Area Agency on Aging & Disabilities of Southwest Washington 2027-2030 Area Plan

AREA AGENCY ON
Aging & Disabilities
OF SOUTHWEST WASHINGTON

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Clark ♦ Cowlitz ♦ Klickitat ♦Skamania ♦ Wahkiakum

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Section 1 - Executive Summary

The 2027–2030 Area Plan outlines how the Area Agency on Aging & Disabilities of Southwest Washington (AAADSW) will support older adults, adults with disabilities, and family caregivers across Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum counties. The plan describes regional challenges, population trends, program priorities, and AAADSW's goals and objectives for the next four years. It also summarizes the Area Plan development process, current and emerging programs, and the demographic profile of the region.

AAADSW's mission is to empower our community through advocacy, connection, and support. As the designated Area Agency on Aging for Southwest Washington, AAADSW provides access to information and assistance, caregiver support, case management, nutrition services, and other long-term care services that help people remain safely in the setting of their choice.

Southwest Washington is experiencing rapid growth in the number of older adults, adults with disabilities, and family caregivers. These demographic shifts will significantly increase demand for home and community-based services.

By 2030, AAADSW's five-county region is projected to have:

- Over 202,677 residents aged 60+, representing 27% of the region's total population
- Nearly 13,000 adults aged 65+ living with dementia
- More than 86,000 individuals providing unpaid care to an adult aged 18 or older
- Nearly 99,000 adults aged 18+ living with a disability or cognitive impairment

These trends underscore the importance of strengthening community supports, expanding access to services, and ensuring equitable outreach to individuals with the Greatest Economic Need and Greatest Social Need.

Two principal factors shape AAADSW's 2027–2030 goals, objectives, and discretionary funding priorities:

- Feedback from more than 705 surveys completed by community members, caregivers, community partners, and AAADSW staff
- Washington State Department of Social & Health Services Home and Community Living Administration Issue Area Themes.

Across the region, respondents identified several high-priority needs, including:

- Yard care and home maintenance support
- Dental care
- Information and referral services

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- Fitness and wellness programs
- Low-income resources and financial assistance

Caregivers emphasized that maintaining their own well-being is the most important factor in sustaining their caregiving role. The need for respite and regular breaks closely followed as a critical support.
AAADSW's plan aligns with the five required issue area themes:

1. Greatest Social Need and Greatest Economic Need
2. Healthy Aging and Older Americans Act Core Programs
3. Expanding Access to Home and Community-Based Services
4. Caregiving
5. 7.01 Planning with Federally Recognized Tribes

Over the next four years, AAADSW will help older adults, adults with disabilities, and family caregivers thrive in the setting of their choice by advancing the goals and objectives outlined in this Area Plan. Key strategies include:

- Expanding access to home and community-based services
- Strengthening caregiver supports
- Enhancing outreach to individuals with the greatest economic and social needs
- Supporting healthy aging through evidence-based programs
- Improving coordination with community partners, health systems, and tribal governments
- Ensuring culturally responsive and equitable service delivery

Section 2 – Stewardship and Oversight

2.1 Mission, Vision, Values

AAADSW's mission is to empower our community through advocacy, connection, and support. Our vision is every older adult, adults with disabilities, and their family members have access to information, programs and services to help them thrive in the setting of their choice. To fulfill this vision, AAADSW adheres to the following values:

Access: Recognizing diverse needs and strengths and reducing barriers that disproportionately impact people or groups.

Accountability: Holding oneself and others to a measure of reliability, performance, and ethics, and taking responsibility for the result of one's actions or inaction.

Client Choice: Honoring the dignity and individuality of our clients through person-centered planning aligned to their values and goals.

Collaboration: Working with others in a supportive and productive way to achieve a common purpose.

Respect Recognizing the inherent worth of others and the contributions they make.

Access: Recognizing diverse needs and strengths and reducing barriers that disproportionately impact people or groups.

2.2 AAA Services and Partnerships

AAADSW offers over 35 programs and services, directly or through its network of subcontracted providers, striving to ensure all programs are available in full and equal measure in every county.

However, there are significant challenges to accomplishing this goal:

1) limited funds to distribute
2) shortage of agencies/contractors available to do the work
3) diversity of perceived needs as per recent survey responses

Despite these challenges, AAADSW continues to think creatively about ways to bring programs and services to scale across all five counties, as appropriate.

With an eye toward future needs and a successful record of program innovations, AAADSW collaborates with community partners to launch pilot projects that meet the needs of the local community through its Area Plan Grants. Examples include the Community Aid Navigation, RUOK, Rapid Rehousing Project, Music Therapy, Winter Fruits and Vegetable, and Health and Wellness Supports Programs.

Three departments comprise the core of AAADSW's services. The largest of these programs is Medicaid (Title XIX) Case Management. Under this program, case managers conduct assessments, authorize and coordinate services to many of the areas' most medically complex individuals on Medicaid in-home services. Annually, approximately 6,000 individuals receive case management services through this program, accounting for roughly XX% of the agency's budget.

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Our Health Home Care Coordination department provides six core services designed to support individuals with complex, chronic health conditions. The program focuses on improving health outcomes and reducing avoidable medical costs by working with clients to develop personalized goals in a Health Action Plan (HAP). Participation is voluntary, and services are delivered by Care Coordination Organizations (CCOs) for people enrolled in Medicaid, including those who are dually eligible for Medicare and Medicaid. Services may include:

1) comprehensive care management
2) comprehensive transitional care from inpatient to other settings, including the client's home, with appropriate follow-up
3) referral to community and social support services

The third department is Community Services, which includes State Health Insurance Benefits Advisors (SHIBA), Medicare Improvements for Patients and Providers (MIPPA), and Long-Term Care Ombudsman (LTCOP), and Older Americans Act programs. SHIBA is a service of the Washington State Office of the Insurance Commissioner and provides free, unbiased, confidential help with Medicare to people of all ages and backgrounds. The LTCOP protects and promotes the rights of residents living in skilled nursing homes, assisted living communities, and adult family homes guaranteed under federal and state law and regulations. Trained volunteers and staff receive complaints and resolve problems in situations involving quality of care and life, use of physical or chemical restraints, or abuse/neglect and other aspects of residents dignity and rights.

The Medicaid Transformation Program (MTP) launched in 2017 and included Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA). These demonstration programs help clients avoid, or delay accessing, Medicaid long-term services and supports.

MAC and TSOA have proven effective, resulting in a renewal of the demonstration for five years effective July 1, 2023.

Community Services also provides the following Older Americans Act programs:

- Aging & Disability Resource Centers
- Family and Kinship Caregiver Support
- Nutrition
- Transportation

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- Case Management
- Dental Care
- Healthy Aging and Fitness
- Personal Emergency Response Systems and other Supplemental Services (medical equipment, supplies and assistive devices)

Partnerships and Networks

Forming and maintaining meaningful community partnerships remains a high priority to AAADSW. To expand awareness of AAADSW programs and services, staff develop and sustain strong partnerships with professional peers in healthcare, housing authorities, dementia support groups, senior centers and a broad range of other community-based service organizations. AAADSW facilitates the Community Health Action Resource Team in Clark County. This network consists of healthcare, long-term care services, emergency medical services, social services and disability groups. The network convenes to share resources, identify and problem solve gaps in services and collaborate to improve care to clients.

Section 3 – Context

3.1 Planning and review process: needs assessment, surveys, public review

Three surveys were distributed across the region to gather input from key groups: the public, community partners, and AAADSW staff. The public facing survey received 618 responses, the community partner survey received 34 responses, and the AAADSW staff survey received 53 responses, for a total of 705 responses. Responses for the public facing survey were received from all five counties.

- Clark: 57 % (352)
- Cowlitz: 18% (111)
- Wahkiakum: 6% (37)
- Klickitat: 10% (62)
- Skamania: 9% (56)

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3.2 Demographics: PSA profile, data trends

Table 1: Growth in age 60+ population.

County	2027 to 2030	Percent Increase
Clark	140,680 to 151,124	7.4
Cowlitz	34,296 to 35,662	4.0
Klickitat	8,803 to 9,143	3.9
Skamania	4,487 to 4,693	4.6
Wahkiakum	2,058 to 2,055	-.01
Region	190,325 to 202,677	6.5

There will be a regional 6.5% increase in age 60+ population from 2027 to 2030. See Table 2 for specific county statistics.

Table 2: Percentage of population age 60+ in 2030.

County	Total Population	Age 60+ Population	Percent of age 60+ population
Clark	583,307	151,124	25.9%
Cowlitz	118,309	35,662	30.1%
Klickitat	24,511	9,143	37.3%
Skamania	12,529	4,693	37.5%
Wahkiakum	4,713	2,055	43.6%
Region	743,369	202,677	27.3%

Consider the various subgroup statistics within AAADSW's target populations in Tables 3-9.

Table 3: Growth in number of persons age 60+ living at or below 100% of Federal Poverty

County	2027 to 2030	Percent Increase
Clark	12,691 to 14,123	11.3
Cowlitz	2,666 to 2,600	-2.5
Klickitat	1,068 to 1,099	3.0
Skamania	528 to 539	2.1

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Wahkiakum	118 to 106	-10.1
Region	17,071 to 18,468	8.2

Table 4: Growth in number of persons age 65+ with dementia.

County	2027 to 2030	Percent Increase
Clark	8,160 to 9,582	17.4
Cowlitz	2,190 to 2,442	11.5
Klickitat	399 to 465	16.6
Skamania	206 to 243	17.7
Wahkiakum	118 to 135	-3.6
Region	11,074 to 12,868	16.2

Table 5: Growth in population age 18+ with a disability.

County	2027 to 2030	Percent Increase
Clark	37,737 to 40,183	6.5
Cowlitz	12,155 to 12,559	3.3
Klickitat	2,427 to 2,511	3.5
Skamania	1,241 to 1,292	4.1
Wahkiakum	625 to 629	0.6
Region	54,185 to 57,173	5.5

Table 6: Growth in number of persons age 18+ with cognitive impairment.

County	2027 to 2030	Percent Increase
Clark	28,843 to 30,412	5.4
Cowlitz	8,272 to 8,482	2.5
Klickitat	1,584 to 1,635	3.2
Skamania	820 to 854	4.1
Wahkiakum	353 to 360	2.1
Region	39,872 to 41,743	4.7

Table 7: Growth in number of persons age 60+ and People of color.

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County	2027 to 2030	Percent Increase
Clark	18,045 to 21,076	16.8
Cowlitz	1,922 to 2,093	8.9
Klickitat	848 to 941	11.0
Skamania	417 to 464	11.4
Wahkiakum	72 to 74	2.7
Region	21,304 to 24,649	15.7

Table 8: Growth in number of persons age 60+ and American Indian/Alaska Native.

County	2027 to 2030	Percent Increase
Clark	2,034 to 2,307	13.5
Cowlitz	657 to 694	5.7
Klickitat	378 to 402	6.4
Skamania	172 to 192	12.0
Wahkiakum	21 to 21	-0.4
Region	3,260 to 3,616	10.9

Table 9: Growth in number of persons age 60+ and Limited English Proficiency.

County	2027 to 2030	Percent Increase
Clark	4,403 to 4,783	8.6
Cowlitz	118 to 122	3.8
Klickitat	50 to 52	3.9
Skamania	26 to 28	4.8
Wahkiakum	5 to 5	-3.6
Region	4,603 to 4990	8.4

AARP estimates that in 2025 there are 1,143,800 million unpaid family caregivers in Washington State who provide care to adults. Because AAADSW's service area represents roughly 8% of the state's total population, it is reasonable to estimate that approximately 86,000 caregivers reside within our region. For estimated caregiver counts by county, see Table 10.

Table 10: Number of Family Caregivers by County.

County	Family Caregivers

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Clark	54,963
Cowlitz	18,622
Klickitat	7,122
Skamania	4,025
Wahkiakum	1,282
Region	86,014

AAADSW is committed to ensuring that services reach older adults and adults with disabilities with the Greatest Economic Need and Greatest Social Need as defined in 45 CFR 1321.3. For local planning and prioritization, these needs include limited income, limited assets, or circumstances that create barriers to maintaining independence, safety, or community connection.

Target populations include:

- Older adults and adults with disabilities with low income
- Racial and ethnic minority older adults and adults with disabilities
- Individuals living with dementia or caring for someone with dementia
- Adults at risk of institutionalization
- Older adults living in rural communities
- Older adults living with HIV/AIDS
- Adults age 60+ or caregivers of people with disabilities

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3.3 Target Population: serving older adults in greatest social and economic need

			Population and Aging Services Utilization Forecast for 2027					
Age	Measure	Description	PSA - 7	Clark	Cowlitz	Klickitat	Skamania	Wahkiakum
18+	With a disability	Number of adults that reported an ambulatory difficulty or self-care difficulty (dressing or bathing)	54,185	37,737	12,155	2,427	1,241	625
	With cognitive impairment	Number of adults that reported a cognitive difficulty	39,872	28,843	8,272	1,584	820	353
60+	TOTAL	Number of people age 60 and older	190,325	140,680	34,296	8,803	4,487	2,058
	With a disability	Number of people age 60 and older that reported an ambulatory difficulty or self-care difficulty (dressing or bathing)	37,311	25,547	8,423	1,891	945	505
	With cognitive impairment	Number of people age 60 and older that reported a cognitive difficulty	16,425	11,647	3,330	833	417	199
	At or below 100% FPL	Number of people age 60 and older with household income lower than the federal poverty level (FPL)	17,071	12,691	2,666	1,068	528	118
	People of color	Number of people age 60 and older that identify as Hispanic, Latino, American Indian, Alaskan Native, Asian, Pacific Islander, Black, or multi-racial	21,304	18,045	1,922	848	417	72
	American Indian/Alaska Native (AI/AN)	Number of people age 60 and older that identify as American Indian or Alaskan Native	3,260	2,034	657	378	172	21
	With limited English proficiency	Number of people of color age 60 and older that reported speaking English "not well" or "not at all"	4,603	4,403	118	50	26	5
65+	With dementia	Number of people age 65 or greater that have a diagnosis of Alzheimer's Disease or a related dementia	11,074	8,160	2,190	399	206	118

Source: Selected Population and Aging Service Utilization Forecast - PSA7, Southwest Washington AAA, Age Wave Projections: August 2025 Release

			Population and Aging Services Utilization Forecast for 2030					
Age	Measure	Description	PSA - 7	Clark	Cowlitz	Klickitat	Skamania	Wahkiakum
18+	With a disability	Number of adults that reported an ambulatory difficulty or self-care difficulty (dressing or bathing)	51,173	40,183	12,559	2,511	1,292	629
	With cognitive impairment	Number of adults that reported a cognitive difficulty	41,743	30,412	8,482	1,635	854	360
60+	TOTAL	Number of people age 60 and older	202,677	151,124	35,662	9,143	4,693	2,055
	With a disability	Number of people age 60 and older that reported an ambulatory difficulty or self-care difficulty (dressing or bathing)	39,713	27,484	8,761	1,969	994	505
	With cognitive impairment	Number of people age 60 and older that reported a cognitive difficulty	17,509	15,542	3,463	867	438	199
	At or below 100% FPL	Number of people age 60 and older with household income lower than the federal poverty level (FPL)	18,468	14,123	2,600	1,099	539	106
	People of color	Number of people age 60 and older that identify as Hispanic, Latino, American Indian, Alaskan Native, Asian, Pacific Islander, Black, or multi-racial	24,649	21,076	2,093	941	464	74
	American Indian/Alaska Native (AI/AN)	Number of people age 60 and older that identify as American Indian or Alaskan Native	3,616	2,307	694	402	192	21
	With limited English proficiency	Number of people of color age 60 and older that reported speaking English "not well" or "not at all"	4,990	4,783	122	52	28	5
65+	With dementia	Number of people age 65 or greater that have a diagnosis of Alzheimer's Disease or a related dementia	12,868	9,582	2,442	465	243	135

Source: Selected Population and Aging Service Utilization Forecast - PSA7, Southwest Washington AAA, Age Wave Projections: August 2025 Release

Section 4 - Goals, Objectives, Strategies, and Outcomes

Key Issue Areas

4.1 Greatest Social Need/Greatest Economic Need

AAADSW is committed to ensuring that outreach and services reach older adults and adults with disabilities with the Greatest Economic Need and Greatest Social Need as defined in 45 CFR 1321.3. For local planning and prioritization, these needs include limited income, limited assets, or circumstances that create barriers to maintaining independence, safety, or community connection.

Target populations include:

- Older adults and adults with disabilities with low income
- Racial and ethnic minority older adults and adults with disabilities
- Individuals living with dementia or caring for someone with dementia
- Adults at risk of institutionalization
- Older adults living in rural communities
- Older adults living with HIV/AIDS
- Adults age 60+ or caregivers of people with disabilities

To effectively reach these priority groups, AAADSW engages in a broad range of targeted outreach activities, including:

- Participation in community health and senior fairs **to** connect directly with older adults and caregivers
- Presentations to support groups, homeowners associations, service organizations, state agencies, schools, and faith communities to increase awareness of available services
- Paid newspaper and digital advertising to reach individuals who may not engage in community events
- Strategic partnerships with organizations serving similar populations to strengthen referral pathways and expand access

Goal: AAADSW will continue to use targeted outreach, culturally responsive engagement, and coordinated service delivery to ensure these communities have equitable access to information, supports, and programs that promote health, independence, and quality of life.

Objective: Community Services will conduct a minimum of two outreach activities per month during the planning cycle.

Strategy: AAADSW will continue to participate in community partners' outreach events.

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Outcome: Older adults, adults with disabilities and family caregivers will have access to information and services to support aging in place.

4.2 Healthy Aging/Older Americans Act (OAA) Core Programs

Brain Health and Dementia Supports: According to the Alzheimer's Association, there is evidence "people can reduce their risk of cognitive decline by making key lifestyle changes, including participating in regular physical activity, staying socially engaged, and maintaining good heart health." AAADSW and its contractors provide fitness, nutrition and life enrichment programs that facilitate both physical and brain health.

AAADSW will continue its focus on supporting individuals with dementia and their families by connecting them to services and supports, and by facilitating the expansion of Dementia Friendly communities.

- **Goal:** Help individuals with Alzheimer's or a related dementia and their family caregivers connect to services and support.
    - **Objective 1**
        - Connect family caregivers to local support groups.
    - **Objective 2**
        - Offer family caregiver education opportunities via print, online and in-person.
    - **Objective 3**
        - Continue providing dementia capable or dementia friends training to AAADSW staff contractors, and partners.

- **Goal:** Facilitate the expansion of dementia friendly communities.
    - **Objective 1**
        - Collaborate with Washington Dementia Action Collaborative regarding the dementia friendly communities' initiative.
    - **Objective 2**
        - Collaborate with community members, partners, businesses, and volunteers to maintain Dementia Friends in our service area.

Evidence-based Health Promotion Programs: AAADSW and its sub-contractors offer a variety of evidence-based health promotion programs and services, including: TCARE, Powerful Tools for Caregivers, STAR-C, EnhanceFitness, Stay Active and Independent for Life (SAIL), StrongWomen, Group Music Therapy, and Health & Wellness Supports.

Our Disease Prevention and Health Promotion services empower older adults to maintain their health by providing structured, proven wellness programs, including:

1. EnhanceFitness: A research-backed group exercise program for adults 60+ that focuses on balance, flexibility, and strength to support safe, independent living.
2. Oral Health Services: Outreach and essential dental care for uninsured individuals age 60 and older.
3. Stay Active and Independent for Life (SAIL): A community fitness program designed to improve strength and balance for adults 65+.
4. StrongWomen: A strength-training and nutrition education initiative specifically created for midlife and older women.
5. Walk with Ease: An Arthritis Foundation program that teaches participants how to safely incorporate physical activity into their daily lives.
6. Group Music Therapy: The program, focused on increasing social connection and engagement, is funded by an Area Plan Grant awarded to the Vancouver Housing Authority. VHA provides client-centered music therapy interventions at thirteen properties serving older adults and people with disabilities
7. Health & Wellness Supports: Funded by an Area Plan Grant awarded to Wahkiakum County Health and Human Services, the program expands access to supportive services, education, wellness activities, and community connections for older adults and adults with disabilities in Wahkiakum County.

- **Goal:** Enhance the physical and emotional well-being of older adults through accessible, evidence-based wellness education and physical activity.
    - **Objective 1**
        - Sustain at least one new evidence-based offering by the end of the Area Plan period.

Nutrition: Senior Nutrition programs are available throughout AAADSW's five-county service area, and include Congregate Meals, Home Delivered Meals, and the Senior Farmers Market Nutrition Program. Services focus on serving older adults, who are low-income, identify as minorities, and/or are at nutritional risk, nutritious meal and social engagement.

- **Goal:** Increase awareness of Nutrition Programs
    - **Objective 1**
        - Improve awareness and access to the Senior Farmers Market Nutrition Program.
    - **Objective 2**
        - Explore opportunities to increase meal options through Home Delivered Meals Program.
    - **Objective 3**

        - Provide Health Related Social Needs (HRSN) Medically Tailored Meals and explore the possibility of implementing additional HRSN nutrition services.
    - **Objective 4**
        - Convene meetings of nutrition providers, healthcare partners and clients to learn more about clients' unmet nutritional needs.

Addressing Malnutrition: Malnutrition is a common health condition among older adults that is due to not getting enough nutritious foods. Approximately 1 in every 2 older adults are at risk of being malnourished. Senior Nutrition Programs can help to identity and address malnutrition. They are often the first to recognize signs of malnutrition. The programs interact with older adults regularly and are able to notice signs that others may miss.

- **Goal:** Raise awareness of malnutrition and food insecurity.
    - **Objective 1**
        - Provide nutrition education on malnutrition through Senior Farmers Market Nutrition Programs
    - **Objective 2**
        - Provide nutrition services and support through Senior Nutrition Programs, Health Related Social Needs (HRSN), and the Food Box Delivery Program.
    - **Objective 3**
        - During the procurement process for Senior Nutrition Services, include how nutrition providers will address malnutrition.

Grab and Go Provision: Grab and go meal options make meal service more flexible and easier to access. Senior Nutrition Programs can offer an alternative for people who have a barrier or do not feel comfortable accessing meal service through the typical delivery method.

- **Goal:** Provide flexibility for delivery of nutrition services.
    - **Objective 1**
        - Provide Grab and go meals through Home Delivered Meals Program if there is a need.

Culturally Tailored Meals: Culturally Tailored Meals are designed to align with people's cultural background, tradition, religion, or food preferences. These meals are provided through congregate or home delivered meal programs.

- **Goal:** Provide culturally tailored meals through Nutrition Programs.
    - **Objective 1**
        - Continue providing culturally tailored meals through Senior Nutrition Programs and Health Related Social Needs (HRSN) Medically Tailored

Meals.

Senior Centers/Avoiding Isolation/Social Participation: The Area Plan Survey results show social connection and social activities are an important need for older adults in the community. AAADSW and its contractors offer many programs and services which provide connection and engagement to help reduce social isolation and loneliness. AAADSW will continue to work towards addressing the issue of social isolation.

- **Goal:** Reduce loneliness and social isolation.
    - **Objective 1**
        - Work with Nutrition and Transportation providers to provide opportunities for socialization
    - **Objective 2**
        - Encourage volunteers to support agency programs including but not limited to nutrition and transportation for connection and service.

Transportation: Southwest Washington does not have adequate transportation resources to meet the needs of older adults and adults with disabilities. Due to limited funding, AAADSW contracted transportation providers must prioritize who gets a ride to what destination. Often, transportation to life-sustaining medical appointments such as dialysis, oncology, primary and specialty care take priority over rides to the grocery store, congregate meal sites and life enrichment activities. In addition, while transportation to medical appointments is vitally important, so is transportation to life enrichment activities as they reduce social isolation which in-turn improves a person's overall health.

- **Goal:** Advocate for expanded transportation services.
    - **Objective 1**
        - Participate with Accessible Transportation Coalitions Initiative, Gorge TransLink Alliance and other transportation stakeholders.
    - **Objective 2**
        - Contribute feedback to the Southwest Washington Regional Transportation Council and the Cowlitz-Wahkiakum Council of Government Human Services Transportation Plans.
    - **Objective 3**
        - Collaborate with ADRC staff to educate the community about available transportation services in the community.

Universal Design & Community Planning Feedback for Aging Populations: AAADSW will sustain its advocacy and education to promote dementia friendly communities by attending community events to share feedback with community planners.

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- **Goal:** Expand AAADSW's involvement in community events and community planners as it relates to universal design and community planning for the aging population.
    - **Objective 1**
        - Employ a program coordinator whose role focuses on Dementia.
    - **Objective 2**
        - Connect with local community planners and offer input as able.

Mental Health, Counseling: According to the CDC, mental health is a key component to overall health and is closely linked to physical health. In an effort to address mental health needs, AAADSW offers mental health and counseling services through our Family Caregiver Support program. FCSP clients can access up to 6 sessions of counseling through one of our contracted providers.

- **Goal:** Maintain mental health resources to older adults, adults with disabilities, and their family caregivers.
    - **Objective 1**
        - Share mental health resources for our target population via social media, our agency website, and at outreach events as appropriate.

Volunteering and Civic Engagement: AAADSW hosts the Statewide Health Insurance Benefits Advisors (SHIBA), which is a service of the Washington State Office of the Insurance Commissioner (OIC). SHIBA Volunteers provide free, unbiased, confidential help with Medicare to people of all ages and backgrounds. Volunteers help clients compare Medicare options and connect low-income Medicare beneficiaries to programs that lower their costs for premiums, prescription drugs, and health services.

- **Goal:** Continue to expand the volunteer base to better support Medicare beneficiaries across our service area.
    - **Objective 1**
        - Collaborate with OIC staff to develop and deploy a targeted volunteer recruitment campaign in rural counties.
    - **Objective 2**
        - Recruit and train a minimum of 5 new SHIBA volunteers.

Advanced Planning, Guardianship, Protection for Abuse, Neglect, Exploitation:
AAADSW serves as a key regional link to Advanced Care Planning (ACP) education and resources. Since 2011, AAADSW has worked with community partners to support Advanced Care Planning . Our Aging & Disability Resource Specialists provide essential information to community members, referring them to local resources that provide specialized consultations and group education. This collaborative approach ensures community members have access to the expertise needed to document their future care preferences.

- **Goal 1:** Ensure residents can access community resources to provide them with the knowledge and regional connections necessary to document their future care preferences.
    - **Strategy:** Annually update Advance Care Planning Community Resources.
    - **Objective 1**
        - Ensure Aging & Disability Resource Specialists are up-to-date on current ACP resources.

- **Goal**: Case Management and Care Coordination Clients and families will receive and have access to advanced planning, guardianship materials and can connect with professionals when experiencing abuse, neglect, or exploitation.
    - Strategy: Provide ongoing training to direct service staff as they engage with clients and share information about the importance of advanced planning and refer to the appropriate professionals to assist with guardianship when needed. Provide ongoing training on mandatory reporting so all our vulnerable clients who may be experiencing abuse, neglect or exploitation are referred to the appropriate agency, APS or CPS.
    - Objective: At initial intake and as needed, staff will provide information to clients and families.
- Outcomes: Clients and their families will have the information they need to plan for changes in their healthcare and personal situations.

The SHIBA program aims to empower, educate, and assist Medicare beneficiaries to make informed health insurance decisions that optimize access to care and benefits. SHIBA volunteers also help prevent fraud and abuse by educating Medicare beneficiaries on how to spot scams, providing consultation to review claims for errors, and assist in reporting suspicious activity.

- **Goal:** Improve awareness of and access to SHIBA programs and services available through AAADSW.
    - **Objective 1**
        - Maintain quarterly consumer education events across all counties.
    - **Objective 2**
        - Throughout the plan period, continue delivering in-person, one-on-one Medicare counseling sessions tailored to each beneficiary's needs.

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Legal Assistance: The Legal Services Program provides help and advice to seniors who are 60 years of age or older and have low income.

- **Goal:** Increase Awareness of Legal Services.
    - **Objective 1**
        - Connect older adults with information about legal services available in the community.

4.3 Expanding Access to Home and Community-Based Services (HCBS): Addressing Services that support aging in place

Case Management (Medicaid and Non-Medicaid):

Medicaid Case Management provides services to functionally limited older adults and adults with disabilities who are at risk of institutionalization. The goal is to provide services necessary to maintain the highest level of independence in the least restrictive setting, which is typically the client's own home.

- Goals: Continue to meet state-directed ratios for Case Management/Client ratios.
    - Objective: Target a ratio lower than directed to ensure there is time to hire when unexpected direct service staff turnover, or extended leaves occur.
    - Strategy: Monthly review of client and FTE to hire for growth when target ratios are met.
    - Outcomes: Continued ability for direct service staff to meet the care planning and contact requirements of the case management program because caseloads are appropriately balanced to meet program standards.

AAADSW's Community Services department provides case management for Tailored Supports for Older Adults (TSOA), Medicaid Alternative Care (MAC), the Family Caregiver Support Program (FCSP), and the Aging Network Program (ANP). These programs serve individuals who may not meet functional or financial eligibility criteria for Title XIX services, or who choose not to participate in Title XIX services for personal reasons. Community Services case managers support older adults, people with disabilities, and family caregivers by helping them identify needs, coordinate services, and access resources that allow them or their loved ones to remain safely at home. Depending on the program, case management may be short-term or ongoing.

- **Goal:** Support older adults, people with disabilities, and family caregivers who are not eligible for or choose not to access Title XIX services.
    - **Objective 1**
        - Continue providing high-quality case management for all TSOA, MAC, FCSP, and ANP clients.
    - **Objective 2**

        - Continue to identify each family caregiver's needs, provide guidance on available services and supports, and work collaboratively with the caregiver to incorporate their preferred options into their formal plan of care.
    - **Objective 3**
        - Continue supporting case management clients in reviewing the full range of available home and community options to ensure informed decision-making regarding Long-Term Services and Supports.

Health Home Care Coordination provides six core services designed to support individuals with complex, chronic health conditions. The program focuses on improving health outcomes and reducing avoidable medical costs by working with clients to develop personalized goals in a Health Action Plan (HAP). Participation is voluntary, and services are delivered by Care Coordination Organizations (CCOs) for people enrolled in Medicaid, including those who are dually eligible for Medicare and Medicaid.

- Goals: Continue to provide administrative oversight, planning and monitoring of CCOs within our network.
    - Objectives: Ensure CCO network can easily communicate with and receive information necessary to complete and bill for services rendered within program standards.
    - Strategies: Redistribute workload between the LTSS Program Manager, LTSS Program Aide, and the fiscal team to meet the administrative requirements necessary for the HCA HH Lead contract.
    - Outcomes: Broader internal support for the Health Home Lead program and ability to assess network growth in the future.

Person-Centered Counseling/Options Counseling: The ADRC's Person-Centered Options Counseling helps individuals make informed choices about their long-term care goals. This service provides a clear pathway for residents to learn about the services and supports they find best fit their current and future needs.

- **Goal:** Continue to provide a person-centered framework to help residents explore and understand their long-term care options.
    - **Objective 1**
        - Ensure 100% of new Aging and Disability Resource Specialists and Community Services Case Managers are enrolled in or complete person-centered options counseling training within six months of hire.
    - **Objective 2**

        - Maintain an internal communication process to share upcoming person-centered training opportunities with AAADSW's Medicaid Case Management and Care Coordination teams.
    - **Objective 3**
        - Empower Resource Specialists to assist individuals explore the benefits of various resources and service options, and to support individuals in weighing pros and cons.

Self-Directed Services:

- Goals: Maintain practices that continue to demonstrate to our clients that our services are person-centered.
    - Objectives: Providing resources that make it easier for clients to participate in decision making opportunities.
    - Strategies: Create and distribute resources for direct service staff to use with clients and their families.
    - Outcomes: Enhanced participation in person-centered planning activities.

The WA Cares Fund is a statewide, universal, public long term care insurance program that was developed to give beneficiaries the flexibility and autonomy to choose the services and supports that meet their needs. Eligible Washington State workers began accessing their WA Cares benefits to meet long term care needs in July 2026. AAAs provide support and assistance to applicants and beneficiaries who are unable to access or navigate WA Cares online systems. AAADSW's WA Cares team provides support throughout the application process, eligibility determinations, and authorization services.

- **Goal:** Help community members referred by the state WA Cares Beneficiary Customer Center navigate the application, intake, and assessment process to access WA Cares services and benefits.
    - **Objective 1**
        - Assist applicants in person or over the phone who are unable to navigate the WA Cares application process via their online WA Cares account.
    - **Objective 2**
        - Walk applicants through the intake and assessment process for WA Cares
    - **Objective 3**
        - Assist beneficiaries in searching for approved services and providers in their area to meet care needs.

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- **Goal:** Facilitate the transition of beneficiaries from WA Cares fund (once funds are exhausted) into other programs or services they may be eligible for if ongoing support is needed.
    - **Objective 1**
        - Collaborate with internal agency programs and long term support services to determine beneficiary eligibility for ongoing services.
    - **Objective 2**
        - Collaborate with and refer beneficiaries to available community resources or agency providers to address ongoing support needs.

Personal In-Home Care Services: AAADSW offers personal in-home care services through a variety Medicaid Case Management Services, Medicaid Alternative Care, Tailored Supports of Older Adults and Aging Network Program to help meet the needs of older adults.

- **Goal 1**: Maintain a robust pool of home care agency contractors.
    - Objective: Each plan year retain quality home care agencies for clients.
    - Strategy: Continue monitoring and provider support activities of home care agencies, including obtaining feedback from direct service staff.
    - Outcomes: A consistent pool of home care agency providers for direct service staff to utilize for our clients.

- **Goal 2:** Maintain personal in-home care services for older adults and adults with disabilities.
    - **Objective**
        - Promote our personal in-home care services through social media, agency website, and at outreach events.

Supportive Housing

- **Goals: Ensure clients have access to information about accessible and affordable housing resources.**
    - **Objectives: Direct service staff are aware of referrals and resources to share with clients.**
    - **Strategies: Maintain lines of communication with HCLA program staff to receive training on housing resources.**
    - **Outcomes: Direct service staff that can make referrals and provide resources to assist clients and their families with housing information.**

Supported Employment

- **Goal**: Ensure that clients are receiving information about supportive employment and

related opportunities.

- **Objective:** Ensure direct service staff have information and understanding of the CARE assessment tool and supported employment opportunities for clients.
- **Strategy:** Review and provide ongoing training to direct service staff and to HCLA's supported employment teams.
- **Outcome:** Increased referrals for clients interested in the supported employment services available for eligible clients.

Community Living Connections/Aging and Disability Resource Centers: The ADRC serves as a vital entry point for the community, providing people from all backgrounds with information about a broad range of community, social, health, and government services. It effectively opens doors into long-term services and supports and related services; to help people obtain access to the services they need to maintain independence. To ensure equitable local access in our large rural areas, Information & Assistance (I&A) services are subcontracted to local providers in Wahkiakum, Skamania and Klickitat Counties. This partnership ensures that residents in even the most remote areas can connect with the support they require. Core ADRC Services include Options Counseling, Information & Assistance, and Transitional Care Services.

- **Goal:** Connect individuals and families to information, services, and supports that maximize independence and quality of life at home and in the community.
  - **Objective 1**
    - Maintain reliable Information and Assistance (I&A) services in each county through our ADRC network by conducting at least one monitoring of services in each county and providing technical assistance or training as requested or identified to ensure ongoing alignment with state standards.
  - **Objective 2**
    - Maintain representation of at least one local aging and disability focused coalition or committee annually to share ADRC resource information with regional community partners and healthcare providers.
  - **Objective 3**
    - Collaborate individually with each contracted ADRC leader in Klickitat, Skamania, and Wahkiakum counties to discuss regional service delivery and identify potential opportunities to support expanded access in rural areas.

Information and Assistance: Information and Assistance serves as a universal access point for individuals — including older adults, individuals with disabilities, unpaid caregivers, and their representatives. By navigating the complexities of the long-term services and supports service delivery system, we help individuals access the specific resources that best meet their needs.

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- **Goal:** Help residents explore, understand, and connect to long-term care options and other resources in their community.
    - **Objective 1**
        - Sustain Information and Assistance (I&A) services in each county.

Care Transitions: Transitional Care Services empower individuals to make successful transitions back to their homes following a hospital or nursing home stay. Our Transitional Care sub-contractor partners with individuals to provide the specific tools, education, and guidance needed to manage health conditions and avoid readmission into more costly settings.

- **Goal:** Connect individuals and families to the information, services, and supports that maximize independence and quality of life after they transition back home from a hospital or nursing home stay.
    - **Objective 1**
        - Continue to facilitate a high-quality continuum of care in Transitional Care Services by monitoring and supporting contracted providers in their efforts to sustain active partnerships with hospitals and clinics and meet established benchmarks for successful community transitions.

Advocacy: AAADSW strives to provide advocacy for our underserved communities. We do this at a macro level by advocating with the legislature, community leaders, and policy makers to help inform budget, programming, and policy.

- **Goal:** Advocate for our underserved communities
    - **Objective 1**
        - Attend legislative sessions to provide advocacy for programs and services that are integral for our underserved populations.
    - **Objective 2**
        - Continue to provide consultation to policy makers and community leaders about programs and services that affect our target populations.

4.4 Caregiving: Enhancing Services and Supports for Caregivers

State Family Caregiver Support Program: The Family Caregiver Support Program (FCSP)offers tailored services, supports, and resources to unpaid family caregivers, who provide continuous care for adults with functional disabilities or are age 60 or older. These supports and services enable family caregivers to continue at-home care and allow care receivers to remain in their familiar, home environment and postpone or prevent the need for more expensive forms of care. Services include:

a) Information on Community and Caregiver Resources

b) Referral to Support Groups
c) Respite Care Services, including In-home care and Adult Day Care (Clark County only)
d) Caregiver Education
e) Evidence-based caregiver services such as TCARE Assessment, Powerful Tools for Caregivers, and STAR-C
f) Transportation for caregiver and/or care receiver to medical services, essential shopping, wellness activities, meal programs, social services, and/or senior center
g) Counseling Services for caregiver
h) Case Management
i) Assistive Supplies, Devices, and Equipment, and
j) Personal Emergency Response Systems (PERS).

- **Goal:** Maintain support to family caregivers
    - **Objective 1**
        - Connect family caregivers to information about dementia and memory loss through classes, online education, printed materials, and agency and community resources.
    - **Objective 2**
        - Maximize utilization of funding available for all services and supports available through FCSP.

Kinship Caregiver Support Program: AAADSW supports the unique needs of Kinship Families through programs that stabilize the household and provide specialized education for relative caregivers.

Kinship Caregivers Support Program: Provides financial assistance to grandparents and other relatives who are the primary caregivers for children under the age of 19. This program addresses unmet and emergent needs by assisting with costs for basic necessities, legal services, transportation, and school or youth activities. By reducing financial barriers, we help ensure children can remain in the care of their family members. KCSP also provides Caregiver Education through workshops and digital resources, helping relatives develop coping skills and specialized knowledge required for their caregiving roles.

Kinship Navigator Program: Acts as a central point of contact to help kinship families navigate the complexities of the social, health, and legal systems. Our Navigators ensure families are connected to the specific community resources and support groups that foster long-term stability.

- **Goal:** Promote household stability and caregiver resilience for grandparents and relatives raising children in our service area's rural counties.
    - **Objective 1**

        - Increase the number of rural families connected to Kinship Programs through targeted outreach and local community partnerships.

Evidence-Based Caregiver Programs: AAADSW is committed to providing evidence-based caregiver education. We do this by offering the following programs:

1. STAR-C: The STAR-C program was designed to help family caregivers who are caring for someone with Alzheimer's disease or a related dementia. The program was clinically tested and proven to lower depression in caregivers and decrease problem behaviors in the person with dementia.

2. Powerful Tools for Caregivers: The Powerful Tools for Caregivers program helps caregivers develop a wealth of self-care tools to reduce personal stress, change negative self-talk, communicate their needs to family and healthcare or service providers, communicate effectively in challenging situations, recognize the messages in their emotions, deal with difficult feelings, and make tough caregiving decisions.

- **Goal:** Promote family caregiver well-being through connection to evidence-based caregiver education programs
    - **Objective 1**
        - Promote evidence-based caregiver education offerings through the agency website and social media.
    - **Objective 2**
        - Increase the number of caregivers who participate in evidence-based education programs.

Medicaid Alternative Care (MAC): MAC supports older adults age 55+ who are on Apple Health (Medicaid), that need help to live at home. These services are designed to assist unpaid caregivers receive supports necessary to continue to provide care to their loved one and to focus on their own health and well-being. There is no estate recovery or client participation for this program

- **Goal:** Maintain the MAC program
    - **Objective 1**
        - Promote the program through social media, agency website, and at outreach events.
    - **Objective 2**
        - Continue to ensure MAC clients successfully access the benefits for which they are eligible.

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Tailored Supports for Older Adults (TSOA): TSOA helps older adults age 55+ who need help to live at home. These services are for adults who do not meet Medicaid financial eligibility but do meet the functional criteria for care. They may or may not have an unpaid caregiver. There is no estate recovery or client participation for this program.

- **Goal:** Maintain TSOA program
  - **Objective 1**
    - Promote the program through social media, agency website, and at outreach events.
  - **Objective 2**
    - Continue to ensure TSOA clients successfully access the benefits for which they are eligible.

4.5 7.01 Planning with Native American Tribes and Tribal Organizations

AAADSW partners with tribes to develop a formal plan that outlines its coordination with individual tribes within our Planning Service Area (PSA). There are two tribes within AAADSW's PSA, Cowlitz Indian Tribe and Yakama Nation. Below are the current draft 7.01 plans.

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Appendices

Appendix A: Emergency Response Plan

Work in Progress

Appendix B: Advisory Council

Clark County
Joe Bosch
Kevin Callahan
Arnie Dyer
Apryl Schneider
Richard Seekins

Cowlitz County
Diane Craft
Dave Rorden

Klickitat County
Susan Petrie

Skamania County
Mary Repar
Roberta Doster

Wahkiakum County
Eileen Stearns-Raff

Appendix C: Public Process

Work in Progress

Appendix D: Report on Accomplishments from the 2024 – 2027 Area Plan

Work in Progress

Appendix E: Statement of Assurances and Verification of Intent

Work in Progress

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