Area Agency on Aging & Disabilities of Southwest Washington 2020 - 2023 Area Plan Update November 2021

AREA AGENCY ON
Aging & Disabilities
OF SOUTHWEST WASHINGTON

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Clark ♦ Cowlitz ♦ Klickitat ♦ Skamania ♦ Wahkiakum

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Executive Summary

The Area Agency on Aging & Disabilities of Southwest Washington (AAADSW) is approaching the halfway point of its 2020-2023 Area Plan. This Area Plan ***Update*** reports on progress made toward initial goals, introduces new initiatives for the remaining two years, and includes administrative activities such as budget, organizational chart, staffing plan and governance.

The biggest challenge facing the agency is COVID-19's impact on the lives of older adults, adults with a disability, and family caregivers, as well as employees of AAADSW. Closing of congregate meal sites, increasing demand for home delivered meals, and addressing social isolation requires AAADSW and its contractors to quickly change how many services are being delivered and take advantage of the opportunities to develop new programs.

Through the diligent work of AAADSW employees, Advisory Council members, and key stakeholders throughout the five-county planning and service area, as well as the support of our governing board, I'm pleased to report significant progress on first- and second-year goals has been made.

Sincerely,

Mike Reardon
Executive Director
Area Agency on Aging & Disabilities of Southwest Washington

Pearl Blackburn
Advisory Council Chair
Area Agency on Aging & Disabilities of Southwest Washington

"I want to extend my gratitude for everything your team does for our patients. These are trying times for many. I had a patient recently who practically had me in tears. She said because of the referral I sent and the resources AAADSW gave her that she might have a chance of [improving her living situation]. She was very thankful for everyone's help."

- Alex RN, BSN – Internal Medicine Network

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The format for the 2022-2023 Area Plan Update is like the format used for the 2020-2023 Area Plan. Dates in goal tables in section C reflect target dates. Appendix F includes date goal accomplishment dates.

What's new for plan period 2022-2023?

1. AAADSW will include Statewide Health Insurance Benefit Advisors (SHIBA) Program as part of its suite of services available in Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum Counties. The SHIBA program aims to empower, educate, and assist Medicare-eligible Washington state consumers, their families, and caregivers through objective outreach, counseling, and training, to make informed health insurance decisions that optimize access to care and benefits.

2. AAADSW will use American Rescue Plan funding to augment nutrition, transportation, ADRC, Senior Health and Wellness, and family caregiver programs and services.

3. One new education service:
   - *I.* TRUALTA is an interactive eLearning platform to help manage care for aging adults at home.

4. Programs to reduce social isolation:
   a. *Furry Friends*: This pilot program uses Joy for All Companion [Robotic] Pets to reduce social isolation and loneliness within the PSA.
   b. *Senior Companions*: Program development is underway to pilot a Senior Companion Program.

5. AAADSW will amend its reporting practice to align with the new OAAPS reporting process.

What's changed from plan period 2020-2021 to 2022-2023?

1. Area Plan budget increased from $23.2M in 2020 to $27.5M in 2022.

2. Updated Staffing Plan and Organization Chart to reflect the increase in number of FTE.

3. Due to COVID, stakeholder meetings are held in a digital format.

4. All education transitioned from in-person to a digital format due to COVID.

5. Due to COVID, EnhanceFitness classes transitioned from in-person to a digital format. In-person classes will resume when it is advisable to do so.

6. Addition of COVID-19 Response Services and Supports Section (see page 27).

What's carried forward from plan period 2020-2021 to 2022-2023?

1. Develop an Emergency Response Plan by December 31, 2023.
   a. Letter of Agreement with the Emergency Management Departments in Clark, Cowlitz, Wahkiakum and Skamania counties is fully executed.

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b. Plan for contacting high-risk clients and referring them to first responders is implemented.
c. Establish partnerships with appropriate community preparedness agencies to address identified unmet needs.
d. Provide shelter-in-place education to high-risk clients.
e. Develop internal business continuity plan.

2. Develop a Department of Social & Health Services Policy 7.01 Plan with individual tribes and recognized tribal organizations within AAADSW service area, for two-year period, 2022–2023.

What's removed from 2020-2023 Area Plan and why?

The goal to increase the number of certified caregivers in rural service areas was removed as the contractor requesting this assistance will not renew its contract in 2022.

The need to increase the number certified caregivers in rural and urban areas is a local, state, and national issue. AAADSW has joined efforts with the State Association of AAAs and Washington State Aging & Long-Term Support Administration to address this workforce through advocacy.

Section A: Area Agency Planning and Priorities

A-1 Introduction

The Area Agency on Aging & Disabilities of Southwest Washington (AAADSW) is a regional government agency that receives federal, state and grant funding to help older adults and adults with disabilities remain in their homes as well as to support family caregivers. AAADSW's region, also known as its Planning and Service Area, includes Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum counties with Clark the only urban county. The remaining four counties are rural. One county Commissioner from Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum comprises AAADSWs' governing authority.

AAADSW's 18-member, all volunteer, Advisory Council plays an important role in the agency. They meet with state legislators, educate community members about what programs and services are available, and inform AAADSW leadership about needs in their communities.

AAADSW's core program offerings include (but are not limited

AREA PLAN

- A federal and state requirement
- New plan every 4 years
- Updated every 2 years
- Provides an overview of issues facing:
  - older adults
  - adults with disabilities
  - family caregivers
- Includes goals to address identified issues
- Provides information on:
  - current programs
  - future program offerings
  - agency budget and staffing

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to) Medicaid Case Management, Care Coordination, Community Services, and Medicaid Alternative Care & Tailored Supports for Older Adults (MAC/TSOA). Different and varying levels of services are available in each program area based on an individual's age, income, resources, and amount of assistance needed with activities of daily living such as eating, bathing, walking, managing medications, etc.

"This was good for me to find out all this information. I am grateful for people that put themselves out there to help others."

- Klickitat County Senior Citizen

A-2 Mission, Vision and Values

AAADSW's mission is "To promote independence, choice, well-being, and dignity for older adults, adults with disabilities, and family caregivers in our five-county Planning and Service Area (PSA) through a comprehensive, coordinated system of home and community-based services." We accomplish this in a variety of ways.

"Have taken Powerful Tools for Caregivers from Aging and Disabilities of SW Washington, and currently taking Caring for Loved Ones. Excellent information and support from these classes. Invaluable!"

– Clark County Caregiver

- Providing resources and information on programs and services to:
  - adults age 60 and older
  - adults with disabilities
  - family caregivers
- Offering programs and classes that support family caregivers
- Working with local social service and healthcare providers to strengthen and expand local safety net programs
- Distributing federal, state and grant funding while developing new funding sources
- Engaging in legislative advocacy at state and national levels
- Ensuring contracted service providers operate programs in accordance with state and federal guidelines

AAADSW's **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:

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- **Choice** We encourage and respect individual choice, especially regarding a person's choice to live in the setting that he/she most desires

- **Independence**
  We promote client empowerment and focus on preserving client independence

- **Family support**
  We recognize and support the care of older adults and adults with disabilities provided by family and friends

- **Responsiveness**
  We gather input from those we serve to improve our services

- **Quality**
  We are committed to delivering quality services in a cost-effective manner

- **Teamwork**
  We value the contributions of our dedicated employees and contracted agencies, embrace creative problem solving and foster a teamwork-based environment focused on results

- **Diversity**
  We encourage an environment that accepts differences

- **Leadership**
  We foster strong community partnerships and provide solution focused leadership

"Not needing help now, but with spouse's health failing will need help in the future." - Cowlitz County Senior Citizen/Family Caregiver

"I know personally folks struggling to stay in home but need a lot of help with personal care, yard work, housework, etc." – Clark County Senior Citizen

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A-3 Planning and Review Process

A draft of the 2020-2023 Area Plan Update was presented to AAADSW's Advisory Council Planning & Allocations Committee on November 17, 2021. On November 18, 2021, AAADSW held a virtual Public Hearing to review the Area Plan Update and take public comment. Comments (will be) incorporated into the Area Plan Update. On December 12, 2021, AAADSW's COG Board (will review *& approve*) final draft of the 2020-2023 Area Plan Update.

A-4 Prioritization of Discretionary Funding

While most of our revenue provides mandated federal and state services, AAADSW has a limited amount of discretionary funding from Washington State Senior Citizens Services Act and Federal Older Americans Act Title IIIB. However, there are federal requirements with which AAADSW must comply. Those requirements are:

1. 11% of Older Americans Act Title IIIB funding must be budgeted for Legal Services
2. 15% of Older Americans Act Title IIIB funding must be budged in the Access Services category, i.e., Transportation, Information & Assistance, Aging Network Case Management.
3. 1% of Older Americans Act Title IIIB funding must be budgeted in the In-Home Services category, i.e., Aging Network Personal Care, Adult Day Care, Bath Assistance.
4. Funding for Long-Term Care Ombudsman Program must meet or exceed its 2000 Older Americans Act Title IIIB spending level for ombudsman services. For AAADSW, this amount is $5,352.

In prioritizing which programs to support with the remaining discretionary funds, AAADSW considers the following questions:

a. Does the program/service align with AAADSW's mission?
b. Does the program/service support the person's ability to remain at home?
c. Does the program/service reach our target population(s)?
d. Does the program/service help accomplish Area Plan goals and objectives?
e. Is the program/service currently available through another organization?
f. What are the expressed needs identified through the most recent Area Plan Public Process?

Taking into consideration survey results, input from public meetings and Advisory Council members, interviews with partner agencies and program analysis, as well as impacts of COVID-19, AAADSW will support the following programs with discretionary funding.

- Transportation
- Information & Assistance
- Aging Network Personal Care
- Aging Network Case Management
- Long-Term Care Ombudsman
- Social Isolation
- Telehealth

Prioritizing programs when significant funding reductions or increases occur involves several factors, including but not limited to contractual and legal requirements, ability to carry out Area Plan Goals and Objectives and needs identified through the most recent Area Plan Public Process. In addition to these factors, answers to the following questions will help determine program prioritization.

a. What fund source(s) is reduced and by how much?

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b. Are there alternative revenue sources within AAADSW that can offset the reduction?
c. Which program(s) protect core functions critical to the health and safety of our target populations?
d. What is the impact if reductions are spread across programs versus one program?
e. Is the program currently available through another organization?

SECTION B: PLANNING AND SERVICE AREA PROFILE

B-1 Target Population Profile

Federal and state statutes establish who is eligible to receive AAADSW services. Adults aged 60 and over, adults with disabilities and family caregivers are AAADSW's target populations. The following eight tables focus on a different characteristic of AAADSW's target populations. Demographic information in each table is from Washington State's Department of Social and Health Services Research and Data Analysis, July 16, 2019, report, except Table 8. This data is from Washington State Department of Social & Health Services 2020 estimate that there are 850,000 unpaid family caregivers statewide.

For a more comprehensive look at population forecast, see Appendix L.

Consider the information in Table 1: Growth in age 60+ population by county. The percentage of increase in this population ranges from only 1% in Wahkiakum to over 11% in Clark County.

Table 1: Growth in age 60+ population.

County	2020 to 2023	Percent Increase
Clark	110,873 to 123,228	11.1
Cowlitz	30,671 to 32,857	7.1
Klickitat	7,979 to 8,363	4.8
Skamania	3,938 to 4,310	9.4
Wahkiakum	1,939 to 1,957	1.0
Region	155,400 to 170,715	9.9

Even more alarming than a regional 9.9% increase in age 60+ population by 2023 is the fact that this cohort represents a significant percentage of the region's total population! According to the report by Washington State County Population Projections for Growth Management (January 2002), a minimum of 1 in 4 residents will be age 60+ by year 2023. See Table 2 for specific county statistics.

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Table 2: Percentage of population age 60+ in 2023.

County	Total Population	Age 60+ Population	Percent of age 60+ population
Clark	530,962	123,228	23.2
Cowlitz	132,409	32,857	24.8
Klickitat	25,320	8,363	33.1
Skamania	12,701	4,310	33.9
Wahkiakum	4,943	1,957	39.6
Region	706,335	170,715	24.2

Consider the various subgroup statistics within AAADSW's target populations in Tables 3-8.

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

County	2020 to 2023	Percent Increase
Clark	5,506 to 6,146	11.6
Cowlitz	3,100 to 3,276	5.7
Klickitat	639 to 652	2.0
Skamania	299 to 320	7.0
Wahkiakum	154 to 153	0.0
Region	9,698 to 10,547	8.8

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

County	2020 to 2023	Percent Increase
Clark	7,704 to 9,046	17.4
Cowlitz	2,194 to 2,471	12.6
Klickitat	562 to 641	14.1
Skamania	246 to 282	14.6
Wahkiakum	150 to 171	14.0
Region	10,856 to 12,611	16.2

Table 5: Growth in disabled population age 18+.

County	2020 to 2023	Percent Increase
Clark	33,540 to 36,872	9.9
Cowlitz	9,220 to 9,778	6.1
Klickitat	2,303 to 2,425	5.3
Skamania	1,146 to 1,227	7.1
Wahkiakum	493 to 519	5.3
Region	46,702 to 50,821	8.8

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

County	2020 to 2023	Percent Increase
Clark	20,816 to 22,488	8.0
Cowlitz	5,725 to 5,969	4.3
Klickitat	1,352 to 1,400	3.6
Skamania	697 to 734	5.3
Wahkiakum	254 to 268	5.5
Region	28,844 to 30,859	6.9

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

County	2020 to 2023	Percent Increase
Clark	10,917 to 12,761	16.9
Cowlitz	1,908 to 2,192	14.9
Klickitat	577 to 652	12.9
Skamania	277 to 331	19.5
Wahkiakum	92 to 96	4.3
Region	13,771 to 16,032	16.4

Table 8: Growth in number of persons age 60+ and Limited English Proficiency.

County	2020 to 2023	Percent Increase
Clark	4,049 to 4,697	16.0
Cowlitz	1,115 to 1,243	11.5
Klickitat	298 to 331	8.7
Skamania	140 to 159	13.6
Wahkiakum	61 to 64	4.9
Region	5,663 to 6,494	14.6

Washington State Department of Social & Health Services estimated that in 2020 there were 860,000 unpaid family caregivers throughout the state. Since AAADSW's region accounts for approximately 8% of the state's total population, we can reasonably assume there are a minimum 68,000 caregivers in our region. For number of caregivers by county, see Table 9.

Table 9: Number of Family Caregivers by County.

County	Family Caregivers
Clark	51,000
Cowlitz	12,900
Klickitat	2,380
Skamania	1,320
Wahkiakum	400
Region	68,000

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AAADSW's target populations include low-income, minority, Limited English Proficiency (LEP), older adults residing in rural areas, older Gay, Lesbian, Bisexual, and Transgender (GLBT) and adults with disabilities and their family caregivers.

Improving access to information and services for LEP individuals remains a priority for AAADSW. To accomplish this goal, the agency provides program brochures in Spanish and Russian languages and uses interpreters as needs arise. Additionally, AAADSW staff members conduct presentations and in-service trainings to community partner agencies specializing in serving these populations.

As described in the Population Profile, Clark County is urban while the other four counties are rural. Reaching older adults and adults with disabilities in these rural counties requires a concerted effort. Klickitat and Skamania counties are sub-contracted agencies that serve as focal points and service providers. Klickitat County Senior Services (KCSS) and Skamania County Senior Services (SCSS) distribute regular newsletters to reach target populations and the public and inform them of issues, programs and services touching their lives. In Wahkiakum County, AAADSW helps support financially as well as provides technical assistance and Aging & Disability Resource Specialist training to a Wahkiakum County Health & Human Services staff person so that she can serve as a local Aging & Disability Resource Specialist.

AAADSW's outreach efforts are multiplied through the increasing number of private and public sector organizations joining the Aging & Disability Resource Network (ADRN). Representatives from over 50 organizations attend quarterly ADRN meetings to learn from each other, strengthen partnerships and improve referral processes so vulnerable populations receive quality care.

Through our GWEC program, we have conducted numerous presentations to physicians, social workers and discharge planners at clinics and hospitals in Southwest Washington. As a result of these outreach efforts, we have seen a significant increase in referrals for services for older adults, adults with disabilities and family caregivers.

AAADSW staff members participate on committees including, Clark County Commission on Aging, Cowlitz/Wahkiakum Living Well Aging Well, Clark and Cowlitz Counties Cross Continuum Care Transitions Collaborative, Community Health Access Resource Group, Emergency Medical Services Community Healthcare Coalition, Elder Alliance, , Senior Services Networking and Skamania and Klickitat Interagency Meetings.

Further outreach efforts to target populations include, but not limited to the following:

- participation in health/senior fairs
- presentations to support groups, homeowners' associations, service organizations, state agencies, schools, faith communities,
- paid advertising in newspapers and billboards
- strategic partnerships with staff at organizations serving similar populations

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Lastly, AAADSW's sub-contractors are required to refer vulnerable adults to their local Aging & Disability Resource Center/Focal Point.

B-2 AAA Services and Partnerships

AAADSW offers over 35 programs, 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/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 while securing new funding to create pilot projects. Examples include HOME, Oral Health and embedding Aging & Disability Resource Specialists in healthcare settings. These programs started as pilot projects in a designated county. As funding and partnerships developed, they expanded into other counties. The goal of every successful pilot project is to make it available in all five counties. To the degree feasible, all programs and services are available throughout all five counties. For a list of programs and services offered in each county, see Appendix L.

A trio of related programs 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 4,400 individuals receive case management services through this program, accounting for roughly 40% of the agency's budget.

The second, absorbing approximately 17% of AAADSW's budget is Health Home Care Coordination. Through this program, high-risk, high-cost individuals with chronic health conditions on Medicaid-Medicare (dually eligible), or those on Medicaid only, receive intensive support services. The goal is to improve their health outcomes and reduce unnecessary medical costs by creating a client-centered Health Action Plan (HAP). Care coordination services are voluntary and may include any of the following services:

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, launched in 2017 is 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. These programs allow individuals with higher

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incomes and resources to access certain Medicaid benefits. As of August 2021, approximately 585 clients are currently receiving services through these programs. Evaluation of the effectiveness of MAC and TSOA continues through the end of the demonstration period, 2021.

The remaining services offered by AAADSW are available to older adults, adults with disabilities, and family caregivers, including:

- nutrition
- transportation
- case management
- dental care
- minor repairs to homes
- aging & disability resource centers
- respite care and counseling for caregivers
- educational classes and support groups covering chronic illnesses and caregiving
- healthy aging resources and exercise programs

Additionally, AAADSW is the host agency for the region's Long Term Care Ombudsman program whose purpose is to protect and promote the rights of residents living in skilled nursing facilities, assisted living facilities, 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, use of restraints, abuse and other aspects of resident dignity and rights.

"What volunteers bring is the human touch, the individual, caring approach that no government program, however well-meaning and well-executed, can deliver." – Edward James Olmos

"Volunteers do not necessarily have the time; they just have the heart." – Elizabeth Andrew

For a complete list of programs and services offered, see Appendix J

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 Aging and Disability Resource Network in Clark County and Collaborating On Delivering Effective Services (CODES) in Cowlitz County. Network membership consists of healthcare, long-term care services, emergency medical services, social services and disability groups. The networks convene to share resources, identify and problem solve gaps in services and collaborate to improve care to clients.

For a complete list of partnerships, see Appendix K.

Volunteers

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AAADSW and their contracted providers rely heavily on the talents, skills, and abilities of dedicated volunteers. With the help of these individuals, key services are delivered in a cost-effective manner.

In 2020, volunteers of AAADSW and AAADSW's contracted providers provided more than $380,000 in in-kind services… WOW! These services include:

- serving meals and washing dishes at congregate meal sites
- delivering meals to home-bound seniors
- giving seniors rides to medical appointments
- advocating for residents of nursing homes, adult family homes and assisted living facilities
- building access ramps and installing grab bars
- serving on AAADSW's Advisory Council and committees

This in-kind support helps AAADSW meet its federal funding "match" requirements, and thereby frees up other funding to enhance and expand services.

B-3 Focal Points

A focal point is a facility established to encourage the maximum connection and coordination of services for older individuals.
Listed below are designated focal points in AAADSW's five county region.

County	Organization or Site Name	Focal Point Address	Public Phone Number & E-Mail Address	Services Coordinated at this Site
Clark	AAADSW	201 NE 73rd Street, Vancouver, WA 98665	Phone: 360-694-8144 Toll Free: 888-637-6060 Email: clarkadrc@dshs.wa.gov	ADRC and other AAA Services
Cowlitz	AAADSW	1338 Commerce Avenue, Suite 309, Longview, WA 98632	Phone: 360-501-8399 Toll Free: 800-682-2406 Email: cowlitzadrc@dshs.wa.gov	ADRC and other AAA services
Wahkiakum	Wahkiakum County Health and Human Services	42 Elochoman Valley Road, Cathlamet, WA 98612	Phone: 360-795-8630, Option 4 Email: pattersonk@co.wahkiakum.wa.us	ADRC and referrals to other services

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Skamania	Skamania County Senior Services	710 SW Rock Creek Drive, Stevenson, WA 98648	Phone: 509-427-3990 Email: seniorsia@co.skamania.wa.us	ADRC, Congregate Meals, Home Delivered Meals, DPHP, Transportation
Klickitat	Klickitat County Senior Services	115 W Court Annex IIMC-CH-21, Goldendale, WA 98620	Phone: 509-773-3757 Toll Free: 800-447-7858 Email: kcssinfo@klickitatcounty.org	ADRC, Congregate Meals, Home Delivered Meals, DPHP, Transportation, Case Management, MAC/TSOA and FCSP
Klickitat	Klickitat County Senior Services	501 NE Washington Street, White Salmon, WA 98672	Phone: 509-493-3068 Toll Free: 800-447-7858 Email: info@klickitatcounty.org	ADRC, Congregate Meals, Home Delivered Meals, DPHP, Transportation, Case Management, MAC/TSOA and FCSP

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SECTION C: ISSUE AREA THEMES

This section outlines goals that address issues facing older adults, adults with disabilities, and family caregivers. The selected "Issue Areas" are the result of over 750 survey responses and requirements by Washington State's Aging and Long-Term Services Administration.

C-1 Healthy Aging

Healthy aging influences seniors' and adults with disabilities ability to remain at home and can help reduce healthcare costs. As such, AAADSW provides health and wellness programs and will continue to work with its community partners to address social determinants of health that impact the health of seniors, adults with disabilities and family caregivers in Southwest Washington.

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 facilitates both physical and brain health.

"I am terrified of dementia coming. No family. Ailing wife. No assisted home in the area." – Klickitat County Senior Citizen/Caregiver

AAADSW will continue its focus on supporting individuals with dementia and their families.

Goal: Help individuals with Alzheimer's or a related dementia and their family caregivers connect to services and support.	
Objectives	**Date**
Sustain respite and personal care services.	12/31/2023
Connect family caregivers to local support groups.	12/31/2023
Offer family caregiver education opportunities via print, online and in-person.	12/31/2023
Collaborate with Washington Dementia Action Collaborative regarding their dementia friendly communities' initiative.	12/31/2023
Provide dementia capable training to AAADSW staff.	12/31/2023
Make available Dementia Activity Kits to Klickitat and Skamania Counties.	12/31/2020

Health Promotion Programs

AAADSW and its sub-contractors provide the following evidence-based health promotion programs: TCARE, Powerful Tools for Caregivers, STAR-C, Enhance Fitness, Staying Active and Independent for Life, Strong Women, Walking with Ease, Bridge Transitional Care Services, PEARLS and Chronic Disease Self-Management Program. A key focus of this plan period will be to increase public awareness of available wellness programs in Southwest Washington.

Nutrition

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

"I attend the exercise program and occasionally meals (find them very helpful)." – Skamania County Senior Citizen

Goal: Increase Participation in Nutrition Programs	
Objectives	**Date**
Research ways to deliver congregate nutrition services to the next generation of older adults, for example baby boomers.	12/31/2020
Work with nutrition providers to increase meal options through Home Delivered Meals program.	12/31/2020
Convene meetings of nutrition providers, healthcare partners and clients to learn more about clients' unmet nutritional needs.	12/31/2021
Implement one pilot-program to increase participation in Senior Nutrition Programs.	12/31/2022
Evaluate pilot-program and determine next steps.	12/31/2023

Transportation

Overwhelmingly, Area Plan Survey results show transportation as the single most important need for older adults to remain living in their own home.

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 whom gets a ride to what destination. Often times, transportation to life-sustaining medical appointments such as dialysis, oncology and primary/specialty care take priority over trips 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.

"I don't drive, so having access to things right here at the senior center would be very important to me. As my husband's condition progresses this [transportation] will undoubtedly be my primary concern." – Klickitat County Senior Citizen/ Caregiver

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Goal: Advocate for expanded transportation services.	
Objectives	**Date**
Move Family Caregiver Support Program funding from under-utilized services to support transportation services to family caregivers, older adults and adults with disabilities.	12/31/2020
Research innovative transportation programs, share findings with community partners and determine implementation feasibility.	12/31/2021
Participate with Healthcare Transportation Project team, Accessible Transportation Coalitions Initiative and Gorge TransLink Alliance.	12/31/2023
Contribute feedback to the Southwest Washington Regional Transportation Council's Human Service Transportation Plans.	12/31/2023

Universal Design and Community Planning Feedback for Aging Populations

AAADSW's HOME Program provides seniors with minor home modifications so they can continue to live independently and safely in their own homes. Modifications include grab bars, handrails, handheld showers, and access ramps. The pilot program currently serves adults over age 60 who reside in Clark, Cowlitz, and Skamania counties. AAADSW intends to expand the program to Klickitat and Wahkiakum counties by 2023.

Mental Health and Counseling

AAADSW will continue to collaborate with community partners, such as NAMI, who focus on mental health in the community to connect community members to behavioral health services, local support groups and classes available in the community. AAADSW offers the Program to Encourage Active, Rewarding Lives (PEARLS) to address late-life depression. Family caregivers may also access counseling services.

> ***Affordable housing within walking distance of groceries is needed and desirable. Medical advocates who can accompany you to a doctor's visit, then help with follow up questions Re: diagnosis, meds, etc. This could be very helpful to some older individuals.***
>
> \- Cowlitz County Senior Citizen

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C-2 Expanding and Strengthening Services and Supports that Prevent or Delay Entry into Medicaid-Funded Long-Term Services and Supports

Community Living Connections/Aging and Disability Resource Centers, Information and Assistance and Care Transitions

"Pulling our hair out taking care of mom. Running out of family that can help. Not all help available is affordable, why doesn't Medicare pay for this? We are supposed to go completely broke first?!!"
- Clark County Family Caregiver

Information and Assistance program connect people to community-based service options and provide personalized assistance to individuals to help them access Long-Term Services and Supports.

AAADSW Transitional Care coaches work with patients and their family caregivers to ensure a successful transition from hospital or rehabilitation center to home. Coaches focus on key components of this transition, medication management and self-care, recognizing symptoms that may require immediate attention, and making and keeping follow-up appointments with their primary care physicians. With this support, individuals are more likely to avoid hospital readmissions, with the added benefit of improved medical outcomes and quality of care.

Goal: Connect individuals and families to services and supports that maximize independence and improve quality of life in their home and community.	
Objectives	**Date**
Sustain an information and assistance office in each county.	12/31/2023
Embed Aging and Disability Resource Specialists in local healthcare settings.	12/31/2020
Continue to cultivate healthcare partnerships and collaborations.	12/31/2023
Explore new opportunities to expand ADRC service delivery.	12/31/2020

State Family Caregiver Program

This program supports unpaid family caregivers, who care for an adult with a functional disability or is 60 or older. Services enable family caregivers to continue at-home care and allow care receivers to remain in their familiar environment. Services include:

a) Information on Community and Caregiver Resources
b) Referral to Support Groups
c) Respite Care Services
d) Caregiver Education and
e) Evidence-based caregiver services such as TCARE Assessment, Powerful Tools for Caregivers and STAR-C.

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> ***"It is easy to talk about care-giving for your spouse or relatives but it's a different thing to live it. When your loved one will not let anyone into the house to help you, you are pretty well stuck doing all things*** – Clark County Caregiver

Goal: Expand support to family caregivers	
Objectives	**Date**
Conduct focused outreach to family caregivers in November and December, annually.	12/31/2023
Promote availability of support groups through agency website and social media.	12/31/2020
Connect family caregivers to information about chronic diseases through classes, online education and printed materials.	12/31/2023
Maximize utilization of funding available for respite and personal care services	12/31/2023

Medicaid Alternative Care

MAC supports older adults age 55+ that need help to live at home. It provides support to the person's unpaid family caregiver continue to provide care to their loved one and focus on their own health and well-being. There is no estate recovery or client participation for this program.

Tailored Supports for Older Adults

TSOA helps older adults age 55+ who need help to live at home. The benefit is for individuals who currently do not meet Medicaid financial eligibility criteria but do meet functional criteria for care. They may or may not have a family caregiver. There is no estate recovery or client participation for this program.

Advanced Care Planning

AAADSW plays an active role in advance care planning and education in Southwest Washington. AAADSW has been a member of the Life Transitions: End of Life Coalition since 2011. AAADSW provides both group and one on one Advanced Care Planning consultations. End of life resources are available at AAADSW's website.

C-3 Person-centered Home and Community-based Services

The "person-centered" philosophy focuses on individuals and their personal self-directed goals, preferences, strengths, needs and desires. It changes the conversation from what the "professional" thinks is most important for the individual to know, to finding out what is most important to the individual. This "person-centered" approach puts individuals and their goals and desires at the center of the conversation and, through a series of questions, the "professional" helps individuals explore their options and make informed decisions.

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The person-centered approach is present in all interactions with individuals; regardless of from which department (Medicaid Case Management, Care Coordination, or Community Services) they receive services.

Person-Centered Counseling/Options Counseling

The ADRC's Person Centered Options Counseling facilitates informed decision-making and provides a pathway for individuals to access long-term care services and supports they think are most beneficial to their current and future situation.

Goal: Provide a person-centered approach to explore resources and options for care.	
Objectives	**Date**
Aging and Disability Resource Specialists and Community Services Case Managers complete person-centered options counseling training.	12/31/2023
Share information about upcoming person-centered options counseling trainings with AAADSW's Medicaid Case Management and Care Coordination teams.	12/31/2023
Aging and Disability Resource Specialists will assist individuals to explore resources and service options and support the individual in weighing pros and cons.	12/31/2023
Case managers will continue to use the TCARE assessment to identify family caregivers' needs and provide consultations to share services and supports that meet their needs.	12/31/2023
Case managers will continue to support clients in making informed decision about Long-Term Services and Supports.	12/31/2019

In Medicaid Case Management and Care Coordination, staff receive person-centered training within their first six months of hire. Additionally, embedded in the required assessment tools (electronic and paper versions) is this person-centered approach. Examples include the following:

- Case managers receive information on person-centered planning during their new-hire orientation at Case Management Program Training by Aging and Long-Term Services Administration staff.
- Case managers receive training and support from their supervisors during team meetings.
- Client-directed goals in Comprehensive Assessment and Reporting Evaluation (CARE) become part of the client's service plan.
- Care coordinators participate in a 2-day Health Care Authority training where person-centered planning is the foundational approach to working with clients.
- Care coordinators complete tri-annual client Health Action Plans (HAP) that contain goals created by the client and supported by the care coordinator.
- During the development of a Health Action Plan, a client's level of motivation and confidence is assessed using the Patient Activation Measure (PAM) tool. The scores on the PAM help the care coordinator work with the client to create realistic and achievable goals.

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Equity, Diversity, and Inclusion

AAADSW promotes equity, diversity, and inclusion through its programs and ongoing outreach to community partners serving diverse groups of people in the community. We seek to appreciate strengths, address barriers, and advocate for equity as it fosters an environment of inclusion amongst our diverse community of clients and colleagues. AAADSW focuses outreach efforts to those with the greatest economic and social need, minorities, those who care for or who have dementia, persons at risk of institutionalization, those who have non-dominant-culture relationships or family dynamics, and those who care for or who are 60 years of age or older or living with a disability.

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C-4 Recognizing Tribal Sovereignty in Planning Services for Older Native Americans (7.01 Plan)

Washington State Department of Social & Health Services Administrative Policy 7.01 requires Area Agencies on Aging to develop a formal plan that outlines their coordination with individual tribes within their region. There are two tribes within AAADSW's region, Cowlitz Indian and Yakama Nation.

Policy 7.01 Implementation Plan for Area Agencies on Aging (AAAs) Timeframe: January 1, 2020 to December 31, 2021				
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.**
Continue working relationship with Cowlitz Indian Tribe Health & Human Services.	• Communicate with CITH&HS representatives to analyze past coordination efforts and review Policy 7.01 Implementation Plan.	• Develop a stronger relationship between Area Agency on Aging & Disabilities of SW WA (AAADSW) and Cowlitz Indian Tribe. • Ensure 7.01 Plan objectives are met.	• Lead Staff: AAADSW Community Services Supervisor, Longview Office, Kelli Sweet • Target Date: Semi Annually 2020-2021	
Increase Tribal awareness and utilization of long term services and supports (LTSS) and Community Paramedicine.	• Coordinate information exchange about available programs, services and events and how to access them. • Have a representative from the Tribe at our monthly CODES/Community	• Improve awareness of and access to LTSS and programs and services available through AAADSW.	• Lead Staff: AAADSW Community Services Supervisor, Longview Office, Kelli Sweet • Target Date: Monthly meetings beginning 2020 through 2021	

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	Paramedicine meeting.			
Improve support for Native American informal caregivers.	• Offer one Powerful Tools for Caregivers class to Cowlitz Tribal members annually. • Offer one Direct Skills class to Cowlitz Tribal members annually. • Offer Kinship services to Tribal members who qualify. • Inform CITH & HS of annual Cowlitz/Wahkiakum and Clark County Family Caregiver Conference	• Knowledge and skills of Native American informal caregivers have improved. • Services will be in place for those who qualify.	• Lead Staff: AAADSW Community Services Supervisor, Longview Office, Kelli Sweet • Target Date: 30 days prior to scheduled Direct Skills class • Target Date: 30 days prior to scheduled Cowlitz/Wahkiakum and Clark County Family Caregiver Conference	

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C-5 COVID-19 Response Services and Supports

COVID-19 Response Services and Supports
Washington State was the United States epicenter of the pandemic in January 2020 and on February 29, 2020, Governor Jay Inslee declared a state of emergency in response to the COVID-19 outbreak. As a trusted local community resource, AAADSW anticipated needs in the community and responded by pivoting crucial services to maintain compliance with the Major Disaster Declaration while engaging our local community with expanded and new services and supports to meet needs such as nutrition and information about how to access the COVID-19 vaccine.

Goal: To provide crucial services and supports to meet the needs of older adults, adults with disabilities and family caregivers during COVID-19.	
Objectives	**Date**
Provide access to COVID-19 information and resources. a) Developed a page on the agency website with COVID-19 information and resources. b) ADRC developed frequently asked question pages and translated into 11 languages. c) ADRC partnered with local health departments to support scheduling of vaccine appointments for older adults, adults with disabilities and family caregivers. d) Collaborated with community partners to reduce the digital divide and increase awareness of services. e) Increased outreach to increase awareness of services. i. Developed agency video ii. Posted video on website iii. Launched media campaign	9/30/2023
Modify program service delivery to maintain compliance with the Major Disaster Declaration orders. a) Case management, education and fitness classes transitioned from in-person to telephonic or digital formats and will resume when safe to do so. b) Congregate meals and Adult Day Care remain suspended and will resume when safe to do so. c) Senior Transportation services were modified to comply with COVID-19 safety protocols and to allow for grocery delivery.	9/30/2023
Expand critical service delivery to meet needs. a) COVID-19 relief funding augmented nutrition, transportation, family caregiver, ADRC and Senior Health and Wellness programs. b) Piloted a food box delivery or pick up option with a local foodbank.	9/30/2023

C-6 Additional Goals

During the Area Plan development process, community members, representatives from local agencies and advisory council members brought forward issues that do not fit within the required Issue Area Themes. These issues include (1) need to improve communication and outreach to client populations, especially communities with disabled adults and (2) need to strengthen relationships with and interconnections among contracted providers.

Goal: Improve communication and outreach to adults with disabilities and disability organizations.	
Objectives	**Date**
Meet with disability organizations that were interviewed for the 2020-2023 Area Plan and develop plan to improve communication and collaboration.	6/30/2020
Establish partnerships with two disability organizations not currently connected with AAADSW.	12/31/2020
Conduct outreach to a minimum of three support groups.	12/31/2020

Goal: Strengthen relationships with and interconnections among contracted providers of nutrition and transportation services.	
Objectives	**Date**
Meet with senior transportation providers. Discuss results of Area Plan Partner Agency interviews.	3/31/2020
Develop and implement plan to improve communication between AAADSW and transportation providers.	5/31/2020
Meet with senior nutrition providers. Discuss results of Area Plan Partner Agency interviews.	3/31/2020
Develop and implement plan to improve communication between AAADSW and nutrition providers.	5/31/2020

SECTION D: BUDGET SUMMARY

D-1 Area Plan Budget Summary

AREA AGENCIES ON AGING AREA PLAN BUDGET

AREA PLAN BUDGET SUMMARY

AAA: Area Agency on Aging and Disabilities of Southwest Washington

BUDGET PERIOD: January 1 - December 31, 2020

BARS CODE			Contract or Direct	Number	Unit	Persons Served	ALTSA Funding	All Other Funding	Total	Cost per Unit
AAA BUDGETED SERVICES										
555	.10	**ADMINISTRATION**					**1,105,357**	**929,263**	**2,034,620**	
	.11	Area Agency Planning/Administration	0				662,087	929,263	1,591,350	
	.12	Interfund Payments for Services	0				0	0	0	
	.13	Core Services Contract Management	0				443,270	0	443,270	
555	.21	**COORDINATION**	0				**352,091**	**0**	**352,091**	
555	.31	**LEGAL ASSISTANCE**	C	895	Hours	300	**87,500**	**22,000**	**109,500**	122.35
555	.40	**ACCESS SERVICES**					**10,684,265**	**226,200**	**10,910,465**	
	.41	Transportation	C	22,817	One-way Trips	790	247,107	190,000	437,107	19.16
	.42	Information & Assistance	C/D	13,503	Contacts	9,626	1,383,686	35,000	1,418,686	105.06
	.43.1	Case Management/Nursing Services - Core Services	D	56,750	Cases	56,750	8,985,216	0	8,985,216	158.33
	.43.2	Case Management - Aging Network	D	700	Hours	62	33,256	1,200	34,456	49.22
	.44	Nursing Services - DDA	D	625	Visits	625	35,000	0	35,000	56.00
	.45	Nursing Services - Aging Network	0	0	Sessions	0	0	0	0	#DIV/0!
	.46	Nursing Services - Contracted with HCS	0	0	Visits	0	0	0	0	#DIV/0!
	.49	Contracted Front Door Functions (King only)	0	0	Cases	0	0	0	0	#DIV/0!
555	.50	**IN-HOME SERVICES**					**99,559**	**7,000**	**106,559**	
	.51	Chore Services - Aging Network	0	0	Hours	0	0	0	0	#DIV/0!
	.52	Personal Care Services - Aging Network	C	3,817	Hours	57	99,559	7,000	106,559	27.92
	.53	Home Health	0	0	Hours	0	0	0	0	#DIV/0!
	.54	Health Maintenance	0	0	Hours	0	0	0	0	#DIV/0!
	.55	Bath Assistance	0	0	Hours	0	0	0	0	#DIV/0!
	.56	Visiting and Telephone Reassurance	0	0	Contact	0	0	0	0	#DIV/0!
	.57	Minor Home Repair and Maintenance	0	0	Contact	0	0	0	0	#DIV/0!
	.58	Adult Day Care	0	0	Hours	0	0	0	0	#DIV/0!
	.59	Volunteer Services	0	0	Hours	0	0	0	0	#DIV/0!
	.50	Other In-home Services	0	0	(Enter Unit)	0	0	0	0	#DIV/0!
	.50	Other In-home Services	0	0	(Enter Unit)	0	0	0	0	#DIV/0!
555	.60	**NUTRITION SERVICES**					**1,209,230**	**545,000**	**1,754,230**	
	.61	Congregate Meals	C	71,773	Meals	1,918	538,134	280,000	818,134	11.40
	.63	Nutrition Education & Outreach	C	1,884	Sessions	1,884	500	0	500	0.27
	.64	Home Delivered Meals	C	123,243	Meals	1,212	592,316	265,000	857,316	6.96
	.65	Shopping Assistance	0	0	Assists	0	0	0	0	#DIV/0!

	.66	Registered Dietitian	C		Hours		8,600	0	8,600	
	.67	Senior Farmer's Mrkt (SFMNP) Food/Checks	C/D	1,884	Participants	1,884				33.91
	.67.1	Food Purchased					0	0	0	
	.67.2	Checks Received					63,880	0	63,880	
	.67.3	Service Delivery					5,800	0	5,800	
555	.70- .80	**SOCIAL & HEALTH SERVICES**					**1,347,366**	**194,416**	**1,541,782**	
	.71	Adult Day Health Services	0	0	Hours	0	0	0	0	#DIV/0!
	.72	Geriatric Health Screening	0	0	Sessions	0	0	0	0	#DIV/0!
	.73	Medication Management	0	0	Sessions	0	0	0	0	#DIV/0!
	.74	Senior Drug Education	D	25	Trainings	447	12,612	0	12,612	504.48
	.75	Disease Prevention/Health Promotion	C/D	9,834	Sessions	453	42,550	28,000	70,550	7.17
	.76	Elder Abuse Prevention	0	0	Hours	0	0	0	0	#DIV/0!
	.77	Mental Health	0	0	Hours	0	0	0	0	#DIV/0!
	.78	Kinship Care								
	.78.1	Kinship Caregivers Support Program								
	.78.1a	Service Delivery					11,207	0	11,207	
	.78.1b	Goods and Services	D	215	Items/Services	139	89,660	0	89,660	417.02
	.78.2	Kinship Navigator Services	D	985	Contacts/Activities	75	79,426	0	79,426	80.64
	.79	Family Caregiver Support Program								
	.79.1	Information Services	D				15,000	0	15,000	
	.79.2a	Access Assistance	C/D				339,725	7,000	346,725	57.18
	.79.2b	Support Services	C/D				65,798	0	65,798	71.68
	.79.3	Respite Care Services	C				597,063	0	597,063	26.08
	.79.4	Supplemental Services	C				54,000	0	54,000	101.89
	.79.5	Services to Grandparents/Relatives		**See the FCSP Services Tab to Complete the Number, Units & Persons Served**						
	.79.5a	Information Services	C				5,000	0	5,000	35.97
	.79.5b	Access Assistance	C				6,000	0	6,000	10.07
	.79.5c	Support Services	C				14,302	7,000	21,302	35.74
	.79.5d	Respite Care Services	C				2,671	0	2,671	333.88
	.79.5e	Supplemental Services	0				0	0	0	0.00
	.79.6	Memory Care and Wellness Services	0				0	0	0	0.00
	.84	Health Appliance/Limited Health Care	0	0	Contacts	0	0	0	0	#DIV/0!
	.88	Long Term Care Ombudsman	D	380	Investigations	220	12,352	152,416	164,768	433.60
	.89	Newsletters	0	0	Issues	0	0	0	0	#DIV/0!
555	.90	**OTHER ACTIVITIES**					**229,555**	**6,103,620**	**6,333,175**	
		Disaster Relief					0	0	0	
		Foot care	0	0	Sessions	0	0	0	0	#DIV/0!
		Peer Counseling	0	0	Hours	0	0	0	0	#DIV/0!
		Outreach	0	0	Contacts	0	0	0	0	#DIV/0!
		Aging & Disability Resource Center (ADRC)-TCS	C/D	180	Contacts	80	45,000	47,000	92,000	511.11
		MIPPA	D	225	Applications	225	18,986	0	18,986	84.38
		Chronic Disease Self Management Program (CDSMP)	0	0	(Enter Unit)	0	0	0	0	#DIV/0!
		Home Care Referral Registry (HCRR)	0	0	(Enter Unit)	0	0	0	0	#DIV/0!
		Veterans Directed Home Services	D	150	Clients	150	46,475	0	46,475	309.83
		GWEC	D	0	NA	0	0	108,700	108,700	#DIV/0!

	Mobile Integreated Health(MIH)	C/D	0	NA	0	0	120,000	120,000	#DIV/0!
	HOME	C	50	Contacts	50	0	75,000	75,000	1,500.00
	No Wrong Door	D	NA	Contacts	NA	119,094	0	119,094	#DIV/0!
	Senior Dental Services	C	90	Clients	90	0	75,000	75,000	833.33
	Care Coordination	D	13,000	Cases	0	0	3,873,000	3,873,000	297.92
	Health Home Lead	D	0	NA	0	0	1,804,920	1,804,920	#DIV/0!
Sub-Total - AAA Budgeted						**15,114,923**	**8,027,499**	**23,142,422**	
AAA NON-BUDGETED SERVICES									
	Caregiver Training						440,000	440,000	
	Agency Workers' Health Insurance and CGT for Respite/Non-Core						90,000	90,000	
	Other Funding (Enter Description)		0		0		0	0	
Sub-Total - AAA Non-Budgeted						**0**	**530,000**	**530,000**	
Total AAA - Budgeted and Non-Budgeted						**15,114,923**	**8,557,499**	**23,672,422**	

Notes:

Non-Budgeted funds include all those reimbursed services over which the AAA has no discretion on spending.
The services are either entitlement in nature, or specific spending requirements established by the source of the funds.

Appendices:

Appendix A: Org. Chart

AAADSW Advisory Council

Council of Governments

Exec. Director 1 FTE Kelly, David

- Exec. Admin. Coordinator 1 FTE Wolfe, Karen
- H.R. Manager 1 FTE Rothengass, Tom
  - IT Specialist 1 FTE Thanasouk, Nik
  - IT Coordinator 1 FTE Phan, Julian
  - Health Home Lead Program Coordinator 1 FTE Rose, Amberly

CM Svcs. Mgr. 1 FTE Waldbauer, Samantha

- Care Coord. Spvr. (V) 1 FTE Jones, Leslie
  - Care Coordinator 1 FTE Aceves, Deanna
  - Program Aide 1 FTE Cameron, Mary
  - Care Coordinator 1 FTE Davis, Michelle
  - Care Coord. /Engage. Specialist 1 FTE
  - Care Coordinator 1 FTE Le, Kim
  - Care Coordinator 1 FTE Lule, Jennifer
  - Care Coordinator 1 FTE McQueen, Bonnie
  - Care Coordinator (WS) 1 FTE Michaels, Kim
  - Care Coordinator 1 FTE Young, Chris
  - Care Coordinator 1 FTE Vacant
  - Care Coordinator 1 FTE Vacant
- CM Spvr. 1 FTE Taylor, Ruth
  - Registered Nurse 1 FTE Figone, Lynn
  - Case Manager 1 FTE Haugen, Sophia
  - Case Manager 1 FTE Luzader, Alison
  - Case Manager 1 FTE Micheal, Janiece
  - Case Manager 1 FTE Romento, Lauren
  - Case Manager 1 FTE Scarcella, Rene
  - Case Aide 1 FTE Scudder, Joyce
  - Case Manager 1 FTE Veruca, Kristy
  - Case Manager 1 FTE Young, Erik
- CM Spvr. 1 FTE Whipple, Debbie
  - Registered Nurse 1 FTE Bollinger, Jeannine
  - Case Manager 1 FTE Grant, Margaret
  - Case Manager 1 FTE Johnson, Carrie
  - Case Manager 1 FTE Jones, Rhonda S
  - Case Manager 1 FTE Niemi, Dolcie
  - Case Manager 1 FTE Riley, Sara
  - Case Manager 1 FTE Robinson, Mona
  - Case Manager 1 FTE Scanapico,
  - Case Manager 1 FTE Weitzel, Jourdan
  - Case Manager 1 FTE Vacant
- CM Spvr. 1 FTE Noyes, Mary
  - Case Manager 1 FTE Allinger, Jennifer
  - Case Manager 1 FTE Anderson, Dan
  - Case Manager 1 FTE Cleland, Kathryn
  - Case Aide 1 FTE Eccleston, Kristen
  - Case Aide 1 FTE Krassow, Paige
  - Case Manager 1 FTE Laliberte, Nicole
  - Reg. Nurse 1 FTE Mitchell, Shelly
  - Case Manager 1 FTE Rasmussen, Carmen
  - Case Manager 1 FTE Schmidt, Shelley
  - Case Manager 1 FTE Taylor, Julia
- CM Spvr. 1 FTE Hoxeng, Larry
  - Case Manager 1 FTE Allen, Sarah
  - Case Manager 1 FTE Cruz, Lindsay
  - Case Manager 1 FTE Henson-Anguilla,
  - Case Manager 1 FTE Jones, Johnn
  - Case Manager 1 FTE Peters, Shelley
  - Case Manager 1 FTE Ratcliffe, Amanda
  - Case Manager 1 FTE Sibley, Jen
  - Case Manager 1 FTE Simchuk, Jaclyn
  - Case Manager 1 FTE Sykalo, Oksana
  - Case Manager 1 FTE Weber, Christine
- CM Spvr. 1 FTE Phillips, Sandy
  - Case Manager 1 FTE Briggs, Lori
  - Case Aide/IP 1 FTE Dobbin, Cathy
  - Case Aide/IP 1 FTE Donahue, Tanya
  - Administrative Assistant 1 FTE
  - Case Manager 1 FTE Hearron, Sammi
  - Case Aide/ IP Specialist 1 FTE
  - Case Manager 1 FTE Johnson, Jeri
  - Case Aide/IP 1 FTE King, Kim
  - Registered Nurse 1 FTE Koski, Aona
  - Case Manager 1 FTE Shaw, Mary Ann
  - Receptionist 1 FTE Soderlund, Mandy
- CM Spvr. 1 FTE Montoya-Brown, Myrsa
  - Case Manager 1 FTE Allely, Hannah
  - Case Manager 1 FTE Carson, Taylor
  - Case Manager 1 FTE Duncan, Mertie
  - Case Manager 1 FTE Karnafel, Yelena
  - Case Manager 1 FTE Mueller, Kay
  - Case Manager 1 FTE Radillo, Deborah
  - Registered Nurse 1 FTE Sadoski, Lisa
  - Case Manager 1 FTE Scott, Mark
  - Case Manager 1 FTE Vacant
  - Case Manager 1 FTE Vacant
- CM Spvr. (L) 1 FTE Hilton-Orth, Trisha
  - Case Manager 1 FTE Cramer, Chrystal
  - Case Manager 1 FTE Grasser, April
  - RN 1 FTE Horvath, MaryEllen
  - Case Manager 1 FTE Nam, Michelle
  - Case Manager 1 FTE Neuner-Fischer,
  - Case Manager 1 FTE Oomittuk, Markie
  - Case Manager 1 FTE Whitman, Desi
  - Case Manager 1 FTE Wilson, Kandace
  - Case Manager 1 FTE Vacant
- Care Coord. Spvr. (L) 1 FTE Leatherwood, Ryleigh
  - Care Coordinator 1 FTE Chilson, Kathleen
  - Care Coordinator 1 FTE Doolin, Cynthia
  - Program Aide 1 FTE Hilts, Christina
  - Care Coordinator 1 FTE Libby, Sarah
  - Care Coordinator 1 FTE Taylor, Alicia
  - Care Coordinator 1 FTE Thom, Shawna
  - Care Coordinator 1 FTE Westervelt, Margaret
  - Care Coordinator 1 FTE Vacant
  - Care Coordinator 1 FTE Vacant
  - Care Coordinator 1 FTE Vacant
- CM Spvr.(L) 1 FTE Croney, Colleen
  - Case Manager 1 FTE Bolen, Gary
  - CA/IP Spec 1 FTE Cozad, Melissa
  - Case Manager 1 FTE Eastman, Donna
  - Receptionist 1 FTE Jacobson, Mirella
  - CA/IP Spec 1 FTE Krayer, Ruth
  - Case Manager 1 FTE Pedersen, Katie
  - Case Manager 1 FTE Riley, Emily
  - Case Manager 1 FTE Robarge, Jennifer
  - Case Manager 1 FTE Wonderly, Dawn
  - Case Manager 1 FTE Vacant
- Care Coord. Spvr. (L) 1 FTE Saeger, Shannon
  - Engagement Specialist 1 FTE
  - Care Coordinator 1 FTE Kuper, Kevin
  - Care Coordinator 1 FTE Moriarty, Missy
  - Care Coordinator 1 FTE Spillers, Lavonda
  - Care Coordinator 1 FTE Vela, Teresa
  - Program Aide 1 FTE Vacant
  - Care Coordinator 1 FTE Vacant
- Care Coord. Spvr. (V) 1 FTE Guffey, Amy
  - Care Coordinator 1 FTE Black, Ashley
  - Care Coordinator 1 FTE Carson, Kathleen
  - Care Coordinator 1 FTE Ceccacci, Cait
  - Care Coordinator 1 FTE Loginova, Tatyana
  - Care Coordinator 1 FTE Parrish, Kellie
  - Care Coordinator 1 FTE Ryan, Irina
  - Care Coordinator 1 FTE Salamanca, Jessica
  - Care Coordinator 1 FTE Tomberlin, Lacey
  - Care Coordinator 1 FTE Turk, Donna
  - Care Coordinator 1 FTE Vacant
- CM Supervisor (V) 1 FTE Vacant
  - Case Aide 1 FTE Vacant
  - Case Aide 1 FTE Vacant
  - Registered Nurse 1 FTE Vacant
  - Case Manager 1 FTE Vacant
  - Case Manager 1 FTE Vacant
  - Case Manager 1 FTE Vacant
  - Case Manager 1 FTE Vacant

Community Services Mgr. 1 FTE Reardon, Mike

- MIPPA Spec. .2 FTE Humphrey, Fiona
- RLTCO 1 FTE Degerstedt, Neil
  - ARLTCO .5 FTE Fox-Kilgore, B
  - ARLTCO .5 FTE Herrmann, Deawn
- CS Prg Supervisor 1 FTE Marneris, Christina
  - Program Coord. 1 FTE Coughlin, Brittney
    - EnhanceFitness Trainer .15 FTE
    - Health Educator 1 FTE Evans, Willa
    - Fitness Trainer .45 FTE Porter, Laurie
    - Kinship Navigator 1 FTE Revord, Sarah
    - EnhanceFitness Trainer .15 FTE Vacant
  - Program Coordinator 1 FTE Davenport, Nina
  - Trainer .25 FTE Potts, Shanti
  - Program Aide 1 FTE Ridenour, Maggie
  - Program Coord. 1 FTE Swanson, Breanne
  - Trainer .2 FTE Swanson, Opal
- CS CM Supervisor Longview 1 FTE Sweet, Kelli
  - C.S. CM 1 FTE Garcia Allen, Carmen
  - Aging & Disability Resource Specialist
  - Community Services R.N. 1 FTE Lester, Julia
  - C.S. C.M. 1 FTE McGuire, Ivonne
  - C.S. CM 1 FTE Melin, Jennifer
  - Aging & Disability Resource Specialist 1 FTE Rosian, Amy
- CS CM Supervisor Vancouver 1 FTE Sugano, Katy
  - ADR Specialist 1 FTE Boheman, Lori
  - ADR Specialist 1 FTE Charette, Chasity
  - ADR Specialist 1 FTE Gabalis, Wendy
  - C.S. CM 1 FTE Girard, Jay
  - C.S. C.M. 1 FTE Inahara, Emily
  - C.S. CM 1 FTE Kowalski, Kate
  - C.S. CM 1 FTE Lattanzi, Maria
  - ADR Specialist 1 FTE Lu-Ortega, Yen
  - ADR Specialist 0.5 FTE Meland, Martine
  - C.S.C.M. 1 FTE Parisi, Kira
  - C.S.C.M. 1 FTE Schnitzer, Karen
  - C.S. RN 1.0 FTE Williams-Gibson, Judi
  - C.S. C.M. 1 FTE Vacant
  - C.S. C.M. 1 FTE Vacant

Fiscal Manager 1 FTE Hansen, Monty

- Fiscal Specialist 1 FTE Gustofson, Matt
- Fiscal Specialist 1 FTE Rice, Stephen
- Fiscal Specialist 1 FTE Worden, Shelly
- Maintenance Specialist 1 FTE Vacant

Contract Resources Manager 1 FTE Waltz, Tom

- Quality Coordinator 1 FTE Oswald, Whitney
- Quality Improvement Data Coordinator 1 FTE Qu, Jinyao
- Data/Contract Supp. 1 FTE Rivas, Raina
- Data/Contract Supp. 1 FTE Thackeray, Claire
- Data/Contract Supp. 1 FTE Zornes, Nellya

Appendix B: 2022 Staffing Plan with Names

Position Title	FTE	Position Description	# of staff
Executive Director Mike Reardon	1.0	Serves as chief administrator with the major responsibility of managing social and health services for older adults and persons with disabilities. Coordinates legislative advocacy and community networking activities. Responsible for the direct administration, organization, and coordination of the Agency.	1
Fiscal Manager Monty Hansen	1.0	Provides direction and leadership in the business planning, accounting, asset management and budgeting of the agency. Advises Director on financial policies, strategies, and procedures.	1
Fiscal Specialist-AP Matt Gustofson	1.0	Provides fiscal support to the agency such as establishing and maintaining a comprehensive system for recording AP fiscal activity, coordinating purchasing functions and expenditure control, or maintaining revenue account records.	1
Fiscal Specialist – Payroll Shelly Worden	1.0	Acts as primary payroll specialist for Agency and performs semi-monthly payroll processing and all related payroll support functions as noted below. Also provides fiscal support to the agency such as establishing and maintaining a comprehensive system for recording fiscal activity, coordinating purchasing functions and expenditure control, and/ or maintaining revenue/cash account records.	1
Fiscal Specialist – AR Stephen Rice	1.0	Provides fiscal support to the agency such as establishing and maintaining a comprehensive system for recording AR fiscal activity, coordinating purchasing functions and expenditure control, or maintaining revenue account records.	1
Facilities Maintenance (1.0 Vacant)	1.0	Provides and coordinates on-site facilities maintenance and repair activities.	
HR Manager Tom Rothengass	1.0	Provides generalist human resources support to the agency and staff. Provides advice and assistance on staff policies, regulations, recruitment, compensation, performance management, disciplinary procedures, job descriptions, labor relations, union contract negotiations and training. Administers benefits (insurance,	1

		Washington State Retirement programs) including enrollments and terminations. Responsible for site safety programs and limited facility maintenance.	
IT Specialist Nik Thanasouk	1.0	In support of the agency's information systems and users, independently performs analysis, design, acquisition, installation, configuration, maintenance, quality assurance, troubleshooting and/or technical support for applications, hardware and software products, databases, website, support products, network infrastructure equipment, or telecommunications infrastructure, software, or hardware.	1
IT Coordinator Julian Phan	1.0	In support of the agency's information systems and users, independently performs analysis, design, acquisition, installation, configuration, maintenance, quality assurance, troubleshooting and/or technical support for applications, hardware and software products, databases, website, support products, network infrastructure equipment, or telecommunications infrastructure, software or hardware.	1
Health Home Lead Program Coordinator Amberly Rose	1.0	Administers and implements AAADSW's Health Home Lead (HH) Program in support of Care Coordinating Organizations (CCO) in Area 5 covering a 5-county service area.	1
Contracts and Resources Manager Whitney Oswald	1.0	Develops, monitors, and assesses service provision by subcontractors, provides or arranges for technical assistance and training for service providers, and participates in the implementation of procurement and contracting processes. Develops and manages resource development activities.	1
Communications Manager (1.0 Vacant)	1.0	Supports and manages the agency's External and Internal Marketing/Branding and Communications Activities.	
Contracts & Data Support Specialist Nellya Zornes Raina Andaya Kathy Lagerquist	3.0	Supports program coordinator in administration of programs and services by maintaining all data collection records and producing reports.	3
Community Services Manager Christina Marneris	1.0	Responsible for development, oversight, and management of Title III, SCSA, and Elder Abuse programs and services including Long-Term Care	1

		Ombudsman, Senior Transportation, Senior Nutrition, Minor Home Repair, Adult Day Care, Adult Day Health, Aging Network Case Management, Senior Personal Care, Disease Prevention /Health Promotion, Senior Farmers' Market, Registered Dietician, Medication Management, and Senior Drug Education. Oversees Family Caregiver Support, Kinship Caregiver Support, Kinship Navigator and Information & Assistance programs.	
Community Services Program Supervisor Mikayla Springob	1.0	Responsible for development, oversight, and management of Older American Act Title III, Senior Citizens Services Act, Elder Abuse and Grant funded programs and services including but not limited to Aging & Disability Resource Center (ADRC), Family Caregiver Support, Senior Transportation, Senior Nutrition, Senior Health & Wellness, Kinship caregiver Support and Kinship Navigator programs across agency's five-county planning and service area.	1
Community Services Supervisor Katy Sugano Kelli Sweet Breanne Swanson (.8)	2.8	Supervise and manage Case Managers and part-time staff/trainers and related programs/services. Accountable for supervising the effective coordination and application of specific applicable components of standardized assessment tools in collaboration with individual caregiver/client input to develop customized plans of care which will enable caregiver/client to maintain the highest level of independent living possible. Responsible for initiation, identification, referral and coordination efforts with public community service resources, and promotes and performs outreach and marketing activities by developing and delivering presentations/educational trainings/information on a variety of Agency related programs and services to the general public, providers, professionals and other diverse populations.	3
Community Services Program Coordinator Brittney Coughlin Clair Thackeray Willa Morse (.24)	2.24	Responsible for coordination and oversight of Federal, State, and private grant funded programs including but not limited to Family Caregiver Support, Senior Health & Wellness, Senior Nutrition, Senior Transportation, Kinship Caregiver and Navigator, and Legal Services.	3
SHIBA/MIPPA Program Coordinator (Vacant)	1.0	Responsible for program development, coordination, management and oversight of AAADSW's Medicare Patient and Provider Act (MIPPA) and Statewide Health	

		Insurance Benefit Advisors (SHIBA) programs in Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum counties.	
Health Educator Vacant	1.0	Provide evidenced-based wellness and disease prevention educational services to older adults, adults with disabilities and family caregivers through 1:1 consultation with clients, community presentations and classroom settings.	
Community Services Case Manager Jamie Gerard Jennifer Melin Emily Inahara Max Bartholomew Maria Lattanzi Karen Schnitzer Carmen Garcia-Allen Ivonne McGuire Taylor Carson Paige Krassow Margaret Westervelt Nicole Laliberte Catherine Pedersen (2 Vacant)	14.0	Assess needs of clients utilizing standardized assessment tools. Clients include family caregivers, older persons and adults with disabilities. Develop and administer client centered service plans which will result in maintaining the client (or client's care receiver) at the highest level of independent living possible. Authorize and obtain in-home and community-based services in accordance with the client's service plan. Support unpaid caregivers who have primary responsibility for the care or supervision of an adult (age 18 or older) with one or more functional disabilities. Provide outreach and promotion of the Family Caregiver and Community Services programs.	13
Regional Long-Term Care Ombudsman Neil Degerstedt	1.0	Serves as an effective and visible advocate for the wellbeing of long-term care residents, promotes both individual and systematic complaint resolution activities including community involvement, administrative and legislative monitoring and reporting.	1
Asst. Regional Long Term Care Ombudsman Elda Ramirez Deawn Herrmann	1.1	Assists Regional Long Term Care Ombudsman as an effective and visible advocate for the wellbeing of long-term care residents, promotes both individual and systematic complaint resolution activities including community involvement, administrative and legislative monitoring and reporting.	2
Aging & Disability Resource Specialist Lori Boheman Terry Kinsey Chasity Charette Amy Rosian Wendy Gabalis	8.0	Provides information and assistance/referral to the senior population and individuals with disabilities and their caregivers. Screens and authorizes services for seniors and assists people to access and arrange needed in-home and community services.	8

Yen Lu-Ortega Mertie Duncan Elizabeth Grant (.5) (.5 Vacant)			
Kinship Navigator Sarah Revord	1.0	Assists kinship caregivers of any age with understanding and navigating the system of services for children in out-of-home care while reducing the barriers faced by kinship caregivers when accessing services.	1
Admin. Exec. Coordinator Karen Wolfe	1.0	Provides Admin Support to Executive Director and Mgt. Team	1
Quality Assurance Coordinator Alison Luzader	1.0	Coordinates and assures compliance and quality of ADSA contracted and SWAAD sub-contracted TXIX case management services and core service contracted client and provider records.	1
Receptionist Danae Hoffman Heidi Bunn	2.0	Acts as receptionist and provides administrative support to agency staff.	2
TXIX Case Management Services Manager Samantha Waldbauer	1.0	Program Management and policy development for the Case Management Program. Responsibilities include the identification and implementation of new program standards and corrective actions required, ongoing program and policy development, and oversight, development and monitoring of contracts assigned to this program.	1
TXIX Case Management Supervisors Larry Hoxeng Myrsa Montoya-Brown Ruth Taylor Sandy Phillips Colleen Croney Mary Noyes Trisha Hilton-Orth Debbie Whipple	10.0	Supervises and manages primarily Medicaid funded case management services. Develops and coordinates service delivery, promotes public access to services, including seniors and adults with disabilities receiving in-home and community-based long-term care (LTC) services.	9

Markie Oomitukk (1 Vacant)			
TXIX Registered Nurses Lisa Sadoski Jeannine Bollinger Shelly Mitchell Mary Ellen Horvath Lynn Figone Aona Koski	6.0	Receives client referrals based on assessment of Medicaid Personal Care (MPC), Community Options Entry System (COPES), and/or Senior Personal Care (SPC). Reviews and assesses client's health status, personal care needs and current service plans, identifies and coordinates medically related referrals and follow-up visits/reviews as needed in client's home, adult family home or adult residential facility, reviews performance of client's care provider, implements training or makes training referrals, coordinates with medical professionals, and provides information related to the health/medical condition of at-risk clients as necessary.	6
Community Svcs. RN Julia Lester (Vacant)	2.0	Work with Community Services Team to support clients transitioning from one care setting to another (i.e. hospital to home).	1
Care Coordination Supervisor Amy Guffey Leslie Jones Kathleen Haglund Shannon Saeger	4.0	Responsible for development and supervision of the Care Coordination Organization across the agency's five-county planning and service area to meet the requirements of the Health Home lead contracts for service provision in the six functions of Health Homes; care management, care coordination, health promotion, individual and family/caregiver support, transitional care and referral management.	4
Care Coordinator Alicia Taylor, Deanna Aceves,	30	Provides support for designated clients which includes coordinating an array of services designed to improve	25

Cynthia Doolin, Jennifer Lule, Hong Le, Bonnie McQueen, Shawna Thom, Kimberly Michaels, Ashley Black, Michelle Beaudine-Kier Elizabeth Harper, Jennifer Stanton Donna Ganly, Kathleen Carson, Caitlin Ceccacci, Tatyana Loginova, Kellie Parrish, Irina Ryan, Kathleen Chilson, Kevin Kuper, Missy Moriarty, Lavonda Spillers, Keilah Thostenson, Teresa Vela, Chris Young (5 Vacant)		the health of high needs, high risk clients. Care coordination responsibilities will include assessment, care planning and monitoring of client status, implementation and coordination of services.	
Care Coordination Engagement Specialists Suzette Lanniee Cynthia Burnett (1 Vacant)	3.0	Provides support for designated clients which includes coordinating an array of services designed to improve the health of high needs, high risk clients. Care coordination responsibilities will include assessment, care planning and monitoring of client status, implementation, and coordination of services.	2
Care Coordination Program Aide Mary Cameron Christina Olsen	2.0	Assists RN & CA Care Coordinators with referral and assistance in delivering effective care coordination services.	2
TXIX Case Manager Shelley Peters, Jennifer Robarge, Jennifer Sibley, Jaclyn Simchuk, Dan Anderson, Yelena Karnafel Kay Muller, Oksana Sykalo, Mark Scott, Sara Riley, Gideon Faulconer, Rene Scarcella, Shelley Schmidt, Jeri Kelly, Julia Taylor, Suzana Dzyuba, Mary Ann Shaw, Jennifer Allinger, Rhonda Jones, Hannah Allely, Elizabeth Rodgers, Julie LaRoco	76.0	Assist adults with disabilities and older persons to assess their needs, authorize and obtain in-home and community-based services to: (1) maintain their independence in the community; (2) be diverted from nursing home or other institutional settings (3) make a timely return home following a short hospital or residential stay; and (4) remain at home with support despite functional impairments. Develops and administers a service plan which will result in maintaining the client at the highest level of independent living possible while still addressing the issues which arise in acute situations.	62

Harms Gary Bolen, Dolcie Niemi, Amy Baldwin, Lorraine Kincek, Yvette Silva Laura Neuner-Fischer, Cynthia Chow Erik Young, Deborah Radillo, Stephanie Scanapico, Jennifer Smith, Emily Maciel, Kristy Veruca, Kathryn Cleland, Donna Eastman, Sarah Libby, Carrie Johnson, Sarah Allen, Lindsay Cruz, Samantha Hearron, Jourdan Weitzel, Janiece Michael, Emily Riley, Dawn Wonderly, April Grasser, Desiree Whitman, Rosie Carey, Nicola Cook, Krista Thompson, Katherene McCallister Madison Rathsman, Elyse Benson, Tim Wilson, Erica Hoapili, Annie Agriesti, Heather Smith, Melissa Castonguay, Karen Meacham, Kristina Smoak, Rebecca Traub (14 Vacant)			
TXIX Case Aide Cathy Dobbin, Yuleny Flores, Kimberly King, Marcela Ramos Joyce Scudder, Melissa Cozadd, Mandy Soderlund, Janelle Harvester (3 Vacant)	11	Provides information, referral, and assistance to older persons with disabilities and their caregivers.	8
Admin. Assistant Andrea Zamilpa	1.0	Provides administrative and technical support for case management unit.	1
Community Services Program Aide Maggie Ridenour	1.0	Provides program and administrative support to Community Services Program staff and Supervisors to include program implementation, program/contract monitoring, contract Statement of Work and Special Terms and Conditions, program report writing, data collection, and website updates.	1

Trainer/Researcher Laurie Porter (.45) Barbara Dunlop (.15) Julie Donovan (.25) (.15 Vacant)	1.0	Trainers teach classes to members of the public in Enhance Fitness and Powerful Tools for Caregivers.	3
MIPPA Specialist Fiona Humphrey	.2	Outreach, Medicare LIS and MSP enrollments, coordination with other agencies, data gathering, data sharing & preventative services education.	1

Medicaid Transformation Demonstration Staffing Plan

Position Title	**Staff Name**	**FTE**
Aging & Disability Resource Specialist	Lori Sinclair Terry Kinsey Chasity Charette Amy Rosian Wendy Gabalis Yen Lu-Ortega Mertie Duncan Elizabeth Grant	1.9
Community Services Program Manager	Christina Marneris	.10
Community Services Supervisor	Katy Sugano Kelli Sweet	1.22
Community Services Program Coordinator	Willa Evans	.51
Community Services Case Manager	J. Gerard Emily Inahara Max Bartholomew Maria Lattanzi Karen Schnitzer Carmen Garcia-Allen Ivonne McGuire Taylor Carson Paige Krassow Margaret Westervelt Nicole Laliberte Catherine Pedersen	10

Medicaid Transformation Demonstration position titles, staff names and FTE are included in the 2020 Staffing Plan with Names document.

1 FTE is 40 hours/week

Total number of full-time equivalents is 187.9
Total number of staff is 170
Total number of Asian is 13
Total number of Black/African American is 4
Total number of Hispanic is 11
Total number of Native American is 1
Total number of staff over 60 is 27
Total number of staff indicating a disability is 22

Appendix C: Emergency Response Plan

Emergencies or disasters may occur at any time causing human suffering, injury, disease, emotional crisis, death, public and private property damage, environmental damage, loss of essential services, economic impacts to businesses, families and individuals, and disruption to local and state governments and other governmental entities. Some emergencies or disasters will occur with enough warning that notification is issued to ensure some level of preparation. Other situations will occur with no advanced warning allowing no time for preparation.

The Community Services Manager (CSM) is designated to oversee planning and operation of AAADSW emergency management.

Current Preparedness Activities

Each month, Title XIX case managers receive a list of high-risk clients (name, address, phone numbers, plan period end date and high-risk information) from their respective supervisor. These clients are identified as “High Risk” in CARE and receive disease/disability specific education on how to shelter-in-place from an AAADSW nurse.

Client high-risk criteria:

1. Live in remote area with NO SUPPORT from others AND unprepared to shelter-in-place.
2. Supplemental oxygen dependent requiring oxygen 24hrs/day, not just at night.
3. Requires weekly visits to a hospital/clinic for survival, e.g. attending dialysis or transfusions.
4. Requires power equipment dependent for survival, e.g. clients who cannot evacuate the home without power lifts such as Hoyer, EWC and anyone who is technology dependent, e.g. using a ventilator for survival.

AAADSW has two committees that help with emergency preparedness. The Safety Committee focuses on staff safety in the office and in the field. The Emergency Preparedness Committee focuses on AAADSW clients.

Annually, AAADSW conducts a mock fire drill.

AAADSW staff participate in Clark Regional Emergency Services Area (CRESA) meetings. Here, unmet needs of AAADSW Title XIX clients residing in Clark County are shared and solutions discussed.

ADRC staff distribute warming and cooling center information (location, hours of operation, requirements, etc.) to all AAADSW staff and partner agencies.

Members of the Executive Management team have a current list of their respective team members contact number for emergencies.

During inclement weather, a decision to declare the office closed for a full or partial day is made by 6 a.m. by the Executive Director. The Executive Director will send a message to staff voice mailboxes containing relevant closure information. Employees are responsible for checking their voice mail for an inclement weather message and following the message instructions.

Lastly, AAADSW has a system for tracking unanticipated emergency response expenditures for possible reimbursement.

Goal: Develop Emergency Response Plan.	
Objectives	**Date**
Letter of Agreement with the Emergency Management Departments in Clark, Cowlitz, Wahkiakum and Skamania counties is fully executed.	12/31/2020
Plan for contacting high-risk clients and referring them to first responders is implemented.	12/31/2020 and ongoing
Establish partnerships with appropriate community preparedness agencies to address identified unmet needs.	12/31/2020 and ongoing
Provide shelter-in-place education to high-risk clients.	12/31/2020 and ongoing
Develop internal business continuity plan.	12/31/2020

Appendix D: Advisory Council

2021 ADVISORY COUNCIL ROSTER

Clark County	Cowlitz County	Klickitat County	Skamania County	Wahkiakum County
Anderson, Beth	Bennett, Colleen	DeMent, Sandy	Bacus, Sandy (Secretary)	Blackburn, Pearl (Chair)
Bayautet, Lisa	Kyllonen, Kathy	Miller, John	Vacant	Cole, Carol
Cano, Pat	*Craft, Diane*	*Vacant*	*Vacant*	*Vacant*
Dyer, Arnie (Vice Chair)				
Oliver, Jodi				
Hines, Matthew				

Category	Number of AC Members
# age 60 and over	12
# age 59 and under	2
# of males	3
# of females	11
# with self-identified disability	1
Minority	1

Membership Profile	Number of AC Members
Older persons in greatest economic or social need	1
At least one member with a disability who is a participant or is eligible to participate in an AAADSW service program	2
At least one member of a primary racial minority who is a participant or is eligible to participate in an AAADSW service program	1
Representative from key “senior advocate” groups	2
At least one elected official	0
At least one member with leadership experience in the private and voluntary sectors	6
At least one member of a supportive services provider organization	0
At least one member of a health care provider organization	1

Appendix E: Public Process

Activities	Date
Area Plan Update sent to Advisory Council members.	November 10, 2021
Advisory Council Review and Approval	November 17, 2021
Public Hearing	November 18, 2021
AAADSW Council of Governments Board of Directors meeting	December 10, 2021

Appendix F: Mid-Cycle report on Accomplishments for the 2022-2023 Area Plan Update (Please see attached document)

Appendix G: Statement of Assurances and Verification of Intent

For the period of January 1, 2020 through December 31, 2023, the Agency on Aging & Disabilities of SW Washington (AAADSW) accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (P.L. 106-510) and related state law and policy. Through the Area Plan, AAADSW shall promote the development of a comprehensive and coordinated system of services to meet the needs of older individuals and individuals with disabilities and serve as the advocacy and focal point for these groups in the Planning and Service Area. AAADSW assures that it will:

- Comply with all applicable state and federal laws, regulations, policies and contract requirements relating to activities carried out under the Area Plan.

- Conduct outreach, provide services in a comprehensive and coordinated system, and establish goals objectives with emphasis on:

  a) older individuals who have the greatest social and economic need, with particular attention to low-income minority individuals and older individuals residing in rural areas;
  b) older individuals with significant disabilities;
  c) older Native Americans Indians; and
  d) older individuals with limited English-speaking ability.

All agreements with providers of OAA services shall require the provider to specify how it intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas and meet specific objectives established by AAADSW for providing services to low-income minority individuals and older individuals residing in rural areas within the Planning and Service Area.

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

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

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

B. An assurance that the Area Agency on Aging will, to the maximum extent practicable, coordinate the services the agency provides with services provided under title VI of the Older Americans Act; and
C. An assurance that the Area Agency on Aging will make services under the Area Plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

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

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

____________________ Date	____________________ Mike Reardon, Executive Director Area Agency on Aging & Disabilities of SW Washington
____________________ Date	____________________ Pearl Blackburn, Advisory Council Chair Area Agency on Aging & Disabilities of SW Washington
____________________ Date	____________________ Richard Mahar, Skamania County Commissioner Chair of Southwest Washington Council

Appendix H: Area Plan Public Hearing Legal Notice

November 3, 2021

This is a legal notice.
Required to be published

FOR IMMEDIATE RELEASE – Meeting is open to the public

*** ATTENTION*** Washington State's Governor issued Proclamation 20-28 which among other things, temporarily prohibits in-person public attendance at meetings subject to the Open Public Meetings Act (OPMA).

The Area Agency on Aging & Disabilities of Southwest Washington (AAADSW) and its Advisory Council are holding a Public Hearing to present its 2020-2023 Area Plan Update, on November 18, 2021, from 3:00 P.M. to 4:30 P.M. The meeting will be held via Zoom. AAADSW invites all interested parties to attend.

Registration is required. To register, contact Karen Wolfe (360) 735-5721, Karen.Wolfe@dshs.wa.gov.

The 2020-2023 Area Plan Update provides an overview of issues facing older adults, adults with disabilities and their family caregivers, as well as goals to address identified issues. Additionally, it provides information on AAADSW's current and future program offerings and 2022 budget.

AAADSW will take public comment on the 2020-2023 Area Plan Update goals and objectives at this Public Hearing. Written comments will be accepted until 5:00 P.M. on November 22, 2021. Please send comments to:

Area Agency on Aging & Disabilities of Southwest Washington

201 NE 73rd Street

Vancouver, WA 98665

Attn: Christina Marneris

Effective November 15, 2021, the 2020-2023 Area Plan Update will be available online at www.HelpingElders.org, and in hard copy.

Contact Karen Wolfe, (360) 735-5721, Karen.Wolfe@dshs.wa.gov to:

- **Register for the Public Hearing**
- **Request special accommodations to participate in the Public Hearing**
- **Request a hard copy of the 2020-2023 Area Plan Update**

AAADSW is a regional government agency that receives federal, state and grant funding to help older adults and adults with disabilities remain in their homes as well as to support family caregivers. AAADSW's region, also known as its Planning and Service Area, includes Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum counties.

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Appendix I: Population Forecast 2023

	Population and Aging Services Utilization Forecast for 2023					
	PSA	Clark	Cowlitz	Klickitat	Skamania	Wahk.
Number of persons aged 60 or above	170,715	123,228	32,857	8,363	4,310	1,957
Number of persons aged 60 or above and at or below 100% FPL	10,547	6,146	3,276	652	320	153
Number of persons aged 60 or above and minority	16,032	12,761	2,192	652	331	96
Number of persons aged 60 or above and American Indian/Alaska Native	1,498	689	633	106	30	40
Number of persons aged 60 or above and at or below 100% Federal Poverty Level and minority	985	617	315	26	12	15
Number of persons aged 60 or above with limited English proficiency	6,494	4,697	1,243	331	159	64
Number of persons aged 60 or above and Disabled (American Community Survey 18b or 18c)	35,297	25,078	7,067	1,832	875	445
Number of persons aged 18 or above and Disabled (American Community Survey 18b or 18c)	50,821	36,872	9,778	2,425	1,227	519
Number of persons aged 60 or above with cognitive impairment (American Community Survey 18a)	15,497	10,863	3,215	827	394	198
Number of persons aged 18 or above with cognitive impairment (American Community Survey 18a)	30,859	22,488	5,969	1,400	734	268
Number of persons aged 65 or above with dementia	12,611	9,046	2,471	641	282	171
Number of persons using in-home services, based on June 2018 Community First Choice utilization calibration	5,309	4,047	1,024	122	93	23

Source: Selected Population and Aging Service Utilization Forecast, Southwest Washington AAA, DSHS Research and Data Analysis Division, July 16, 2019

Appendix J: AAADSW Services

The following programs are provided by AAADSW via Older American Act, Washington State Senior Citizens Services Act, Medicaid Transformation Demonstration and grant funding:

Case Management (CM) – Aging Network provides assistance in the form of access, advocacy and/or care coordination in circumstances where older persons and/or their caregivers are experiencing a decline in their ability manage their daily lives. Case Management activities include comprehensive assessment of an individual's needs, developing a detailed service plan, authorizing services, coordinating and monitoring service delivery and follow-up.

Congregate Nutrition Services help meet the social and the nutritional needs of older adults. Other services include nutritional outreach, education and social activities.

Disease Prevention and Health Promotion services help older persons prevent the onset of serious diseases by providing evidence-based health and wellness programs. These include the following:

- EnhanceFitness is an evidence-based group exercise class for seniors age 60 and over that improves your balance, flexibility, bone density, endurance, coordination, mental sharpness and decreases your risk of falling.
- Chronic Disease Self - Management (aka Living Well with Chronic Conditions) are classes offered once a week for six weeks for people with different chronic health problems.
- Oral Health Services provides oral health and dental services to people age 60 and older without dental insurance
- Stay Active and Independent for Life (SAIL) is a strength, balance and fitness program for adults 65 and older
- StrongWomen is a community exercise and nutrition program targeted to midlife and older women
- Walk with Ease – A workshop developed by the Arthritis Foundation that strives to teach participants how to safely make physical activity part of their everyday life.
- PEARLS Program is a highly effective method designed to reduce depressive symptoms and improve quality of life in older adults.

Family Caregiver Support Program (FCSP) provides information, resources, education and support services to unpaid family caregivers who provide continuous care for adults with function disability. These services enable caregivers to continue at-home care and allow the care recipients to remain in their familiar environments. Activities under this program are performed and authorized by case management staff and subcontractors.

FCSP Support Services

- Counseling Services support caregivers by providing up to six sessions per 12-month cycle, of individual, family, short term, solution-focused counseling so the caregiver may continue his/her role as primary caregiver.
- Powerful Tools for Caregivers (PTC) is a six-week educational program providing family caregivers with tools to increase their self-care and confidence.
- Caregiver Education is provided through workshops, books, DVDs, pamphlets and websites. Educational opportunities help the caregiver obtain information about services and resources, develop coping skills and build caregiving skills.
- Star-C is a program designed to help family caregivers who are caring for someone with Alzheimer's disease or a related dementia. This is a clinically tested program proven to lower depression in caregivers and decrease problem behaviors in the person with dementia.

FCSP Access

- TCARE is an award-winning evidence-based caregiver assessment tool.
- Consultation/Coordination assists caregivers with coordinating services. Caregivers may also consult with CM as needed or when there are any significant changes in the health or well-being of the caregiver or care receiver.

FCSP Supplemental Services

- Assistive Devices include items such as grab bars, raised toilet seats, etc. Devices typically help reduce a caregiver's work burden and help maintain safety for the caregiver and/or care receiver.
- Assistive Supplies include items such as incontinent supplies and typically aid the caregiver in attending to the activities of daily living needs of the care receiver.
- Assistive Equipment includes items such as ramps and typically reduces a caregiver's work burden. They may also help to maintain a safe environment for the caregiver and care receiver.

FCSP Respite Services

- In-Home Care is available and provided on an hourly basis. Licensed and trained care workers provide supervision, companionship and personal care services in place of the primary caregiver. Services appropriate to the needs of individuals with dementia and related illnesses are also provided.
- Adult Day Care offers primary caregivers relief from care giving and provides the care recipient with opportunities for socialization. Services are available on a regular or irregular basis and designed to address the social needs of participants as well as

the needs of families for a safe, comfortable place for adults eighteen years or over with functional disabilities. ADC service delivery remains suspended due to COVID.

Family Caregiver Support Program - Services to Grandparents/Relatives

- Grandparents or other relatives aged 55 and over who are raising a child are able to receive the same FCSP services contained in the aforementioned FCSP section. This program is available only in Clark County.

Home-Delivered Meals provide meals and other nutrition services to older adults, and those eligible under Title XIX. Services are intended to maintain and 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.

Aging & Disability Resource Center (No Wrong Door) provides people from all backgrounds, with information about a broad range of community, social, health and government services. It opens doors into the human service delivery system and helps people obtain access to the services they need. To support local access to services in large rural areas, Information & Assistance services are subcontracted to Klickitat and Skamania County government. As part of ADRC, we also provide the following:

- Information and Assistance provides people from all backgrounds, with information about a broad range of community, social, health and government services. It opens doors into the human service delivery system and helps people obtain access to the services they need. To support local access to services in large rural areas, I&A services are subcontracted to Klickitat and Skamania County government.

- Options Counseling provides a person-centered approach to explore resources and options for care. It facilitates informed decision-making provides a clear pathway for individuals to access LTSS.

- Transitional Care Services empowers individuals to successfully transition back to the community following a hospital or nursing home stay. Transitional Care Coordinators partner with individuals to provide tools, information and guidance to help manage health conditions and avoid readmission into more costly settings.

Kinship Caregivers Support Program provides financial support to grandparents and relatives who are the primary caregivers to children under the age of 19. One time per year per recipient funding is provided for basic needs, such as legal services, transportation, school and youth activities, interpreter services, counseling services, etc.

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

Long-Term Care Ombudsman services include investigating and resolving complaints, identifying problems that 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 and citizen organizations concerned about the quality of life in long-term care facilities.

Medicare Improvement for Patients & Providers Act (MIPPA) includes outreach, enrollment assistance, and education about disease prevention and wellness activities to Medicare beneficiaries likely to be eligible for the Low-Income Subsidy program (LIS) or Medicare Savings Program (MSP).

Mobile Integrated Health is a pilot program that aims to decrease the percentage of high utilizers of Emergency Medical Services by providing wrap around services that promote chronic disease self-management and address social determinants of health.

Newsletters are regularly printed publications distributed primarily to persons aged 60 and over for the primary purpose of informing older adults of programs and/or public benefits which will enhance their ability to remain independent.

Personal Care Services - Aging Network program provides personal services to include physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to a care receiver's functional limitations. These services are subcontracted to the local home care agency provider. These services are subcontracted to the local home care agency provider.

Registered Dietician conducts visits to congregate meal sites to ensure compliance with program standards. Annual training and technical assistance to nutrition staff, and review and approval of menus, is also provided.

Senior Drug Education provides information and training to persons 65 years of age and older regarding the safe and appropriate use of prescription and non-prescription medications.

Senior Farmers Market Nutrition Program provided vouchers to eligible seniors are redeemed for fresh fruits, vegetables, edible herbs, and honey at participating farmer's markets and farm stores throughout the service area. Nutrition education is also provided.

Senior Legal Assistance assists older persons in advocating for their rights, benefits and entitlements. Services in non-criminal matters are provided by attorneys and paralegals and range from advice and drafting of simple legal documents to representation in complex litigation. Services include disseminating information about legal issues to: older adults, service groups and bar associations through lectures, group discussions and the media.

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

SHIBA Program, utilizing volunteer advisors, provides free, unbiased and confidential help with Medicare to people of all ages and backgrounds.

Veterans Directed Home Care program assists Veterans, determined by the Veterans Administration, to be at risk of institutional placement. Veterans receive financial assistance and use this funding to purchase, at their discretion, a mix of goods and services that help them live more independently.

Medicaid Alternative Care (MAC) supports older adults age 55+ that need help to live at home. It supports the care receiver's unpaid family caregiver continue to provide care and focus on their own health and well-being. There is no estate recovery or client participation for this program.

Tailored Supports of Older Adults (TSOA) helps older adults age 55+ who need help to remain at home. The benefit is for individuals who currently do not meet Medicaid financial eligibility criteria but do meet functional criteria for care. They may or may not have a family caregiver. There is no estate recovery or client participation for this program.

The following programs are provided by/through AAADSW by Medicaid funding:

Title XIX (Medicaid) Case Management & Nursing Services provides case management services to functionally limited seniors and disabled adults 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 homes. In order to be eligible for this service a comprehensive assessment of an individual's needs is performed, and a detailed service plan is developed to authorize, coordinate and monitor the delivery of services. Case Managers from many programs refer clients to Nursing services, including TXIX, Developmental Disabilities Administration and Family Caregiver Programs to provide health related consultation and education to clients and caregivers involved in community-based care services.

Personal Care Services (In-Home), provide caregiving assistance for personal care tasks. Tasks include assistance with activities of daily living, transportation and household chores to eligible adults who have met income and resource guidelines and are at risk of institutionalization. Services are provided by a licensed home care agency or Individual Provider.

Community First Choice (CFC) and Community Options Program Entry System (COPES) is the statewide Medicaid waiver program that funds in-home and related services for eligible adults who would otherwise receive like services in a nursing home. Types of services included, but are not limited to, personal care, transportation, housework (as it relates to personal care), adult day care, environmental modifications, specialized medical equipment

and supplies, skilled nursing, client training, and Personal Emergency Response Systems (PERS).

Health Home Care Coordination is a program that includes six core services provided to high-risk, high-cost clients with chronic health conditions to improve their health outcomes and reduce unnecessary medical costs by creating client-centered goals in a Health Action Plan (HAP). Care coordination services are voluntary and provided by Care Coordination Organizations (CCOs) to Medicaid only and dually eligible clients. The six core services provided are:

4) Comprehensive care management
5) Care coordination and health promotion
6) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
7) Individual and family support, which includes authorized representatives
8) Referral to community and social support services
9) Use of Health Information Technology (HIT) to link services as feasible and appropriate.

Health Home Lead Entity is an administrative function supporting the work of the Health Home program. Health Home lead entities hold contracts with the Health Care Authority and CCOs to manage the payment of services from HCA to the CCOs and monitor the quality of work performed by CCOs when carrying out the six core services of the Health Home program.

Interpreter Services are available by phone, in person and in writing, by certified interpreters, to non-English and LEP clients.

The table below shows programs and services provided by AAADSW or an AAADSW contracted provider, by county.

Key
- Number (1-8) represents total number of contracted providers in corresponding county
- N/A is Not Available
- Asterisk (*) means program/service is available to eligible persons. No local provider

SERVICE or PROGRAM	CLARK	COWLITZ	KLICKITAT	SKAMANIA	WAHKIAKUM
Legal Assistance	1	1	1	1	1
Medicare Improvement for Patients & Providers Act (MIPPA)	1	*	1	1	*
Statewide Health Insurance Benefits Advisors (SHIBA)	1	1	1	1	1
Access Services					
Transportation	2	1	1	1	1
Information & Assistance	1	1	1	1	1
Transitional Care	1	1	N/A	N/A	1
Case Management – Aging Network	1	1	N/A	1	1
In-home Services					
Personal Care - Aging Network	7	6	3	3	6
Nutrition Services					
Congregate Meal Sites (Temporarily suspended due to COVID)	7	5	6	1	2
Home Delivered Meals	1	1	1	1	1
State Home Delivered Meals Expansion	1	1	1	1	1
Registered Dietitian	1	1	1	1	1
Senior Farmers Market Vouchers	1	1	1	1	1
Social & Health Services					
Senior Drug Education	1	1	1	1	1
Fitness/Exercise	5	N/A	1	2	N/A
Oral Health Care	1	1	*	*	*
Kinship Care Support	1	1	1	1	1
Kinship Navigator	1	1	1	1	1
PEARLS	1	1	N/A	N/A	N/A

HOME	3	2	N/A	1	N/A
Family Caregiver Support - Assessment & Coordination					
TCARE	1	1	1	1	1
Consultation & Coordination	1	1	1	1	1
Family Caregiver Support -Access & Support Services					
Powerful Tools for Caregivers	1	1	N/A	*	1
Counseling	1	1	N/A	*	1
Family Caregiver Support - Supplemental Services					
Assistive Devices	Multiple providers available in all counties				
Assistive Supplies					
Assistive Equipment					
Family Caregiver Support - Respite Services					
Respite (in-home)	8	6	3	3	6
Respite (adult day care)	1	N/A	N/A	N/A	N/A
Family Caregiver Support - Grandparents/Relatives					
	1	N/A	N/A	N/A	N/A
Long Term Care Ombudsman					
	1	1	1	1	*
Newsletters					
	N/A	N/A	1	1	1
Medicaid					
Case Management	1	1	1	1	1
Nurse Consultation	1	1	*	*	1
Personal Care (In Home)	7	6	3	3	6
Community First Choice	6	5	3	2	5
Community Options Program Entry System	6	5	3	2	5
Health Home Lead/Care Coordination	1	1	1	1	1
Interpreter Services	5	5	5	5	5
Medicaid Demonstration					
Medicaid Alternative Care	1	1	1	1	1
Tailored Supports for Older Adults	1	1	*	*	1
Mobile Integrated Health/Community Paramedicine (via Cascade Pacific Action	N/A	1	N/A	N/A	1

Alliance)					

Appendix K: Community Partnerships

211
AMR
Adult Protective Services
Battle Ground Health Clinic
Beacon Health Options
Cascade Pacific Action Alliance
Catholic Community Services
CDM
Children's Home Society
Community Health Plans of Washington
City of Vancouver Parks and Recreation
Clark & Cowlitz Counties Cross Continuum Care Transitions Collaborative
Clark County Commission on Aging
Clark County Community Health Access Resource Group
Clark County Community Services
Clark County Crisis
Clark County Fire & Rescue
Clark County Public Health
Columbia River Mental Health
Community Health Partners
Community Home Health & Hospice
Community Housing Resource Center
Community Services NW
Council for the Homeless
Cowlitz 2 Fire and Rescue
C-Tran
Discovery Nursing & Rehab
Elder Justice Center
Faith Community Nursing Health Ministries Northwest
Fort Vancouver Kidney Center
Fort Vancouver Regional Library
Home & Community Services
HOPE Dementia Support Groups
Human Services Council
Kaiser Permanente
Klickitat County Senior Services
Koelsch Communities
Life Transitions: End of Life Southwest Washington
Lifeline Connections
Longview Fire Department
Lower Columbia Community Action
Lutheran Community Services
Meals on Wheels People
Molina Healthcare
NAMI SWWA
North Country Emergency Medical Services
Northwest Justice Project
Oregon State Unit on Aging
PeaceHealth
REACH CDC
Rose Urgent Care & Family Practice
Safety One Specialty Transport
SeaMar
Skamania County Senior Services
Skamania Klickitat Community Network
University of Washington
Vancouver Clinic
Veterans Administration
Vancouver Housing Authority
Wahkiakum Public Health and Human Services
Washington Aging and Longterm Services Administration
Washington Dementia Action Collaborative
Washington Independent Living Council
Washington State University-Vancouver