Aging & Adult Care of Central Washington
2024 – 2027 Area Plan

www.aaccw.org

E. Wenatchee Main Office
270 9th St. NE, Ste 100
East Wenatchee, WA 98802
509-886-0700
1-800-572-4459

Moses Lake Branch Office
1336 S. Pioneer Way Ste 103
Moses Lake, WA 98837
509-766-2568

Omak Branch Office
739 Haussler, Units A&B
Omak, WA 98841
509-826-7452

SECTION A

AREA AGENCY PLANNING AND PRIORITIES

Aging & Adult Care of Central Washington

Introduction

This is Aging & Adult Care of Central Washington's four-year (2024-2027) Area Plan. Accomplishments on the goals and objectives in the issue areas are addressed. The updated goals and plans for the next four years (2024-2027) including the 2024 projected budget are detailed.

Aging & Adult Care of Central Washington (AACCW) is an Area Agency on Aging (AAA) and is part of a network of 13 AAAs in Washington State. Under the Federal Older Americans Act, AACCW operates and serves a Public Service Area (PSA) that is comprised of Adams, Chelan, Douglas, Grant, Lincoln and Okanogan Counties (excluding the Colville Indian Reservation). AACCW's Policy Board is the Council of Governments (COG). One County Commissioner from each of the six sponsoring counties serves on the COG. The COG provides a local governing structure for AACCW by assuming responsibility for promoting the development and enhancement of a comprehensive and coordinated service system.

2023 Council of Governments

Adams County Commissioner – Mike Garza
Chelan County Commissioner – Kevin Overbay
Douglas County Commissioner – Marc Straub
Grant County Commissioner – Cindy Carter (Chair)
Lincoln County Commissioner – Rob Coffman
Okanogan County Commissioner – Chris Branch

Requirements for the AAAs include a primary responsibility for building a comprehensive, coordinated service delivery system that integrates, augments and supports the informal system. Services must take into account participants' views about the services they receive. An informal support system is the primary resource for meeting the needs of older persons and adults with functional disabilities.

AAA's requirements include establishing an Advisory Committee (AC) to advise on all matters related to developing, administering, planning, coordinating and operating community-based services. Advisory Committee members, five representatives from each of the six counties, serve as advocates, identify needs, and explain to the community the functions of and services available through AACCW. AACCW serves as an advocate and focal point for seniors, unpaid family caregivers and vulnerable adults with disabilities.

AACCW provides information and assistance, care transitions, case management, health home care coordination, kinship, and nurse consultation services directly, and contracts with non-profit/for profit companies to provide services that assist individuals to stay in their own home. Our Family Caregiver Support Program provides six core service components: Information Services, Access Assistance, Supplemental Services, Support Services, Respite Care Services and services to Grandparents and Relatives.

In April 2023, AACCW held five planning meetings to discuss services to seek input and identify unmet needs. One public hearing was held in August 2023 to gather additional information and comments on AACCW's four-year plan.

Questions or comments may be directed to Bruce Buckles, Executive Director at 1-800-572-4459.

MISSION

THE MISSION OF AGING & ADULT CARE OF CENTRAL WASHINGTON (AACCW) IS TO ENHANCE A PERSON'S ABILITY TO MAINTAIN A LIFE OF INDEPENDENCE AND CHOICE.

Aging & Adult Care of Central Washington provides assistance to aging adults, caregivers and persons with disabilities by providing them with information regarding resources and the opportunity to access services. AACCW strives to provide the fullest possible array of cost-effective home care and community-based services. The objective of these programs is to maintain individuals at the most appropriate (least restrictive) level of service and to minimize premature or unnecessary residential care placement.

Our mission will be achieved by coordinating with local, state, and national service providers, support groups, local and county governments, and consumer advocate groups to plan, promote and develop quality, non-duplicated, long-term care services on behalf of seniors and persons with disabilities age 18 and older.

VALUES

- AACCW values volunteerism as a crucial service to the community and clients, and as a rewarding activity for the individual volunteers. Advisory Committee members are volunteers that advocate for each of their individual communities as well as perform an essential role to plan for AACCW services. AACCW values and supports a variety of volunteer activities, groups and organizations including but not limited to the Alzheimer's Walk Committee, SHIBA, SAIL, and individuals that provide family caregiver support groups.

- AACCW values diversity. Bilingual staff members are employed to help non-English speaking consumers access services. Materials and service plans are translated into other languages as needed.

- AACCW values collaboration with others to help provide information and access to services to those with the greatest social, economic and health needs.

VISION

Our vision is that residents of Central Washington will receive services that enhance the quality of their lives and that we provide support that allows them to remain in the setting of their choice.

Planning and Review Process

In April of 2023, AACCW held five planning meetings (see Appendix E for dates and locations). An open process was used during the planning meetings. Invitations to the community planning meetings were publicized through newspapers, mailings, and flyers. Planning booklets were also mailed to interested individuals who were unable to attend the meetings. These planning booklets contained information about current services, service levels, and budgets. AACCW Advisory Committee members and COG members were encouraged to attend.

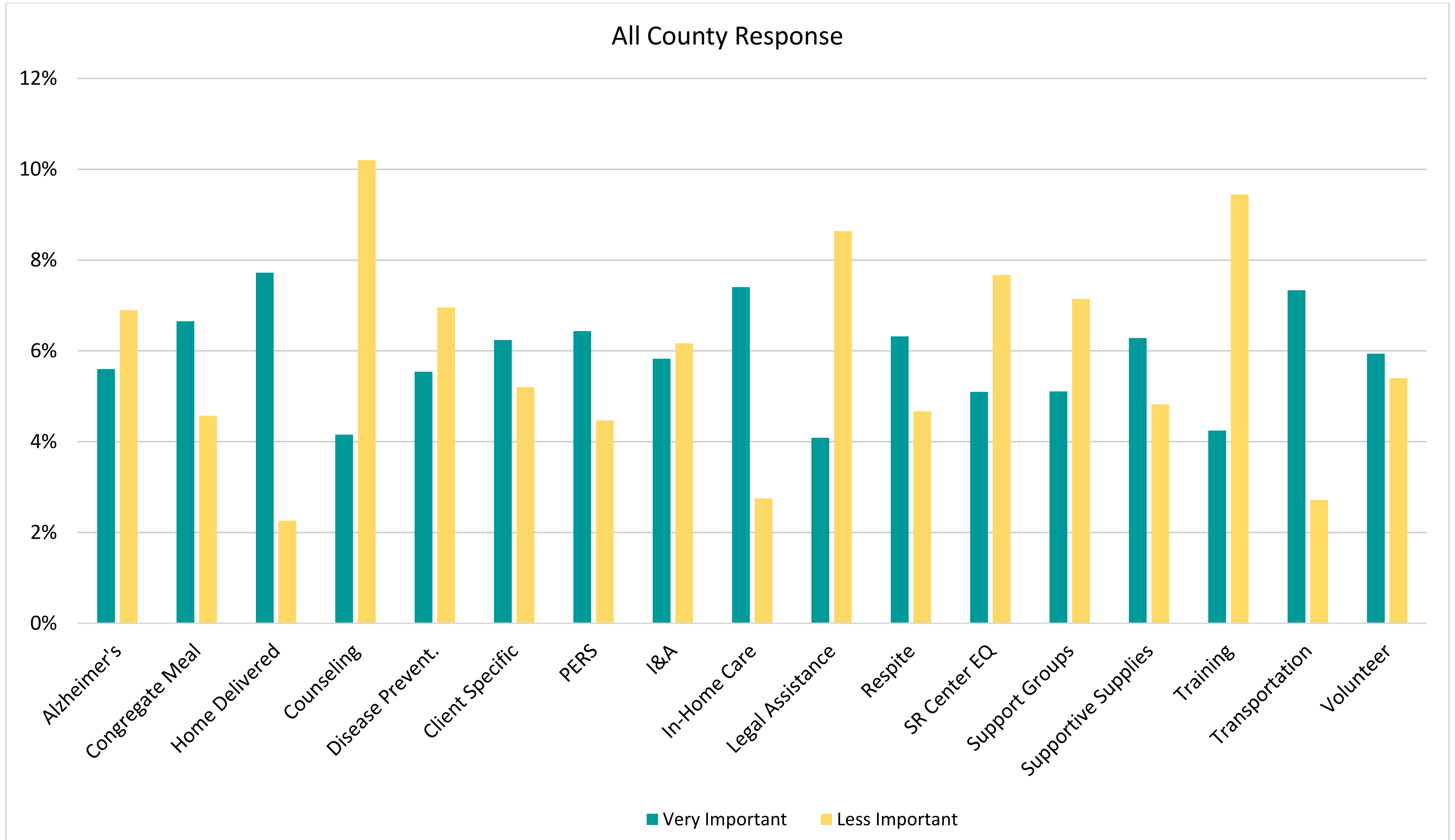
Between March and April of 2023, AACCW distributed 2,035 surveys throughout the six-county service area. The survey asked respondents to rate the importance of each of our services. Possible responses were "Very Important" and "Less Important". The survey also provided space for general comments and/or suggestions regarding unmet needs. Responses were coded with unique identifiers and analyzed by frequency, percent and mean. The results were tabulated for the PSA and for each county. Based upon survey responses, services rated as very important include: Nutrition Services, In-Home Care Services, Transportation, Personal Emergency Response Systems (PERS), and Respite Services.

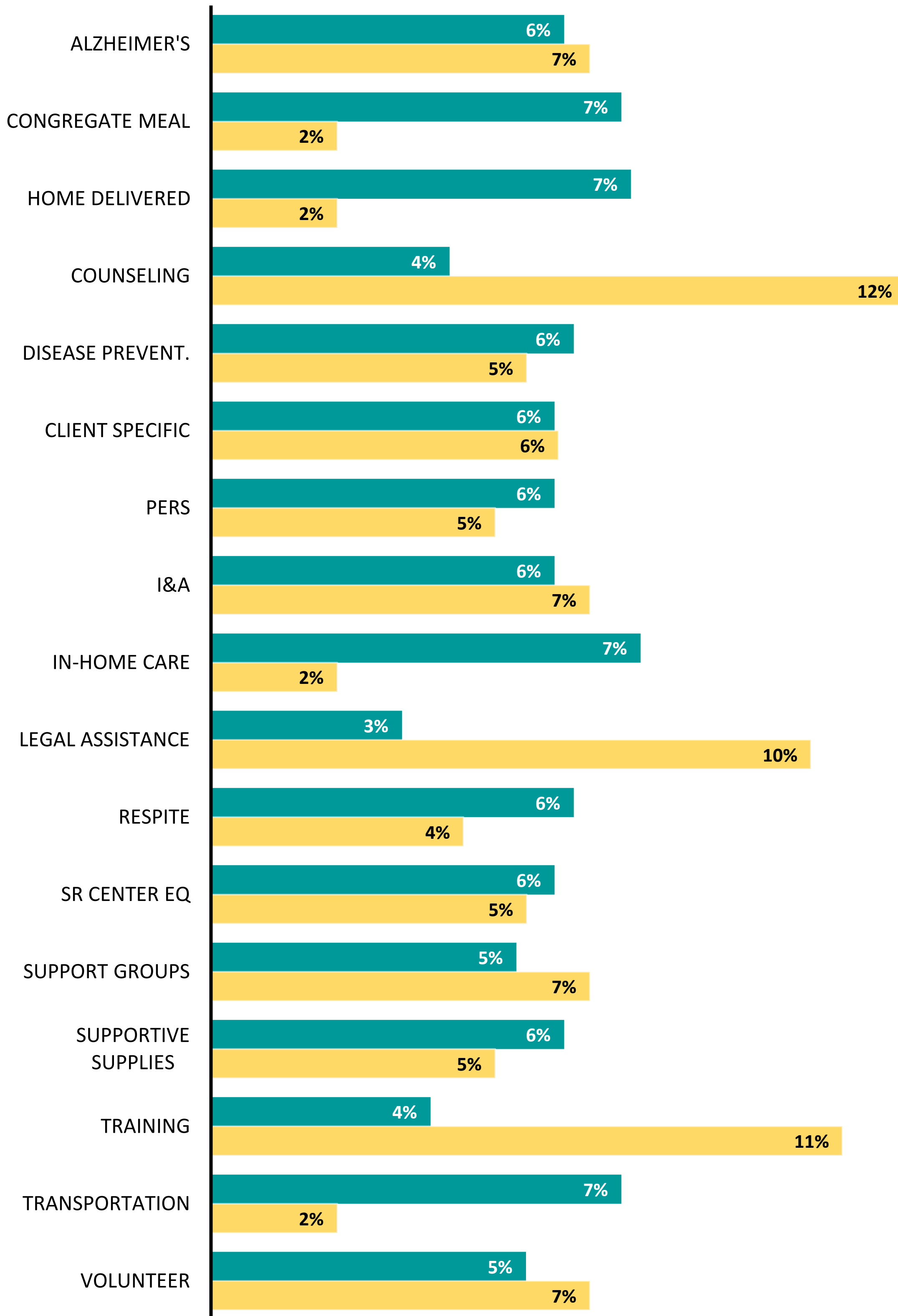
One public hearing was held to present this plan to the public. Comments received and updates to the Area Plan were reviewed by the AACCW Advisory Committee and the COG. The committees had the opportunity to make changes to the plan based on the public hearings. Information was open for comment at a public hearing before the COG's action.

Aging & Adult Care of Central Washington
2024-2027 Area Plan
2023 Planning Schedule

April	Five planning meetings were held in Chelan, Moses Lake, Odessa, Twisp, and Ritzville.
March - April	Survey responses and comments were compiled and analyzed. Draft plan summary prepared. Public hearing notices mailed and publicized through newspapers.
June	Advisory Committee and Council of Governments reviewed survey results and public comments.
Aug.- Sept.	Advisory Committee and Council of Governments reviewed the draft plan summary. One public hearing was held in person and via Zoom in East Wenatchee. Advisory Committee Chair and Council of Governments approved the Area Plan.
November	Deadline to submit the 2024 - 2027 Area Plan.

Aging & Adult Care of Central Washington
2024-2027 Area Plan: Planning Survey Results

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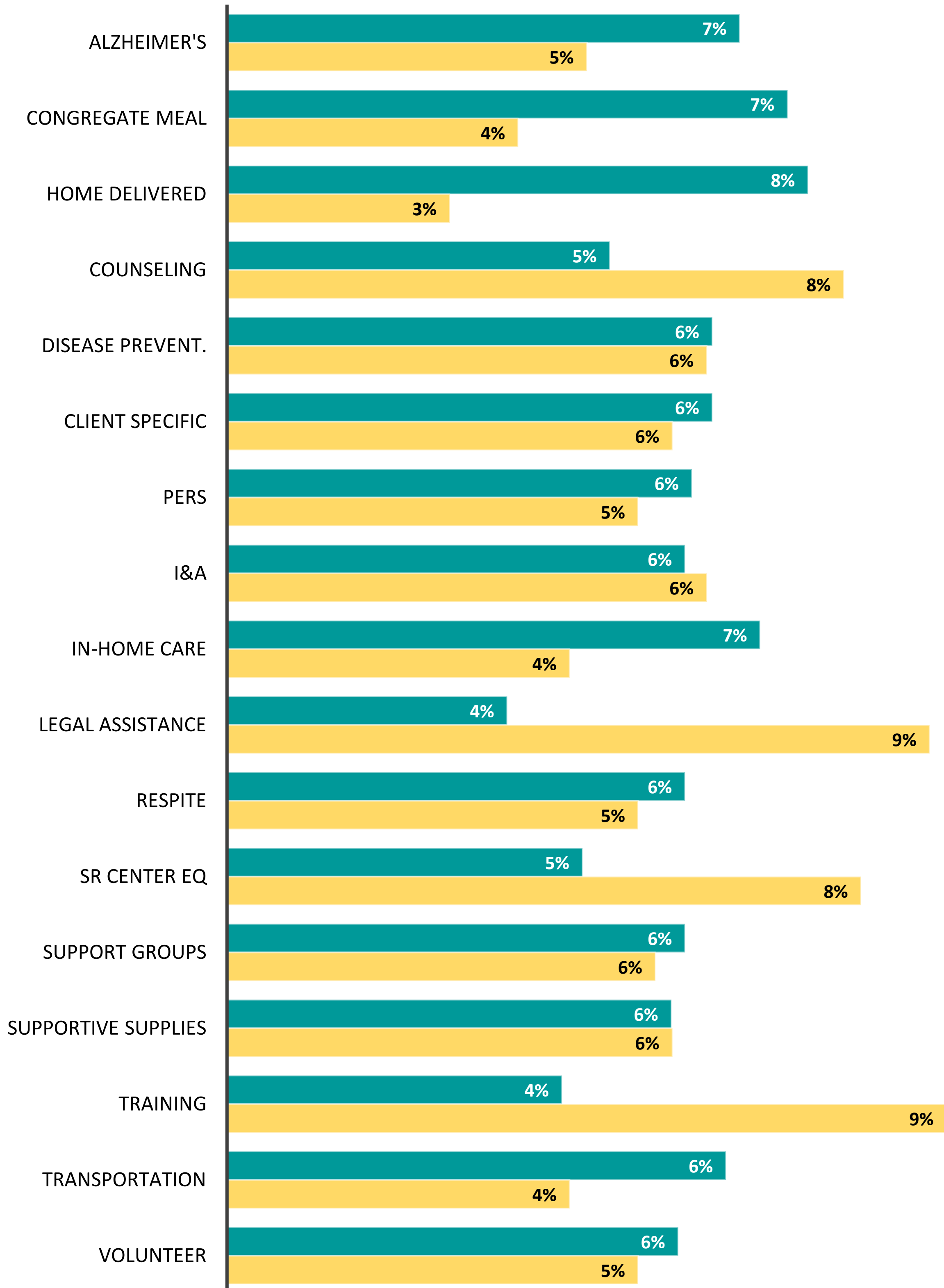
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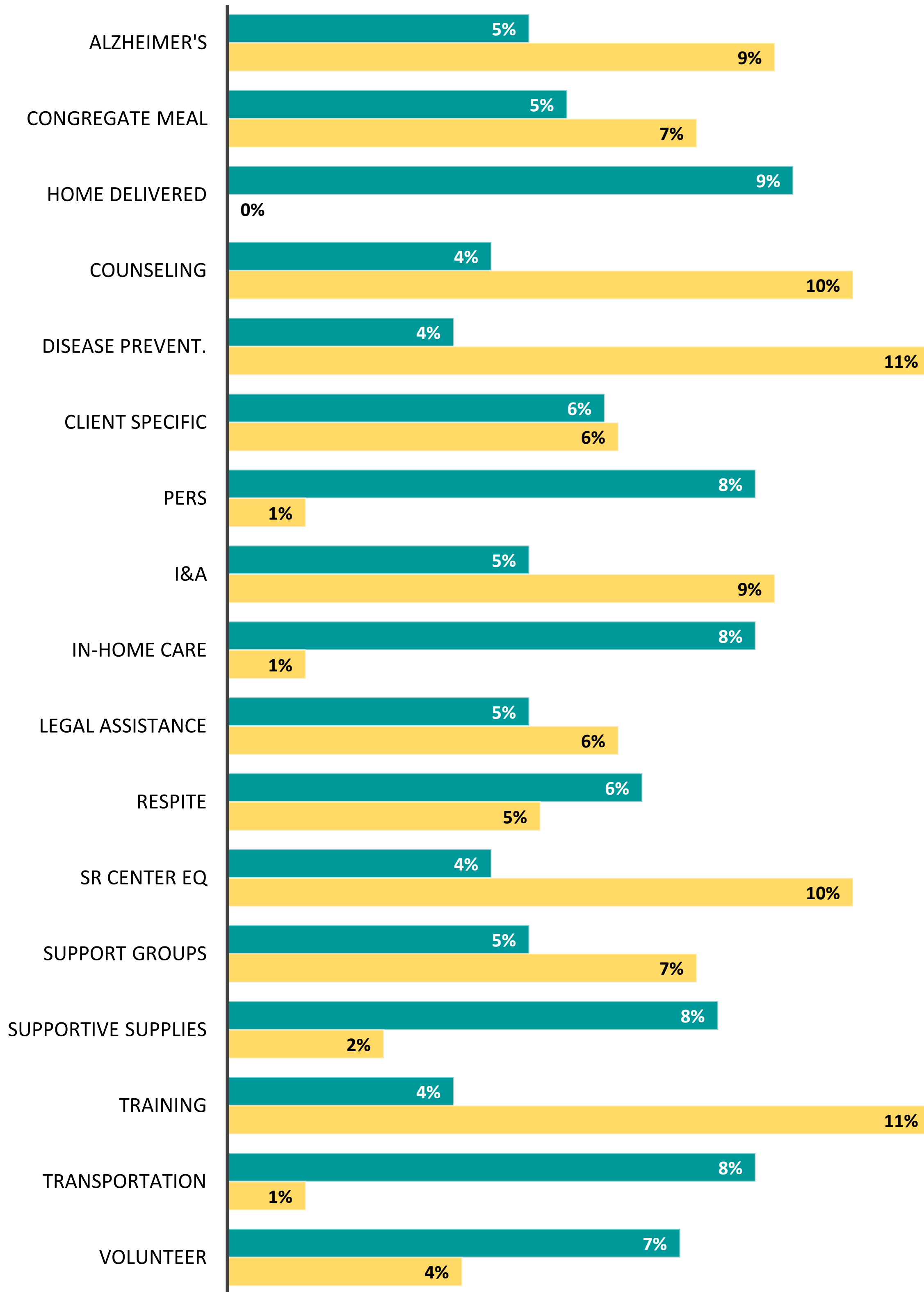
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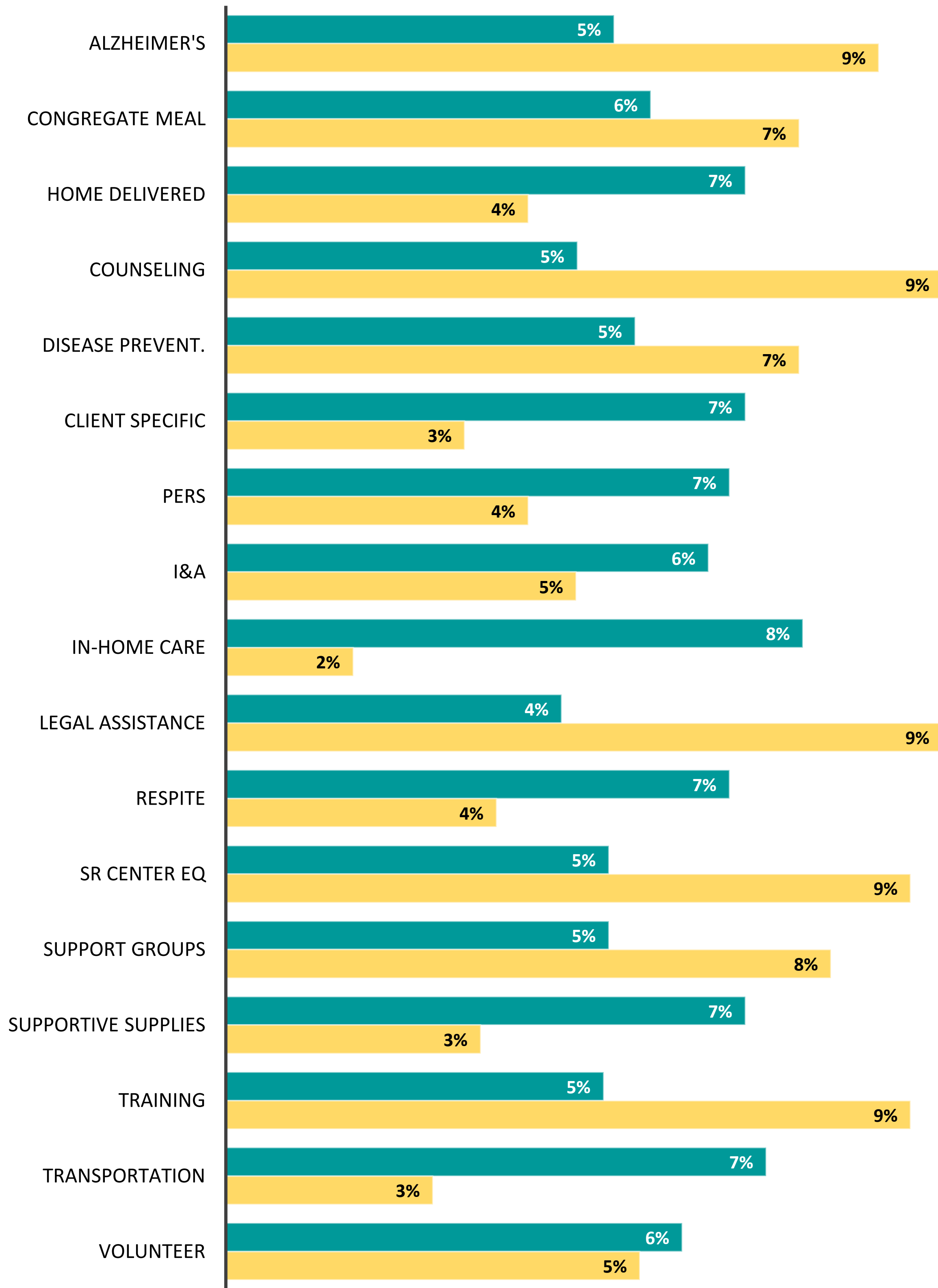
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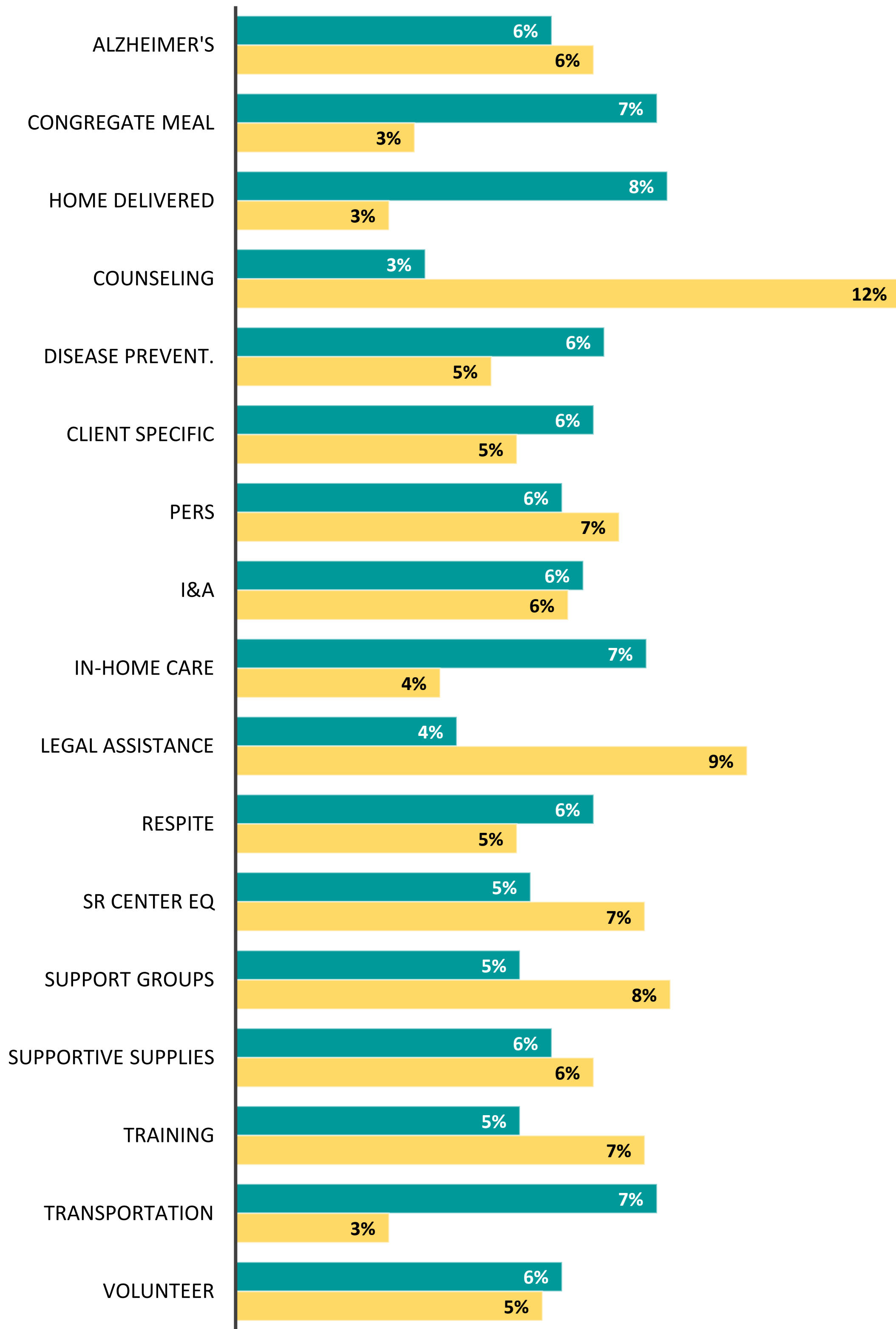
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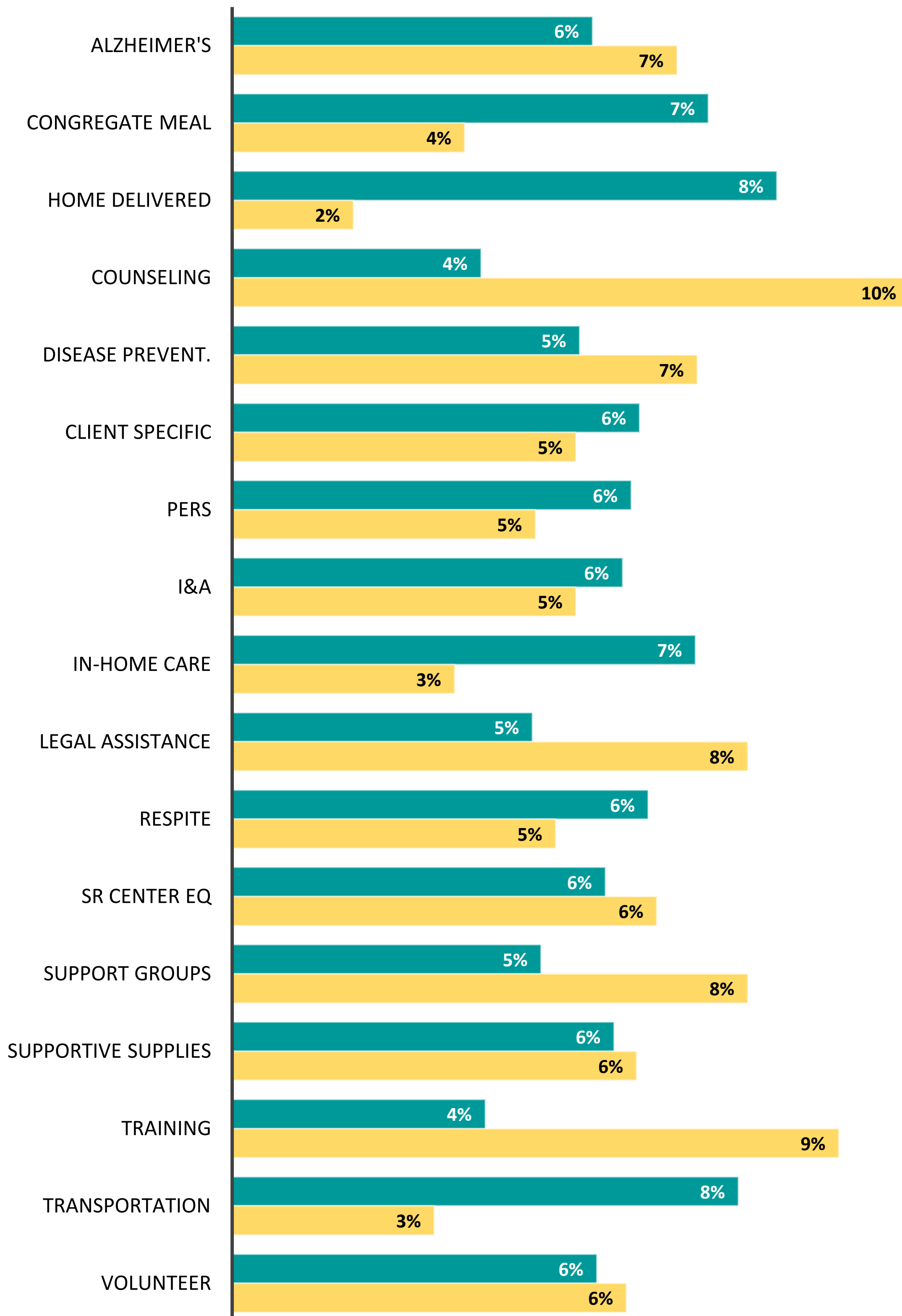

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Prioritization of Discretionary Funding

Service priorities are determined during the planning process and throughout the year as the need arises. Priorities are established through information gathered from surveys and from written and verbal comments received during the planning meetings. Social and economic factors and identifying unmet needs within our target population must take priority when planning for referral and assistance for individuals to maintain a life of independence and minimize premature or unnecessary residential care placement.

Sixty-eight percent (68%) of the 2024 budget of $9,311,279 is non-discretionary. Non-discretionary dollars must be used exclusively for the specific program funded by that source. 8% of the total budget is allocated for planning, administration, and coordination. Twenty-four percent (24%) of the budget or $3,255,456 are "discretionary" dollars, provided through the Federal Older Americans Act and Washington State's Senior Citizen's Services Act.

AACCW's Advisory Committee administers a discretionary fund of $13,000 for 2024 for our PSA. Requests are received from senior centers and other organizations for items such as computers, copy machines, refrigerators, ovens, etc. If approved by the Advisory Committee, requests are sent to the COG who has final approval authority. Additionally, the AACCW Advisory Committee established a Client Specific Fund to provide funding for needs that were not addressed by other programs or funding streams.

Discretionary Funds

Client Specific Fund	Information & Assistance
Congregate Meals	Multipurpose Senior Center Fund
Disaster Relief	Personal Emergency Response Systems
Disease Prevention / Health Promotion	Transportation
Home-Delivered Meals	Volunteer Services
In-Home Care (ANC, Respite)	

In the event of funding reductions and changes in the intrastate funding formula, priorities would again be reviewed by staff. If necessary, a public hearing would be held. All information would then be presented to the Advisory Committee for review, consideration, and recommendation for the COG, who would have final approval regarding changes to the Area Plan. For 2024, funding for nutrition is anticipated to increase based on unobligated OAA nutrition funding from the previous year due to COVID-19. The table on the next page itemizes the proposed budget as approved by the COG.

Services	2023 Area Plan Budget	2024 Proposed Budget	Difference
Aging Network Chore	179,000	179,000	0
Client Specific Fund	7,000	7,000	0
Congregate & Home Delivered Meals	989,124	1,206,657	217,533
Disaster Relief	1,000	1,000	0
Disease Prevention/Health Promotion	24,837	24,837	0
Information & Assistance	487,480	532,144	44,664
Multipurpose Senior Center	6,000	6,000	
Personal Emergency Response System	38,140	38,140	0
Transportation	124,242	124,242	0
Volunteer Services	10,000	10,000	0
Total	1,866,823	2,129020	262,197

SECTION B

PLANNING AND SERVICE AREA PROFILE

Aging & Adult Care of Central Washington
Target Population Profile

Aging & Adult Care of Central Washington (AACCW), PSA #8, consists of citizens residing in Adams, Chelan, Douglas, Grant, Lincoln and Okanogan Counties, Washington. Wenatchee and East Wenatchee are defined as urban. All other county service areas are defined as rural.

Colville AAA, PSA #12, is responsible for serving the Colville Reservation within Okanogan County. Therefore, the 60+ population residing in Okanogan County has been extrapolated from the profile projections contained below, except for those categories specific to Native American citizens. All Native American Elders living outside the reservation qualify for services provided by AACCW.

Future population projections for PSA #8 *(1)*:

Characteristics	**2024**	**2025**	**2026**	**2027**
Number of persons aged 60 or above	81,361	82,842	83,893	84,881
Number of persons aged 60 or above and at or below 100% FPL	4,893	4,960	5,014	5,044
Number of persons aged 60 or above and minority	10,640	11,083	11,619	12,116
Number of persons aged 55 or above and American Indian/ Alaska Native	2,079	2,109	2,151	2,184
Number of persons aged 60 or above, American Indian/Alaskan Native	1,622	1,651	1,679	1,703
Number of persons aged 60 or above and at or below 100% FPL and minority	1,243	1,279	1,313	1,349
Number of persons aged 60 or above with limited English proficiency	3,979	4,121	4,279	4,427
Number of persons aged 60 or above, and Disabled (ACS 18b or 18c)	17,453	17,940	18,340	18,811
Number of persons aged 18 or above and Disabled (ACS 18b or 18c)	25,033	25,557	26,036	26,589
Number of persons aged 60 or above with cognitive impairments (ACS 18a)	7,723	7,934	8,104	8,318
Number of persons aged 65 or above with dementia	6,312	6,560	6,790	7,039
Number of persons using in-home services, based on June 2018 CFC utilization calibration	1945	1982	2022	2063
Number of persons using community residential services, based on June 2018 CFC utilization calibration	643	659	674	693
PSA #8 Tribes represented	0	0	0	0

(1) Research and Data Analysis Division (RDA) of DSHS
(2) Federal Poverty Level (FPL)
(3) American Community Survey (ACS)

AAA Services and Partnerships

Per the Older Americans Act, we are mandated to provide services to individuals with the greatest economic and social needs. Target groups include minority individuals, limited English speaking people, and seniors living in rural areas. With nearly 17,000 square miles to cover and almost all of it rural, AACCW has some unique challenges in serving these groups. We have offices in Wenatchee, Moses Lake and Omak. Regularly scheduled visits to communities where we do not have office locations are planned.

The 22 senior centers in PSA #8 are major conduits through which our services reach those target populations. Information is distributed through literature racks, special flyers, posters, and presentations. We also distribute information to, and receive referrals from, all our contractors and community partners. Groups such as Moses Lake Community Forum, Senior Services Network and Serving Our Seniors bring stakeholder groups together and are important venues for identifying and making services known to target populations.

Our efforts to improve service to older Native Americans in cooperation with local Native American Tribes are described in Section C-1, Policy 7.01 Implementation Plan.

We continue to advertise through Spanish newspapers and radio, as well as other media throughout our region. Good relationships with newspapers and radio stations allow us to provide regular public service announcements at no cost.

Keeping up with advancements in technology will be an important part of our future. As demand for services and costs continue to rise, and resources remain static, working smarter with technology will become increasingly important. Our IT Coordinator endeavors to keep apprised of IT advances and resources serving seniors. Interactive websites have become a reality as our aging population becomes increasingly tech-savvy. The advent of the Aging & Disability Resource Center (ADRC) brings with it the need to establish more cooperative working agreements with stakeholders in the coming years.

Increasingly, language is a barrier when providing services. In our region, Grant and Adams County in particular, range between 22% and 31% of residents who speak languages other than English, primarily Spanish, but also Russian and Ukrainian. AACCW has 8 bilingual staff to serve our diverse population. Currently we have a nationwide caregiver shortage which has a great impact on our contracted home care agencies as they see a great need of bilingual caregivers to keep up with the increasing demand. We currently contract with Language Link Service, Inc. to provide interpreter and translation services for many languages.

Increasing food and fuel costs coupled with a declining economy are making it increasingly difficult for rural seniors to access essential services. Two of our rural counties have no publicly funded transportation.

AAA Services

Aging Network Chore (Age 60+) Donations accepted

Aging Network Chore (ANC) provides household care, assistance with activities of daily living and personal care to older persons who need help with allowable chore services tasks if they are to live independently in their own homes. Priority is given to persons determined at risk of institutional placement, who meet the vulnerability criteria and are unable to access needed care through other community resources.

Case Management (Age 18+)

Case Management (CM) conducts assessments and reassessments for functionally impaired adults at risk of institutionalization. Case Management also helps clients in accessing, obtaining and effectively using the necessary services which will enable them to maintain the highest level of independence in the least restrictive setting.

Information & Assistance (I&A) (Age 60+) Donations accepted

Information and Assistance (I&A) is the publicly recognized access point for receiving I&A/CM. I&A functions include information giving, service referral, assistance, client advocacy and screening to determine whether a person should be referred to the appropriate agency for a comprehensive assessment. I&A is also responsible for I&A/CM program publicity and developing and maintaining an extensive database of community resources which serve older people. Additionally, I&A administers the RX Program and works in conjunction with the Statewide Health Insurance Benefit Advisors (SHIBA).

Kinship Caregiver Support Program (Caregiver 18+)

Kinship care is the full-time care of children by relatives. Kinship care occurs informally, when children are not involved with public child welfare agencies, and formally, when public child welfare agencies are involved in placing children with relatives. The Kinship Caregivers Support Program funds can be used to help pay for the cost of emergent needs incurred by grandparents or other relatives at the time a child (or children) comes to live with them as well as after the initial period.

Kinship Navigator Program (Caregiver 18+)

The Kinship Navigator Program is designed to assist grandparents and other relatives navigate the system of services for children living with relatives. Assistance is provided to relatives connecting them to needed services and resources to prevent children from entering foster care.

Professional Nursing Services (Age 18+)

Nursing services are targeted at the high-risk older person or disabled adult in residential and home settings. Services are referred by a CM or social worker to coordinate their health care and provide consultation in support of the care plan. Includes nursing services for Developmental Disabilities and Home and Community Services.

Senior Farmer's Market Nutrition Program (Age 60+)

The Senior Farmers Market Nutrition Program is designed to provide low-income seniors with resources in the form of fresh, nutritious, locally grown fruits, vegetables and honey from farmers markets, farm stores and community supported agriculture programs. Educational information about the benefits, selection, storage and preparation of fresh foods is also provided.

Congregate Nutrition (Age 60+) Donations accepted

Congregate meals help meet the complex nutritional needs of older persons who are nutritionally at risk by providing nutritionally sound and satisfying meals and other nutrition services, including nutrition outreach and nutrition education in a group setting. Each meal served contains at least one-third of the current Recommended Dietary Allowances. Congregate meals are served on various days and times (breakfast, lunch, or dinner) at numerous sites throughout the region.

Home-Delivered Nutrition (Age 60+) Donations accepted / COPES Home-Delivered (Age 18+)

Home-Delivered meals provide nutritious meals to older persons who are home-bound by reason of illness, incapacitating disability, or who are otherwise isolated. Services are intended to maintain or improve the health status of these individuals, support their independence, prevent premature institutionalization and allow earlier discharge from hospitals, nursing homes or other residential care facilities. Each meal served contains at least one-third of the current Recommended Dietary Allowances.

COPES Environmental Modification (Age 18+)

The COPES Environmental Modification program provides physical adaptations to the home of a client. The adaptations must be necessary to ensure the client's health, welfare and safety. They must enable the client to function with greater independence in the home, must be of direct and remedial benefit to the client and without which, the client would require institutionalization.

Community First Choice Option (CFCO) Personal Care (Age 18+)

Community First Choice Option provides assistance with personal care and household tasks. The client must be determined Medicaid eligible for nursing home level of care. Financial participation may be required.

Disease Prevention / Health Promotion (Age 60+) Donations accepted

Disease Prevention and Health Promotion services are provided at a variety of community settings. The information is designed to assist older persons to prevent the onset of serious diseases, to promote good health habits and to rid themselves of bad ones in such a way as to enhance their lives and prevent premature institutionalization.

Family Caregiver Support Program (Caregiver 18+) Donations accepted

The Family Caregiver Support Program helps unpaid caregivers who provide care to persons 18 years and older to make informed decisions about current and future care plans, solve day-to-day caregiving problems, learn essential caregiving skills and locate services that may strengthen their capacity to provide care. Services include: information, assistance, counseling, respite care (relief from caregiving), aging network chore services, support groups, personal emergency response systems, and help purchasing needed supplies, etc.

Legal Services (Age 60+) Donations accepted

The Legal Services program assists older persons in advocating for their rights, benefits and entitlements. Assistance in non-criminal matters is provided by referrals to attorneys, paralegals and qualified others, and range from advice and drafting of simple legal documents to representation in complex litigation. The focus is on socially and economically needy older individuals with legal problems. Services include disseminating information about legal issues to older persons, service groups and bar associations through lectures, group discussions and the media.

Medicaid Personal Care (Age 18+)

The Medicaid Personal Care program provides assistance with personal care and household tasks for persons with at least one personal care task need. The client must be SSI eligible.

Personal Emergency Response System [PERS] (Age 60+) CFCO PERS (Age 18+)

Provides for the installation, rental, and monthly monitoring of Personal Emergency Response System equipment. PERS monitor the frail, homebound elderly by means of an electronic device that secures help in the event of an emergency. The response center has access to the client's local response network including police, fire, ambulance, friends and/or neighbors, depending on the nature of the emergency.

Respite (Age 18+)

Respite provides relief for families or other caregivers of adults 18 years and over with functional disabilities. In-home respite care is available and provided on an hourly and daily basis including 24-hour care for several consecutive days. Respite care workers provide supervision, personal care services and nursing tasks usually provided by the primary caregiver of the disabled adult.

Transportation (Age 60+) Donations accepted

Transportation services are designed to transfer older persons, who have no other means of transportation, to and from social services, medical and health care services, meal programs, senior centers, shopping and recreational activities. Personal assistance for those with limited physical mobility is provided.

Volunteer Services

Volunteer services provide meaningful, rewarding volunteer opportunities, especially for older adults and people with disabilities. Volunteer services exist in AACCW's three offices, in our contracted programs and in serving clients not being served through existing programs.

Client Specific Services

The AACCW Advisory Council developed this fund to provide funding for needs that are not addressed by other programs. For example, funds may be used or go toward the cost of such things as transportation, prescription medication, eyeglasses or hearing aids.

Community Living Connections

The National Aging and Disability Resource Center (ADRC) program is a collaborative effort of the Administration for Community Living, the Centers for Medicare and Medicaid Services and the Veteran's Health Administration. In Washington State, the ADRC program is called Community Living Connections. The program is designed to streamline access to home and community supports and services for consumers of all ages, incomes and disabilities and their families.

Health Homes

As part of the Affordable Care Act, DSHS and the Health Care Authority have created health homes to improve coordination between Medicaid and Medicare, and to improve outcomes for individuals with chronic conditions.

Veterans Directed Home Services (VDHS)

VDHS offers eligible veterans who have functional disabilities more choices about how to get help at home.

Medicaid Transformation Project Demonstration

Medicaid Alternative Care (MAC) – A benefit package for individuals who are eligible for Medicaid, but not currently accessing Medicaid-Funded Long Term Services and Supports (LTSS). This benefit package will provide services to unpaid caregivers designed to assist them in getting supports necessary to continue to provide high-quality care and to focus on their own health and well-being.

Tailored Supports for Older Adults (TSOA) – A new eligibility category and benefit package for individuals and their caregivers at risk of future Medicaid Long Term Services and Supports (LTSS) use who currently do not meet Medicaid financial eligibility criteria. This is designed to help individuals avoid, or delay impoverishment and the need for Medicaid-funded services. Tailored Supports for Older Adults also serves individuals without an unpaid family caregiver. The services available to individuals are slightly different than those offered to unpaid caregivers.

MAC and TSOA include, but are not limited to, the following benefits:

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

Multipurpose Senior Center

Senior Centers are community facilities where older persons can meet, receive services and participate in activities to support their independence and encourage their involvement in the lives and affairs of the community. Funding is available to assist senior centers with equipment purchases.

Disaster Relief

This primarily serves as a place holder should our agency need to add additional funding if a disaster occurs in our region.

Agency Worker's Health Insurance

Costs of health care coverage for home care workers who provide respite and other non-core personal care services.

Caregiver Training

Reimbursement for class time of Home Care Agency workers while receiving required education for Basic Training, Continuing Education, Home Care Worker Orientation, Safety Training, and In-Home Nurse Delegation training.

Elder Abuse Prevention

Prevention services are designed to prevent abuse, neglect, and exploitation of older individuals. These services may include public education, conferences, outreach, and referrals to appropriate agencies.

Home Delivered Meal Expansion Program

Expands Home Delivered Meal services to new or underserved populations or areas within the contractor's service area. These funds must not replace existing funds.

Nutrition Services Incentive Program (NSIP)

NSIP is funded through the Older Americans Act (OAA) Program. The purpose is to help provide additional funding for delivery of nutritious meals with either the congregate or home-delivered meal program. Funding may only be used for the purchase of raw food.

Senior Drug Education

Services provided to inform and train persons, 65 years of age and older, in the safe and appropriate use of prescription and non-prescription medications.

Services Provided Through the AAA

Service	Adams	Chelan	Douglas	Grant	Lincoln	Okanogan
Aging Network Chore	X	X	X	X	X	X
Case Management	X	X	X	X	X	X
Information and Assistance	X	X	X	X	X	X
Kinship Caregiver's Support Program	X	X	X	X	X	X
Kinship Navigator Program	X	X	X	X	X	X
Professional Nursing Services	X	X	X	X	X	X
Senior Farmer's Market Nutrition Program	X	X	X	X	X	X
Congregate Nutrition	X	X	X	X	X	X
Home-Delivered Nutrition (including COPES Home-Delivered)	X	X	X	X	X	X
COPES Environmental Modification	X	X	X	X	X	X
CFCO Personal Care	X	X	X	X	X	X
Disease Prevention / Health Promotion	X	X	X	X	X	X
Family Caregiver Support Program	X	X	X	X	X	X
Legal Services	X	X	X	X	X	X
Medicaid Personal Care	X	X	X	X	X	X
Personal Emergency Response System (including CFCO Personal Emergency Response System)	X	X	X	X	X	X
Respite	X	X	X	X	X	X
Transportation	X				X	
Volunteer Services	X	X	X	X	X	X
Client Specific Services	X	X	X	X	X	X
Community Living Connections	X	X	X	X	X	X
Health Homes	X	X	X	X	X	X
Veteran's Directed Home Services	X	X	X	X	X	X
Multipurpose Senior Center	X	X	X	X	X	X
Medicaid Transformation Project Demonstration	X	X	X	X	X	X

AREA AGENCY ON AGING DESIGNATED FOCAL POINTS

County	Organization or Site Name	Focal Point Address	Public Phone Number (required) & E-Mail Address (if applicable)	Services Coordinated at this Site (Optional)
Adams	H.E.Gritman Center	118 West Main Ritzville, WA 99169	509-659-1921	Congregate & Home Delivered Meals (own Program)
Adams	Lind Senior Center	117 N "I" St. Lind, WA 99341	509-677-3620	Congregate & Home Delivered Meals
Adams	Othello Senior Center	755 N 7th St. Othello, WA 99344	509-488-5700	Congregate & Home Delivered Meals (own Program)
Chelan	Chelan Senior Center	534 E. Trow Chelan, WA 98816	509-682-2712	Congregate & Home Delivered Meals
Chelan	Entiat Senior Center	1920 Entiat Way Entiat, WA 98822	No phone on site	Congregate & Home Delivered Meals
Chelan	Leavenworth Senior Center	423 Evans St Leavenworth, WA 98826	509-548-6666	Congregate & Home Delivered Meals
Chelan	Manson Meal Site Northshore Bible Church	123 Wapato Point Pkwy Manson, WA 98831	No phone on site	Congregate & Home Delivered Meals
Chelan	Wenatchee Valley Sr. Activity Center	1312 Maple St. Wenatchee, WA 98801	509-662-7036	Congregate & Home Delivered Meals (own program)
Douglas	Brewster Sr. Center	109 South Bridge St. Brewster, WA 98812	509-689-2815	Congregate & Home Delivered Meals
Douglas	Waterville	103 Locust Waterville, WA 98858	No phone at this site	No meals

AREA AGENCY ON AGING DESIGNATED FOCAL POINTS

County	Organization or Site Name	Focal Point Address	Public Phone Number (required) & E-Mail Address (if applicable)	Services Coordinated at this Site (Optional)
Grant	Coulee City Senior Center	520 W. Douglas Coulee City, WA 99155	509-632-8701	Congregate & Home Delivered Meals
Grant	Ephrata Senior Center	124 “C” St. NW Ephrata, WA 98823	509-754-2382	Congregate & Home Delivered Meals (own program)
Grant	Grand Coulee Dam Seniors	203 Main St. Grand Coulee, WA 99133	509-633-2321 or 509-633-3214	Congregate & Home Delivered Meals
Grant	Moses Lake Senior Opportunity and Services	608 E. Third Ave Moses Lake, WA 98837	509-765-7809	Congregate & Home Delivered Meals
Grant	Quincy Senior Center	522 “F” St. SE Quincy, WA 98848	509-787-3231	Congregate Own Program
Grant	Royal Slope Seniors	13702 Dodson Rd. S Royal City, WA 99357	No phone at site	No Meals
Grant	Sage Brush Senior Center	23 Desert Aire Dr. SW Mattawa, WA 99349	509-932-4725	Congregate Own Program
Grant	Soap Lake Senior center	121 2nd Ave. SE Soap Lake, WA 98851	509-246-1913	Congregate & Home Delivered Meals
Lincoln	Davenport Senior Center	728 Morgan St Davenport, WA 99122	509-725-7055	Congregate & Home Delivered Meals
Lincoln	Harrington Meal Site – Mid County Seniors	S. 6 Third St Harrington, WA 99134	No phone at site	Congregate & Home Delivered Meals

AREA AGENCY ON AGING DESIGNATED FOCAL POINTS

County	Organization or Site Name	Focal Point Address	Public Phone Number (required) & E-Mail Address (if applicable)	Services Coordinated at this Site (Optional)
Lincoln	Odessa Sr. Center	104 W. 1st Ave Odessa, WA 99159	509-982-2654	Congregate & Home Delivered Meals
Lincoln	Wilbur Senior Center	101 Main Ave. Wilbur, WA 99185	509-647-5503	Congregate & Home Delivered Meals
Okanogan	Methow Valley Sr. Center	215 Methow Valley Hwy Twisp, WA 98856	509-997-7722	Congregate & Home Delivered Meals
Okanogan	Okanogan Senior Center	1300 2nd St. Okanogan, WA 98840	509-422-6776	Congregate & Home Delivered Meals
Okanogan	Omak Senior Center	214 N. Juniper Omak, WA 98841	509-826-4741	Congregate & Home Delivered Meals
Okanogan	Oroville Senior Center	1521 Golden St. Oroville, WA 98844	509-476-2412	Congregate & Home Delivered Meals
Okanogan	Tonasket Senior Center	22 W. 5th St Tonasket, WA 98855	509-486-2483	Congregate & Home Delivered Meals

SECTION C

ISSUE AREA THEMES

Issue Area C - 1: Healthy Aging

Profile of the Issue: Many factors can affect seniors' quality of life as they age, a key one is to prevent falls and injuries. Statistics show a fall that results in a break or other injury has a direct correlation with needing long-term support services sooner. Informing seniors about how to prevent falls is crucial to their quality of life. Similarly, the stress for those taking care of seniors in their role as a caregiver can reduce their quality of life and lead to their own rapid decline in health. Caregivers need education and support to help them realize their health is important too. Cognitive decline can increase the chance of falling, and it contributes to the challenges of caregiving. Addressing these factors collectively can improve the quality of life for seniors and caregivers as well as delay the need for medical care and long-term services and supports.

Goal/s: 1) Educate older adults and their families about the impact of falling; 2) Reduce the risk of falls with programs that address the cause of falls; 3) Support families & individuals dealing with Alzheimer's or dementia; 4) Provide support for family caregivers and individuals experiencing emotions related to chronic illness and taking care of loved ones.

Major Objectives	Key Tasks and Benchmarks	2024				2025				2026				2027			
		Jan-March	April-June	July-Sept	Oct-Dec	Jan-Marc	April-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec
Expand outreach and education about the impact of falls.	Senior Health Fair annually with a focus on fall prevention. Track event attendance and engage with attendees about what they learned from event.			x				x				x				x	
	Presentations at senior centers and service groups to educate about the impact of falls. Determine success by attendance and feedback.	x			x	x			x	x			x	x			
	Use local, state, and national data on the impact of falls related to hospitalization and deaths.																
Work more closely with community partners on ways to reduce falls and the risk of falling.	Work with businesses and healthcare providers to create a standard brochure for public education. Determine success by brochure distribution.	x	x	x	x		x	x			x	x			x	x	
	Educate emergency services such as fire and ambulance providers about services AACCW provides. Determine success by a decline in emergency calls caused by falling, including those who repeatedly call for emergency help to get up from the floor when they fall.	x	x	x	x			x				x				x	
Expand evidence-based programs that prevent falls.	Expand contracts with Matter of Balance providers so these classes are more available in all six counties.	x	x			x				x				x			
	Enhance sharing information about available SAIL classes in all six counties.	x	x			x				x				x			
Train Information & Assistance staff to screen for fall risk and offer more preventive measures to their clients.	Find a screening tool to implement in conversations and assessments that better determines fall risk.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Add medication dispensers and strengthen prescription education in our programs and outreach. Medication errors are a primary cause of falls.	x	x	x			x	x			x	x			x	x	
	Make sure to include walk-through of home during visits to identify potential causes of falls. Suggest ways to reduce falls, such as better lighting.	x	x	x	x												

Issue Area C - 1: Healthy Aging																	
Major Objectives	Key Tasks and Benchmarks	2024				2025				2026				2027			
		Jan-March	April-June	July-Sept	Oct-Dec	Jan-Marc	April-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec
Expand Care Transitions partnerships with medical providers in order to reduce rehospitalization of patients.	**Reorganize Care Transitions staffing in order to more effectively implement program to include home visits and greater patient follow-up.**	x	x			x				x				x			
	Meet with medical providers in each county and create MOUs, particularly with hospitals. Success will be measured by an increase in Care Transitions referrals.			x			x	x			x	x			x	x	
Help families & individuals dealing with Alzheimer's and dementia to understand and cope with the disease.	**Expand current Powerful Tools for Caregiver workshops to offer in-person courses in all six counties.**	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Begin using a standard screeening tool to help new referrals, clients, and their families determine if a neurologist should be consulted for a formal diagnosis; Provide Alzheimer's Association contact information and materials when memory loss is identified.	x	x	x			x	x			x	x			x	x	
	Make sure to include walk-through of home during visits to identify potential causes of falls. Suggest ways to reduce falls, such as better lighting.	x	x	x	x												
Volunteering & Civic Engagement	**Promote volunteerism through AACCW's Website, Facebook, and other electronic or published medium.**	x	x	x			x	x			x	x			x	x	
	Work cooperatively with RSVP, Senior Centers, and similar organizations that routinely recruit volunteers.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Advocacy	**Host Senior Service Network (SSN) monthly meetings to present and discuss issues relevant to local seniors and the organizations and collaboratives that serve and advocate for their needs.**	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Promote volunteerism through AACCW's Website, Facebook, and other electronic or published medium.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Attend Statewide network meetings of organizations or associations that publicly advocate for the needs of seniors and/or people with disabilities.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Work collaboratively on health issues that impact seniors and adults with disabilities by hosting various events, meetings, and support groups that support Dementia, Parkinsons Disease, Heart Disease, etc..	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Equity, Diversity & Inclusion	**Comply with all Federal and State Contract Requirements Associated with DEI**	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Participate in conferences, meetings, or collaboratives that involve DEI discussion and/or provide continuing education opportunities.				x				x				x				x

Issue Area C - 2: Expanding And Strengthening Services And Supports That Prevent Or Delay Entry Into Medicaid Funded Long-Term Services & Supports

Profile of the Issue: Most people prefer to live at home as they age. Facility care is expensive and most people cannot afford this type of care. This creates a heavy burden for families, federal, and state government and leads to impoverishment for individuals who cannot privately pay for care. Family caregiver support-related programs are essential to address these challenges. Connecting people with tools to plan for long-term care needs can help them avoid these challenges as they age.

Goal/s: 1) Expand support for unpaid caregivers so their care receivers can remain at home & they can protect their well-being. 2) Augment team's ability to serve an increased number of clients created by these efforts.

Major Objectives	Key Tasks and Benchmarks	2024				2025				2026				2027			
		Jan-March	April-June	July-Sept	Oct-Dec	Jan-Marc	Apr-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec
Increase outreach and education of the public about FCSP and MAC/TSOA services for unpaid caregivers and their care receivers.	Implement use of tools provided by ALTSA to educate about MAC/TSOA, such as table tents for Senior Centers, television and radio ads, and provide social media information.	x	x			x	x			x	x			x	x		
	Increase distribution of MAC/TSOA & FCSP brochures to Senior Centers, churches, and service organizations such as Rotary and Kiwanis groups.		x		x		x		x		x		x		x		x
	Increase presentations to Senior Centers, service organizations and churches with emphasis on FCSP and MAC/TSOA services for dyads.			x	x			x	x			x	x			x	x
	Success of all these measures will be tracked by increases in numbers of FCSP and MAC/TSOA clients.																
Increase support and messaging that reaches Latinx populations about assistance for family caregivers.	Identify and utilize the mediums that will best reach Hispanic audiences to inform of the Family Caregiver Support Programs. This is especially important as it is the only program that can serve undocumented individuals.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Contract with a Spanish-speaking support group facilitator to accommodate Hispanic family caregivers and offer the groups throughout our six counties.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Maintain and promote the CLC Resource Directory, making sure the resources listed are continually updated for accuracy.	The CLC Resource Directory will be used and promoted by staff as a tool for future planning and long-term care needs.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	The CLC Resource Directory will be used by staff for new caller referrals and care plan creation.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Community organizations and partners will become familiar with the CLC web site and begin using it as a go-to source for information and resources.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
The Kinship Navigator/Caregiver Program will grow in proportion to the increase in grandparents and other relatives taking care of children who are not their biological children.	Develop partnerships with school districts in our six counties so they know about the Kinship program and learn to identify and refer these families to AACCW.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Expand outreach to Kinship Caregivers at events and through methods such as Facebook and radio, making sure to include Latinx/Spanish-speaking populations in the messaging and outreach.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Issue Area C-3 Person Centered

Profile of the Issue: 75%, choose to receive care in their homes. As health care options for those with disabilities and complex conditions improve, people achieve increased wellness and independence and more people are able to remain successfully living at home longer. Unfortunately, the health care system often is confusing and provides fragmented care. That can create daunting challenges for those with complex conditions who must interact frequently with that fragmented system, often for the remainder of their lives. More than 800,000 Washington State citizens provide care to an adult who needs help with care. We must ensure individuals know all of the services & options available for care and allow them to choose what works best for them.

Goal/s: 1.) Provide person-centered, in-home LTSS, integrated with health care, for older adults & adults with disabilities to allow them to remain as independent, healthy, & safe as possible. 2.) Provide person-centered coordination of health and community supports for people with significant health challenges, including mental health and substance use, to improve their health and reduce avoidable health care costs. Ensure we always honor and respect an individual's choices for care and help individuals access the supports and services they choose.

Major Objectives	Key Tasks and Benchmarks	2024				2025				2026				2027			
		Jan-March	April-June	July-Sept	Oct-Dec	Jan-Marc	April-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec
Provide training and resources to Case Management quarterly with the expectation the information will then reach our clients and families we serve.	Provide additional training and resources to Case Management continuously with the focus on maintaining independence.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Identify gaps in service supply or referral patterns, and develop strategies to close them			x				x				x				x	
Vulnerability to mental health conditions tends to increase as older adults age and become more likely to encounter stressful events, including declines in health and the loss of loved ones..Additionally, suicide rates for men 65 and older are higher than any other age group and are more than twice the national rate for all persons.	Provide person-centered coordination of health and community supports for people with significant health challenges, including mental health and substance use, to improve their health and reduce avoidable health care costs.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Identifying the socioeconomic factors may play an even larger role than race and ethnicity with regard to differences in the use of preventative services. For example, low-income older adults are less likely to receive a mammogram, colonoscopy, or influenza vaccination than are high-income older adults.	To engage lower-income older adults to receive preventative services, i.e. mammogram, colonoscopy, or influenza vaccination. Cultural disparities in health status and utilization persists after controlling for other factors, such as income level. All these differences demand examination of whether the health care system for older Americans is equitable according to the standards set by the Institute of Medicine report Crossing the Quality Chasm.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Provide person-centered, in-home LTSS, integrated with health care, for older adults and adults with disabilities to allow them to remain as independent, healthy, and safe as possible.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Extra efforts to include Targeted Case Management for the older adults living in rural areas are more likely to rate their health as "fair" or "poor" than are those in urban areas, and those in rural areas have higher rates of chronic illness, disability, and mortality. The geographic distribution of older adults also affects workforce needs because different regions have differing needs for geriatric services.		x				x				x				x		

Issue Area C-3 Person Centered-Continued

Major Objectives	Key Tasks and Benchmarks	2024				2025				2026				2027			
		Jan-March	April-June	July-Sept	Oct-Dec	March	April-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec	Jan-March	April June	July-Sept	Oct-Dec
Health Homes: Provides comprehensive care management, care coordination, health promotion, transition support, linkage to community-based services and supports to clients and families. Services currently target high cost/high risk beneficiaries covered by Medicare and Medicaid (dual eligible), as well as Medicaid managed care	Provide accurate and timely information and education about a broad range of long term services and supports to expand public knowledge and better serve the population of the counties we serve.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Improve the quality, responsiveness and availability of critical services, such as information/education, transportation and health promotion programs.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Enhance Person-Centered Options Couseling for new referrals to the Information & Assistance Department as well as ongoing options counseling for current clients who might be better served by other long-term services and supports.	Send staff to trainings offered by ALTSA on Person-Centered thinking when they are offered and as staff time allows.			x	x			x	x			x	x			x	x
	Utilize on-line trainings that focus on Person-Centered Options Counseling to strengthen and refresh Information & Assistance staff skills and abilities.	x	x			x	x			x	x			x	x		
	Incorporate modeling of best practice options counseling in regular staff trainings via Teams or during Information & Assistance Department meetings.			x	x			x	x			x	x			x	x
Increase staff knowledge of eligibility criteria for home and community-based programs so individuals can better understand their options.	Invite Public Benefits Specialists to train staff on eligibility criteria and determining an applicant's eligibility for CFC/COPES and MAC/TSOA.		x				x				x				x		
	Invite facility respresentatives to discuss the criteria potential residents must meet and the services that are available in different settings.			x				x				x				x	
Increase contractors to provide a broader variety of in-home services and supports for MAC/TSOA, FCSP and OAA-funded programs so individuals have more home-based options.	Add transportation vouchers to the mix of services that can pay for taxis, Uber, and Lyft to meet the needs of clients who cannot be fully served by public transportation.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Add counseling contractors who can meet with clients in their homes. These contractors should cover all six counties.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Add contractors to conduct support groups in more counties/communities so more caregivers can be properly supported.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Policy 7.01 Implementation Plan for Area Agencies on Aging (AAAs)

Timeframe: January 1, 2024 to December 31, 2027

Implementation Plan				Progress Report
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff and Target Date**	**(5) Status Update for the previous year.**
Provide outreach to tribal family caregivers in our PSA.	Concentrate on advertising the Family Caregiver Support Program, as well as MTP (MAC/TSOA) in the County, especially in Omak, Grand Coulee, and other communities which are adjacent to the Colville Reservation. ALTSA is producing a new DSHS video that will be representative of indigenous family caregivers and care receivers. The video is slated for production this fall and release in early spring. AACCW will use this video for promotions and information-sharing as part of our regular outreach activities.	Increased outreach efforts to reach tribal caregivers and subsequently an increased participation of tribal members who live in our PSA in programs that support family caregivers.	State/AAA: AACCW Diane Tribble Director of Information and Assistance diane.tribble@dshs.wa.gov AnDee Desrosier, Information & Assistance Lead andee.desrosier@dshs.wa.gov Tribe: Colville Confederated Tribes	Contact information for both the Colville AAA and AACCW would be listed on the last frames of the ad. The voice-over informed that both AAAs are available to help seniors, family caregivers, and adults with disabilities. In 2023 we reached out to Colville AAA Leadership and invited them to attend a Senior Fall Prevention & Wellness Fair in Okanogan Sept. 22nd. This was a first-time event primarily organized by AACCW. The Colville AAA provided a resource table. The event was successful and will be expanded in 2024. We will seek out additional outreach opportunities in 2024 for events and possibly joint presentations to Medical Providers in PSA8 coverage area of Okanogan County. Often they are not familiar with the differences in programs available to non-tribal members living on tribal lands and patients who belong to the tribe but live in PSA8.
Health Home Services Demystified Health Homes	Offer Health Home program support/ resources	AACCW will reach out to Raina Peone, Regional Tribal Liaison Tribal affairs, Health Care Authority to collaborate. Offer to be a resource to the Contract held and contact for resources Managed Care HH Leads.	State/AAA: Debbie Peterson Erin Nelson Tribe: Colville Confederated Tribes	Identified Tribal Liaison Raina Peone and Joel Boyd AAA Manager for the Colville Tribal to train and education opportunities.

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the previous year.
Recruitment for the Advisory Committee membership.	AACCW will seek to recruit a tribal member to sit on the advisory committee. This goal is in line with efforts to reach out to Colville Tribal Liaison, Rana Peone	The needs of tribal members will be brought to our attention during our advisory committee meetings, or outside of the meetings via direct contact with a tribal member who sits on our Advisory Committee	State/AAA: Ken Sterner Erin Nelson Debbie Peterson Tribe: Colville Confederated Tribes March 2023	AACCW did have a Tribal member enrolled for approximately 10 months and then resigned due to health issues. Recruiting efforts will continue until position is filled.
Improve communication and relationship between the Colville AAA and AACCW.	Select AACCW staff will participate in meetings with representatives of the Colville AAA, Omak HCS and tribal organizations as meetings are scheduled. We will initiate a yearly joint meeting with staff in key programs. AACCW will extend an invitation to the Colville AAA When we do large trainings of our staff. We will look into providing access to additional trainings that could be accessed remotely by video for the Title XIX case managers. We will offer an MTP Training to the Colville AAA staff conducted by the AACCW Information & Assistance Lead AnDee Desrosier. AnDee is based in AACCW's Omak office and serves as our MTP Subject Matter Expert. We will also offer ongoing program education and support if requested.	Identified barriers to provide services will be reduced, when possible, through efforts suggested in these meetings. Colville AAA will benefit by not having to replicate training that is available within traveling distance or by video. AACCW will benefit by meeting and engaging with Colville AAA.	State/AAA: AACCW Melanie Divis Diane Tribble Erin Nelson Debbie Peterson Tribe: Colville Confederated Tribes Yearly – Tribal AAA/HCA/ALTSA meeting. On-going	On August 3, 2023 AACCW Information & Outreach Specialist Lisa McGowan met with Kim Leaf, Colville AAA Omak Elder Assistant Kim Leaf. Lisa provided Kim with a donated wheelchair from the AACCW medical equipment supplies inventory. Kim had reached out to Lisa because she heard we provided DME. While at the AACCW Omak office Lisa and Kim discussed the various resources in the area that could benefit tribal elders. Lisa shared brochures and information with Kim and encouraged her to join the Serving Our Seniors network. This is a group of organizations and agencies in Okanogan County that share and receive information in an electronic bulletin. The information is helpful for seniors and adults with disabilities. Lisa McGowan prepares the twice weekly bulletins by searching for up-to-date community, state, and federal information.
To ensure that the goals set forth in this document are achieved.	We will place a review of the 7.01 plan on the agenda of our Director's/Manager's meetings on a quarterly basis	We will meet the goals we have set for ourselves in our 7.01 plan.	State/AAA: AACCW Directors/Management Ongoing on a quarterly basis. Tribe: Colville Confederated Tribes On-going	For the most part, we have achieved the goals of our previous plans but did not meet our goal of having a review of the 7.01 plan as a standing quarterly agenda item. This will remain our goal. Met with Lisa Adolph 10/09/2023 to review 7.01 Plan..

Issue Area C - 5: COVID-19 Response Services and Supports
Profile of the Issue: 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. As a trusted local community resource, Aging & Adult Care of Central 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.

Major Objectives	Key Tasks and Benchmarks	2024				2025				2026				2027			
		Jan-March	April-June	July-Sept	Oct-Dec	Jan-March	Apr-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec	Jan-March	April-June	July-Sept	Oct-Dec
Maintain senior's access to Covid-19 information by providing area Senior Centers with CV-19 information, and participating with the Region 7 Healthcare Alliance.	AACCW will share Covid-19 information with every senior center.		x		x		x		x		x		x		x		x
	AACCW will continue to participate and provide meeting facilities for the Region 7 Healthcare Alliance of local hospitals, health districts, EMS, and other medical or service providers.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

APPENDICES

Emergency Response Plan

1. **A designated staff person to oversee planning tasks and determine how emergency management is carried out in the local jurisdiction:**

   Ken Sterner, Director of Business Operations, is the designated staff person to oversee all emergency planning activities within AACCW jurisdiction.

2. **Preparedness activities done by the AAA:**

   - AACCW makes emergency preparedness information available to local senior centers across the region and to the clients we serve.

   - AACCW has previously acquired equipment and supplies for both wildfire and other emergency situations that have occurred in our region. Our agency will continue to do so as needed or requested in the future. Items such as mobile computers, communication systems, air scrubbers, air purifiers, face masks and other PPE has been and will be provided to residents, hospitals, and emergency responders.

3. **Policy and Procedures Developed and/or Implemented due to Covid-19 Pandemic**

   - AACCW is an active member of the Local Emergency Planning Committee with the Chelan and Douglas Counties shared Emergency Management Department, and a continuing partner with the American Red Cross. AACCW also maintains close contact with the emergency responders (fire, police, ambulance, etc..) and Emergency Management Departments of other counties within its current six-county PSA during the wildfire season and other emergency situations as they may arise. However, with the onset of the COVID-19 pandemic AACCW also forged relationships with more organizations, groups, who are collectively responding to the health and social issues associated with the pandemic:

     - AACCW will continue to provide physical space, technical assistance, and staff support within its offices to the region's Emergency Management Team (EMT) and other involved entities as requested.

     - AACCW will continue to participate in meetings consisting of high-level leaders from regional hospitals, the medical community, elected officials, police, and businesses in planning and strategizing regional responses to the COVID-19 pandemic or other emergency situations.

4. **Letters of agreement between the AAA and local emergency operations leadership that identify responsibilities.**

   Various Letters of Agreement (LOA's) with local and regional Emergency Operations Centers (EOC), first responders, American Red Cross and allied organizations are currently available or in process of renewal.

5. **Criteria for identifying high-risk clients and referring to first responders as necessary:**

   A high-risk client is someone with high ADL needs and/or cognitive deficit that has little or no informal support. This also includes clients with a history of falls, a poor history of managing medications and/or those who have a history of pressure ulcers. This occurred throughout the year and across the region as home evacuations occurred due to wildfires and other natural calamities.

6. **Plan for contacting high-risk clients and referring to first responders as necessary:**

   In the event of an emergency, AACCW will first attempt to contact the isolated and/or high-risk client by any means (phone, email, text, Facebook, friend, relative, neighbor, etc.) mutually available to AACCW and the client. This may also include direct contact with AACCW personnel, but ONLY if EOC communications indicate safe levels for public access.

7. **Local Partners:**

   - AACCW works in a support role with the local American Red Cross, law enforcement and other emergency first responders as needed or requested.

   - AACCW actively supports and partners with the local health districts within this region to address the needs of the elderly and disabled population.

   - AACCW is actively working with local allied providers, businesses, families, and the public, including, but not limited to, Region 7 Healthcare Coalition, Local Emergency Planning Coalition (LEPC) and Accountable Community of Health.

8. **Cooperation with the appropriate community agency preparedness entities when areas of unmet need are identified:**

   - As unmet needs are identified by AACCW or the appropriate community preparedness agency, the Agency works directly with the entity to resolve these needs or provides information or referral services to the extent the need can be addressed by another agency, community partner, or resource.

9. **A system for tracking unanticipated emergency response expenditures for possible reimbursement:**

   - AACCW currently maintains policies and procedures for regular expenditures and business operations. However, in the event of an emergency, AACCW has issued credit cards to management personnel that can be tracked on-line or via monthly statements and incorporated later into the organization's regular business operations.

10. An internal Business Continuity Plan that emphasizes communications, back-up systems for data, emergency service delivery options and transportation.

AACCW does not provide direct emergency service delivery or transportation. However, it does provide supportive information to emergency service responders and transportation authorities that can assist them in responding to emergency situations. Thus, the focus of AACCW's business continuity planning is to maintain the Agency's ability to both store and distribute this information in a timely and effective manner in times of crisis when normal operations are not possible.

In the event of a communications outage at AACCW, all managers and directors have been provided SSL VPN access to perform normal job duties while away from the effected zone(s). In the event of network/telecommunication outages, each office would be able to communicate internally and externally using personal cell phones for those who choose to utilize them. Servers are backed up to local NAS systems that also replicate to offsite NAS systems.

Report on Accomplishments for the 2022-2023 Area Plan Years

Creating Healthy Communities

Profile of the Issue: Aging & Adult Care of Central Washington (AACCW) encourages all ages of individuals to strive for good health to help them age in place. Generally, most individuals want to remain at home as they age. However, their ability to do so for a lengthy period depends on both physical and mental strength, as well as having solid long-term care supports in place.

Selected Focus and Goals: AACCW will continue, and even expand, educational programs to teach individuals how to achieve better health. To support this, Aging & Adult Care will offer programs, services, and appropriate referrals to educational opportunities about chronic disease management, low-impact exercise, good nutrition, and behavioral health.

Objective: To continue and expand programs that offer information about chronic disease prevention, progression and management.

Outcome: AACCW will continue to collaborate with providers in the community to help individuals understand how they can prevent or slow disease development or how they can manage symptoms if they have a chronic illness. AACCW will work to promote these programs through networking and outreach.

2022-2023 Update: AACCW offered classes, workshops, and support groups for people needing support and education about their chronic illnesses. We partnered with the Alzheimer's Association in 2022-2023 by hosting and advertising informational workshops about memory loss. We will continue to do this in the future, and plan to work with the Association to host a dementia forum in 2024.

Parkinson's Disease is another chronic illness affecting many of the clients we serve. To educate and assist Parkinson's patients and families, we provide office space for a monthly support group, which is an organization intended to help people who have suffered a cardiac event or stroke.

In 2022-2023 AACCW worked closely with the North Central Regional (NCR) Falls Prevention Coalition to create a health and wellness event for seniors. This coalition consists of medical providers, emergency response professionals, social services agencies, and other organizations focused on reducing falls and injuries in our senior populations. AACCW was a lead sponsor of the events and a key organizer of the Okanogan Falls Prevention Fair.

Objective: To help individuals reduce their risk of falling. This will include collaboration with partners across our six counties to educate consumers and promote fall-prevention resources.

Outcome: The I&A Department has started a partnership with local fire departments, ambulance services, and medical providers to educate communities on fall prevention. AACCW will grow this partnership and follow clients referred to us by members of this partnership to see if their incidence of falls declined.

AACCW will also promote *Matter of Balance*, a new program sponsored by our agency focusing on reducing fall risk. Continued work with the Retired Senior Volunteer Program to implement and expand Staying Active and Independent for Life (SAIL) in our six counties.

2022-2023 Update: Our work in the Information & Assistance Department on fall prevention has blossomed into a partnership with the NCR Falls Prevention Coalition. This group consists of medical providers,

emergency management, fire departments, senior centers, and other agencies and social services serving the elderly and vulnerable adults.

This coalition worked together to organize a Senior Fall Prevention Event & Health Fair in September 2023 called *Finding Our Balance*. Five venues held these events located in Twisp, Okanogan, Chelan, Leavenworth, and Wenatchee. Aging & Adult Care of Central Washington was a primary sponsor of all five events. The collaboration between the members of the NCR Falls Prevention Coalition is an exciting partnership that helps elderly adults avoid hospitalization and premature institutionalization or death as a result of falling.

Objective: To improve mental health and well-being of family caregivers and individuals with chronic disease.

Outcome: AACCW will expand the availability of caregiver support groups across all counties to help families in their caregiver journey. There will be continued promotion of resources that encourage seniors to connect with others and engage in activities using such materials as *Aging Mastery Program*, which offers exercise and Tai Chi DVDs.

In addition, AACCW plans to start a support group for individuals with a recent diagnosis of Alzheimer's or another dementia-causing illness. This group will help individuals cope with their diagnosis.

2022-2023 Update: The Information & Assistance Department has offered four family caregiver support groups since 2021. The groups are located in: Davenport, Moses Lake, Chelan, and East Wenatchee. After the Public Health Emergency ended, we began to see a greater interest in the four support groups.

In June 2023, we contracted with a new facilitator who retired from working several years for the Alzheimer's Association. Her knowledge of the disease and the challenges of caring for people with dementia brought insight and expertise that is leading to an increase in group attendance.

AACCW began offering Powerful Tools for Caregivers, which is a six-week course designed to give caregivers the tools they need to take care of loved ones as well as take care of their own well-being. Powerful Tools is available virtually and in person.

Report on Accomplishments for the 2022-2023 Area Plan Years

Expanding and Strengthening Services and Supports That Prevent or Delay Entry into Medicaid Funded Long Term Services and Supports (LTSS)

Profile of the issue: Washington is very progressive in its efforts to care for aging and disabled individuals, investing in programs that many other states do not provide. However, to continue this level of care, we must find ways to slow the use of publicly funded programs, to stretch the resources for those who truly need a higher level of care. Statistics show more than two-thirds of the care provided in-home is conducted by family members and friends. How do we assist these unpaid caregivers who make up the backbone of long-term care in our state?

Selected Focus and Goals: Referrals for Medicaid Alternative Care (MAC), Tailored Supports for Older Adults (TSOA) dyads, and Family Caregiver Support Program (FCSP) clients will increase due to 1) outreach to medical and social services professionals through presentations virtually or in person when possible; 2) through participation in networking opportunities in our communities; and 3) media promotions through traditional media and internet-based platforms, including more emphasis on Spanish-speaking populations. MAC, TSOA and FCSP support family members and friends who take care of someone without being paid to do so. Without these unpaid caregivers, care receivers would be unable to remain safely at home and would need to rely upon more expensive Long-Term Services and Supports (LTSS) such as Medicaid.

Objective: To increase information sharing about supports and services for unpaid caregivers with medical and social service professionals. AACCW will seek out virtual and in-person presentation opportunities for hospital and clinic staff, social workers, nurses and medical assistants regarding the services we offer for unpaid family caregivers.

Outcome: AACCW will strengthen partnerships with our primary source for referrals which will result in an increase in caregiver/care receiver clients.

2022-2023 Update: The Information & Assistance Department consistently counts medical providers as the primary source of new referrals. These referrals increased in 2022-2023 and continue to grow rapidly.

As pandemic-related restrictions lifted, medical providers have invited us to present to their staff, and most are surprised to learn how many services AACCW offers. Hospital social workers, nurse case managers, and physicians incorporate us as a regular part of patient discharge planning. Medical clinics are also sending us more referrals. Medical practitioners in our region are becoming reliant upon AACCW to meet their requirements for adequate patient care and support.

Objective: Increase participation in networking opportunities in our communities.

Outcome: While AACCW currently takes part in several networking groups, untapped opportunities remain to conduct presentations to these groups offering in-depth information about services for unpaid caregivers. Referrals to our Agency will increase and greater number of unpaid caregivers will access the help they need.

2022-2023 Update: The Information & Assistance Department continues to coordinate the Senior Services Network, which covers Chelan and Douglas Counties. We also send at least one staff member to attend the monthly Interagency Networking group, the Moses Lake Senior Forum, and the Moses Lake Community Resource Forum.

Each of these groups offers time for attendees to share news from their organizations Staff regularly talk about our programs that help family caregivers and share brochures and flyers with these networking groups.

The Serving Our Seniors group which we've coordinated for several years transitioned from bi-monthly meetings to a twice-weekly electronic bulletin. Our Information & Outreach Specialist in Omak compiles the bulletins, which include our program information as well as informative links to articles and web sites. We have received very positive feedback about the bulletins, which keep our network participants informed.

Objective: Promote supports for unpaid caregivers through radio, print, internet platforms, television, and movie advertising. Increase messaging to Spanish speaking populations using culturally appropriate communications.

Outcome: A broader cross-section of consumers living in our region will reach out to AACCW for help to take care of their relatives and friends. Many communities in our region with greater numbers of Spanish-speaking residents will feel comfortable contacting us for help.

2022-2023 Update: In 2022-2023 the Information & Assistance Department moved away from print advertising and explored digital and social media platforms, including Facebook and targeted email promotions. These campaigns produced impressive results, with a higher-than-average click-through to our web site.

Reaching Spanish-speaking populations has proven to be challenging as there are few publications printed in Spanish in our region and a smaller number of radio stations that reach the population we serve. Now that we've seen the success of digital marketing and social media promotions, we are making plans to use the same methods to reach Spanish-speaking family caregivers and care receivers.

Report on Accomplishments for the 2022-2023 Area Plan Years

Person-Centered Home and Community Based Services

Profile of the Issue: Emphasizing our primary mission statement which is to enhance a person's ability to maintain a life of independence and choice is key to being person-centered. The goals of each individual are front and center of our care plan as we go forward in providing the essential care and means to provide a safe environment while meeting the needs of our vulnerable population. The objective of these programs is to maintain individuals at the most appropriate (least restrictive) level of service and to minimize premature or unnecessary residential care placement.

Selected Focus and Goals: Aging & Adult Care of Central Washington is about Person-Centered Care, Community Based Services, as it is our mission to be responsive to the person-centered needs and choices of our older adults and people with disabilities with the goal of maximizing their independence and honoring their choices as allowed by policies and procedures. AACCW will continue to provide professional delivery of quality care in our communities and appropriate resources and support to the clients we serve in a committed and passionate design.

Objective: Providing choices for our long-term care population.

Outcome: Consumers will be well informed of relevant services, programs, and provider options available to meet their needs and preferences. This includes but is not limited to providing appropriate referrals to community resources; reviewing all programs available through AACCW, such as MAC, TSOA, FCSP, and ANC; and supporting consumers wherever they are in their decision-making process. Each person should be encouraged to decide what is best for them. Our duty is to thoroughly inform and honor the choices they make.

2022-2023 Update: The Information & Assistance Department has seen an influx of referrals, especially from medical providers. Each referral is provided an explanation of all their options, including our chore program, the Family Caregiver Support Program, MAC/TSOA, CFC/COPES, and community resources. They are screened for all programs for possible financial and functional eligibility and provided information about what to expect regarding services available, possible participation, and estate recovery if this is a potential concern. Each person is encouraged to choose what is best for their situation and needs. The staff focuses on meeting the person where they are at in their decision-making process and allowing them to make their own choices.

In addition, if current clients need more services than their program provides, they are given information about other programs that might be a better fit. The staff helps the client to apply and assists in the transition, whether it is a program Information & Assistance manages, or a program administered by another agency or department.

The choice by the client is always respected and advocacy and service has been a strength in the Department and will be an ongoing focus for the Information & Assistance Team.

Objective: To increase our Health Home Program census and focus on outreach to all six counties.

Outcome: Our Health Home Program will continue to grow and serve eligible patients and be sustainable both physically and financially.

2022-2023 Update: The objective and outcome will continue in the 2024-2027 Area Plan.

Person-Centered Home and Community Based Services *Continued*

Objective: Transition and Implementation of the Consumer Direct CARE Network of Washington Employer (CDWA). CDWA will be the legal employer for all Individual Providers who care for clients receiving services from the Department of Social and Health Services (DSHS). CDWA Phase 2 is projected to start January 2022 and April 1st in full operation.

Outcome: Training in transitioning to the CDWA by staying informed, i.e., Talking Points and webinars as they are made available. Also, to hold team meetings to voice concerns and provide answers when available.

2022-2023 Update: The objective and outcome were met.

Outcome: Seamless implementation of the Consumer Direct Employer (CDWA) is legislation requires DSHS to implement the CDWA by April 30th, 2022.

2022-2023 Update: The objective and outcome were met.

Objective: During the Emergency Proclamation around COVID-19 implement agency requirements and guidelines that allow adaptability in a safe and responsible manner.

Outcome: Employee and customer safety comes first. Use the best public health and safety practices. Provide timely and equitable public service.

2022-2023 Update: The objective and outcome were met.

Objective: Self-Awareness gives us an opportunity to recommit to daily self-care practices. Also, an opportunity to remind our clients to practice self-care and to learn about the programs we offer that can help them improve their overall well-being.

Outcome: For our clients to be able to take care of their basic physical and mental needs – such as eating well, exercising, and managing their chronic conditions as their overall health will improve as well. Educate our staff and clients to the programs within HCS that support clients to improve health and wellness. Health Homes, Wellness Education Newsletter, Chronic Disease Self-Management Education (CDSME).

2022-2023 Update: The objective and outcome will continue in the 2024-2027 Area Plan.

Report on Accomplishments for the 2022-2023 Area Plan Years

Medicaid Transformation Demonstration

Profile of the Issue: The Medicaid Transformation Demonstration (MTD) was designed to help family caregivers, care receivers, and individuals living at home without information supports. The program continues to gradually attract clients, although COVID-19 negatively impacted growth especially in 2020.

Our Information & Assistance Department must renew our efforts to maximize the benefits of the MTD program. MTD has helped many people who don't qualify for or do not want to access Medicaid LTC services.

Selected Focus and Goals: Information & Assistance (I&A) staff will focus on the unique features and advantages of MTD, including presumptive eligibility, home modifications, and the wide array of assistive technology MTD offers. The Family Caregiver Support Program, Aging Network Chore, and Medicaid LTC cannot provide some of these features. Staff will make sure clients and new referrals understand these benefits thereby increasing AACCW's MTD caseloads.

Objective: To reduce the time between the Presumptive Eligibility assessment and the implementation of services. The advantages of PE are not being fully utilized at this time.

Outcome: Individuals and family caregivers will receive help with less delay. Patients discharging from hospitals will have the supports needed to assure their transition home is successful. Staff will maximize the unique advantages of presumptive eligibility.

2022-2023 Update: While presumptive eligibility is a positive feature of MTP, service implementation was often delayed, especially for personal care and respite due to a shortage of homecare workers. This will continue to be a barrier until the worker shortage improves.

Objective: For staff to become proficient in Exception to Rule and Exception to Policy requests, especially for necessary home modifications, ramps, and assistive technologies difficult to access in other programs.

Outcome: Family caregivers and individuals will enjoy the full benefits of the MTD program even if they don't remain on the program for a lengthy time. Participants can use the program to obtain short-term services such as a ramp for an electric wheelchair.

2022-2023 Update: In 2022 a staff member in our Omak office was designated as program lead/trainer. This has resulted in the Departments' proficiency in using the Exception to Rule process as well as improved overall staff performance.

Objective: To inform medical providers about the benefits of Presumptive Eligibility and gain their confidence that patients will quickly receive services when they are discharged.

2022-2023 Update: Due to the challenges we have experienced with quick implementation of services, 2022-2023 we did not emphasize presumptive eligibility as a primary benefit of the MTP program.

Report on Accomplishments for the 2022-2023 Area Plan Years

In-Home Services

Profile of the Issue: The primary mission of Aging and Adult Care of Central Washington Case Management is to assist the client to develop a Plan of Care to enable them to reside in the setting of their choice and to monitor that plan. Case managers will support the client's independence by coordinating and offering assistance to access needed services. As custodians of the state's resources, it is paramount for Case Managers to balance a client's choice within program limits.

Following the concept of continuum of care utilizing our integrated systems available that guides Case Management to educate clients, family members, support systems, and other service providers resulting in a comprehensive plan of care that is developed within the choices and resources available.

Selected Focus and Goals: AACCW staff will provide client-centered services, evaluating informal and community supports, with an overarching goal of preventing unnecessary institutionalization and to maximize client independence and self-direction. Consumer Direct Care Network Washington (CDWA) will be the legal employer for all Individual Providers who care for clients receiving services from the Department of Social and Health Services (DSHS). CDWA Phase 2 is projected to start January 2022 and April 1st in full operation.

Objective: Assure that clients receive appropriate quality services which meet their needs and recognize their capabilities and choices through timely and responsive assessment, service delivery, reassessment, and case management.

Outcome: Staff will receive training and resources necessary to be knowledgeable on local advocacy resources; or ensure vulnerable populations have access and support systems to allow them to live in the settings of their choice.

2022-2023 Update: This objective will continue in the current Area Plan.

Outcome: Case Managers/Family Caregiver Resource Managers will be trained on Assistive Technology options and authorizations.

2022-2023 Update: This objective will continue in the current Area Plan.

Objective: On-going training to all offices to ensure Case Management staff are proficient in providing client assessments that are person centered in CARE Desk and CARE Web depending on access availability.

Outcome: Case Management Supervisors will continue to use the Quality Assurance (QA) CARE tool to monitor Case Manager' work at 100% compliance per ALTSA requirements.

2022-2023 Update: This objective will continue in the current Area Plan.

Objective: Seamless implementation of the Consumer Direct Employer (CDWA) as legislation requires DSHS to begin implementation of the CDWA Phase 2 is projected to start January 2022 and April 1st in full operation for our region.

Outcome: Training in transitioning to the CDWA by staying informed, i.e., Talking Points and webinars as they are made available. Team meeting to voice concerns and provide answers when available.

2022-2023 Update: Objective met as implementation training has been completed.

- Ongoing communication with monthly meetings with the Directors via Teams meetings.
- Ongoing monthly updates to Provider training.

Report on Accomplishments for the 2022-2023 Area Plan Years

In-Home Services – Information & Assistance Perspective

Profile of the Issue: AACCW's Information & Assistance Department (I&A) implements several different programs that offer in-home services. These programs include Aging Network Chore, MAC/TSOA and the Family Caregiver Support Program. I&A staff also screen for LTC Medicaid eligibility as some individuals can benefit most from COPES or CFC.

The I&A Department relies upon medical providers and organizations in our communities who also serve seniors and adults with disabilities to provide most of our referrals. I&A efforts must assure they understand the many programs and services available to their patients and clients. In addition, we must streamline the referral process, realizing nurses, discharge planners, and social workers need our help to meet the needs of their patients.

The I&A Department must also reach relatives, neighbors and friends taking care of loved ones living at home. These outreach efforts must improve inclusiveness of non-English speaking individuals and touch very rural areas as well.

In addition, I&A staff must be trained to keep client choice top-of-mind and avoid telling the individual what is best for them but rather presenting what is available and allowing the individual to choose.

Selected Focus and Goals: AACCW Information & Assistance outreach will increase messaging to medical providers and other agency professionals. I&A supervisors will assure staff have training to present in-home service options in a person-centered approach. In addition, I&A supervisors will also assure informational efforts and promotional campaigns adequately reach the demographic and very rural areas we serve.

Objective: To train and certify all Information & Assistance staff in person-centered options counseling by participating in the new series of PC trainings offered by ALTSA.

Outcome: Staff will improve their ability to help individuals select in-home services & supports that best meet their needs and preferences. This will assure the individual receives the LTSS that he or she envisions without influence from AACCW staff.

2022-2023 Update: In 2022-2023 the majority of our new employees participated in person-centered options counseling trainings provided by ALTSA. Others used self-paced webinars and videos to learn person-centered best practices. This depended upon class availability and training preferences.

Objective: To implement an informational campaign designed to reach medical providers and others associated with the healthcare field, which is the primary source of referrals for our in-home services.

Outcome: Medical practitioners, social workers, discharge planners, and others will be familiar with the many in-home services options AACCW offers and refer more patients for assistance. This will ensure individuals

and families receive the assistance they need and help overly burdened medical professionals care for their patients.

2022-2023 Update: Information & Assistance successfully engaged in an outreach program with medical professionals in 2022-2023. This is demonstrated by the increase we have seen in referrals from hospitals and clinics in 2022-2023. AACCW services are a standard part of hospital discharge planning. We have become true partners with some of the largest medical providers in our region.

We will build on this momentum in 2024-2027 by cultivating closer relationships with smaller hospitals and clinics that may not realize the support we can offer to their patients.

Objective: To design AACCW's media campaigns, outreach efforts, and agency collateral to be culturally sensitive and inclusive.

Outcome: More adults with disabilities, seniors, family caregivers and others will feel AACCW's programs are also "for them", accessible and beneficial no matter their ethnicity, language, location or socioeconomic circumstances.

2022-2023 Update: In 2022-2023 we incorporated a mix of images in our advertising, including photos of Hispanic, Indian, Native American, Black, and Asian individuals and their families. We are constantly seeking to be more inclusive of all populations. This will be an area where we will invest more effort and resources in 2024-2027.

Report on Accomplishments for the 2022-2023 Area Plan Years

Nutrition

Profile of the Issue: Comments received at planning meetings, survey results, and input received from stakeholders consistently shows nutrition as one of the most important discretionary services AACCW provides. This program was never intended to be fully funded by AACCW. Nutrition contractors must make up the difference through fund raising and other community support.

Selected Focus and Goals: For some contractors, traditional sources of revenue have recently decreased their support. Costs continue to rise, due to higher food and fuel costs and a minimum wage that increases every year. The standards that dictate the frequency of meals provided by our contractors can be challenging to meet due to the rural nature of our PSA; where such frequency is not feasible, less frequency has been approved.

Objective: Identify the appropriate use of federal funds to maintain existing meal sites that may be at risk.

Outcome: Help restore/maintain nutrition services in our most rural areas by increased awareness of the senior nutrition program through flyers and public service announcements. Offer support to contractors to engage community partners to assist with ways to increase sources of revenue. Continue to research all options for contracting with qualified contractors for home-delivered meals for the most rural areas.

2022-2023 UPDATE: When the pandemic started, we had to shift gears immediately to make sure people in our region would have access to nutrition programs. Each of our Nutrition Providers adapted quickly to the necessary changes that allowed for 'take-out' meals rather than congregate meals. AACCW's I&A Department helped to promote the home-delivered meal program as so many seniors were isolated at home and unable to go to the store during the 'stay at home' period. A contract was procured with PurFoods to get meals delivered to the most rural and underserved areas. As some nutrition sites began to re-open, AACCW was able to use federal funds to purchase necessary equipment such as plexiglass dividers, a commercial stove, shelving, tables, and two vehicles for transporting home-delivered meals.

Appendix G

Statement of Assurances and Verification of Intent

For the period of January 1, 2024 through December 31, 2027, Aging & Adult Care of Central Washington (AACCW) accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (P.L. 116-131) and related state law and policy. Through the Area Plan, Aging & Adult Care of Central 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 Services and Service Area. Aging & Adult Care of Central 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 and 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 & Adult Care of Central Washington for providing services to low-income minority individuals and older individuals residing in rural areas within the Planning and Service Area.

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

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

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

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

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

Obtain input from the public and approval from the AAA Advisory Committee 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 & Adult Care of Central Washington shall publicize the hearing(s) through legal notice, mailings, advertisements in newspapers, and other methods determined by the AAA to be the most effective in informing the public, service providers, advocacy groups, etc.

10/30/2023	Bruce Buckles
Date	Bruce Buckles, Executive Director, AACCW
10/30/2023	Judith Tonseth
Date	Judith Tonseth, Advisory Committee Chair
10/30/2023	Cindy Carter
Date	Cindy Carter, CRCOG Chair Legal Contractor Authority