or designing materials and curriculum items on the appropriate use of medications; (b) Offering classes in small and large groups settings; (c) Disseminating information and materials; (d) Utilizing the SHIBA Coordinator as the project and training coordinator; (d) Recruiting and utilizing SHIBA volunteers to conduct training and dissemination activities; and (e) Outreaching to pharmacists, physicians, nurses and other health care professionals and requesting their assistance in conducting training and dissemination activities.

Medicare Improvement of Patients and Providers Act (MIPPA)

The Medicare Improvement for Patients and Providers Act (MIPPA) Program provides outreach and assistance services for individuals residing in targeted zip codes throughout PSA #11 (northern Ferry, Pend Oreille, Spokane, Stevens and Whitman Counties). Targeted outreach and assistance activities are provided to eligible individuals applying for the Medicaid Part D Low-Income Subsidy and Medicare Savings Programs.

Caregiver Training

The ALTCEW Training Center is dedicated to providing quality caregiver training. ALTCEW instructors provide students with comprehensive training that equips them to handle the challenges presented by the day-to-day responsibilities of providing care in multiple care settings. The Training Center provides courses to Northwest Training Partnership students as a subcontracted provider of Catholic Community Services. The Center is also an approved Community Trainer for Aging and Long Term Support Administration, as well as an approved Private Career School through the Washington State Workforce Training and Education Coordinating Board. Classes include the following:

- Nursing Assistant Certified Training
- Home Care Aide Training
- Continuing Education – Online
- Continuing Education – In Person
- Nurse Delegation Core and Diabetes
- Dementia and Mental Health Specialty Training
- CPR and First Aid Training

Bridging Care
Community Based Care Transitions Program (Section 3026) of the Affordable Care Act

ALTCEW was awarded a contract from the Centers for Medicare and Medicaid Services to provide a Community-Based Care Transitions Program. The goal of the program is to reduce hospital readmissions by 20% for Fee for Services Medicare Beneficiaries. The Care Transitions Intervention Program is an evidence-based program that provides a Care Transition Coach to patients being discharged from local hospitals. During this 30 day program, patients with complex care needs receive specific tools, are supported by a Care Transitions Coach, and learn

self-management skills to ensure their needs are met during the transition from hospital to home. ALTCEW is working with Providence Sacred Heart Medical Center and Holy Family Hospital to provide this service.

Care Coordination (Health Home)

ALTCEW provides Care Coordination services as part of the Health Home pilot in Washington State. As a Care Coordination entity, ALTCEW serves high-risk dual-eligible and Medicaid clients using trained Social Worker and RN staff. Services include comprehensive care transitions, coordination of medical and social service supports, and assisting individuals in identifying and reaching their health goals.

Chronic Care Intervention (National Institute of Health Grant)

The Chronic Care Intervention (CCI) is a four year study to test the Chronic Care Intervention model at a Federally Qualified Health Center. This study is funded by the National Institute on Aging and is being provided in partnership with Washington State University College of Nursing and the Community Health Association of Spokane. This study uses a randomized single-blind clinical trial and will evaluate the impact of the chronic care intervention (CCI) on: 1) participants level of health activation (participation in self-management and engagement with healthcare professionals); 2) health-related quality of life (HRQoL); and 3) acute care use. The study is available for eligible Spokane County residents.

Evidence Based Programs (Disease Prevention/Health Promotion)

ALTCEW has provided evidence based programming in our service area for several years. ALTCEW is currently in the process of expanding and developing evidence based programming in Spokane County to include falls prevention training, A Matter of Balance, and other like programs.

Dementia Capable Systems

Through support from the Alzheimers Association and funding from Aging and Long Term Support Adminstration, ALTCEW is working with the Alzheimers Association to offer community workshops that address early stage memory loss in Spokane and Whitman counties.

B - 4 Non-AAA Services

NON- AAA SERVICES

This table lists the types and locations of non-AAA services in PSA #11 that are not included as part of Aging & Long Term Care of Eastern Washington and/or its network of subcontractors. Not all need is addressed by AAA programs, and the following services help meet the need of elders living throughout PSA #11. Though the number of resources is great, agencies are unable to meet the complete need of elders in PSA #11 due to lack of funding and other resources. This list is not all - inclusive

SERVICES	SPOKANE COUNTY	WHITMAN COUNTY	FERRY	PEND OREILLE COUNTY	STEVENS
Case Management Programs	X	X	X	X	X
Computer Training	X	X	X	X	x
Dementia, Alzheimer's Services	X	X	X	X	X
Developmental Disabilities focused	X	X	X	X	X
Disability/Issue Groups	X	X	X	X	X
Elder Abuse	X	X	X	X	X
Employment Services	X	X	X	X	X
Education & Counseling Programs	X	X	X	X	X
Food Banks	X	X	X	X	X
Homeless Programs	X				X
Hospital/Medical Centers, Medical & Dental Clinics	X	X	X	X	X
Housing Services	X	X	X	X	X
Geriatric, Mental Health & Alcohol/Substance Abuse Services	X				X
Older Lesbian, Gay, Bi-Sexual, and Transgender Programs	X				
Senior Centers, Senior Fitness and Social Programs	X	X	X	X	X
Senior Employment	X	X	X	X	X
Senior I&A Services (211, SHIBA, Benefits Check Up)	X	X	X	X	X
Services to Ethnic Groups	X				
Spiritual/Faith based Organizations	X	X	X	X	X

SERVICES	SPOKANE COUNTY	WHITMAN COUNTY	FERRY	PEND OREILLE COUNTY	STEVENS
Transportation	X	X	X	X	X
Volunteer Programs	X	X	X	X	X
Legal Services	X	X	X	X	X
Title VI Programs	X		X		X
Energy Assistance Programs	X	X	X	X	X

Issue Areas, Goals and Objectives

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 2014, our network helped almost 30,000 people living in PSA #11. To continue to address the needs of individual is 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

"My mother is living alone and getting more frail. We are trying to talk her into moving into a nursing home but we can't get anywhere. Is there a reason why mother can't continue living alone? What is the difference between nursing facilities, assisted living, and adult family homes?" These are not uncommon scenarios presented to our information and referral staff with Community Living Connections For families who need answers, an options counselor from ALTCEW's contracted providers may be the best starting point.

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.

PROFILE: According to the Middle series projections, between 2012 and 2050, the U.S. population is projected to grow from 314 million in 2012 to 400 million in 2050, an increase of 27 percent. The nation will also become more racially and ethnically diverse, with the aggregate minority population projected to become the majority in 2043. The population is also expected to become much older. By 2030, more than 20 percent of U.S. residents are projected to be aged 65 and over, compared with 13 percent in 2010 and 9.8 percent in 1970.[3] The change in the aging population will bring with it a corresponding growth in the number of older adults with functional and cognitive limitations.

Approximately 20 percent (7.7 million) of older Americans receive assistance with their care needs. Most receive services or supports from family, friends, or professional workers in their homes and communities. An estimated 1.1 million older adults receive services in a nursing home, either as a long-stay resident or for short-stay post-hospital rehabilitation. The likelihood of needing assistance increases sharply with age: 11 percent of adults aged 65-69 have a functional limitation, compared to 62 percent of the population 90 and older. Women are more likely than men to need long-term services and supports primarily because they tend

[3] The main series, referred to as the Middle series, was released in December 2012. The three alternative series, released in May 2013, were based on assumptions of low, high, and constant levels of net international migration (U.S. Census Bureau, 2012b).

to live longer. Individuals with Alzheimer's disease or other dementia frequently need more of these services and supports than those older adults who have physical disabilities.

In recent years, the Administration has expanded efforts to ensure that older adults and individuals with disabilities have access to person-centered services in community settings. For example, the Money Follows the Person Rebalancing demonstration helps states rebalance their Medicaid long-term services and supports systems and provides opportunities for older Americans and people with disabilities to transition back to the community from institutions. The Affordable Care Act extended and expanded this program. As of December 2013, more than 40,500 individuals with disabilities and chronic conditions have transitioned to the community through the program.

Long term services and supports (LTSS) refers to the types of assistance provided to people with functional or cognitive limitations to help them perform daily activities. This assistance is provided in several different form and venues. About 80 percent of older adults receiving such care live in the community. Most receive services or supports from family, friends, or professional workers in their homes and communities.

Washington State has been at the forefront in providing long-term services and supports in community settings or clients' individual homes. The State has recently undertaken radical changes that will have an impact on the lay of the landscape in which services are provided. Specifically, the State has introduced Community First Choice, which provides clients a more person centered approach and greater choice in services and supports they access. Additionally, there are numerous initiatives, such as Healthier Washington, and the 1115 C Waiver, that will enhance the scope of services available and reinforces the need to ensure that information and outreach ensures adequate understanding of available resources. The implication of these changes results in a need for increasing access to information and assistance and providing support in ensuring clients are receiving services best suited to meet their needs.

Efforts to address the needs of individuals living in the community by increasing access to information and assistance to long term services and supports options are important in the face of a rapidly aging population. In a budget environment where resources are scarce and there are numerous changes to the existing system, a concerted effort to maintain and enhance service networks is needed more than ever before. At ALTCEW, through Community Living Connections, we are helping older adults, persons with disabilities, and caregivers access a wide range of public and private resources and providing the long term care services and supports necessary for them to remain in the community for as long as possible. Our services include:

<u>Information Assistance/Referral</u>

Information and Referral (I&R) brings people and services together. When people don't know where to turn, I&R is there for them. I&R is an integrated system of functions designed to assist gatekeepers, individuals and/or their advocates to identify, understand, and effectively access resources available to the aging population. The purpose of information giving is to provide a

person and/or their representative with enough information to enable them to locate and obtain needed services without additional assistance from staff.

I&R offices work with community partners to ensure a "No Wrong Door" system is available in the community.

Options Counseling

The primary goal of Person-Centered Options Counseling (OC) is to facilitate informed decision-making about Long-Term Services and Supports (LTSS) that allows people to avoid or delay the impoverishment that would make them eligible for LTSS through the Medicaid program. OC will support individuals as they consider their options and access the right services and supports at the right time. OC is an interactive process where individuals receive support to make informed choices about LTSS. The process is directed by the individual and may include others that the individual chooses. No eligible person may be denied service because he/she will not or cannot contribute to the cost of the service. All the general terms and conditions and special terms and conditions found in the contract apply to OC.

OC is available to all persons with a disability, older adults, caregivers and/or legal representatives who request or require LTSS for a current need and/or future planning, for individuals of all incomes and asset levels. Priority will be given to those who are most likely to financially impoverish themselves or experience emotional exhaustion. Our goal through Community Living Connections is to promote well-being, independence, dignity and choice for all individuals we serve.

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.

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.

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.

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.

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.

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 CLCGetCare database.

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.

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.

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.

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.

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.

ISSUE AREA: Family Caregivers and Kinship Caregivers

Family Caregiver Support

"I am so grateful for this program I could cry"

"This program has given me hope and optimism again."

Kinship Caregiver Support

"Please tell everyone at the Kinship Program how much of a blessing this is to our family. Thank you."

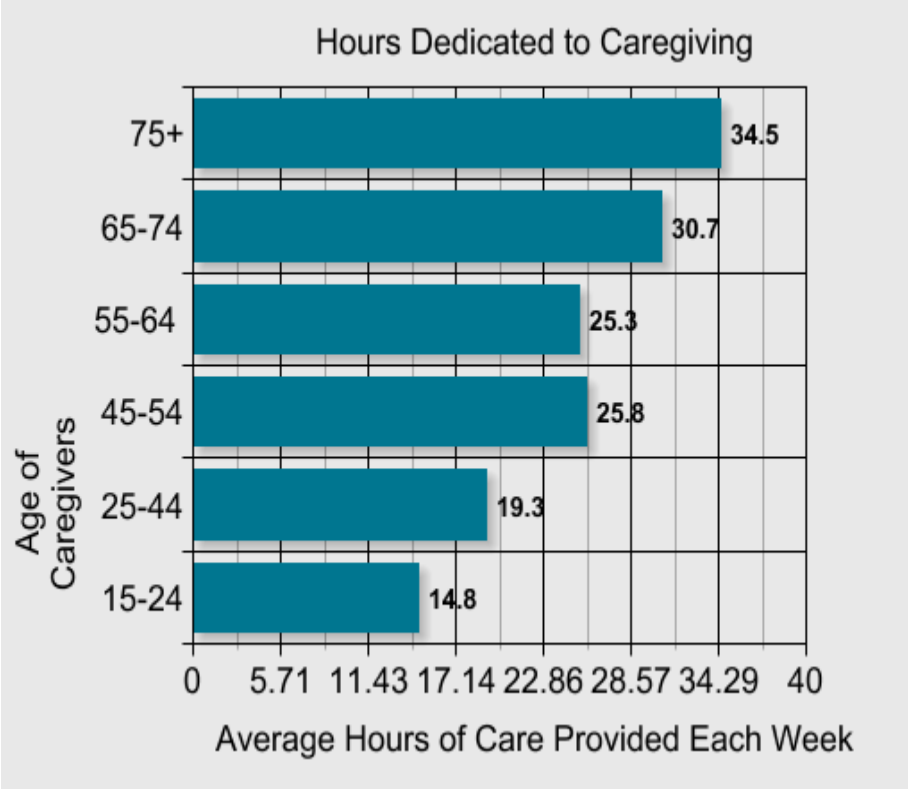
"This program has been a tremendous help"

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.

PROFILE: Caregiving for friends and family members is a challenging job. Family and other non-paid caregivers struggle with the demands of caregiving 24 hours a day. These demands often generate tremendous stress, which can negatively affect physical and emotional health, relationships with others, as well as create isolation and loneliness. Life is often a balancing act between caregiving duties, family, and work. Continual caregiving can cause a decline in physical and mental health, resulting in a decline in the quality of care or the institutionalization of the person receiving care. The Aging Network must provide information and support to family and non-paid caregivers so they are able to maintain their health and continue to provide quality care to their family member or friend.

In the United States, 65.7 million caregivers make up 29% of the U.S. adult population providing care to someone who is ill, disabled or aged. 52 million caregivers provide care to adults (aged 18+) with a disability of illness. 43.5 million of adult family caregivers care for someone 50+ years of age and 14.9 million care for someone who has Alzheimer's disease or other dementia. On average, family caregivers spend 25 hours per week providing care and caregivers 75+ dedicate an average of 34.5 hours per week providing care.

Number of Hours Dedicated to Caregiving by Age of Family Caregiver



The number of hours dedicated to caregiving increases with the age of the caregiver.[4]

[Graph Data: Partnership for Solutions, Chronic Conditions: Making the Case for Ongoing Care. Johns Hopkins, University, Baltimore, MD. (2004).] - Updated: November 2012

At ALTCEW, the Family Caregiver Support Program (FCSP), Kinship Caregiver Support Program (KCSP) and Kinship Navigator Program (KNP) provides information, resources and support services to unpaid family and other unpaid caregivers who provide continuous care for a

[4] *Graph Data Partnership for Solutions, Chronic Conditions: Making the Case for Ongoing Care. Johns Hopkins University, Baltimore, M.D. (2004).]*

functionally disabled adult 18 years of age or older so that they can continue in their caregiving role.
FCSP is a multi-faceted system of support services to respond to the needs of family and other unpaid caregivers. The federal and state FCSP in ALTCEW's service area is combined and integrated utilizing the existing administrative and program management system. FCSP services are provided to family or non-paid caregivers based on their individual situation and need. An array of options is available for the caregiver to allow for the broadest range of possible choices to meet their needs. Beginning in July 2009, ALTCEW began incorporating an evidence-based screening/assessment and consultative care planning intervention, called Tailored Caregiver Assessment and Referral (TCARE), into FCSP. TCARE is designed to assess the stress, depression and burdens of unpaid family caregivers and recommend strategies and services that can best help those caregivers who are most burdened with their caregiving responsibilities. With TCARE, caregivers are offered a broader service package through an individualized care plan; provided more consistent services across the state; educated and empowered to seek out available community resources; and provided the right service at the right time.

The Kinship Caregiver Support Program provides supportive services to respond to the needs of grandparents and other relatives who are caregivers, who are raising minor children, and those who are at the greatest risk of not being able to continue the role of caregiving. KCSP funds can be used to help pay for the cost of emergent needs incurred by grandparents or other relatives at the time the child or children comes to live with them, as well as after the initial period.
The Kinship Navigator Program (KNP) connects grandparents and relatives who are raising children to community resources, such as health, financial and legal services, support groups, and emergency funds. These crucial links, between kinship caregivers and services, help families create healthier environments and establish the self-sufficiency and long-term stability needed to keep their children out of foster care.

Aging & Long Term Care of Eastern Washington (ALTCEW) collaborates with community partners serving family and kinship caregiver populations. These efforts strengthen and improve the information, support and services provided to informal caregivers by offering conferences, educational resources and support groups, in addition to respite services. Specially trained case managers and Information and Assistance specialists provide support and instruction to help caregivers navigate the caregiver journey.

<u>Family Caregiver Support Program</u>
The Family Caregiver Support program provides information, resources, and support services to unpaid family and other unpaid caregivers who provide continuous care for a functionally disabled adult 18 years of age or older. These services enable caregivers to continue at-home care and allow care receivers to remain in their familiar environment.

<u>Kinship Caregiver Support Program</u>
The Kinship Caregiver Support Program provides financial support to grandparents and relatives who are the primary caregivers to children under the age of 19. One time per year per recipient

funding is provided for basic needs, such as legal services, transportation, school and youth activities, interpreter services, counseling services, etc.

Kinship Navigator Program

The Kinship Navigator Program connects grandparents and other relatives who are raising children with community resources, such as health, financial, and legal resources.

FCSP Core Elements

TCARE Screening and Assessment

TCARE is the Tailored Caregiver Assessment and Referral process that identifies the stress, burdens and uplifts of a caregiver. Care managers use this tool to recommend helpful services and supports to caregivers. Those recommended services may include Information and Assistance, Supplemental Services, Caregiver Education and Training, Respite Care, One on One Consultation and local community resources and services.

Information and Assistance

Many community resources are available to help ease a family caregiver's workload. Information and Assistance Specialists provide information about aging and long-term care support services, as well as assistance accessing these services.

Supplemental Services

Funds are available to eligible family caregivers for the purchase of medical equipment, supplies and services that assist the caregiver in providing care to a loved one. Items include but are not limited to grab bars for the shower, walkers, raised toilet seats, personal emergency response systems, incontinence supplies, durable medical equipment and minor home modifications.

Caregiver Education, Support Groups & Training

Workshops, classes and forums are available periodically for unpaid family caregivers. Topics include self-care for the caregiver, practical hands-on caregiving skills, and other areas of interest to caregivers. The Family Caregiver Support Program lending libraries contain helpful books, DVDs and video tapes for family caregivers.

Respite Care

Respite care offers family caregivers a break from their daily routine by providing temporary care for their loved one in or out of the home. The service focuses on the caregiver, allowing him/her time to take care of his/her needs and pursue activities essential to maintaining a healthy, well-balanced life. Respite care is available both in home and out of home in Clark and Cowlitz counties. In Skamania, Klickitat and Wahkiakum counties in home respite is available.

One on One Consultation/Counseling

Family caregiver counseling services provide professional assistance in coping with the emotional demands of being a caregiver. Licensed counselors provide short term and solution focused sessions to offer assistance in coping with stress that may occur due to caregiving

duties. Counseling services is currently available in Clark, Cowlitz, Skamania, and Wahkiakum counties.

Grandparents and Relatives Raising Children

Ten percent of the National FCSP budget is designated for services to Grandparents and Relatives Raising Children. The services are provided by the Children's Home Society Of Washington, Vancouver. Services provided include information, assistance and support both over the phone and in person. Parenting classes and group respite is also available.

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.

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.

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 Specialist and associated benefits of the Family Caregiver Support Program resources.

Objective D: Between January 1, 2016 and December 31, 2019, ALTCEW will support increased resources and coordination of caregiving 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.

ISSUE AREA: Healthy Aging Health Promotion and Disease Prevention and Delay of Medicaid-funded Long Term Services and Supports

Chronic Disease Self Management Program

"This class really helped me to get back on track with eating breakfast each morning and reminded me to make sure that I am listening to my body. Learning how to read food labels helped me to make healthier choices for breakfast. The sessions are great, and they offer information that is relevant no matter which chronic health condition you are dealing with. "

-Workshop Participant

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.

PROFILE: Older Americans are calling for a shift in the way we think and talk about aging. Rather than focusing on the limitations of aging, older adults across the nation want to focus instead on the opportunities of aging. Older adults are seeking ways to maximize their physical, mental, and social well-being to remain independent and active as they age.

Healthy aging means more than just managing and preventing disease and chronic conditions. It also means continuing to live a productive, meaningful life by having the option to stay in one's home, remain engaged in the community, and maintain social well-being. Older adults may require other services and supports, including social and community services, and age-friendly communities, in order to maximize their independence.

Although the risk of developing chronic diseases increases as a person ages, the root causes of many of these diseases often begin early in life. Practicing healthy behaviors from an early age and getting recommended screenings can substantially reduce a person's risk of developing chronic diseases and associated disabilities. ALTCEW continues to promote evidence-based health promotion and disease prevention programs, including Chronic Disease Self-Management, Matter of Balance, Chronic Care Management and Congregate Meals. ALTCEW staff participates in monthly meetings with the Chronic Care Management team with Washington State University meetings. In addition, ALTCEW is pursing A Matter of Balance, a Falls Prevention Evidenced Based Program. Strategies for health promotion and prevention of chronic diseases are woven throughout this plan, in each of the goal areas.

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.

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%).

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.

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.

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.

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.

Issue Area: Service Integration & Systems Coordination

Health Home Program

Health Homes provide Care Coordinators that help clients with multiple challenges navigate systems of care. Our Care Coordinator has worked with a homeless man to obtain housing, mental health services, and peer support. He has become more active in his health and has reduced ER visits. He recently left a phone message expressing his gratitude and indicated that he never had anyone believe in him as she had.

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

PROFILE: Consumers and their families in the State of Washington rely on a health delivery system that supports improved outcomes. They require better integrated care that coordinates physical care, behavioral health care services, and social supports. They depend on responsive services in community settings that maximize their ability to control daily decisions that affect them. The flexibility available through expanded federal waiver authority provides an opportunity to address underlying health care delivery challenges through strategic investments in delivery system reform.

Leveraging new community capacity through Accountable Communities of Health, Medicaid will support care transformation that goes beyond the four walls of a provider setting. Workforce capacity development, payment policies focused on paying for value and workflow redesign will allow care delivery to interact with social and physical environments in which clients live and work. New benefit design will help clients recover through outreach and engagement services, supportive housing, and supported employment.

Efforts to work across systems of care to ensure planned and coordinated care for older persons and individuals in the community will require a strategic approach to leveraging relationships and ensuring that ALTCEW is familiar with and engaged in emerging initiatives to reform care at both a state and national level.

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.

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.

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.

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.

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.

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.

Issue Area: Older Native Americans

Development of the 7.01 Plan

Preliminary meetings were held with the Spokane Tribe of Indians and the Kalispel Tribe of Indians. Tribes will sponsor and ALTCEW will participate in a two day forum to facilitate discussions with community providers and identify opportunities that ensure the needs of older adults in Indian country are adequately addressed.

GOAL: ALTCEW will consult and collaborate with representatives from the 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.

PROFILE: Title VI of the Older Americans Act is the primary means for funding services provided for older Native American and Alaskan Natives living in PSA #11. Available information indicates that older Native Americans and Alaskan Natives are among the most economically disadvantaged minority group in the nation. Historically, there has also been a lack of proper investment in funding for the Older Americans

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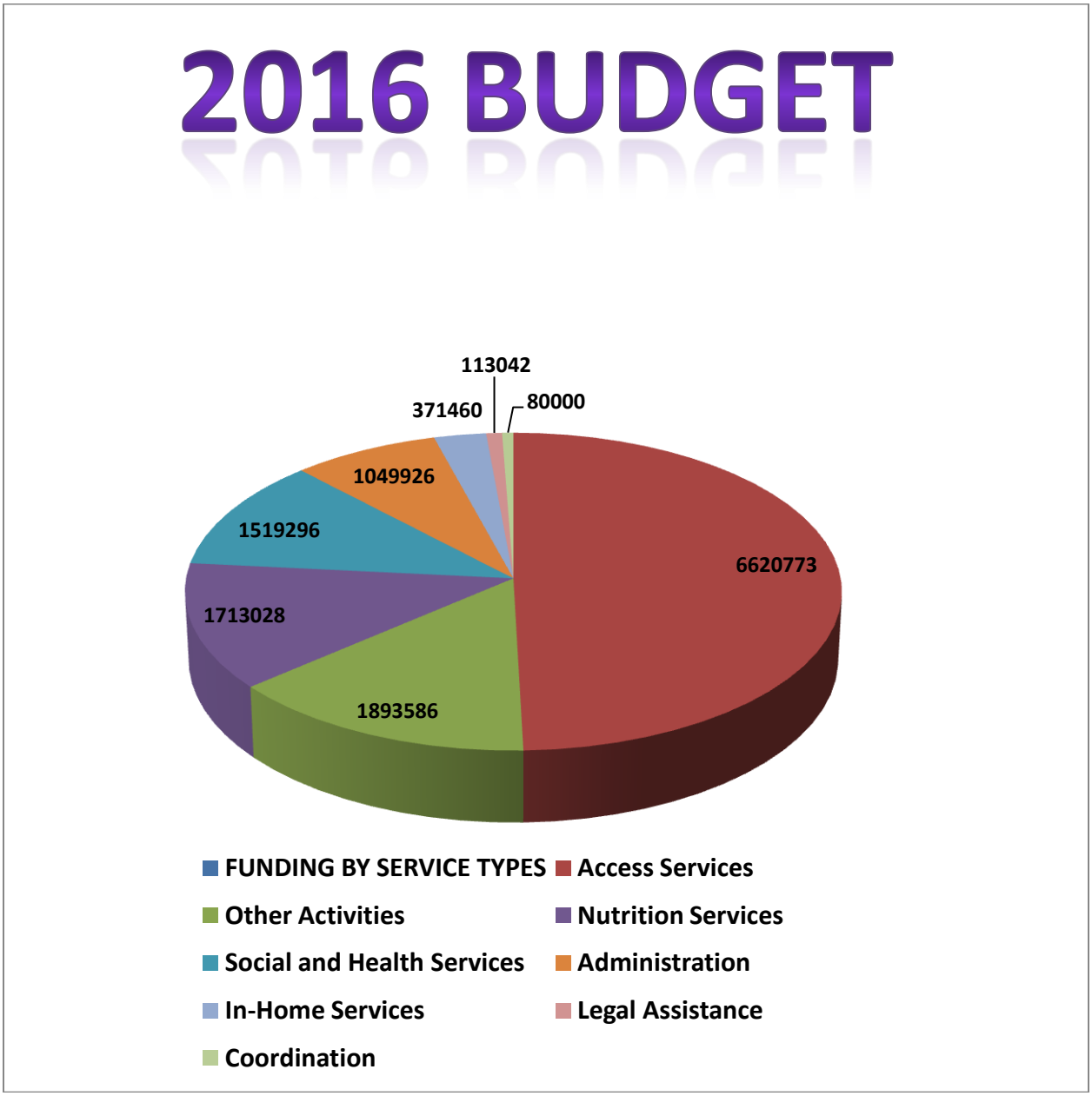
Act's Title VI Programs. This has further exacerbated the challenges Indian elders face.

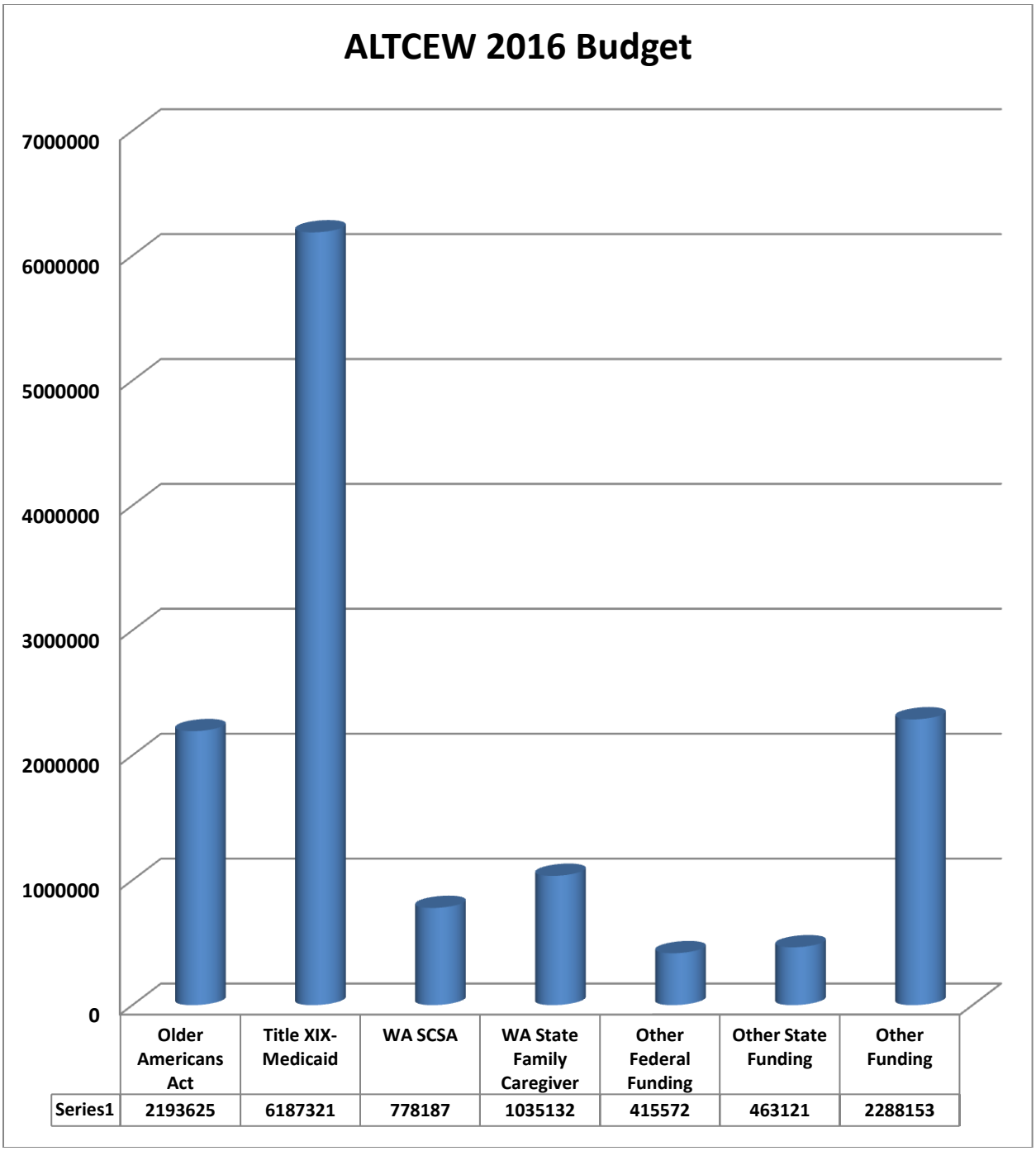
In Washington, Native Americans and Alaskan Natives have the lowest life expectancy of all races surveyed by the US Census Bureau. Their life expectancy is 2.4 years less than the bureau's population demographics for all races. It is significant to note that they frequently contend with issues that prevent them from receiving quality medical/health care. Examples of issues include poverty, cultural barriers, geographic isolation, inadequate supply of water, lack of sewage disposal and little or no access to transportation service. Nationally, 25.6% of Native Americans and Alaskan Natives live in poverty. Home ownership is estimated to be as low as 33% and is the lowest among all ethnic groups. In 2000, the Census Bureau reported that 14.7% of the Native American and Alaskan Native homes are overcrowded compared to 5.7% of the general U.S. population. In 2003, the U.S. Commission on Human Rights asserted that, "one of the largest barriers to adequate medical/health care for Native Americans is access." Many reservations are located in areas that transcend the standard "rural" classification and are often referred to as "frontier." Reaching vital services such as medical facilities, dialysis and nutrition centers require long trips over difficult terrain. Often access is also hampered by the hardships associated with high levels of poverty.

In PSA #11, we work primarily with the Native Project, the Kalispel Tribe of Indians and Spokane Tribe of Indians. We are actively engaged in discussions with tribal representatives and representatives from the Office of Indian Policy to work collaboratively in developing a 7.01 Plan that reflects the needs of older Native Americans in our service region.

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.

SECTION D – AREA PLAN BUDGET




ALTCEW 2016 Budget
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6000000
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4000000
3000000
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1000000
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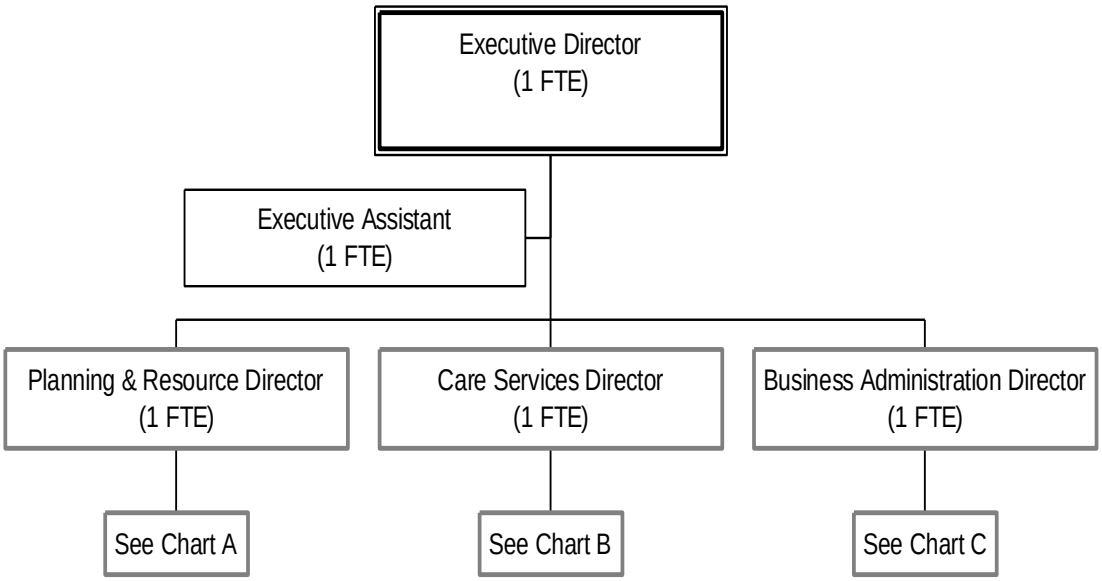
Older Americans Act
Title XIX-Medicaid
WA SCSA
WA State Family Caregiver
Other Federal Funding
Other State Funding
Other Funding
Series1
2193625
6187321
778187
1035132
415572
463121
2288153

$ 13,361,111

AGING AND LONG TERM CARE OF EASTERN WASHINGTON

Appendix A

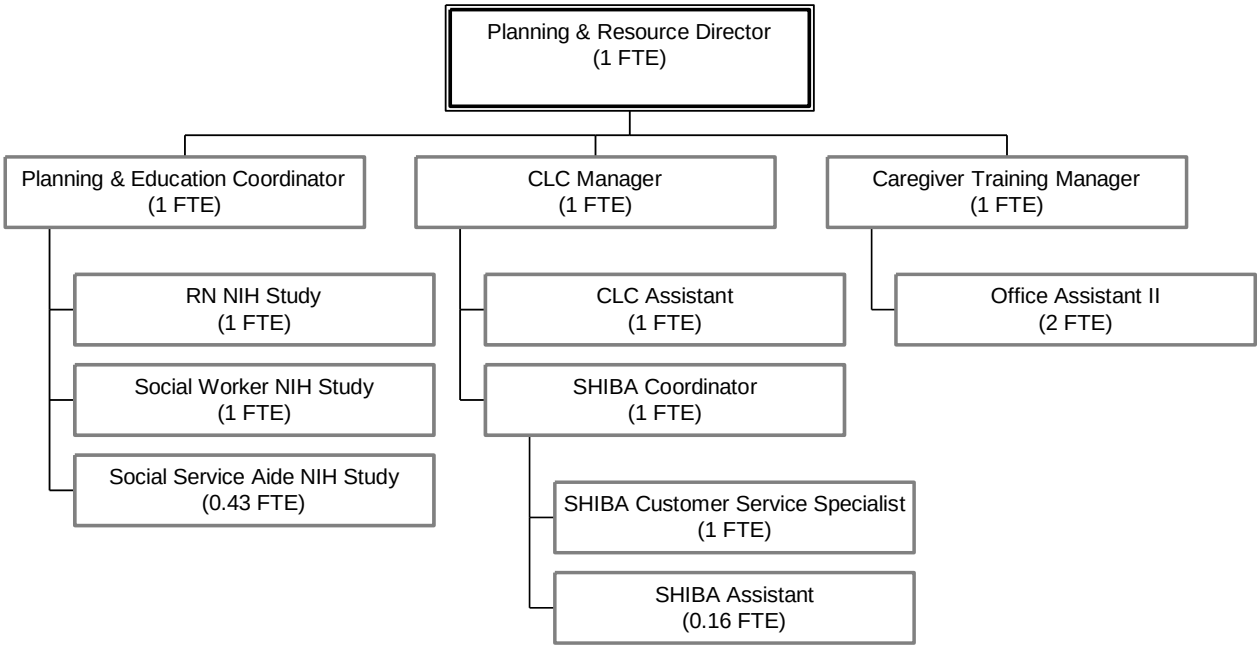
Staff Organization – 9/15



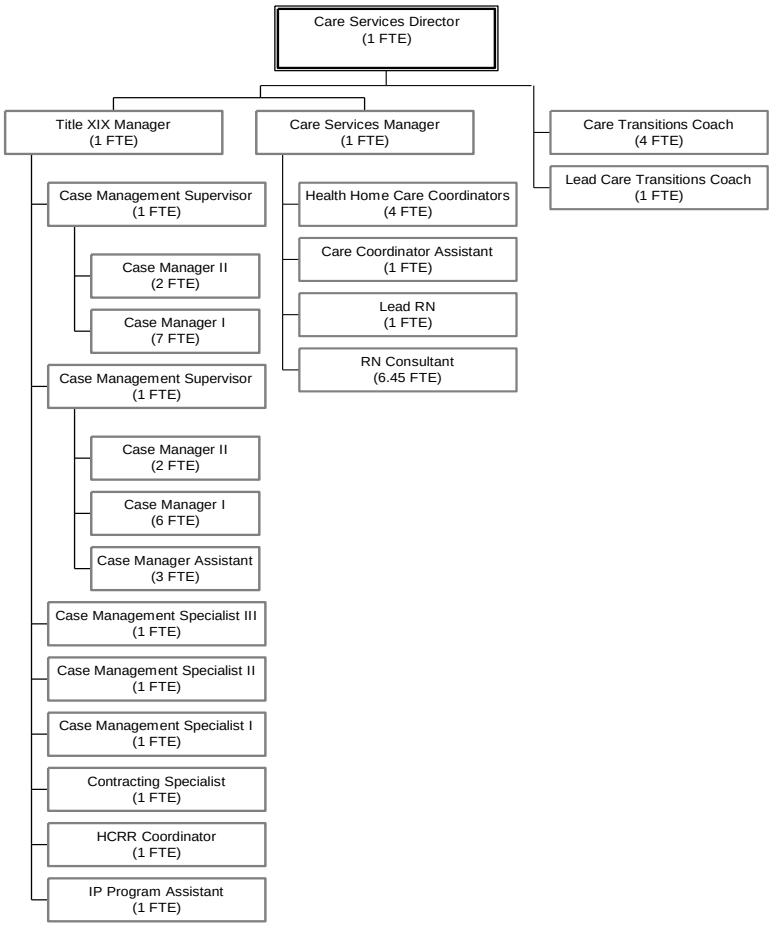
AGING AND LONG TERM CARE OF EASTERN WASHINGTON

Staff Organization – 9/15

CHART A



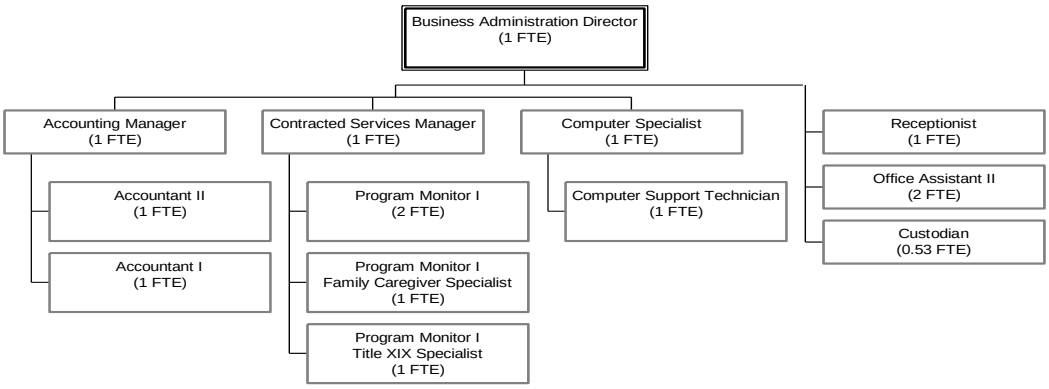
AGING AND LONG TERM CARE OF EASTERN WASHINGTON
Staff Organization – 9/15
CHART B



AGING AND LONG TERM CARE OF EASTERN WASHINGTON

Staff Organization – 9/15

CHART C



APPENDIX B – STAFFING PLAN

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
Care Services Director	Michielli, Teresa	1 FTE	Advocacy; Public Information; Oversees Title XIX/General Case Management programs; HCRR Administration; Care Transitions Management; Care Coordination Management; Public Disclosure Officer
Care Services Manager	Sanford, Bob	1 FTE	Care Services Supervision
Case Management Specialist III Case Management Specialist II	Rollins, Pam Kristi Eppinger	1 FTE 1 FTE	Program Monitoring/QA; Administrative Hearings Coordination; CARE TA; Nurse Delegation TA
Program Monitor I	Tostenrude, Kathy Robinson, Patricia Leppert, Rhiannon Longhofer, Annie	4 FTE	Program Monitoring/QA, ETR Review; Case Management Training Coordinator; COPES Waiver contracting/monitoring, program monitoring support
Case Management Specialist I	McFarlen, Jacki	1 FTE	In-Home Medicaid Programs Reauthorization/Service Level and Provider Changes to State Payment System
Contracting Specialist IP Program Assistant Case Management Assistant	Potapenko, Vladimir Winter, Tina Dumbrava, Svetlana Vivian Chau	5 FTE	IP and Registry Contracting Case Management Assistance Case Management Assistance

Case Management Assistant /IP Specialist	Kovalenko, Taina		Case Management Assistance
Title XIX Manager	Lichorobiec, Jennifer	1 FTE	Case Management Supervision
Case Management Supervisor	Simpson, Sue Spencer, Steve	2 FTE	Case Manager/Case Management Assistant Supervisor
Case Manager II	Andrews, Ron Mercer, Amy King, Leslie Smith, Terresa	4 FTE	Case Management
Case Manager I	Calvert, Kayla Garcia, Greg Koski, Teri Largent, Angela Morehead, Rebecca Putnam, Rose Roupe, Dee Dee Fisher, LeeAnne Ambartsumyan, Olga Warren, Alison Lucas, Becky Trammell, Petra Vacant Position	13 FTE	Case Management
Care Transitions Coach	Donally, David Pring, Brittany Freeland, Derrick Crawford, Josette Prouty, Jessica	5 FTE	Coaching patients from hospital to home, CTI, Health Homes
Health Home Care Coordination	Carver, Danielle French, Halina Bezold, Jodi Day, Lisa Robinson, Jeanie	5 FTE	Care Coordination
Home Care Referral Registry Coordinator	Riehl, Sheri	1 FTE	Contracting Unit/ Home Care Referral Registry; IP Contracting; HCRR Coordination and Recruitment

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; Agency contact for complaints from clients/public about ALTCEW provided direct services; Human Resources Policy Development; Support Staff Supervision and Workflow Coordination
Accounting Manager	Gottsch, Diane	1 FTE	State Billings; Financial Statements; General Ledger
Accountant II	Soheili-Richards, Faran	1 FTE	Billing/Reconciliation Support/Payroll
Accountant I	Martin, Darlene	1 FTE	Accounts payable; agency and Provider Billing; OFR Payment Process
Receptionist	Cunningham, Marilyn	1 FTE	Front Desk Reception
Office Assistant II	Willey, Johanna Karen Carskaddon	2 FTE	Administrative Support, Dental Access Program
Custodian	Kadantsev, Yury	.53 FTE	Building Maintenance
Contract Specialist	Pratt, Gail	1 FTE	Program Monitoring/QA/Contracts
CLC Manager	Bouchard, Pearl	1 FTE	CLC coordination
CLC Assistant	Shepard, Mary	1 FTE	CLC
Computer Specialist	Ehr, Russ	1 FTE	MIS Services; Computer Technical Assistance
Computer Support Technician	Robertson, Justin	1 FTE	Computer Support
Planning and Resource Director	Yolanda Lovato	1 FTE	Planning; Special Studies and Data TA; RN Services, Caregiver Training, SHIBA Supervision; NIH Grant; Staff Support to Board and Council
Planning and Education Coordinator	McIntyre, Jamie	1 FTE	Planner; Title V Program Coordinator and Monitor; Staff for Disaster Preparedness Planning; Title V Recruitment and Placement Supervision, NIH Supervision

Caregiver Training Manager	Sanders, Resa	1 FTE	Caregiver Training Services
Office Assistant II	Vilar, Heather Michael Small	2 FTE	Caregiver Training Support
SHIBA Coordinator	Dugan, Kathy	1 FTE	SHIBA/MIPPA Coordinator; Agency Contact for Client/Public Complaints on Subcontracted Services
SHIBA Customer Service Specialist SHIBA Assistant	Ball, Mike Walsh, Margaret	1 FTE .16 FTE	SHIBA
Lead RN	Harris, Cher	1 FTE	RN Supervisor
RN Consultants/ Care Coordination	Atlas-Parsons, Anna Cole, Robin Edmunds, Dominique Morris, Jodi Nelson, Sue Sinclair, Anne Prugh, Sheila	6.45 FTE	RN Consultation Services/ Care Coordination
Registered Nurse , NIH Study	Garpestad, Terri	1 FTE	Registered Nurse NIH
Social Worker, NIH Study	Butler, Colleen	1 FTE	Social Worker NIH
Social Service Aide, NIH Study	Fryar, Wendla	.43 FTE	Social Service Aid NIH

APPENDIX C – Emergency Response Plan

Emergency Response and Business Continuity Plan

9-15 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. Requirements under 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 Whitman, Pend Oreille, Stevens, Ferry, and Spokane counties.

III. Limitations

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

IV. 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, it is comprised of representatives from public, private and not for-profit agencies. COAD works to enhance the community's ability to mitigate, prepare, respond and recover from disasters thus ensuring that human needs inherent in a disaster situation are evaluated and addressed. Members include organizations such as the United Methodist Church, the American Red Cross, and the Sheriff Community Oriented Policing Effort. The COAD meets quarterly at the Inland NW Chapter of the American Red Cross.

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

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, housing and human services needs of individuals and families impacted by disasters and emergencies in Spokane County.

Region 9 Health Care Coalition (Emergency Support Function # 8) - 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 medical, health, mental health, and mortuary services for emergencies and disasters.

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 long term consequences of a disaster.

V. Command/Control Structure

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

A. 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 (examples include the Great Shakeout, and staff safety trainings in collaboration with the Spokane Sheriff's Department). ALTCEW will also participate in planning and exercise events that relate to the appropriate ESF's within our service area.

VI. 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 Contractors agrees to have a written emergency operations and business contingency plan in place. The plan shall reference emergency preparedness and mitigation activities and shall address steps to be taken before, during and after an emergency/disaster to prevent or minimize interruptions in business operations and assure long-term recovery.

(Applies to Title XIX Contactors only)

1) Maintenance of services to existing clients;

2) The plan needs to pay particular attention to those clients who are at most risk and include:

a) Criteria used to identify those clients who are at most risk;
b) Procedures to contact high-risk clients and referral to first responders as needed; and
c) Emergency communication.

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. MOU's have been developed with county Emergency Management Departments in each county of PSA # 11.

B. Staff

Staff will be educated on being prepared at an All Staff meeting 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

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 in-house Case Management Program has developed the following Vulnerable Adult Criteria that is used to identify the most at-risk clients on the case load:

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 Manager 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 at home in case of emergency or disaster. The list will also be kept at the office with Care Services Director and Disaster Preparedness Coordinator.

VII. 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 EOC Emergency Operations Center 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.

- 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.

1.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 situation, 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 at a later time.

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

VIII. 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 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.

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 all staff may not 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 can not 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.

C. Technology

Though many mission-critical applications are available from Consolidated Technology Services (CTS) wide area network (WAN) and CTS and DSHS Servers, many functions rely on the integrity of the ALTCEW servers. When backing up the ALTCEW servers, Information Technology (IT) will create daily backups of critical data using a method that will provide at least three copies. Backups shall be stored off site in a secure location in the Caregiver Training building at 1235 N. Post Street together with system documentation. Weekly 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.

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.

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. Communication

In the case of a temporary office closure, all calls can be rerouted to Elder Services or Frontier Behavioral Health First Call For Help. 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. Lead Staff will maintain phone lists for all staff, including home phone and cell phone numbers. Upon the occurrence of a disaster situation, lead staff will contact one another and determine who is available to be the Responsible Staff. The Responsible Staff will then contact supervisors. Supervisors and supervisor alternates will maintain a phone list of their staff and will contact them under the direction of the Responsible 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 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. As a backup procedure, the list of vulnerable clients will be submitted to the ALTSA AAA Specialist on a quarterly basis with directions to furnish the list to emergency personnel in the case of an area-wide disaster in Eastern Washington where ALTCEW is unable to respond.

E. 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, 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.

F. 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

2015 GOVERNING BOARD MEMBERSHIP

Fran Bessermin
Planning and Management Council Chair

Mike Blankenship
Ferry County Commissioner

Don Dashiell
Stevens County Commissioner

Mike Fagan, Vice Chair
Spokane City Council

Al French
Spokane County Commissioner

Karen Skoog
Pend Oreille Commissioner

John Snyder, Chair
Spokane City Council

Arthur D. Swannack
Whitman County Commissioner

Michael J. Piccolo
Governing Board Legal Counsel

Vacant
City of Spokane Appointee

Advisory Council

PLANNING AND MANAGEMENT COUNCIL
2015 MEMBERSHIP

Spokane County Residents
John Annal
Aruna Bhuta
Sharon Bowland
Dick Clauss
Allan Cory
Donna Flanagan
Martha Haynes
Maria Hernandez-Peck
Marty Johnston
Bruce Kellam
Jean Kindem
Linda King
Karen Lewandowski
Joyce McNamee
Kent Moline
Dan Mortensen
Bernie Nelson
Jan Rasberry
Jean Rose
Diane Smith
Marie Raschko-Sokol
Gail Synoground

Ferry County Residents
Ron Bacon
Gary Kohler

Pend Oreille County Residents
Beryl Pielli
Kenneth Smith

Stevens County Residents
Fran Bessermin, Chair
Hal Balzert
Barry Lamont, Vice Chair

Whitman County Residents
Dennis McDonald

Planning and Management Council Membership
Total number of members age 60 and over: 28
Total number of members self-indicating minority status: 4
Total number of members self-indicating a disability: 5
Total number of members who are elected officials: 5

APPENDIX E – Public Process

If you are not familiar with ALTCEW, we are the Area Agency on Aging that serves Eastern Washington (Ferry, Stevens, Pend Oreille, Spokane and Whitman counties). ALTCEW provides services both directly, and indirectly to help older adults and people living with disabilities to stay in their homes as long as is safely possible. As part of our planning process, we create an Area Plan every four years. This plan helps us to understand what the current need is, and how we can provide services. We are currently in the process of developing our 2016-2019 Area Plan. For this plan, we want to learn what steps we need to take to provide supports for seniors to stay active, independent and living in the community.

As part of this process, the planning department is conducting focus groups to learn about what we can do to further support aging friendly communities. Listed below are the areas we address during our focus groups.

Guided discussion

- *What support do you think you need to age at home:*
  - *Now*
  - *In 5 years*
  - *In 10 years*
  - *In 15+ years*

- *What support do you think your family members will need?*
- *What support do you think paid/formal caregivers will need?*
- *What in your community makes it a good place to grow older?*
- *If you were in charge of making your current community a better place to live and age, what would you change?*
  - *What improvements would you make?*
  - *What improvements would your friends or family make?*
  - *What is important about these improvements?*

Above is a focus group invitation for a focus group held with community members at the Community Action Center in Pullman. Fourteen focus groups were held to receive and gather information on available resources and needs of older persons and individuals living with disabilities in PSA #11. These focus groups were used to inform draft goals and work objectives presented at the community planning meetings.

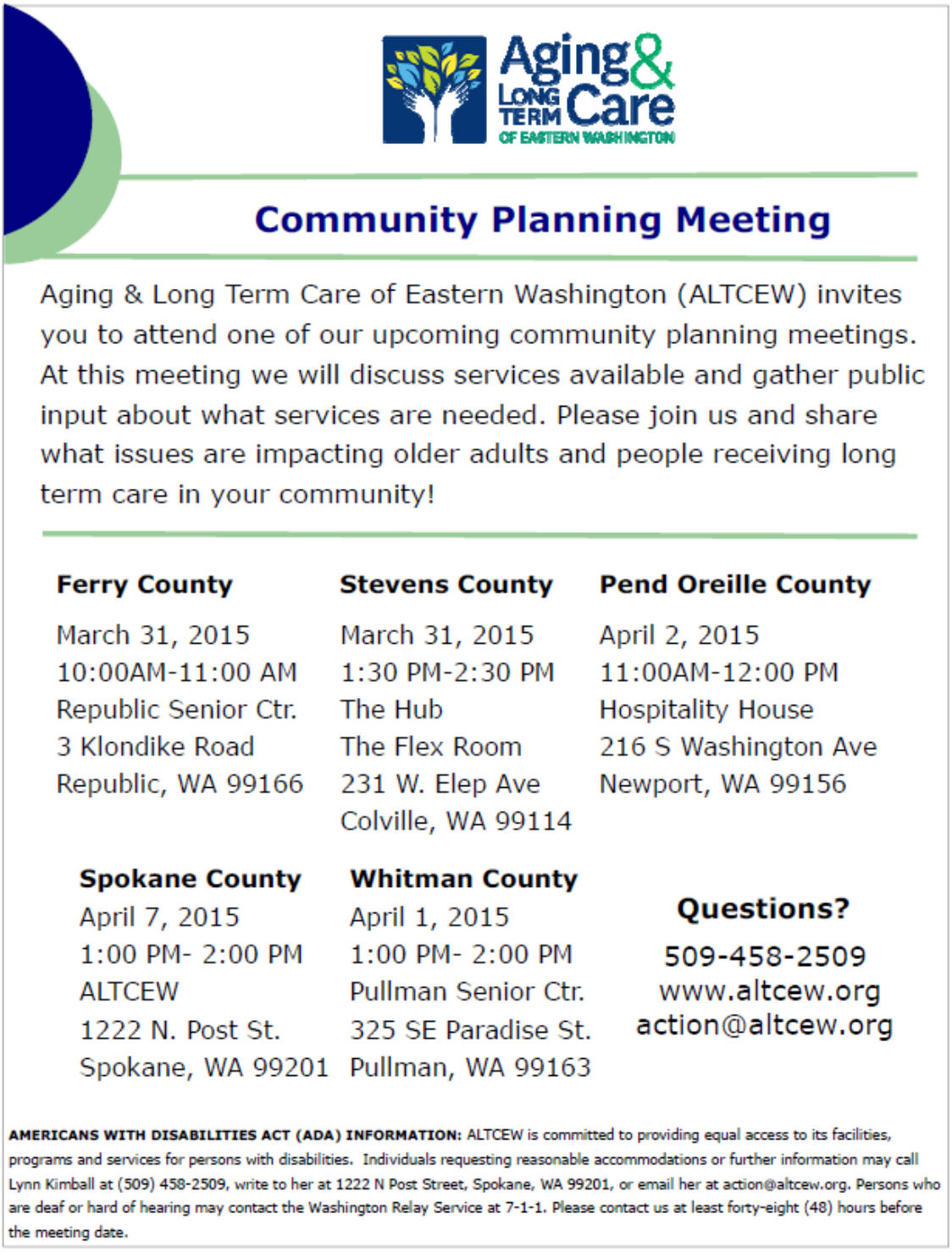
Community Planning Meetings Notice

A series of Community Planning meetings are being held to receive comments on plans for addressing significant issues, needs, gaps or obstacles that impact older persons or individuals needing long term care services in Planning and Service Area #11. Discussions will focus on gathering public input on service prioritization methods, planning agency work objectives for building and enhancing age friendly communities, and studies of services being bid for 2016 in the Spokane County.

A community planning meeting will be held on April 7th, 2015, from 1:00 to 2:00 pm at Aging & Long Term Care of Eastern Washington, 1222 N Post St in Spokane, WA 99201.

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 call Lynn Kimball at (509) 458-2509, write to her at 1222 N. Post Street, Spokane, WA 99201, or email her at action@altcew.org. Persons who are deaf or hard of hearing may contact the Washington Relay Service at 7-1-1. Please contact us at least forty-eight (48) hours before the meeting date.

Above is a copy of the Community Planning Meeting Notice that ran in the Spokesman Review on 3/23/15. Similar notices also ran in the Statesman Examiner, Ferry County View, Newport Miner, Whitman County Gazette and the Moscow-Pullman Daily News.



Above is a copy of the Community Planning Meeting flyer for PSA#11. Individual flyers were also made for each individual Subregion, Spokane, Whitman, and Tri-County Subregions.

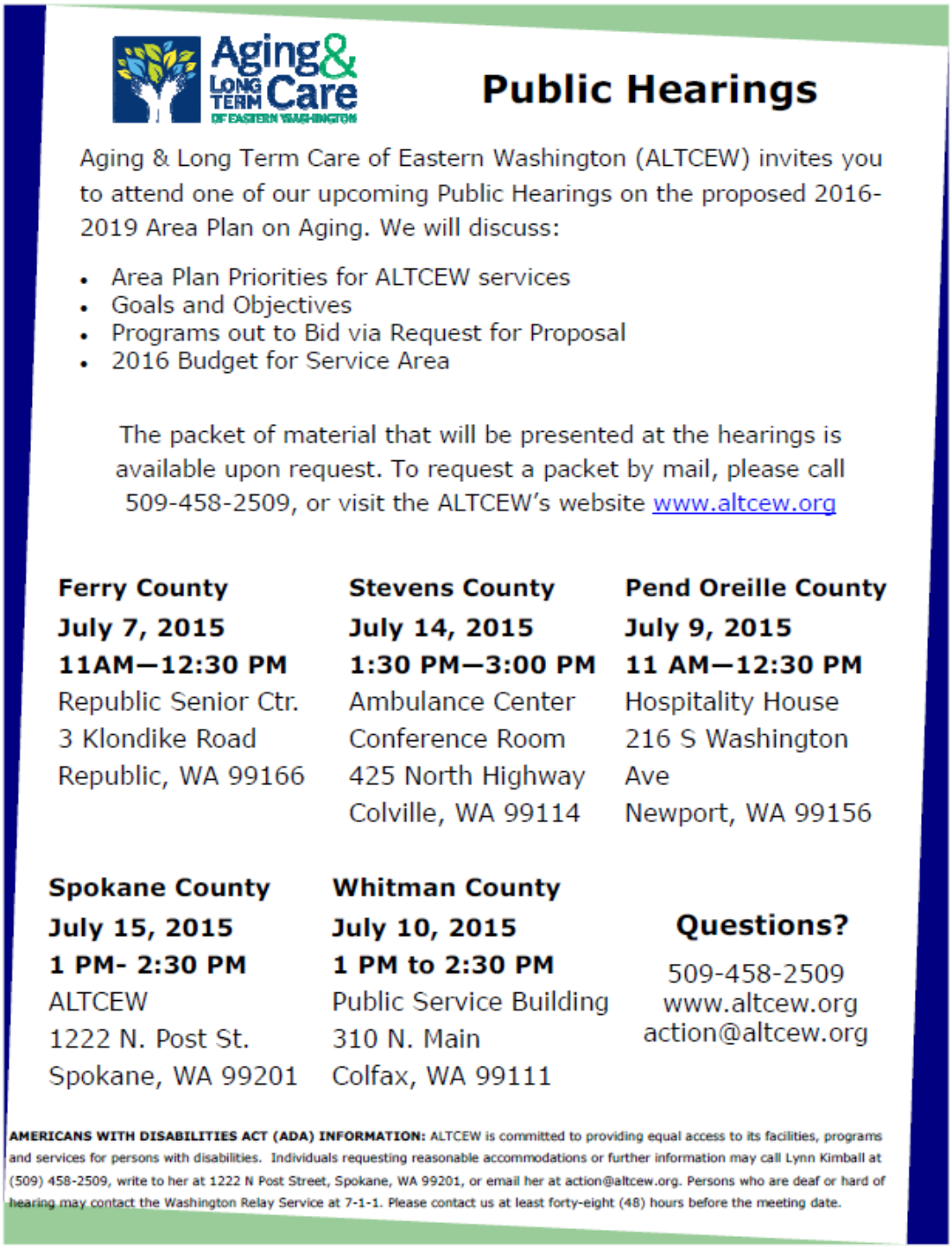
Public Hearing Notice

Aging & Long Term Care of Eastern Washington (ALTCEW) is holding a Public Hearing to receive comments on plans for addressing significant issues, needs, gaps or obstacles that impact older persons or individuals needing long-term care services in Spokane County. Topics will include discussion on the prioritization of discretionary funds, the programs and services out for bid via a Request for Proposal, the proposed 2016 budget, and a report on accomplishments during 2014-2015.

The hearing will be held from 1:00 PM to 2:30 PM on July 15, 2015 at Aging & Long Term Care of Eastern Washington's building located at 1222 N. Post Street in Spokane, Washington.

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 call Lynn Kimball at (509) 458-2509, write to her at 1222 N. Post Street, Spokane, WA 99201, or email her at action@altcew.org. Persons who are deaf or hard of hearing may contact the Washington Relay Service at 7-1-1. Please contact us at least forty-eight (48) hours before the meeting date.

Above is a copy of the Public Hearing Notice that ran in the Spokesman Review on 6/26/15. Similar notices also ran in the Statesman Examiner, Ferry County View, Newport Miner, Whitman County Gazette and the Moscow-Pullman Daily News.



Public Hearings

Aging & Long Term Care of Eastern Washington (ALTCEW) invites you to attend one of our upcoming Public Hearings on the proposed 2016-2019 Area Plan on Aging. We will discuss:

- Area Plan Priorities for ALTCEW services
- Goals and Objectives
- Programs out to Bid via Request for Proposal
- 2016 Budget for Service Area

The packet of material that will be presented at the hearings is available upon request. To request a packet by mail, please call 509-458-2509, or visit the ALTCEW's website www.altcew.org

Ferry County
July 7, 2015
11AM—12:30 PM
Republic Senior Ctr.
3 Klondike Road
Republic, WA 99166

Stevens County
July 14, 2015
1:30 PM—3:00 PM
Ambulance Center
Conference Room
425 North Highway
Colville, WA 99114

Pend Oreille County
July 9, 2015
11 AM—12:30 PM
Hospitality House
216 S Washington Ave
Newport, WA 99156

Spokane County
July 15, 2015
1 PM- 2:30 PM
ALTCEW
1222 N. Post St.
Spokane, WA 99201

Whitman County
July 10, 2015
1 PM to 2:30 PM
Public Service Building
310 N. Main
Colfax, WA 99111

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

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 call Lynn Kimball at (509) 458-2509, write to her at 1222 N Post Street, Spokane, WA 99201, or email her at action@altcew.org. Persons who are deaf or hard of hearing may contact the Washington Relay Service at 7-1-1. Please contact us at least forty-eight (48) hours before the meeting date.

Above is a copy of the 2016-2019 Area Plan Public Hearing flyer for PSA #11. Individual flyers were also made for each individual Subregion, Spokane, Whitman, and Tri-County Subregions.

APPENDIX F Report on Accomplishments for 2014-2015 Area Plan Update

ISSUE AREA: Information and Assistance/Aging and Disability Resource Centers

PROBLEM/NEED STATEMENT: Seniors and individuals with disabilities needing services are often faced with the challenge of navigating the system to get connected to services such as long-term care, health care, income security, insurance, housing, financial management and more. Needing several services such as in-home care, housing and benefits counseling, has often meant going to three separate agencies and filling out identical paperwork. Complex and changing benefits, eligibility standards, agencies and programs contributes to this confusing consumer climate. Persons are left not knowing where to turn for help and can make dozens of contacts before finding the assistance they need.

GOAL: Support the successful building of aging friendly communities by increasing the number of older persons and individuals with disabilities that have access to quality information and assistance about long-term care services and support options.

Objective A: Between January 1, 2012 and September 30, 2012, ALTCEW and it community partners will continue to research and identify challenges in realigning Information and Assistance (I&A) services with the Aging and Disabilities Resource Network (ADRN) in PSA #11.

Outcome: By October 31, 2012, the writing and submission of a report summarizing recommended ways to further realign I&A services with the ARDN in PSA #11.

Accomplishments: ALTCEW and its community partners have continued to collaborate to identify challenges with implementation of the ADRC model, the biggest of which is a flexible funding source. A report was not completed due to changing climate of the ADRC model.

Modification: Contracts with I&A providers were updated effective 2015 to incorporate CLC services and Options Counseling.

Objective B: Between January 1, 2012 and September 30, 2012, ALTCEW and its community partners will continue to research, develop and implement a process for establishing an Aging and Disabilities Resource Network (ADRN) that provides a coordinated system of comprehensive information on a full range of available public and private long-term care services and supports, and options counseling to assist individuals in assessing and planning for long term needs and assistance in accessing needed services.

Outcome: The documentation of information supporting continued development and implementation of the process for providing a full range of ADRN services in PSA #11.

Accomplishments: Network successfully created.

Modification: Remove objective for 2014-2015.

Objective C: Between January 1, 2012 and December 31, 2015, ALTCEW and its community partners will continue to explore ways to be more effective in delivering information services in partnership with the Benefits Checkup, State Health Insurance Benefits Advisors and WIN-211 system(s) in PSA #11.

Outcome: The writing and submission of a brief report summarizing recommended ways to be more effective in delivering information services.

Accomplishments: ALTCEW has worked collaboratively with multiple providers that deliver information services as part of the organization of the ADRN, including the Statewide Health Insurance Benefits Advisor (SHIBA) Program and Washington Connections. ALTCEW will continue work with current and potential partners in 2014-2015.

Modification: Organizational changes were made to combine SHIBA, and In-Person Assisters into one unit, allowing the public to access counseling and enrollment services for Medicare, Medicaid, and qualified health plans in one stop shopping.

Objective D: During the planning period of January 1, 2012 through September 30, 2012, the I&A/GCM subcontractors will continue to collaborate and cooperate in developing and implementing the Aging and Disabilities Resource Network (ADRN) in PSA #11.

Outcome: The documentation of efforts at collaboration, coordination and implementation of the process to provide a full range of ADRN services in PSA #11, as reflected in monitoring reports completed by staff from ALTCEW.

Accomplishments: Subcontractors have implemented the ADRC model throughout their network.

Modification: Remove for 2014-2015.

Objective E: During the four-year planning period, the I&A/GCM subcontractors will participate in implementation of the Area Agency on Aging Statewide Information System (ASIS) throughout PSA #11.

Outcome: The implementation of the ASIS throughout PSA #11, as reflected in the monitoring reports completed by staff from ALTCEW.

Accomplishments: This objective was eliminated for 2012-2015 during the approval process for the initial Area Plan submission, due to a halt in the statewide development of ASIS.

Objective F: By December 31, 2013, ALTCEW will work in conjunction with the state, other Area Agencies on Aging, and the PPC topical work group to develop and incorporate ADRC Options Counseling standards.

Outcome: By December 31, 2013, the creation and submission of a brief report summarizing the potential ways to implement statewide options counseling standards for persons age sixty and older living in PSA #11.

Accomplishments: Statewide options counseling standards are still being established.

Modification: Draft options counseling standards were developed and used as the basis for contracts with CLC partners.

Objective G: By December 31, 2013, ALTCEW will research and develop a plan for the potential expansion of long-term care services and supports and options counseling services in PSA #11 for persons under age sixty.

Outcome: By December 31, 2013, the writing and submission of a brief report summarizing potential ways to provide long term care services and support and options counseling services for persons under age sixty living in PSA #11.

Accomplishments: ALTCEW will explore a different model for Older Americans Act and Senior Citizens Services Act funding for I & A and Referral, Extended Assistance and Options Counseling funding.

Modification: Draft options counseling standards and CLC guidelines are inclusive of persons 18 and older with disabilities. A combination of state and federal funding allows us to serve the broader population as well as collaborative efforts with our community partners that focus on disability services.

Objective H: By June 30, 2013, ALTCEW and the GCM subcontractors will examine potential tools to be used in options counseling or assessments that focus on identifying and leveraging client strengths. ALTCEW will work in conjunction with the state and other Area Agencies on Aging in developing and incorporating statewide Options Counseling tool(s).

Outcome: By September 30, 2013, the writing and submission of a brief report summarizing ways to implement statewide Options Counseling tool(s) or assessments that focus on identifying and leveraging client strengths.

Accomplishments: Standards are being determined on the national level. ALTCEW will implement as directed.

Modification: Remove brief report.

Objective I: By June 30, 2013, ALTCEW and its community partners will participate as appropriate in the national efforts to develop tool(s) to assist individuals in making informed decisions about long term care services and support options.

Outcome: Documentation of participation in the national efforts to research and develop decision support tools that assist individuals in making informed decisions about long term care services.

Accomplishments: ALTCEW staff has participated in national webinars when appropriate.

Modification: Eliminate objective for 2014-2015.

Objective J: Between October 1, 2012 and December 31, 2015, ALTCEW and its ADRN partners will continue implementation of efforts achieved during the ADRN planning grant including participation in ASIS, Resource Directory, Self-Service, client management and data collection, as well as the partnerships developed in subregions of PSA #11.

Outcome: The documentation of efforts to continue the work of the ADRN following the end of the ADRN grant.

Accomplishments: Systems are still being developed.

Accomplishments: ALTCEW was a major player in assisting the state with implementation of the CLCGetCare database, which collects data, stores electronic records, and houses a robust resource directory. The electronic resource directory is expected to be publically promoted statewide fall of 2015.

Objective K: During the four-year planning period, ALTCEW will continue its involvement in activities that facilitate understanding and participation by individuals living in PSA #11 with limited-English-speaking skills.

Outcome: Documentation showing efforts of involvement in activities that facilitate understanding and participation by individuals living in PSA #11 with limited-English-speaking skills.

Accomplishments: ALTCEW has continued developing collaborative relationships with agencies serving LES populations, including World Relief, Refugee Connections, and others. ALTCEW and its subcontractors continue to serve individuals with limited English speaking skills.

Objective L: Between January 1, 2012 and December 31, 2015, staff from ALTCEW and the I&A/GCM Programs will participate in developing partnerships with organizations serving non-traditional family caregivers. This will include organizations currently serving Gay, Lesbian, Bisexual and Transgender (GLBT) individuals and other caregivers who may not be seen as a traditional family member. In implementing the goal(s) for this objective, ALTCEW and the subcontractors will work towards identifying organizations to provide in-service training for staff from ALTCEW and the subcontractors.

Outcome: The overall goal is to ensure persons delivering I&A/GCM services have knowledge and understanding of the specific issues faced by older non-traditional families in PSA #11.

Accomplishments: An in-service has not been completed during 2012-2013, continue objective for 2014-2015. ALTCEW staff is working with EWU School of Social Work to coordinate a staff and subcontractor training on considerations when working with the GLBT community. Training will occur during fall 2015 for ALTCEW staff and subcontractors.

ISSUE AREA: Healthy Aging

PROBLEM/NEED STATEMENT: Improved medical care and prevention efforts have contributed to dramatic increases in life expectancy in the United States over the past century. This has also produced a major shift in the leading causes of death for all age groups from infectious diseases and acute illnesses to chronic diseases and degenerative illnesses. Currently, about 80% of older Americans are living with at least one chronic condition. Making healthy lifestyle choices can prevent or control many of the nation's leading causes of death. Nearly 35% of deaths in America are linked to smoking, physical inactivity, poor diet or alcohol abuse.[5] Through Health Promotion and Disease Prevention Programs seniors and individuals with disabilities can receive information and instruction that will enable them to make healthier choices, thereby reducing the frequency of chronic conditions.

[5] Centers for Disease Control and Prevention and The Merck Company Foundation, 2007, *The State of Aging and Health in America 2007*, (http://www.cdc.gov/Aging/pdf/saha_2007.pdf, accessed August 2011).

GOAL: Support the successful building of aging friendly communities by increasing the array of affordable health, prevention and wellness service options for older persons and individuals with disabilities.

Objective A: Between January 1, 2012 and December 31, 2015, the staff from ALTCEW will continue to provide staff and facility support to the Aging and Mental Health Advisory Committee. The members of the committee focus coordination efforts with local providers of mental health services to better serve persons who require both aging network and mental health services in PSA #11.

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 staff and the facility were used to host Aging and Mental Health Advisory Committee meetings. ALTCEW staff worked collaboratively with the Aging and Mental Health Advisory Committee members to host an aging and mental health conference in the spring of 2013, *Behavioral Health in the Later Years: what your aging patient may not be telling you.* The purpose of the conference was to increase community awareness about the mental health needs of older adults. After completion of the conference, the committee was disbanded. Monitoring of pertinent local and national issues regarding mental health and aging continues through the ALTCEW Planning and Management Council, and Frontier Behavioral Health/Elder Services.

Objective B: Between January 1, 2012 and December 31, 2015, the PMC and staff at ALTCEW will continue to work with, and provide support for other organizations to explore concepts, develop, implement and coordinate community engagement activities that promote wellness, prevention and socialization for older persons.

Outcome: Documentation supporting efforts at implementation and coordination of a wider array of community engagement activities that promote wellness, prevention and socialization for older persons living throughout PSA#11.

Accomplishments: ALTCEW has worked in collaboration with the Senior Assistance Fund of Eastern Washington (SAFE), Prevention Education Development (PED), SHIBA, Vulnerable Adults Link United (VALU), and Elder Services to coordinate local conferences to address the health and wellness of older adults. Examples include: *The Unexpected Pleasures of Growing Older* with Wendy Lustbader, PED Senior Wellness Conference, SHIBA Medicare Workshops, VALU summit, and Elder Services annual caregiver conference. ALTCEW has also partnered with CHAS and RRCA to implement the Chronic Disease Self Management Program. In 2014 and 2015 ALTCEW worked collaboratively with

SAFE to bring two local conferences to the Spokane area, *Boomers and Beyond.* The conference addressed issues such as healthy aging, falls prevention, hobbies and physical activities for older adults.

Objective C: During the planning period of January 1, 2012 through December 31, 2015, ALTCEW will partner with local organizations in exploring options for creating a dementia-capable model designed to improve access and utilization of Family Caregiver Support, Adult Day Care and dementia-specific family consultation services. When an opportunity becomes available, special attention will be given to securing funding for the model.

Outcome: The creation and dissemination of a brief report summarizing the options for creating a dementia-capable model designed to improve access and utilization of services for individuals with dementia and their families.

Accomplishments: This objective was not completed during 2012-2013.

Accomplishments: Continued to pursue grant funding, but eliminated report for 2014-2015. We secured a Dementia Capable Grant which was distributed to the Alzheimer's Association for work with Early On-set Dementia.

Objective D: Between January 1, 2012 and December 31, 2015, conduct advocacy activities and support other efforts that provide additional funding for dental, vision, hearing and other related health services in PSA #11.

Outcome: The writing and dissemination of a position paper advocating that additional funding be provided for dental, vision, hearing and other related health services throughout PSA #11.

Accomplishments: ALTCEW and the Planning and Management Council have continued to monitor activity pertaining to health related services in PSA#11. Dental services for low income and Medicaid clients have been added to the legislative priorities for the PMC Advocacy Committee, emphasizing support of proposed legislation. ALTCEW continues to partner with the Washington Dental Foundation Dental Outreach Program. A position paper was not completed during 2012-2013. Continue objective for 2014-2015. No position paper was completed, but ALTCEW continues to advocate for and partner with the Washington Dental Foundation. During 2014, dental was restored for Medicaid clients in Washington State. ALTCEW has worked with the Washington Dental Foundation to offer resources, including oral health kits, and education, including oral health red flag warnings, to low income older adults in the ALTCEW service area.

Objective E: Between January 1, 2012 and December 31, 2015, support efforts that provide adequate funding to meet the five-day a week home-delivered meal requirement and serve congregate meals two or three days a week.

Outcome: The dissemination of a position paper that supports adequate funding to meet the five-day a week home-delivered meal requirement and serve congregate meals two or three days a week in all subregions of PSA #11.

Accomplishments: Due to the current economic climate with sequestration, a position paper was not completed. Advocacy efforts have been focused on increasing funding to funding levels prior to sequestration. Examples of advocacy efforts include press conferences with home delivered meal providers.

Modification: Eliminate position paper.

Accomplishments: Continued advocacy efforts for 2014-2015 with an emphasis on increasing and sustaining funding levels prior to the implementation of sequestration.

Objective F: During the four-year planning period, the staff from ALTCEW will continue to implement and expand the Chronic Disease Self Management (CDSM) Program as an evidence-based practice in PSA #11.

Outcome: The documentation that supports the continued implementation or expansion of CDSM Program throughout PSA #11.

Accomplishments: ALTCEW has worked in collaboration with community partners to implement the CDSM Program throughout the Spokane, Whitman and Tri-County regions. CDSM Facilitators and ALTCEW staff have expanded the program through partnerships with Frontier Behavioral Health, YMCA, Adult Day Health providers, DDD providers, medical facilities and educational institutions. During 2014-2015 ALTCEW partnered with Community Health Association of Spokane (CHAS) and Rural Resources Community Action (RRCA) to further expand the CDSM Programs. Program funding through ALTSA ended in 2015, and community partners have committed to sustaining the program in the ALTCEW service area.

ISSUE AREA: Housing

Problem/ Need Statement: Safe and affordable housing options are increasingly inaccessible for older individuals and individuals with disabilities with the greatest economic and social needs. This population is expected to increase substantially through 2030, while the national economic downturn has caused the median income to decrease, the number of renters to increase, the cost of renting to increase, and the number of affordable rentals for low-income

individuals to decrease. This is coupled with continued Federal and State budget cuts from services that provide housing assistance. If unaddressed, the gap between the housing needs in PSA#11 and the accessibility of safe, affordable housing will continue to increase leaving many individuals homeless, institutionalized, or housing cost-burdened.

GOAL: Support the successful building of aging friendly communities by increasing the number of accessible, safe and affordable housing options that are available to meet the needs of older persons and individuals with disabilities.

Objective A: Between January 1, 2012 and December 31, 2015, the Governing Board, PMC, Advocacy Committee and staff will continue to provide copies of the position paper, advocating a minimum eight-percent (8%) increase in the resources that middle and low-income persons traditionally use to purchase safe and affordable housing options, to members of the Washington State Legislature and Congress, as needed.

Outcome: As reported by the Spokane Regional Housing Authority, an eight-percent (8%) increase in housing options and other resources for middle and low income seniors and individuals with disabilities living in the urban and rural areas of PSA #11.

Accomplishments: ALTCEW staff, PMC and Governing Board members have remained active with polices related to housing through community collaboration and focused ongoing advocacy efforts. Advocating for a minimum of 8% increase was listed as a monitoring priority for the 2012 State Legislative Session for the Advocacy Committee of the Planning and Management Council. Advocacy efforts pertaining to housing options continued for 2014-2015.

Objective B: Between January 1, 2012 and December 31, 2015, the Governing Board, PMC, Advocacy Committee and staff will continue to provide copies of the position paper, proposing the full-funding of a National Housing Trust Fund that would use surplus Federal Housing Administration insurance payments to provide safe and affordable housing options for eligible persons living in PSA #11, to members of the Washington State Legislature and Congress, as needed.

Outcome: The continued dissemination of the position paper and other efforts supporting increased awareness of the need to fully fund a National Housing Trust Fund.

Accomplishments: Staff and volunteers have continued to support funding for affordable housing options. Position paper and advocacy continued for 2014-2015.

Objective C: Between January 1, 2012 and December 31, 2015, the Governing Board, PMC, Advocacy Committee and staff will revise and provide copies of the position paper supporting increased funding for the Washington State Housing Trust Fund, to members of the Washington State Legislature and Congress, as needed.

Outcome: The continued dissemination of the position paper and other efforts supporting increased funding for the Washington State Housing Trust Fund.

Accomplishments: ALTCEW and its community partners have remained active on the national and state level advocating for the National and Washington State Housing Trust Fund through collaboration with N4A and W4A. Funding of the Washington State Housing Trust Fund was listed as a monitoring priority for the 2012 State Legislative Session for the PMC Advocacy Committee. ALTCEW continued advocacy and dissemination of position paper for 2014-2015.

Objective D: Between January 1, 2012 and December 31, 2015, the Governing Board, PMC, Advocacy Committee and staff will attend community meetings and provide copies of correspondence, testimony and statements of support to other organizations in PSA #11 to secure sufficient funding to increase affordable and safe housing options throughout PSA #11.

Outcome: The continued dissemination of a position paper and documentation of other efforts supporting an increase in the number of affordable and safe housing options throughout PSA#11.

Accomplishments: The PMC, Governing Board and ALTCEW staff have remained active participants in community coalitions and advocacy efforts. Examples include meetings with regional housing providers, planners and developers (Spokane Low Income Housing Consortium, Community Frameworks, Spokane Housing Authority, assisted living providers and subsidized housing facilities).

Objective E: In anticipation of the increased demand for aging-related services, ALTCEW will continue to collaborate with other agencies and organizations in PSA #11, to inform and urge developers, contractors, owners, managers and public officials to build and/or remodel homes, apartments, assisted living facilities and other forms of housing to meet the special needs of older persons and individuals with disabilities.

Outcome: The documentation of collaboration efforts with other organizations and the continued dissemination of a position paper supporting an increase in the number of accessible, affordable and safe housing options throughout PSA#11.

Accomplishments: ALTCEW has sustained ongoing advocacy and remained active with polices related to housing through community collaboration and coordination with housing providers. Examples include education through the SHIBA program, collaboration through case management, nursing staff, Bridging Care, senior employment program, and the Chronic Disease Self Management Program. Staff have coordinated and met with local housing developers to discuss the housing needs of older adults and individuals living with disabilities.

ISSUE AREA: Duals Integration

PROBLEM/NEED STATEMENT: Medical and social service care are uncoordinated for individuals dually eligible for Medicare and Medicaid. This population is often the most vulnerable for decline due to the complexity of facing multiple health challenges with little financial resources. Our current system of care for dual eligible individuals is complex and fragmented, requiring individuals to access multiple service providers and payment systems in order to manage their physical and mental health.

GOAL: Reduce fragmentation of care by participating in Health Homes as part of Washington State's Duals Integration Plan.

Objective: A: ALTCEW will participate in Health Home application for Region 6 as an organization providing Care Coordination services.

Outcome: Direct provision of Care Coordination services to a dually eligible population in ALTCEW's service area during the Washington State Duals Integration pilot.

Accomplishments: Contracted with Community Health Plan of Washington, Molina Health, United Healthcare and Community Choice as a Care Coordination Organization.

ISSUE AREA: Successfully Building Aging Friendly Communities

PROBLEM/NEED STATEMENT: Efforts to develop aging friendly communities are important in the face of a rapidly aging population. By 2030, one out of five people in America will be over 65. The overwhelming majority of older Americans will age in place, meaning that existing communities need to look forward to how to tap into and care for the existing population as they age. In a budget environment where resources are scarce, a concerted effort to maintain and enhance service networks is needed more than ever before.

GOAL: In order to successfully build aging friendly communities, focus efforts on creating vibrant communities that are prepared to meet the needs and aspirations of older adults and individuals living with a disability.

Objective: A: Between January 1, 2013 and December 31, 2015, ALTCEW and other partners will continue assessing how well communities help older adults remain healthy, live independently and lead productive and satisfying lives. The dissemination of the report to individuals and organizations within PSA #11 that helps create local communities were older adults remain healthy, live independently and lead productive and satisfying lives.

Outcome: By no later than December 31, 2015, the completion of a report summarizing the measurements of aging-friendliness in PSA #11. The dissemination of the report to individuals and organizations within PSA #11 that can help create local communities where older adults remain healthy, live independently and lead productive and satisfying lives

Accomplishments: Staff efforts have integrated the livable community perspective into advocacy, planning and coordination efforts during the 2012-2013 period. Coordination and advocacy efforts have included participation in Complete Streets, Spokane City Pedestrian Plan, Aging and Disability Resource Network meetings, Access 4 All, Spokane Low Income Housing Consortium (SLIHC), and state and federal advocacy.

Modification: Given the restraints of the current budget period, expending resources to develop a measure of aging friendliness and conduct a scientific survey is not a wise use of limited resources. Instead, ALTCEW's efforts will focus on continued integration of the livable community framework into all advocacy, planning, and coordination efforts in 2014-2015. During 2014 and 2015 ALTCEW continued participation with existing advocacy and added committee involvement with the Spokane County Accessible Communities Advisory Committee and the Spokane Regional Transportation Council (SRTC) Transportation Advisory Committee.

Objective B: During the four-year planning period, facilitate efforts to use information to raise awareness about aging issues and drive a broad range of community-planning efforts. The dissemination of a series of action plans to individuals and organizations that help to facilitate the creation of more age-friendly communities in PSA #11.

Outcome: The documenting of efforts to increase community awareness of aging issues and creation of an action plan(s) to facilitate more aging-friendly communities for today and tomorrow. By no later than December 15, 2015, the full dissemination of the series of action plans to individuals and organizations that can help to facilitate the creation of more age-friendly communities in PSA #11.

Accomplishments: This objective was not completed during 2012-2013, but will be completed by 2015. During 2014-2015, ALTCEW staff opted to be involved in local coalitions and groups in lei of writing another report.

Objective C: Between January 1, 2012 and December 31, 2015, continue implementing the Building Communities for Successful Aging Forums' recommendations.

Outcome: By December 31, 2015, the dissemination of the Building Communities for Successful Aging Forums' recommendations to community partners located throughout PSA #11. The potential implementation of the forums' recommendations by community partners in local communities throughout PSA #11.

Accomplishments: ALTCEW continued disseminating recommendations throughout PSA #11 in 2012 and 2013.

Modification: Eliminate objective for 2014-2015. Recommendations have been distributed.

Objective D: During the planning period of January 1, 2012 and December 31, 2015, continue to advocate and support efforts at dedicating funding authorizations to support ALTCEW and the aging network in providing assistance to proactively prepare for the aging of their communities during the next 10-15 years.

Outcome: By no later than September 30, 2013, the creation of a position paper and documentation of participation in other efforts supporting the need for increased funding authorizations dedicated to providing assistance in proactively preparing for the aging of communities in PSA #11 during the next 10-15 years. Dissemination of the position paper to individuals and organizations that can help efforts to support the need for increased funding authorizations dedicated to providing assistance in proactively preparing for the aging of communities in PSA #11 during the next 10-15 years.

Accomplishments: This material has been incorporated into existing position papers, though the focus has been on maintaining funding levels given the current economic climate.

Modification: Eliminate objective for 2014-2015.

Objective E: In anticipation of the increased demand for aging-related services, support the increase of reauthorization levels for all titles of the Older Americans Act (OAA) by creating a position paper by no later than September 30, 2012.

Outcome: Dissemination of the position paper to members of the US House of Representatives, US Senate, the Administration on Aging and other organizations that can help achieve an eight-percent (8%) increase in funding levels for all titles of the OAA during the 2012-2015 funding period. A minimum of an eight-percent (8%) increase in funding levels for all titles of the OAA during the 2012-2015 funding period.

Accomplishments: A position paper on the Older Americans Act Appropriations increase of at least 12% for all titles was created and disseminated during the 2012 session to members of the US House of Representatives and Senate. During the 2013 session, advocacy efforts instead focused on the impacts of sequestration and funding reductions on older adults.

Modification: Continued distributing position paper in 2014-2015.

Objective F: During the course of the four-year planning period, support increased federal funding through the Administration on Aging (AoA) by eight-percent (8%) to support community level work by ALTCEW and its community partners in implementing emergency preparedness activities for older adults and special needs populations living throughout PSA #11.

Outcome: By September 30, 2013, the creation of a position paper requesting that funding is increased by eight-percent (8%) through the AoA to support emergency preparedness activities for older adults and special needs populations living throughout PSA #11. Dissemination of the position paper to members of the US House of Representatives, US Senate, the Administration on Aging and other organizations that can help achieve an eight-percent (8%) increase in funding levels for implementing emergency preparedness activities for older adults and special needs populations living throughout PSA #11.

Accomplishments: This position paper was not created, due to advocacy efforts needing to focus on maintaining and restoring current funding for critical Older Americans Act services.

Modification: Eliminate objective for 2014-2015.

Objective G: Between October 1, 2013 and December 31, 2015, support activities that reduce restriction on local flexibility within the Older Americans Act (OAA) and increase local transfer authority within the OAA.

Outcome: By no later than September 30, 2013, the writing of a position paper requesting that restriction on local flexibility within the OAA be reduced and local transfer authority within the OAA is increased. Dissemination of the position paper to members of the US House of Representatives, US Senate, the

Administration on Aging, the State Unit on Aging, Office of the Washington State Governor and other organizations that can help reduce restriction on local flexibility within the Older Americans Act (OAA) and increase local transfer authority within the OAA.

Accomplishments: A position paper on the reauthorization of the Older Americans Act addresses the need for local flexibility within the OAA was created and disseminated to members of the US House of Representatives, US Senate, the Administration on Aging, the State Unit on Aging, Office of the Washington State Governor and other organizations in 2012-2015.

Objective H: Between July 1, 2013 and December 31, 2015, advocate and participate in activities that support the formation of a volunteer management grant program supporting the creation of volunteer management positions and training activities focused specifically on recruiting, placing and retaining of volunteers age fifty years and older.

Outcome: By June 30, 2013, researching and writing of a position paper supporting the creation of a volunteer management grant program supporting the formation of volunteer management positions and training activities focused specifically on recruiting, placing and retaining of volunteers age fifty and older. Dissemination of the position paper to members of the US House of Representatives, US Senate, the Administration on Aging, the State Unit on Aging, State Council on Aging and other organizations that can help in the formation of volunteer management positions and training activities focused specifically on recruiting, placing and retaining of volunteers age fifty and older.

Accomplishments: This position paper was not created, due to advocacy efforts needing to focus on maintaining and restoring current funding for critical Older Americans Act services.

Modification: Eliminate objective for 2014-2015.

Objective I: During the four-year planning period, advocate and support activities that assess the adequacy of the minimum state funding level for coordination of statewide long-term care services, support activities, planning efforts, monitoring and evaluating processes.

Outcome: By October 31, 2012, the creation of a position paper supporting activities that assesses the adequacy of the minimum state funding level for coordination of statewide long-term care services, support activities, planning efforts, monitoring and evaluation processes. Dissemination of the position paper to members of the US House of Representatives, US Senate, the Administration on Aging, Washington State Legislature, Office of the Washington

State Governor, the State Unit on Aging, State Council on Aging and other organizations that can help assess the adequacy of the minimum state funding level for coordination of statewide long-term care services, support activities, planning efforts, monitoring and evaluation processes.

Accomplishments: A position paper on the Reauthorization of the Older Americans Act for 2012 incorporated the need for capacity building initiatives including developing core competencies, effectively tracking program outcomes, performing evaluations, and consistently attending to staff/ volunteer development, training and retention. It was disseminated to members of the US House of Representatives, US Senate, the Administration on Aging, Washington State Legislature, Office of the Washington State Governor, the State Unit on Aging, State Council on Aging and other organizations in 2012-2015.

GOAL: Support the successful building of aging friendly communities by increasing the economic security of older adults and persons living with a disability.

Objective A: Between July 1, 2012 and December 31, 2015, advocate and participate in other activities that help to establish the Elder Economic Security Index (EESI) as a goal of the Older Americans Act (OAA).

Outcome: By no later than June 30, 2012, the writing and dissemination of a position paper supporting economic security as a goal of the OAA.

Accomplishments: This has not been completed. Due to limited capacity and staff time, the Advocacy Committee of the Planning and Management Council has decided to track rather than advocate/ support the establishment of the EESI as the measure to determine financial eligibility for state funded programs for older adults rather than the Federal poverty level while focusing on more pertinent advocacy efforts in 2012-2013. However, the Washington Association for Area Agencies on Aging will be advocating for the implementation of the EESI on the state level.

Modification: Continue advocacy but eliminate position paper for 2014-2015. The EESI was included as an advocacy priority for the Advocacy Committee of the ALTCEW Planning and Management Council for the 2014 session. ALTCEW and the Advocacy Committee will continue to support economic security of older adults.

Objective B: During the four-year planning period, advocate and participate in other activities that help increase the Senior Citizens Service Act (SCSA) using the Elder Economic Security Index (EESI) to illustrate the impact of SCSA funding in maintaining economic security for older adults living in PSA #11.

Outcome: By January 1, 2012, the creation and dissemination of a position paper and other efforts that illustrate the impact that SCSA funds have in maintaining economic security for older adults living in PSA #11.

Accomplishments: ALTCEW used the position papers and advocacy materials produced by the Washington Association of Area Agencies on Aging for the 2012-2013 state legislative sessions.

Modification: Continue to use W4A materials to advocate for funding maintenance or increases in the Senior Citizen Services Act (SCSA) in 2014-2015. This objective was accomplished. There were no cuts to SCSA funding during 2014-2015.

Objective C: Between October 1, 2012 and December 31, 2015, support reauthorization of and increased funding for the Senior Community Services Employment Program (SCSEP) by twenty-five percent (25%) to serve a greater number of low-income seniors.

Outcome: By no later than September 30, 2012, the creation and dissemination of a position paper supporting reauthorization and increased funding for the SCSEP by twenty-five percent (25%) to serve a greater number of low-income seniors living throughout PSA #11.

Accomplishments: ALTCEW did not provide national-level advocacy for SCSEP during 2012-2013 due to advocacy efforts focusing on sequestration.

Modification: Eliminate objective for 2014-2015 to focus on restoring funding lost due to sequestration.

ISSUE AREA: Family and Kinship Caregivers

PROBLEM/NEED STATEMENT: Caregiving for friends and family members is a challenging job. Family and other non-paid caregivers struggle with the demands of caregiving 24 hours a day. These demands often generate tremendous stress, which can negatively affect physical and emotional health, relationships with others, as well as create isolation and loneliness. Life is often a balancing act between caregiving duties, family, and work. Continual caregiving can cause a decline in physical and mental health, resulting in a decline in the quality of care or the institutionalization of the person receiving care. The Aging Network must provide information and support to family and non-paid caregivers so they are able to maintain their health and continue to provide quality care to their family member or friend.

GOAL: Support the successful building of aging friendly communities by increasing the number of family and other non-paid caregivers that receive information and support in providing care for older persons and individuals with disabilities.

Objective A: During the four-year planning period, the Governing Board, PMC, Advocacy Committee, staff and subcontractors will continue to advocate for a ten-percent (10%) increase in Family Caregiver Support Program, Kinship Caregiver Support Program and Kinship Navigator Program funding for family and non-paid caregivers in PSA #11.

Outcome: At a minimum, a ten-percent (10%) increase over 2010-2011 funding levels to provide FCSP, KCSP and KNP services in PSA #11.

Accomplishments: Aging and Long Term Care of Eastern Washington has created a position paper on the Older Americans Act Appropriations for 2013 asking for a 12% increase in funding for FCSP and all other titles of the OAA. Continued advocacy for 2014-2015.

Objective B: Between January 1, 2012 and December 31, 2015, the Family Caregiver Support Program's subcontractors will maintain or expand, if funding is available, outreach and targeting activities to unpaid relative caregivers by five-percent (5%).

Outcome: Maintenance of 2010-2011 outreach and targeting levels or, if increased funding is available, a five-percent (5%) increase over 2010-2011 service levels in outreach and targeting activities provided individuals as reflected in the monitoring reports completed by staff from ALTCEW.

Accomplishments: Targeted outreach activities were completed by subcontractors. Due to the amount of specific information required in monitoring reports, information was not required in monitoring reports but was discussed with monitoring staff at review.

Objective C: Between 01/01/12 and 12/31/15, the subcontractors will continue to outreach and target family and unpaid relative caregivers that are age 55 and older and caring for persons under age 19 or over the age of 60 with severe disabilities, including developmental disabilities.

Outcome: As reflected in the monitoring reports completed by staff from ALTCEW, the maintenance of 2010-2011 outreach and targeting levels or, if increased funding is available, a five-percent (5%) increase over 2010-2011 service levels in outreach and activities provided to targeted individuals.

Accomplishments: Elder Services and Rural Resources Community Action have continued outreach and targeting family and non-paid caregivers that are age 55 and older and caring for persons under age 19 or over the age of 60 with severe disabilities.

Objective D: By March 31, 2012, the FCSP and KCSP subcontractors will draft and submit to ALTCEW a plan that ensures 10% of the services will be provided to caregivers in the 18 to 59 age group. The draft plan will included specific information describing how this special group of caregivers will be targeted, outreached and served as part of the FCSP and KCSP delivered in each subcontractor's service area.

Outcome: The approved plan will be implemented by the subcontractors during the remainder of the four-year planning period and reflected in the documentation submitted to ALTCEW as part of the ongoing monitoring process.

Accomplishments: Plan was completed by Elder Services and submitted to ALTCEW. Rural Resources Community Action's compliance was verified at monitoring visit. When the 2012 contract was completed requirement was removed due to no longer being applicable.

Modification: Report completed. Remove for 2014-2015.

Objective E: By December 31, 2012, ALTCEW and the subcontractors will explore options for continuing or expanding the series of recommended best practices included in the special study of the Family Caregiver Support Programs and Kinship Caregiver Support Programs in PSA #11. At a minimum, subcontractors' exploration will include the use of regional-based telecommunication technologies to facilitate or expand the FCSP's and KCSP's support groups and training activities, the practice of holding Powerful Tools For Caregivers training classes, continuation or expansion of support groups for male caregivers as part of the FCSP activities, and the distribution of quarterly flyers or newsletters for FCSP and KCSP activities.

Outcome: The documentation of efforts by the subcontractors to explore the options as reflected in the monitoring reports completed by staff from ALTCEW.

Accomplishments: During the current planning period efforts were completed by subcontractors to expand the series. Examples of this effort include the annual Caregiver Conference sponsored by Elder Services as well as outreach to schools throughout Spokane County. FCSP staff members are partnering with other local agencies such as the Alzheimer's Association in Powerful Tools of Caregiver and other trainings. RRCA has a multi-faceted outreach plan in place that utilizes various print media, broadcast media, Website, and face-to-face encounters by staff and volunteers. Staff members represent all RRCA programs out in the community with brochures and flyers for all the services.

Objective F: ALTCEW will subcontract to provide Kinship Navigator activities as a direct service in Whitman County, if adequate funding is available, for the period of January 1, 2012 through December 31, 2015.

Outcome: The completion of a brief report summarizing an analysis of information to determine if the Kinship Navigator Program's activities should be provided as a direct service in Whitman County.

Accomplishments: Data was presented by subcontractor in Whitman County that supported implementation of the Kinship Navigator Program in Whitman County.

Modification: Services subcontracted in Whitman County. Remove for 2014-2015.

Objective G: During the four-year planning period, support efforts that enhance the flexibility of how National Family Caregiver Support Program funds may be used at the local level by the Area Agencies on Aging (AAAs) and their subcontractors.

Outcome: The creation and dissemination of a position paper supporting efforts that enhance the flexibility of how National Family Caregiver Support Program funds may be used at the local level by the AAAs and their subcontractors.

Accomplishments: This task has not been completed during 2012-2013 due to advocacy efforts needing to focus on maintaining and restoring current funding for critical Older Americans Act services.

Modification: Eliminate objective for 2014-2015.

Objective H: Between January 1, 2012 and December 31, 2015, staff from ALTCEW and the FCSP, KCSP and KNP subcontractors will participate in developing partnerships with organizations serving non-traditional family caregivers. This will include organizations currently serving Gay, Lesbian, Bisexual and Transgender (GLBT) individuals and other caregivers who may not be seen as a traditional family member. In implementing the goal(s) for this objective, ALTCEW and the subcontractors will work towards identifying organizations to provide in-service training for the staffs from ALTCEW and the subcontractors.

Outcome: The overall goal is to ensure persons delivering the FCSP, KCSP and KNP services have knowledge and understanding of the specific issues faced by non-traditional family caregivers providing caregiving services in PSA #11.

Accomplishments: This objective was not completed in 2012-2013; however, we have partnered with EWU School of Social Work and are developing an in-service for case management staff.

ISSUE AREA: In-Home Services

PROBLEM/NEED STATEMENT: Though the need for in-home services for personal care and household tasks continues to increase as the baby boomers age, reductions in state funding and the lack of alternative resources jeopardizes quality of care for current clients and does not present an adequate safety net for the future to keep persons in their homes or setting of choice as they age.

GOAL: Support the successful building of aging friendly communities by increasing the number of older persons and individuals with disabilities that have access to an array of quality community-based health and social service options.

Objective A: Between January 1, 2012 and December 31, 2015, the staff from ALTCEW will research and develop concepts for implementing a private pay caregiver registry for customers living in PSA #11. Special attention will be given to securing funding for the private pay registry concept.

Outcome: Documentation of efforts to research, develop and implement the private pay concept and obtain source(s) of on-going funding for a project in PSA #11.

Accomplishments: ALTCEW explored multiple models of private pay registries in 2012 and previous years, but had not chosen or implemented a model due to funding constraints. We continued to pursue development in 2015 and have focused staff efforts on ACL Business Acumen Project.

Objective B: During the four-year planning period, research and propose options that enhance ALTCEW's and the aging network's potential for providing evidence-based health promotion and disease prevention services as part of the Affordable Care Act (ACA).

Outcome: The submission of at least one application and/or proposal implementing an evidence-based health promotion and/or disease prevention model as part of the ACA.

Accomplishments: ALTCEW submitted applications for the Community Based Care Transitions Program (CCTP), funded by Section 3026 of the Affordable Care Act, to provide the evidence-based Care Transitions Intervention. Applications were submitted in January, May and August 2012. The final application was approved, and ALTCEW is now implementing the CTI program throughout an eleven-county region in eastern Washington and northern Idaho.

Accomplishments: ALTCEW implemented the CTI Program through Bridging Care Across the Inland Northwest, with the goal of reducing all-cause Medicare readmission rates by 20% by 2015. We have reduced readmission rates by 33%.

Objective C: Between January 1, 2012 and December 31, 2015, the staff at ALTCEW will continue to operate and/or expand the Chronic Case Management (CCM) Project that provides intensive services based on evidence-based practices in PSA #11.

Outcome: The operation and/or expansion of the CCM Project to reduce disease and disability, improve health outcomes and reduce medical expenditures for eligible clients living throughout PSA #11.

Accomplishments: ALTCEW continued to operate the CCM Program through 2012 and 2013. This program will be phased out in 2014 and replaced with health homes in October 2013.

Modification: Eliminate objective for 2014-2015.

Objective D: During the planning period of January 1, 2012 and December 31, 2015, the staff from ALTCEW will research concepts for the potential implementation of a Chore-Like Program in PSA #11. When an opportunity becomes available, special attention will be given to securing funding and eligibility requirements that focus on easy access to services.

Outcome: Documentation of efforts to research, develop, fund and implement the Chore-Like concept and locate on-going funding for a project in PSA #11.

Accomplishments: This objective was not accomplished during 2012-2013. Continue for 2014-2015. There was no funding available; however, we continued coordination with Volunteer Chore and advocated for inclusion of housework in 1115 waiver service package for LTSS.

Objective E: Between January 1, 2012 and December 31, 2015, the staff from ALTCEW will research opportunities that help to provide moving assistance for low-income persons living PSA #11. When an opportunity becomes available, special attention will be given to securing funding and developing eligibility requirements that focus providing access to this service(s).

Outcome: Documentation of efforts to research, develop, and implement the moving assistance concept and find on-going funding for a moving assistance project in PSA #11.

Accomplishments: This objective was not accomplished during 2012-2013. Continue for 2014-2015. During 2014-2015, moving assistance was added as a

resource for eligible clients on Roads to Community Living and Washington Roads. This resource was additionally added as a Community Transition Service in 2015 for eligible Community First Choice clients. Private pay resources are also available for individuals who have the resources to pay. ALTCEW will continue to advocate of additional moving assistance resources for low income older adults and people living with disabilities.

ISSUE AREA: Transportation

PROBLEM/NEED STATEMENT: The projected increase in the aging population will make senior mobility and independence greater concerns for society in the near future. For many seniors, the physical or financial ability to maintain a car is lost with increasing age. When seniors stop driving, they can experience a drastic decline in mobility. Reduced mobility puts older individuals at higher risk of poor health due to loss of access to goods, services, and social contact.

GOAL: Support the successful building of aging friendly communities by increasing the availability of transportation and other access service options for older persons and individuals with disabilities.

Objective A: Between January 1, 2012 and December 31, 2015, the Governing Board, PMC, Advocacy Committee and staff will continue disseminating the position paper proposing at least a ten-percent (10%) increase in funding be made available for "special needs" transportation services in PSA #11. Special focus will be given to increasing resources for older persons and individuals with disabilities living in rural areas of PSA #11.

Outcome: The continued dissemination of position paper and documentation of other efforts in securing at least a ten-percent (10%) increase in funding for special needs transportation services in PSA #11.

Accomplishments: This objective was not completed during 2012-2013.

Modification: Due to financial restraints of the current budget period, advocacy efforts to increase funding for special needs transportation services is not a wise use of the limited advocacy resource. Advocacy efforts will be focused on sustaining special needs transportation services at or near current program funding levels. ALTCEW will track advocacy activities, but will not produce a separate position paper on the issue for 2014-2015. During the 2014-2015 legislative sessions, ALTCEW advocated for increased transportation options in rural communities.

Objective B: Between January 1, 2012 and December 31, 2015, ALTCEW will continue to collaborate with other organizations in tracking, writing supporting testimony, and applications that help increase the availability of transportation options for older persons and individuals with disabilities living in PSA #11.

Outcome: The continued dissemination of the position paper and documentation of other efforts in obtaining at least a five-percent (5%) increase in transportation options for older persons and individuals with disabilities living in PSA #11.

Accomplishments: No position paper was created for 2012-2013. ALTCEW provided technical assistance and a letter of support to Elder Services / Frontier Behavioral Health for their application to Spokane Regional Transportation Council and Washington State Department of Transportation, in an application to secure funding for the Care Cars program serving Spokane County.

Modification: Due to financial restraints of the current budget period, advocacy efforts to increase funding for transportation services for older adults and individuals living with disabilities is not a wise use of the limited advocacy resource. Advocacy efforts will be focused on sustaining transportation services at or near current program funding levels. ALTCEW will track advocacy activities, but will not produce a separate position paper on the issue for 2014-2015. ALTCEW staff advocated for adequate transportation funding during the 2014 and 2015 Legislative sessions. ALTCEW staff also facilitated connection between local transportation providers and Spokane Transit Authority to partner on transportation services funded through MAP21 with a specific target on older adults and people living with disabilities.

Objective C: Between January 1, 2012 and December 31, 2015, ALTCEW will continue its efforts at building linkages with Spokane Transit Authority (STA), the Spokane Regional Transportation Council (SRTC), and other community organizations in securing funding opportunities that help provide transportation options for older persons and individuals with disabilities.

Outcome: Documentation of efforts at securing funding opportunities that help provide transportation options for older persons and individuals with disabilities living throughout PSA #11.

Accomplishments: Staff has worked with STA, SRTC and other transportation providers during the 2012-2015 period. Staff completed a letter of support, and provided technical assistance, for the Care Cars program to obtain funding through Washington State Department of Transportation. Qualified transportation providers were made aware of the surplus van program through

STA. ALTCEW is also representing the needs of older adults and people living with disabilities as a member of the SRTC Transportation Advisory Committee.

Objective D: During the planning period of January 1, 2012 through December 31, 2015, conduct efforts that formalize and build upon ALTCEW's and the aging network's role in coordinating public transportation services, on planning processes, funding support, and technical assistance.

Outcome: The documentation of collaborative efforts formalizing and building upon ALTCEW's and the aging network's role in coordinating public transportation services as part of the planning processes, funding support, and technical assistance in PSA #11.

Accomplishments: ALTCEW staff has worked collaboratively with regional transportation providers through staff presence and feedback at SRTC board meetings, Transportation Advisory Council (TAC) meetings, and commented on the Horizon 2040 transportation plan and at STA public hearings. ALTCEW does not function as a direct transportation provider and does not function in the coordination capacity.

Objective E: Between January 1, 2012 and December 31, 2015, advocate and support efforts to increase non-medical transportation services for older adults and individuals with disabilities living throughout PSA #11.

Outcome: The dissemination of a position paper and documenting of other efforts supporting increased non-medical transportation services for older adults and individuals with disabilities living throughout PSA #11.

Accomplishments: This objective was not completed during 2012-2013.

Modification: Continue advocacy efforts but eliminate the creation of a position paper for 2014-2015. During 2014-2015 ALTCEW worked with STA to support increased transportation for older adults through MAP 21 5210 federal transportation funds. ALTCEW facilitated meetings, and provided technical assistance during the development of the implementation priorities and potential partner identification.

Objective F: During the course of the four-year planning period, continue to pursue funding opportunities for transportation services for older adults and individuals with disabilities living throughout PSA #11.

Outcome: Documentation of efforts at completing research, evaluation, writing and submission of appropriate funding opportunities for transportation services for older adults and individuals with disabilities living throughout PSA #11.

Accomplishments: No funding applications were submitted by ALTCEW in 2012-2013. During 2014-2015, no funding applications were provided. ALTCEW provided letters of support to organizations pursing transportation funding for seniors and people living with disabilities.

Objective G: In anticipation of the increased demand for aging-related services, ALTCEW will continue to advocate that the local transportation providers include the needs of older adults and individuals with disabilities as part of their planning and policy development processes.

Outcome: Position paper and other related activities that support the local transportation providers including the needs of older adults and individuals with disabilities as part of their planning and policy development processes.

Accomplishments: Staff has participated in meetings with regional transportation planners. Activities included: SRTC board meeting and Transportation Advisory Council, and regional social service transportation planning meeting. Staff additionally provided feedback on the local Human Services Transportation Plan, Horizon 2040 and completed a need assessment of transportation services for older adults and individuals living with disabilities in PSA#11. The recommendations from the need assessment were shared at community planning meetings and with regional transportation planners.

ISSUE AREA: Elder Rights and Abuse Prevention

PROBLEM/ NEED STATEMENT: Elder abuse is an often overlooked and hidden issue that will increase substantially, given the aging baby boomer generation, if not addressed. An estimated 11% of older Americans have been affected by some form of elder abuse. Despite the seriousness of the issue, an estimated 86% of cases go unreported. Elders who experience abuse, neglect, or self-neglect face considerably higher risk of premature death than elders who have not been mistreated.[1]

GOAL: Support the successful building of aging friendly communities by increasing the number of older persons who benefit from activities that protect their rights, and prevent elder abuse, neglect and exploitation.

Objective A: During the four-year planning period, ALTCEW will continue to partner with other community organizations by participating in the Vulnerable Adults Linked United (VALU) work group to do public education activities designed to identify, prevent and report elder abuse.

Outcome: Documentation that supports efforts at partnering and enhancing public awareness on ways to prevent, identify and report elder abuse in PSA #11.

Accomplishments: During the 2012- 2015 time period, ALTCEW has continued its support and presence on the VALU work group. Activities have included a presentation on care transitions, a presentation on the elder economic security index, and staff has presented at multiple VALU conferences.

Objective B: Between January 1, 2012 and December 31, 2015, the Governing Board, PMC, and Advocacy Committee will disseminate the updated position paper advocating funding of the Elder Justice Act. Appropriate funding of the act would help to refine, develop and implement promising practices within the field of elder abuse prevention.

Outcome: Continued dissemination of the position paper advocating full-funding of the Elder Justice Act and other efforts to enhance public awareness on the need for the concepts covered in the Elder Justice Act.

Accomplishments: Position paper was not completed in 2012-2013 time period. We continued this as an objective to be completed for 2014-2015 time period. We did not develop a position paper.

Objective C: During the course of the four-year planning period, advocate and support other efforts to ensure stable and sufficient resources for the Long Term Care Ombudsman Program (LTCOP) in PSA #11.

Outcome: The creation and dissemination of a position paper advocating and supporting efforts to ensure stable and sufficient resources for the LTCOP in PSA #11.

Accomplishments: This position paper was not created due to needing to direct a focus towards advocacy issues related to funding for the LTCOP in the 2012-2013 time period. During the 2012-2015 time period, ALTCEW has participated in advocacy related to the LTCOP at the state and federal level including advocacy at W4A and N4A for increased support and funding.

Appendix G Statement of Assurances and Verification of Intent

For the period of January 1, 2016 through December 31, 2019, 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. 106-510) 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;

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

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

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

Obtain input from the public and approval from the AAA Advisory Council on the development, implementation and administration of the Area Plan through a public process, which should include, at a minimum, a public hearing prior to submission of the Area Plan to DSHS/ADS. 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.

10/1/2015
Date

Lynn Kimball
Executive Director

10/1/15
Date

Fran Bessermin
Chair, Planning and Management Council

10/7/15
Date

Jon Snyder
Chair, Governing Board