Aging & Long Term Care of Eastern Washington

Proposed 2024-2027 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 Department 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 or action@altcew.org

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2024-2027 AREA PLAN

ACKNOWLEDGEMENTS

First and foremost, Aging & Long Term Care of Eastern Washington (ALTCEW) wants to acknowledge that our service region is on the traditional territory of numerous tribes who are connected through a shared history in Eastern Washington including the Spokane, the Confederated Tribes of the Colville Reservation, and Kalispel Tribes. The land we are on has been inhabited and cared for by Indigenous peoples for thousands of years. We recognize the struggle, strength, and stewardship of Native elders and Tribal leaders in our shared communities.

Washington State Indian Tribes Map - Bing images

AREA PLAN CONTRIBUTORS

The Planning and Resources Department and Area Planning Team would like to express profound gratitude to all the ALTCEW staff that helped us gather information, proofread, contributed, and supported our efforts to put this plan together. None of this could have been possible without your support and knowledge to help guide us through this process. We cannot thank you enough for all your time and efforts to assist us in putting such a great and resourceful plan together.

ALTCEW's Planning and Management Council Board played an integral role in assisting the area plan team with guidance and accountability that is greatly appreciated. They were able to be our checks and balances and make sure that our information is true and correct. Words cannot express our gratitude and appreciation for the wisdom that we so graciously are able to utilize through this board.

ALTCEW would like to acknowledge our Governing Board. Without their process and due diligence, we never would have been able to move through this procedure successfully. Their support and helpful advice played a key role throughout the area plan process.

Last but not least, we would like to thank all of our amazing volunteers who show up every day to support their family, friends, and our community. From A Matter of Balance, to SHIBA, whether it's shoveling snow, delivering meals, or checking on each other in person or by phone, we owe them our gratitude and appreciation for all that they do. Without our dedicated volunteers we couldn't be as successful as we are in building healthy communities and making Eastern Washington a great place to age with dignity.

A special thank you to the Office Assistance team who assisted with the Area Plan:
Amanda Stevens, Victoria DeLeon, and Ben Matlock

A huge shoutout to the following writers and editors of the Area Plan:
Bethany Osgood, Jenni Jones, Savannah Reams-Taylor, and Tara Hill-Matthews.




LETTER FROM THE AREA AGENCY ON AGING LEADERS

A letter from Lynn Kimbal, Executive Director at ALTCEW -

Dear Community,

This plan is the result of many interviews, focus groups, and community meetings held throughout our region. Thank you to everyone who reached out to comment, and those that let us intrude on their meal site or community meeting to gather information. Local communities are the experts in what they need, and what gaps they see in current systems of care. Thank you for providing valuable feedback so we can direct the resources we have most effectively, and target areas for improvement, development, collaboration, and advocacy.

Your stories and experience matters, and we hope to have done justice in this plan sharing stories and making plans that are truly informed by the older adults, people with disabilities, and caregivers we serve. We know the resources available pale in comparison to the need we see in our communities, so we strive to target them to be as effective as possible, and work hard to elevate your voice and concerns to drive needed change.

Thank you to our staff, partner agencies, and volunteers that work daily to serve older adults, people with disabilities, and caregivers. You truly make a difference in people's lives, and without you none of this would be possible.

Finally, thank you to our Governing Board and our Planning and Management Council for keeping us grounded in the community and both encouraging and challenging us to be better and do better. We will be working hard over the next four years to carry out this plan and meet the needs of Eastern Washington.

Thank you,

Lynn Kimball

Lynn Kimball

Executive Director - ALTCEW

A letter from the Leadership Team -

Dear Community,

We want to introduce you the ALTCEW team. This amazing group of wonderful humans are passionate, dedicated, and live our mission every day serving older and disabled adults. We want to thank you as our friends, neighbors, and community members for sharing your stories, lives, and what matters to you most while pursuing healthy aging. We at ALTCEW are on a journey with you, as we develop new programs, offer additional resources, and seek out more partner agencies who can offer better solutions.

We don't just work hard; we play hard too. We celebrate our rural and diverse communities, volunteer with Meals on Wheels with local fire districts, show our PRIDE, celebrate our diversity, participate in the Walk to end Alzheimer's, donate to the Tree of Sharing, and so much more. In 2023, ALTCEW was nominated and won this year's State Council on Aging award for "Excellence in Action" celebrating the Building Dementia Capable Communities program. ALTCEW was also picked as one of the Inland Northwest Best Places to Work! Our team truly loves what we do.

Our collective hope is to walk with you, to provide support, compassion, and dignity, through the Area Plan work over the next four years and beyond. We are humbled and honored you have asked us to join you on your path for wellness.

This letter is dedicated to the hardworking and committed employees of ALTCEW who show up every day to make a difference, change the narrative, honor diversity, elevate inclusion, and provide the best care possible.

Sincerely,

Bethany Osgood

Bethany Osgood.

Planning and Resource Director, Tribal Liaison - ALTCEW

SECTION A – AREA AGENCY PLANNING AND PRIORITIES

A.1 Introduction:

Ad from ALTCEW's 2023 Marketing Campaign

Aging & Long Term Care of Eastern Washington (ALTCEW) is a social service agency that helps older adults and people living with disabilities stay in their homes. ALTCEW provides services such as case management for people who need a caregiver, assistance accessing local resources to help people stay at home, and answers to questions about Medicare and Medicaid.

Alone, we cannot fulfill our mission, so we work with local partners in the community to provide services such as home delivered meals, family caregiver support, transportation, and information. Through community partners, ALTCEW provides funding for services to older adults and individuals living with a disability in our five-county area.

ALTCEW is the local Area Agency on Aging for Ferry, Pend Oreille, Spokane, Stevens, and Whitman counties. Area Agencies on Aging were established by the 1973 amendments to the 1965 Older Americans Act. There are over 600 of these agencies across the nation. They are part of what is known as the "Aging Network." This network includes the Administration for Community Living at the federal level, State Units on Aging in each state, Area Agencies on Aging (AAA) at the local level and other public and private agencies, such as senior centers and nutrition project sites, all working together to serve the nation's elderly.

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

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

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

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

1. Determining the needs.
2. Planning services to meet the needs.
3. Coordinating the delivery of services, which are already operating in the area.
4. Searching for new sources of funds to pay for the development and continuance of needed services.
5. Providing leadership and advocacy.
6. Administering the federal and state dollars available for services in the community, including providing direct services and contracting with local agencies to provide services.
7. Providing technical assistance to service providers and other agencies.
8. Developing community education programs to keep the community informed as to what programs and services are available.

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

1. Governing Board - made up of one county commissioner from each county, one City of Spokane council member, the Director of Community Housing and Human Services at City of Spokane, one City of Spokane Valley council member, and the Planning and Management Council's Chairperson.
2. Planning and Management Council – an advisory council made up of 35 volunteers broadly representative of older persons and the community served by the Agency.
3. Staff - deliver agency programs, monitor contracted providers, plan for community needs, provide technical assistance, and ensure funding is spent in compliance with federal and state guidelines.

AREA PLAN PURPOSE:

The Area Plan on Aging is a plan that each Area Agency on Aging including ALTCEW is required to submit the State Unit on Aging, that identifies goals for the service delivery that reflect the priorities of the Older Americans Act. The Area Plan included demographics, trends, budget information, available services, target population profiles, focal points, issue area themes, past accomplishments, internal organizational structure, strategic partnerships, and much more. The Area Plan is developed every four years by the Area Agency on Aging as a response to current needs of the community. The Area Plan specifically outlines actions and programs that ALTCEW will undertake to further its mission and vision to advocate and advance healthy aging for older adults, vulnerable adults, and disabled adults.

ALTCEW's continued commitment to honor Diversity, Equity, and Inclusion will be woven into everything we accomplish as an agency over the next four years. We will be seeking out new partnerships and expanding our continued work with organizations that focus on providing resources and programs for serve low-income minority individuals, limited English speaking persons, Tribal Elders, and older adults residing in rural areas. ALTCEW will continue to identify and collaborate with organizations that represent and provide supportive resources for older Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Two Spirit, plus (LGBTQIA2+) individuals and persons under sixty (60) with disabilities. This includes additional DEI trainings for ALTCEW staff, providing healthy aging education via multiple venues, support for people living with dementia and their care partners, and enhancing our marketing, social media, and outreach with translations services for limited English speaking persons. One of our current aspirations is working towards building dementia friendly spaces, built communities, and supporting those living with cognitive loss decline and their care partners.

If you would like to contact ALTCEW about our Area Plan proposal with any questions or comments, please see the contact information below.

Individuals wishing to submit comments on this plan should contact:

Aging & Long Term Care of Eastern Washington, Planning Department:
1222 North Post Street Spokane, Washington 99201 | 509-458-2509
www.altcew.org | action@altcew.org

ALTCEW Staff Members at Winter 2022 All Staff

A.2 Mission, Vision, Values:

Walter, ALTCEW Client, Spokane, WA

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.
- Providing planning, program development and administration, public information, advocacy, and direct service.
- Emphasizing that the above functions and services are targeted on those with greatest social, economic and health needs and on culturally diverse individuals.
- Promoting a long-term care system through integrating acute and chronic care services.
- 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.

DIVERSITY, EQUITY, & INCLUSION AT AGING & LONG TERM CARE

ALTCEW endeavors to embrace and promote a culture of equity, diversity, and inclusion in our workplace and community. We demonstrate this commitment by seeking out and listening to diverse viewpoints, looking intentionally and critically at data, and using feedback to improve policies, services, and practices to be inclusive and equitable. We strive to be a safe and productive environment that promotes a sense of fairness and belonging for our staff and the community we serve. We foster a workplace where everyone feels welcome to be their authentic selves.

A.3 Planning and Review Process:

PLANNING PROCESS

Aging & Long Term Care of Eastern Washington's process for developing the 2024-2027 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 2024-2027 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 2024-2027 Area Plan on Aging and Long-Term Care planning process for PSA #11.

2. The staff and Planning and Resources Committee conducted a series of activities to gather information on available resources and needs of older persons and individuals with disabilities living in PSA #11. This included six focus groups to receive and gather information on available resources and needs of older persons and individuals with disabilities living in PSA #11. A variety of diverse and underserved audiences from the community and professional care providers were invited to participate in focus groups including the LGBTQ+ community, rural, the interfaith community, racial and ethnically diverse older adults. We heard from many care partners, community members and professional staff including long-term care ombudsmen, social workers, health care professionals, and Aging & Long Term Care case managers that reported on the experiences of homebound older adults and adults living with a disability. Additionally, one community meeting was held in partnership with the Alzheimer's Association. These focus groups were used to gain information, ideas, suggestions and to form draft goals and work objectives presented at the community planning meetings. These goals were then incorporated into the Area Plan Draft.

3. The Planning and Resources Committee and PMC held a series of community planning focus group meetings in PSA #11 to receive information and comments on issues that may impact development of the 2024-2027 Area Plan on Aging and Long-Term Care. Input gathered from the community planning meetings was used to draft the proposed plan presented at the public hearings. The following community planning meetings were held.

    a. Ferry County - Location: Keller Senior Meal Site
    7 Jim James Rd, Keller, WA 99140
    Date: April 27, 2023
    Time: 1:00pm – 2:30pm PST

    b. Pend Oreille County - Location: Camas Center for Community Wellness
    1821 Leclerc Rd. N. Cusick, WA 99119
    Date: May 11, 2023
    Time: 4:00pm – 5:00pm PST

c. Stevens County - Location: Rural Resources
956 S Main St, Colville, Washington 99114
Date: May 19, 2023
Time: 1:00pm – 2:30pm PST

d. Whitman County - Location: Pullman Senior Center
190 SE Crestview St, Bldg. B, Pullman, WA 99163
Date: April 10, 2023
Time: 2:00pm – 3:30pm PST

e. Spokane County - Location: Martin Luther King Jr. Community Center
500 S. Stone St. Spokane, WA 99202
Date: March 30, 2023
Time: 2:00pm – 4:00pm PST

f. ALTCEW PMC - Location: ALTCEW Spokane and Zoom
Date: May 1, 2023
Time: 12:00pm – 1:00pm PST

g. ALTCEW and Alzheimer's Assoc. Location: Corbin Senior Activity Center
827 W. Cleveland Ave, Spokane, WA 99205
(Joint meeting) Date: April 12, 2023
Time: 3:30 to 5:00pm PST

4. The Planning and Resources Committee and PMC held a series of public hearings in PSA #11 to receive formal information and comments on the proposed 2024-2027 Area Plan on Aging and Long-Term Care. The schedule for the public hearings that were held are below:

a. Spokane County - Location: Martin Luther King Jr. Community Center
500 S. Stone St. Spokane, WA 99202
Date: July 7, 2023
Time: 2:00pm – 3:00pm PST

b. Tri-County Region - Location: Camas Center
1821 Leclerc Rd. N. Cusick, WA 99119
Date: July 12, 2023
Time: 1:00pm – 2:30pm PST

c. Whitman County - Location: Pullman Senior Center
190 SE Crestview St, Bldg. B, Pullman, WA 99163
Date: July 10, 2023
Time: 2:00pm – 3:00pm PST

5. The Planning and Resources Committee and PMC reviewed, modified, and accepted sections of the proposed 2024-2027 Area Plan on Aging and Long-Term Care based on public comments and information received at the public hearings at their meeting on July 28, 2023. The PMC made recommendations to ALTCEW's Governing Board on acceptance of the proposed 2024-2027 Area Plan on Aging and Long-Term Care for PSA #11.

6. At its meeting on August 11, 2023, ALTCEW's Governing Board accepted the proposed 2024 - 2027 Area Plan on Aging and Long-Term Care based on recommendations from the PMC.

7. ALTCEW's proposed 2024 - 2027 Area Plan on Aging and Long-Term Care for PSA #11 will be submitted to Aging and Long-Term Support Administration on November 1, 2023.

Advocacy in Action: Leadership team attending and presenting at the USAging Conference 2023.

We are honored and proud to serve locally, contribute nationally, and represent the amazing people who contribute daily to improving healthy aging in our region.

A.4 Prioritization of Discretionary Funds:

PRIORITIZATION OF DISCRETIONARY FUNDS

For the 2024-2027 Prioritization Process, the following questions were used to prioritize discretionary-funded services in each area:

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

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

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

PROPOSED PRIORITIZATION MATRIX

SPOKANE COUNTY SUBREGION DISCRETIONARY FUNDS

2020-2023 SERVICE PRIORITIES

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

PROPOSED 2024-2027 SERVICE PRIORITIES

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

In addition to the above prioritized services, the following areas are up for consideration if increased funding is available and discretionary funding could be used to leverage outside funds:

- Workforce development for the direct care workforce
- Senior Van and Volunteer Transportation
- Evidence-based health programs
- Expanding dementia support services for people living with memory loss and their care partners
- Expanded support for hospital transitions and medication management

TRI-COUNTY SUBREGION DISCRETIONARY FUNDS

2020-2023 SERVICE PRIORITIES

(Pend Oreille, Stevens, and Northern Ferry counties)

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

PROPOSED 2024-2027 SERVICE PRIORITIES

(Pend Oreille, Stevens, and Northern Ferry counties)

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

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

- Support for hospital transitions
- Expanded support for senior nutrition services and transportation services
- Chore services
- Evidence-based health programs

WHITMAN COUNTY DISCRETIONARY FUNDS

2020-2023 SERVICE PRIORITIES

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

PROPOSED 2024-2027 SERVICE PRIORITIES

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

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

- Evidence-based health programs
- Chore services
- Expanded support for transportation services
- IT and technology support to access services and resources

SECTION B – PLANNING AND SERVICE AREA PROFILE SECTION

B.1 Target Population Profile

PLANNING AND SERVICE AREA #11

OVERVIEW

Each of these subsections provide data that looks at three key demographic characteristics: age, geography, and race.

The primary purpose of the Area Plan is to outline the Area Agency on Aging's future activities for older adults and individuals with disabilities. There are notable differences in outcomes depending on where a person lives.

Most of the geographic data is presented by subregions. The subregions are:

1) Spokane County subregion, which is comprised of the City of Spokane, City of Spokane Valley, and several smaller outlying communities.
2) Whitman County subregion, located at the northeastern edge of the Palouse agricultural area; and
3) Tri-County subregion (including Ferry, Pend Oreille, and Stevens Counties), which is a mountainous, rural, and frontier area.

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 is called Public Service Area #11 (PSA#11).

Eastern Washington is a unique region that can be at times, a step into history. The region is diverse and can change from one moment to the next. Here, you get the best of all worlds. Eastern Washington is made up of urban, suburban, rural, Tribal Land, and frontier rural areas.

- **Urban** areas are densely populated and refer to the core area of a city.
- **Suburban** areas are large residential areas that surround cities.
- **Rural** is an area outside of the city with a country like feeling with a low population density.
- **Frontier rural** is a population that is even more remote than rural with a lower population density and high in geographical remoteness.
- **American Indian Reservation and Tribal Land** are areas of land held and governed by a U.S. federal government-recognized Native American Tribal Nation, whose government is semi-sovereign, subject to regulations passed by the United States Congress and administered by the United States Bureau of Indian Affairs, and not to the U.S. state government in which it is located.

Rural and frontier rural communities are isolated from the larger population and have less services and resources available. Living in these areas can be very difficult, but citizens that live in this area, have a desire to live and work in these communities that are rich in culture and history.

Each area has its own way of doing things and is distinctive in the day to day lives of its citizens. From cities, to mountains, to rolling hills, lakes, and rivers. Every county in eastern Washington has beautiful natural resources that are enjoyed all year.

Welcome to Eastern Washington where you get a little bit of everything!

SPOKANE COUNTY:

Infrastructure

Spokane County covers 1,764 square miles and as of April 2020, the population count is 539,340. Of all the forces that shaped the Spokane County economy, none is more powerful than Spokane's historic role as a regional center of services for the surrounding rural populations of Eastern Washington and Northern Idaho. Regional services include government and higher education, medical services, retail trade and finance. 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. Given this strong infrastructure and the natural beauty of the area, it is no surprise that the population of Spokane County has grown by about 5.26% since 2020[1] (World Population Review, 2023).

Housing/Cost of Living

According to data collected in 2022, the homeless population in Spokane County (primarily in the city of Spokane) has increased by 13% in just two years in Spokane County[2] (City of Spokane, 2023). The vacancy rate in Spokane County is only 5%, and the cost of rent has continued to rise as the community continues to grow in population while housing units struggle to meet demand. This has severely impacted individuals who receive social security and disability; many individuals were displaced from their homes due to their fixed income no longer able to meet their cost of living. 13% of Spokane County is at or below the poverty line, while 25% is Asset Limited Income Constricted Employed (ALICE). Additionally, 17.3% of Spokane County experiences food insecurity. During the height of the Covid-19 pandemic, many local nonprofit organizations rushed to address this need.

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[1] World Population Review. (2023, September). *Spokane County, Washington Population 2023*. Retrieved from World Population Review: https://worldpopulationreview.com/us-counties/wa/spokane-county-population

[2] City of Spokane. (2023, April 27). *Annual Snapshot of Spokane County Homeless Population Reveals Overall Increase*. Retrieved from City of Spokane: https://my.spokanecity.org/news/releases/2023/04/27/annual-snapshot-of-spokane-co-homeless-pop-reveals-overall-increase/

Health Outcomes

Life expectancy in Spokane is 79.9 years. 97.1% of adults in Spokane have health insurance. 85.2% have a primary healthcare provider and 69.3% of see the dentist for preventative cleanings. 29.3% of adults in Spokane County are obese, which is slightly higher than the Washington state average of 28.8%[3] (Tweedy, Spokane County Profile, 2022).

Falls in Spokane County continue to be higher than the state average. This is likely due to a variety of factors including tracking and reporting criteria, 16.8% of the population being 65+, and the climate conditions.

Opioid deaths for Spokane County were steadily rising since 2003 but have declined significantly between 2021 and 2022.

Poor mental health in adults continues to trend slowly upward, decreasing 0.7% between 2020 and 2021 while serious mental illness appears to have been decreasing.

Physical fitness is something that has been prioritized by Spokane County through large-scale community events such as Hoopfest and Bloomsday. Many gyms and senior centers also offer fitness classes for the aging population.

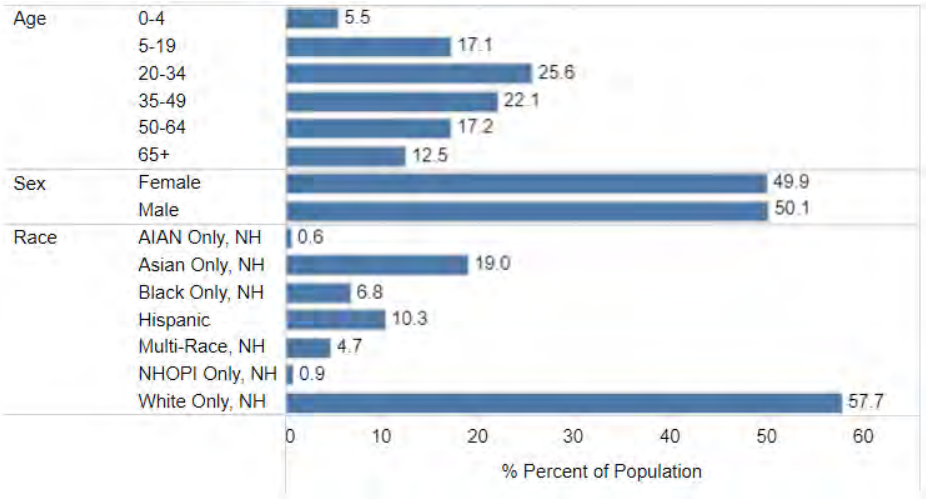
Spokane was the smallest city to host a World's Fair, with the "International Exposition one the environment" (also known as "The Expo") taking place in 1974. The Expo (World's Fair) was held in Spokane in 1974. This was the first environmental themed world's fair. The original intent of hosting the fair, was to clean up and reclaim the land alongside of the falls of the Spokane River. This area had been obstructed for decades with railroad tracks, trestles, and warehouses. Under the leadership of King Cole (1922-2010), a veteran of urban renewal projects, Spokane made the bold decision to host a world's fair and then convert the downtown site into a public park. After the fair closed, the site was revamped to become Riverfront Park, today the city's downtown showcase and gathering spot. David H. Rodgers, Spokane's mayor at the time, said, "Reduced to its essentials, we gave a great big party, and the rest of the world came and paid the bill" [4](Kershner, 2014).

Expo '74: Spokane World's Fair - HistoryLink.org

[3]Tweedy, D. (2022, March). *Spokane County profile*. Retrieved from Employment Security Department of WA State: https://esd.wa.gov/labormarketinfo/county-profiles/spokane

[4] Kershner, J. (2014, May 28). *Expo '74: Spokane's World Fair*. Retrieved from History Link: https://www.historylink.org/File/10791

Spokane County Demographics



[5] Data and Resources | County Health Rankings & Roadmaps

Spokane	2023	2027	2030
Number of persons aged 60 or above	132,487	142,725	149,341
Number of persons aged 60 or above and at or below 100% FPL	8,491	9,140	9,641
Number of persons aged 60 or above and at or below EESSI	23,566	26,000	27,840
Number of persons aged 60 or above and minority	10,450	12,099	13,398
Number of persons aged 55 or above and American Indian/Alaska Native	1,447	1,548	1,567
Number of persons aged 60 or above and American Indian/Alaska Native	648	708	747
Number of persons aged 60 or above, American Indian/Alaska Native, and Disabled (ACS 18b or 18c)	157	177	193
Number of persons aged 60 or above and at or below 100% FPL and minority	1,244	1,404	1,558
Number of persons aged 60 or above with limited English proficiency	4,785	5,422	5,883
Number of persons aged 60 or above and Disabled (ACS 18b or 18c)	27,833	31,268	34,131
Number of persons aged 18 or above and Disabled (ACS 18b or 18c)	42,492	46,317	49,551
Number of persons aged 60 or above with cognitive impairment (ACS 18a)	12,477	14,010	15,383
Number of persons aged 18 or above with cognitive impairment (ACS 18a)	27,819	29,754	31,488
Number of persons aged 60 or above with IADL (ACS 19)	17,103	19,526	21,743
Number of persons aged 18 or above with IADL (ACS 19)	28,454	31,184	33,664
Number of persons aged 65 or above with dementia	9,723	11,422	12,970
Number of persons using SNF services, based on June 2018 CFC utilization calibration	952	1,087	1,207
Number of persons using in-home services, based on June 2018 CFC utilization calibration	3,788	4,108	4,364
Number of persons using community residential services, based on June 2018 CFC utilization calibration	1,433	1,589	1,731

[5] Data and Resources | County Health Rankings & Roadmaps

TRI-COUNTY SUBREGION

The Tri-County Subregion consists of Ferry, Pend Oreille, and Stevens counties (all of which are classified as rural) and is in the northeastern corner of Washington State. This subregion 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.

The Tri County Economic Development District (TEDD) plays an important role in supporting business development, expansion, and recruitment in the area. Services offered include start-up funding and funding through the Rural Opportunities Loan Fund, as well as business training and advising and connecting business owners to other supportive resources. Successful ventures that TEDD has funded in the tri-county area include the Republic Brewing Company, Woodworker Network Expansion Project, and a gym called COR 620. Other important establishments in the Tri-County area include Rural Resources, the Northeast Tri-County Health District, and more.

About 40% of households in the Tri-County subregion are either below the poverty line or are Asset Limited Income Constricted Employed (ALICE). Rates of high school graduation are on par with the state average, but rates of attending college are only about half of the state average.

STEVENS COUNTY

Infrastructure

Stevens County is the largest county in the tri-county area, being home to 45,260 people, including the Spokane Tribe. The average household income is $60,180. Important industries in Stevens County are timber, agriculture, mining, recreation, and tourism. There are two hospitals in Stevens County, Mount Carmel in Colville, and St. Joseph's in Chewelah. There is one public transit program known as Dial-A-Ride, which primarily serves the aging and disabled population. Government is the largest employment sector in the county, accounting for more

than 30% of total jobs. The Spokane Tribe's reservation is mostly located in Stevens County with 237.5 square miles[6] (Tweedy, Stevens County Profile, 2022).

Stevens County is ranked 19th of the 39 counties in Washington for health. 14% of the population has "poor or fair health". Only 47% of residents reported having access to exercise opportunities, compared to 86% as the Washington average. Rates of adult obesity, physical inactivity and adult smoking are also slightly higher than the Washington State average[7] (Tweedy, Stevens County Profile, 2022) .

Stevens County is a vibrant area with a variety of natural resources and many different types of wildlife that congregate there at various times of the year. In 1939 the Little Pend Oreille Wildlife Refuge was established. The land for the refuge was acquired through the Resettlement Administration, which was a program that retired marginal farmland. The refuge is 40,198 acres with a mix of low- and high-level elevation. There are many different types of wildlife in the refuge, but the main goal was to provide a sanctuary and breeding ground for migratory birds. There are 200 bird species, 58 mammal, 8 reptile, and 6 amphibian species. The refuge provides habitat for several threatened species and provides a migration area in the winter for mammals and other birds.

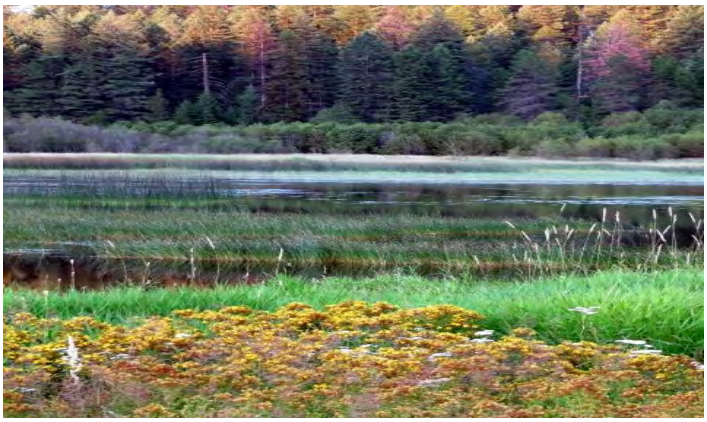


Photo By/Credit - USFWS/JJ, (U.S. Fish & Wildlife Service, 2023)

Refuge Wildlife Through the Seasons:[8]

- Winter: bald eagle, coyote, finches, great horned owl, northern shrike, white-tailed deer, wild turkey, woodpecker
- Spring: beaver, black bear, bluebirds, chipmunks, magpies, moose, snipe, warblers, waterfowl
- Summer: coyote, hummingbird, osprey, painted turtle, red-tailed hawk, swallows, wild turkey
- Fall: crossbill, grouse, kinglets, waterfowl, white-tailed deer

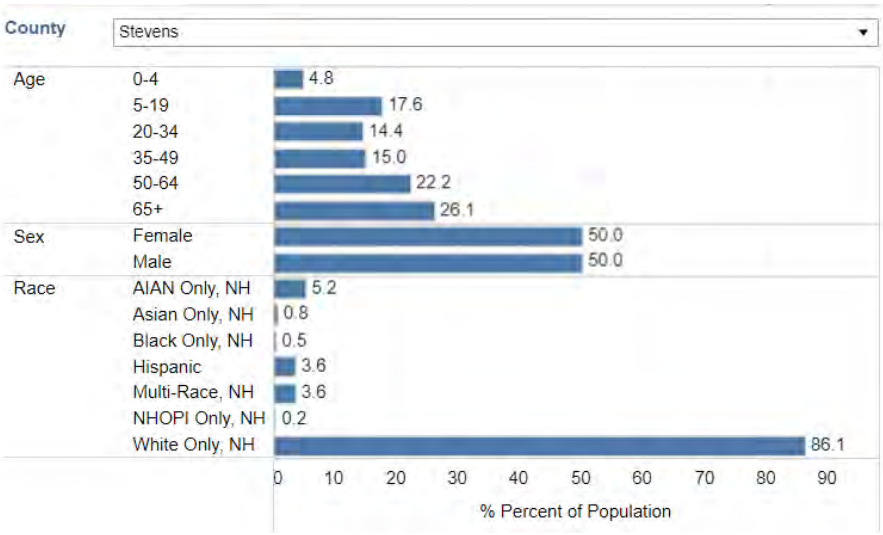
Source: (U.S. Fish & Wildlife Service, 2023)

[6] Tweedy, D. (2022, March). *Stevens County Profile*. Retrieved from Employmenty Security Department of WA State: https://esd.wa.gov/labormarketinfo/county-profiles/stevens

[7] Tweedy, D. (2022, March). *Stevens County Profile*. Retrieved from Employmenty Security Department of WA State: https://esd.wa.gov/labormarketinfo/county-profiles/stevens

[8] U.S. Fish & Wildlife Service. (2023, September). *Little Pend Oreille National Wildlife Refuge*. Retrieved from U.S. Fish & Wildlife Service Web site: https://www.fws.gov/refuge/little-pend-oreille

Stevens County Demographics



[9]Data and Resources | County Health Rankings & Roadmaps

Stevens	2023	2027	2030
Number of persons aged 60 or above	16,895	17,417	17,562
Number of persons aged 60 or above and at or below 100% FPL	1,450	1,416	1,379
Number of persons aged 60 or above and at or below EESSI	3,392	3,521	3,596
Number of persons aged 60 or above and minority	1,633	1,819	1,966
Number of persons aged 55 or above and American Indian/Alaska Native	754	789	806
Number of persons aged 60 or above and American Indian/Alaska Native	570	607	635
Number of persons aged 60 or above, American Indian/Alaska Native, and Disabled (ACS 18b or 18c)	156	175	193
Number of persons aged 60 or above and at or below 100% FPL and minority	275	288	292
Number of persons aged 60 or above with limited English proficiency	639	688	721
Number of persons aged 60 or above and Disabled (ACS 18b or 18c)	3,646	3,984	4,232
Number of persons aged 18 or above and Disabled (ACS 18b or 18c)	5,009	5,337	5,582
Number of persons aged 60 or above with cognitive impairment (ACS 18a)	1,657	1,815	1,943
Number of persons aged 18 or above with cognitive impairment (ACS 18a)	2,952	3,120	3,260
Number of persons aged 60 or above with IADL (ACS 19)	2,243	2,519	2,744
Number of persons aged 18 or above with IADL (ACS 19)	3,204	3,481	3,710
Number of persons aged 65 or above with dementia	1,246	1,455	1,622
Number of persons using SNF services, based on June 2018 CFC utilization calibration	103	119	132
Number of persons using in-home services, based on June 2018 CFC utilization calibration	378	387	393
Number of persons using community residential services, based on June 2018 CFC utilization calibration	52	59	67

[9] Data and Resources | County Health Rankings & Roadmaps

PEND OREILLE COUNTY

Infrastructure

Pend Oreille County is rich with natural resources and scenic beauty. Residents describe it as having "pioneer spirit and small-town hospitality." Pend Oreille County has a population of 13,600 people, including the Kalispel Tribe. The average income is $55,021, an increase of 8.76% since 2021. Average household income is $72,051. The major employment sectors in Pend Oreille County are manufacturing and government. Government employment accounts for more than 50 percent of all jobs. Pend Oreille County is unique in terms of population density, transportation, industries, and infrastructure. It is very rural with only 9.3 people per square mile and has a rural economy, with limited transportation routes and dependence on resource extraction, specifically lead and zinc mining followed by timber and cement manufacturing[10] (Tweedy, Pend Oreille County profile, 2022).

Pend Oreille is ranked in 38th of the 39 counties in Washington for health, meaning it has the second worst health outcomes in the entire state. This is partly due to the high number injury deaths and alcohol-impaired driving deaths, which is also nearly double the rest of Washington State's percentage of driving deaths with alcohol involvement[11] (Tweedy, Pend Oreille County profile, 2022).

Pend Oreille County is a vast region of natural resources, particularly timber. In 1910, pend Oreille County experience the most detrimental fire, that burned more than 3 million acres. The fire spanned from Northeastern Washington to Western Montana. After weeks of drought and high temperatures, on August 20th a strong wind ripped through the county and combined multiple small fires into one explosive fire. In the Pend Oreille area, "There was a solid front of fire ten miles wide, from just south of Dalkena down to three miles north of Newport" [12](Arksey, 2006). The people of Pend Oreille County were able to survive by digging holes and waiting out the treacherous fire. Smoke from all the fires reached New England and soot travelled all the way to Greenland[13] (Forest History Society, 2023).

Courtesy Service Photo Courtesy of The Us Forest Service

Many stands of timber were demolished from the fire, but extensive salvage logging was able to be done after the fires to recoup some of the damages. Through this, extensive fire suppressions tactics were created and put into place. Pend Oreille County continues to thrive on its natural resources and has many tourists that come each year to visit the natural beauty of the area.

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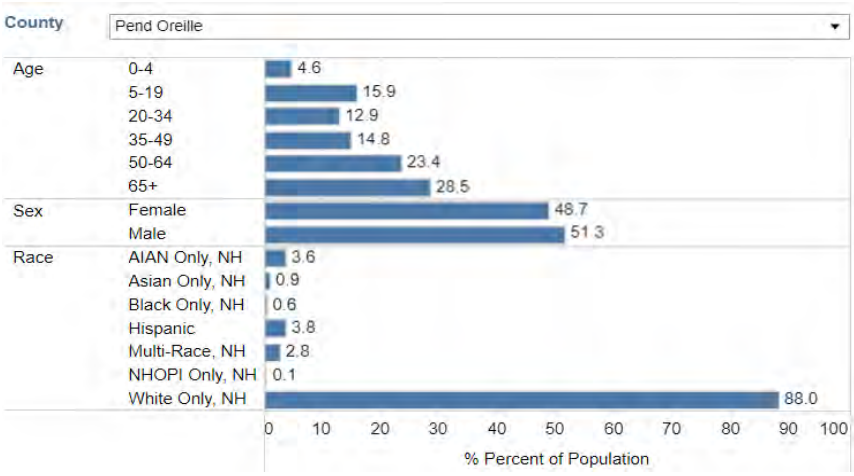
[10] Tweedy, D. (2022, March). *Pend Oreille County profile*. Retrieved from Employment Security Department of WA State: https://esd.wa.gov/labormarketinfo/county-profiles/pend-oreille

[11] Tweedy, D. (2022, March). *Pend Oreille County profile*. Retrieved from Employment Security Department of WA State: https://esd.wa.gov/labormarketinfo/county-profiles/pend-oreille

[12] Arksey, L. (2006, January 22). *Pend Oreille County - Thumbnail History*. Retrieved from History Link: https://www.historylink.org/File/7618

[13] Forest History Society. (2023, September). *The 1910 Fires*. Retrieved from Forest History Society Web site: https://foresthistory.org/research-explore/us-forest-service-history/policy-and-law/fire-u-s-forest-service/famous-fires/the-1910-fires/

Pend Oreille County Demographics



[14]Data and Resources | County Health Rankings & Roadmaps

Pend Oreille	2023	2027	2030
Number of persons aged 60 or above	5,688	5,867	5,867
Number of persons aged 60 or above and at or below 100% FPL	458	450	434
Number of persons aged 60 or above and at or below EESSI	1,111	1,166	1,185
Number of persons aged 60 or above and minority	394	443	474
Number of persons aged 55 or above and American Indian/Alaska Native	183	188	186
Number of persons aged 60 or above and American Indian/Alaska Native	133	142	145
Number of persons aged 60 or above, American Indian/Alaska Native, and Disabled (ACS 18b or 18c)	30	33	35
Number of persons aged 60 or above and at or below 100% FPL and minority	72	80	84
Number of persons aged 60 or above with limited English proficiency	206	222	230
Number of persons aged 60 or above and Disabled (ACS 18b or 18c)	1,230	1,359	1,451
Number of persons aged 18 or above and Disabled (ACS 18b or 18c)	1,600	1,714	1,800
Number of persons aged 60 or above with cognitive impairment (ACS 18a)	553	613	661
Number of persons aged 18 or above with cognitive impairment (ACS 18a)	907	961	1,009
Number of persons aged 60 or above with IADL (ACS 19)	757	863	951
Number of persons aged 18 or above with IADL (ACS 19)	1,019	1,119	1,204
Number of persons aged 65 or above with dementia	432	513	583
Number of persons using SNF services, based on June 2018 CFC utilization calibration	43	51	59
Number of persons using in-home services, based on June 2018 CFC utilization calibration	108	109	107
Number of persons using community residential services, based on June 2018 CFC utilization calibration	26	31	36

[14] Data and Resources | County Health Rankings & Roadmaps

FERRY COUNTY

Infrastructure

Ferry County has been described as one of the last frontiers of the American West and is considered frontier rural. The rugged mountain environment is influenced by mining and logging industries and has the awe-inspiring beauty of a wilderness retreat. Ferry County is home to 7,649 residents, including the Colville Tribe. The median household income is $41,685. The economy of Ferry County remains static, which can be seen in the minimal population growth, an older than average population and declining growth in real employment. Ferry County also lacks public transportation and is projected to experience decreases in employment and income. Republic is the largest city in Ferry County. Ferry County has an older population compared to the rest of the counties the state. Those 65 and older make up 28.2% of Ferry County's 2021 population compares to the state's 15.9% [15](Tweedy, Ferry County profile, 2022). The Colville Confederated Tribe resides on a large portion of Ferry County.

Ferry County is unfortunately ranked as the unhealthiest county in Washington State. Premature death, injury deaths, and adult smoking are nearly double the Washington State average. Adult obesity is at 33%, despite 75% of residents reporting that they have access to exercise opportunities. The food index, which is based on access to healthy food and food insecurity, is 4.8 on a scale of 1-10, whereas the state average is 8.4 [16](countyhealthrankings.org, 2023).

Photo Source: (Ferry County, 2023)

Ferry County is home to the smallest Washington State Park in the State, Ranald MacDonald Historic Gravesite. The location of the park is close to the Canadian and Ferry County border and is in a Native American cemetery. Ranald MacDonald was the first American to teach English in Japan. Ranald had given up his life as a banker at 21 and decided to join a whaling crew in 1848. Through this adventure, Ranald had always wanted to visit Japan. At this time, the 1800's, no one was allowed into Japan and citizens of Japan were not allowed to leave the country. Visitors and citizens were put to death for violating this law. Ranald had made a deal with the captain of the ship that he worked on, he would give all his earnings to the captain for a small boat. The captain agreed and Ranald took the boat. He came up with an idea to capsize his boat to get the attention of

[15] Tweedy, D. (2022, March). *Ferry County profile*. Retrieved from Employment Security Department of WA State: https://esd.wa.gov/labormarketinfo/county-profiles/ferry

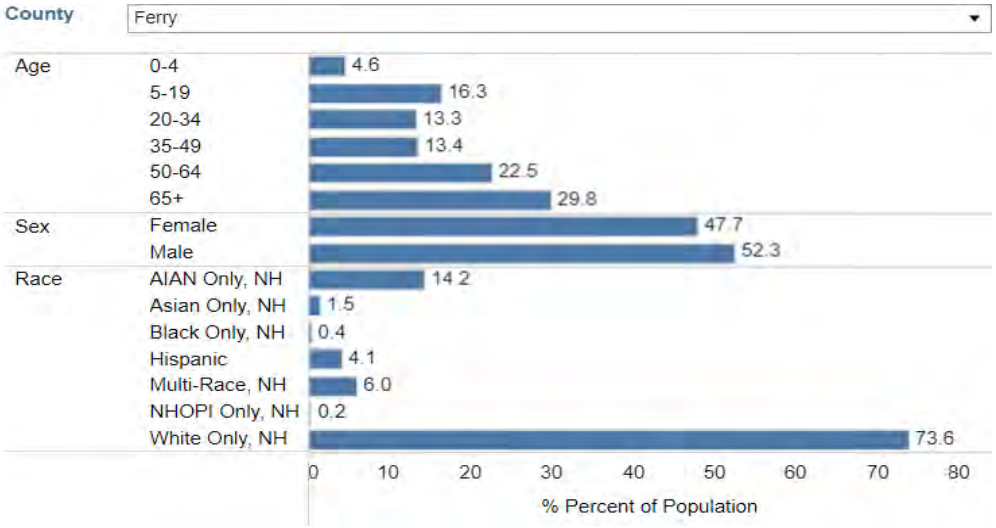
[16] County Health Rankings. (2023). *Ferry, WA*. Retrieved from County Health Rankings: https://www.countyhealthrankings.org/explore-health-rankings/washington/ferry?year=2023

Japan and hope that they would have compassion for him. His plan worked! He spent most of his time there in prison, but he learned Japanese, taught English, showed the world cultural misconceptions, and paved the way for Commodore Matthew Calbraight Perry to formally open U.S. relations with the Japanese in 1853. Ranald MacDonald died in 1894[17] (Ferry County, 2023). He risked his life to do what he loved and opened the door to embrace a new culture for the whole world.

White Water Rafting

[17] Ferry County. (2023, September). *Ranald MacDonald*. Retrieved from Ferry County Web site: https://ferrycounty.com/ranald-macdonald-burial-site

Ferry County Demographics



[18]Data and Resources | County Health Rankings & Roadmaps

Ferry	2023	2027	2030
Number of persons aged 60 or above	3,111	3,170	3,159
Number of persons aged 60 or above and at or below 100% FPL	299	288	275
Number of persons aged 60 or above and at or below EESSI	664	690	704
Number of persons aged 60 or above and minority	610	685	739
Number of persons aged 55 or above and American Indian/Alaska Native	417	439	446
Number of persons aged 60 or above and American Indian/Alaska Native	343	373	386
Number of persons aged 60 or above, American Indian/Alaska Native, and Disabled (ACS 18b or 18c)	96	110	121
Number of persons aged 60 or above and at or below 100% FPL and minority	109	114	116
Number of persons aged 60 or above with limited English proficiency	116	124	129
Number of persons aged 60 or above and Disabled (ACS 18b or 18c)	699	760	805
Number of persons aged 18 or above and Disabled (ACS 18b or 18c)	934	992	1,041
Number of persons aged 60 or above with cognitive impairment (ACS 18a)	324	354	378
Number of persons aged 18 or above with cognitive impairment (ACS 18a)	554	585	613
Number of persons aged 60 or above with IADL (ACS 19)	432	483	526
Number of persons aged 18 or above with IADL (ACS 19)	599	650	695
Number of persons aged 65 or above with dementia	234	273	306
Number of persons using SNF services, based on June 2018 CFC utilization calibration	13	14	15
Number of persons using in-home services, based on June 2018 CFC utilization calibration	89	90	92
Number of persons using community residential services, based on June 2018 CFC utilization calibration	8	9	10

[18] Data and Resources | County Health Rankings & Roadmaps

WHITMAN COUNTY

Infrastructure

Whitman County occupies approximately 2,159 square miles and has about 47,970 residents. The county seat is located in the east central portion of the county in Colfax. 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. There are a large number of small communities interspersed throughout the county.

The elevation within the county ranges from 740 to 4,000 feet above sea level. The elevation increases about 25 feet in height per mile from the southwest to the northeast. Deep soil, rolling hills and relatively moderate weather combine to make Whitman County well suited for dry land farming of barley, wheat, dry peas, and lentils. 12 Section B-1 Target Population Profile 2020-2023 Area Plan Whitman County borders seven Washington counties and three Idaho counties. The Colfax Transportation Department serves Whitman County.

Findings from Annual Health Summary

In 2022, Whitman County published their first-ever Annual Health Summary, which included targets for Healthy People 2030, a federal initiative to promote, strengthen, and evaluate the nation's efforts to improve the health and well-being of all people.

This report indicated that poverty rates in Whitman County are higher than the Washington State average, even when removing the WSU student population from the data. 27% of households live at or below the Federal Poverty Level, while 25% were Asset Limited Income Constricted Employed (ALICE). In other words, 52% of Whitman County households have difficulty affording their basic needs. Additionally, 12% of households in Whitman County are Food Insecure.

Data on preventative care indicates that only about 30% of Medicare recipients are attending annual wellness visits, although this is an increase of about 5% from 2020. Mammograms and screenings for cervical cancer have also been declining steadily since 2019. In 2022, over 650 flu

shots and over 475 COVID boosters at no cost to individuals[19] (Whitman County Public Health, 2022).

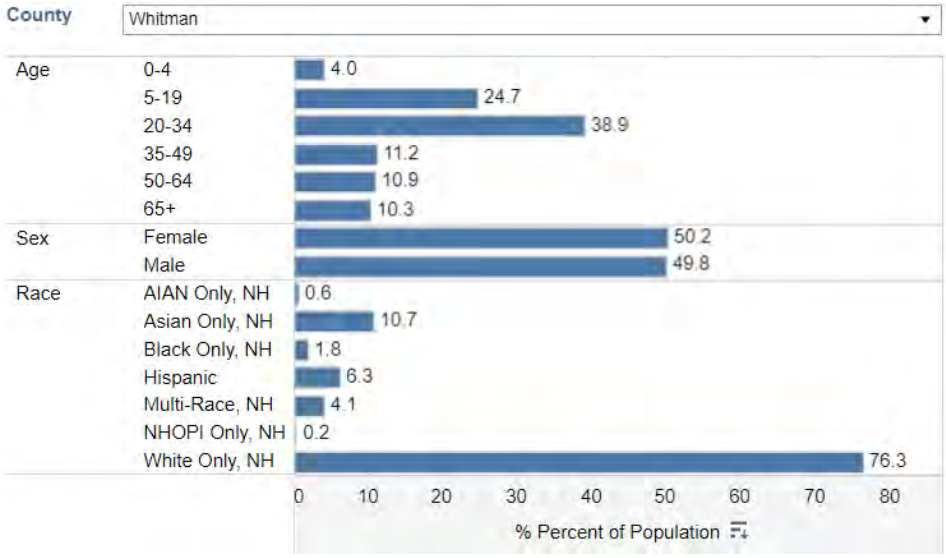
T. A. Leonard Barn is a photograph by William Krumpelman which was uploaded on March 29th, 2017.

Whitman County is known for its breathtaking landscape and vibrant rolling hills of the Palouse. It has a picturesque feel as you are looking out across the vast landscape. A visual delight in Whitman County is the Leonard Barn, which is located about 4 miles south of Pullman. Thomas Leonard built the barn in 1917 after he lost his current barn to a fire. He had saw round barns in Ohio while on a trip back east. The barn was built round so the animals would face inward and could be viewed while working. A litter carrier system was designed which ran on runners in a circle and could be used to feed the stock and clean the barn[20] (Leonard Round Barn, 2023). The barn was very inventive for its time. Thomas and his wife Kitty had three children, George, Oliver, and Esther. George farmed the land after his father had passed and began to restore the barn. George died in 1984 and in 1985 two Washington State University students researched the history of the barn and outlined architectural plans of the barn. This project was presented for competition in the Charles E. Peterson Historic American Buildings Survey where it took first place. This project is now a part of the National Park Service (Leonard Round Barn, 2023). The barn has been considered by many as the most photographed barn in the Western United States and was placed on the National Register of Historic Places in 1987. The Oliver Leonard Family Trust decided to fund the restoration of the barn and keep the farm in the family. Each element of the restoration was completed with preservation of the original structure in mind. The restoration began in 2000 and was completed in 2001 (Leonard Round Barn, 2023).

[19] Whitman County Public Health. (2022). *2022 Whitman County Annual Health Summary.* Retrieved from Whitman County Public Health: https://whitmancountypublichealth.org/assets/globals/2022-Whitman-County-Annual-Health-Summary.pdf

[20] Leonard Round Barn. (2023, September). Retrieved from Leonard Round Barn: https://leonardroundbarn.wordpress.com/

Whitman County Demographics



[21]Data and Resources | County Health Rankings & Roadmaps

Whitman	2023	2027	2030
Number of persons aged 60 or above	8,311	8,722	9,019
Number of persons aged 60 or above and at or below 100% FPL	516	545	563
Number of persons aged 60 or above and at or below EESSI	1,863	1,961	2,033
Number of persons aged 60 or above and minority	719	837	933
Number of persons aged 55 or above and American Indian/Alaska Native	43	48	49
Number of persons aged 60 or above and American Indian/Alaska Native	23	25	26
Number of persons aged 60 or above, American Indian/Alaska Native, and Disabled (ACS 18b or 18c)	5	5	5
Number of persons aged 60 or above and at or below 100% FPL and minority	123	147	160
Number of persons aged 60 or above with limited English proficiency	401	446	478
Number of persons aged 60 or above and Disabled (ACS 18b or 18c)	1,845	2,009	2,155
Number of persons aged 18 or above and Disabled (ACS 18b or 18c)	3,760	3,969	4,151
Number of persons aged 60 or above with cognitive impairment (ACS 18a)	838	911	982
Number of persons aged 18 or above with cognitive impairment (ACS 18a)	3,161	3,265	3,365
Number of persons aged 60 or above with IADL (ACS 19)	1,149	1,270	1,387
Number of persons aged 18 or above with IADL (ACS 19)	2,880	3,028	3,166
Number of persons aged 65 or above with dementia	650	735	819
Number of persons using SNF services, based on June 2018 CFC utilization calibration	81	86	90
Number of persons using in-home services, based on June 2018 CFC utilization calibration	113	116	119
Number of persons using community residential services, based on June 2018 CFC utilization calibration	139	149	158

[21] Data and Resources | County Health Rankings & Roadmaps

B.2 AAA Services and Partnerships

SERVICE DESCRIPTIONS

Community Living Connections: Provides seamless access to information, referral, assistance, decision support, and person-centered planning on long-term services and support options in local communities. Services include benefits counseling and assistance applying for public benefits. Information & Assistance - Aging & Long Term Care of Eastern Washington (altcew.org).

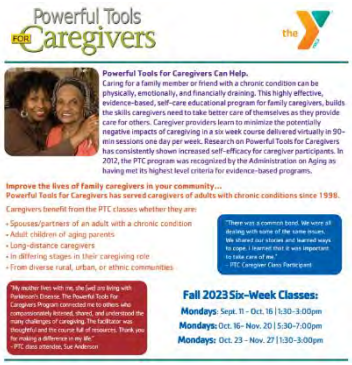
Check and Connect: A phone-based reassurance program, where volunteers connect with older adults by phone once or twice a week to check in, have a conversation, and refer to resources where appropriate. This service helps to reduce social isolation, encourage good mental health, and provides a phone-based wellness checks for each client.

> "The **Check and Connect Program** has been very important to me for about two years now. It has offered up patience and a wonderful escape from the silence. I have not been fortunate to have family or friends in Spokane to just call and check on how I am doing. Thank God, this wonderful Program does that once a week." – Check and Connect Client

Family Caregiver Support Program: Provides a multifaceted system of support services to respond to the needs of family and other unpaid caregivers. Counseling, respite care, support groups, and other supportive services available based on assessment. Caregiver Support in WA | Aging & Long Term Care of Eastern Washington (altcew.org).

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

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



Powerful Tools for Caregivers: This evidence-based course provides caregivers a support-group environment combined with a curriculum that will help them learn to reduce stress and develop new tactics to manage the demands of being a family caregiver. Classes are offered in-person and through Zoom.

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

Kinship Caregiver Support Program: Provides support services to grandparents and other relative caregivers, over the age of 18, who are raising minor children, and who are at the greatest risk of not being able to maintain their caregiving role. Grandparents Raising Grandkids | Kinship Caregivers | Aging & Long Term Care of Eastern Washington (altcew.org).

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

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

Case Management Success Story - Kyle is in his 30's and spent the last 10 years at Eastern State Hospital. He manages multiple medical conditions in addition to his mental health. Several years ago, Kyle was able to qualify for CFC, COPES, and GOSH funding to move out of Eastern State Hospital and into his own home. Through the services Kyle received while being on these programs, he has been able to live on his own and has not returned to the hospital. This has enabled Kyle to live the life he wants on his personal health journey.

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

Community First Choice (CFC): Is a Medicaid State Plan program. CFC eligibility includes clients who, in the absence of the caregiver services provided under CFC, would otherwise need to be in a hospital or Nursing Facility. CFC pays for personal care and, if eligible, for Relief Care, Nurse Delegation, Skills Acquisition Training, Personal Emergency Response Systems (PERS), Assistive Technology, Community Transition Services, and Caregiver Management Training.

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

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

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

Program for All Inclusive Care of the Elderly (PACE): ALTCEW conducts in-home assessments for the PACE program in Spokane, Providence ElderPlace, for individuals receiving services in their own homes. PACE provides the ongoing structured care including complete medical care, medications, medical supplies, adult day care, in-home care, care coordination, transportation and more.

Governor's Opportunity for Supportive Housing (GOSH): This program provides intensive supports for clients on CFC and CFC+COPES that transition from Eastern State Hospital to the community. Case Managers work with an interdisciplinary team to support clients in stabilizing in the community.

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

Home Delivered Meals: Provides nutritious meals and other nutrition services to persons aged 60 and over who are homebound by reason of illness, incapacitating disability, or otherwise isolated. Meals are delivered to the person's home, usually by a volunteer. Get Meals - Meals on Wheels Greater Spokane County - Meals for Seniors (gscmealsonwheels.org).

Congregate Meals: Provides nutritious meals and other nutrition services, including nutrition outreach and nutrition education, in a group setting. Silver Cafes - Meals on Wheels Greater Spokane County - Eat with Friends (gscmealsonwheels.org).

Diner's Choice: Diner's Choice is offered in the Tri-County region. This program provides seniors coupons that can be redeemed at participating restaurants for a meal.

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

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

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

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

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

Legal Assistance: Provide access to the system of justice by offering representation by a legal provider who acts as an advocate for the socially and economically needy older individual who is experiencing legal problems. Visit Elder Law | Gonzaga University School of Law | gonzaga.edu/law | Gonzaga University for one of the legal assistance programs.

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

Veteran's Directed Care: This program is provided in partnership with the local Veteran's Administration Hospital. The VA social worker refers veterans who need in-home support. We provide case management services for those veteran's and help them locate caregivers and needed equipment. The case manager helps the veteran manage a monthly of budget that they can direct to services that will help them stay safely at home.

Statewide Health Insurance Benefit Advisors (SHIBA): Provides free, unbiased counseling to consumers regarding all aspects of publicly funded health insurance and health care access in Spokane and Whitman counties. Counseling is provided by staff and volunteers trained by the Washington State Office of the Insurance Commissioner. Get Help with Medicare | Aging & Long Term Care of Eastern Washington (altcew.org).

A woman called into Aging & Long Term Care's Statewide Health Insurance Benefits Advisors (SHIBA) program on behalf of her mom who was not able to see her doctor because her insurance had been switched without her knowledge. The family had not initiated any such change. SHIBA was able to find out that the change happened during open enrollment and the SHIBA representative "explained to the Medicare rep that the client lives in Pend Oreille County and should not have been sold an Advantage plan. The rep agreed and I was able to get the clients Original Medicare and a standalone part D plan back to be effective March 1, 2021. Now she can go back to the Native Health Project and see her doctor." This is just one example of how SHIBA can offer free Medicare assistance.

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

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

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

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

and dually eligible (Medicaid/Medicare) clients. Care Coordination - Aging & Long Term Care of Eastern Washington (altcew.org).

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

Advanced Medication Management: This award-winning program helps clients find solutions to address complex health conditions such as asthma, diabetes, COPD, and hypertension. Trained coordinators and pharmacists work together to create safe and effective medication management plans catered to meet client needs. The program serves patients over the age of 50 with chronic health conditions and who take multiple prescriptions.

A Matter of Balance: An evidence-based falls prevention program, for people who are 60 or older, is provided in a workshop format. Participants who have sustained a fall or have a fear of falling learn fall prevention techniques and participate in exercises from the National Institute on Health. Workshops are led by volunteers who are often peers who have sustained falls. Workshops are provided in person and via Zoom.

Image of MOB class graduates.

Falls Talk: An evidence-based fall prevention program, provided through facilitated one-on-one phone conversations with older adults to assess their fall risk and recommend actions to reduce risk.

Dementia Friends: Facilitates public awareness and education training on dementia. "A Dementia Friend is someone who, through the training, learns about what it's like to live with dementia and then turns that understanding into action."

Care Transitions: An evidence-based program that helps people transition from hospital to home. Care Coordinators work closely with clients to help navigate complicated medical and social service systems, create a plan to determine necessary supports, and reduce the likelihood of hospital readmissions.

24/7 Helpline: The Alzheimer's Association's specialists and master's-level clinicians offer confidential support and information to people living with dementia, caregivers, families, and the public.

Memory Café: A comfortable, social gathering that allows people experiencing memory loss and their loved ones to connect, socialize, and to build new support networks.

Dementia Support Group: An unmoderated group for families, partners, and other caregivers of adults with dementia. The group offers a safe place to discuss the stresses, challenges, and rewards of providing care for a loved one.

SUB-REGION	PROVIDER	PROGRAM/SERVICE
Spokane County	Aging & Long Term Care of Eastern Washington	• Community Living Connections • SHIBA / MIPPA • Senior Drug Education • Senior Medicare Patrol • A Matter of Balance • FallsTalk • Case Management • Nursing Consultation Services • Care Coordination • Supportive Housing • Check and Connect • Medication Management • Care Transitions • Dementia Education and Outreach
	Catholic Charities of Eastern Washington	• Senior Farmers Market Nutrition Program
	Frontier Behavioral Health	• Case Management • Family Caregiver Support • Medicaid Alternative Care • Tailored Support for Older Adults • Kinship Navigator • Kinship Caregiver Support
	Greater Spokane County Meals on Wheels	• Senior Nutrition (*Congregate Meals/Home Delivered Meals*) • Fee Subsidy Transportation
	Spokane Neighborhood Action Programs (SNAP)	• Minor Home Repair • Long-Term Care Ombudsman
	Alzheimer's Association	• Memory café • Support groups • 24/7 help line
	Gonzaga University Elder Law Clinic	• Senior Legal Assistance
	Providence ElderPlace	• Adult Day Services (Day Health and Day Care)
	Family Resource Home Care	• Bathing Assistance and Limited Home Care

Tri-County (Stevens, Ferry, Pend Oreille)	Rural Resources Community Action (RRCA)	• Community Living Connections • Case Management • Family Caregiver Support • Medicaid Alternative Care • Tailored Support for Older Adults • Kinship Navigator • Kinship Caregiver Support • Senior Nutrition (*Congregate Meals/ Home Delivered Meals*) • Fee Subsidy Transportation • Van and Volunteer Transportation • Legal Assistance
	SNAP	• Long-Term Care Ombudsman
Whitman County	Rural Resources Community Action (RRCA)	• Community Living Connections • Case Management • Family Caregiver Support • Medicaid Alternative Care • Tailored Support for Older Adults • Kinship Navigator • Kinship Caregiver Support
	Council on Aging & Human Services	• Transportation (Van & Volunteer) • Senior Nutrition (*Congregate Meals/ Home Delivered Meals*) • Fee Subsidy Transportation
	SNAP	• Long-Term Care Ombudsman

B.3 Focal Points

Throughout ALTCEW's service area, the Community Living Connections (CLC) program offices serve as the Focal Point in each county. Specific information, by county, follows.

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

Ferry County
Rural Resources Community Action
Community Living Connections
42 Klondike Rd
Republic, WA 99116
509-775-3331
1-800-873-5889

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

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

Whitman County
Rural Resources Community Action
Community Living Connections
1610 NE Eastgate Blvd STE, 250/Box 5
Pullman, WA 99163
509-332-0365
1-800-873-5889

SECTION C – ISSUE AREA THEMES, GOALS, AND OBJECTIVES

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

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

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

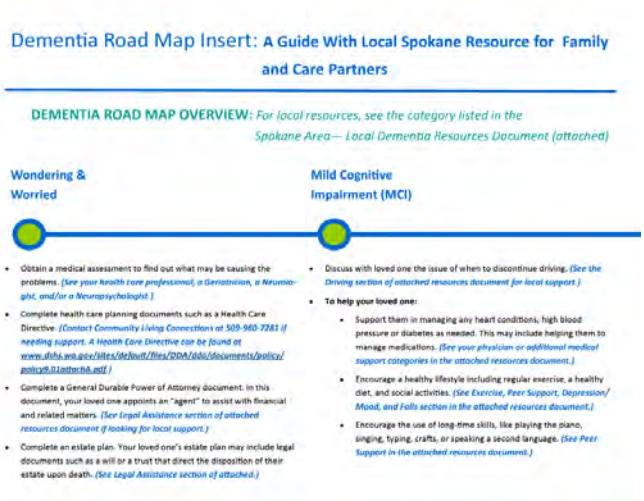
- The year 2030 marks an important demographic turning point in U.S. history according to the U.S. Census Bureau's 2017 National Population Projections. By 2030, all baby boomers will be older than age 65. This will expand the size of the older population so that 1 in every 5 residents will be retirement age.
- "The aging of baby boomers means that within just a couple of decades, older people are projected to outnumber children for the first time in U.S. history," said Jonathan Vespa, a demographer with the U.S. Census Bureau. "By 2034 (previously 2035), there will be 77.0 million (previously 78.0 million) people 65 years and older compared to 76.5 million (previously 76.7 million) under the age of 18."[22]

To highlight the multifaceted and sweeping impacts that memory loss will bring, the Alzheimer's Association provides these 2021 facts and figures:

- More than 6 million Americans are living with Alzheimer's. By 2050, this number is projected to rise to nearly 13 million.

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

- In the United States, Alzheimer's and other dementia deaths have increased 16% during the COVID-19 pandemic.
- 1 in 3 seniors die with Alzheimer's or another type of dementia. It kills more than breast cancer and prostate cancer combined.
- In 2021, Alzheimer's and other dementias will cost the nation $355 billion. In 2050, these costs could rise as high as $1.1 trillion.
- More than 11 million Americans provide unpaid care for people with Alzheimer's or other dementias. In 2020, these caregivers provided an estimated 15.3 billion hours of care valued at over $257 billion.



Dementia Road Map Insert: A Guide With Local Spokane Resource for Family and Care Partners

DEMENTIA ROAD MAP OVERVIEW: For local resources, see the category listed in the Spokane Area— Local Dementia Resources Document (attached)

Wondering & Worried

- Obtain a medical assessment to find out what may be causing the problems. (See your health care professional, a Geriatrician, a Neurologist, and/or a Neuropsychologist.)
- Complete health care planning documents such as a Health Care Directive. (Contact Community Living Connections at 509-960-7281 if needing support. A Health Care Directive can be found at www.dshs.wa.gov/sites/default/files/DDA/ddd/documents/policy/policy9.01attachA.pdf)
- Complete a General Durable Power of Attorney document. In this document, your loved one appoints an "agent" to assist with financial and related matters. (See Legal Assistance section of attached resources document if looking for local support.)
- Complete an estate plan. Your loved one's estate plan may include legal documents such as a will or a trust that direct the disposition of their estate upon death. (See Legal Assistance section of attached.)

Mild Cognitive Impairment (MCI)

- Discuss with loved one the issue of when to discontinue driving. (See the Driving section of attached resources document for local support.)
- To help your loved one:
  - Support them in managing any heart conditions, high blood pressure or diabetes as needed. This may include helping them to manage medications. (See your physician or additional medical support categories in the attached resources document.)
  - Encourage a healthy lifestyle including regular exercise, a healthy diet, and social activities. (See Exercise, Peer Support, Depression/Mood, and Falls section in the attached resources document.)
  - Encourage the use of long-time skills, like playing the piano, singing, typing, crafts, or speaking a second language. (See Peer Support in the attached resources document.)

Local Dementia Roadmap Created by the Spokane Regional Dementia Friendly Community, led by ALTCEW. www.altcew.org/wp-content/uploads/sites/24/2023/09/Spokane-Local-Roadmap-and-Dementia-Resource-List.pdf

- Only 53% of Black Americans trust that a future cure for Alzheimer's will be shared equally regardless of race, color, or ethnicity.
- 3 in 10 Hispanics do not believe they will live long enough to develop dementia.
- Between 2000 and 2019, deaths from heart disease have decreased 7.3% while deaths from Alzheimer's have increased 145%.[2]

To continue to address the direct service needs of individuals in our service area and to advocate for current and emerging community needs, during the planning period of January 1, 2024 – December 31, 2027, ALTCEW will focus on the following Issue Areas.

C.1 Healthy Aging:

Healthy aging programs are designed to improve the health and well-being and reduce disease and injury in older adults. Evidence-based disease prevention and health promotion programs reduce the need for more costly medical interventions Healthy aging at ALTCEW means aging in place, feeling safe and supported, and choosing the healthy lifestyle that us as individuals would like to lead. Everyone deserves to age at their home or resident and we try our best to provide resources and services to make that happen. ALTCEW understands that each community is unique and has its own individual necessities. Our agency takes the time to listen to each independent community and help provide solutions with respect to what the community requests and needs. We as an agency advocate for those with the greatest social, economic, and health needs. Promoting well-being, independence, dignity, and choice for all older adults and adults with disabilities is what ALTCEW strives for.

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

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

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

Twenty-eight percent of Washington residents over age 65 fall each year. In 2018, Washington State had the 16th highest rate of fall-related deaths of adults aged 65 and older in the United States, and the 5th highest rate of self-reported falls. The total number of deaths from falls and fall-related injuries has more than doubled in the last 15 years, from 393 in 2000 to 920 in 2018.[23] Within Spokane County the rate of deaths from falls is more than double that of the rest of the U.S. and Washington State as a whole.[24]

In September 2021, ALTCEW begins its seventh year as a Master Training Site for the evidence-based falls prevention workshop, A Matter of Balance (MOB), proven to help older adults reduce their fear of falling and to increase physical activity. MOB access to classes has grown by 150% and has on-going classes in our entire service region including rural communities, at Tribal community centers, and in city center hubs. Additionally, as the coronavirus pandemic forced the suspension of in-person classes, ALTCEW falls prevention staff became certified to

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

[24] https://www.spokanejournal.com/local-news/fatal-fall-rate-in-spokane-county-is-higher-than-state-nation/

offer the recently-approved A Matter of Balance Virtual Translation and Falls Talk, an evidence-based falls prevention program delivered to individuals entirely by telephone.

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

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

GOAL: Improve health and wellbeing of older adults by increasing the array of affordable health, prevention, and wellness services for older adults and people living with disabilities.

Objective A: Between January 1, 2024, and December 31, 2027, ALTCEW will expand the use of Evidence-based Programming, specifically A Matter of Balance (MOB), A Matter of Balance – Virtual (MOBV) Translation, FallsTalk, FallsTalk-C, and FallsScape-D to support prevention and wellness options for older persons and individuals living with fall risks and disabilities.

Objective B: Between January 1, 2024, and December 31, 2027, ALTCEW will continue to increase awareness of the Senior Farmer's Market Nutrition Program (SFMNP) through flyers, public service announcements, and other media opportunities.

Objective C: Between January 1, 2024, and December 31, 2027, ALTCEW will elevate the housing issue within the greater community, advocating for universal design methodology, retrofitting of older housing structures, and highlighting the need for a larger number of accessible units within new multi-housing construction. ALTCEW will also advocate for the creation of additional affordable and accessible housing units for older adults.

Objective D: Between January 1, 2024, and December 31, 2027, ALTCEW will continue to advocate for awareness of the transportation needs of older adults and individuals living with disabilities, with a focus on rural communities, through staff participation in coalitions and committees within the ALTCEW Service Area.

Objective E: Between January 1, 2024, and December 31, 2027, ALTCEW will promote Brain Health and Dementia Support programs, direct services, outreach, and education for persons living with dementia and their care partners. ALTCEW will continue to partner with other community and professional agencies such as: Rural Resources – Community Action, Elder Services, Frontier Behavioral Health, the Alzheimer's Association, EMS and hospital agencies, and Aging and Long-Term Support Administration (ALTSA).

Objective F: Between January 1, 2024, and December 31, 2027, ALTCEW will continue to work with partners in the agency's service region to combat social isolation and increase social and community engagement in heathy aging programs.

C.2 Supporting Pre-Medicaid Long-Term Services and Supports:

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

ALTCEW is committed and focused on expanding and strengthening services and supports that prevent or delay entry into Medicaid funded long-term services and supports (LTSS): Supports that prevent or delay entry into Medicaid funded LTSS are tailored to community strengths and promote an interdependence of natural supports and paid services.

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

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

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

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

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

Objective A: Between January 1, 2024, and December 31, 2027, ALTCEW will promote increased public awareness of wellness resources, Community Living Connections, and services for family caregivers. Activities will continue to include the ALTCEW Insider newsletter; the Dementia Friends newsletter and website for resources and programs; diverse media campaigns that include print, radio, television, and social media; online surveys for focus groups and needs assessments that will be available in person, by mail or virtually.

Objective B: Between January 1, 2024, and December 31, 2027, ALTCEW will continue to provide benefits counseling and enrollment assistance to Medicare and Medicaid beneficiaries and assist low-income individuals with the application process for other types of cost-saving benefits.

Objective C: Between January 1, 2024, and December 31, 2027, ALTCEW will collaborate with providers for more thorough and effective hospital discharge planning to ensure a successful transition to home and to minimize the possibility of re-hospitalization.

Objective D: Between January 1, 2024, and December 31, 2027, ALTCEW will collaborate with local primary care and behavioral health providers to improve access, increase education and awareness, and facilitate referrals to Community Living Connections and other agency services.

Objective E: Between January 1, 2024, and December 31, 2027, ALTCEW will assist with public education and provider network development for the WA Cares Program. In addition, ALTCEW will advocate for person-centered options counseling to assist beneficiaries in navigating services to help them maintain living at home and prevent institutionalization.

C.3 Person-Centered Home and Community-based Support Services:

ALTCEW works daily on expanding and strengthening services and supports that prevent or delay entry into Medicaid funded long-term services and supports (LTSS): Supports that prevent or delay entry into Medicaid funded LTSS are tailored to community strengths and promote an interdependence of natural supports and paid services. ALTCEWS on-going goals are to the address family caregiver support programs and focus on person-centered counseling that empowers people to make informed choices about their care. Our efforts also include efforts to support hospital to home care transitions as appropriate.

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

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

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

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

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

Information, Referral, and Awareness – Aging and Disability Resource Centers (ADRCs) serve as highly visible and trusted places where people of all ages, disabilities and income levels know they can turn for objective information on the full range of home and community supports and service options.

The ADRC's information, referral, and awareness services are designed to help consumers navigate the variety of agencies and organizations offering services and supports with differing eligibility criteria, application processes, and cost sharing requirements for public pay, private pay, and local community or faith-based resources.

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

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

Person-Centered Care Transitions supports movements of individuals between health care settings require some coordination. The Person-Centered Care Transitions component of the CLC assists individuals to coordinate care needs for people transitioning from one setting of care to another.[25]

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

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

Medicaid Alternative Care (MAC) provides caregiver support services to unpaid caregivers of individuals currently eligible for Medicaid long-term care but choosing to receive caregiver support services in lieu of personal care. Counseling, respite care, support groups and other

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

supportive services are available based on assessment for both the caregiver and care receiver.

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

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

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

Objective A: Between January 1, 2024, and December 31, 2027, ALTCEW will collaborate with partners to facilitate the growth, expansion, and sustainability of the Advanced Medication Management Program.

Objective B: Between January 1, 2024, and December 31, 2027, ALTCEW will continue with the expansion of the Health Home Program, to reduce care costs and promote wellness for clients served through Medicaid, Medicare, and Apple Health Medicare Connect. Additionally, ALTCEW will continue to increase the agency staffs' ability to refer to community and social supports, as new needs arise that are beyond the traditional Medicaid or Medicare benefit packages.

Objective C: Between January 1, 2024, and December 31, 2027, through the Supportive Housing Program, ALTCEW will collaborate and promote partnership with public agencies and private sectors to assist in identifying and securing housing resources for clients in need of assistance to prepare for and transition to housing in Spokane County. ALTCEW will continue to provide services to support individuals to maintain tenancy once housing is secured.

Objective D: Between January 1, 2024, and December 31, 2027, ALTCEW will advocate for adequate funding for Title XIX Case Management to reduce caseloads and ensure quality client care.

Objective E: Between January 1, 2024, and December 31, 2027, ALTCEW will work with local and state partners to encourage and facilitate the recruitment and training of Home Care Aides, so that clients are able to receive timely services through the Medicaid In-Home Care program.

C.4 7.01 Planning with Native American Tribes and Tribal Organizations:

ALTCEW is committed to continue to collaborate and work with Tribes and Tribal organizations to provide culturally appropriate and person centric programs, resources, and common outreach events to promote healthy aging.

PROFILE: DSHS Administrative Policy 7.01 requires Area Agencies on Aging to develop a formal plan that outlines their coordination with individual tribes within their PSA. ALTCEW has a dedicated Tribal Liaison who will continue to meet, collaborate, coordinate, work with, learn from, and provide access to all ALTCEW programs. The work may include developing new resources and creative programs to support all elders on their journey of healthy aging.

GOAL: ALTCEW will consult and collaborate with representatives from Regional Tribes and Recognized American Indian Organizations to ensure quality and comprehensive planning and service delivery to all American Indians and Alaskan Natives in Planning and Service Area #11.

Objective A: Between January 1, 2024, and December 31, 2027, ALTCEW will develop and implement 7.01 Plans in collaboration with Regional Tribes and Recognized American Indian Organizations. ALTCEW will continue to meet with Tribes and Urban Indian Organizations as requested to update the 7.01 plans. ALTCEW will continue to promote healthy aging programs and dementia education in partnership with tribes in the service region.

Objective B: Between January 1, 2024, and December 31, 2027, ALTCEW's Tribal Liaison will continue to advocate and participate in Tribal Centric work groups at the local and state levels, to ensure quality and comprehensive healthy aging planning and supportive services are championed in the agency's service region.

C.5 COVID-19 Response Services and Supports:

Washington State was the United States epicenter of the pandemic in January 2020 and on February 29, 2020, Governor Jay Inslee declared a state of emergency in response to the COVID-19 outbreak. The AAA's anticipated needs in the community and responded by pivoting crucial services to maintain compliance with the Major Disaster Declaration orders while engaging their local community with new services and supports to meet needs such as food security and social isolation.

PROFILE: As a trusted local community resource, Aging & Long Term Care of Eastern Washington anticipated needs in the community and responded by pivoting crucial services to maintain compliance with the Major Disaster Declaration orders while engaging their local community with new services and supports to meet needs such as food scarcity and social isolation.

GOAL: ALTCEW will continue to support post-pandemic efforts and expand access to resources, supports, services, and service delivery for older adults and adults living with disabilities utilizing approaches that meet COVID-19 safety protocols.

Objective A: Between January 1, 2024, and December 31, 2027, ALTCEW will continue to support the unique, ongoing needs of local communities for post-pandemic supportive services and programs that align with the agency's mission and goals.

Objective B: Between January 1, 2024, and December 31, 2027, ALTCEW will champion integrated vaccine efforts for the service region to promote awareness, education, and access to vaccines for older adults and people living with disabilities. ALTCEW will work to ensure there is no wrong door in accessing vaccines in the agency's service area.

C.6 Mental Health and Aging:

Supporting good mental and physical health is paramount to our core values. ALTCEW is committed to combating social isolation, providing resources, access to counseling, promoting good mental through education and supportive services and promoting healthy communities. ALTCEW understands as our population grows in diversity and we prepare for the "Silver Wave" that providing dementia friendly spaces, promoting healthy aging education, and creating resources and programs to combat the progression of mental illness is a key priority of our continued work with older and disabled adults.

PROFILE: The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[26] Because mental health is essential to overall health and well-being, it must be recognized and treated in all Americans, including older adults, with the same urgency as physical health.

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

- Most older people have good mental health. However, approximately 20 – 22% of older adults may meet criteria for some form of mental disorder, including dementia.
- Fewer than 40% of older adults with mental health and/or substance use disorders get treatment.
- The prevalence of dementia increases dramatically with age, with approximately 5% of the population between ages 71 and 79 and 37% of the population above age 90 suffering with this condition.
- Emergency room visits by older adults with opioid misuse increased over 220% from 2006 to 2014.
- If the prevalence of mental health disorders among older adults remains unchanged, the number of older adults with mental health and/or substance disorders could reach 14 million people by the year 2030.
- Older adults have one of the highest suicide rates in the nation. White males 85+ complete suicide at 4 times the rate of the general population.
- Mental health disorders, particularly depression and anxiety, are major contributors to – and are exacerbated by – social isolation, which results in diminished quality of life, further barriers to intervention and premature institutionalization.
- By 2020, an estimated 5 million older adults will have substance abuse problems.[27]

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

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

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

Objective A: Between January 1, 2024, and December 31, 2027, ALTCEW will continue to advocate and promote partnerships to offer Early-Stage Memory Loss resources and education for individuals with early-stage memory loss and their care partners.

Objective B: Between January 1, 2024, and December 31, 2027, ALTCEW will collaborate and promote partnership with local government, home care entities, hospitals and the medical community, community services and supports, the business community, local universities, and first responders to support the continued development of Dementia Friendly Communities.

Objective C: Between January 1, 2024, and December 31, 2027, ALTCEW will continue to advocate for the mental health needs of older adults through coordination efforts with providers of mental health services and community educational events.

Client Outreach Stories:

Walter – Spokane, WA
Care Coordination Services

"I would recommend Aging & Long Term Care for anybody that can qualify for it. They've guided me, prompted me the whole way. They've been a blessing. They care man, they care."

ALTCEW 15 Walter (vimeo.com)

You don't have to do it alone.

Find local services to help your loved ones age at home.

(509) 960-7281

Aging& Long Term Care

Karla – Airway Heights, WA
Supportive Housing Services

"The services with Aging & Long Term Care have allowed me to keep my independence and my dignity."

ALTCEW 15 Karla (vimeo.com)

Get support to live at home longer.

One number connects you to all the services you need to age safely at home.

(509) 960-7281

Aging& Long Term Care

Lucille – Spokane Valley, WA
Options Counseling

"It's just been amazing to me, how they've been there for me. The information and services that Aging & Long Term Care has offered me has helped me keep my independence. My first contact with Susie was a phone call, and she just made me feel very comfortable with the questions she asked. We all have fears and sometimes they can overtake you especially in your older age, you know, so just make the call, ask the questions, maybe they can help you, maybe they can't. But you don't know if you don't make the call."

ALTCEW 30 Lucille (vimeo.com)

Client Success Stories:

The names in these stories have been changed to protect individual's privacy.

Case Management:

Christina is a 53-year-old woman who is living with 43 allergies in addition to several other medical conditions. Her home is wrapped in plastic due to her allergies, and she has wounds on her body that need regular treatment. Due to the severity of her allergies, Christina is not able to do many necessary tasks. Christina does not have familial support and is unable to live in a facility as they cannot cater towards her specific needs. Due to her current funding, Christina receives over 200 hours of service per month between two caregivers. They assist with things like wound management, household chores, grocery shopping, food preparation, and allergy management. This helps Christina greatly and enables her to live at home alone. Without this assistance, Christina would not be able to maintain her current quality of life.

Greg is a 35-year-old male with two children under the age of 10. He lives with Narcolepsy and requires a caregiver to wake him up daily to give him medication that helps him stay awake throughout the day. This enables him to spend time with his children, get them ready for school, and get to work on time. He can enjoy the time he's with his children, be alert and productive at work, and not suffer from excessive daytime sleepiness. Without this basic assistance from his caregiver and medication, Greg would not be able to support his children and his entire family would suffer. This assistance isn't just helping Greg, but his son Joseph and daughter Milah as well. As a family, they can maintain the life they deserve.

Health Homes / Care Coordination:

Alina is a 35-year-old female who suffers with Anxiety, Depression, Chronic pain, Post Traumatic Stress Disorder (PTSD) and history of abuse. Her Care Coordinator supports her through a variety of challenges, including learning proper use of the medical system, acquiring greater skills in communicating with providers and specialists, navigating shelters during a period of homelessness, navigating pain management, and achieving stability in the home. Alina is now working part-time at an assisted living facility. Her home and family life are going well, and she is preparing to move to a larger apartment to accommodate her growing daughter. Alina no longer visits the ER as frequently and has achieved a stable income, stable mental health, and a stable home for her daughter.

Adil is a 66-year-old Arab male who does not speak English and needs an interpreter. Adil and his Care Coordinator have been working together for 8 months. Since working together, Adil shared that he is better able to get his health concerns addressed in a timely manner. His Care Coordinator helps him advocate for specialized care needs such as pain specialists, imaging, food benefits, and more. Adil is hopeful that with the continued help of the Health Home Program, he will have his pain adequately addressed so that he can continue his passion for making children laugh through magic shows.

Frontier Behavioral Health / Elder Services:

Dmitry lives with a significant medical history on top of memory loss that often causes him to forget who he is talking to halfway through a conversation. During in-person interactions, he can start making a bowl of cereal and forget what he is doing halfway through the task. While Dmitri is mostly mobile, due to his memory loss, he needs constant cueing and supervision. Without his caregiver, he would not remember to eat, go to the bathroom, or get to appointments. Additionally, if Dmitry is not constantly monitored and reminded to take his medication, he will not take them at all, or will take too many which could be life threatening. Without the help of his caregiver, Dmitry would not be able to complete his daily tasks and live safe and healthy life.

Mai is an 82-year-old Vietnamese woman who receives 22 hours of assessed monthly care. She lives at home alone managing her vertigo and diabetes. Mai does not speak English, cannot use public transportation, and needs assistance food shopping. Mai is very proud to be independent of her children's support and counts on the support of her caregiver to shop for fresh fruits and vegetables, visit with others from Vietnam to maintain her mental health, and go to necessary appointments. If Mai did not have the support of her caregiver, she would be house bound, would not have access to a well-rounded diet, and her quality of life would be greatly limited.

Heri has multiple chronic conditions and mental illnesses including schizophrenia and diabetes. On top of this, Heri is a fall risk and lives with seizures. Recently, he was admitted to the hospital for dehydration and malnutrition because he often forgets to eat and drink. When he does remember to prepare food, he has forgotten meals on the stove and smoked up his apartment building. Heri's caregiver has stepped in to help him manage daily cleaning, cooking, transportation, and medication usage. Without this assistance, he would not be able to go to regular appointments or remember to take necessary medications. Heri has depended on his caregiver to help him manage these necessities and live in the community independently. If he did not have this support, he would not be able to maintain his quality of life.

Rural Resources:

Courtney is a 38-year-old female with schizophrenia. She started to receive services after experiencing an episode with frightening hallucinations that led her to break out the windows of her neighbor's home. Once receiving services, she was able to work with a caregiver to stabilize on medication. Courtney's caregiver currently helps her with medication management, behavior monitoring, and transportation to medical appointments. These are all things Courtney struggled with prior to receiving assistance. Her caregiver is also able to intervene when hallucinations do occur which can prevent episodes like the one mentioned prior. Receiving this care has helped Courtney to manage her mental health and live at home independently.

Hank is a 68-year-old male living with a traumatic brain injury (TBI). Due to his TBI, he has memory issues, severe mobility issues, and can't drive. Despite this, Hank is very active

spending his days walking around town. Hank will often forget to take necessary medications or even eat. His caregiver must call him each morning to remind him to do so. While Hank can walk to local medical appointments, his caregiver has to drive him out of town to important doctor's appointments. Because of his caregiver's support, Hank has been able to live a productive life, continue doing the things he loves, and walk around town.

Peng is currently living with cystic fibrosis, arthritis, and neuropathy as a 58-year-old male. He additionally had a stroke and struggles to take care of himself and his home. Peng refused help for a very long time and because of this, his home condition has degraded, and he is facing unsafe living conditions. Now that he has a caregiver, they have been able to help manage his health, personal hygiene, and home maintenance. He is also receiving assistance with long-term planning when it comes to improving his home. Receiving this care has greatly helped Peng improve his life, and overall wellbeing. He truly wouldn't be able to continue living independently without this kind of support.

Volunteer Testimonials:

SHIBA:

Kathe has been a SHIBA volunteer for over 2 years. She's a retired mother of two, worked in sales for 40 years, and owned a restaurant for 15 with her husband. She enjoys traveling, cooking, gardening, and long drives exploring the PNW. Kathe has served on several committees with the City of Spokane Valley in the past 5 years in addition to her current role with SHIBA. "My volunteer work keeps my brain active and engaged and I love being able to give back to the community… I began volunteering during the pandemic and for a couple years, it was my primary source of interaction with the outside world. I so appreciate being able to share Medicare information with fellow volunteers and our clients! People who want to help others and give back to the community while staying engaged in what matters will find SHIBA very beneficial. We're always learning and growing our skills!"

Beverly has been a SHIBA volunteer over a year. She is a retired geriatrician and spent most of her career with the Veteran's Affairs (VA). Beverly enjoys spending time knitting, baking, walking, swimming, biking, and reading. Along with her work for SHIBA, she is busy volunteering with the Blood bank, Riverside State Park, Deaconess Medical Center, and the Spokane Regional Health District. She also previously volunteered with the Hospice of Spokane, spent 5 years at SCRAPS, and served at Aging & Long Term Care on their Planning & Management Council. Through her work with SHIBA, Beverly finds that it's "interesting and challenging work, and very much needed as health insurance in the US is so complex, nuanced and intimidating but utterly important due to the cost of care."

Check and Connect:

Jessica has been a volunteer with Aging & Long Term Care's Check and Connect program for over a year! In this role, she makes weekly phone calls to older adults to provide companionship and information about local resources. "The Check and Connect program enriches lives in the most basic ways, as so many elderly people just need to know someone cares about them. We can change the world with small gestures every day, and a phone call can be that small gesture that means so much." When asked by a friend if she enjoys making phone calls to people very week, Jessica pondered this question. At the end, it was clear to her that "I like the feeling that someone is looking forward to connecting with me. I just reach out and change someone's day or week by being available. And they change my day or week as well... My clients count me as a friend.

We laugh and chat and tell stories. One gal who I've been talking to for a year says "Love ya!" when we're saying goodbye. Does that make my day? Yes, many times over. I am grateful for the lift my ALTCEW friends give me."

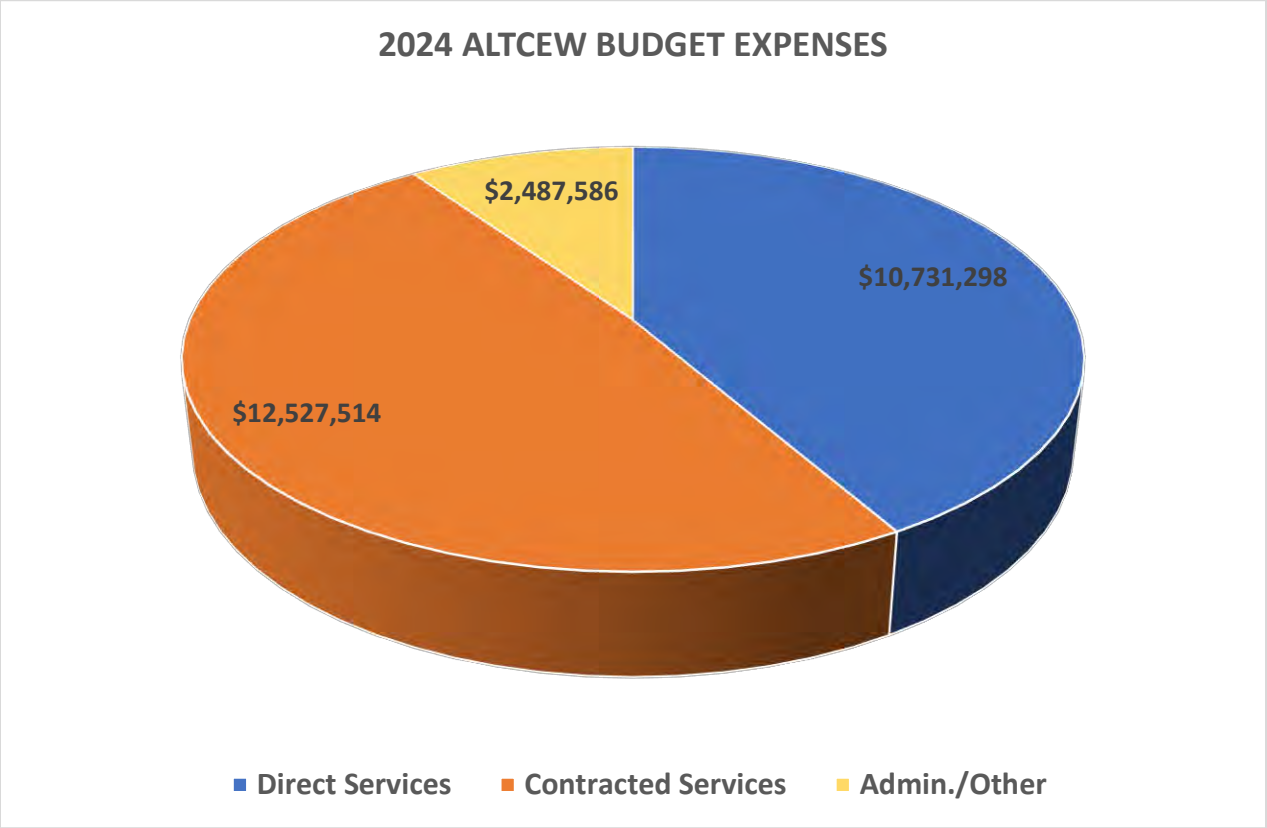
A Matter of Balance:

Patricia is a volunteer for A Matter of Balance (MOB). She is a registered nurse, with a passion and goal of contributing to our community. "Investing time as a volunteer coach for the MOB classes is fulling that goal. Additionally, as a coach I can testify from personal experience, having fallen from my e-bike and breaking my wrist, that balance is one of the keys to fall prevention." Patricia notes that her experience as a MOB coach has helped her sharpen her skills in listening to, learning from, and guiding participants to recognize common negative fears of falling. "I am so glad that I volunteered for this valuable program because it promotes safer, healthier and active lifestyles."

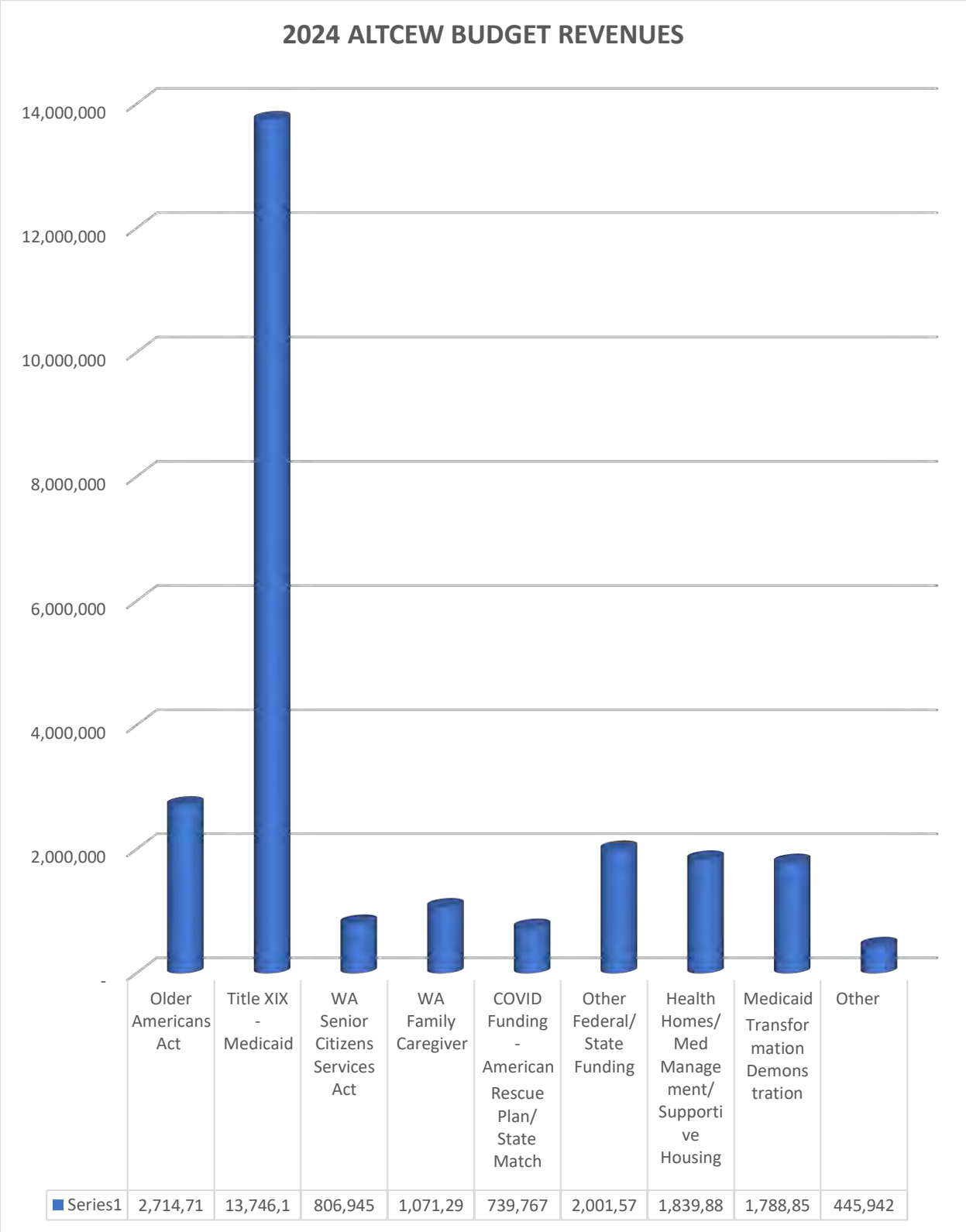
Building Dementia Capable Communities:

Our Dementia Care Specialist diligently worked with a client's daughter who had been seeking placement for her mother in memory care. The client's daughter called into our CLC hotline seeking out dementia care resources for her mother. Our team assisted her with the Medicaid application for her mother, but there were various behavioral issues that were making their situation become a crisis on more than one occasion. We suggested the client's daughter to have a medical evaluation done for her mother for early diagnosis screening for Alzheimer's and Dementia, while the application was pending. Due to this medical evaluation and medication changes made by the doctor the client is doing amazingly well and is back in her own apartment and they have withdrawn the application as they feel she is once again safe and cognitively able to manage her days somewhat independently. What was thought to be a dementia related diseases turned out to be a simple medication error, identified by the primary care physical upon recommendation from our team for a medication and cognitive evaluation. This could have ended with an unnecessary memory care placement, costing a lot of time and money the family did not have. Through the supportive direct services, promotion for early diagnosis, health care provider education training series, and the work of our diligent Dementia Care Team, ALTCEW was able to provide the right care and resources at the right time. The client's daughter shared "You saved us so much time, money, and prevented unnecessary heart ache. Thank you"

SECTION D – AREA PLAN BUDGET



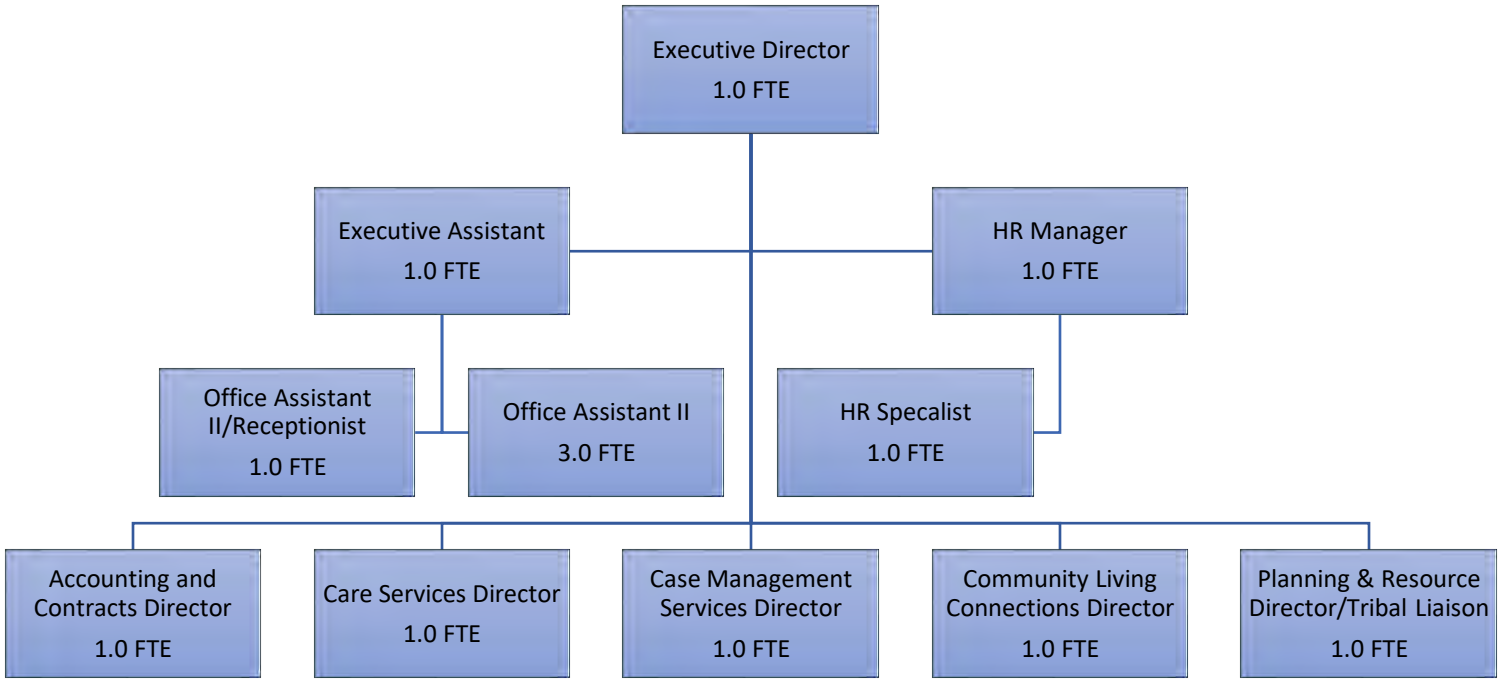
Direct Services	41.7%	$ 10,731,298
Contracted Services	48.7%	$ 12,527,514
Admin./Other	9.7%	$ 2,487,586
Total	100.0%	$ 25,746,398


2024 ALTCEW BUDGET REVENUES
14,000,000
12,000,000
10,000,000
8,000,000
6,000,000
4,000,000
2,000,000
-
Older Americans Act
Title XIX - Medicaid
WA Senior Citizens Services Act
WA Family Caregiver
COVID Funding - American Rescue Plan/ State Match
Other Federal/ State Funding
Health Homes/ Med Management/ Supportive Housing
Medicaid Transformation Demonstration
Other
Series1
2,714,71
13,746,1
806,945
1,071,29
739,767
2,001,57
1,839,88
1,788,85
445,942

APPENDIX A – Organization Chart

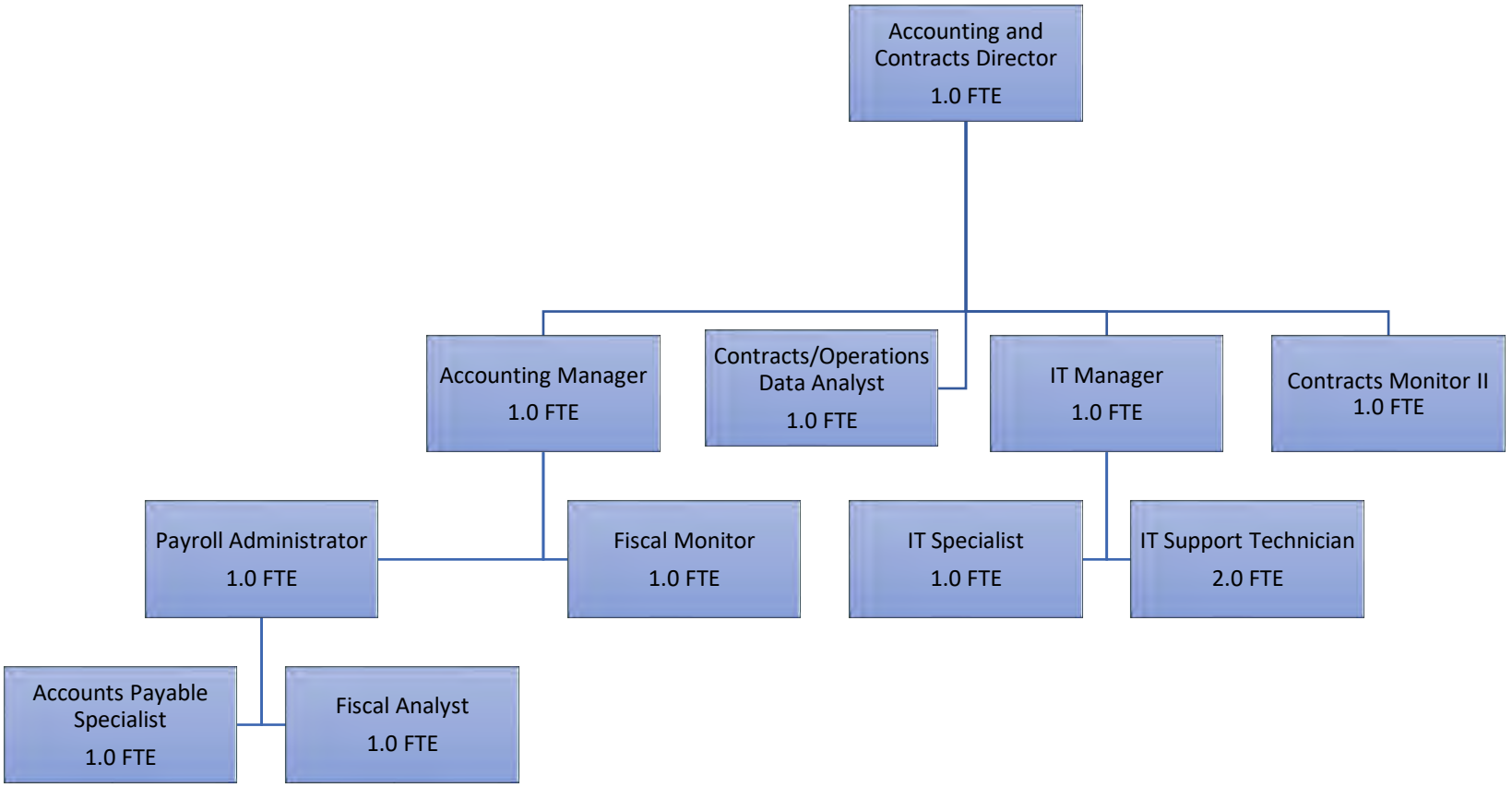
Aging & Long Term Care of Eastern Washington

Lead Staff Organization – September 2023



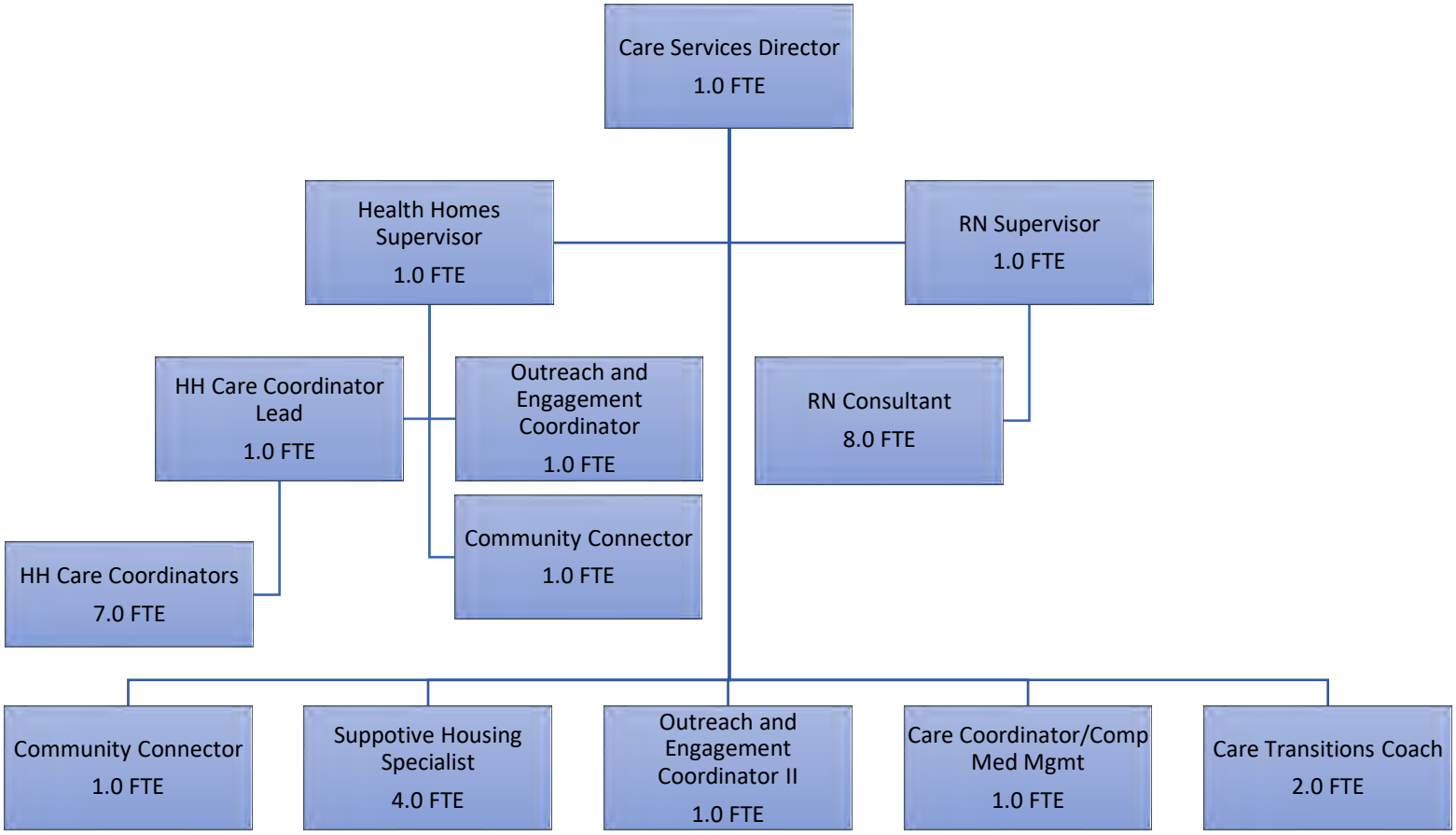
Aging & Long Term Care of Eastern Washington

Accounting and Contracts – September 2023



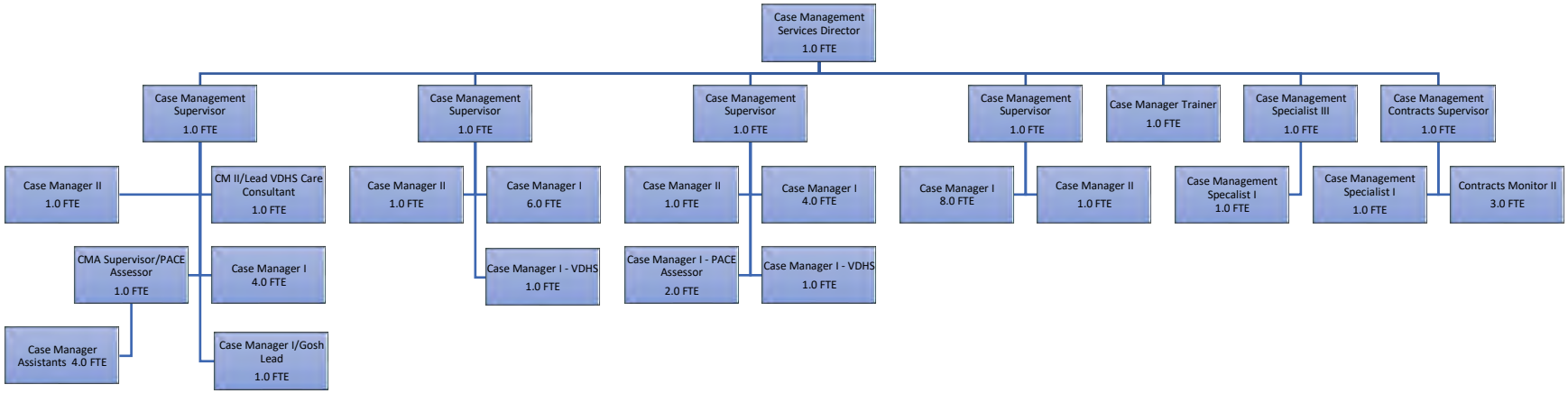
Aging & Long Term Care of Eastern Washington

Care Services – September 2023



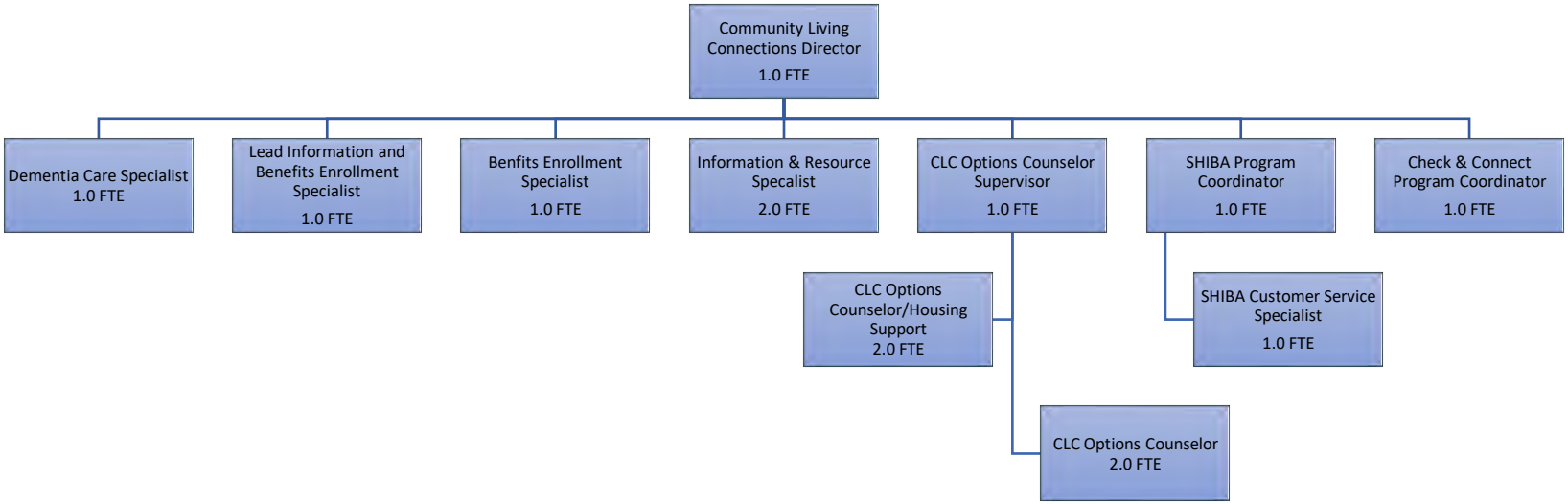
Aging & Long Term Care of Eastern Washington

Case Management – September 2023



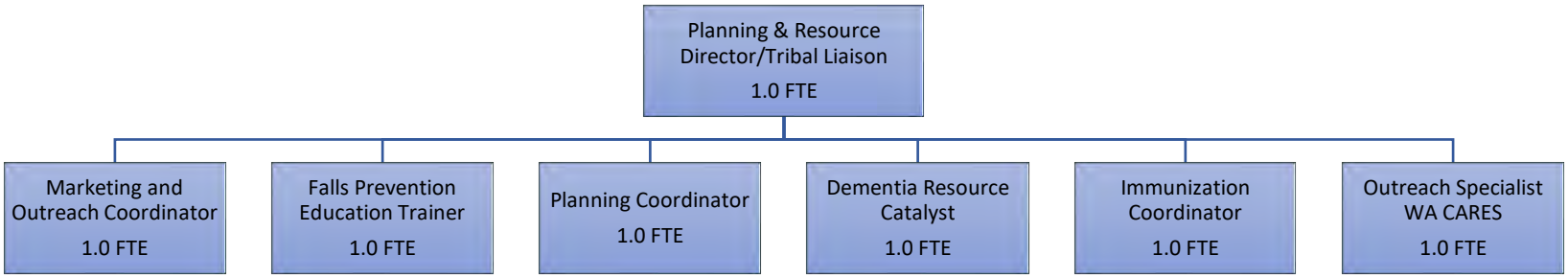
Aging & Long Term Care of Eastern Washington

Community Living Connections (CLC) – September 2023



Aging & Long Term Care of Eastern Washington

Planning & Resource – September 2023



APPENDIX B – STAFFING PLAN (ALTCEW 2024)

Position Title	Name	Total Staff	Position Description
Executive Director	Kimball, Lynn	1 FTE	AAA Administration; Coordination; Staff Support to Board and Council
Executive Assistant	Scheideler, Khristina	1 FTE	Assistant to the Executive Director
Human Resources Manager	Guillen, Monique	1 FTE	Provides Generalist Human Resources expertise, support, and advisement to Agency management and staff
Human Resources Specialist	Monnier, Emily	1 FTE	Provides a variety of administrative services to support the human resource's function. Specializes in administration of staffing and employee on-boarding
Care Services Director	Michielli, Teresa	1 FTE	Health Homes, Supportive Housing, RN Supervisor
Case Management Specialist III	Moore, Brittany	1 FTE	Program Monitoring/QA; Administrative Hearings Coordination; CARE TA; Nurse Delegation TA
CM Specialist I	Willis, Ashley	1 FTE	Assists Case Management Specialist III in Administrative Hearings and Program Monitoring / QA activities.
Case Management Contracts Supervisor	Eppinger, Kristi	1 FTE	Supervisor/program oversight, COPES waiver vendors, Quality assurance assessment and administration, Public Disclosure officer
Contracts Monitor II	Breidt, Patricia Kelly, Rachel Ibarra, Joshua Mesaros, Katie	4 FTE	Monitor service performance and quality of service delivery by ALTCEW sub-contractors.
Contracts/Operations Data Analyst	Soheili -Richards, Faran	1 FTE	Monitors data reporting and service performance, compiles agency metrics and OAAPS reporting.

Case Management Support Specialist	Potapenko, Vladimir	1 FTE	Assists with the solicitation, application, and intake process of Title XIX and MTD Open Procurement contract applicants.
Case Management Assistant Supervisor/ PACE Assessor	Fisher, Lee	1 FTE	Supervise Case Management Assistants, PACE Assessments, may also provide caseload coverage for Case Managers on an as-needed basis
Case Manager Assistant	Open Dumbrava, Svetlana Miller, Gwen Miles, Maxine	4 FTE	Case Manager Assistance
Case Management Director	Lichorobiec, Jennifer	1 FTE	Title XIX Case Management oversight
Case Manager Supervisor	Mercer, Amy Scott, Brenda Spencer, Steve Whalen, Leslie	4 FTE	Case Manager Supervisor
Case Manager Trainer	Trammell, Petra	1 FTE	Train newly hired Case Managers and provide ongoing training support to Case Managers
Case Manager II	Eisenman, Alexis Miller, Kylie Sellers, Keith Smith, Terresa	4 FTE	Provides case management and provides training and technical assistance to case management teams.
Case Manager II – Lead VDC Consultant	Bond, Becky	1 FTE	Provides case management and provides training and technical assistance to case management teams about the Veteran's Directed Care Program.
Case Manager II – GOSH Lead	Prouty, Jessica	1 FTE	Provides case management and provides training and technical

			assistance to case management teams about the GOSH Program.
Health Homes Supervisor	Donally, David	1 FTE	Manages day to day implementation of Health Home program, Supervises Care Coordinator team
Health Homes Lead Care Coordinator	Robbins, Beverly	1 FTE	Provide the lead support to Health Homes Care Coordinators
Care Coordinator	Gnatenko, Yelena Gorski, Lydell Hernandez, Jenna Ibarra, Cassandra Njoku, Nnebueze Norred, Shawna Pointer, Milena	7 FTE	Health Homes Care Coordination
Medication Management Care Coordinator	Gilbert, Rubi	1 FTE	Provide care coordination services to eligible patients enrolled in the Comprehensive Medication Management Program
Supportive Housing Specialist	Robinson, Mary Jean Putnam, Rose Krahn, Lori Katz, Alisa	4 FTE	Supportive housing services
Outreach & Engagement Coordinator	Sims, Eric	1 FTE	Coordinates services to patients referred to the Health Homes program.
Community Connector	Brown, Theresa Small, Michael	2 FTE	Patient enrollment, admin support, finds community resources for Health Homes and supportive Housing teams
Care Transitions Coach	Castaneda-Rodriguez, Araceli Dalich, Laura	2 FTE	This position is responsible for providing care transition services to eligible patients enrolled in Care Transitions Program.
Case Manager I	Ayzenberg, Alexander	27 FTE	Responsible for case management services for older and/or disabled

	Bies, Molly Boulter-Reed, Katrina Carlson, Mary (Jessie) Cochran, Samantha Dhital, Kamal Dunlap, Wendi Hernandez, Alicia Kersey, Ashley Krout, Deanna Lee, Angela Livingston, Kaila Martin, Sara Mattozzi, Shelley May, Rebekah Mershon, Ally Myers, Hailey Okura, Madeleine Percy, Elizabeth Prouty, Jessica Smith, Nathanael Stang, Jennifer Stewart, Jillian Symonenko, Erika Waggoner, Ashley Wann, Tatyana Yelton, Elyssa		adults in need of community based long-term care services.

Accounting & Contracts Director	Williams, Erin	1 FTE	AAA Fiscal Management; Staff Support to Board and Council; Building Maintenance; State Fiscal Taskforce; Employee Benefits; Accounts Receivable; Accounts Payable; Cash flow; Payroll; Support Staff Supervision
Accounting Manager	Jessop, Ben	1 FTE	State Billings; Financial Statements; General Ledger
Fiscal Monitor	Pereira, Christine	1 FTE	Fiscal Monitoring of agency programs and contracts
Payroll Administrator	Hewitt, Jennifer	1 FTE	Payroll and employee benefits processing and accounting
Fiscal Analyst	Willey, Johanna	1 FTE	Responsible for accounts receivable, billing and reconciliation for state/federal programs.
Accounts Payable Specialist	Thoet, Shannon	1 FTE	Responsible for accounts payable, deposits, and other bookkeeping/accounting processes.
Office Assistant II	DeLeon, Victoria Matlock, Benjamin Stevens, Amanda	3 FTE	Administrative Support
Office Assistant II Receptionist	Cunningham, Marilyn	1 FTE	Reception
Community Living Connections Director	Stevens, Kari	1 FTE	Community Living Connections program supervision.
CLC Options Counselor Supervisor	Crawford, Josette	1 FTE	Options counseling, supports program activities related to CLC, Provides additional support to CLC team
CLC Options Counselor	Stokes, Susan Wright, Michelle	2 FTE	Assessment, counseling, referral
Options Counselor/Housing Specialist	Jackson, Christopher Mogan, Deanna	2 FTE	Options counseling, Offers short term housing services to CLC clients

Dementia Care Specialist	Matlock, Dawn	1 FTE	Screen consumers seeking dementia supports and services, referring individuals to community resources
Information & Resources Specialist	Brockie, Jamie Winter, Tina	2 FTE	Provides information, referral, and assistance to individuals contacting Community Living Connections
Benefits Enrollment Specialist	Breen, Deborah Riehl, Sheri	1 FTE	Medicaid/other Enrollment Assistance and referral
Check and Connect Program Coordinator	Lehman, Jessica	1 FTE	Directly support program activities related to CLC, Manage Reassurance, Call volunteers
IT Manager	Ehr, Russ	1 FTE	MIS Services; Computer Technical Assistance
IT Specialist	Christiansen, Cary	1 FTE	Computer Support, end-user training
IT Support Technician	Armstrong, Gary Watlington, Marcus	2 FTE	Provide initial software and hardware support; Provide technical assistance for the Agency, Contractors, and volunteers.
Planning & Resource Director / Tribal Liaison	Osgood, Bethany	1 FTE	Planning; Special Studies and Data TA; Staff Support to Board and Council
Falls Prevention Education Trainer	Helean, Philip	1 FTE	Falls Prevention Program Development
Immunization Coordinator	West, Kristen	1 FTE	Provides community education about immunizations.
Planning Coordinator	Jones, Jenni	1 FTE	Planner; Staff for Disaster Preparedness Planning; A Matter of Balance Master Trainer
Marketing and Outreach Coordinator	Reams-Taylor, Savannah	1 FTE	Marketing and coordination of outreach for Agency services
Outreach Specialist WA Cares	Estes, Patrick	1 FTE	Provides community education about the WA Cares program.
Dementia Resource Catalyst	Hill Matthews, Tara	1 FTE	Dementia resource development and community engagement (Grant)

SHIBA Program Coordinator	Kudrna, Monica	1 FTE	SHIBA/MIPPA Coordinator
SHIBA Customer Service Specialist	Dalich, Michael	1 FTE	Consumer education of Medicare/Medicaid and other insurances
RN Supervisor	Prugh, Sheila	1 FTE	RN Coordination, supervision
RN Consultant	Ayzenberg, Julia Besser, Beth Edmunds, Dominique Garpestad, Terri Jones, Shelley Moeser, Zachary Morris, Jodi Parsons, Anne	8 FTE	RN Consultation Services/Care Coordination

Total number of full-time equivalents = 120 FTE = 37.5 hours/week

Total number of staff = 120

Total number of BIPOC staff = 9

Total number of staff over age 60 = 17

Total number of staff self-indicating a disability = 9

Disaster and Business Continuity Plan 2024

ALTCEW Area Plan 2024-2027

*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 Northern Ferry, Stevens, Pend Oreille, Spokane, and Whitman counties.*

I. Purpose

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 individuals needing long-term care in Stevens, Pend Oreille, Spokane, Whitman, and Northern Ferry counties. Language contained in the Older Americans Act, Section 306, requires Area Agencies on Aging (AAAs) to include information on how they will coordinate activities with other agencies and develop long-term preparedness plans in case of emergencies. The State of Washington's Aging and Long-Term Support Administration (ALTSA) also requires all AAAs to have disaster plans in place. These plans are to be used as tools by ALTCEW to address the requirements of the Older Americans Act, as well as to map out a proactive approach to carrying out the organization's mission.

Major provisions within this plan identify the disasters that occur in our service areas; client 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, or more frequently as needed.

II. Scope

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

III. Limitations

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

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

Type of Disaster	Description	Probability
Flood	A flood is an inundation of dry land with water. Types of floods in our service area are primarily river, surface water, and flash.	Medium to High
Wildfire	Wildfires are the uncontrolled destruction of forests, brush, field crops, and grasslands caused by nature or humans.	Medium to High

Volcanic Eruption	A volcano is a vent in the earth's crust through which molten rock, rock fragments, gases, and ashes are ejected from the earth's interior. A volcano creates a mountain when magma erupts from the earth's interior through a vent in the earth's crust and lava flows onto the earth's surface.	Low to Medium
Severe Local Storm	Severe local storms are atmospheric disturbances manifested in strong winds accompanied by rain, snow, or other precipitation, and often by thunder or lightning.	Medium to High
Earthquake	An earthquake is the shaking of the ground caused by an abrupt shift of rock along a fracture in the earth, called a fault. The Cascadia subduction zone is of particular concern.	Medium
Drought	Drought is a condition of climatic dryness that is severe enough to reduce soil moisture and water and snow levels below the minimum necessary for sustaining plant, animal, and economic systems.	Low to Medium
Urban Fire	Urban fires occur primarily in cities or towns, with the potential to spread rapidly to adjoining structures. These fires damage and destroy homes, schools, commercial buildings, and vehicles.	Medium
Hazardous Material	Hazardous materials are materials which, because of their chemical, physical, or biological nature, pose a potential risk to life, health, or property when released. A release may occur by spilling, leaking, emitting toxic vapors, or any other process that enables the material to escape its container, enter the environment, and create a potential hazard. The hazard can be explosive, flammable, combustible, corrosive, reactive, poisonous, or radioactive. It may consist of toxic materials or biological agents.	Low to Medium
Terrorism	Terrorism is the unlawful use of force or violence against persons or property to intimidate or coerce a government or civilian population, in furtherance of political or social objectives.	Medium
Civil Disturbance	Any incident that disrupts a community where intervention is required to maintain public safety is a civil disturbance. Examples include demonstrations, riots, strikes, public nuisance, and criminal activities. The hazard can surface in any community and be sparked by racial, ethnic, religious, political, social, or economic reasons.	Low to Medium
Pandemic/ Epidemic	A pandemic is an outbreak of a disease that occurs over a wide geographic area and typically affects a significant proportion of the population, such as COVID-19 or influenza.	Medium
Landslide	A landslide is the sliding movement of masses of loosened rock and soil down a hillside or slope. Landslide causes depend on rock type, precipitation, seismic shaking, land development and zoning practices, soil composition, moisture, and slope steepness.	Low

V. Community Coordination/Planning

ALTCEW participates in ongoing 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 Northern Idaho areas. COAD's purpose is to bring together organizations, agencies, and businesses to promote mitigation and preparedness activities, and to efficiently respond to disasters and recover therefrom. COAD is a coordinating organization and does not assume direct operational responsibility in any disaster situation. COAD meets on the first Tuesday of each month (except July) at the Salvation Army (222 E. Indiana Avenue, Spokane, WA 99207).

B. Greater Spokane Emergency Management Planning Committees for Emergency Support Functions (ESFs)

The ESF's in Spokane City/County Emergency Plan are updated regularly.

C. Emergency Support Function (ESF) #14 Committee (aka LEPC)

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

D. REDi Healthcare Coalition (Spokane Regional Health District)

Formerly Washington State Region 7, Region 8, and Region 9 Healthcare Coalitions, the Regional Emergency and Disaster (REDi) Healthcare Coalition serves the 19 counties and four tribes that make up Eastern Washington. The REDi Healthcare Coalition's mission is to prepare for, respond to, and recover from crises using all available resources to provide patient care at the appropriate level and in the most efficient manner. In all their work, the coalition strives to build emergency preparedness across the healthcare system to create resilient communities.

E. Avista Community Response for Vulnerable Groups During Outages

This group was formed by the local utility company to better coordinate community response during outages due to weather and heat events. The group includes broad participation from community and disaster response agencies.

F. Health Equity Disaster Preparedness & Response Task Force E. WA.

This group coordinated with the SRHD, the World Institute on Disability (WID), and the Assistant Secretary for Preparedness and Response (ASPR) to establish a Health Equity in Disasters Task Force in our community. The group brings together community representatives to assess the causes of health inequities after disasters and develop strategies to improve outcomes post-disaster, thus creating positive health and social outcomes for people in our community. The group looks for leaders in emergency management, community healthcare clinics, emergency medical services (EMS), disability-lead organizations, community and social services, community policymakers, people with disabilities, and disproportionately impacted communities.

VI. Command/Control Structure

A. Government Command/Control Structure: In General

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

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

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

4. During the response phase, ECC staff will document the damage throughout the county, evaluate community needs, and commence planning for recovery and restoration. Resources and services will be arranged, as necessary, to meet urgent community needs.

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

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

B. ALTCEW: In General

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

C. Community Disaster Emergency Exercises/Events

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

VII. 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:

B. Disaster Preparedness

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

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

1. Organization

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

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

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

2. Staff

Staff, volunteers, interns, and temporary staff will be educated on being prepared during an all-staff meeting or by email at least once per year. This educational overview may include, 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 for clients

3. Clients

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

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

1. Individuals who live alone or without reliable support (including living with young children), and/or lack family or informal support with ONE or more of the following conditions:

Vulnerable Adult Criteria

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 with Insulin Dependence
i. Inability to Transfer Without Assistance
j. Condition of Being Bedfast/Chairfast
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. Amputee/Wound Care
q. Technologically Dependent (Respirator/Ventilator, Peritoneal Dialysis Machine, IV Nutritional Support, Oxygen)
r. Geographically Remote (meaning living more than 45 minutes from essential services, especially in extreme weather conditions impacting ability to use the roads)

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

   a. CMs review clients in CARE to identify those with the Vulnerable Adult Criteria and provide their names to the Case Management Supervisor. CMs will keep the contact information up to date by reporting changes to the Case Management Assistants.

   b. 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.

4. Response

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

a. Communicating with ALTSA, local health jurisdictions, Washington State Department of Health, the ECC, and other partners regarding the needs of the population served by ALTCEW.

b. Using alternative worksites, including the use of remote work for agency response.

c. Coordinating with contractors and other community partners to locate and obtain assistance for clients that need immediate assistance.

d. Sharing information from the ECC with staff, contractors, and the public through website and social media during disasters.

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

5. ALTCEW Internal Coordination

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

In the event of a smaller-scale disaster, the Planning and Resource Director, Case Management Director, and Disaster Preparedness Coordinator will be responsible for coordinating internal ALTCEW disaster response activities, in consultation with the ALTCEW Executive Director, as appropriate. Together, the Planning and Resource Director, Case Management Director, and Disaster Preparedness Coordinator will be responsible for sharing information and coordinating activities with case management service providers in Planning and Service Area (PSA) #11. The Disaster Preparedness Coordinator and Case Management Director will function as the liaison with ALTSA and other partner organizations.

In the event that the Case Management Director and/or the Planning and Resource Director are not available, the Community Living Connections (CLC) Director will fill in. If the Disaster Preparedness Coordinator is not available, the CLC Director or Care Transitions Director will cover designated responsibilities.

A. Evacuations

Department of Natural Resources (DNR) evacuation level definitions:

Green/LEVEL 1 (Ready): Conditions are moderate. Prepare to leave your current location if conditions escalate.

Yellow/LEVEL 2 (Set): Be prepared to leave at a moment's notice. Dangerous conditions threaten your residence or business. Hazards severely limit emergency services protection. If you or anyone at your location has special needs, pets or livestock, is medication-dependent, or uses electric-assisted medical devices, you should leave at this time.

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

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

Response to Activation of DNR Evacuations

If a Level 1 evacuation is issued, vulnerable clients in the affected geographic area will be notified.

During the contact, Case Managers (CMs) will:

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

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

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

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

- Direct the client to evacuate their residence.
- Advise the client of their local area shelter.
- Advise the Case Management Director if the client is unable or unwilling to evacuate.
    - The Case Management Director will contact Greater Spokane Emergency Management Duty officer if the client has been identified as unwilling or unable to evacuate in a Level 3 evacuation area.

Response to Large Scale Power Outages

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

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

Emergencies outside of business hours

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

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

- Case Management Supervisors and Health Homes Supervisors will divide the list of vulnerable clients and contact them, from home or the office. They will work with the ALTCEW Director to direct clients to the appropriate Emergency Services in the community as needed.
- ALTCEW will communicate with staff, media, volunteers, and clients to assist with the dissemination of information if necessary and critical to disaster response.

6. Recovery

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

ALTCEW and its contractors will coordinate the delivery of services to clients in the community. ALTCEW can choose to participate in after-disaster recovery and resource efforts. Task assignments for outreach and referral assistance will be coordinated by the CLC director and communicated to all ALTCEW staff and clients as needed.

7. Evaluation Component/Debriefing

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

8. Emergency Expenditures

Emergency expenditures are available under the Older Americans Act (OOA), Title III, Sec. 310. The OOA helps assure that AAAs will be reimbursed for extra services they may provide during a disaster. In the event of a disaster, the following 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, state and federal emergency management agencies, and regional office(s).
3. As ALTCEW is responding to an emergency, staff will be responsible for maintaining diaries of expenditures and the amount of time they have spent working on the disaster. These receipts and documentation will need to be kept on file for reimbursement later.

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

IX. Business Continuity Plan

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. The Responsible Staff will coordinate with emergency responders and disaster response agencies, as well as coordinate intra- 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 Planning and Resource Director and the Disaster Preparedness Coordinator.

Supervision

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

Planning and Management Council

In the case of an emergency, the Planning and Management Council (PMC) will be temporarily suspended until conditions improve to the extent that a meeting can be facilitated. ALTCEW values the PMC volunteers and ensuring their safety is important. Responsible Staff will update the PMC Executive Committee by email on updates to agency operations and disaster response as soon as feasible. The agency may use remote meeting options as needed during disaster recovery to meet.

Governing Board

Governing Board meetings, if scheduled during or after a disaster, will attempt to be facilitated using remote meeting options. This will be to ensure the safety of Governing Board members. Responsible Staff will update the Governing Board Chair by phone or email on agency operations and disaster response as soon as feasible.

B. Personnel

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

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

During a disaster, ALTCEW will make every effort to maintain agency operations and direct services to the community and may alter methods of service delivery in order to facilitate response. ALTCEW will leverage remote work options during disasters and may temporarily reassign staff to disaster response activities if their current position is impacted by the disaster. Department considerations during disaster response are listed below.

Case Management

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

Nursing Consultants

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

Accounting

The accounting department will continue operation during a disaster to ensure continuity of payroll, accounts payable, and accounts receivable. Additional responsibilities may include tracking disaster response expenses for future reimbursement or helping to reallocate and award funds for disaster response.

Information Technology (IT)

During and after a disaster, IT plays an important role in response and recovery since so many mission-critical functions are technology dependent. The IT department will be responsible for server maintenance and backup procedures, restoring the server, establishing necessary technology at an alternate site, maintaining access to remote

work options, and procuring needed technology after the significant loss of technology during a disaster. The IT department will work closely with ALTCEW Leaders in each department to ensure that the appropriate systems are in place to ensure agency operations can continue.

Contract Monitoring/Quality Assurance

Ongoing monitoring duties can be suspended temporarily during a disaster. In the case of an area-wide disaster, the Accounting and Contracts Director will work closely with contractors to help facilitate regional disaster response. Contracts Monitoring staff will shift focus during a disaster from monitoring to technical assistance and support.

Case Management Administration

Case Management Administration staff will support Case Managers and case management subcontractors as needed during the disaster. The Case Management director will work directly with the ALTCEW staff and ALTSA to ensure that all clients are contacted and offered resources when needed during a disaster.

Community Living Connections (CLC)

CLC services can continue to offer supportive services if needed.

Care Services (Health Homes/Supportive Housing/Medication Management/Care Transitions)

Services may shift to telephonic and virtual options if needed during a disaster. The Care Services Director will coordinate any shifts in service delivery with contracting agencies.

State Health Insurance Benefits Advisors (SHIBA)

SHIBA may continue to provide remote and telephonic services as needed during a disaster. If necessary, functions can be temporarily transferred to other SHIBA providers or the Office of Insurance Commissioner (OIC).

Planning & Resource Department

Staff functions may continue remotely, and staff work may be temporarily reprioritized to disaster response and coordination.

Support Staff

ALTCEW may use remote work options for Support Staff as needed during a disaster and response. The agency may use remote options to manage calls if physical locations are not open or accessible.

C. Technology

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

technical assistance to staff using the Virtual Private Network (VPN) for remote work during a disaster.

D. Facilities

In the event of a disaster, one or more facilities may be entirely lost or temporarily vacated. ALTCEW may prioritize use of remote work during building closures, rather than temporarily relocating physical offices. Following are alternative physical locations for ALTCEW operations:

Alternative for ALTCEW Main Office: 316 W Boone, Ste. 258, Spokane, WA 99201
Alternative for ALTCEW Rock Pointe Office: 1222 N Post, Spokane, WA 99201

E. Communication

In the case of a temporary agency closure, the agency's incoming voicemail message is scripted below. In the event that critical personnel are moved to an alternate facility or work remotely, they will continue to be able to call both inbound and outbound, thanks to the agency's shift to a software-based phone system which functions off of any internet connection and are not reliant on DSHS or agency servers.

Voicemail script:

The agency is currently closed due to an emergency (*optionally "state event"*). If this is an emergency, hang up and dial 911. If you know your party's extension, please enter it now or you may press 0 to leave a message in our general delivery mailbox.

If staff are unable to access agency computer or cell phones, essential calls may be made using personal cell phones via the Zoom app. The accounting department will work with the Responsible Staff to determine guidelines for reimbursing staff if personal cell phones are used in a disaster situation. The Planning & Resource department will create website and social media announcements.

When an area-wide disaster occurs ALTCEW will utilize and share communications via agency email, Zoom, and Teams, and the use emergency phone such as cell and land lines when supervisors have had difficulty reaching their staff.

A phone list of all staff is maintained by the HR Coordinator and Executive Assistant and is accessible by supervisors to use in the case of an emergency. Upon the occurrence of a disaster situation, lead staff will contact one another and determine who is available to be the Responsible Staff. Once the next course of action is determined, lead staff will contact all supervisors and direct reports via Zoom or email, who will in turn contact their staff. If a staff member 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 members are accounted for. If a supervisor or lead staff member is unavailable or does not respond, the Responsible Staff will contact all their direct reports to ensure all staff receive instructions.

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

F. Transportation

Transportation can be challenging in Spokane and surrounding areas during the winter and during summer storms. Staff will use discretion when transporting themselves to a client's home or to the office during inclement weather. In-person services may be temporarily suspended or rescheduled in the case of a short-term weather crisis due to heavy snow, icy roads, windstorms, or ice storms. The Responsible Staff will notify supervisors of office closure or travel advisories. Any temporary closures of physical offices will be communicated to staff via email, Teams and Zoom platforms if needed, and the agency will shift fully to remote work during closures.

G. Other

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

APPENDIX D – ADVISORY COUNCIL AND GOVERNING BOARD 2023

2023-2024 ALTCEW Governing Board Membership

Dan Mortensen
Planning and Management Council Chair

Michael Heath
Ferry County Commissioner

Mark Burrows
Stevens County Commissioner

Karen Stratton
Spokane City Council

Chris Jordan, Vice Chair
Spokane County Commissioner

John Gentle
Pend Oreille Commissioner

Rod Higgins
Spokane Valley City Council

Arthur D. Swannack, Chair
Whitman County Commissioner

Vacant
City of Spokane Appointee

Michael J. Piccolo
Governing Board Legal Counsel

Advisory Council

Planning and Management Council
2023-2024 Membership

Spokane County Residents

Jan Abrams
Aruna Bhuta
Margaret Ennis
Kathryn Garras
Mary Giannini
Connie Jay
Marty Johnston
Jean Kindem
Marlene Todd-Lippert
Genevieve Lecou
Dan Mortensen, Chair
Ana Matthews
Cy Parker
Maria Hernandez-Peck
Beryl Pielli
Martha Raske
James Renner
Bob Scarfo
Bonnie Sullivan
Debra Trowbridge
Adell Whitehead

Ferry County Residents

Ron Bacon
Karen Giebel

Pend Oreille County Residents

Kent Moline, Vice Chair
Ken Smith

Stevens County Residents

Fran Bessermin
Joy Eastgate
Barry Lamont

Whitman County

Sue Hallett
Karen Kiessling
Lin Moeller

Planning and Management Council Membership

Total number of members age 60 and over: 28
Total number of members self-identifying BIPOC: 2
Total number of members self-identifying a disability: 6
Total number of members who are elected officials: 1

APPENDIX E – PUBLIC PROCESS

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

- Focus Group and Community Meeting Locations
- Focus Group Questions
- Community Planning Meeting Flyer
- Community Survey and Results
- Public Hearing Meeting Notice
- Public Hearing Meeting Flyer, with Locations and Times

Information included below illustrates the number of events held during the Public Process. We had approximately:

- Six Focus Groups
- 117 Community Survey Respondents
- Two Community Planning Meetings
- Three Public Hearings

ALTCEW will continue to consult and collaborate with Native American Tribes and Tribal Organizations in our service region. We are dedicated to listening, learning, and working together through our partnerships, participation on advisory work groups and councils, and honoring traditional healthy aging through supportive services, resources, and programs. Our goal is to provide culturally competent and supportive services for our diverse, rural, and Native communities.

Aging & Long Term Care of Eastern Washington
Area Plan 2024-2027

Focus Group & Community Meeting Locations

Focus Group & Community Meetings	Location	Date/Time
Spokane County Focus Group	MLK Center 500 S Stone St, Spokane, WA 99202	03/30/23 2-4 PM
MultiCare Grand Rounds Community Meeting	Virtual Teams Meeting	04/05/23 12 – 1 PM
Whitman County Focus Group	Pullman Senior Center 190 SE Crestview St, Bldg. B, Pullman, WA 99163	04/10/23 2-3:30 PM
Alzheimer's Association Community Meeting	Corbin Senior Center 827 W Cleveland Ave, Spokane, WA 99205	04/12/23 2:30-5:30 PM
Ferry County Focus Group	Keller Senior Meal Site 7 Jim James Rd, Keller, WA 99140	04/27/23 1-2:30 PM
PMC Members Focus Group	Zoom meeting for all PMC members.	05/01/23 12-1 PM
Pend Oreille County Focus Group	Camas Center 1821 Leclerc Rd N, Cusick, WA 99119	05/11/23 4-5 PM
Stevens County Focus Group	Rural Resources 956 S Main St (956 S Main St, Colville, Washington 99114)	05/19/23 1-2:30 PM

Aging & Long Term Care of Eastern Washington
Area Plan 2024-2027

Focus Group Questions

Housing

1. What does your housing situation look like right now?
    a. What is working? What isn't?
    b. What has been your experience finding and maintaining your housing?
    c. Where would you go to find housing support?
2. (Rural communities) Where does someone go to find housing in this community?

ADRC

3. If you noticed a family member or neighbor having a hard time taking care of themselves, what services would you call?
    a. What would make it easier to find resources and help?
    b. What barriers have you run into while trying to get help?
4. What kinds of trainings and presentations would you be interested in attending (regarding aging and disabled population)?

In-Home Care

5. What challenges have you faced trying to meet your basic needs?
    a. What specific things do you need help within order to care for yourself and your home?
6. What has been your experience in getting and keeping in-home care?

Caregiver Support

7. What are your greatest challenges as a caregiver?
    a. How has your quality of life changed since becoming an informal caregiver?
    b. Have you ever accessed caregiver support services? If not, why?
8. (Rural communities) What resources for caregivers are there?

Transportation

9. For what types of activities or errands do you need to get around in your community?
    a. How do you get around when your usual transportation is not available?
    b. What is your most significant unmet need/barriers for transportation in your community? (ADA difficulties, etc.)
    c. (Rural): What transportation services are offered for individuals who do not drive?

Dementia and Brain Health

10. What supports would help a person living with dementia stay in their home longer?
11. What kinds of resources do people living with dementia need in your community?

General

12. What do you know about Aging & Long Term Care of Eastern Washington?
13. What kinds of services have you utilized in the past year?
14. What is stopping you from accessing support? What could encourage you to access support services?

Aging & Long Term Care of Eastern Washington
Area Plan 2024-2027

Community Meeting Flyer

Alzheimer's Community Forum

Join us for a listening session on Alzheimer's disease, dementia and memory loss

Wednesday, April 12, 2023 | 3:30 to 5 p.m.

Corbin Senior Activity Center
827 W. Cleveland Ave. | Spokane, WA 99205

We want to hear from you! Join us to share your experience with Alzheimer's disease and discuss how the association can best serve your community. Together, we can help enhance care and support resources in our community for those facing the disease.

Light refreshments will be provided.

Pre-registration encouraged.
Register online at
bit.ly/SpoForum
or phone 800.272.3900

For more information contact: Joel Loiacono at 509.321.4581 or jloiacono@alz.org

ALZHEIMER'S ASSOCIATION

Aging & Long Term Care

Aging & Long Term Care of Eastern Washington
Area Plan 2024-2027

Community Survey and Results

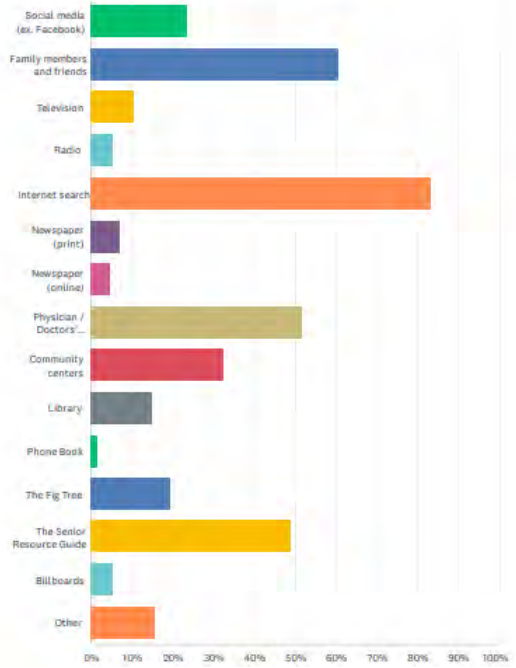
A Community Survey was created and distributed electronically to ALTCEW staff, volunteers, the Governing Board, and Planning and Management Council members. The survey was additionally distributed to community partners, other interested parties, and was posted online for community participation. One hundred seventeen people responded.

In addition to the survey, over the course of several months, ALTCEW met with community members, the PMC board, and staff in person and via zoom. ALTCEW utilized a local and online distribution process to identify goals, objectives, and issue areas for our region. Through our work, we plan to target those in greatest economic and social need, reflecting priorities noted during the local planning process. This includes how we will support and engage individuals who are hard to reach. We appreciate all who participated in our community forums, public hearings, in person and on-line surveys, and for the transparency and trust given to ALTCEW to address and improve healthy aging resources, services and outcomes.

The survey questions and responses are shown below.

Q1 Please select all that apply. If you noticed a family member or neighbor having a hard time keeping up with daily activities, where would you turn for helpful information about in-home support services?

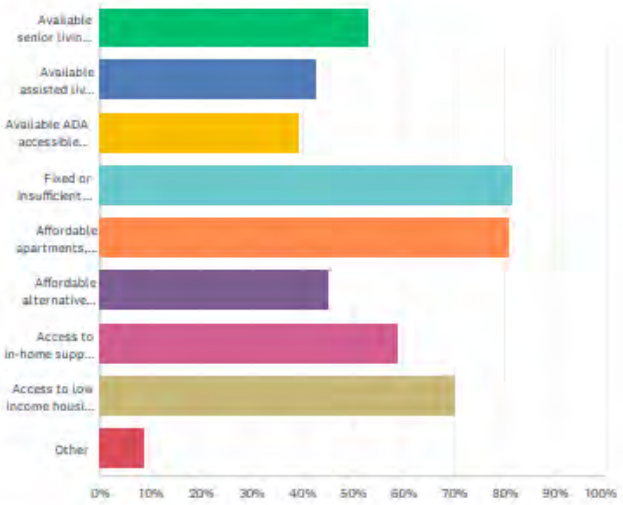
Answered: 114 Skipped: 1



ANSWER CHOICES	RESPONSES	
Social media (ex. Facebook)	23.68%	27
Family members and friends	60.53%	69
Television	10.53%	12
Radio	5.26%	6
Internet search	83.33%	95
Newspaper (print)	7.02%	8
Newspaper (online)	4.39%	5
Physician / Doctors' offices	51.75%	59
Community centers	32.46%	37
Library	14.91%	17
Phone Book	1.75%	2
The Fig Tree	19.30%	22
The Senior Resource Guide	49.12%	56
Billboards	5.26%	6
Other	15.79%	18
Total Respondents: 114		

Q2 Please select all that apply. What do you see as the greatest barriers for older adults and people living with disabilities who struggle to find safe and reliable housing?

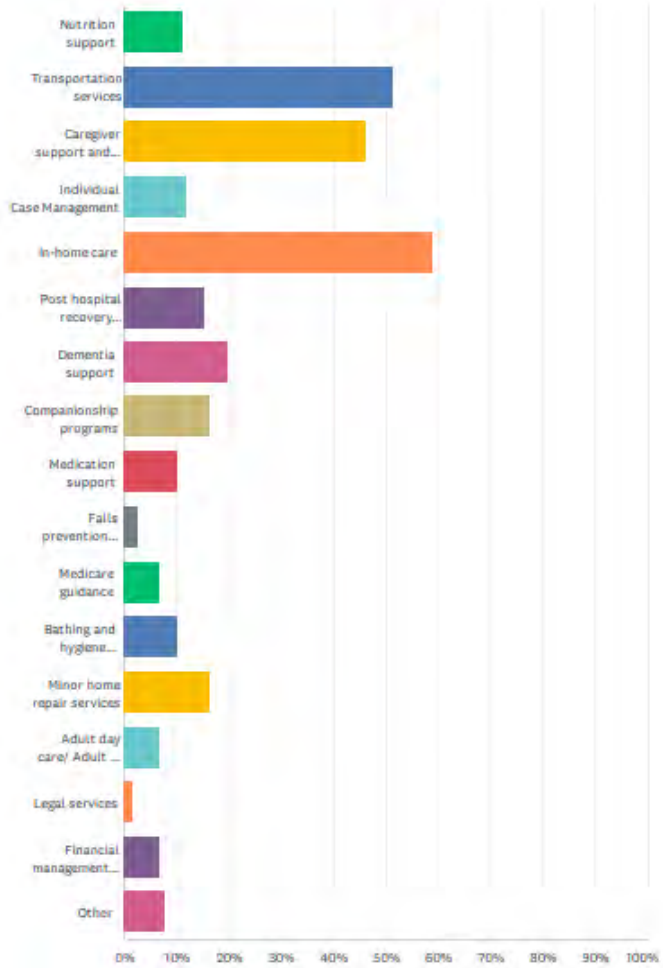
Answered: 115 Skipped: 2



ANSWER CHOICES	RESPONSES	
Available senior living complexes	53.04%	61
Available assisted living housing	42.61%	49
Available ADA accessible housing	39.13%	45
Fixed or insufficient incomes	81.74%	94
Affordable apartments, condos, houses	80.87%	93
Affordable alternative housing (such as tiny homes, micro-units, and mobile homes)	45.22%	52
Access to in-home support services	59.13%	68
Access to low income housing programs	70.43%	81
Other	8.70%	10
Total Respondents: 115		

Q3 What are the top 3 needs regarding In-Home Care Services for people living with disabilities and older adults?

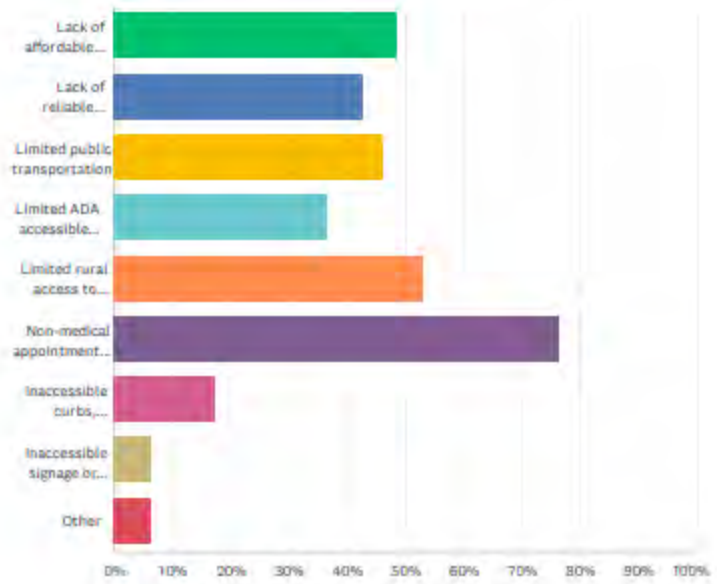
Answered: 117 Skipped: 0



ANSWER CHOICES	RESPONSES	
Nutrition support	11.11%	13
Transportation services	51.28%	60
Caregiver support and respite care services	46.15%	54
Individual Case Management	11.97%	14
In-home care	58.97%	69
Post hospital recovery services	15.38%	18
Dementia support	19.66%	23
Companionship programs	16.24%	19
Medication support	10.26%	12
Falls prevention education and classes	2.56%	3
Medicare guidance	6.84%	8
Bathing and hygiene services	10.26%	12
Minor home repair services	16.24%	19
Adult day care/ Adult day services	6.84%	8
Legal services	1.71%	2
Financial management services	6.84%	8
Other	7.69%	9
Total Respondents: 117		

Q4 Please select all that apply. What are the most significant barriers for transportation in your community? (For ex. the greatest transportation challenges you or a loved one face when unable to drive to appointments, pick up prescriptions, or run errands).

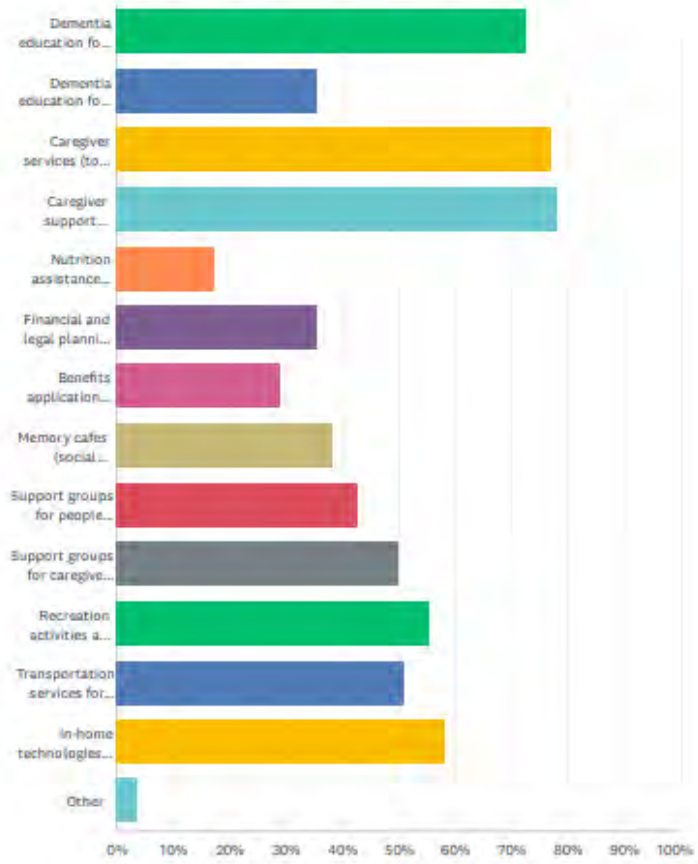
Answered: 115 Skipped: 2



ANSWER CHOICES	RESPONSES	
Lack of affordable transportation	48.70%	56
Lack of reliable transportation	42.61%	49
Limited public transportation	46.09%	53
Limited ADA accessible transportation with proper vehicle design	36.52%	42
Limited rural access to transportation services	53.04%	61
Non-medical appointment transportation options	76.52%	88
Inaccessible curbs, crosswalks, or other architectural factors when taking public transportation	17.39%	20
Inaccessible signage or other communication barriers	6.09%	7
Other	6.09%	7
Total Respondents: 115		

Q5 Please select all that apply. If you or a loved one are impacted by memory loss such as Alzheimer's or dementia, what supports could help this individual remain in the home longer?

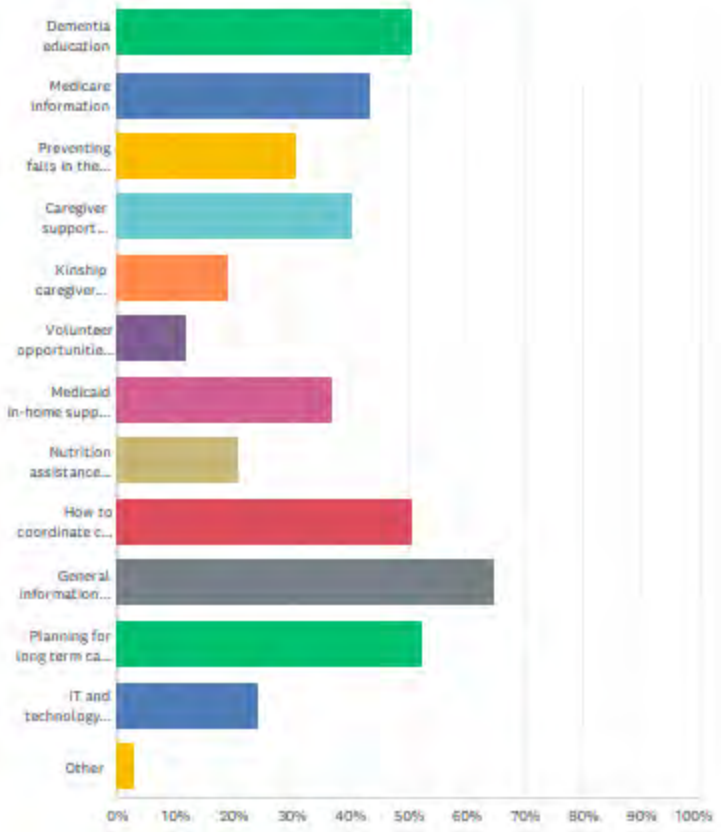
Answered: 110 Skipped: 7



ANSWER CHOICES	RESPONSES	
Dementia education for caregivers or family members	72.73%	80
Dementia education for the person living with memory loss	35.45%	39
Caregiver services (to provide in-home support services for the person living with memory loss)	77.27%	85
Caregiver support services (such as respite and adult day services to relieve caregivers for periods of time)	78.18%	86
Nutrition assistance programs	17.27%	19
Financial and legal planning services	35.45%	39
Benefits application assistance	29.09%	32
Memory cafes (social gatherings that allow people experiencing memory loss and loved ones to connect)	38.18%	42
Support groups for people living with memory loss	42.73%	47
Support groups for caregivers and family members	50.00%	55
Recreation activities and safe spaces for people living with memory loss	55.45%	61
Transportation services for people with memory loss	50.91%	56
In-home technologies with dementia support applications (such as medic alert, apple watches that remind you to take your medication, etc.)	58.18%	64
Other	3.64%	4
Total Respondents: 110		

Q6 Please select all that apply. Which of the following presentations would you consider attending?

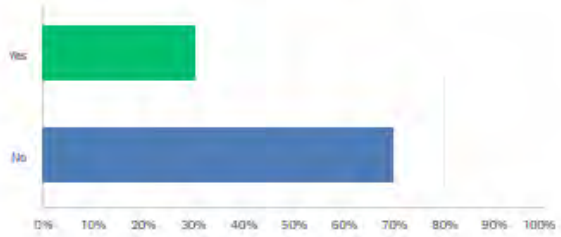
Answered: 111 Skipped: 8



ANSWER CHOICES	RESPONSES	
Dementia education	50.45%	56
Medicare information	43.24%	48
Preventing falls in the home and community	30.63%	34
Caregiver support services	40.54%	45
Kinship caregiver support services (for relatives raising grandchildren, or children of other family members)	18.92%	21
Volunteer opportunities with Aging & Long Term Care	11.71%	13
Medicaid in-home support services	36.94%	41
Nutrition assistance services	20.72%	23
How to coordinate care for yourself or a loved one	50.45%	56
General information about support services in the home and community	64.86%	72
Planning for long term care needs	52.25%	58
IT and technology support	24.32%	27
Other	2.70%	3
Total Respondents: 111		

Q8 Are you a caregiver? (Mark yes if paid, unpaid, or consider yourself a family caregiver)

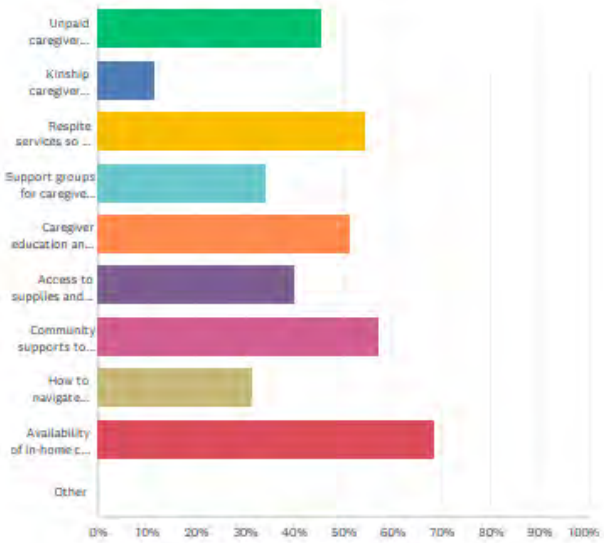
Answered: 116 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	30.17%	35
No	69.83%	81
TOTAL		116

Q9 Please select all that apply. What gaps do you see regarding supports in the home and community for caregivers?

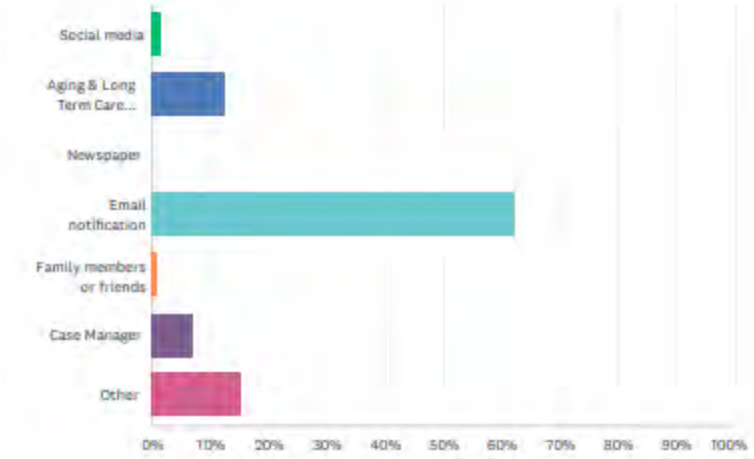
Answered: 35 Skipped: 82



ANSWER CHOICES	RESPONSES	
Unpaid caregiver support services	45.71%	16
Kinship caregiver support services (for relatives raising grandchildren, or children of other family members)	11.43%	4
Respite services so you can take a break (such as Adult day care/ Adult day services)	54.29%	19
Support groups for caregivers and family members	34.29%	12
Caregiver education and training courses	51.43%	18
Access to supplies and medical equipment	40.00%	14
Community supports to help reduce caregiver tasks (such as transportation, bathing, and nutrition services)	57.14%	20
How to navigate becoming a paid caregiver	31.43%	11
Availability of in-home care workers	68.57%	24
Other	0.00%	0
Total Respondents: 35		

Q11 How did you hear about this survey?

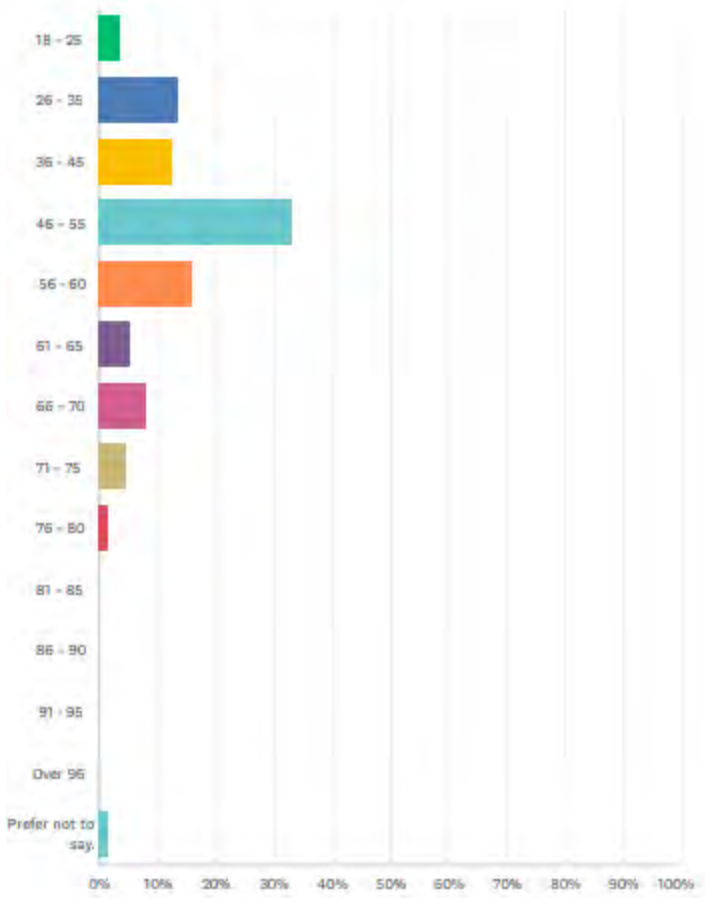
Answered: 112 Skipped: 5



ANSWER CHOICES	RESPONSES	
Social media	1.79%	2
Aging & Long Term Care website	12.50%	14
Newspaper	0.00%	0
Email notification	62.50%	70
Family members or friends	0.89%	1
Case Manager	7.14%	8
Other	15.18%	17
TOTAL		112

Q12 What is your age?

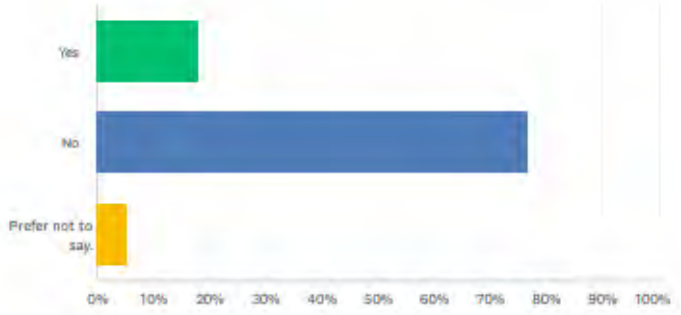
Answered: 112 Skipped: 5



ANSWER CHOICES	RESPONSES	
18 - 25	3.57%	4
26 - 35	13.39%	15
36 - 45	12.50%	14
46 - 55	33.04%	37
56 - 60	16.07%	18
61 - 65	5.36%	6
66 - 70	8.04%	9
71 - 75	4.46%	5
76 - 80	1.79%	2
81 - 85	0.00%	0
86 - 90	0.00%	0
91 - 95	0.00%	0
Over 96	0.00%	0
Prefer not to say.	1.79%	2
TOTAL		112

Q13 Are you a person living with a disability?

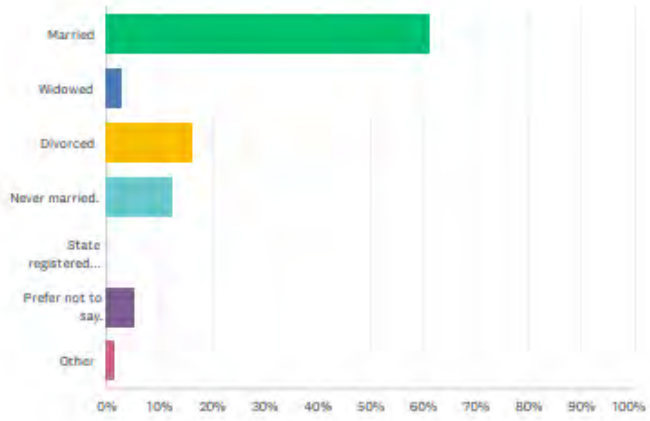
Answered: 112 Skipped: 5



ANSWER CHOICES	RESPONSES	
Yes	17.86%	20
No	76.79%	86
Prefer not to say.	5.36%	6
TOTAL		112

Q14 What is your marital status?

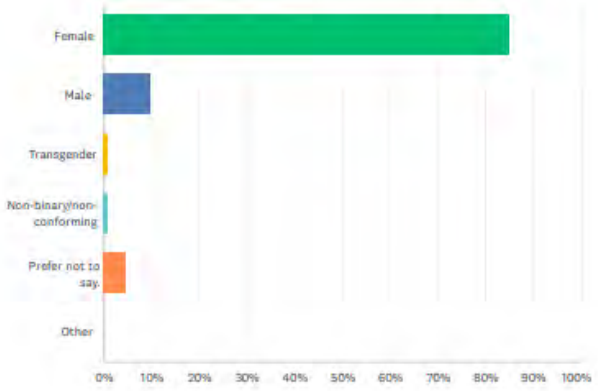
Answered: 111 Skipped: 6



ANSWER CHOICES	RESPONSES	
Married	61.26%	68
Widowed	2.70%	3
Divorced	16.22%	18
Never married.	12.61%	14
State registered domestic partnership.	0.00%	0
Prefer not to say.	5.41%	6
Other	1.80%	2
TOTAL		111

Q15 Please select all that apply. What is your gender?

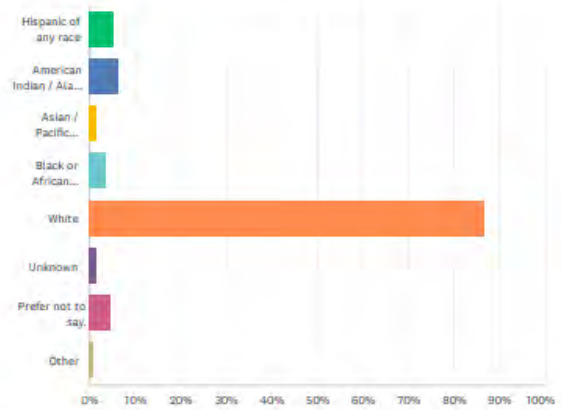
Answered: 113 Skipped: 4



ANSWER CHOICES	RESPONSES	
Female	84.96%	96
Male	9.73%	11
Transgender	0.88%	1
Non-binary/non-conforming	0.88%	1
Prefer not to say.	4.42%	5
Other	0.00%	0
Total Respondents: 113		

Q16 Please select all that apply. Which race or ethnicity best describes you?

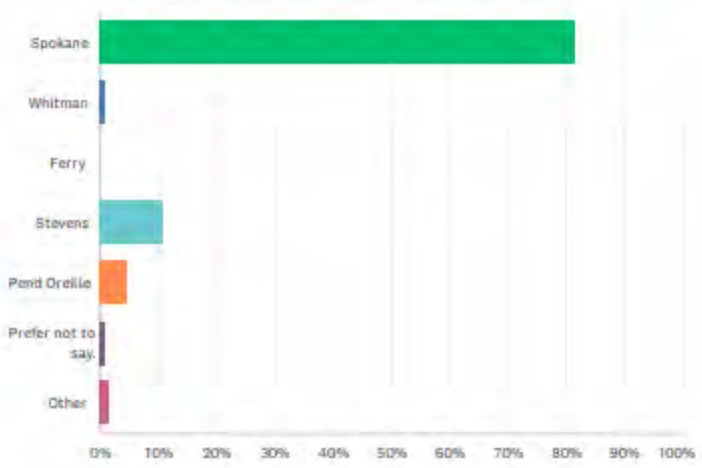
Answered: 113 Skipped: 4



ANSWER CHOICES	RESPONSES	
Hispanic of any race	5.31%	6
American Indian / Alaska Native	6.19%	7
Asian / Pacific Islander	1.77%	2
Black or African American	3.54%	4
White	86.73%	98
Unknown	1.77%	2
Prefer not to say.	4.42%	5
Other	0.88%	1
Total Respondents: 113		

Q17 What county do you live in?

Answered: 113 Skipped: 4



ANSWER CHOICES	RESPONSES	
Spokane	81.42%	92
Whitman	0.88%	1
Ferry	0.00%	0
Stevens	10.62%	12
Pend Oreille	4.42%	5
Prefer not to say.	0.88%	1
Other	1.77%	2
TOTAL		113

Aging & Long Term Care of Eastern Washington
Area Plan 2024-2027

Public Hearing Meeting Notice

The following notice was places in the Spokesman Review notifying the public of the Public Hearing. Similar notices were placed in The Selkirk Sun, and The Chewelah Independent.

Date:

To: The Spokesman Review

From: Aging & Long Term Care of Eastern Washington

RE: Public Hearing

Public Hearing Notice

Aging & Long Term Care of Eastern Washington (ALTCEW) is holding a Public Hearing to receive comments on the proposed 2024-2027 Area Plan and budget for providing services in Ferry, Stevens, Pend Oreille, Spokane and Whitman counties.

The hearing will be held on July 7th, 2023 at the Martin Luther King Center, 500 S Stone St, Spokane, WA 99202 from 2-3pm.

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

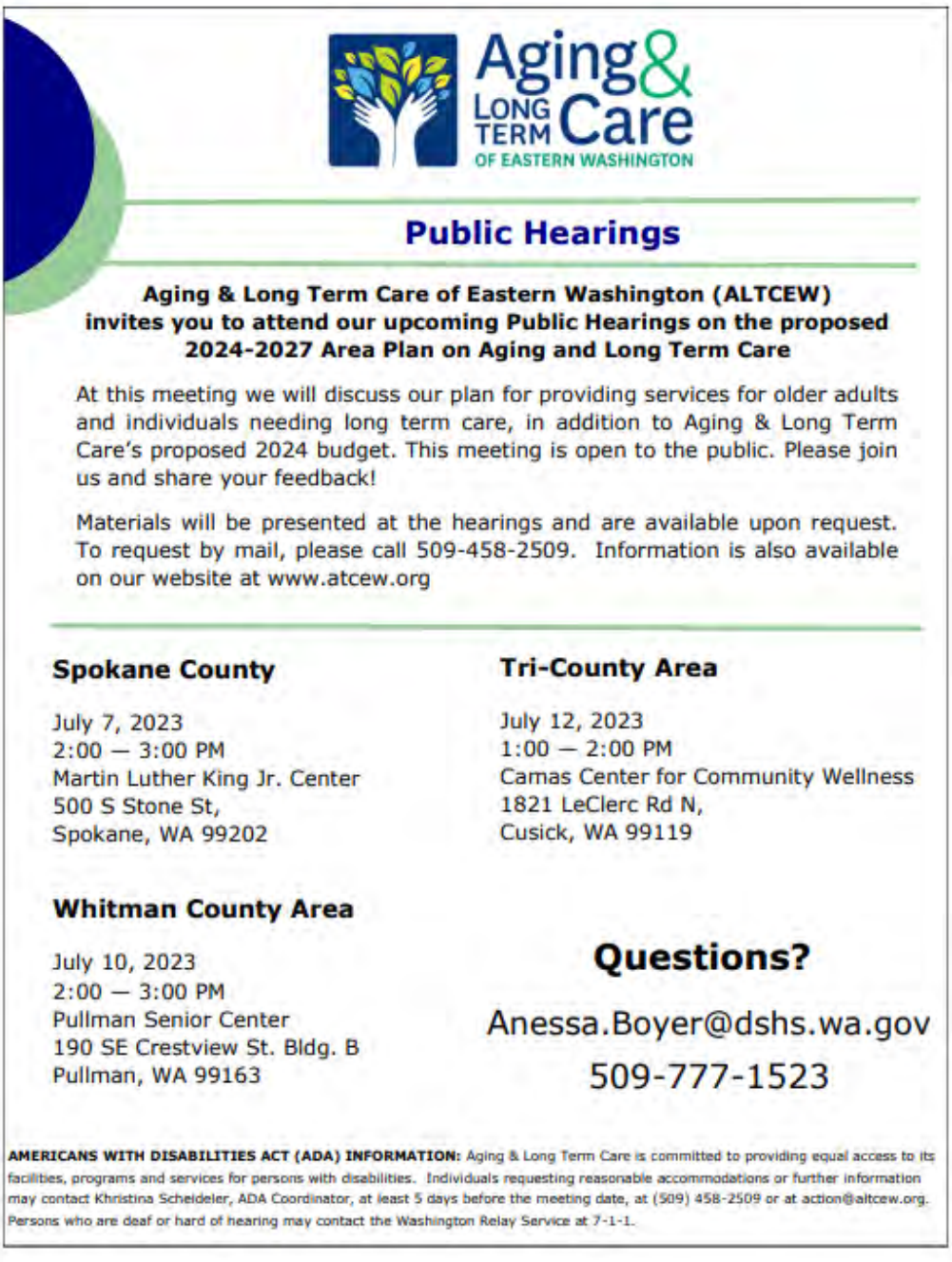
Please send any request for reimbursement to the individual and address listed below:

Attention: Erin Williams, Accounts and Contracting Director
Aging & Long Term Care of Eastern Washington
1222 North Post Street
Spokane, WA 99201

Aging & Long Term Care of Eastern Washington
Area Plan 2024-2027

Public Hearing Meeting Flyer

The Public Hearing Flyer below was distributed to those attending hearings as well as with community partners.



Aging & Long Term Care of Eastern Washington

Public Hearings

Aging & Long Term Care of Eastern Washington (ALTCEW) invites you to attend our upcoming Public Hearings on the proposed 2024-2027 Area Plan on Aging and Long Term Care

At this meeting we will discuss our plan for providing services for older adults and individuals needing long term care, in addition to Aging & Long Term Care's proposed 2024 budget. This meeting is open to the public. Please join us and share your feedback!

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

Spokane County

July 7, 2023
2:00 — 3:00 PM
Martin Luther King Jr. Center
500 S Stone St,
Spokane, WA 99202

Tri-County Area

July 12, 2023
1:00 — 2:00 PM
Camas Center for Community Wellness
1821 LeClerc Rd N,
Cusick, WA 99119

Whitman County Area

July 10, 2023
2:00 — 3:00 PM
Pullman Senior Center
190 SE Crestview St. Bldg. B
Pullman, WA 99163

Questions?

Anessa.Boyer@dshs.wa.gov

509-777-1523

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

APPENDIX F – REPORT ON ACCOMPLISHMENTS

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. To continue to address the needs of individuals in our service area during the planning period of 2020 - 2023, ALTCEW will focus on the following Older American Act and Statewide Issue Areas:

Aging & Long Term Care of Eastern Washington

REPORT ON ACCOMPLISHMENTS FOR THE 2020 – 2023 AREA PLAN

Aging & Long Term Care of Eastern Washington (ALTCEW) has accomplished the following work from the 2020-2023 Area Plan:

ISSUE AREA: Healthy Aging

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

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

Outcome: Expanded the number of MOB coaches and host sites, thus also expanding the reach of MOB class offerings to a larger number of participants and supporting further wellness options for older persons and individuals living with disabilities.

Accomplishments: As the COVID-19 pandemic closures took effect during March 2020, multiple "A Matter of Balance" in-person classes were suspended. Additionally, the MOB coach trainings were suspended, and numerous coach candidates were notified of this suspension.

During the pandemic closures, ALTCEW Falls Prevention staff used virtual platforms to train one internal staff member and one community volunteer in FallsTalk. This evidence-based Falls Prevention program is for individuals that can be conducted entirely over the telephone. Program implementation began in October 2020.

In the winter months of 2021, ALTCEW Falls Prevention staff were trained in a recently approved virtual platform, A Matter of Balance Virtual (MOBV). The first virtual classes were held in May and the second series in September 2021.

In 2022, two more virtual classes were held in January and April. Following the retirements of previous Falls Prevention staff and the Planning Director, two new staff members were hired and trained as Master Trainers for MOB. In addition, the first two in-person MOB classes were held in August and October of 2022.

In 2023, volunteer recruitment and coach trainings resumed. Four Eastern Washington University students completed the virtual MOB training in January. In February and April of 2023, coach trainings were held for a total of twenty volunteers. In March, the program expanded to Republic in Ferry County, where four volunteers were trained. In May, three additional coaches were trained in Ferry County. The two new Falls Prevention staff also finishing their training in FallsTalk and FallsTalk-C.

With the newly hired staff relaunched, the MOB in-person classes resumed in January of 2023, with one virtual class offered in May. During this time, seven in-person classes were completed, with a record-setting total of 75 participants who received certificates of attendance. In June, three more classes began, including one in Ferry County. Another coach training was scheduled for mid-June in Whitman County, with at least four new volunteers. Additional classes are planned throughout Spokane, Ferry, Stevens, Pend Oreille, and Whitman counties for the remainder of 2023, with an estimated 150 graduates and over 50 volunteer coaches trained before the end of December 2023.

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

Outcome: Additional funding for the SFMNP was supported by ALTCEW decision-making entities and the program reach was expanded through enhanced marketing processes.

Accomplishments: ALTCEW staff have worked with the agency's Planning and Management Council (PMC) and Governing Board to allocate additional funding each year to SFMNP, in order to expand the number of vouchers available for purchase. Each year, they have endorsed putting the agency's admin allocation priority toward voucher purchases, as well as allocating additional Senior Citizens Service Act (SCSA) funds.

As newspaper advertising increased in pricing with less impact, we modernized our messaging around the SFMNP in all five counties. This included integrated website messaging, additions to virtual newsletters, and placing notices on Facebook and other social media platforms.

Running messaging in targeted minority publications and neighborhoods has been effective using the translated affidavits and brochures.

Spokane County program contractors distributed SFMNP brochures in English and additional copies that were translated into several languages for community housing complexes, specifically targeting the complex's Social Worker(s) (where applicable). We also observed that the information was shared widely in aging and low-income neighborhoods through word of mouth. Spokane County SFMNP staff began to received phone calls about the program well before vouchers were available. SFMNP staff indicated that early interest tended to come from the Russian/Slavic communities.

In 2022, the amount of benefit per client increased from $40 to $80 for State-funded benefits. Spokane County had far more applicants than anticipated based on their allocation of checks and had to wait-list clients. Unused checks from Tri-County were reallocated to Spokane County, which served these additional participants. Spokane County SFMNP staff received phone calls about the program well before vouchers are available, and throughout the entire voucher season.

Messaging about SFMNP included a dedicated page on the ALTCEW website and an SFMNP hotline where callers can phone in to hear recorded information on the program.

In 2023, the program transitioned from paper vouchers ("checks") to an electronic benefit card." and the standard benefit stayed at $80 for 2023.

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

Outcome: The health and wellbeing of older adults and individuals living with disabilities has improved through an increased array of options for affordable semi-permanent and permanent housing options.

Accomplishments: ALTCEW had expanded housing advocacy participation throughout the plan period, with the goal of highlighting the need for affordable and accessible housing for older adults and individuals living with disabilities. This work has been both through advocacy and

planning work, as well as by supporting programs and models that support tenancy and gaps in the housing process.

ALTCEW staff partnered with local organizations working on housing advocacy and coordination issues. During this period, that has included participation in the Continuum of Care Council for Community Housing and Human Services in Spokane County, participation in an Affordable Housing Workgroup of the Accountable Communities of Health Spokane Collaborative, participation as a member of the Spokane Low Income Housing Consortium, participation in the Resident Action Project run by the Washington Low Income Housing Alliance, and participation in the Homeless Coalition. ALTCEW participated in planning sessions for revisions to the City of Spokane's Compressive Plan. ALTCEW staff also provide leadership and support to organizing the Spokane Homeless Connect, participated in the Spokane Valley Connect, and supported our clients temporarily residing at Camp Hope, to help unhoused community members connect with agency services and supports.

ALTCEW has evolved programs and supports beyond providing supportive housing, in order to target gaps impacting seniors. The agency funded a staff position at Catholic Charities of Eastern Washington that provided support for seniors in accessing coordinated entry and homelessness diversion resources. The agency also provides support for rental assistance applications and utilities debt assistance programs through the Community Living Connections (CLC) HelpLine. Many of these assistance programs prioritized online applications, and CLC is able to facilitate access to this assistance that can maintain housing by gathering application information over the phone. In addition, CLC hired two Options Counselors that specialize in housing supports and link clients to community programs, coordinate entry, and maintain specialized knowledge of local housing resources. ALTCEW applied for and received one housing voucher per month in partnership with the Spokane Housing Authority, which is used to assist clients served by CLC and Supportive Housing programs in securing housing.

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

Outcome: Transportation barriers and gaps experienced by ALTCEW clients were identified and solutions were advocated for through staff participation in coalitions and committees within the ALTCEW service area.

Accomplishments: The agency's Planning & Resource Director served until 2022 on the Transportation Advisory Council of the Spokane Regional Transit Council, the agency designated

as a Metropolitan Planning Organization at the federal level, and a Regional Transportation Planning Organization by state law; as well as the Spokane Transportation Collaborative, a collaborative advocating for an accessible, coordinated system to improve mobility options for health and wellbeing in Spokane County. ALTCEW staff regularly participate in opportunities to serve, offer resources to, and advocate for any coalition that addresses the needs of our service region.

ISSUE AREA: Mental Health and Aging

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

Objective A: Between January 1, 2020, and December 31, 2023, ALTCEW will collaborate and promote partnership with the Alzheimer's Association Spokane office and additional community partners to offer "Staying Connected," an "Early Stage Memory Loss" for individuals with early-stage memory loss and their care partners.

Outcome: Individuals with early-stage memory loss and their care partners are supported as they begin to travel the radically altered journey of memory loss.

Accomplishments: ALTCEW contracted with the Alzheimer's Association to offer classes, provide meeting space for in-person meetings, and promote the classes. Community education classes on early diagnosis, support groups (including "Memory Café's"), and community forums were offered by the Alzheimer's Association in Spokane, Stevens, and Whitman Counties.

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

Outcome: The Spokane Area Dementia Friendly Community collaboration is advanced through active leadership and facilitation by ALTCEW staff and volunteers through active community engagement.

Accomplishments: ALTCEW has provided staff leadership for the Spokane Area Dementia Friendly Community project through our Dementia Capable Grant. Highlights during the period under consideration include:

- Facilitated contracting with a consultant from the National Association of Area Agencies on Aging to provide support for the formation of a local Action Team and development of next steps. ALTCEW staff wrote a successful proposal with a local funder to underwrite costs.
- Provided support for building structures and processes necessary to receive designation as a Dementia Friendly Community.
- Provided facilitation and support for the development of a community needs assessment survey, as well as compilation and analysis of the survey data.

- Provided leadership for a process of taking the community needs assessment survey results to the community for public comment.
- Facilitated ongoing work towards the Dementia Friendly Community Plan and leveraged efforts to support goals of the Dementia Action Catalyst program.
- Facilitated on-going work to support a Spokane County "Memory Garden" and a Spokane County Parks and Recreation "Dementia Exercise" program.
- Supported and guided the creation a series of professional "Dementia" development trainings for ALTCEW, Home and Community Services, Elder Services, Frontier Behavioral Health, and Hospital Systems located in Spokane County. These trainings included: 1) Early diagnosis 2) Dementia and communication 3) Preparing for the holidays 4) Preparing for an emergency 5) The 10 warning signs of dementia and 6) The journey of Alzheimer's.

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

Outcome: The mental health needs of older adults received greater attention because of coordination efforts with providers of mental health services and community educational events.

Accomplishments: ALTCEW advocated for access to mental health to be included in the USAging policy agendas. ALTCEW also provided American Rescue Plan (ARP) funding to Rural Resources Community Action to implement the Healthy Ideas program, which is designed to impact depressive symptoms in older adults and their caregivers. Additionally, the creation of the Check and Connect program, which connects homebound and isolated clients with a volunteer who contacts them by phone on a weekly basis, has greatly increased awareness of mental health needs and provided opportunities for intervention and referral.

ISSUE AREA: Community Based Supports

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

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

Outcome: Public awareness was enhanced regarding access to resources and information of the services available within the ALTCEW Service Area.

Accomplishments: Combining funding for Community Living Connections (CLC) and the Medicaid Transformation Demonstration (MTD) has allowed us to use a professional advertising agency to target messaging throughout our area. The results show in our increasing metrics in most programs. In anticipation of tighter funding in the future we are systematically leveraging less expensive media such as social media enhancements, getting a systematic brochure distribution process running post-COVID, and organizing "word of mouth" campaigns.

MTD and Family Caregiver Support Program (FCSP) staff at contractor agencies were diligent in screening potential caregivers/care receivers to ensure that they were offered the program(s) most applicable to their situation.

In addition to the work done by the professional advertising agency, the CLC department continually reached out and presented to different local community resources to create partnerships for referrals. The Department is responsible for a resource database, and consistently looks for new services to add that fill gaps in the community, so that staff can use the database to find appropriate referrals. The agency's social media and website also posted consistent and newsworthy information to increase awareness. Press releases for pandemic specific programs and resource assistance were also advertised to ensure the aging and disabled population had equitable access to financial resources for crisis assistance.

Additionally, there was a significant increase in the agency's social media following and reach through Facebook and LinkedIn, continued growth and reach of the website, and regular utilization of the website to share relevant news and information for the target audience. ALTCEW also created a biannual digital newsletter, which shares agency updates and resources.

In 2023 so far, three press releases had been sent to newspapers and picked up for publishing. The releases were about the agency's Area Plan Community Forum, Volunteer Recruitment, and National Volunteer Month. In 2022, several press releases were picked as a result of our efforts.

Objective B: Between January 1, 2020, and December 31, 2023, for Community Living Connections, ALTCEW will conduct quality assurance cycles that examine and improve 1) content of electronic resource directory, 2) services to provide information and referral, and 3) services to provide options counseling.

Outcome: Improvements are documented for CLC's electronic resource directory, services to provide information and referral, and services to provide options counseling.

Accomplishments: The CLC resource directory continued to be updated monthly, with listings checked for accuracy and additions. Staff regularly communicated with ALTSA for needed improvements. Quality assurance (QA) checks were conducted weekly by the QA lead for accurate provision of Information and Referral services, and monthly by the CLC Director to ensure accountability and accuracy. Options counseling followed the same QA schedule, and 5% of all calls received engaged in a satisfaction survey to ensure quality customer service.

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

Outcome: Medicare and Medicaid beneficiaries were provided benefits counseling and enrollment assistances, and low-income individuals were assisted with the application process for other types of cost-saving benefits.

Accomplishments: Statewide Health Insurance Benefits Advisors (SHIBA) staff and counselors assisted clients in four counties to enroll and counsel for Medicare coverage needs. Benefits Enrollment Specialists were trained to assist Medicaid callers with insurance navigation and supplemental application assistance. They also assisted with property exemption applications and rental/utility assistance applications.

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

Outcome: Community members were discharged from the hospital to home successfully as the result of collaborative efforts of multiple partners.

Accomplishments: ALTCEW staff participated in quarterly meetings with Managed Care Organizations, Acute Hospital Social Work Unit Supervisors, Home and Community Services, and

the Developmental Disabilities Administration to collaborate on clients in acute hospital settings regarding long length of stays, discharge needs, and medication assistance at home. In 2022, ALTCEW received a combination of Administration for Community Living and State funds to start providing Care Transitions, helping older adults transition from hospital to home. ALTCEW worked directly with Providence and MultiCare to help older adults successfully transition to the community and help prevent re-hospitalization.

In addition, ALTCEW designed and piloted the Advanced Medication Management Program in partnership with Rural Resources Community Action, Empire Health Foundation, Washington State University, and the Alliance for Medication Management. The agency was able to integrate Advanced Medication Management services into the Care Transitions program, as a complementary service. The Advanced Medication Management Program was the second-place recipient of the 2022 USAging Innovations Award. The program was on track to graduate 200 clients before the end of the grant contracted timeline and will be arranging a demonstration project to explore cost savings created by the intervention.

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

Outcome: ALTCEW subcontractors assisted in promoting the Family Caregiver Support Program and the Medicaid Transformation Demonstration (MAC and TSOA).

Accomplishments: As mentioned above, a robust media campaign and active outreach designed to get clients to make the first call for help through CLC was very effective. Options Counselors are great navigators in explaining the various options available for in-home services and had been key to linking individuals to all caregiver support programs.

ALTCEW's CLC department assisted with the promotion of all contracted programs and events, ensuring local providers were informed and referrals were received. Information and Referral staff were kept up to date so they could offer access to services immediately upon availability to the public.

ISSUE AREA: Medicaid Supported Services

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

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

Outcome: Community members were able to navigate community transitions successfully as the result of collaborative efforts between multiple community partners.

Accomplishments: As mentioned above, ALTCEW staff attended quarterly meetings with Managed Care Organizations, Acute Hospital Social Work Unit Supervisors, Home and Community Services, and the Developmental Disabilities Administration to collaborate on how to best serve clients in the acute hospital with long length of stays or needing discharge assistance to get back home.

ALTCEW also participated in regular meetings to coordinate and collaborate on Behavioral Health Personal Care, Governor's Opportunity for Supported Housing (GOSH), Veteran's Directed Services, and the Program for All Inclusive Care of the Elderly (PACE). The focus of these meetings was to improve client care, ensure regular communication with partnering providers, and help facilitate coordinated transitions of care.

In addition, ALTCEW staff met quarterly with the Home and Community Services Regional Administrator and the Adult Protective Services' Regional Administrator to coordinate and communicate updates to services.

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

Outcome: Community members have increased access to local behavioral health providers.

Accomplishments: ALTCEW continued to help clients link with appropriate local behavioral health providers, as well as connect to other providers via telehealth. The Consolidated Appropriations Act, which passed Congress in 2022, allowed for an expansion of Medicare-covered providers to include marriage and family therapists and licensed mental health counseling, which will greatly help older adults find mental health treatment through their Medicare benefit.

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

Outcome: Access to translation services has been enhanced to support communication, including languages encountered less frequently.

Accomplishments: ALTCEW created a Diversity, Equity, and Inclusion (DEI) committee in 2021 to address needed improvements in internal agency structure, as well as gaps in service due to language barrier issues. The committee worked to revise policy around hiring practices to increase staff language and cultural diversity. Information being distributed by DSHS (utilized by ALTCTEW staff) was available in many languages and the DEI committee will continue to review ALTCEW-specific documents that may need translated into the most commonly needed languages for our local area. The language and TTY (teletypewriters) line was made available to assist staff with communication, and clients were paired with any staff that may be able to communicate in their native language to assist with engagement. In addition, the agency updated its website to provide accessibility options and added a translation option so that it could be accessed in 20 different languages. The ALTCEW general brochure, CLC brochure, and the ALTCEW Informer newsletter were translated to Spanish and Russian. A Matter of Balance brochures were also translated, with the goal of eventually being able to offer classes in other languages as new volunteers are recruited and trained. ALTCEW participated in the creation and distribution of the Washington State "Dementia Road Map", which was also translated into Russian and Spanish in June of 2023. ALTCEW had increased outreach to Russian- and Spanish-speaking communities by running translated ads in the Spokane Russian newspaper, La Latina magazine, and La Prensa newspaper.

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

Outcome: Title XIX Case Managers receive necessary mental health training to equip them to effectively meet the needs of their clients.

Accomplishments: The agency has worked to secure Mental Health First Aid training for staff and has provided verbal de-escalation and crisis intervention training as well.

Objective E: Between January 1, 2020, and December 31, 2023, ALTCEW will continue with the expansion of the Health Home Program to include dual eligible, Medicaid/Medicare, and

Medicaid clients to reduce care costs and promote client wellness. Additionally, ALTCEW will increase its ability to refer to community and social supports, as new needs arise that are beyond the traditional Medicaid or Medicare benefit packages.

Outcome: The reach of the Health Home Program has expanded to include dual eligible, Medicaid/Medicare, and Medicaid clients, to reduce care costs and promote client wellness.

Accomplishments: Health Homes had increased client services from an average of 400 clients served per month in 2020 to an average of 500 in 2021. Part of the impact can be attributed to additional care coordination hours and COVID-19, as Care Coordinators were able to contact clients via Zoom or phone. Home visits resumed in 2022 and became the primary method of visit, except when directed by the client. In 2022, an additional supervisor was added to assist with day-to-day program management and ensure quality services were being delivered timely. Each care coordinator was able to provide quality services to an average of 60 individuals per month.

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

Outcome: Supportive Housing clients were supported with resources to prepare and transition to housing and to maintain tenancy in Spokane County. Supportive housing specialists worked with several community agencies for apartment vacancy updates, heating needs, rent subsidies, responsible renters training, transportation needs, etc.

Accomplishments: Supportive Housing had grown from serving an average of 40 clients per month to 120 clients per month. An additional staff member was added to provide administrative support. Interns were utilized to assist in locating housing specific to client needs. A full-time community connecter was also added to assist with additional housing resources, funding sources, and auditing needs to ensure quality was achieved and maintained.

In 2022, the agency began offering Road to Renting classes for clients, in partnership with Spokane Housing Authority. Staff participated in regular trainings to stay up to date on skills and housing resources. In addition, staff had been active participants in local housing symposiums, coalitions, and outreach events.

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

Outcome: Access to planned and coordinated care has been ensured for older adults and individuals with disabilities.

Accomplishments: The agency's Planning and Management Council (PMC) participated in state-level advocacy to support funding for Title XIX Case Management. The PMC participated in activities in partnership with the Washington Association of Area Agencies on Aging (W4A). As a result of this advocacy, in 2020 the state legislature appropriated a $2.939 million increase at the statewide level for Case Management to work with individuals with significant mental illness, and $4.685 million for Service Summary Signature implementation. In 2021, additional advocacy resulted in one-time funding statewide to Area Agencies on Aging of $7.58 million to offset cost impacts associated with COVID-19. Advocacy in 2022 resulted in historic increases to sustain the Case Management program for years to come, including $24 million for rate parity, as well as additional funding to decrease caseloads to 75 clients per case manager. The 2023 session resulted in $2.4 million in rate adjustments for inclusion in the maintenance level of future budgets.

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

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

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

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

Accomplishments: Throughout the plan period, ALTCEW regularly met with the Confederated Tribes of the Colville Reservation, the Kalispel Tribe of Indians, and the Spokane Tribe of Indians to update the 7.01 Plans. ALTCEW also offered to create 7.01 Coordination Plans with the NATIVE Project and the American Indian Community Center. In May of 2023 ALTCEW signed a Business Agreement with The NATIVE Project creating opportunities to provide supportive programs and services to the aging and disabled Native Populations served by The NATIVE Project.

Issue Area: COVID-19 Response Services and Supports

GOAL: ALTCEW will support and expand access to resources, supports, services, and service delivery for older adults and adults living with disabilities, utilizing approaches that meet COVID-19 safety protocols.

Objective A: Between January 1, 2020, and December 31, 2023, ALTCEW will plan for and implement the resumption of in-person services, in alignment with guidance from the Aging and Long Term Support Administration (ALTSA) and the Spokane Regional Health District.

Outcome: ALTCEW resumed in-person services safely and in alignment with health and program guidance.

Accomplishments: The agency worked with each internal program and subcontracted provider to determine individual program requirements for returning to in-person services. This included developing masking and safety procedures for offices, as well as developing in-home visit procedures for staff. ALTCEW provided COVID-19 safety kits and tests for any ALTCEW employee as needed to ensure an extra level of protection. All programs returned to in-person services in 2022.

Objective B: Between January 1, 2020, and December 31, 2023, ALTCEW will plan for and implement vaccination education and outreach to program participants and the larger older adult community and people living with disabilities.

Outcome: Increased community awareness of the importance of vaccination and increased vaccination rates for older adults and caregivers.

Accomplishments: In 2021, ALTCEW provided vaccine outreach to clients and caregivers of the Case Management program, including coordination with local health departments to facilitate in-home vaccination for homebound clients. ALTCEW provided regular outreach and education to clients and caregivers about COVID-19 vaccinations, mailed information about the vaccines, and assisted with scheduling vaccine appointments. The agency website was kept up to date with relevant vaccine information, as ways to arrange vaccine appointments evolved over time and became more available. In addition, CLC provided regular information and access assistance for callers trying to connect to a vaccine appointment and provided a critical link for clients without technology that needed to make appointments.

Objective C: Between January 1, 2020, and December 31, 2023, ALTCEW will plan for and implement programs and supports to address social isolation and gaps in services for older adults and adults living with disabilities.

Outcome: Increased connection and support for isolated and/or homebound older adults.

Accomplishments: The agency developed and implemented the "Check and Connect" Program in response to the need to connect with isolated, vulnerable adults during the pandemic. The agency recruited volunteers and provided staffing to make weekly reassurance calls and provide a point of connection to CLC services if needs were discovered during the calls. The "Check and Connect" program was able to partner with community organizations such as Greater Spokane County Meals on Wheels and local health care partners, to identify those with potential isolation needs. The clients were then paired with a volunteer to speak with weekly, thus reducing social isolation and identifying needs before they reach crisis level.

ALTCEW Staff Members at PRIDE 2023

APPENDIX G - STATEMENT OF ASSURANCES AND VERIFICATION OF INTENT

For the period of January 1, 2024, through December 31, 2027, 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) (as amended through P.L. 116-131) 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 American 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.

1222 N. Post St. | Spokane, WA 99201 | TEL 509-458-2509 | FAX 509-458-2003
WWW.ALTCEW.ORG | ADVOCACY. ACTION. ANSWERS.
SERVING: Northern Ferry, Pend Oreille, Spokane, Stevens & Whitman counties

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

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

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

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

8/11/2023
Date

Lynn Kimball
Executive Director

8-11-2023
Date

Dan Mortensen
Chair, Planning and Management Council

8-11-2023
Date

Art Swannack
Chair, Governing Board