2016-2019 Area Plan

Aging & Adult Care of Central Washington

Serving the counties of Adams, Chelan, Douglas, Grant, Lincoln and Okanogan (excluding the Colville Indian Reservation)

Aging & Adult Care
OF CENTRAL WASHINGTON

AGING & ADULT CARE OF CENTRAL WASHINGTON
2016 – 2019 AREA PLAN

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AGING & ADULT CARE OF CENTRAL WASHINGTON
2016 – 2019 AREA PLAN

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*AOR = Available On Request

SECTION A

AREA AGENCY PLANNING AND PRIORITIES

Aging & Adult Care of Central Washington

Introduction

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 develops an Area Plan which describes services, goals and objectives for our six-county area. AACCW operates and serves a Public Service Area (PSA) that is comprised of Adams, Chelan, Douglas, Grant, Lincoln and Okanogan Counties. AACCW's Policy Board is the Council of Governments (COG). One county commissioner from 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.

The COG established the AACCW 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, case management and nurse consultation services directly, and contracts with non-profit and for-profit companies to provide services that assist individuals to stay in their own home. Our Family Caregiver Support Program provides five core service components; access and support, assessment and coordination, supplemental services, respite and services to grandparents and relatives.

In May 2015, AACCW held multiple planning meetings throughout our PSA to discuss services in order to seek input and identify unmet needs. Three public hearings were held in August 2015 to gather additional information and comments on AACCW's Area Plan.

Questions or comments may be directed to Bruce Buckles, Executive Director. Main office and satellite office locations and phone numbers:

Main Office
50 Simon St. SE, Ste A
East Wenatchee, WA 98802
509-886-0700
1-800-572-4459

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

Branch Office
739 Haussler, Unit B
Omak, WA 98841
509-826-7452

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 (AACCW) 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 adheres to the following values:

- We value volunteerism as a crucial service to the community and the clients, and as a rewarding activity for the individual volunteers. Advisory Committee members advocate for each of their individual communities as well as perform an essential role to plan for AACCW services. AACCW administers a volunteer Long-Term Care Ombudsman program to advocate for individuals in adult family homes, assisted living, veteran's homes and nursing homes.

- AACCW values and supports Twin River Productions, a group of dedicated volunteers who produce informative, entertaining videos for public access television and training videos for non-profit organizations. Other volunteer programs include, SHIBA and Wishmasters.

- 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 May of 2015, AACCW held six planning meetings (see Appendix D for dates and locations). An open process was used during the planning meetings. Invitations to the community planning meetings were publicized through radio, newspapers, mailings and flyers. Planning booklets were also mailed to interested individuals who were unable to attend the meetings.

Planning booklets contained information about current services, service levels, budgets, census data and demographics by county. AACCW Advisory Committee members and COG members were encouraged to attend, and some did participate. Additional planning packets and contact information were left at the meeting sites and at senior centers for distribution.

Between April and June of 2015, AACCW distributed 1,085 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 "Not as 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.

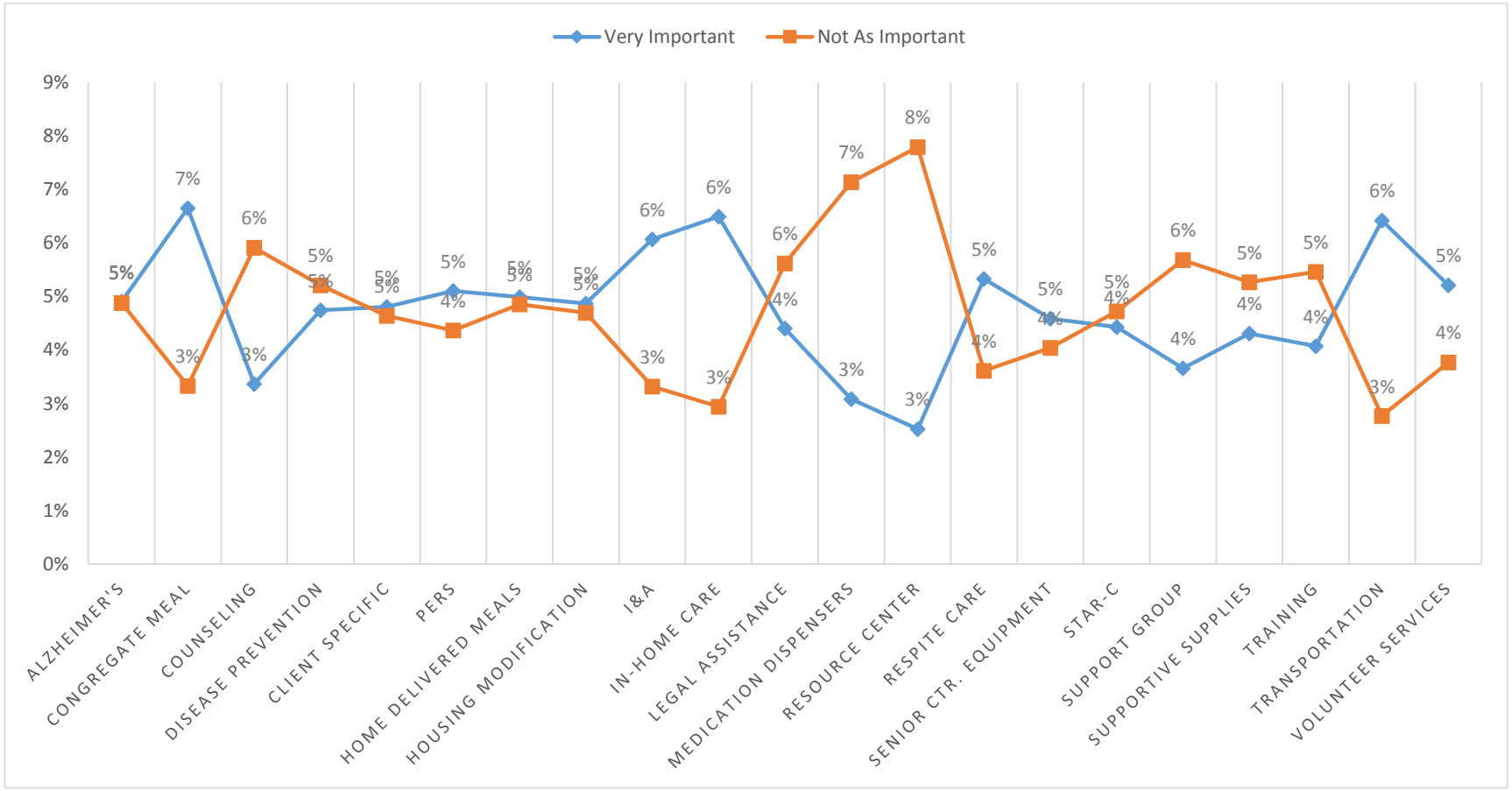
Based upon survey responses, services rated as very important include In-Home Care, Congregate Meals and Transportation. Also of concern for seniors were I&A Services, Respite Care and Personal Emergency Response Systems.

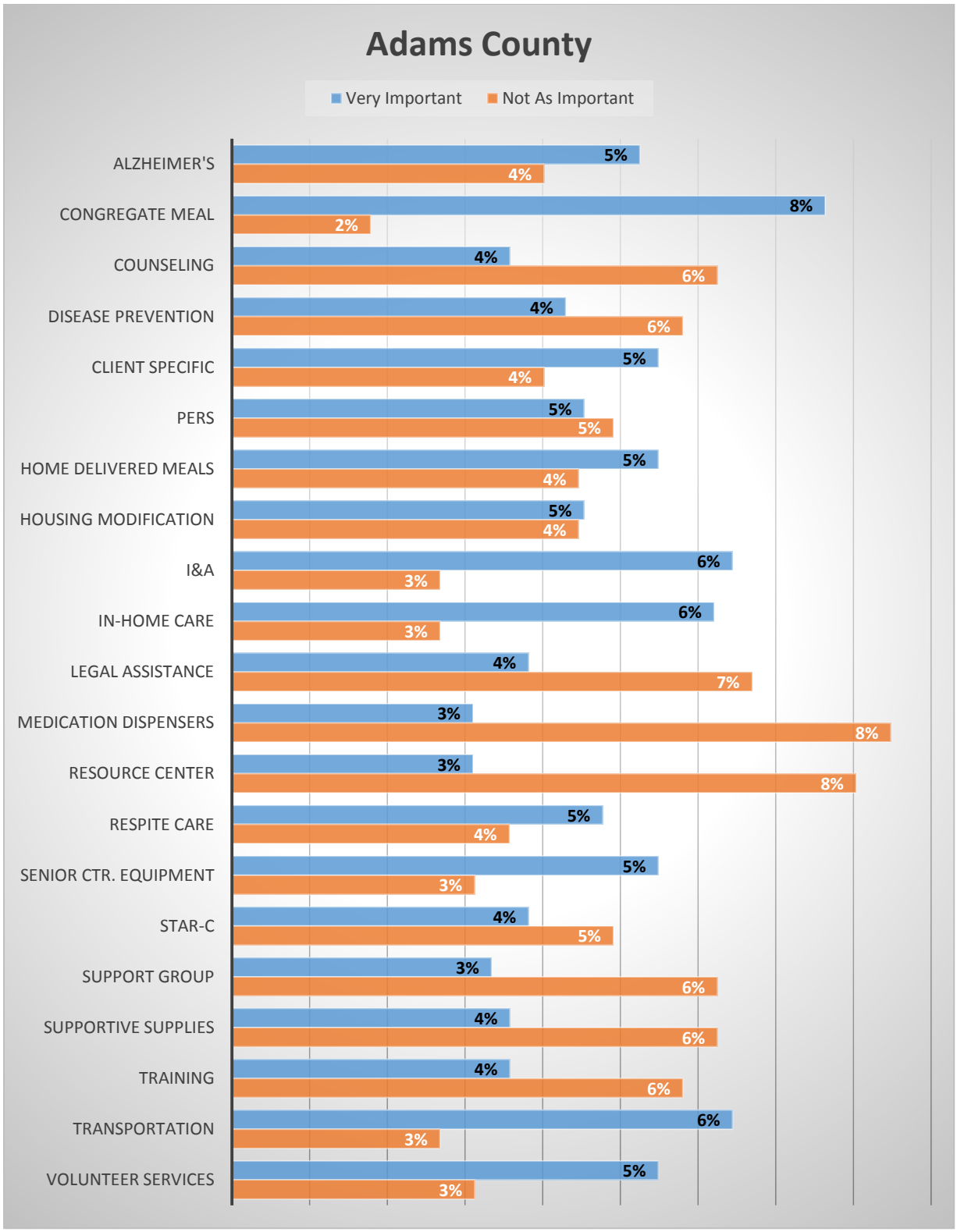
Three public hearings were held to present this plan to the public. Comments received and updates to the Area Plan were reviewed by the AACCW Advisory Committee and the COG at their respective monthly meetings. The committees had the opportunity to make changes in the plan based on the public hearings. (Information was open for comment at public hearings before the COG's action). The Advisory Committee approved the Area Plan during their August meeting and the COG approved the Area Plan during their September meeting.

Aging & Adult Care of Central Washington
2016 – 2019 Area Plan
2015 Planning Schedule

April – June	Six planning meetings were held in communities throughout our six county area. Surveys were distributed and collected.
June – July	Survey responses and comments were compiled and analyzed. Draft plan summary prepared. Public hearing notices mailed and publicized through newspapers.
August	Advisory Committee and Council of Governments reviewed survey results, public comments and draft plan summary. Three public hearings were held; one in Brewster, one in Ephrata and the third in East Wenatchee.
August –Sept.	Advisory Committee and Council of Governments approved the Area Plan.
October	Deadline to submit the 2016 - 2019 Area Plan.

Aging & Adult Care of Central Washington
2016 – 2019 Planning Survey Results
All Counties

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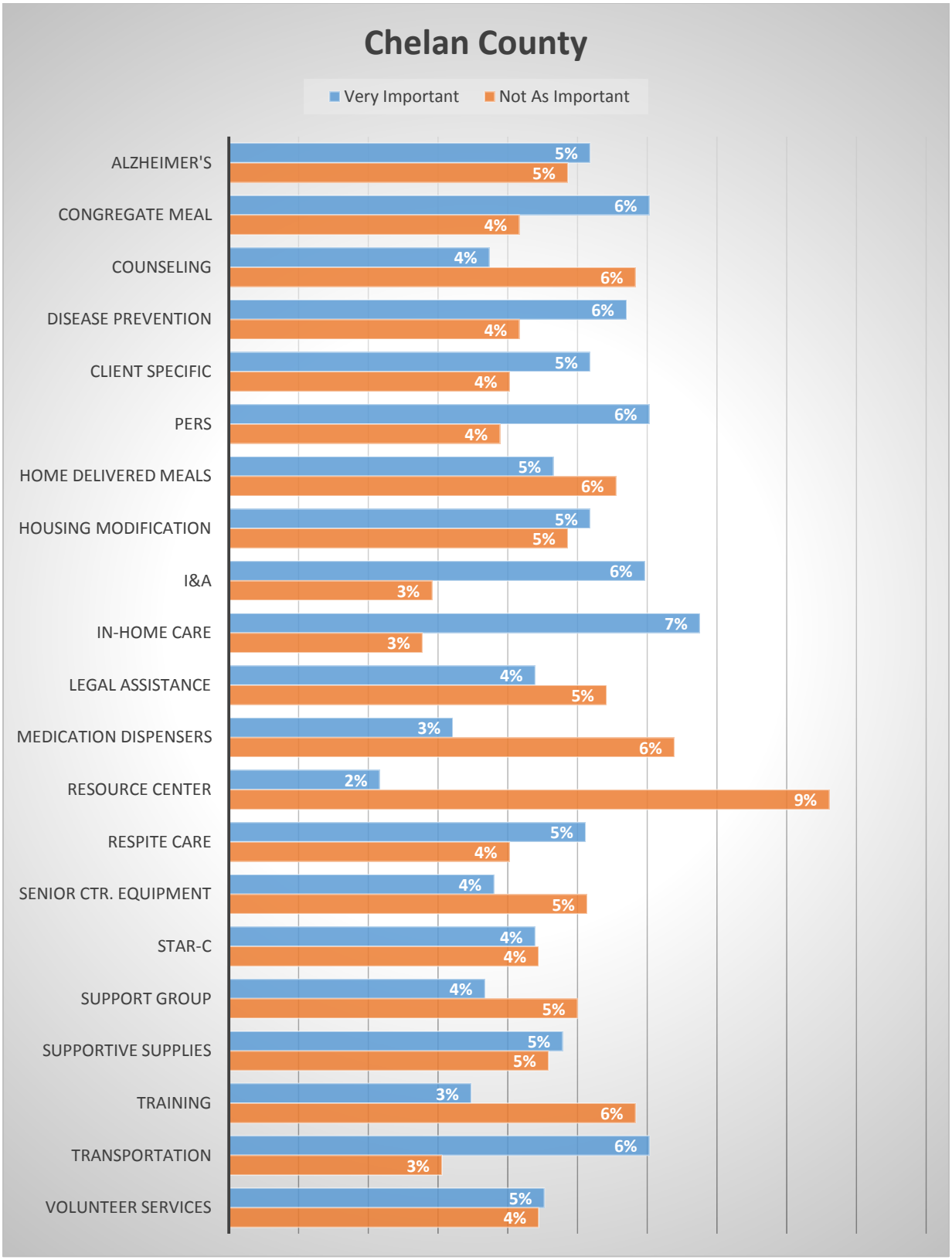
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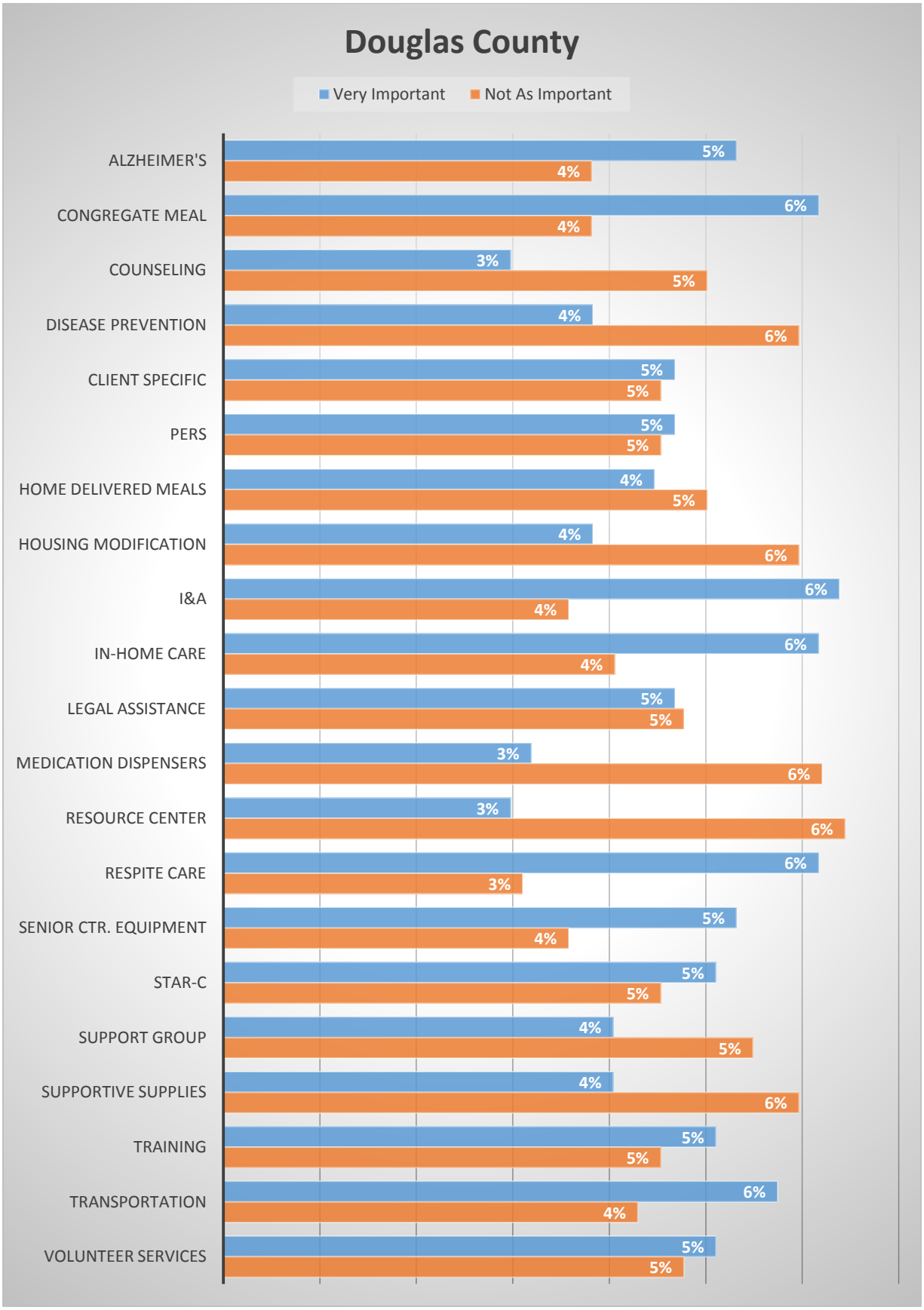
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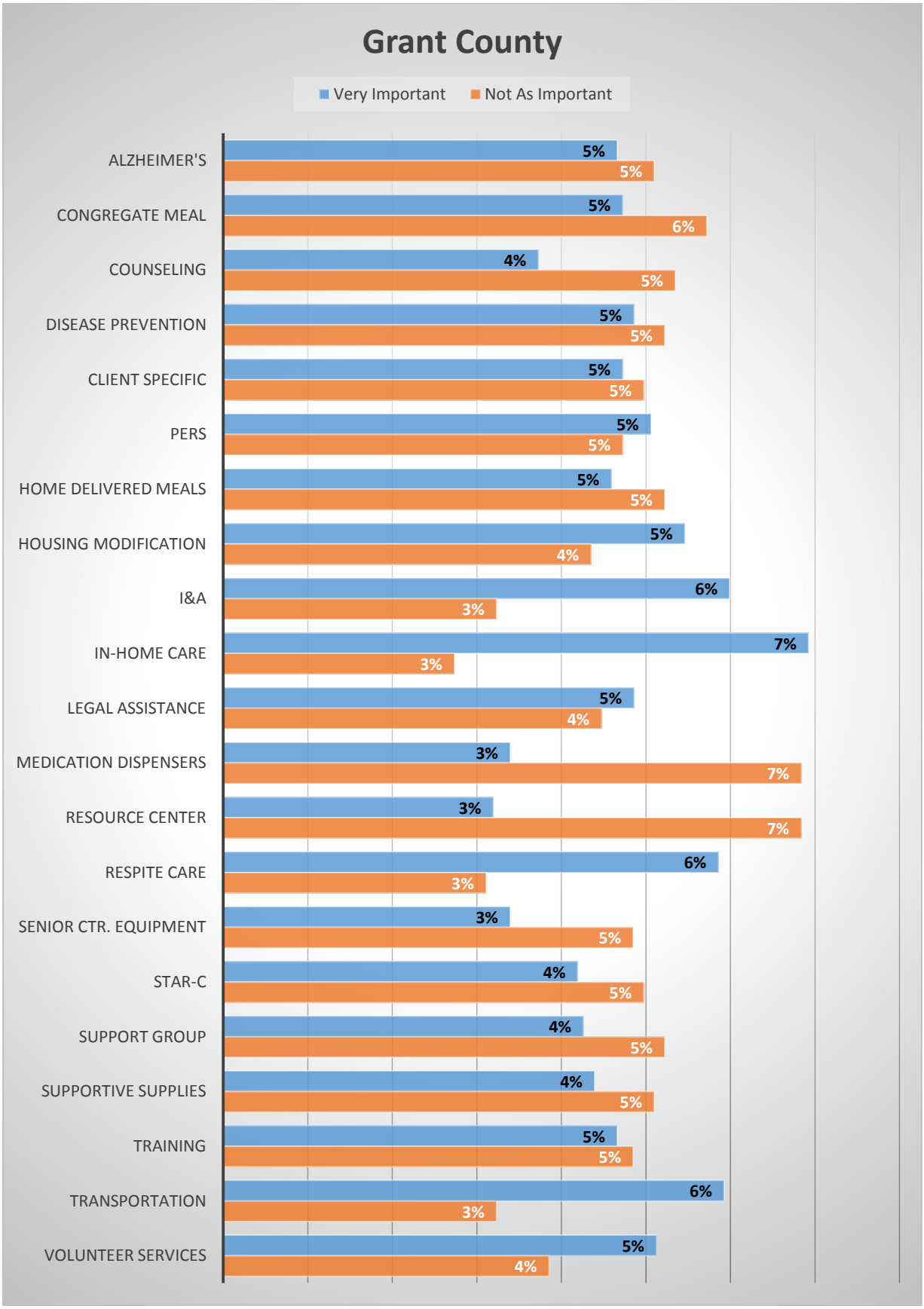
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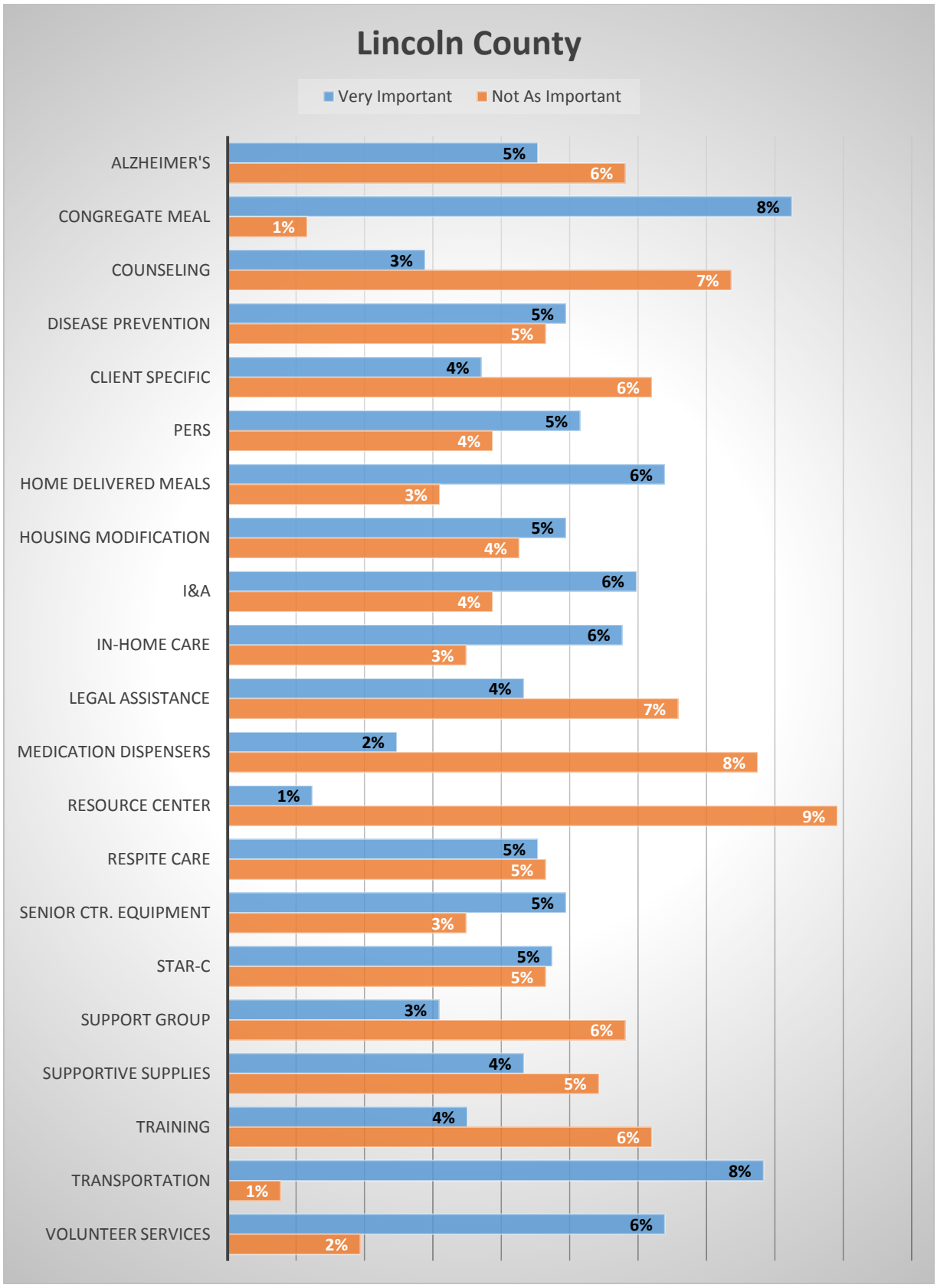
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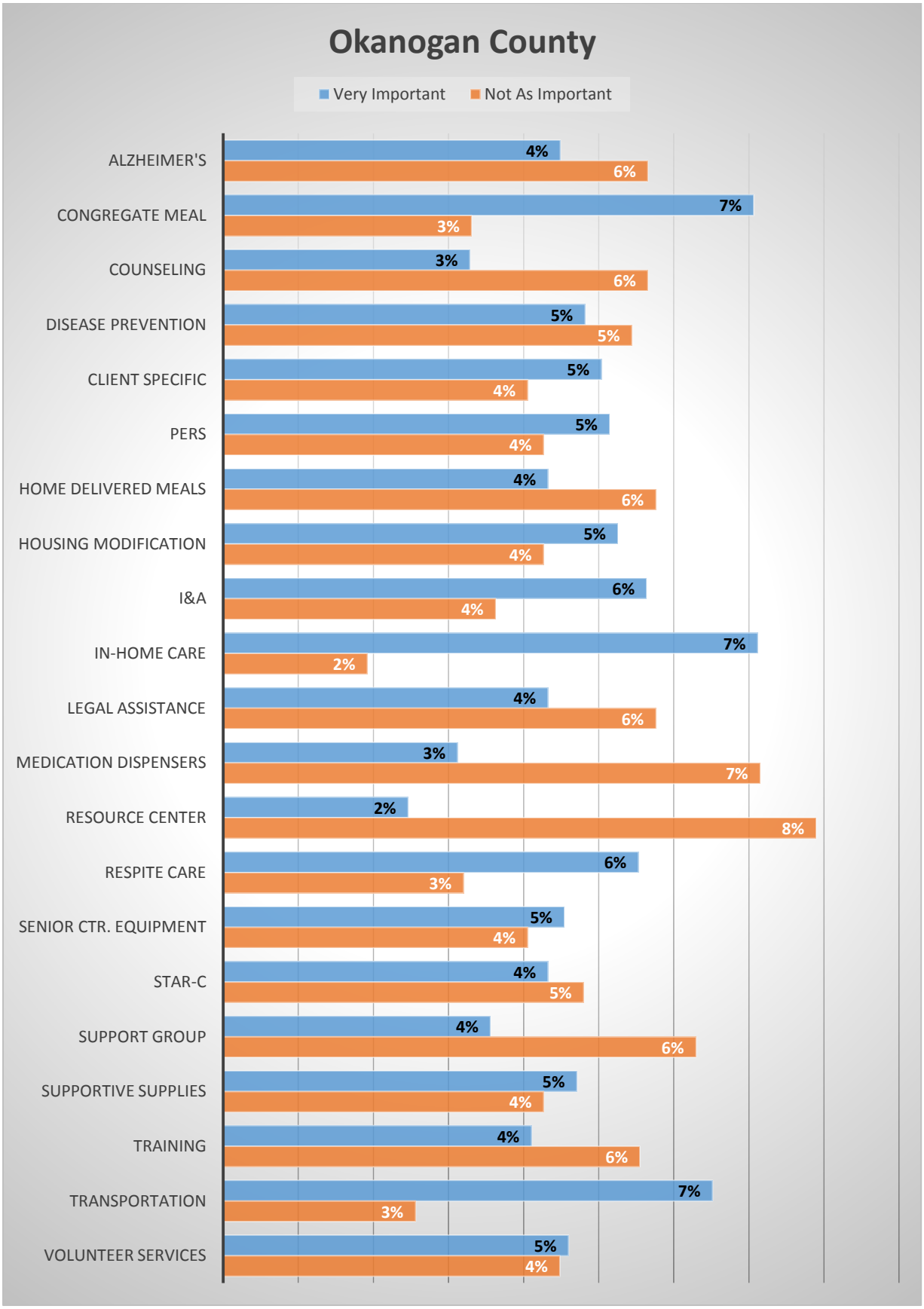
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Prioritization of Discretionary Funding

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 referral and assistance for individuals to maintain a life of independence and minimize premature or unnecessary residential care placement.

66% of the 2016 budget of $4,593,761 is "restricted". Restricted dollars must be used exclusively for the specific program funded by that source. 11% of the total budget is allocated for planning, administration, and coordination. 23% of the budget or $1,586,910 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 $11,000 for 2016 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

Congregate Meals	Home-Delivered Meals
Transportation	Client Specific Fund
Information and Assistance	Multipurpose Senior Center
Volunteer Services	Disease Prevention / Health Promotion
Personal Emergency Response System	In-Home Care
Long Term Care Ombuds	Disaster Relief

In the event of funding reductions due to sequestration 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 2016, funding levels are anticipated to remain the same due to OAA carryover from 2015. The table on the next page itemizes the proposed budget as approved by the COG.

Services	2015 Area Plan Budget	2016 Proposed Budget	Difference
Aging Network Chore	115,000	135,000	20,000
Client Specific Fund	3,000	5,000	2,000
Congregate Meals	402,224	402,224	0
Disaster Relief	5	1,000	995
Disease Prevention/Health Promotion	24,837	24,837	0
Home-Delivered Meals	267,974	267,974	0
Information & Assistance	472,475	449,480	(22,995)
LTC Ombudsman	15,000	15,000	0
Multipurpose Senior Center	6,000	6,000	0
Personal Emergency Response System	18,140	18,140	0
TIIIB Coordination	53,763	53,763	0
Transportation	124,242	124,242	0
Volunteer Services	30,000	30,000	0
Unobligated	99,617	108,013	8,396
Total	1,632,277	1,640,673	8,396

SECTION B

PLANNING AND SERVICE AREA PROFILE

Aging & Adult Care of Central Washington
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, East Wenatchee, Rock Island and Moses Lake areas are defined as urban. All other county service areas are defined as rural. In 2014, it was estimated that approximately 278,200 people resided in PSA#8, of which about 22% were aged 60 and over. *(1)*

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 *(2)*:

Characteristics	**2016**	**2017**	**2018**	**2019**
Number of persons aged 60 or above	66,879	69,005	71,169	73,218
Number of persons aged 60 or above and at or below 100% FPL*	4,761	4,873	4,926	4,989
Number of persons aged 60 or above and at or below EESSI**	12,377	12,718	13,061	13,412
Number of persons aged 60 or above and minority	6,101	6,425	6,754	7,084
Number of persons aged 60 or above and American Indian/Alaska Native	1,237	1,278	1,319	1,360
Number of persons aged 60 or above, American Indian/Alaska Native, and Disabled (ACS 18b or 18c)***	305	315	326	337
Number of persons aged 60 or above and at or below 100% FPL and minority	696	720	736	754
Number of persons aged 60 or above with limited English proficiency	2,654	2,771	2,890	3,006
Number of persons aged 60 or above and Disabled (ACS 18b or 18c)	14,385	14,821	15,292	15,752
Number of persons aged 18 or above and Disabled (ACS 18b or 18c)	22,510	22,928	23,356	23,785
Number of persons aged 60 or above with cognitive impairment (ACS 18a)	6,310	6,487	6,669	6,847
Number of persons aged 18 or above with cognitive impairment (ACS 18a)	13,676	13,853	14,012	14,177
PSA #8 Tribes represented	0	0	0	0

(1) Annual Estimates of the Resident Population, April 1, 2010 to July 1, 2014 (PEPANNRES)

*(2) Selected Population and Aging Utilization Forecast, Aging & Adult Care of Central Washington, May, 2015. Data available, by County, upon request. *Federal Poverty Level;**Elder Economic Security Standard Index;***American Community Survey*

Estimated Total PSA #8 Population Projections *(3)*	303,995	313,660	323,495	332,810

(3) Population Projections based on use of PSA#8 population as approximately 22% of Total Population, as in 2014 (AACCW)

Targeting Services

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. Considerations will be given in the next four years to decentralizing even more. Regularly scheduled visits to communities where we do not have office locations are planned.

The 25 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 of our contractors. Groups such as Gatekeepers, Moses Lake Community Forum, Senior Services Network and Serve 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 Manager 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.

Soap Lake in Grant County is estimated to have 1/3 Russian-speaking, 1/3 Spanish-speaking, and 1/3 English-speaking residents. AACCW has 7 bilingual staff to serve our diverse population. Our contracted home care agencies will need more bilingual caregivers to keep up with the increasing demand. We currently contract with CTS Language Link and The Language Exchange, Inc. to provide interpreter and translation services for many languages.

Increasing food and fuel costs coupled with 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+)

Aging Network Chore provides household care, assistance with activities of daily living, personal care and/or protective supervision to older persons who need help with allowable chore services tasks if they are to live independently in their own homes.

Case Management (Age 18+)

Case management 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 and Assistance (I&A)

Information and Assistance is the publicly recognized access point for receiving I&A/case management (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.

Kinship Caregivers Support Program

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

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 provided in residential and home settings. The services enhance the Community Options Program Entry System (COPES), Medicaid Personal Care, and the Developmental Disabilities program. Nursing services are initiated on a referral basis from case managers and social workers.

Long-Term Care Ombuds Services

The Long-Term Care Ombuds program is a coordinated system of services designed to improve the quality of life for residents of nursing homes, assisted living and adult family homes. Services provided by state and local ombuds include investigating and resolving complaints made on behalf of residents; identifying problems which affect a substantial number of residents; recommending changes in federal, state and local legislation, regulations and policies to correct identified problems; and assisting in the development of resident councils, family councils, and citizen organizations concerned about the quality of life in long-term care facilities.

Mental Health Ombuds Services

The Mental Health Ombuds is an advocate for individuals ensuring their rights are respected and services respond to consumer needs and preferences. The Ombuds helps to resolve problems at the lowest level possible and can also help with the grievance and/or fair hearing process.

Senior Farmers 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, unprepared, 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+)

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+) / 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.

Chore Personal Care (Age 18+)

The Chore Personal Care program provides assistance with personal care and household tasks. Financial participation may be required. *This program was grandfathered in and is now closed.*

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, safety and 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) (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+)

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

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.

Legal Services (Age 60+)

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. 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+)

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+)

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

Client Specific funded services are aimed to provide funding for needs that are not addressed by other programs or funding streams.

Chronic Disease Self-Management Program

The Chronic Disease Self-Management program is an evidence based workshop developed by Stanford University to help people with chronic conditions take charge of their health care challenges and improve their quality of life. Workshops are led by peer trainers, many of whom have a chronic disease themselves. Participants meet once a week for 2.5 hours over the course of six weeks.

Star-C

Star-C is a combination in-home/telephonic consultation service to help family caregivers who are caring for someone with Alzheimer's disease or related dementia. The program has been clinically tested and proven to lower depression in caregivers and decrease problem behaviors in the person with dementia. This evidence based program was developed by the University of Washington.

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.

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 Caregivers 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
Long-Term Care Ombuds Services	X	X	X	X	X	X
Mental Health Ombuds Services (Includes assistance to counties outside PSA #8 – Pend Oreille, Ferry & Stevens Counties)	X	X	X	X	X	X
Senior Farmers 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
Chore Personal Care (Grandfathered Program, closed)	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
Chronic Disease Self-Management Program	X	X	X	X	X	X
Star-C	X	X	X	X	X	X
Community Living Connections	X	X	X	X	X	X

Non-AAA Services

Service	Adams	Chelan	Douglas	Grant	Lincoln	Okanogan
Accountable Community of Health – Future Development	1	1	1	1	1	1
Adult Family Homes	6	22	8	20	2	11
Alzheimer's Associations	*Spokane	*King	*Spokane	*Spokane	*Spokane	*Spokane
Alzheimer's Support Groups	0	4	*Chelan	2	0	1
Assisted Living Facilities	2	10	4	6	2	3
Assistive Technology -Knights of Columbus	*Chelan	*Chelan	*Chelan	*Chelan	*Chelan	*Chelan
Caregiver Support Groups	0	10	*Chelan	2	1	1
Case Management – Confluence Healthcare	0	1	1	1	0	1
Clinics (General & Specialty) -Veterans Administration	7	10	4	9	4	5
Community Action Councils	*Yakima	1	*Chelan	*Yakima	*Stevens	1
Community Health Centers	1	1	*Chelan	2	0	1
Deaf & Hard of Hearing Svcs. -Eastern & Central WA	*Spokane	*Yakima	*Yakima	*Yakima	*Spokane	*Spokane
Developmental Disabilities -DSHS – DDD -County - DDD	*Grant 0 1	0 1 1	*Chelan 0 0	0 1 1	*Grant 0 1	0 1 1
Elder Abuse Prevention -DSHS –APS -Phoenix Place Rape Crisis -CLEAR *Sr	*Grant 0 0 *King	0 1 1 *King	*Chelan 0 Chelan *King	0 1 0 *King	*Spokane 0 0 *King	*Ferry 0 0 *King
Energy Assistance	1	2	2	1	1	1
Food Banks -Salvation Army -Food Distribution Center -WIC	3 1 0 2	8 1 1 3	5 *Chelan *Chelan *Chelan	7 1 1 10	2 0 0 1	10 0 1 5
Health Districts	1	1	*Chelan	1	1	1
Healthy Aging – SAIL Prog.	1	3	*Chelan	4	0	3
Home Health/Hospice	*Grant	3	*Chelan	2	*Okanogan	1
Hospitals	2	4	*Chelan	4	2	3
Housing Authorities	1	1	*Chelan	1	0	0
Immigration Rights Advocate	**Grant	1	*Chelan	1	0	0
Information & Referral – 211	1	1	1	1	1	1
-Lilac Foundation for the Blind	*Spokane	*Spokane	*Spokane	*Spokane	*Spokane	*Spokane
Mental/Behavioral Health Org	1	4	*Chelan	1	1	1
Nursing Homes	2	3	1	4	1	4
Senior Centers	5	6	2	7	5	6
SHIBA	*Chelan	1	*Chelan	*Chelan	*Stevens	*Chelan
Transportation Broker PTBA	1 0	1 1	1 *Chelan	1 1	1 0	1 0
United Way	0	1	*Chelan	0	0	0
Veterans Assoc. & Services	3	8	14	7	7	7
Volunteer Chore Services	*Lincoln	1	*Chelan	1	1	1

**Service is available but is provided by an organization located in the named county.*

***Service is available from a Statewide or Regional Organization that performs outreach in this area.*

SECTION C

ISSUE AREAS, GOALS AND OBJECTIVES

Long Term Services and Supports

Profile of the Issue

Aging & Adult Care of Central Washington has as its core mission the provision of services and supports in a person's own home whenever possible. This is a "win-win" in that this is where people generally want to receive services and they can be delivered at a cost that is far less than the cost of institutional placement. For example, the AAA case management component of Washington State's Long Term Services and Supports system is one of the reasons our state ranks 2nd in the nation for quality and 34th in per capita spending.

Problem/Need Statement

In the 2016-2019 planning period Aging & Adult Care of Central Washington will implement some changes in how services are provided based on legislation passed in the 2014-2015 biennium. A major change that has already occurred is the implementation of the Community First Choice Option (CFCO).

- Personal Care services for our Medicaid Case Management clients has been refinanced under the Community First Choice Option of the Affordable Care Act. In some ways clients have more choices than they did before and it costs WA State less. This program was implemented as of July 1, 2015, per Legislative directive. The 56% federal match will save the state 80 million over the biennium. About half of that savings will go directly back into the program. For the most part, it will replace our two main Medicaid programs for In-Home Services (COPES and MPC), although some clients will only be eligible for MPC and others will require COPES services in addition to CFCO.

Goal: Provide case managers with timely training should caseloads continue to rise and standards are adjusted accordingly.

Objective: AACCW will provide timely training to case managers as soon as any changes are made to the case management standards. This training will be in the form of reviewing Management Bulletins, providing information at team meetings and/or having a formal training with all program staff. If there are any local options to be decided, they will be done by case management staff and AACCW Directors.

Goal: AACCW is committed to providing person-centered planning when working with our clients. Community Living Connections staff utilize Options Counseling. Title XIX case management staff provide information about person-centered planning in conjunction with the Community First Choice Option and conduct assessments in such a way that a client's preferences are clear.

Objective: Both Community Living Connections and Title XIX staff will receive training at least once a year on how to conduct person-centered assessments. Supervisors will review assessments as part of their normal QA functions to include utilization of the CARE QA Monitor Tool to review at least 3 clients per case manager, per year. These will be completed on an ongoing basis, and will take particular care to monitor that the plans reflect the client's preferences.

Goal: The care needs of our clients are becoming more complex as we successfully support more and more people from institutional care to in-home services. Our goal is to ensure that staff are aware of all the resources available to these clients in order to create the most effective service plan possible.

Objective: AACCW seeks to train staff on changes to services as they occur. Managers will identify training needs and provide information to their staff on a monthly basis about new contractors, newly identified community resources, and new services that are available. In addition, they will review with staff information that is not new, but may not be utilized to the extent that it could be.

Goal: While we recognize that not every need can be met every time, AACCW strives to be aware of any resources that are available in the community.

Objective: We will continue to populate our Community Living Connections Resource Directory with resources from throughout our coverage area. In addition, new resources and/or partnerships that are known to either the Title XIX managers or the CLC manager will be added in an effort to have as many staff as possible fully apprised of community resources. CLC staff will continue to attend and hold networking meetings within our six counties. These offer opportunities for staff to learn about other agencies' programs and share about our CLC services.

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

Profile of the Issue

The vision from ALTSA is that Washington State will have a fully functioning and operational Community Living Connections service (originally known Aging and Disability Resource Centers) in all of the state's Area Agencies on Aging. They would include:

- Information, referral and awareness
- Options counseling
- Streamlined eligibility screening or determination for public programs
- Person-centered transition support
- Consumer populations, partnerships and stakeholder involvement
- Quality assurance and continuous improvement

Problem/Need Statement

Funding restrictions still hamper our efforts to be fully operational, but many components of a Community Living Connection are in place at Aging & Adult Care of Central Washington.

Goal: Staff have been initially trained in Options Counseling, but will continue to require training. Options counseling assists people in making plans for and accessing long term services and supports. A key feature of Options Counseling is the recognition that what is right for one person may not be right for the next, so all available options should be explored.

Objective: I&A staff will receive on-going Options Counseling Training at least every six months and all will become AIRS certified. In-person training will be augmented by webinar-based training.

Goal: A new directory resource has been implemented for use with staff and will soon also be available to the public. Much more time will need to be invested in it to make it a truly useful tool.

Objective: We have hired a staff person whose primary duty is to populate and monitor the CLC Resource Directory. We will ensure that staff continues to have adequate time for this task. CLC staff will use the Resource Directory and provide on-going suggestions for new agencies, businesses, and services that should be added.

Goal: We know that supporting unpaid family caregivers is key to delaying or avoiding the use of Medicaid resources. We have a strong Family Caregiver Support Program, but are challenged to provide all of the assistance that is needed. Many unpaid caregivers are not aware of our program and we would not be able to assist more than we do at the present time, both in terms of staff time and budget. We are committed to expanding this valuable program.

Objective: We recognize that we will never be able to directly serve every person in our service area who is a family caregiver. We will work instead, to publish through our website and Facebook page the resources in our communities that we are aware of. We will advertise in various media to increase traffic on both of these sites. We will also promote and advertise the Community Living Connections web site designed for consumers, including Family Caregivers.

Goal: Provide health promotion and disease prevention programs that are evidence-based.

Objective: We currently provide for the Chronic Disease/Pain Management Program, support our local SAIL (Staying Active and Independent for Life) program as well as the Dementia Support program Star-C. We will expand our Star-C program by training four more of our CLC staff to provide Star-C counseling. In addition, the Dementia Capable System practices we will implement are derived from an evidence-based program. Our plan is to continue these programs. One goal is to promote heart health. As funding allows, we are open to researching other options for evidence-based health promotion programs. As the future definition of "evidence-based" changes we will be analyzing what requirements need to be met in order to implement future programs.

Goal: To address the needs in our communities related to Alzheimer's and other dementias.

Objective: AACCW currently supports those with Alzheimer's and their loved ones in a number of ways, including support groups, the Star-C program, and the local Alzheimer's walks. Going forward, we will be adding a new program called Dementia Capable Systems. We will also have a certified "Positive Approach to Care" trainer on staff, which will be available to educate both staff and community on the Teepa Snow method of assisting those with Alzheimer's.

Goal: To ensure that the programs we provide are implemented correctly and that client outcomes are positive.

Objective: Supervisors will conduct ongoing quality review checks. This includes, but is not limited to, review of paperwork, review of assessments and direct contact with clients. We will strengthen our customer service by using the best practices recommended by the Alliance of Information and Referral Systems and also follow AIRS quality assurance protocols.

Goal: To ensure that the services we provide meet the needs and reflect the desires of our communities.

Objective: AACCW conducts surveys and holds public meetings as required in the development of our area plan. We incorporate the feedback we receive into our provision of services. In addition, we encourage community members to engage us directly or by attending COG and Advisory Council meetings. We serve Hispanic and Russian/Ukrainian persons in our communities and provide for comprehensive interpreter/translation services as well as employ bilingual staff. We are committed to increasing our presence in these communities by stepping up advertising and outreach specific to these populations. We have already added Spanish-language radio and print advertising into our campaigns and have begun offering prescription education in Spanish. We have a formal partnership with the Statewide Health Insurance Benefits Advisors (SHIBA) and we will continue to build on these efforts to add Medicare-related education in other languages. Other methods we now use and will continue expanding include hosting local networking meetings in Chelan, Grant and Okanogan counties to gather feedback from other professionals who work with seniors and adults with disabilities.

Service Integration and Systems Coordination

Profile of the Issue

Washington is proving itself to be a leader in the United States in integrating care across systems. This ensures that a person and their health care needs are treated as a whole, and not in a piecemeal fashion. By integrating services and systems, the health care recipient receives better care and ultimately the costs of those services are reduced.

Problem/Need Statement

Aging & Adult Care of Central Washington is currently involved in efforts to integrate service delivery. However, we are challenged by multiple changes and fast moving timelines.

Goal: AACCW Community Living Connections will continue to provide "No Wrong Door" services.

Objective: AACCW staff, in particular those involved with the Community Living Connections program, will continue to gain skills and information needed in order to truly and fully serve those who have questions about long term care services and supports. Staff will be provided information and skills training using the following methods: ongoing updates circulated by Resource Directory Specialists when services in communities are added or changed; refining staff members' options counseling abilities through webinar training and practice; improving staff understanding of disabilities through Alliance of Information and Referral Systems training; and expanding our knowledge of how to reach and support family caregivers. We currently partner with SHIBA in order to offer a level of expertise that is above what our staff currently have, but will endeavor to provide additional training so that staff can be a greater resource in this regard.

Goal: AACCW has been a participant in the Health Home Pilot that was implemented through the Affordable Care Act.

Objective: At this time we are unclear if funding will be available for the Health Home program of the Health Care Authority (HCA) after December 31, 2015. We will support any efforts to continue this service, or will work with ALTSA if a hybrid is created in the future. We closely monitor the Washington State Health Care Innovation Plan and anticipate participating in our Regional Service Area. We are involved with the planning for and governance of the NCW Accountable Community of Health.

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

Timeframe: January 1, 2016 to December 31, 2019

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.
Increase awareness of the Senior Farmer's Market Nutrition Program by native American Elders residing both on and off the Colville reservation.	Continue to collaborate with Colville AAA Director to serve native American elders, both on and off the Colville reservation through SFMNP.	Colville AAA & AACCW will work collaboratively to ensure the tribal members are aware of and receive SFMNP vouchers.	Contracts Dept. March – October 2016 – 2019	For the 2015 SFMNP season AACCW distributed 160 vouchers to Colville AAA, which were then distributed by Colville AAA.
Provide outreach to tribal family caregivers in our PSA.	Concentrate on advertising the FCSP in Omak and Grand Coulee which are adjacent to the Colville Indian Reservation. Ensure that the advertising is tribal specific. Have a presence at tribal gatherings.	Increased outreach efforts to reach tribal caregivers.	I&A Department June 2016.	While we did advertise our FCSP in Omak and Grand Coulee, it did not result in an increase of tribal clients in this program. We are hopeful that by making the advertising more targeted to tribal members we will see a resultant increase in the number of tribal members we serve.
Increase staff understanding of cultural barriers to provide services to tribal members living in our PSA.	Every two years, an invitation will be extended to Colville AAA to attend a staff meeting at the Omak AACCW office to discuss cultural issues to be aware of when assisting tribal members.	Tribal members will have positive experiences when accessing services from AACCW.	Case Manager Supervisor, Omak December 2016 December 2018	Initial efforts in this regard have fallen by the wayside in recent years. It is our intention to resume this practice.

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

Timeframe: January 1, 2016 to December 31, 2019

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.
To become more aware of issues important to tribal members in our service area.	AACCW will seek to recruit a tribal member to sit on the advisory committee. This goal is in line with efforts to also recruit Hispanic, Russian AC members, as well as representatives from the disabled community.	The needs of tribal members will be brought to our attention during out advisory council meetings, or outside of the meetings via direct contact with a tribal member who sits on our Advisory Committee.	AACCW directors AC Membership committee	We currently have no tribal members on our advisory committee.
Improve communication and relationships 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.	Identified barriers to providing services will be reduced, when possible, through efforts suggested in these meetings.	Director CM/ I&A Yearly – Tribal AAA/HCS/ALTSA meeting. Yearly joint AACCW/Colville AAA meeting	AACCW attended the October, 2015 joint AAA/ HCS/ALTSA/Tribal meeting in Shelton. We have had frequent phone contact with Colville AAA.

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

Timeframe: January 1, 2016 to December 31, 2019

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.
To ensure that the goals set forth in this document are achieved.	We will place a review of the 701C 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 701C plan.	Directors/Mgmt. Ongoing on a quarterly basis.	For the most part we have achieved the goals of our previous plans.

Family Caregivers

Profile of the Issue:

Family Caregivers provide the framework for our long term care system. They include spouses, children, siblings and friends driven by a commitment to care for their loved one at home. Family caregivers provide a variety of assistance, from cooking and cleaning to administering medications, dressing and bathing.

Statistics from the Administration on Aging tell us that 66% of older persons with chronic disabilities are cared for by a family member. Approximately 65 million people provide care for a clinically ill, disabled, or aged family member or friend each year. Approximately 471,000 grandparents over 65 years old have primary responsibility for their grandchildren.

While great satisfaction can be achieved through this type of selfless act, it is also by its nature stressful and may have negative health implications for the caregiver. Family caregivers need support such as the Family Caregiver and Kinship Caregiver Programs to help ensure they are able to continue with their caregiving roles.

Problem/Need Statement:

America's long term care system depends on its framework of unpaid caregivers. These caregivers may be a grown daughter who checks on her mother on her way to work, after dropping off her children at school, and who does the same thing after work on the way home. She may be the grandmother who has taken in her daughter's children, because she is not able to do so herself. Or perhaps it's the young man who lives with his elderly uncle and in exchange for room and board ensures that his uncle is properly fed and cared for.

While the caregiving role is rewarding, it can be both emotionally and financially draining. The Family Caregiver Support Program acknowledges these issues and addresses them.

<u>Core Family Caregiver Support Services</u>

- Information services and support groups help family caregivers connect, learn from each other, and find out about services that work for fellow caregivers. Outreach to family caregivers is achieved via health fairs, community resource meetings, presentations, advertising, and distribution of brochures.

- Specialized family caregiver information is offered through one-on-one consultations with our Community Services Specialists. Family caregivers can share details of their situation with Specialists and receive assistance and referrals to resources specific to their needs.

- Specialized family caregiver case management– AACCW at this time has one (1) TCARE screener, six (6) Community Services Specialists and one (1) supervisor in the I&A department. The Community Services Specialists are responsible for conducting TCARE assessments and creating care plans based on the results.

- Counseling; Counseling is available to family caregivers through a referral to our contracted therapist. Counseling typically is for crisis management or assistance with challenging family dynamics affecting the caregiver. A maximum of three (3) sessions is usually authorized, but in some cases we provide more.

- Training – AACCW is planning to increase the opportunities for family caregivers to attend seminars, conferences and continuing education, including Teepa Snow Conferences and the annual Family Caregiver Conference in Tukwila. They are also provided with materials that are relevant to their caregiving experiences. These materials include articles and information regarding general coping skills and strategies for caregivers, and more specific information about diseases specific to their family members. AACCW has three (3) offices, each with libraries containing materials available to caregivers.

- Support Groups – Experienced volunteers and professionals facilitate caregiver support groups for our agency.

- Respite Care Services – Both in-home and out-of-home respite services through AACCW are currently provided through three (3) subcontracted in-home care agencies. We have offered out-of-home respite services in the past in a nursing home setting, but currently do not have a provider contracted to offer this service. Caregivers typically receive 36 hours of respite quarterly. Services may be used all at once or distributed over the three-month period as needed.

- Supplemental Services – Family caregivers are able to receive assistive technology and supplemental equipment such as, but not limited to; grab bars, raised toilets, ramps and hospital beds, and incontinence supplies. In addition, Personal Emergency Response Units are available. These and other services are successfully tied to care interventions listed in TCARE.

Goal:

Provide caregivers with the strategies and practical help they need to prevent burnout, minimize stress, and provide for their own well-being.

Objective:

Provide assistance as needed to support groups affiliated with AACCW and continue to look for opportunities to foster the creation of additional support groups throughout the region.

Goal:

Provide outreach to limited English-speaking and ethnic caregivers.

Objective:

AACCW will advertise this program in Spanish publications and on Spanish-language radio stations in our service area. Advertising will cover areas within our six counties where the greatest number of Spanish-speaking individuals reside.

Goal:

Provide outreach to geographically isolated caregivers.

Objectives:

- AACCW will strive to promote the FCSP to caregivers who are isolated, and for whom that isolation threatens the capacity of the individual to live independently. This will be done by newspaper, radio and outreach efforts made to hospital discharge planners and senior centers. In addition, we will continue to grow our partnerships with other organizations such as the Alzheimer's Association to offer educational workshops in remote areas of our six counties.

- Provide caregivers the opportunity for individual counseling with either a Mental Health Professional, or other certified counselor.

In-Home Services

Profile of the Issue:

A primary mission of our agency is to assist eligible elderly and disabled residents in our service area to receive services that enable them to remain in their own homes when possible. AACCW helps clients develop care plans that will enhance the quality of their lives and minimize premature or unnecessary residential care placement. This is accomplished through various programs including Community First Choice Option, COPES, Medicaid Personal Care, Medically Needy In Home Waiver, Roads to Community Living, Aging Network Chore, Respite and Family Caregiver Support services.

Problem/Need Statement:

AACCW staff need to be proficient in providing accurate client assessments that are person-centered, timely, comprehensive and accurate. The citizens of our six (6) county service area need to be aware of services that may enhance their abilities to live in the setting of their choice.

Goal:

Continue to improve the quality of the assessments that are done by case managers to ensure that client needs are accurately captured and addressed. The assessment process for Title XIX programs that use the CARE tool is complex. Frequent changes are made to the assessment process and ongoing training and monitoring is required to ensure that accurate comprehensive assessments of client needs are being conducted.

Objectives:

- Supervisors will review at least three files per case manager per calendar year using the quality assurance (QA) monitoring tool provided by ALTSA.

- Supervisors will spot check assessments for issues identified as problem areas. These spot checks will be for issues identified as problematic for case managers in general, and also for issues that have been identified as needing remediation for individual case managers. Supervisors will spot check a minimum of 3 assessments per year per case manager.

- Training will be held either in local offices and/or at the central office when changes are made to the CARE tool or when Management Bulletins (MB's) identify changes in assessment practices.

Goal:

Improve information distribution to ensure that staff are aware of information relevant to their work that is contained in and/or provided by Home and Community Services (HCS) (MB's), (QA) review, AAA program standards and Long Term Care manual revisions.

Objective:

The Director of Case Management and I&A will ensure that relevant and necessary information is received by appropriate staff. This will be done via a number of methods including but not limited to: staff meetings, training manuals and email communications. In addition, an internal website will be developed by 6/2016, for Title XIX case managers that will be a central repository for information. The goal of the website will be to provide limited information regarding issues relevant to their work, as well as guidance regarding where to find more detailed information.

Goal:

To ensure those who are most in need of our services are aware of what services we provide and how to access them.

Objective:

The Manager of Community Services will provide for community outreach through advertising in print and radio, radio and television interviews, Facebook posts and brochure distribution. The AACCW public website will be reviewed quarterly to ensure that the information it provides is timely, comprehensive and accurate.

Goal

Two of our in-home assistance programs, Respite and Aging Network Chore, are funded by multiple budgets which are on differing funding cycles making it difficult to project how many hours can be authorized in any given month. In addition, the number of hours available must be adjusted after billing is received to reflect the fact that not all hours authorized are served. Our goal is to make these adjustments as seamless as possible for staff and clients.

Objective:

The Respite/Aging Network Chore committee will continue to meet monthly to determine the number of hours available to authorize for the next month (ANC) or quarter (Respite). The Manager of Community Services will relay this information to staff immediately following the meeting to allow as much time as possible for adjustments and so that staff can advise new clients correctly.

Goal:

To have a person-centered focus in interactions with all of our clients. Person-centered planning is an ongoing problem-solving process used to help our clients plan for their future as they envision it.

Objective:

- To incorporate person-centered planning when conducting assessments for the Community First Choice Options program in the CARE tool. One method by which this will be achieved is by the documentation of the client's goals in the CARE assessment.

- AACCW Community Service Specialists will provide Options Counseling, a person-centered process, for individuals, family members and/or significant others to develop a plan for addressing long term services and supports needs that align with their preferences, strengths, values, and needs.

Nutrition

Problem/Needs Statement:

Comments received at planning meetings, survey results, and input received from stakeholders consistently show congregate nutrition as one of the most important discretionary services AACCW provides. This program was never intended to be fully funded by AACCW. As of 2015, the suggested donation per meal is $3.50. Nutrition contractors must make up the difference through fund raising. 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.

Goal: Identify the appropriate use of federal funds to increase the number of meals, the number of individuals served, and maintain existing meal sites that may be at risk.

Objectives: Help restore/maintain nutrition services in our most rural areas by increased awareness of the senior nutrition program through flyers and public service announcements by June 2016.

Stimulate greater interest for the senior nutrition program among eligible participants by offering alternatives for meal services, days and times by December 2016.

Continue to research all options for contracting with qualified contractors for home-delivered meals for the most rural areas.

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, Business Coordinator, is the designated staff person to oversee all emergency planning activities within AACCW jurisdiction.

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

- AACCW contracted with an independent contractor to provide information and outreach activities about emergency preparedness and response to local communities through the region's local senior centers.

- AACCW is cooperating with the State to acquire equipment or funding for various emergency supplies including: mobile computers and communication systems, air scrubbers, air purifiers, and air filtration masks.

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

- AACCW is actively seeking local Letters of Agreement (LOA's) with local and regional Emergency Operation Centers (EOC), first responders, American Red Cross, and allied organizations. This effort was originally delayed due to management turnover with the local American Red Cross Chapter; and further delayed by the current fire emergency sweeping across the region and other parts of Eastern Washington over the past Spring/Summer. Pending the resolution of this current emergency, AACCW anticipates receiving MOU's from local emergency operations leadership.

4. **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 a 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.

5. **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.

- AACCW will also provide a list of isolated and/or high risk individuals at its earliest opportunity to first responders. This will include contractually available information that is pertinent to the client's location, transportation resources, contact information, and current health status.

6. **Local Partners:**

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

- AACCW is actively working with local, state, and federal Emergency Operation Centers (EOC) for both emergency preparedness and response.

- AACCW is actively working with Washington State's DSHS Emergency Management Services and their "Mass Care and Animal Taskforce's" in response to statewide and regional emergencies.

- AACCW is actively working with local allied providers, businesses, families, and the general public.

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

- As unmet needs are identified by AACCW or 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.

8. **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 at a later date into the organization's regular business operations.

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

- AACCW does not provide 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 communications outage at AACCW, all managers and directors *will* have SSL VPN access to be able to perform normal job duties while away from the effected zone(s). In the event of network/telecommunication outages, we have established several track phones in each office to communicate internally and externally as well as personal cell phones for those who chose to utilize them. Client systems are not backed up, but would not be impacted

physically by any outage, unless catastrophic damage was caused to one or all of the three AACCW buildings. Servers are backed up to local NAS systems and NAS systems replicate to offsite NAS systems. Future plans to setup a secondary server in Moses Lake to perform DFS between East Wenatchee and Moses Lake to balance network loads and act as a backup in the event of failure are currently being considered. Server shares are backed up to local portable hard drives by department.

AGING & ADULT CARE OF CENTRAL WASHINGTON
ADVISORY COMMITTEE

Member	**Representing**
Janel Rieve, Ritzville	Adams County
Peggy Berk, Othello	Adams County
Vacant	Adams County
Vacant	Adams County
Vacant	Adams County
Margarita Comer, Wenatchee	Chelan County
*Gwyneth Thorsen, Wenatchee (Advisory Council Vice-Chair)	Chelan County
Verna Zuttermeister, Wenatchee	Chelan County
Dean Warren, Entiat	Chelan County
Ellen Warren, Entiat	Chelan County
*Dora Adams, Bridgeport	Douglas County
Geneva McCoy Jardine, E. Wenatchee	Douglas County
Barbara Berry, E. Wenatchee	Douglas County
Judy Main, E. Wenatchee	Douglas County
Maureen Reynolds, E. Wenatchee	Douglas County
*****Marylu Martin, Moses Lake	Grant County
William Riley, Soap Lake (Advisory Council Chair)	Grant County
Linda Finlay, Moses Lake	Grant County
Vera Hurd, Moses Lake	Grant County
Vacant	Grant County
*****Leanne Wilson, Davenport	Lincoln County
Jim Wilson, Davenport	Lincoln County
Salley Siegel, Odessa	Lincoln County
Steve Siegel, Odessa	Lincoln County
Larry Lindbloom, Wilbur	Lincoln County
Judy Tonseth, Twisp	Okanogan County
*****Judy Gladden, Tonasket	Okanogan County
Noble Kelly, Malott……	Okanogan County
Peggy Kelly, Malott	Okanogan County
Kristy Longanecker, Omak	Okanogan County

***** Advisory Council Executive Committee

State Council on Aging Representative (SCOA)
Peggi Moxley, Wenatchee

SCOA Purpose: To serve as an advisory council to the Governor, the Secretary of DSHS and the office designated as the State Unit on Aging –Aging & Long-Term Support Administration.

COMMUNITY PLANNING MEETINGS
For
SENIOR & DISABILITY SERVICES
(2016-2019 Area Plan)

50 Simon Street SE, Suite A
East Wenatchee, Washington
509.886.0700 or 1.800.572.4459

YOUR INPUT IS NEEDED TO PLAN FOR SENIOR & DISABILITY SERVICES

2015 SCHEDULE

MONDAY, MAY 4
12:30 p.m.
Chelan Senior Center
534 E. Trow
Chelan, Washington

TUESDAY, MAY 5
12:15 p.m.
Moses Lake Senior Center
608 E. Third
Moses Lake, Washington

WEDNESDAY, MAY 13
12:00 p.m.
Othello Senior Center
755 N 7th St
Othello, Washington

THURSDAY, MAY 14
12:30 p.m.
Wilbur Senior Center
101 NE Main Ave
Wilbur, Washington

TUESDAY, MAY 19
11:30 a.m.
Omak Senior Center
214 N. Juniper
Omak, Washington

WEDNESDAY, MAY 27
12:45 p.m.
Wenatchee Valley Senior Center
1312 Maple Street
Wenatchee, Washington

If you are interested in senior and disability issues (funding and services), you are invited to attend a planning meeting at the location most convenient for you. Locations are accessible to persons with disability. For more information, call Aging and Adult Care of Central Washington.

Serving Adams, Chelan, Douglas, Grant, Lincoln and Okanogan Counties

PUBLIC HEARINGS
on the
Aging & Adult Care of Central Washington
Four (4) Year 2016-2019 Area Plan

SENIOR SERVICES

Aging & Adult Care of Central Washington, which is the designated Area Agency on Aging for Adams, Chelan, Douglas, Grant, Lincoln and Okanogan Counties, will conduct three public hearings on its proposed Four (4) Year 2016 – 2019 Area Plan for aging services. Required by the Older Americans Act, the Area Plan identifies needs of older persons, sets priorities, and specifies how both federal and state funds will be expended. It includes such programs as Case Management, Senior Information and Assistance, Nutrition, Legal Services, Personal Emergency Response System and Transportation. The premises are accessible to everyone, but if you need accommodation or interpretive services, please call 509-886-0700 or 1-800-572-4459 by July 15th, 2015. If you cannot attend, please send your written comments to Erin Nelson at Aging & Adult Care of Central Washington 50 Simon St. SE, Suite A, East Wenatchee, WA 98802 before August 7th, 2015.

2015 PUBLIC HEARINGS

Monday, August 3
Time: 1:00 p.m.
Brewster Senior Center
109 South Bridge St.
Brewster, WA 98812

Tuesday, August 4
Time: 1:00 p.m.
Ephrata Senior Center
124 "C" Street NW
Ephrata, WA 98823

Wednesday, August 5
Time: 1:30 p.m.
Aging & Adult Care of Central WA
50 Simon St SE, Ste. A
East Wenatchee, WA 98802

Area Plan Senior Survey

We need your help in prioritizing our services in North Central Washington. Your responses will support development of the Four (4) Year 2016-2019 Aging & Adult Care of Central Washington Area Plan.

Serving - - Adams, Chelan, Douglas, Grant, Lincoln and Okanogan Counties.

SURVEY RESULTS DUE BY JUNE 5, 2015

1. **The County I live in is?**

Adams_____ Chelan_____ Douglas _____ Grant _____

Lincoln _____ Okanogan _____

2. **How old are you?**
   a. Under age 60 _____ Age 60 to 74 _____ Age 75 to 84 _____
   b. Age 85 or older _____

3. **What services are important to you or someone you know to remain at home?**

CURRENT DISCRETIONARY AND FAMILY CAREGIVER FUNDED SERVICES	Very Important	Not as Important
Alzheimer's information / education		
Congregate meals (lunch at senior center or other meeting place)		
Counseling and Consultation		
Disease Prevention / Health Promotion (seminars include: Dining with Diabetes, Healthy Aging, etc.)		
Client Specific Funding (emergent purchase of items that are not covered by any other funding source)		
Emergency Response Monitor Button (PERS)		
Home-Delivered Meals		
Housing modifications (such as a ramp or changes to a bathroom)		
Information and Assistance (referral to services that can help you regarding medical insurance, housing, Medicaid, how to plan for your future needs, etc.)		

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SERVICES, Continued…	Very Important	Not as Important
Legal Assistance for advice and referrals		
Medication Dispensers		
Resource Center (books, videos, CD's)		
Respite Care (supervision, personal care services and nursing tasks usually provided by the primary caregiver of the disabled adult)		
Senior Center Equipment Funding		
STAR-C (one-on-one assistance to help caregivers of those with Alzheimer's)		
Support Groups		
Supportive Supplies (Ensure, Depends, etc.)		
Training / Conferences / Workshops on Caregiving		
Transportation (to medical appointments, senior center meals, shopping, etc.)		
Volunteer Services (to help serve clients not already being served through existing programs)		

Other services not listed above (please specify):

_____

4. **Do you?**
   a. Live alone? _____ Live with a spouse or partner? _____
   b. Live with a friend or relative? _____

5. **What is your gender?** Male _____ Female _____

6. **What is your race or ethnic background:** White or Caucasian _____

   Black or African American _____ Hispanic _____

   Native Hawaiian or Other Pacific Islander _____ Asian _____ Other _____

Aging & Adult Care OF CENTRAL WASHINGTON

7. **Monthly Income (please check one)**

Family of 1	Above $980.83 a month	☐	Below $980.83 a month	☐
Family of 2	Above $1,327.50 a month	☐	Below $1,327.50 a month	☐

8. **Do you provide unpaid caregiving for someone over the age of 60?** Yes No

9. **Do you provide unpaid caregiving for someone between the age of 18 and 59:** Yes No

If yes, are you legally responsible for:

Children / Grandchildren #_____ Spouse _____

Other relative(s) # _____ Non relative(s) # _____

10. **Do you have one or more disabilities? Yes _____ No _____**
If yes, please specify.

_____

_____

11. **Please list below any other actions or services that would benefit you or other seniors that are not listed.**

a) _____

b) _____

c) _____

d) _____

Thank you for your input on this survey.

Please return to Aging & Adult Care of Central Washington, Attn: Erin Nelson at 50 Simon Street SE, Suite A., East Wenatchee, WA 98802. For more information, call 509.886.0700 or 1.800.572.4459, extension 232.

Report on Accomplishments from 2014-2015 Area Plan Update

Issue Area: **Family Caregivers**

Goal: Provide caregivers with the strategies and practical help they need to prevent burnout, minimize stress, and provide for their own well-being.

Measurable Objective: Provide assistance as needed to support groups which AACCW established and handed off to community partners, who now have the responsibility for running the groups.

Accomplishment Or Update: Community partnerships regarding support groups have lapsed due to the partners' lack of interest in continuing the groups. However, we now have three caregiver support groups. All meet twice monthly and are facilitated by volunteers. They are well-attended and growing. One is held in Moses Lake, another in East Wenatchee, and the third in Othello.

Goal: Provide outreach to limited English-speaking and ethnic caregivers.

Measurable Objective: AACCW will advertise this program in Spanish publications in our service area. Advertising will include the Omak and Grand Coulee areas which are adjacent to the Colville Indian Reservation (AAA#12), in an effort to reach tribal caregivers by June 2015.

Accomplishment Or Update: In 2015 we placed advertising in a Spanish-language phone directory distributed in Chelan, Douglas and Grant Counties. We had not advertised in the directory previously. We also advertised on a Spanish language radio station in Chelan and Douglas Counties. In addition, all our main brochures were translated into Spanish in 2015. We increased efforts to assure these are present in medical facilities, senior centers, social service agencies and organizations throughout our six counties. Our goal in 2016 will be to increase Spanish-language advertising and outreach in less populated communities.

Goal: Provide outreach to geographically isolated caregivers.

Measurable Objective: 1. AACCW will strive to promote the FCSP to caregivers who are isolated, and for whom that isolation threatens the capacity of the individual to live independently. This will be done by newspaper, radio and outreach efforts made to hospital discharge planners, senior centers, the Alzheimer's Associations, movie theaters, etc. by June 2015.

Accomplishment Or Update: In an average year we conduct approximately 20 presentations about the family caregiver support program and other services AACCW offers. We speak to service clubs, social workers, medical professionals, and various other groups. We also participated with an average of 40 events annually. These include health fairs and networking meetings where we interact with the public and professionals to share information about the family caregiver program and other services AACCW offers.

Issue Area: Family Caregivers - *continued*

Measurable Objective: 2. Provide caregivers the opportunity for individual counseling with either a Mental Health Professional, or other certified counselor.

Accomplishment Or Update: In 2015 we contracted with a new MH Professional with greater ability and willingness to conduct home visits to caregivers, even in remote areas. Caregiver interest in counseling has grown, and we added funding to the program in order to meet demand. Caregivers receive at least three sessions with a certified mental health counselor. We can provide more than three sessions if funding is available.

Report on Accomplishments from 2014-2015 Area Plan Update

Issue Area: **In-Home Services**

Goal: Continue to improve the quality of the assessments that are done by case managers to ensure that client needs are accurately and consistently captured

Measurable Objective: 1. Supervisors will review at least three files per case manager per year using the QA monitoring tool provided by ALTSA.

Accomplishment Or Update: 2015 update: Accomplished and ongoing. Going forward our goal is to spread these reviews out over the year so that we can provide feedback to case managers on an ongoing basis, rather than all at once.

Measurable Objective: 2. Supervisors will spot check files for issues identified as problem areas for most case managers.

Accomplishment Or Update: 2015 update: Accomplished and ongoing. In some files/assessments of all case managers are reviewed in regard to a specific topic. In other cases, an issue which is problematic for only some case managers are only reviewed for them.

Measurable Objective: 3. Trainings will be held either in local offices and/or at the central office when the entire case management team meets when changes are made to the CARE tool.

Accomplishment Or Update: 2015 update: Accomplished and ongoing. Our focus has shifted to more frequent meetings in our three offices to save the time and expense associated with travel to Wenatchee. This allows us to meet more spontaneously as training issues present themselves.

Goal: Improve information distribution to ensure that staff is aware of information relevant to their work that is contained in and/or provided by HCS, Management Bulletins, QA review, AAA program standards and LTC manual revisions.

Measurable Objective: The Director of Case Management and I&A will ensure that relevant and necessary information is received by appropriate staff. This will be done via a number of methods including but not limited to: newsletters, staff meetings, training manuals and email communications.

Accomplishment Or Update: 2015 update: Accomplished and ongoing. In addition, in 2015, a website was created for case managers that serves as a directory for the various sources of information they require. It provides links to MBs, sections of the LTC manual, instructional emails, etc. in a format that is intuitive and allows quick access to information.

Issue Area: In-Home Services – *continued*

Goal: To ensure those who are most in need of our services do not fall between the cracks by fostering and maintaining strong working relationships with hospitals, including discharge planners at all the hospitals in our PSA.

Measurable Objective: Community Service Specialists, nurses and staff involved with the Coleman model of Care Transitions will make contact with the discharge planners that are in their service area. The purpose of these contacts will be to ensure that discharge planners are aware of, and are making patients aware of, all available in-home services.

Accomplishment Or Update: Partially accomplished. We have a good working relationship with discharge planners and work well with them when they contact us, but we have not as of yet done the outreach we envisioned to introduce ourselves and explain our programs to those we may not have worked with yet. We plan to do this before 12/31/2016.

Goal: To ensure that in spite of increasing caseloads, AACCW clients receive the services they require through their case managers.

Measurable Objective: Continue with the increased use of case aides and volunteers to contact clients on behalf of case managers. These individuals are trained by a case management supervisor to make scheduled calls to clients to check on how their plan of care is going. Case aides and volunteers take notes which are provided to case managers who follow-up as appropriate, ensuring that the case managers' time is well spent on those clients most in need.

Accomplishment Or Update: 2015 update: Accomplished and ongoing. While we continue to use case managers for client contacts when the case managers are not able to do so in a timely manner, we prefer to have these contacts made by the case manager whenever possible, and in general we are able to do so.

Goal: To assist individuals and families to have a more active role in their health care during a care transition (hospital to home) and to promote better health information exchange across settings.

Measurable Objective: In order to meet our Care Transition goals, we have additional staff that have been trained in the Coleman Model. When possible, their first contact with their clients is in the hospital prior to discharge. Within a few days, a home visit is conducted to assess safety and recommend adaptations to the home environment. The Care Transitions coach helps ensure that individuals understand and comply with their medications regimes. In addition, they review "red flag indicators" that may indicate a worsening condition and help individuals and their families communicate care needs with health care professionals. To accomplish this, three phone contacts are made after the home visit. The program is completed over a period of four weeks.

Issue Area: In-Home Services – *continued*

Accomplishment Or Update: 2015 update: Suspended. Our care Transition efforts have been put on hold at this time. Our efforts instead shifted to our work with Health Homes. We continue our Health Home program at this time and hope that the funding required to support the program remains in place. If we should lose that funding, we will look at re-establishing our Care Transition services within our PSA.