Washington State Plan on Aging Attachments

October 1, 2023 through September 30, 2027

Washington State Department of Social and Health Services
Aging and Long-Term Support Administration

Washington State Department of Social & Health Services
Transforming lives

Contents

Attachment A - State Plan Assurances and Required Activies

STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES

Older Americans Act, As Amended in 2020

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2020.

Sec. 305, ORGANIZATION

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title—. . .

(2) The State agency shall—

(A) except as provided in subsection (b)(5), designate for each such area after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area;

(B) provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan; . . .

(E) provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas), and include proposed methods of carrying out the preference in the State plan;

(F) provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16); and

(G)

(i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older individuals and older individuals residing in rural areas;

(ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals;

(iii) provide a description of the efforts described in clause (ii) that will be undertaken by the State agency; . . .

(c) An area agency on aging designated under subsection (a) shall be—…

(5) in the case of a State specified in subsection (b)(5), the State agency;

and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

(d) The publication for review and comment required by paragraph (2)(C) of subsection (a) shall include—

(1) a descriptive statement of the formula's assumptions and goals, and the application of the definitions of greatest economic or social need,

(2) a numerical statement of the actual funding formula to be used,

(3) a listing of the population, economic, and social data to be used for each planning and service area in the State, and

(4) a demonstration of the allocation of funds, pursuant to the funding formula, to each planning and service area in the State.

Note: States must ensure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306, AREA PLANS

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, modernization, or construction of multipurpose senior centers (including a plan to use the skills and services of older individuals in paid and unpaid work, including multigenerational and older individual to older individual work), within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals who have greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals at risk for institutional placement residing in such area, and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community), evaluating the

effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3) (A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4) (A)

(i)

(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared —

(I) identify the number of low-income minority older individuals in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

(B) provide assurances that the area agency on aging will use outreach efforts that will—

(i) identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and

(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) 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 severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities;

(6) provide that the area agency on aging will—

(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;

(C) (i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—

(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs;

and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) in coordination with the State agency and with the State agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the area agency on aging with mental and behavioral health services provided by community health centers and by other public agencies and nonprofit private organizations;

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

(H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate; and

(I) to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the areawide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that—

(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) (A) provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2019 in carrying out such a program under this title;

(B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older 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 this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; 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;

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency—

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and

(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

(14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;

(15) provide assurances that funds received under this title will be used—

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

(17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery;

(18) provide assurances that the area agency on aging will collect data to determine—

(A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and

(B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals; and

(19) provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on those individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019.

(b)(1) An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include—

(A) the projected change in the number of older individuals in the planning and service area;

(B) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(D) an analysis of how the change in the number of individuals age 85 and older in the planning and service area is expected to affect the need for supportive services.

(3) An area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service area to meet the needs of older individuals for—

(A) health and human services;

(B) land use;

(C) housing;

(D) transportation;

(E) public safety;

(F) workforce and economic development;

(G) recreation;

(H) education;

(I) civic engagement;

(J) emergency preparedness;

(K) protection from elder abuse, neglect, and exploitation;

(L) assistive technology devices and services; and

(M) any other service as determined by such agency.

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

(d)(1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f)(1) If the head of a State agency finds that an area agency on aging has failed to comply with Federal or State laws, including the area plan requirements of this section, regulations, or policies, the State may withhold a portion of the funds to the area agency on aging available under this title.

(2) (A) The head of a State agency shall not make a final determination withholding funds under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the State agency.

(B) At a minimum, such procedures shall include procedures for—

(i) providing notice of an action to withhold funds;

(ii) providing documentation of the need for such action; and

(iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

(3) (A) If a State agency withholds the funds, the State agency may use the funds withheld to directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

(g) Nothing in this Act shall restrict an area agency on aging from providing services not provided or authorized by this Act, including through—

(1) contracts with health care payers;

(2) consumer private pay programs; or

(3) other arrangements with entities or individuals that increase the availability of home and community-based services and supports.

Sec. 307, STATE PLANS

(a) Except as provided in the succeeding sentence and section 309(a), each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan for a two, three, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a State failed in 2 successive years to comply with the requirements under this title, then the State shall submit to the Assistant Secretary a State plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the State is in compliance with such requirements. Each such plan shall comply with all of the following requirements:

(1) The plan shall—

(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and

(B) be based on such area plans.

(2) The plan shall provide that the State agency will—

(A) evaluate, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; and

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under section 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2).

(3) The plan shall—

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning intrastate distribution of funds); and

(B) with respect to services for older individuals residing in rural areas—

(i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000…

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas).

(5) The plan shall provide that the State agency will—

(A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under section 316.

(6) The plan shall provide that the State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(7) (A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that—

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(8) (A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency—

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

(9) The plan shall provide assurances that—

(A) the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2019, and an amount that is not less

than the amount expended by the State agency with funds received under title VII for fiscal year 2019; and

(B) funds made available to the State agency pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712.

(10) The plan shall provide assurances that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11) The plan shall provide that with respect to legal assistance —

(A) the plan contains assurances that area agencies on aging will (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance; (ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and (iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

(E) the plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals —

(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent abuse of older individuals;

(ii) receipt of reports of abuse of older individuals;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(iv) referral of complaints to law enforcement or public protective service agencies where appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low-income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to

assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who—

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall—

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made—

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

(27) (A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels

can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

(28) The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

(29) The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

(30) The plan shall contain an assurance that the State shall prepare and submit to the Assistant Secretary annual reports that describe—

(A) data collected to determine the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019;

(B) data collected to determine the effectiveness of the programs, policies, and services provided by area agencies on aging in assisting such individuals; and

(C) outreach efforts and other activities carried out to satisfy the assurances described in paragraphs (18) and (19) of section 306(a).

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS

(a) ELIGIBILITY.—In order to be eligible to receive an allotment under this subtitle, a State shall include in the state plan submitted under section 307—

(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order…

Bea Rector _____ 06/29/2023

Signature and Title of Authorized Official *Date*

Attachment B - Information Requirements

INFORMATION REQUIREMENTS

Section 305(a)(2)(E)

Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

RESPONSE:

Washington State assures preference will be given to older individuals with greatest economic need and older individuals with greatest social need through its Intrastate Funding Formula (IFF – see attachment C). The IFF was collaboratively developed in consultation with Washington's area agencies on aging. Funding is prioritized to planning and service areas based on weighted factors. Factors include total populations of individuals 60 and over, or total population of BIPOC individuals 60 and older, for example, which target funding towards service areas with greatest need.

AAAs are also required to develop goals and objectives to outline their plans in targeting older individuals in greatest economic and social need. This includes: "how individuals of hard to reach/target groups are identified, engaged, and served. Identify how the AAA will serve low-income minority individuals, limited English speaking persons and older adults residing in rural areas. Include engagement strategies for older Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Two Spirit, Plus (LGBTQIA2+) individuals and persons under sixty (60) with disabilities." Please see Attachment U – Area Plan Instructions.

Section 306(a)(6)(I)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will, to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

RESPONSE:

ALTSA assures that Area Plans include goals that support building a person-centered home and community-based system. This includes case management and community living connections/aging and disability resource network development as appropriate. Please see the "Assistive Technology" section of the State Plan narrative for other mechanisms for coordinating state and local assistive technology access, which includes the robotic pet program, as well as ALTSA's partnerships with Trualta and GetSetUp.

Section 306(a)(17)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

RESPONSE:

AAAs are required to include with their area plans an emergency response plan. This plan includes the following required elements:

- A designated staff person to oversee planning tasks and determine how emergency management is carried out in the local jurisdiction.
- Letters of agreement between the AAA and local emergency operations leadership that identify responsibilities.
- Preparedness activities done by the AAA.
- Criteria for identifying high risk clients in the community.
- Plan for contacting high-risk clients and referring to first responders as necessary.
- Local partners such as the American Red Cross
- Cooperation with the appropriate community agency preparedness entities when areas of unmet need are identified.
- A system for tracking unanticipated emergency response expenditures for possible reimbursement.
- An internal Business Continuity Plan that emphasizes communications, back-up systems for data, emergency service delivery options, and transportation
- Policy and procedures developed and/or implemented due to the COVID-19 pandemic.

Section 307(a)(2)

The plan shall provide that the State agency will —…
(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2). (Note: those categories are access, in-home, and legal assistance. Provide specific minimum proportion determined for each category of service.)

RESPONSE:

Washington's IFF requires the following minimum proportion of funds to carry out the specificied Title III B services below:

Service:	Percentage of III-B Service Expenditures
Access	52%
In-home	5%
Legal Services	11%

Section 307(a)(3)

The plan shall—

...

(B) with respect to services for older individuals residing in rural areas—

(i) provide assurances the State agency will spend for each fiscal year not less than the amount expended for such services for fiscal year 2000;
(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and
(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

RESPONSE:

ALTSA assures the State agency will spend for each fiscal year not less than the amount expended for such services for fiscal year 2000. Please see Attachment C for detail on Washington's IFF.

Section 307(a)(10)

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

RESPONSE:

ALTSA assures that the special needs of older individuals residing in rural areas are taken into consideration through several strategies. The IFF designates funding based on a factor specific to the square mileage of each service area to support larger, often more rural regions of the state. Additionally, ALTSA collaboratively works with its network of AAAs to improve the service delivery of all areas of the state. Each PSA will also appoint a member of its Advisory Council to

the State Council on Aging, which serves to advise ALTSA on the concerns of older adults across the state.

Section 307(a)(14)

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—
(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and
(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

RESPONSE:

American Community Service 5-year data (ACS 5-year 2020 data) estimates the number of minority older individuals below the poverty level was 33,495 in WA State. The tabulation for low-income minority older individuals with limited English proficiency is unknown, however the ACS 5-year 2020 data estimates there are 65,570 adults aged 60 and over who speak English "not well" or "not at all" in Washington State.

Washington's Intrastate Funding Formula (IFF) serves to target funding to service areas based on a list of eight (8) factors. A majority of the funding is weighted towards three factors—these include:

- 60+ population at or below poverty 30%
- 60+ population black, indigenous, and people of color (BIPOC, minority) 12%
- 60+ population limited English speaking 10%

These three factors contribute 52% of the weight towards each planning and service areas' IFF total factor (see attachment C). Together, these factors aim to target funding, and subsequent services to populations in greatest social and economic need.

Section 307(a)(21)

The plan shall —

. . .

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

RESPONSE:

ALTSA will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits through ongoing "7.01" planning and implementation (see "Coordinating Title III programs with Title VI Native American programs" in narrative). Additionally, through Goal 5 – "Tribal Affairs – Continue to build strong relationships with, and expand contract opportunities for, tribes/tribal organizations to increase access to culturally attuned long-term services and supports for American Indians/Alaska Natives to age in their homes or community-based settings of their choice", ALTSA commits to several strategies aimed at assuring these activities are met (see "Goals" section in narrative, Goal #5).

Section 307(a)(27)

(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services

RESPONSE:

ALTSA plans for the growth in the number of older adults, and older adults needing long term services and supports through several strategies. First, the Research and Data Analysis Division of the Department of Social and Health Services supports the planning of state and local agencies through 10-year population forecasting. This data supports the planning and implementation of services and supports by anticipating the change in state and local populations. These estimates help to target services towards populations with greatest social and economic need by forecasting the following data:

Population 60+, Population 60+ at or below FPL, Population 60+ at or below EESSI, Population 60+ minority, Population 55+ American Indian/Alaska Native, Population 60+ American Indian/Alaska Native and disabled, Population 60+ at or below FPL and minority, Population 60+ LEP, Population 60+ disabled, Population 18+ disabled, Population 60+ with cognitive impairment, Population 18+ with cognitive impairment, Population 60+ with IADL, Population 18+ with IADL, Population 65+ with dementia,

Number of persons using SNF services, Number of persons using in-home services, and number of persons using community residential services.

ALTSA also plans to support the growth in the population of older adults through the Dementia Action Collaborative State Plan to Address Alzheimer's Disease and Other Dementias (see "Equity" section in narrative), improving access to LTSS through the ongoing work of Washington Community Living Connections (see "Equity" section in narrative), implementation of pro-equity antiracist planning (see "Equity" section in narrative), and through several efforts to strengthen the direct care workforce, namely the WA Cares Fund (see "Caregiving" section in narrative).

Section 307(a)(28)

The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

RESPONSE:

ALTSA assures coordination of emergency preparedness throughout the aging network partners, especially AAAs and other local agencies through the area planning process (see "Goals" section in narrative, Goal 6). As a part of the Area Plan, AAAs are required to develop a detailed emergency response plan. This includes coordinating with local emergency response agencies and identifying high risk clients (see "Services as a Part of the PHE and Emergency Preparedness" section in narrative).

Section 307(a)(29)

The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

RESPONSE:

See Attachment T – DSHS Administrative Policy – 09-11. ALTSA, an administration under the Department of Social and Health Services adheres to this policy which is written "to provide guidance, direction, and standards that promote DSHS organizational and individual employee preparedness to respond effectively to emergencies and disasters".

Section 705(a) ELIGIBILITY —

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307—. . .
(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6).
(Note: Paragraphs (1) of through (6) of this section are listed below)
In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307—
(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;
(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;
(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;
(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;
(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);
(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for-

(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public

protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order.

RESPONSE:

The Washington State Plan on Aging, through its narrative and attachment sections, details the programs and services in accordance with Section 705(a)(7). Please see the following State Plan narrative sections and corresponding paragraphs for these assurances:

- Paragraph 1 – see "Older Americans Act (OAA) Core Programs" section in narrative.
- Paragraph 2 – see "State Council on Aging", "Washington's Area Agencies on Aging and the Long-Term Support Network", and "Ensuring AAAs will conduct efforts to facilitate coordination of HCB LTSS" sections in narrative.
- Paragraph 3 - see "Washington's Area Agencies on Aging and the Long-Term Support Network" and "Ensuring AAAs will conduct efforts to facilitate coordination of HCB LTSS" sections in narrative.
- Paragraph 4 – Washington assures that funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.
- Paragraph 5 - Washington assures that will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5). See "Supporting and enhancing multi-disciplinary responses to elder abuse, neglect and exploitation involving adult protective services, LTC ombudsman programs, legal assistance programs, law enforcement, health care professionals, financial institutions, and other essential partners across the state" for more information.
- Paragraph 6 (and its subsections) - Washington assures that the sections and subsections in paragraph 6 are met through the activities of its Adult Protective Services (APS) division. Please see the "Preventing, detecting, assessing, intervening, and/or investigating elder abuse, neglect, and financial exploitation" section in the narrative for more information.

Attachment C - Intrastate Funding Formula

The following funding formula uses population estimates from the American Community Survey 5-Year Data (2015-2019). Prior to this, the funding formula began using 2010 census data in 2013. In 2013, the funding formula was prepared with input from the Washington Association of Area Agencies on Aging (W4A), which requested that allocations based on the 2010 census be phased in over a three-year period (2013-2015).

The following funding formula has been prepared in consultation with W4A. ALTSA and W4A collaborated to develop this formula, which updates data using American Community Survey 5-year population estimates for each of Washington's 13 planning and service areas. This IFF includes updated factors (Age: split out into a 60-74 category and a 75+ category, as well as a new "60+ Living Alone" category), updated weights corresponding to each factor, and changes to the base allocations (increasing the total base and adding tribal planning allotments). Changes from the previous IFF will be phased in over a two-year period (2024-2025).

The formula is calculated as follows:

1. Census information is calculated for each Area Agency on Aging (AAA) by the following categories:

    1. Total population of 60-74
    2. Total population 75+
    3. 60+ population at or below poverty
    4. 60+ BIPOC (black, indigenous, and people of color) population
    5. Square miles in each AAA service area
    6. 60+ Limited English Speaking
    7. 60+ population living alone
    8. 60+ needing assistance with Activities of Daily Living (ADLs)

2. Data from #1 is calculated as a percent of the total by category, for each AAA.

3. Percent from #2 is multiplied by weighted coefficients as listed below. A series of meetings and discussions with AAAs, the State Council on Aging, and DSHS management staff determined these weights, which resulted in a Total Factor by AAA. The weighted averages are as follows:

    - Total population of 60-74 15%
    - Total population 75+ 10%
    - 60+ population at or below poverty 30%
    - 60+ BIPOC population 12%
    - Square miles in each AAA service area 10%
    - 60+ Limited English Speaking 10%
    - 60+ population living alone 5%
    - 60+ needing assistance with ADLs 8%

4. An annual base allotment is determined as follows:

    - $250,000 is allotted to all AAAs.
    - An additional allotment of $10,000 is made to all multi-county AAAs for each county over one.
    - An additional allotment of $10,000 is for tribal 7.01 planning between federally recognized tribes and AAAs.

5. These allotments are split proportionately between Title 3B, Title 3C, and SCSA.
6. The total annual base allotments (from #4 above) are subtracted from the total grant award by funding source, after State Unit on Aging Admin has been held back.
7. The weighted percent factor from #3 is multiplied by the adjusted grant award amount calculated in #6 above.
8. The annual base allotments are added to the figure calculated in #7 above resulting in the amount allocated to Title 3B by AAA.
9. The same process is used to allocate all Title 3 funds (B, C1/C2, D, and E), SCSA, State Family Caregiver Support Program, Senior Farmers Market Nutrition Program, State-Funded Senior Nutrition Program, and Volunteer Services; however, there is no other base allotment for these funds.
10. Title VII Elder Abuse Prevention funds have also used this method after a holdback by Headquarters. (Normally $20,000)
11. For the Ombuds program, DSHS provides grant and state funds to Commerce who oversees the grant and the allocation formula which is a weighted percentage of number of beds, facilities, and square miles for each region.
12. Nutrition Services Incentive Program (NSIP) funds are allocated using percentages of each AAAs' share of reported previous FFY NSIP eligible meal counts.

The mathematical formula to demonstrate the IFF is as follows:

Factor 1: [(AAA factor data / total state population data for factor) *weighted coefficient from step 3] +
Factor 2: [(AAA factor data / total state population data for factor) *weighted coefficient from step 3] +
Factor 3: [(AAA factor data / total state population data for factor) *weighted coefficient from step 3] +
Factor 4: [(AAA factor data / total state population data for factor) *weighted coefficient from step 3] +
Factor 5: [(AAA factor data / total state population data for factor) *weighted coefficient from step 3] +
Factor 6: [(AAA factor data / total state population data for factor) *weighted coefficient from step 3] +
Factor 7: [(AAA factor data / total state population data for factor) *weighted coefficient from step 3] +
Factor 8: [(AAA factor data / total state population data for factor) *weighted coefficient from step 3]
= **Total Factor for each AAA**

Total Grant Award – (Step 4: Total AAA Base Allotments + SUA Admin holdback) = **Total AAA Funding**

Total Factor for each AAA * Total AAA Funding = **Adjusted Grant**

Adjusted Grant + Base allotment in Step 4 = **Proposed Total for AAA**

Aging and Long-Term Support Administration
Intra-State Funding Formula
Funding Formula Variables

AAA	2015-2019ACS Pop 60-74	2015-2019ACS Pop 75+	2015-2019ACS Poverty	2015-2019ACS BIPOC	2015-2019ACS Miles	2015-2019ACS L E S	2015-2019ACS 60+ Living Alone	2015-2019ACS ADL/IADL
Olympic	4.5144	4.8759	5.0935	2.0633	9.5733	0.8620	4.6490	4.0448
Northwest	7.4654	7.8090	7.4797	4.2795	6.3842	3.1276	7.1183	6.3373
Snohomish	10.1075	9.0574	9.0610	10.1557	3.1501	11.8621	9.2255	10.5268
King	25.9412	25.9808	26.8049	40.8800	3.1996	48.4095	27.3480	25.2907
Pierce	10.8606	10.6473	9.5569	12.9570	2.5164	8.4446	10.9424	11.2849
L/M/T	6.8105	6.7331	6.1707	4.3720	6.1950	2.2732	6.3860	6.8573
Southwest	8.9743	8.5948	8.9350	5.2729	8.4262	4.7067	8.4731	9.2689
Central WA	4.0142	4.3414	4.7317	3.3845	24.2110	4.5160	3.9220	3.8031
Southeast	7.9223	8.6519	8.2033	7.8933	16.3358	11.3434	8.0733	9.0986
Yakama Nation	0.3097	0.2844	0.5041	1.1945	3.2086	1.2510	0.2079	0.3424
Eastern	8.8856	8.9843	10.0285	4.0422	13.8374	2.4411	9.8398	9.7413
Colville Indian	0.0996	0.1405	0.2276	0.3218	2.3723	0.0153	0.1261	0.1337
Kitsap	4.0946	3.8994	3.2033	3.1834	0.5901	0.7476	3.6886	3.2703
TOTALS	**100.00**	**100.00**	**100**	**100**	**100**	**100**	**100**	**100**

Funding Formula Variables by Populations

AAA	2015-2019ACS Pop 60-74	2015-2019ACS Pop 75+	2015-2019ACS Poverty	2015-2019ACS BIPOC	2015-2019ACS Miles	2015-2019ACS L E S	2015-2019ACS 60+ Living Alone	2015-2019ACS ADL/IADL
Olympic	51,670	21,345	6,265	5,130	6,376	565	17,330	11,045
Northwest	85,445	34,185	9,200	10,640	4,252	2,050	26,535	17,305
Snohomish	115,685	39,650	11,145	25,250	2,098	7,775	34,390	28,745
King	296,910	113,735	32,970	101,640	2,131	31,730	101,945	69,060
Pierce	124,305	46,610	11,755	32,215	1,676	5,535	40,790	30,815
L/M/T	77,950	29,475	7,590	10,870	4,126	1,490	23,805	18,725
Southwest	102,715	37,625	10,990	13,110	5,612	3,085	31,585	25,310
Central WA	45,945	19,005	5,820	8,415	16,125	2,960	14,620	10,385
Southeast	90,675	37,875	10,090	19,625	10,880	7,435	30,095	24,845
Yakama Nation	3,545	1,245	620	2,970	2,137	820	775	935
Eastern	101,700	39,330	12,335	10,050	9,216	1,600	36,680	26,600
Colville Indian	1,140	615	280	800	1,580	10	470	365
Kitsap	46,865	17,070	3,940	7,915	393	490	13,750	8,930
TOTALS	**1,144,550**	**437,765**	**123,000**	**248,630**	**66,602**	**65,545**	**372,770**	**273,065**

Weighted Variable Factors and Total Funding Factor

AAA	2015-2019ACS Pop 60-74	2015-2019ACS Pop 75+	2015-2019ACS Poverty	2015-2019ACS BIPOC	2015-2019ACS Miles	2015-2019ACS L E S	2015-2019ACS 60+ Living Alone	2015-2019ACS ADL/IADL	Total Factor
Olympic	0.6772	0.4876	1.52804878	0.247596831	0.9573	0.08620032	0.232448963	0.32358596	**4.5399**
Northwest	1.1198	0.7809	2.243902439	0.513534167	0.6384	0.312762224	0.355916517	0.50698552	**6.4722**
Snohomish	1.5161	0.9057	2.718292683	1.218678357	0.315	1.186207949	0.46127639	0.84214381	**9.1635**
King	3.8912	2.5981	8.041463415	4.905602703	0.32	4.840948966	1.367398128	2.02325454	**27.9879**
Pierce	1.6291	1.0647	2.867073171	1.554840526	0.2516	0.844458006	0.547120208	0.90278871	**9.6617**
L/M/T	1.0216	0.6733	1.851219512	0.524635	0.6195	0.227324739	0.319298763	0.54858733	**5.7855**
Southwest	1.3461	0.8595	2.680487805	0.632747456	0.8426	0.470669006	0.423652654	0.74150843	**7.9973**
Central WA	0.6021	0.4341	1.419512195	0.406145678	2.4211	0.451598139	0.196099472	0.3042499	**6.2350**
Southeast	1.1883	0.8652	2.46097561	0.947190605	1.6336	1.13433519	0.403667141	0.7278853	**9.3612**
Yakama Nation	0.0465	0.0284	0.151219512	0.143345534	0.3209	0.12510489	0.01039515	0.02739275	**0.8533**
Eastern	1.3328	0.8984	3.008536585	0.485058118	1.3837	0.244107102	0.491992381	0.77930163	**8.6240**
Colville Indian	0.0149	0.0140	0.068292683	0.038611592	0.2372	0.001525669	0.006304155	0.01069342	**0.3916**
Kitsap	0.6142	0.3899	0.96097561	0.382013434	0.059	0.0747578	0.184430078	0.26162269	**2.9269**
TOTALS	**15**	**10**	**30**	**12**	**10**	**10**	**5**	**8**	**100.00**
Age 60-74 population									15
Age 75+ population									10
Age 60+ at or below poverty									30
Age 60+ BIPOC									12
Square miles in the AAA service area									10
Age 60+ limited-English speaking									10
Age 60+ living alone									5
Age 60+ needing assistance with activities of daily living									8
TOTAL FACTORS									**100**

Base Allotment Calculations

Base Allotment for all PSAs	$250,000
Base Allotment for each county over 1 for multi-county PSAs	$10,000
Base Allotment for tribal 7.01 planning between federally recognized tribes and AAAs	$10,000

Proposed IFF Annual Base Allotment Calculations

Base Allotment for all PSAs	$ 250,000
Base Allotment for each county over 1 for multi-county PSAs,	$ 10,000
Base Allotment for each federally recognized tribe for 7.01 planning	$ 10,000

	Total Allocation	% of Total	Base Allot. (Allocated)	Multi-County (Allocated)	7.01 Tribes (Allocated)
FFY23 Title 3B AAA Svcs Allot.	$ 7,998,205	22.9%	$ 57,250	$ 2,290	$ 2,290
FFY23 Title 3C1 AAA Svcs Allot.	$ 10,848,425	31.0%	$ 77,500	$ 3,100	$ 3,100
FFY23 Title 3C2 AAA Svcs Allot.	$ 7,341,824	21.0%	$ 52,500	$ 2,100	$ 2,100
SFY23 SCSA Allot.	$ 8,761,000	25.1%	$ 62,750	$ 2,510	$ 2,510
TOTAL	**$ 34,949,454**	**100%**	**$ 250,000**	**$ 10,000**	**$ 10,000**

Example Total AAA Funding

$ 28,500,000

	Updated Factor (step #3)	Updated Base Allotment (step #4)	Adjusted Grant x Factor (step #7)	Proposed Total
Olympic	**4.539936926**	$360,000	$1,115,916	$1,475,916
Northwest	**6.472206202**	$340,000	$1,590,868	$1,930,868
Snohomish	**9.16345616**	$280,000	$2,252,378	$2,532,378
King	**27.98793113**	$270,000	$6,879,433	$7,149,433
Pierce	**9.661697168**	$260,000	$2,374,845	$2,634,845
L/M/T	**5.785452335**	$310,000	$1,422,064	$1,732,064
Southwest	**7.997285159**	$310,000	$1,965,733	$2,275,733
Central WA	**6.234978635**	$310,000	$1,532,558	$1,842,558
Southeast	**9.361193207**	$330,000	$2,300,981	$2,630,981
Yakama Nation	**0.853257054**	$280,000	$209,731	$489,731
Eastern	**8.62396129**	$320,000	$2,119,770	$2,439,770
Colville Confederated	**0.391616527**	$280,000	$96,259	$376,259
Kitsap	**2.926928202**	$270,000	$719,439	$989,439
TOTALS	**100**	$3,920,000	$ 24,579,975	$28,499,975

Base Allotment for PSAs	$	250,000
Base Allotment for each county over 1 for multi-county PSAs	$	10,000
Base Allotment for tribal 7.01 planning between federally recognized tribes and AAAs	$	10,000

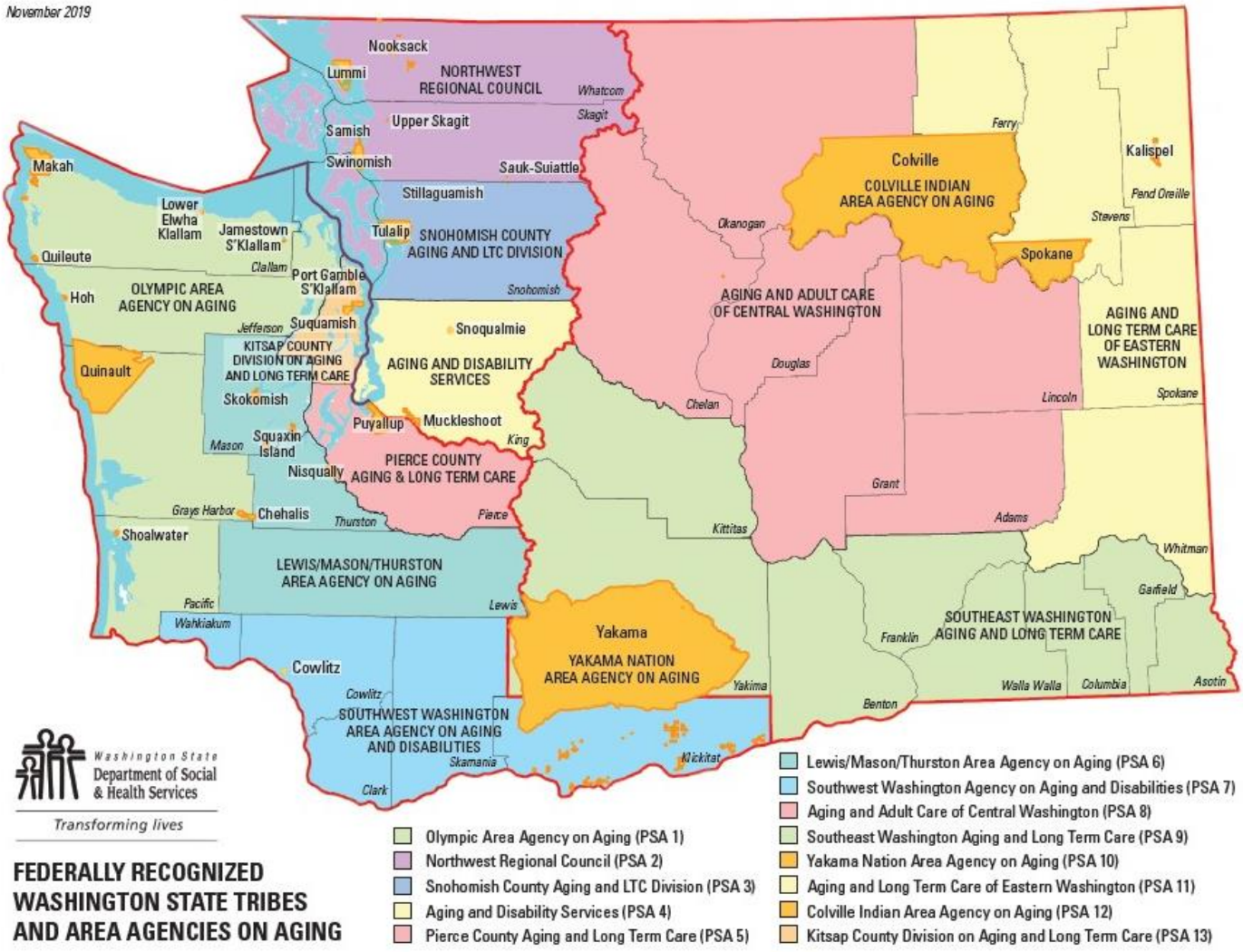
Attachment D - Area Agencies on Directory + Map

Olympic Area Agency on Aging 2200 W Sims Way, Unit 100 Port Townsend, WA 98368 Phone: 360-379-5064, Toll free:1-866-720-4863 Fax: 360-379-5074 ***Laura Cepoi, Executive Director*** Laura.Cepoi@dshs.wa.gov	**PSA #1 (DSHS REGION 3)** Clallam, Grays Harbor, Jefferson, Pacific **AAA Specialist: *Lexie Bartunek*** Lexie.Bartunek@dshs.wa.gov 360-725-3548 RU 61-66
Northwest Regional Council 600 Lakeway Drive, Bellingham, WA 98225 Phone: 360-676-6749, Toll free:1-800-585-6749 Fax: 360-738-2451 ***Amanda McDade, Executive Director*** Amanda.McDade@dshs.wa.gov	**PSA #2 (DSHS REGION 2)** Island, San Juan, Skagit, Whatcom **AAA Specialist: *Mark Towers*** Mark.Towers@dshs.wa.gov, 360-725-2446 RU 67,68, 154-157
Snohomish County Aging & Disability Services Division 3000 Rockefeller Ave. M/S 305, Everett, WA 98201 Phone: 425-388-7200, Toll free:1-800-422-2024 Fax: 425-388-7304 ***Laura White, Division Manager*** L.White@snoco.org	**PSA #3 (DSHS REGION 2)** Snohomish **AAA Specialist: *Mark Towers*** Mark.Towers@dshs.wa.gov, 360-725-2446 RU 69
Aging & Disability Services 700 5th Ave., 51st Floor (Office); PO Box 34215 (Mail), Seattle, WA 98124-4215 Phone: 206-233-5121 Fax: 206-684-0689 ***Mary Mitchell, Director*** Mary.Mitchell2@seattle.gov	**PSA #4 (DSHS REGION 2)** King **AAA Specialist: *Mark Towers*** Mark.Towers@dshs.wa.gov, 360-725-2446 RU 70, 71, 73, 74 and 36, 37
Pierce County Aging and Disability Resources 4301 S Pine St, Suite 446, Tacoma, WA 98409 Phone:253-798-4600, Toll free: 1-800-562-0332 Fax: 253-798-2839 ***Aaron Van Valkenburg, Director*** Aaron.VanValkenburg@piercecountywa.gov	**PSA #5 (DSHS REGION 3)** Pierce **AAA Specialist: *Lexie Bartunek*** Lexie.Bartunek@dshs.wa.gov 360-725-3548 RU 75
Lewis/Mason/Thurston Area Agency on Aging 2404 Heritage Court SW, Olympia, WA 98502 Phone: 360-664-2168, Toll free: 1-888-545-0910 Fax: 360-664-0791 ***Nicole Kiddoo, Executive Director*** Nicole.Kiddoo@dshs.wa.gov	**PSA #6 (DSHS REGION 3)** Lewis, Mason, Thurston **AAA Specialist: *Caroline Wood*** Caroline.Wood@dshs.wa.gov, 360-725-3466 RU 81-82, 84
Area Agency on Aging & Disabilities of Southwest WA 201 NE 73rd St, Vancouver, WA 98665 Phone: 360-735-5720, Toll free : 1-888-637-6060 Fax: 360-696-4905 ***Mike Reardon, Director*** Mike.Reardon@dshs.wa.gov	**PSA #7 (DSHS REGION 3)** Clark, Cowlitz, Klickitat, Skamania, Wahkiakum **AAA Specialist: *Paula Renz*** Paula.Renz@dshs.wa.gov, 360-725-2560 RU 31, 34, 86-88

Aging & Adult Care of Central WA 270 9th Street NE, Suite 100 East Wenatchee, WA 98802 Phone: 509-886-0700, Toll free: 1-800-572-4459 Fax: 509-884-6943 ***Bruce Buckles, Executive Director*** Bruce.Buckles@dshs.wa.gov	**PSA #8 (DSHS REGION 1)** Adams, Chelan, Douglas Grant, Lincoln, Okanogan **AAA Specialist: *Paula Renz*** Paula.Renz@dshs.wa.gov, 360-725-2560 RU 53, 54, 90
Southeast WA Aging and Long Term Care 7200 W Nob Hill Blvd., Suite 12 (Office); PO Box 8349 (Mail), Yakima, WA 98908-0349 Phone: 509-965-0105, Toll free: 1-877-965-2582 Fax: 509-965-0221 ***Lori Brown, Director*** Lori.Brown@dshs.wa.gov	**PSA #9 (DSHS REGION 1)** Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Yakima, Walla Walla **AAA Specialist: *Paula Renz*** Paula.Renz@dshs.wa.gov, 360-725-2560 RU 91-92, 95-99
Yakama Nation Area Agency on Aging 91 Wishpoosh (Office); PO Box 151 (Mail), Toppenish, WA 98948 Phone: 509-865-7164 Fax: 509-865-2098 ***Launa Ambrose, Interim Program Manager*** launa_Ambrose@yakama.com	**PSA #10 (DSHS REGION 1)** Yakama Reservation **AAA Specialist: *Caroline Wood*** Caroline.Wood@dshs.wa.gov, 360-725-3466 RU 153
Aging & Long Term Care of Eastern WA 1222 North Post, Spokane, WA 99201 Phone: 509-458-2509 Fax: 509-458-2003 ***Lynn Kimball, Director*** Lynn.Kimball@dshs.wa.gov	**PSA #11 (DSHS REGION 1)** Ferry, Pend Oreille, Spokane, Stevens, Whitman **AAA Specialist: *Caroline Wood*** Caroline.Wood@dshs.wa.gov, 360-725-3466 RU 41-43, 76
Confederated Tribes of the Colville Reservation 21 Colville Street (Office), PO Box 150 (Mail), Nespelem, WA 99155 Phone: 509-634-2759 Toll free: 1-888-881-7684 Fax: 509-634-2793 or 4116 (Tribal Administration) ***Joel Boyd, Director 509-634-2759*** Joel.Boyd.AAA@colvilletribes.com	**PSA #12 (DSHS REGION 1)** Colville Reservation **AAA Specialist Unit Manager:** ***Aime Fink*** Aime.Fink@dshs.wa.gov 360-725-2554 RU 77
Kitsap County Division of Aging & LTC 1026 Sidney Avenue (Office); 614 Division, MS-5 (Mail), Port Orchard, WA 98366 Phone: 360-337-7068, Toll free: 1-800-562-6418 Fax: 360-337-5746 ***Stacey Smith, Director*** sasmith@kitsap.gov	**PSA #13 (DSHS REGION 3)** Kitsap **AAA Specialist: *Lexie Bartunek*** Lexie.Bartunek@dshs.wa.gov 360-725-3548 RU 78

Washington Association of Area Agencies on Aging (W4A)
2404 Heritage Court SW, Olympia, WA 98502
Phone: 360-485-9761 Fax: 360-664-0791
Nicole Kiddoo, Chair Nicole.Kiddoo@dshs.wa.gov
Cathy Knight, State Director Cathy.Knight@agingwashington.org

Revised 5/9/23 WM =i=


November 2019
Nooksack
Lummi
NORTHWEST REGIONAL COUNCIL
Whatcom
Skagit
Upper Skagit
Samish
Swinomish
Sauk-Suiattle
Stillaguamish
Tulalip
SNOHOMISH COUNTY AGING AND LTC DIVISION
Snohomish
Makah
Lower Elwha Klallam
Jamestown S'Klallam
Quileute
Clallam
Port Gamble S'Klallam
Hoh
OLYMPIC AREA AGENCY ON AGING
Jefferson
Suquamish
Snoqualmie
KITSAP COUNTY DIVISION ON AGING AND LONG TERM CARE
AGING AND DISABILITY SERVICES
Quinault
Skokomish
Puyallup
Muckleshoot
King
Mason
Squaxin Island
Nisqually
PIERCE COUNTY AGING & LONG TERM CARE
Pierce
Grays Harbor
Chehalis
Thurston
Shoalwater
LEWIS/MASON/THURSTON AREA AGENCY ON AGING
Pacific
Lewis
Wahkiakum
Cowlitz
SOUTHWEST WASHINGTON AREA AGENCY ON AGING AND DISABILITIES
Skamania
Clark
Ferry
Colville
COLVILLE INDIAN AREA AGENCY ON AGING
Okanogan
Kalispel
Pend Oreille
Stevens
Spokane
AGING AND ADULT CARE OF CENTRAL WASHINGTON
Douglas
Chelan
Lincoln
AGING AND LONG TERM CARE OF EASTERN WASHINGTON
Spokane
Grant
Adams
Kittitas
Yakama
YAKAMA NATION AREA AGENCY ON AGING
Yakima
Benton
Whitman
Garfield
Franklin
SOUTHEAST WASHINGTON AGING AND LONG TERM CARE
Walla Walla
Columbia
Asotin
Klickitat
Washington State Department of Social & Health Services
Transforming lives
FEDERALLY RECOGNIZED WASHINGTON STATE TRIBES AND AREA AGENCIES ON AGING
Olympic Area Agency on Aging (PSA 1)
Northwest Regional Council (PSA 2)
Snohomish County Aging and LTC Division (PSA 3)
Aging and Disability Services (PSA 4)
Pierce County Aging and Long Term Care (PSA 5)
Lewis/Mason/Thurston Area Agency on Aging (PSA 6)
Southwest Washington Agency on Aging and Disabilities (PSA 7)
Aging and Adult Care of Central Washington (PSA 8)
Southeast Washington Aging and Long Term Care (PSA 9)
Yakama Nation Area Agency on Aging (PSA 10)
Aging and Long Term Care of Eastern Washington (PSA 11)
Colville Indian Area Agency on Aging (PSA 12)
Kitsap County Division on Aging and Long Term Care (PSA 13)

Attachment E - State Plan Survey Summary

(Attached separately as a standalone)

Attachment F - Equity Focus Groups

Introduction

The Aging and Long-Term Support Administration (ALTSA) began updating its 2023-2027 State Plan on Aging in 2022. As a critical part of this process, ALTSA solicited input from the public in a variety of ways. The equity focus groups enabled older state residents, their families, service providers and caregivers to share their voice and provide input into the needs and concerns for our state and help address our prioritization of equity within state planning efforts.

Focus Group Summary

Three equity focus groups were held virtually via Zoom. Participants had the option to join online or call-in, and each meeting was password protected. Interpreters were available in ASL for each focus group, with Spanish interpreters available at one focus group. The sessions lasted approximately two hours each and 53 individuals were in attendance.

The equity focus groups occurred on:

- March 29th, 2023, at 11:00am
- March 30th, 2023, at 9:00am
- March 30th, 2023, at 6:00pm

Target Audience

- Older adults
- Family members of older adults
- Caregivers
- Service providers

Operational Structure

Staff across ALTSA managed the equity focus group process, including marketing, meeting set-up, facilitation, and report-out. This team worked closely with the Office of the Deaf and Hard of Hearing and the Office of Equity, Diversity, Access, and Inclusion for consultation and interpretation needs.

Focus Groups Goals

The State Plan sought to address a variety of equity topic areas in effort to serve individuals with the greatest economic and social need, ensuring equity in all aspects of plan administration.

These topic areas, as listed below, helped to inform the questions and facilitation of our Equity Focus Groups.

- Determining services needed and effectiveness of programs, policies, and services for older individuals whose needs were the focus of all centers funded under Title IV in fiscal year 2019;
- Engagement in outreach with older individuals whose needs were the focus of all centers funded under Title IV in fiscal year 2019;
- Impacting social determinants of health of older individuals;
- Ensuring meals can be adjusted for cultural considerations and preferences and providing medically tailored meals to the maximum extent practicable;
- Preparing, publishing, and disseminating educational materials dealing with the health and economic welfare of older individuals;
- Supporting cultural experiences, activities, and services, including in the arts; and

- Supporting participant-directed/person-centered planning for older adults and their caregivers across the spectrum of long term supports and services (LTSS), including home, community, and institutional settings.

Focus Group Deliverables

1. Zoom registration pages
2. DSHS website landing page
3. Outreach Toolkit
4. Social Media posts
5. Facilitation Guide
6. Facilitator's Training
7. Participant Guide – English
8. Participant Guide – Spanish
9. Focus Group PowerPoint Presentation
10. Focus Group Survey
11. Focus Group Themes Report
12. Operations Manual

Marketing & Outreach

The workgroup worked with ALTSA-HCS Communications team in February and March to develop an outreach toolkit (*Appendix A*) for internal and external purposes. A social media calendar was also implemented.

Zoom Registration & Set-Up

Zoom registration pages were created on 2/17and Zoom registration opened to the public on 3/7.

The Zoom meeting details, registration, branding, and Question & Answer set-up guidelines for the three focus groups were implemented as agreed upon by the workgroup. The most up-to-date banner images provided by the communication team was utilized for the Zoom branding banner. Closed captioning was enabled for all Zoom sessions.

Breakout rooms were formed prior to the start of the meetings in the administrative panel, under the "Registration" tab. The Zoom breakout rooms template for importing breakout room attendees was utilized. Individual participants were assigned at random to participate in each breakout room. Interpreters were then added to breakout rooms containing individuals who needed language accommodations. Facilitators and notetakers were also pre-assigned to these rooms. Changes in attendance during the equity focus groups were manually assigned a breakout room during the meeting.

Accommodations

Accommodations were made at all of the equity focus group meeting times. Each session had ASL interpreters available, and one session had Spanish interpreters available. Closed captioning was enabled for all Zoom sessions.

The following statement regarding accommodations was listed on every Zoom registration page:

ACCOMMODATIONS:

> Reasonable accommodations for people with disabilities are available upon request. Include a description of the accommodation you will need in your registration, including as much detail as you can. Also include a way we can contact you if we need more information. Please allow at least two weeks (14 days) advance notice. Last-minute requests will be accepted but may be impossible to fill. Send an email to heather.otten@dshs.wa.gov with requests and/or questions.

Email requests for Spanish and ASL interpreters were sent on 2/10. ASL interpreter requests were sent to Berle Ross, ALTSA-ODHH Program Manager of the Sign Language Interpreter Contracts & Resources Program. Spanish language interpreter services were sent to Linda Garcia, ALTSA-OAS Manager of ADA/LEP/Voter Registration Assistance Program.

Emails were sent at the beginning of March to the interpreter services outsourced for each event to confirm their needs and communication preferences. Two weeks prior to the focus groups, emails were sent to confirm the interpreters for each session; these individuals were added to the Zoom registration details section under "interpreters." One week prior to the focus group, the PowerPoint presentation was sent to the interpreters to assist them in preparing for the meetings. Two days prior to the focus groups, the interpreters were confirmed, and any changes made to their registration/availability were processed at that time; interpreters were also sent the Participant Guides at that time.

Interpreters were asked to sign-in up to 15 minutes prior to the meeting start time, which was often needed due to technical issues. Zoom meetings often required interpreters to re-register prior to joining the meeting. We are unsure why this issue arose during these Zoom meetings, but it is strongly suggested that all interpreters sign in 15 minutes prior in the future to ensure that this can be troubleshooted if it happens again.

Emails confirming accommodations requests were sent beginning 3/13. Confirmation emails with English and Spanish participant guides were sent on 3/28 and 3/29 to all participants.

ASL and Spanish language were determined to be most critical for the focus groups due to information from the SPA surveys sent just months prior. However, it is suggested that attempts be made to have more equity focus groups in-person and/or online with more languages and cultures represented, including the tribal populations across Washington. See *Appendix B* for a list of common languages DSHS translates into.

Language interpretation services do have fees attached, and budgets/prices should be confirmed prior to requests being sent out.

Incentives

No incentives were utilized for this equity focus group due to timing and budget. However, the workgroup has noted that future equity focus groups should strongly consider utilizing some form of incentive or payment to increase equity amongst participants.

Participant Guide

To provide for a more inclusive conversation, participant guides were sent to all participants 1 to 2 days prior to their scheduled focus group session. These forms were made fillable for ease of use. Participants were instructed that they could use these optional forms to prepare for their meetings. At the end of the focus group, participants were offered the opportunity to submit their participant guides as well as their surveys as another mechanism to provide feedback.

See *Appendices C & D* for the English and Spanish versions of the Participant Guide. Zoom meeting tips (*Appendix E*) were also created and shared as requested.

Facilitation Training & Materials

Facilitators and notetakers were chosen from various units across ALTSA. Initial email outreach to potential facilitators began on 2/13. Facilitators and notetakers were scheduled throughout the month of March based on registration numbers and were registered for their respective sessions in Zoom. Schedules were discussed with the team of facilitators and notetakers at our training on 3/22, with final roles and schedule being disseminated on 3/28 via email along with all resources/tools needed.

Facilitators and notetakers attended a training session on 3/22 to discuss roles, facilitation questions and timing, various tools, and Zoom technology logistics. Facilitators and notetakers were added to a Teams channel where schedules, facilitation guides, notetaking guides, timing guides, participant materials, and presentation PowerPoint were provided.

Facilitators and notetakers were asked to sign-in up to 15 minutes prior to the meeting start time, which was often needed due to technical issues. Zoom meetings often required facilitators and notetakers to re-register prior to joining the meeting. We are unsure why this issue arose during these Zoom meetings since it did not happen to everyone each meeting, but it is strongly suggested that all facilitators and notetakers sign in at least 15 minutes prior in the future to ensure that this can be troubleshooted if it happens again.

A meeting to celebrate the team's efforts and discuss lessons learned occurred on 3/31.

Focus Group Presentation & Facilitation Questions

The focus groups all started with a short introduction to the State Plan and our goals for the equity focus groups before dividing the participants into breakout rooms with facilitators and notetakers. *Appendix F* includes a copy of the PowerPoint presentation we utilized for the focus groups.

To facilitate ALTSA's efforts to address the State Plan's Equity Topic Areas, we facilitated dialogue with participants in regard to the following questions:

- What are the biggest needs of older adults?
- What services and programs do older adults rely on the most?
- What are the biggest challenges of older adults?
- What does it mean to live in the setting of your choice?
- What kinds of cultural supports/services do older adults need?
- What would you like to see your state or local government do to help older adults live independently?

Post-focus group survey

During the last five minutes of each focus group, we thanked our participants for their participation and provided time for them to take a quick post focus group survey. The survey can be found in *Appendix G* and a brief overview/summary of survey results can be found in *Appendix H*.

All registrants to the focus groups were contacted via email on 3/31 to thank them for their attendance and also offer one more opportunity to participate in the survey. Thirty-nine responses were gathered

from the survey, including 8 individuals who had registered but were not able to attend the focus groups for various personal reasons.

Data Review

The workgroup reviewed focus group notes provided by the notetakers for each focus group session, post-focus group survey results, and any submitted participant guides. The comments in these focus groups were then categorized by the topic area sections listed under the focus group goals in the Data Review.

Themes/Results

Primary themes and results of focus group efforts fell into the following topic areas and were included in the State Plan narrative.

Determining services needed and effectiveness of programs, policies, and services for older individuals whose needs were the focus of all centers funded under Title IV in fiscal year 2019;

The themes on this topic area focused on mobility, housing, respite, availability and location of resources, calls for intergenerational housing opportunities, and economic barriers to accessing services in low income populations.

Engagement in outreach with older individuals whose needs were the focus of all centers funded under Title IV in fiscal year 2019;

The themes on this topic area focused on availability and accessibility of resources, barriers in communication access, and requests for information to support preventative measures and early planning for transitioning into aging.

Impacting social determinants of health of older individuals;

The themes on this topic area focused on economic stability, social and community barriers, health care and quality (safety, mental health, resources, barriers, communication and access), neighborhood and the built environment (i.e. housing), and education access and quality.

Ensuring meals can be adjusted for cultural considerations and preferences and providing medically tailored meals to the maximum extent practicable;

The themes on this topic area focused on cultural considerations.

Preparing, publishing, and disseminating educational materials dealing with the health and economic welfare of older individuals;

The themes on this topic area focused on readily identifying and connecting with resources and communication access barriers particularly around resources only available online.

Supporting cultural experiences, activities, and services, including in the arts;

The themes on this topic area focused on cultural considerations, race, ethnicity, arts integration and accessibility, LGBTQ+, language supports, access to services for individuals with disabilities, and intergenerational considerations.

Serving older adults living with HIV/AIDS; and

This topic area was not discussed in the equity focus groups to protect private health information.

Supporting participant-directed/person-centered planning for older adults and their caregivers across the spectrum of LTSS, including home, community, and institutional settings.

The themes on this topic area focused on individual choice of setting, dignity, and respect.

Focus Group Timeline

- March 2022 – Workgroup meetings
- November – December 2022 – Survey
- January 2023 – Focus group planning meetings began
- 2/1/2023 – Began work with Comms team
- 2/10/2023 – Interpreter requests: Began contacting Berle & Linda
- 2/13/2023 – Facilitation requests sent out to ALTSA teammates
- 2/17/2023 – Zoom registration pages created
- 3/3/2023 – Interpreter services contracted/booked
- 3/7/2023 – Marketing outreach began
- 3/7/2023 – Focus Group registration opened
- 3/13/2023 – Accommodations confirmation emails sent to participants indicating accommodations need
- 3/13/2023 – Language interpreters confirmed for sessions
- 3/20/2023 – Facilitator Training
- 3/21/2023 – Rush request for Spanish translation of participant guides
- 3/22/2023 – PowerPoint presentations sent to interpreters
- 3/24/2023 – Participant guides translated
- 3/28/2023 – 3/29/2023 – Participant guides sent to registered participants
- 3/29/2023 – 3/30/2023 – Focus Groups
- 3/29/2023 – 4/2/2023 – Surveys
- 3/31/2023 – After Action Meeting & Celebration
- 4/17/2023 – Data Review performed
- 6/30/2023 – Operational Manual completed

Aging and Long-Term Support Administration

STATE PLAN ON AGING

EQUITY FOCUS GROUPS

Outreach Toolkit for Partners

Washington State Department of Social & Health Services

Transforming lives

dshs.wa.gov/altsa/state plan aging

Outreach Toolkit

State Plan on Aging – Equity Focus Groups 2023

Overview

ALTSA designed the toolkit to help our partners use it in their outreach efforts to encourage participation in the State Plan on Aging Focus Group. Please use the materials in this toolkit to reach the intended target audience – 60+ adults who need care, relatives or friends, caregivers, or service providers.

Need help with the toolkit? Send an email to Cynthia.shipley@dshs.wa.gov.

Outreach Toolkit

State Plan on Aging – Equity Focus Groups 2023

About the Washington State Plan on Aging - *Equity Focus Group*

Purpose:

The purpose of the focus groups is to gather feedback from older Washingtonians, their family members, caregivers, and service providers on the needs and concerns of older adults. Our goal is to hear from diverse communities with lived experience in accessing services and critical issues/needs related to aging care and services.

Every four years, the Aging and Long-Term Support Administration (ALTSA) submits a State Plan on Aging (SPA) to the U.S. Department of Health and Human Services Administration for Community Living. ALTSA develops the plan as a requirement under the Older Americans Act (OAA). More importantly, it provides the opportunity to align current services with the mission and vision of our administration and develop our future efforts by setting goals, objectives, and strategies surrounding key topic areas. This year, the SPA focuses on five priority topics:

- OAA Core Programs
- Expanding Access to Home and Community-Based Services
- Building a Caregiving Infrastructure
- COVID-19 Recovery
- Advancing Equity

The feedback collected from the focus groups will help inform the goals, objectives, and strategies for the 2023-2027 SPA.

Participants:

We are looking for 60+ adults who need care, relatives or friends, caregivers, or service providers.

Format:

The focus groups will consist of up to 50 participants and will meet virtually via Zoom. Participants may join through an online meeting link or call the designated phone number. The ALTSA Wellbeing, Improvement, and Nursing (WIN) Unit team members will facilitate the conversation, provide a brief orientation for the discussion, and then break out into small groups to discuss equity-specific questions. Co-facilitators will lead small group discussions. Participants may remain unnamed by changing their display name through the Zoom meeting settings feature.

Outreach Toolkit

State Plan on Aging – Equity Focus Groups 2023

Focus Group Details

Focus groups will be held virtually via Zoom on the following dates:

- **Mar 29, 2023, 11:00 AM (ASL interpreters available)**
  Zoom Meeting Registration
- **Mar 30, 2023, 09:00 AM (Spanish and ASL interpreters available)**
  Zoom Meeting Registration
- **Mar 30, 2023, 6:00 PM (ASL interpreters available)**
  Zoom Meeting Registration

Discussion Topics:

Facilitated topics will focus on understanding diverse communities and their lived experience in accessing services and critical issues/needs related to aging care and services.

Focus Group Sponsors and Partners:

- Aging and Long-term Support Administration, Home and Community Services Division

Other Resources:

Please reference Washington's previous State Plan on Aging; you can find additional information by reading the Guidance for Developing State Plans on Aging.

Outreach Toolkit

State Plan on Aging – Equity Focus Groups 2023

Email Message to Share with Communities

Download the Email Template.

Are you a 60+ adult? Or a relative, friend, caregiver, or service provider for an older adult who needs care?
Then ALTSA wants your feedback! Join one of the upcoming focus groups to address older adults' care needs and voice your concerns about barriers experienced or services that could improve.

Who should participate?
We are looking for 60+ adults who need care, relatives or friends, caregivers, or service providers. We aim to hear from diverse communities with lived experience in accessing services and critical issues/needs related to aging care and services.

Your participation will help us better understand your experiences. It will also help ALTSA plan services and develop the State Plan on Aging for 2023-2027.

Your participation in a focus group is voluntary. If you know someone else who would be interested in participating, please forward this email.

Focus Group Details

Focus groups will be held virtually via Zoom on the following dates:

- **Mar 29, 2023, 11:00 AM (ASL interpreters available)**
  Zoom Meeting Registration
- **Mar 30, 2023, 09:00 AM (Spanish and ASL interpreters available)**
  Zoom Meeting Registration
- **Mar 30, 2023, 6:00 PM (ASL interpreters available)**
  Zoom Meeting Registration

For more information, visit the State Plan on Aging | DSHS (wa.gov) Focus Group page. Reasonable accommodations are available upon request.

About the Washington State Plan on Aging
ALTSA develops a State Plan on Aging (SPA) every four years as mandated under the Older Americans Act. The SPA documents achievements and planned activities related to Washington state's long-term support and services planning efforts.

For more SPA information, access the 2018-2022 Washington State Plan on Aging State Plan or find additional information on the Guidance for Developing State Plans on Aging.

Outreach Toolkit

State Plan on Aging – Equity Focus Groups 2023

Social Media Content

Use the sample social media content to distribute among your social media platforms.

- **Are you a 60+ adult? Or a relative, friend, caregiver, or service provider for an older adult who needs care?** Then ALTSA wants your feedback on upcoming focus groups! We will address older adults' care needs and hear their concerns about barriers experienced or services we could improve. Registration information is available at dshs.wa.gov/altsa/state-plan-aging.
- Aging and Long-Term Support Administration (ALTSA) wants your feedback about the most critical issues facing older adults needing care—barriers, and solutions for equitable access to services and community. Sign up and share your experiences at dshs.wa.gov/altsa/state-plan-aging.
- ALTSA needs your feedback about the most critical issues facing older adults needing care—barriers and solutions for equitable access to services and community. Register in advance for a virtual focus group at dshs.wa.gov/altsa/state-plan-aging.
- ALTSA wants feedback from diverse communities with lived experience accessing services and critical issues/needs related to aging care and services. Your participation will help us build a better tomorrow. Sign up for an online focus group at dshs.wa.gov/altsa/state-plan-aging.
- ALTSA wants feedback from diverse communities with lived experience accessing services and critical issues/needs related to aging care and services. Your participation will help us build a better tomorrow. Sign up for an online focus group that fits your schedule at dshs.wa.gov/altsa/state-plan-aging.
- ALTSA wants to hear about the diverse experiences of older Washingtonians. Give us your feedback about the most critical issues facing older adults needing care—barriers and solutions for equitable access to services and community. Sign up for a virtual focus group at dshs.wa.gov/altsa/state-plan-aging.

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Outreach Toolkit

State Plan on Aging – Equity Focus Groups 2023

Social Media Graphics

Download the [State Plan on Aging Focus Group Social Media Graphics](#).

Focus Group Social Media -1

Focus Group Social Media -2

Focus Group Social Media -3

Focus Group Social Media -4

Focus Group Social Media -5

Focus Group Social Media -6

Focus Group Social Media -7

Focus Group Social Media -8

Focus Group Social Media -9

Outreach Toolkit

State Plan on Aging – Equity Focus Groups 2023

Flyers

Print, share, or post the flyers within your communities. ***[Download the State Plan on Aging Focus Group Flyers](#)***.

Outreach Toolkit

State Plan on Aging – Equity Focus Groups 2023

QR Code

When scanned by a smartphone camera, the QR Code will direct people to the Listening Sessions registration URL. ***Download the State Plan on Aging Focus Group QR Code.***

DSHS TRANSLATION GUIDANCE, Effective November 1, 2021

To align with federal guidance on providing meaningful access for clients, DSHS will regularly translate vital documents into the following languages and alternate formats to be simultaneously published with the English versions:

Note: Bold = Required

1. **Spanish**
2. **Vietnamese**
3. **Russian**
4. **Chinese (Simplified, Traditional or both)**
5. **Korean**
6. **Arabic**
7. **Khmer (Cambodian)**
8. **Ukrainian**
9. **Somali**
10. **Punjabi**
11. **Amharic**
12. **Farsi/Persian/Dari**
13. Tigrigna* (optional)
14. Tagalog* (optional)
15. **Lao**
16. **Large Print English (20pt Standard)** See Best Practices for Large Print
17. **ASL Video (Coming Soon)**

Programs may deviate from this guidance if program-specific data indicates client language needs differ from agency-wide or due to demonstrated budget limitations. For help applying this guidance contact your Language Access Advisor.

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Aging and Long-Term Support Administration
HOME AND COMMUNITY SERVICES

State Plan on Aging Equity Focus Group – Participant Guide

To help you prepare for a great conversation where your contributions are heard, we are providing you with this participant guide. Feel free to take notes about your experience prior to our focus group or use the form to gather your thoughts during the focus group breakout sessions.

Participant Info	
Your name	
What's your role?	
Zoom Date & Time	
Discussion Topics	**Optional: write your thoughts below**
What are the biggest needs of older adults?	
What services and programs do older adults rely on the most?	
What are the biggest challenges of older adults?	
What does it mean to live in the setting of your choice?	
What kinds of cultural supports/services do older adults need?	
What would you like to see your state or local government do to help older adults live independently?	

You may email this form to Heather.Otten@dshs.wa.gov after the focus group.

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Aging and Long-Term Support Administration
HOME AND COMMUNITY SERVICES

Grupo de enfoque del Plan Estatal para la Equidad en la Tercera Edad – Guía del participante

State Plan on Aging Equity Focus Group – Participant Guide

Para ayudarle a prepararse para una gran conversación, le ofrecemos una guía para el participante.

Tome notas en los espacios siguientes, antes o después de los grupos de enfoque, sobre sus experiencias, pensamientos, ideas y soluciones.

Información del participante	
Su nombre	
¿Cuál es su función?	
Fecha y hora de la sesión por Zoom	
Temas de conversación	**Opcional: escriba sus pensamientos abajo**
¿Qué significa "vivir en el entorno de su elección"?	
¿Cuáles son las principales necesidades de los adultos mayores?	
¿De qué servicios y programas dependen más los adultos mayores?	
¿Cuáles son los mayores desafíos para los adultos mayores?	
¿Qué tipos de apoyos o servicios culturales necesitan los adultos mayores?	
¿Qué le gustaría que su gobierno estatal o local haga para ayudar a los adultos mayores a vivir de manera independiente?	

Puede enviar este formulario por correo a Heather.Otten@dshs.wa.gov después del grupo de enfoque.

Washington State Department of Social & Health Services
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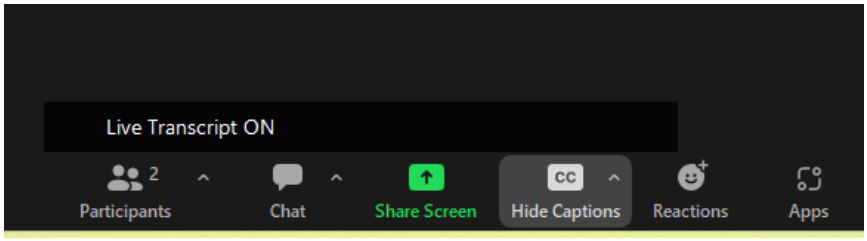
Aging and Long-Term Support Administration
HOME AND COMMUNITY SERVICES

State Plan on Aging Equity Focus Group – Meeting Tips

Turning on Closed Captioning

1) Click "Show Captions" button at the bottom of your screen and choose English.
   If you cannot find it, you may have to press the "More …" button, and then "Captions."

2) When you have enabled closed captioning, you will see this at the bottom of your screen:



ASL Interpreters

1) You can select ASL interpreters from the menu by clicking "More…" and then "Interpretation" to enable interpreter view.

2) Interpreters will also be pinned as primary speakers in the meeting.

3) However, if you have any trouble viewing the interpreters and would like to pin them for yourself, click on "Participants" at the bottom of your screen, then choose the three dots next to the interpreter's name and select "Pin" to keep their video stream visible even when others are talking.

4) During the breakout rooms, facilitators will pin ASL interpreter assigned to your breakout room so their videos are visible.

Chat Tips & Asking Questions

- You can contribute to the discussion by clicking on "Chat and typing your responses to everyone.

- You can also send a direct message to the host or co-hosts in the chat by clicking on their names and then typing your message. Please note that if a host/co-host is speaking, they will not be actively looking at the chat during their presentation, so you may want to send a chat to a different co-host.

- You may also use the Q&A button to send in a question and answers will be published to the group.

Transforming Lives

Washington State Plan on Aging Equity Focus Group

1. **Please mute yourself for the introductions.**
2. **Closed captioning and interpreters are available.**
3. **Please message a host in the chat if you have any questions.**

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Transforming lives

Welcome!

2

Introductions

Washington State Aging and Long-Term Support Administration
Home and Community Services Division

Mission
To transform lives by promoting choice, independence and safety through innovative services.

Agenda

- **Introductions**
- **Purpose of focus groups**
- **Housekeeping**
- **Background on State Plan on Aging**
- **Breakout Rooms**
- **Next Steps**
- **Survey**

Purpose of Equity Focus Group

- **Gather feedback older adults, family, caregivers, and service providers**
- **Hear from Washington's diverse communities**
- **Discuss individuals' experiences, successes, and challenges with Washington's system of long term services and supports**
- **Inform the Washington State Plan on Aging**

Housekeeping

- **Zoom guidelines**
  - Cameras & microphone
  - Chat & reactions
  - Questions & comments
- **Bio & stretch breaks**
- **Survey**

State Plan on Aging Purpose

Every four years, the Aging and Long-Term Support Administration (ALTSA) submits a State Plan on Aging (SPA) to the U.S. Department of Health and Human Services Administration for Community Living. ALTSA develops the plan as a requirement under the Older Americans Act (OAA). More importantly, it provides the opportunity to align current services with the mission and vision of our administration and develop our future efforts by setting goals, objectives, and strategies surrounding key topic areas. This year, the SPA focuses on five priority topic areas.

Washington State Plan on Aging:
https://www.dshs.wa.gov/altsa/state-plan-aging

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State Plan on Aging Topic Areas

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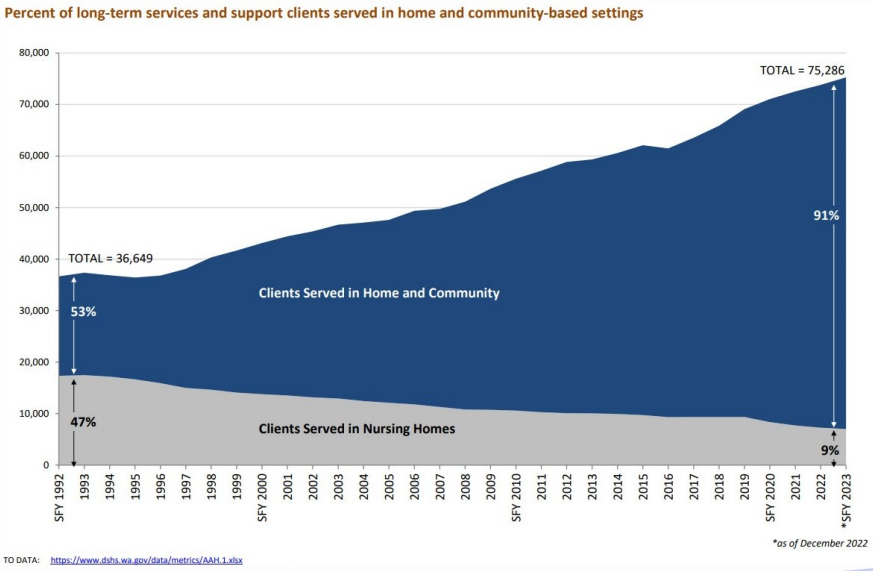
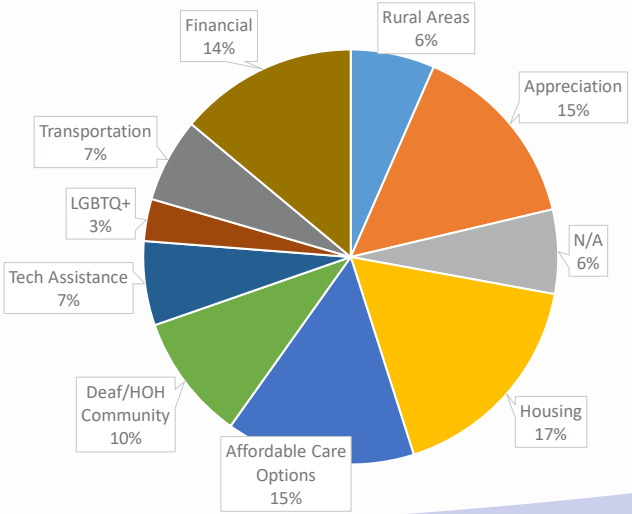
Data Trends



2022 State Plan on Aging Survey

"Please provide any other comments you may have about the needs, priorities, and access to services of older persons in Washington State."

- Top themes from responses:
  1. Housing
  2. Affordable Care Options
  3. Words of Appreciation



Ground Rules

- We are brainstorming. All solutions suggested are valid.
- Use your voice instead of chat whenever possible.
- Allow everyone the chance to speak.
- No interrupting.
- Criticize ideas, not individuals.
- Avoid blame, speculation, and inflammatory language.
- Personal information that comes up in the conversation should be kept confidential

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Discussion Topics

LIVED EXPERIENCE

LIVING IN THE SETTING OF CHOICE

ACCESS TO PROGRAMS AND SERVICES

CULTURAL CONSIDERATIONS

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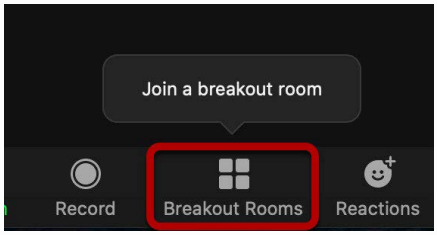
Breakout Room Instructions

1. You will be assigned to a small breakout room
2. Click the breakout room icon to take you to your small discussion room
3. Once all participants are in their breakout rooms, a facilitator will start the discussion



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Breakout Rooms

14

Welcome back!

15

Next Steps

- Complete all focus groups
- Compile feedback from focus groups and develop themes
- Incorporate themes into 2023-2027 State Plan on Aging draft
- Submit State Plan on Aging to Administration on Community Living by July 1, 2023
- State Plan on Aging takes effect on October 1, 2023

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Washington State Department of Social and Health Services

Survey

- Complete the survey in just a few minutes!
- Link: https://forms.office.com/g/91VnAh027n
- QR Code ---->
- Your survey feedback will help us to improve our processes.
- Give you an additional chance to express your ideas, suggestions, questions, concerns.
- Survey is anonymous.

Thank you!

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State Plan on Aging Equity Focus Group Survey March 2023

Please take a few minutes and provide feedback on your experience today. Your responses will be used to improve our processes and allow you a chance to provide additional feedback to be considered!

This survey is anonymous, unless you choose to share your contact information below.

Thank you!

1. Which Focus Group did you attend?

- ◯ Focus Group 1 - 3/29/2023 @ 11am
- ◯ Focus Group 2 - 3/30/2023 @ 9am
- ◯ Focus Group 3 - 3/30/2023 @ 6pm
- ◯ I couldn't attend, but want to share my thoughts.

2. Please indicate the degree to which you agree with the following statements.

	Absolutely	For the most part	Neutral	A little bit	Not at all
The focus group valued my time.	◯	◯	◯	◯	◯
The breakout rooms were engaging and created a safe, inclusive environment.	◯	◯	◯	◯	◯
I felt comfortable sharing my thoughts, ideas, and experiences with others.	◯	◯	◯	◯	◯
The discussion tools made it easier for me to contribute.	◯	◯	◯	◯	◯
I am confident that my contributions will be considered in drafting the final State Plan.	◯	◯	◯	◯	◯

3. Are there any additional barriers preventing older adults from living in the setting of their choice?

4. Are there any additional barriers preventing access to available programs or services for older adults?

5. What culturally appropriate supports or services would you like to see your state or local government provide to help older adults in your community live independently?

6. Is there anything else that you would contribute to the focus group discussion? Ideas, comments, suggestions, and concerns are all welcome here!

7. How do you describe yourself? (select all that apply)

- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Latino/Latinx/Hispanic
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White
- [ ] Not listed above (please specify in next question).
- [ ] Prefer not to answer

8. If you selected "Not listed above," please specify below:

9. Are you a veteran?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer.

10. Do you have one or more disabilities?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer.

11. What is your gender?

12. Do you think of yourself as:

- ◯ Lesbian or gay
- ◯ Straight, that is, not gay or lesbian
- ◯ Bisexual
- ◯ Not sure
- ◯ Prefer not to answer.
- ◯ Not listed above (please specify in next question).

13. Optional

    This survey is anonymous. If you prefer to share your contact information so we may contact you in the future, please provide your email below.

14. If you selected "Not listed above," please specify below:

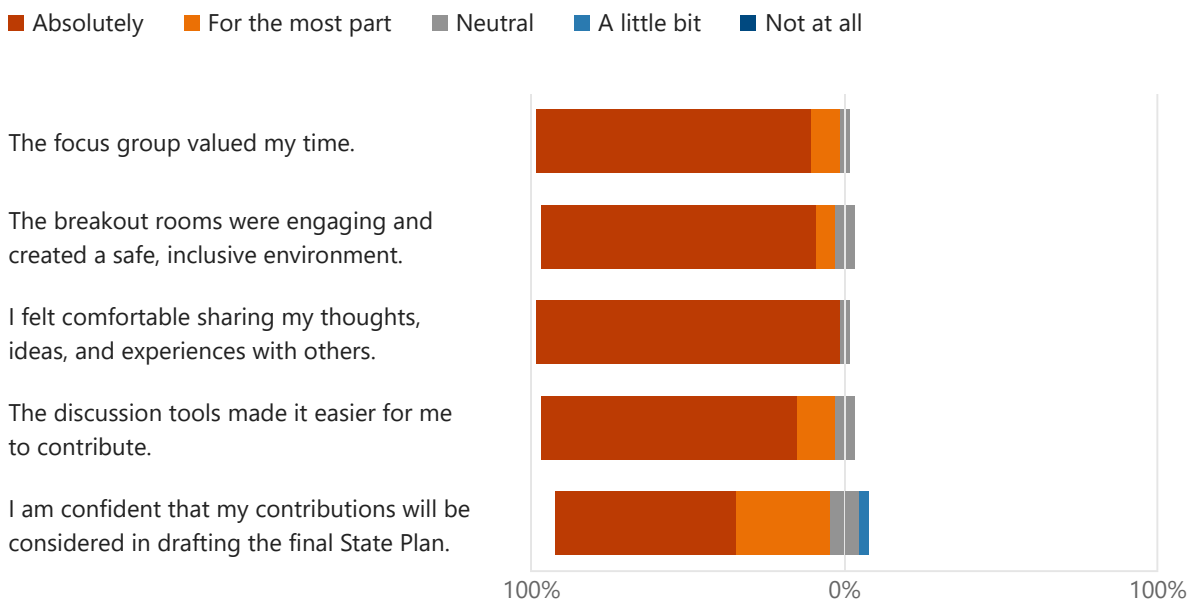
State Plan on Aging Equity Focus Group Survey March 2023

39	43:08	Active
Responses	Average time to complete	Status

1. Which Focus Group did you attend?

Focus Group 1 - 3/29/2023 @ 1...	14
Focus Group 2 - 3/30/2023 @ 9...	12
Focus Group 3 - 3/30/2023 @ 6...	4
I couldn't attend, but want to sh...	8

2. Please indicate the degree to which you agree with the following statements.



3. Are there any additional barriers preventing older adults from living in the setting of their choice?

31
Responses

Latest Responses

"Money."

"Information for older adults and their primary care physicians ...

4. Are there any additional barriers preventing access to available programs or services for older adults?

30
Responses

Latest Responses

"Adequate transportation"

"(provided to facilitator)"

"Information for older adults and their primary care physicians ...

5. What culturally appropriate supports or services would you like to see your state or local government provide to help older adults in your community live independently?

32
Responses

Latest Responses

"help with getting a driver's license and vehicle."

"(provided to facilitator)"

"religious "

6. Is there anything else that you would contribute to the focus group discussion? Ideas, comments, suggestions, and concerns are all welcome here!

24
Responses

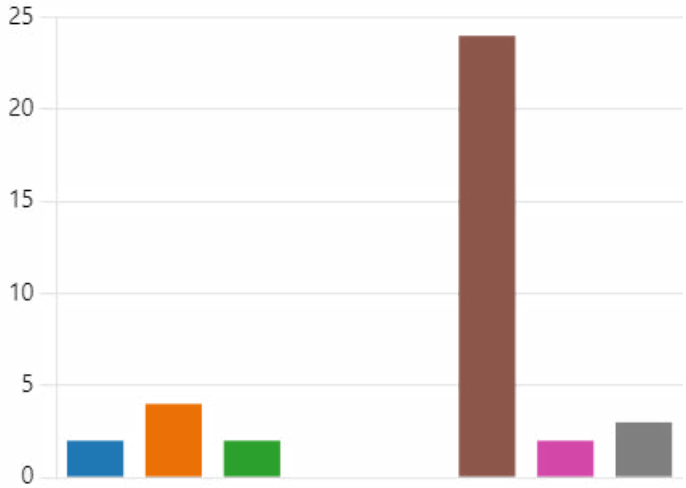
Latest Responses

"I wish there was a way to partner with senior centers to get m...

"Information for older adults and their primary care physicians ...

7. How do you describe yourself? (select all that apply)

American Indian or Alaska Native	2
Asian	4
Black or African American	2
Latino/Latinx/Hispanic	0
Native Hawaiian or Other Pacific...	0
White	24
Not listed above (please specify ...	2
Prefer not to answer	3



8. If you selected "Not listed above," please specify below:

5
Responses

Latest Responses

9. Are you a veteran?

Yes	3
No	34
Prefer not to answer.	0

10. Do you have one or more disabilities?

Yes	12
No	22
Prefer not to answer.	3

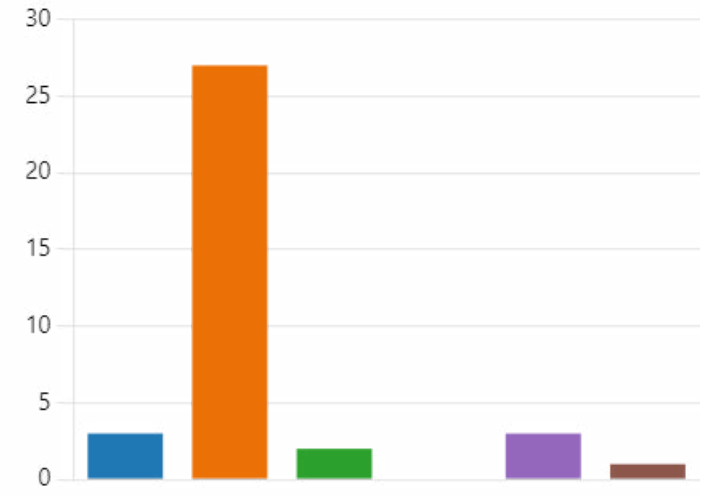
11. What is your gender?

35
Responses

Latest Responses
"*male*"
"*Female*"
"*male*"

12. Do you think of yourself as:

Lesbian or gay	3
Straight, that is, not gay or lesbi...	27
Bisexual	2
Not sure	0
Prefer not to answer.	3
Not listed above (please specify ...	1



13. Optional

This survey is anonymous. If you prefer to share your contact information so we may contact you in the future, please provide your email below.

20
Responses

Latest Responses

14. If you selected "Not listed above," please specify below:

5
Responses

Latest Responses

"*Pansexual*"

Attachment G - Washington Housing Profile

Across Washington, there is a shortage of rental homes affordable and available to extremely low income households (ELI), whose incomes are at or below the poverty guideline or 30% of their area median income (AMI). Many of these households are severely cost burdened, spending more than half of their income on housing. Severely cost burdened poor households are more likely than other renters to sacrifice other necessities like healthy food and healthcare to pay the rent, and to experience unstable housing situations like evictions.

KEY FACTS

242,726 OR 22%
Renter households that are extremely low income

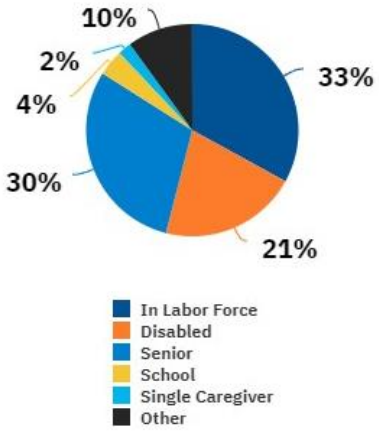
-174,821
Shortage of rental homes affordable and available for extremely low income renters

$30,900
Maximum income for 4-person extremely low income household (state level)

$75,556
Annual household income needed to afford a two-bedroom rental home at HUD's Fair Market Rent.

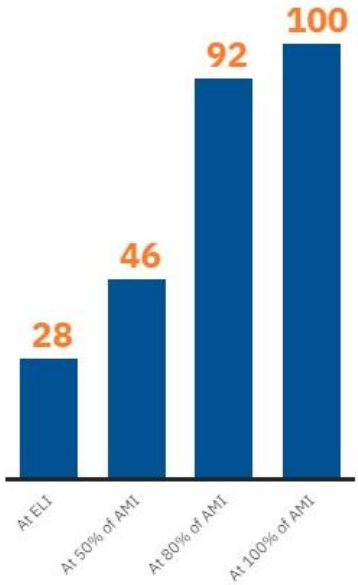
75%
Percent of extremely low income renter households with severe cost burden

EXTREMELY LOW INCOME RENTER HOUSEHOLDS



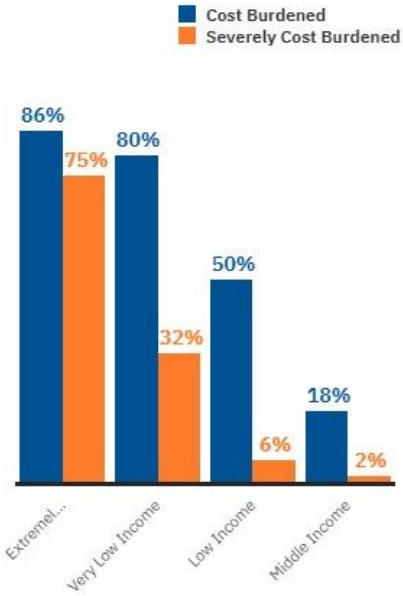
Note: Mutually exclusive categories applied in the following order: senior, disabled, in labor force, enrolled in school, single adult caregiver of a child under 7 or a person with a disability, and other. Thirteen percent of extremely low-income renter households include a single adult caregiver, 49% of whom usually work at least 20 hours per week. Ten percent of extremely low-income renter householders are enrolled in school, 47% of whom usually work at least 20 hours per week. Source: 2021 ACS PUMS
Source: 2021 ACS PUMS

AFFORDABLE AND AVAILABLE HOMES PER 100 RENTER HOUSEHOLDS



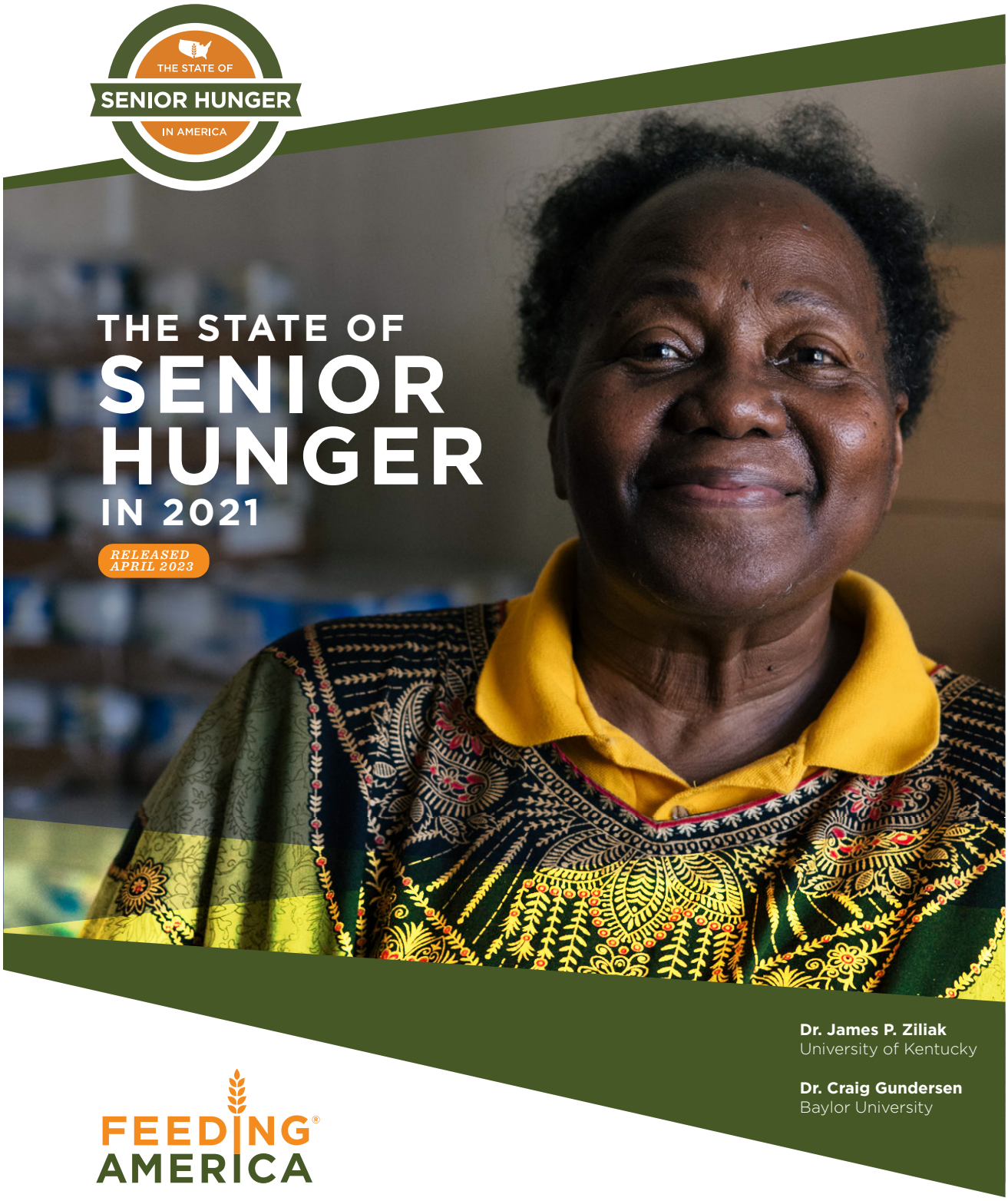
Source: NLIHC tabulations of 2021 ACS PUMS

HOUSING COST BURDEN BY INCOME GROUP



Note: Renter households spending more than 30% of their income on housing costs and utilities are cost burdened; those spending more than half of their income are severely cost burdened.
Source: NLIHC tabulations of 2021 ACS PUMS

Attachment H - Feeding America State of Senior Hunger in 2021



The State of Senior Hunger in America in 2021: An Annual Report

Prepared for Feeding America

April 26, 2023

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ACKNOWLEDGEMENTS

This report was made possible in partnership with Feeding America by a generous grant from the Enterprise Rent-A-Car Foundation. The conclusions and opinions expressed herein are our own and do not necessarily represent the views of any sponsoring agency.

EXECUTIVE SUMMARY

In this report, we provide a broad overview of the extent and distribution of food insecurity among seniors (those 60 years of age and older) in the United States in 2021, along with trends over the past two decades using national, state-level, and metropolitan-level data from the December Supplement to the Current Population Survey (CPS).

We concentrate on two measures of food insecurity: food insecurity and very low food security (VLFS). These are based on the full set of 18 questions in the Food Security Supplement (FSS), the module used by the United States Department of Agriculture (USDA) to establish the official food insecurity rates of households in the United States. We define food insecurity by three or more affirmative responses and very low food security as eight or more affirmative responses in households with children and six or more in households without children. All VLFS persons are also included in the food insecure category.

In 2021, we find that:

- Out of 78 million persons age 60 and over, 7.1% are food insecure and 2.7% are VLFS. This translates into 5.5 million and 2.1 million seniors, respectively.
- From 2020 to 2021, there was not a statistically significant change in the rate or numbers for food insecurity or VLFS.
- Compared to 2001, the fraction of food insecure and VLFS seniors increased by 35% and 90%. The number of seniors in each group rose 140%, and 239%, which also reflects the growing population of seniors.
- Continuing with historic trends documented in prior reports, we find that food insecurity is greatest among Black and Hispanic seniors, seniors with lower incomes, seniors who are younger (ages 60-69), seniors in households with someone with a disability, and seniors who are renters.
- State-level food insecurity rates range from a high of 13.4% (Louisiana) to a low of 2.8% (North Dakota).
- Metro-level food insecurity rates range from a high of 13.8% (New Orleans) to a low of 2.0% (Rochester, NY).

Unlike the population overall, senior rates of food insecurity and VLFS still have not returned to their pre-Great Recession levels, and thus millions of seniors still remain vulnerable to food hardships and the associated negative health consequences. This risk is particularly acute among those seniors experiencing VLFS, the ranks of which have especially swelled since 2001. While food insecurity did not increase dramatically in the first year of the Covid-19 health pandemic, this was likely due to the dramatic influx of resources to households in the form of stimulus payments and expansion of federal food assistance. In this report there are some hints that in the second year of Covid-19 those defenses started to crack. This was especially notable among seniors who are over age 80, who experienced the largest increase in food insecurity in 2021 since the Great Recession. In 2022 and into 2023, there were some factors going against food security among older seniors, including very large declines in equity markets, a surge in inflation, and withdrawals of some forms of federal assistance. This suggests that ongoing monitoring of food insecurity is needed to better inform policy on the well being of seniors.

I. FOOD INSECURITY IN 2021

We document the state of hunger among senior Americans ages 60 and older in 2021 using data from the most recently available Current Population Survey (CPS). This is part of a series of reports on food insecurity among seniors, which began with Ziliak et al. (2008) and has been produced annually since 2012.

In December of each year, households in the Current Population Survey (CPS) respond to a series of 18 questions (10 questions if there are no children present in the household) that make up the Food Security Supplement (FSS), the module used by the USDA to establish the official food insecurity rates of households in the United States. The CPS is a nationally representative survey conducted by the Census Bureau for the Bureau of Labor Statistics, providing employment, income and poverty statistics. Households are selected to be representative of civilian households at the state and national levels, using suitably appropriate sampling weights. The CPS does not include information on individuals living in group quarters, including nursing homes or assisted living facilities. Each question on the FSS is designed to capture some aspect of food insecurity and, for some questions, the frequency with which it manifests itself. Respondents are asked questions about their food security status in the last 30 days, as well as over the past 12 months. Following the standard approach used by the USDA, we focus on the questions referring to the past year. The questions from the FSS are found in Appendix Table 1. Because our focus is on food insecurity among those 60 and over, in 2021, this results in 19,808 sample observations. Appendix Table 2 presents selected summary statistics for the CPS sample, adjusted using the FSS survey weight to make the sample nationally representative among those over the age of 60.

Based on the full set of 18 questions in the FSS, we concentrate on two measures: food insecurity (three or more affirmative responses) and very low food security (VLFS; eight or more affirmative responses in households with children; six or more in households without). All VLFS seniors are also included in the food insecure category and, thus, VLFS seniors constitute a subset of food insecure seniors. Another measure, marginal food insecurity (one or more affirmative responses), is included in Appendix Tables 3a-e.)

In Table 1, we present estimates of food insecurity among seniors in 2021. We find that 7.1% were food insecure (5.5 million seniors) and 2.7% were VLFS (2.1 million seniors). The table also presents estimates of food insecurity across selected socioeconomic categories. Here we see great heterogeneity across the senior population. For example, for those with incomes below the poverty line, 26.4% were food insecure and 10.5% were VLFS. In contrast, for seniors with incomes greater than twice the poverty line, these numbers fall dramatically to 2.7%, and 1.0%. Turning to race, Black seniors have a food insecurity rate that is over three times higher than that of white seniors. Similarly, the food insecurity rate of Hispanic seniors (of any racial category) is just over twice the rate of non-Hispanic seniors. (In Appendix Table 4 we provide a breakdown where the race and Hispanic categories are combined.)

Table 1. The Extent of Senior Food Insecurity in 2021

	Food Insecure	Very Low Food Secure
Overall	7.1%	2.7%
By Income		
Below the Poverty Line	26.4	10.5
Between 100% and 200% of the Poverty Line	14.4	4.5
Above 200% of the Poverty Line	2.7	1.0
Income Not Reported	5.8	2.5
By Race		
Asian American, Pacific Islander, Native American, and people who identify as multi-racial	10.0	3.8
Black	17.2	6.6
White	5.6	2.1
By Hispanic Status		
Hispanic	13.8	4.5
Non-Hispanic	6.4	2.5
By Marital Status		
Divorced or Separated	13.3	5.8
Married	4.1	1.1
Never Married	13.3	5.6
Widowed	9.0	3.8
By Metropolitan Location		
Metro	7.0	2.7
Non-Metro	7.6	2.6
By Age		
60-69	8.2	3.5
70-79	6.0	2.0
80 and older	6.0	1.8
By Employment Status		
Disabled[1]	23.5	9.9
Employed	4.5	1.6
Retired	5.8	2.1
Unemployed	23.1	9.1
By Gender		
Female	7.5	2.7
Male	6.6	2.6
By Grandchild Present		
Grandchildren Present	15.0	6.3
No Grandchild Present	6.8	2.5
By Homeownership Status		
Homeowner	5.0	1.6
Renter	17.1	7.6
By Veteran Status		
Not a Veteran	7.3	2.7
Veteran	5.6	2.7
By Disability Status[2]		
With a disability	13.4	5.5
Without a disability	5.0	1.7

Source: Authors' calculations from 2021 December Current Population Survey. The numbers in the table show the rates of food insecurity under two measures for various groups.
[1]Disabled employment status means the person is out of the labor force because of a disability or other reason.
[2]Disability status refers to those with limitations on select activities of daily living.

Food insecurity among divorced or separated seniors and for never married seniors is more than three times greater than married seniors. As age increases, food insecurity rates generally fall. For example, seniors between the ages of 60 and 69 have VLFS rates that are almost twice as high as those aged 80 and older. Prior reports revealed a stronger age gradient, but as we note below there was a marked increase in food insecurity among the those over the age of 80 in 2021—a worrying development that will require monitoring. In terms of employment categories, food insecurity rates are five times higher among those who report being disabled as the reason for being out of the labor force in comparison to the employed. For VLFS the difference is over six times higher. For seniors with a grandchild present, food insecurity rates for both measures are substantially higher than when no grandchildren are present. Seniors who are renters have rates of both food insecurity and VLFS that are three to four times higher in comparison to homeowners. Non-Veteran seniors have slightly higher food insecurity rates than seniors who are Veterans. We also include a measure of disability in addition to the one tied to labor force participation noted above. This measure defines an individual as having a disability if they report any of the following limitations on activities of daily living (ADLs): hearing, visual, cognitive, ambulatory, self-care, or independent living. Seniors with limitations in ADLs have food insecurity rates over two times higher and VLFS rates over three times higher as those without limitations in ADLs.[1]

Table 1 allows us to see the proportions of persons within various categories who are food insecure, and, with this information, we can make statements about who is most in danger of being food insecure. For example, seniors with lower incomes are more likely to be food insecure than seniors with higher incomes. Also, of interest is the distribution of senior hunger. In other words, out of seniors who are food insecure, what proportion fall into a particular category? We present these results in Table 2.

As seen in Table 2, the majority of seniors in either food insecurity category have incomes above the poverty line. For example, out of those reporting income, 3 of 4 food-insecure seniors have incomes above the poverty line. A similar story holds for race—while Black seniors are at greater risk of food insecurity under either measure than white seniors, almost 2/3 of food-insecure seniors are white. Despite the lower food insecurity rates among older seniors, 13.9% of food-insecure seniors are over the age of 80; the figure is 10.8% for VLFS. And while the rates of food insecurity are below average for retired persons, they make up a large portion of both categories—50.6%, and 48.1%.

Table 2. The Distribution of Senior Food Insecurity in 2021

	Food Insecure	Very Low Food Secure
By Income		
Below the Poverty Line	30.5%	32.0%

[1] We note that those seniors who are out of the labor force due to disability likely overlap with the group reporting limitations in ADLs. The fact that their rates of food insecurity are higher than the rate overall for those with ADLs suggests that disability associated with labor force exit is likely more severe.

Between 100% and 200% of the Poverty Line	25.6	21.3
Above 200% of the Poverty Line	18.5	17.2
Income Not Reported	25.4	29.5
By Race		
Asian American, Pacific Islander, Native American, and people who identify as multi-racial	9.9	10.1
Black	25.5	26.1
White	64.6	63.8
By Hispanic Status		
Hispanic	19.0	16.6
Non-Hispanic	81.0	83.4
By Marital Status		
Divorced or Separated	28.6	32.9
Married	33.7	25.2
Never Married	15.1	16.9
Widowed	22.5	25.0
By Metropolitan Location		
Metro	82.8	84.2
Non-Metro	17.2	15.8
By Age		
60-69	58.1	64.9
70-79	28.0	24.3
80 and older	13.9	10.8
By Employment Status		
Disabled[1]	28.5	31.8
Employed	18.1	17.3
Retired	50.6	48.1
Unemployed	2.8	2.9
By Gender		
Female	57.4	55.1
Male	42.6	44.9
By Grandchild Present		
Grandchildren Present	8.0	8.8
No Grandchild Present	92.0	91.2
By Homeownership Status		
Homeowner	57.4	50.1
Renter	42.6	49.9
By Veteran Status		
Not a Veteran	89.6	87.0
Veteran	10.4	13.0
By Disability Status[2]		
With a disability	47.6	52.3
Without a disability	52.4	47.7

Source: Authors' calculations from 2021 December Current Population Survey. The numbers in the table show the distribution of food insecurity under two measures for various groups.
[1]Disabled employment status means the person is out of the labor force because of a disability or other reason.
[2]Disability status refers to those with limitations on select activities of daily living.

As seen in Tables 3 and 4, along with the accompanying figures, there is substantial geographic variation of food insecurity among seniors across states and large metropolitan areas. The range for food insecurity spans from 2.8% in North Dakota to 13.4% in Louisiana and, for VLFS, from 0.5% in New Hampshire to 4.8% in Louisiana.

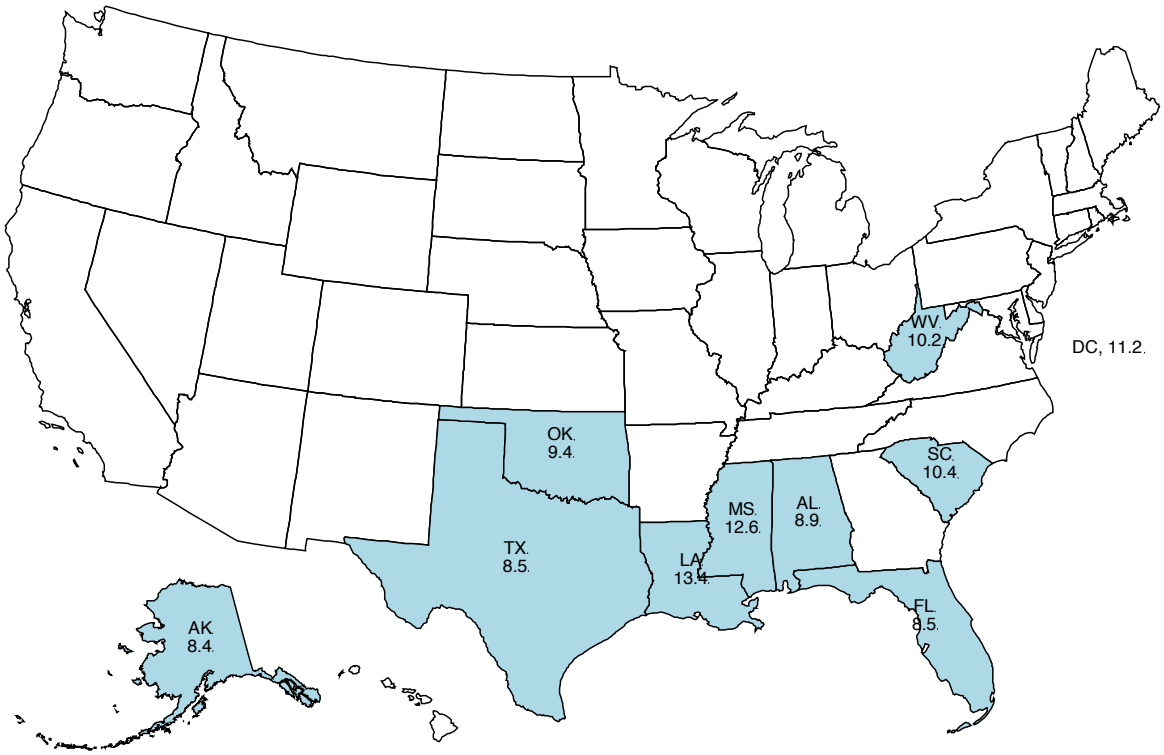
Table 3. State-Level Estimates of Senior Food Insecurity in 2021

	Food Insecure	Very Low Food Secure		Food Insecure	Very Low Food Secure
AL	8.9%	3.0%	MT	4.3%	1.9%
AK	8.4	2.3	NE	4.7	2.6
AZ	7.4	2.8	NV	4.6	1.4
AR	7.6	3.3	NH	2.9	0.5
CA	7.4	2.4	NJ	6.4	1.9
CO	7.4	2.5	NM	5.9	1.8
CT	5.5	3.2	NY	6.6	2.2
DE	6.0	2.2	NC	7.2	2.4
DC	11.2	3.2	ND	2.8	1.1
FL	8.5	3.5	OH	4.9	1.6
GA	8.0	3.2	OK	9.4	3.6
HI	3.7	1.2	OR	6.9	2.8
ID	5.4	1.5	PA	4.7	1.7
IL	7.6	3.2	RI	5.2	1.3
IN	6.4	3.2	SC	10.4	4.6
IA	4.3	0.9	SD	3.4	0.6
KS	4.6	1.5	TN	6.9	2.7
KY	6.9	3.4	TX	8.5	3.3
LA	13.4	4.8	UT	5.4	1.1
ME	4.3	1.7	VT	4.3	1.1
MD	7.2	2.9	VA	5.2	2.1
MA	6.4	3.1	WA	3.7	1.4
MI	6.0	2.7	WV	10.2	3.4
MN	3.8	1.3	WI	6.0	2.8
MS	12.6	4.5	WY	7.3	3.0
MO	7.9	3.6			

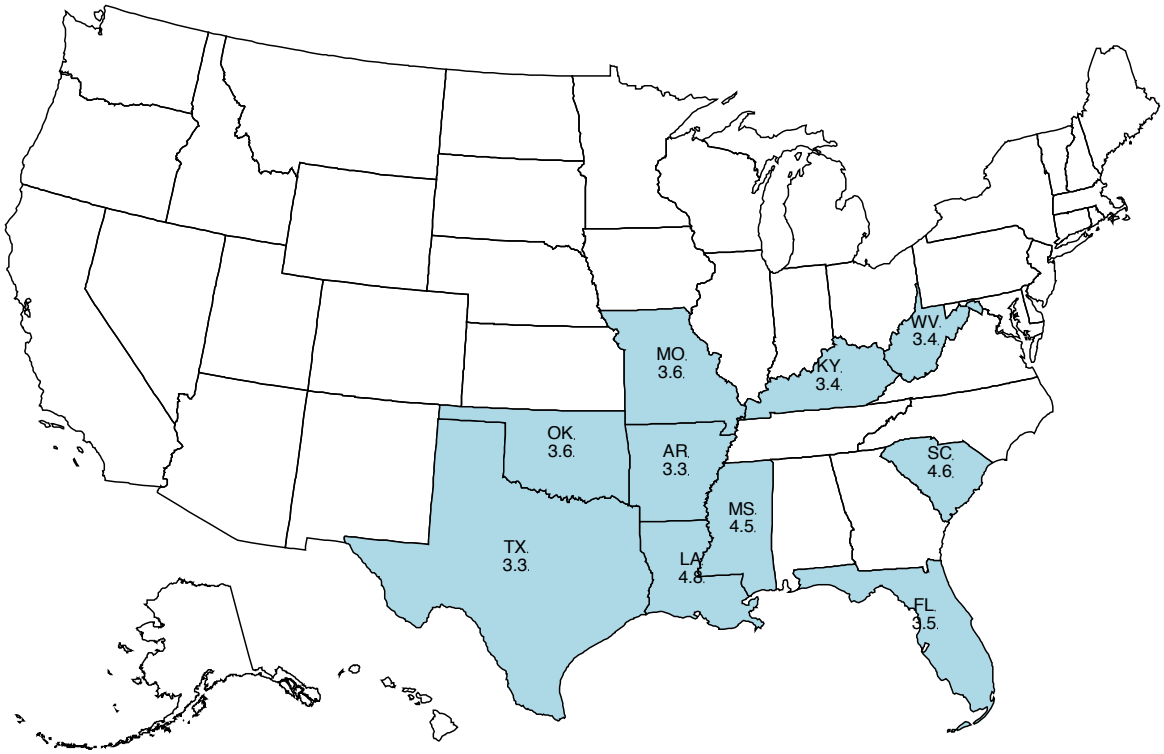
Source: Authors' calculations. The numbers are two-year averages found by summing the weighted number of food-insecure seniors in each category by state across the 2020-2021 December Current Population Surveys and dividing by the corresponding weighted total number of seniors in each state across the two years.

In the maps below we highlight the ten states with the highest rates of senior hunger in 2021. For food insecurity, all states are located in the South (with the exception of Alaska). The same holds for VFLS (with the exception of Missouri). There is some movement in the top ten classifications from one year to the next both because of changes in economic circumstances within states and variation from survey sample sizes, but overall, many of the states consistently appear. For example, seven of the ten states with the highest rates of food insecurity were on the list last year and five with the highest rates of VLFS were on the list last year.

Map 1: Top 10 States with the Highest Rates of Senior Food Insecurity in 2021



Map 2. Top 10 States for Rates of Very Low Food Security among Seniors



In Table 4 are estimates of food insecurity and VLFS rates by large metropolitan areas (i.e., more than 1 million in total population). These are based on data from 2017 to 2021. For food insecurity, the highest rate, in the New Orleans metro area, is over six times higher than the lowest rate, in Rochester, NY (13.8% versus 2.0%). For VLFS, the highest rate is, like last year, in the New Orleans metro area (5.4%) and the lowest are in San Diego and Rochester, NY (0.7%).

Table 4. Estimates of Senior Food Insecurity in Metropolitan Areas > 1,000,000 Persons in 2021

	Food Insecure	Very Low Food Secure
Atlanta-Sandy Springs-Roswell, GA	6.7%	2.3%
Austin-Round Rock, TX	6.4	2.2
Baltimore-Columbia-Towson, MD	8.6	3.8
Birmingham-Hoover, AL	8.2	3.0
Boston-Cambridge-Newton, MA-NH	6.4	2.7
Buffalo-Cheektowaga-Niagara Falls, NY	7.7	2.9
Charlotte-Concord-Gastonia, NC-SC	4.9	1.8
Chicago-Naperville-Elgin, IL-IN-WI	8.0	3.3
Cincinnati, OH-KY-IN	5.4	1.5
Cleveland-Elyria-Mentor, OH	6.5	2.6
Columbus, OH	7.1	2.5
Dallas-Fort Worth-Arlington, TX	6.7	2.2
Denver-Aurora-Lakewood, CO	8.8	3.5
Detroit-Warren-Dearborn, MI	6.7	2.6
Hartford-West Hartford-East Hartford, CT	7.0	2.1
Houston-Baytown-Sugar Land, TX	11.1	3.7
Indianapolis, IN	7.7	4.4
Jacksonville, FL	7.6	3.4
Kansas City, MO-KS	8.4	3.4
Las Vegas-Henderson-Paradise, NV	6.9	3.3
Los Angeles-Long Beach-Anaheim, CA	8.6	2.7
Louisville, KY-IN	7.2	3.1
Memphis, TN-MS-AR	10.8	3.1
Miami-Fort Lauderdale-West Palm Beach, FL	9.8	3.5
Milwaukee-Waukesha-West Allis, WI	8.3	3.9
Minneapolis-St Paul-Bloomington, MN-WI	3.0	1.4
Nashville-Davidson-Murfreesboro, TN	3.3	2.3
New Orleans-Metairie, LA	13.8	5.4
New York-Newark-Jersey City, NY-NJ-PA	7.0	2.5
Oklahoma City, OK	6.5	3.0
Orlando, FL	5.8	1.3
Philadelphia-Camden-Wilmington, PA-NJ-DE	6.0	2.0
Phoenix-Mesa-Scottsdale, AZ	6.5	2.8
Pittsburgh, PA	3.6	1.9

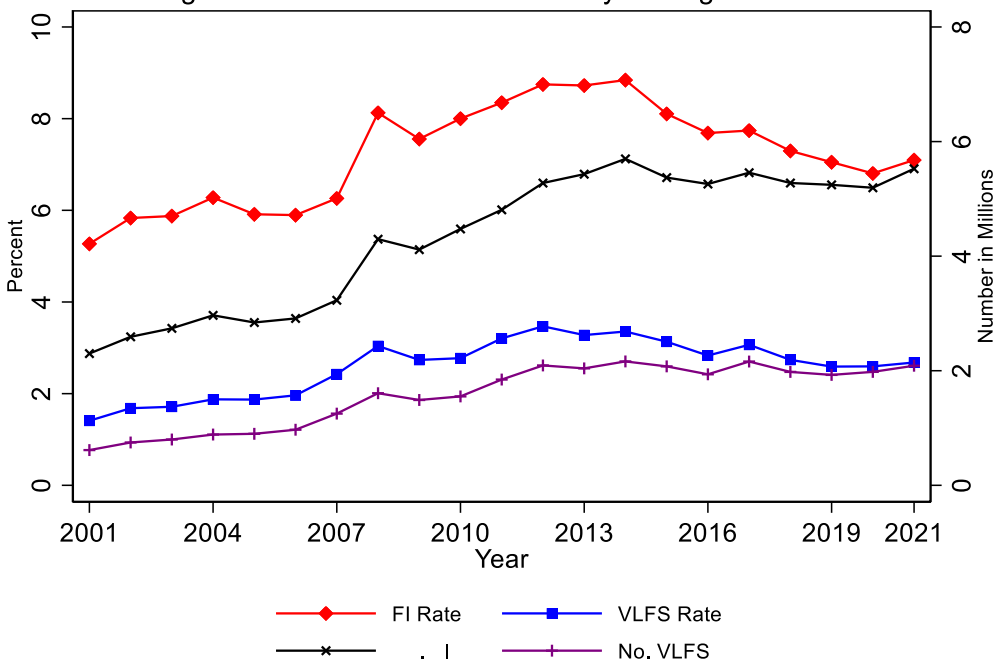
Portland-Vancouver-Hillsboro, OR-WA	4.5	2.1
Providence-Warwick, RI-MA	5.5	1.5
Raleigh, NC	10.7	3.5
Richmond, VA	4.6	1.7
Riverside-San Bernardino-Ontario, CA	7.8	2.9
Rochester, NY	2.0	0.7
Sacramento-Arden-Arcade-Roseville, CA	4.2	2.9
St. Louis, MO-IL	6.6	3.0
Salt Lake City, UT	6.0	2.4
San Antonio, TX	7.7	3.0
San Diego-Carlsbad-San Marcos, CA	4.3	0.7
San Francisco-Oakland-Fremont, CA	6.5	1.6
San Jose-Sunnyvale-Santa Clara, CA	6.8	1.5
Seattle-Tacoma-Bellevue, WA	5.0	1.3
Tampa-St. Petersburg-Clearwater, FL	7.6	3.5
Virginia Beach-Norfolk-Newport News, VA-NC	3.4	1.4
Washington-Arlington-Alexandria, DC-VA-MD-WV	5.2	2.4

Source: Authors' calculations. The numbers are five-year averages found by summing the weighted number of food-insecure seniors in each category by metro areas across the 2017-2021 December Current Population Surveys and dividing by the corresponding weighted total number of seniors in each metro area across the five years.

II. FOOD INSECURITY OVER TIME

To place the 2021 estimates into perspective, we now examine trends in food insecurity since 2001. In Figure 1, we display results in terms of the percentage of seniors (left-hand axis) and number of seniors in millions (right-hand axis). While food insecurity and VLFS increased slightly from 2020 to 2021, these changes were not statistically different from the 2020 level. However, these food insecurity rates remain stubbornly high insofar as it is still higher in 2021 than before the Great Recession that started in December 2007 (7.1% versus 6.3%). This is in contrast to the full population whose food insecurity rate in 2021 fell below that at the start of the Great Recession (10.4% versus 12.2%) as reported in Coleman-Jensen et al. (2022). This food insecurity rate for the full population is the lowest since measurement of food insecurity began. Likewise, the senior VLFS rate also slightly exceeds its 2007 level (2.7% versus 2.4%). Both rates are far higher than in 2001— the fraction of seniors experiencing food insecurity and VLFS has increased by 35%, and 90%—and the number of seniors in each group rose 140%, and 239%, reflecting both the growing number of seniors and their rising food insecurity rates.

Figure 1. Trends in Food Insecurity among Seniors



In Table 5, we take a deeper look into underlying changes in the composition of food-insecure seniors from 2020 to 2021. The table presents percentage point changes in both categories of food insecurity by the same set of socioeconomic characteristics in Table 1. Insofar as there were not statistically significant changes in food insecurity or VLFS, it is not surprising that there are not many statistically significant changes by categories either. However, there were some sizable increases in food insecurity in some groups, including among seniors who are Asian American, Pacific Islander, Native American, and people who identify as multi-racial; persons over the age of 80; homeowners; and seniors without ADL disabilities. The increase in Asian American, Pacific Islander, Native American and people who identify as multi-racial was also observed for the general population perhaps due, in part, to this increase in the senior population. For VLFS, two saw statistically significant increases – those over the age of 80 and the retired.

Table 5. Percentage Point Changes in the Composition of Senior Hunger from 2020 to 2021

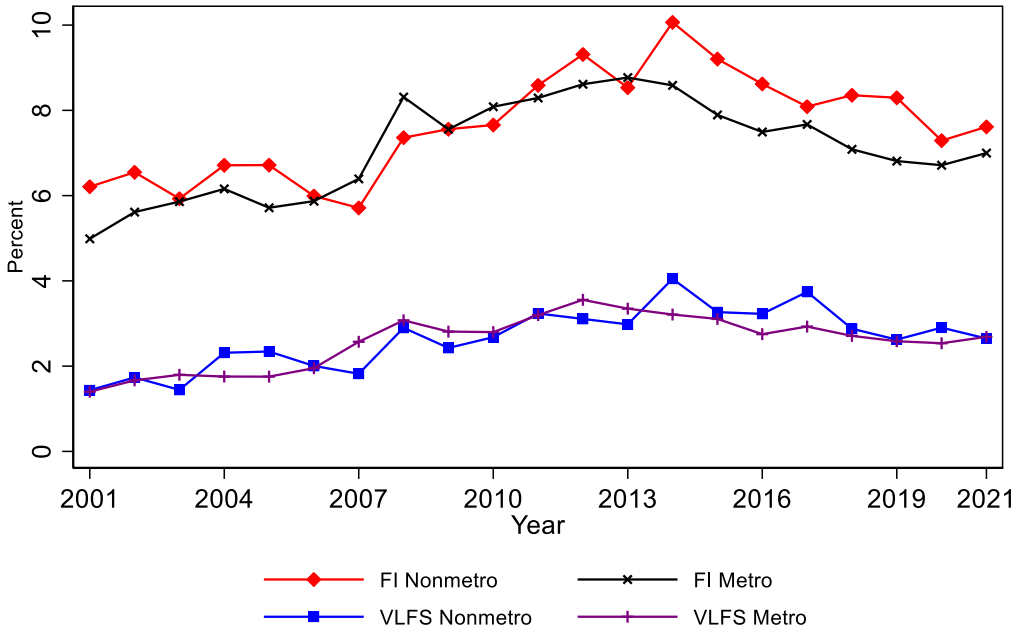
	Food Insecure	Very Low Food Secure
Overall	0.29	0.08
By Income		
Below the Poverty Line	-0.18	-1.23
Between 100% and 200% of the Poverty Line	-1.29	-0.87
Above 200% of the Poverty Line	-0.16	0.02
Income Not Reported	0.05	0.14

By Race		
Asian American, Pacific Islander, Native American, and people who identify as multi-racial	2.76**	1.03
Black	-1.89	-1.02
White	0.38	0.15
By Hispanic Status		
Hispanic	0.58	0.15
Non-Hispanic	0.24	0.07
By Marital Status		
Divorced or Separated	0.56	0.03
Married	0.09	0.06
Never Married	0.50	-0.40
Widowed	0.50	0.37
By Metropolitan Location		
Metro	0.29	0.15
Non-Metro	0.32	-0.25
By Age		
60-69	0.12	0.02
70-79	-0.02	-0.08
80 and older	1.56**	0.68*
By Employment Status		
Disabled[1]	1.94	-1.16
Employed	-0.16	-0.09
Retired	0.54	0.48**
Unemployed	2.96	0.76
By Gender		
Female	0.26	0.08
Male	0.33	0.10
By Grandchild Present		
Grandchildren Present	-2.85	-1.77
No Grandchild Present	0.49	0.19
By Homeownership Status		
Homeowner	0.52*	0.19
Renter	-1.18	-0.59
By Veteran Status		
Not a Veteran	0.21	0.07
Veteran	0.72	0.15
By Disability Status[2]		
With a disability	-0.34	-0.11
Without a disability	1.72**	0.42

Source: Authors' calculations. The numbers in the table reflect percentage point changes from 2020-2021. The asterisks denote statistical significance at the following levels: *** p<0.01; ** p<0.05; * p<0.1,
[1]Disabled employment status means the person is out of the labor force because of a disability or other reason.
[2]Disability status refers to those with limitations on select activities of daily living.

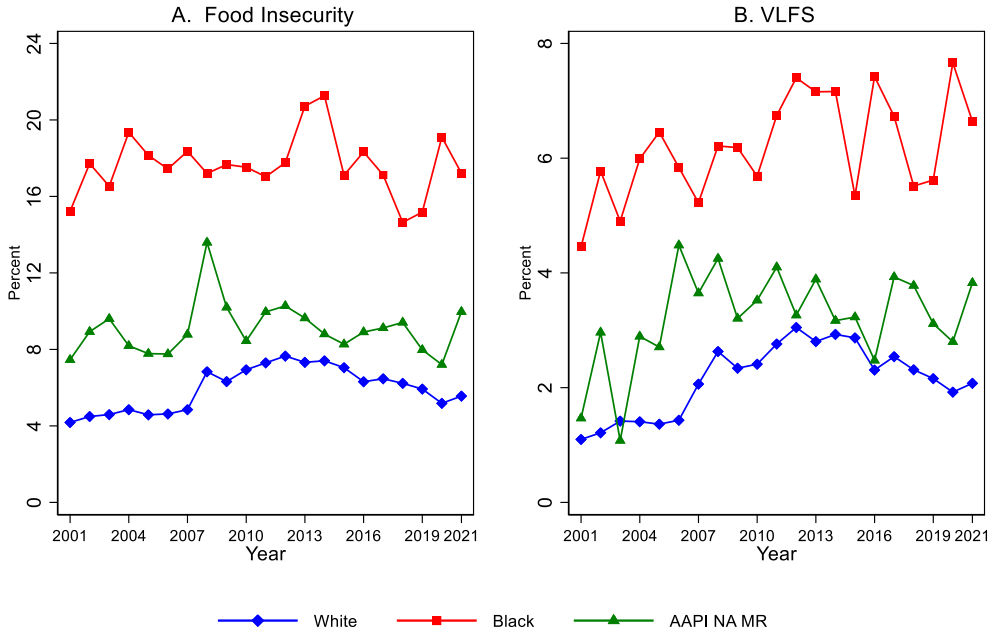
In the next set of figures, we examine trends in food insecurity since 2001 across a variety of subpopulations found in Tables 1 and 5. We begin in Figure 2 with trends in food insecurity for seniors living in metropolitan areas versus nonmetropolitan areas. The figure shows that, for most years, but not all, food insecurity rates were higher in nonmetro areas. After an increase in this gap in both 2018 and 2019, the gap fell in 2020 and 2021. For VLFS, though, whether the rates are higher or lower in nonmetro areas shows no clear pattern.

Figure 2. Trends in Food Insecurity among Seniors by Metropolitan Status



Panel A of Figure 3 depicts trends in food insecurity across different races and panel B is for VLFS. As discussed above, food insecurity and VLFS for Black seniors are much higher than for white seniors. These figures reveal that these differences were present in all years with a sharp increase in this difference in 2020. The gap diminished in 2021, albeit it is still larger than in 2019. Comparing white seniors and the Asian American, Pacific Islander, Native American, and people who identify as multi-racial, rates are higher among the latter category in all years except one for VLFS.

Figure 3. Trends in Senior Food Insecurity by Race



Note: 'AAPI NA MR' denotes Asian American, Pacific Islander, Native American, and people who identify as multi-racial

In Figure 4, we present trends broken down by Hispanic status. For food insecurity, the rates are higher among Hispanic seniors than non-Hispanic seniors in all years. The trends in VLFS are similar, with the exception of 2005. In 2007, interestingly, the VLFS rate of Hispanic seniors was higher than the food insecurity rate of non-Hispanic seniors (7.1% versus 5.6%), highlighting the impact of the Great Recession on Hispanic seniors.

Figure 4. Trends in Senior Food Insecurity by Hispanic Ethnicity

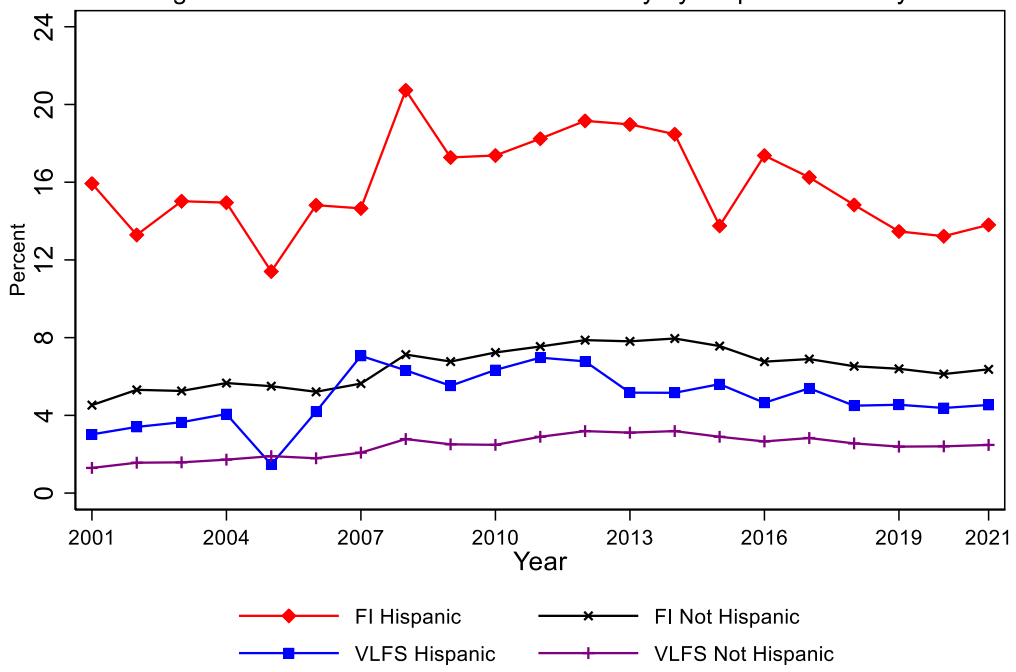
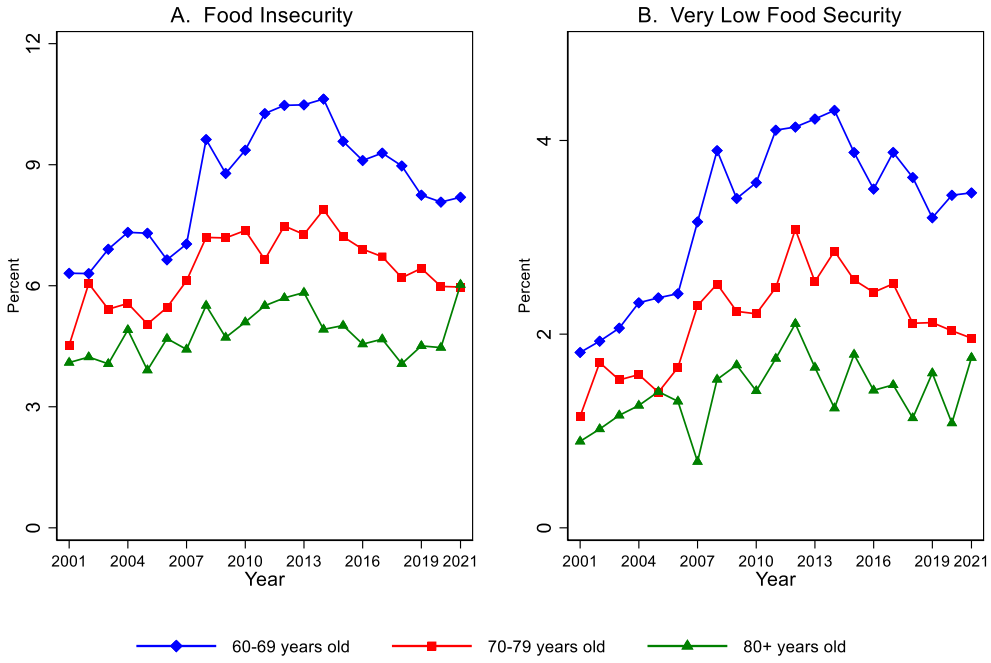


Figure 5 presents a parallel set of results for seniors broken down into three age groups – 60-69 years-old, 70-79 years old, and age 80 and older. Since reaching the highest rates ever in 2014 (2012 for VLFS for 70-79 years old), rates have declined in most years and are now substantially below 2014. In all years until 2021, these rates have been higher than for the 80+ group. This changed in 2021, though, and, for the food insecurity rates among 80+ are now higher than the 70-79 group and they are almost the same for VLFS. This is primarily due to the sharp increase among the 80+ group in 2021.

Figure 5. Trends in Senior Americans Food Insecurity by Age



III. CONCLUSION

Food insecurity among seniors in America is a continuing challenge facing the nation insofar as rates of senior food insecurity remain elevated compared to the Great Recession of 2007-2009, unlike for the general population. Given the compelling evidence in Gundersen and Ziliak (2021) that food insecurity is associated with a host of poor nutrition and health outcomes among seniors, this report implies that food insecurity among seniors will continue to lead to additional public health challenges and costs for our country (Berkowitz et al., 2017; Berkowitz et al., 2019).

It was perhaps surprising that there was not a significant increase in food insecurity in the first year of the Covid-19 health pandemic. This good fortune was likely due to the dramatic influx of resources to households in the form of stimulus payments and expansion of federal food assistance. These additional resources started to be withdrawn in 2021, and the evidence in this report hints that food insecurity among seniors started to increase. While this rise was not statistically significant compared to 2020 for the whole population of seniors, it was among some groups who traditionally are relatively protected from food insecurity; namely seniors who are retired, over age 80, and homeowners. The economic headwinds in 2022 were substantially worse, with an average decline in equity markets of about 20%, a tripling of inflation, and even further retrenchment of federal assistance for relief from Covid-19; notably the elimination of emergency assistance as part of Supplemental Nutrition Assistance Program benefits in nearly half the states. This suggests that ongoing monitoring of food insecurity will be crucial to inform policy on the well being of vulnerable seniors.

Appendix Table 1: Questions on the Food Security Supplement		
Food Insecurity Question	Asked of Households with Children	Asked of Households without Children
1. "We worried whether our food would run out before we got money to buy more." Was that **often, sometimes**, or never true for you in the last 12 months?	x	x
2. "The food that we bought just didn't last and we didn't have money to get more." Was that **often, sometimes**, or never true for you in the last 12 months?	x	x
3. "We couldn't afford to eat balanced meals." Was that **often, sometimes**, or never true for you in the last 12 months?	x	x
4. "We relied on only a few kinds of low-cost food to feed our children because we were running out of money to buy food." Was that **often, sometimes**, or never true for you in the last 12 months?	x	
5. In the last 12 months, did you or other adults in the household ever cut the size of your meals or skip meals because there wasn't enough money for food? (**Yes**/No)	x	x
6. "We couldn't feed our children a balanced meal, because we couldn't afford that." Was that **often, sometimes**, or never true for you in the last 12 months?	x	
7. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? (**Yes**/No)	x	x
8. (If yes to Question 5) How often did this happen—**almost every month, some months but not every month**, or in only 1 or 2 months?	x	x
9. "The children were not eating enough because we just couldn't afford enough food." Was that **often, sometimes**, or never true for you in the last 12 months?	x	
10. In the last 12 months, were you ever hungry, but didn't eat, because you couldn't afford enough food? (**Yes**/No)	x	x
11. In the last 12 months, did you lose weight because you didn't have enough money for food? (**Yes**/No)	x	x
12. In the last 12 months, did you ever cut the size of any of the children's meals because there wasn't enough money for food? (**Yes**/No)	x	
13. In the last 12 months did you or other adults in your household ever not eat for a whole day because there wasn't enough money for food? (**Yes**/No)	x	x
14. In the last 12 months, were the children ever hungry but you just couldn't afford more food? (**Yes**/No)	x	
15. (If yes to Question 13) How often did this happen—**almost every month, some months but not every month**, or in only 1 or 2 months?	x	x
16. In the last 12 months, did any of the children ever skip a meal because there wasn't enough money for food? (**Yes**/No)	x	
17. (If yes to Question 16) How often did this happen—**almost every month, some months but not every month**, or in only 1 or 2 months?	x	
18. In the last 12 months did any of the children ever not eat for a whole day because there wasn't enough money for food? (**Yes**/No)	x	

Notes: Responses in bold indicate an "affirmative" response.

Appendix Table 2: Selected Characteristics of Seniors Age 60 and older in 2021	
Income Categories	
Below the Poverty Line	0.08
Between 100% and 200% of the Poverty Line	0.13
Above 200% of the Poverty Line	0.48
Missing Income	0.31
Racial Categories	
Asian American, Pacific Islander, Native American, and people who identify as multi-racial	0.07
Black	0.11
White	0.82
Hispanic Status	
Hispanic	0.1
Non-Hispanic	0.9
Marital Status	
Divorced or Separated	0.15
Married	0.59
Never Married	0.08
Widowed	0.18
Metropolitan Location	
Metro	0.84
Non-Metro	0.16
Age	
60 to 69	0.5
70 to 79	0.33
80 and older	0.16
Employment Status	
Disabled[1]	0.09
Employed	0.28
Retired	0.62
Unemployed	0.01
By Gender	
Female	0.54
Male	0.46
Grandchild Present	
Grandchild Present	0.04
No Grandchild Present	0.96
By Homeownership Status	
Homeowner	0.82
Renter	0.18
By Veteran Status	
Not a Veteran	0.87
Veteran	0.13
By Disability Status	
With a disability[2]	0.25
Without a disability	0.75

Source: Authors' calculations from 2021 December Current Population Survey.
[1]Disabled employment status means the person is out of the labor force because of a disability or other reason.
[2]Disability status refers to those with limitations on select activities of daily living.

Appendix Table 3a. The Extent of Senior Marginal Food Insecurity in 2021	
Overall	12.9%
By Income	
Below the Poverty Line	43.5
Between 100% and 200% of the Poverty Line	28.3
Above 200% of the Poverty Line	5.6
Income Not Reported	9.8
By Race	
Asian American, Pacific Islander, Native American, and people who identify as multi-racial	18.0
Black	28.9
White	10.4
By Hispanic Status	
Hispanic	24.3
Non-Hispanic	11.6
By Marital Status	
Divorced or Separated	22.6
Married	8.1
Never Married	22.5
Widowed	15.9
By Metropolitan Location	
Metro	12.8
Non-Metro	13.2
By Age	
60-69	14.6
70-79	11.6
80+	10.1
By Employment Status	
Disabled[1]	35.8
Employed	8.8
Retired	11.2
Unemployed	36.2
By Gender	
Female	13.6
Male	12
By Grandchild Present	
Grandchildren Present	25.7
No Grandchild Present	12.4
By Homeownership Status	
Homeowner	9.2
Renter	29.8
By Veteran Status	
Not a Veteran	13.3
Veteran	9.9
By Disability Status[2]	
With a disability	22.5
Without a disability	9.6

Source: Authors' calculations from 2021 December Current Population Survey. The numbers in the table show the rates of food insecurity under two measures for various groups.
[1]Disabled employment status means the person is out of the labor force because of a disability or other reason.
[2]Disability status refers to those with limitations on select activities of daily living.

Appendix Table 3b. The Distribution of Senior Marginal Food Insecurity in 2021	
By Income	
Below the Poverty Line	27.8%
Between 100% and 200% of the Poverty Line	27.8
Above 200% of the Poverty Line	20.8
Income Not Reported	23.6
By Race	
Asian American, Pacific Islander, Native American, and people who identify as multi-racial	9.8
Black	23.7
White	66.5
By Hispanic Status	
Hispanic	18.5
Non-Hispanic	81.5
By Marital Status	
Divorced or Separated	26.8
Married	37.2
Never Married	14.1
Widowed	21.9
By Metropolitan Location	
Metro	83.6
Non-Metro	16.4
By Age	
60-69	57.0
70-79	30.1
80+	12.9
By Employment Status	
Disabled[1]	23.9
Employed	19.5
Retired	54.3
Unemployed	2.4
By Gender	
Female	57.4
Male	42.6
By Grandchild Present	
Grandchildren Present	7.5
No Grandchild Present	92.5
By Homeownership Status	
Homeowner	59.1
Renter	40.9
By Veteran Status	
Not a Veteran	89.9
Veteran	10.1
By Disability Status[2]	
With a disability	44.3
Without a disability	55.7

Source: Authors' calculations from 2021 December Current Population Survey. The numbers in the table show the distribution of food insecurity under two measures for various groups.

[1]Disabled employment status means the person is out of the labor force because of a disability or other reason.

[2]Disability status refers to those with limitations on select activities of daily living.

Appendix Table 3c. State-Level Estimates of Senior Marginal Food Insecurity in 2021			
AL	15.1%	MT	8.5%
AK	14.5	NE	9.4
AZ	12.1	NV	8.9
AR	14.0	NH	6.4
CA	12.5	NJ	11.7
CO	9.0	NM	12.5
CT	11.7	NY	11.8
DE	10.7	NC	12.0
DC	18.2	ND	5.6
FL	15.4	OH	10.6
GA	13.4	OK	20.9
HI	7.0	OR	12.1
ID	11.2	PA	11.1
IL	13.4	RI	10.2
IN	9.7	SC	16.1
IA	7.2	SD	9.6
KS	9.6	TN	11.3
KY	15.2	TX	14.9
LA	20.9	UT	8.9
ME	9.9	VT	8.0
MD	12.2	VA	10.2
MA	12.0	WA	8.2
MI	9.8	WV	19.3
MN	7.4	WI	10.1
MS	21.6	WY	11.2
MO	13.0		

Source: Authors' calculations. The numbers are two-year averages found by summing the number of marginally food-insecure seniors in each category by state across the 2020-2021 December Current Population Surveys and dividing by the corresponding total number of seniors in each state across the two years.

Appendix Table 3d. Estimates of Senior Marginal Food Insecurity in Metropolitan Areas > 1,000,000 Persons in 2021	
Atlanta-Sandy Springs-Roswell, GA	11.6%
Austin-Round Rock, TX	12.7
Baltimore-Columbia-Towson, MD	13.5
Birmingham-Hoover, AL	14.1
Boston-Cambridge-Newton, MA-NH	9.6
Buffalo-Cheektowaga-Niagara Falls, NY	11.2
Charlotte-Concord-Gastonia, NC-SC	10.0
Chicago-Naperville-Elgin, IL-IN-WI	14.6
Cincinnati, OH-KY-IN	10.3
Cleveland-Elyria-Mentor, OH	14.5
Columbus, OH	11.6
Dallas-Fort Worth-Arlington, TX	12.5
Denver-Aurora-Lakewood, CO	12.5
Detroit-Warren-Dearborn, MI	10.6
Hartford-West Hartford-East Hartford, CT	11.8
Houston-Baytown-Sugar Land, TX	18.3
Indianapolis, IN	10.6
Jacksonville, FL	11.5
Kansas City, MO-KS	13.0
Las Vegas-Henderson-Paradise, NV	14.1
Los Angeles-Long Beach-Anaheim, CA	14.1
Louisville, KY-IN	14.2
Memphis, TN-MS-AR	15.4
Miami-Fort Lauderdale-West Palm Beach, FL	18.9
Milwaukee-Waukesha-West Allis, WI	14.0
Minneapolis-St Paul-Bloomington, MN-WI	6.3
Nashville-Davidson-Murfreesboro, TN	7.4
New Orleans-Metairie, LA	22.2
New York-Newark-Jersey City, NY-NJ-PA	12.8
Oklahoma City, OK	15.2
Orlando, FL	12.1
Philadelphia-Camden-Wilmington, PA-NJ-DE	11.6
Phoenix-Mesa-Scottsdale, AZ	9.8
Pittsburgh, PA	10.0
Portland-Vancouver-Hillsboro, OR-WA	7.8
Providence-Warwick, RI-MA	13.3
Raleigh, NC	13.5
Richmond, VA	8.1
Riverside-San Bernardino-Ontario, CA	14.5
Rochester, NY	8.2
Sacramento-Arden-Arcade-Roseville, CA	9.9
St. Louis, MO-IL	11.8

Salt Lake City, UT	11.0
San Antonio, TX	16.7
San Diego-Carlsbad-San Marcos, CA	8.1
San Francisco-Oakland-Fremont, CA	10.5
San Jose-Sunnyvale-Santa Clara, CA	11.0
Seattle-Tacoma-Bellevue, WA	8.7
Tampa-St. Petersburg-Clearwater, FL	14.4
Virginia Beach-Norfolk-Newport News, VA-NC	6.9
Washington-Arlington-Alexandria, DC-VA-MD-WV	9.0

Source: Authors' calculations. The numbers are five-year averages found by summing the number of food-insecure seniors in each category by metro areas across the 2017-2021 December Current Population Surveys and dividing by the corresponding total number of seniors in each metro area across the five years.

Appendix Table 3e. Percentage Point Changes in the Composition of Senior Marginal Food Insecurity from 2020 to 2021	
Overall	0.93**
By Income	
Below the Poverty Line	0.03
Between 100% and 200% of the Poverty Line	0.73
Above 200% of the Poverty Line	-0.24
Income Not Reported	0.33
By Race	
Asian American, Pacific Islander, Native American, and people who identify as multi-racial	4.83***
Black	-0.51
White	0.81**
By Hispanic Status	
Hispanic	2.81
Non-Hispanic	0.70*
By Marital Status	
Divorced or Separated	2.25*
Married	0.72*
Never Married	0.89
Widowed	0.27
By Metropolitan Location	
Metro	1.24***
Non-Metro	-0.69
By Age	
60-69	0.62
70-79	1.02
80+	1.89***
By Employment Status	
Disabled[1]	2.82
Employed	-0.04
Retired	1.43***
Unemployed	7.52
By Gender	
Female	0.92*
Male	0.94*
By Grandchild Present	
Grandchildren Present	-0.30
No Grandchild Present	1.07***
By Homeownership Status	
Homeowner	0.87**
Renter	0.58
By Veteran Status	
Not a Veteran	0.92**
Veteran	0.82
By Disability Status[2]	
With a disability	-0.01
Without a disability	3.02***

Source: Authors' calculations. The numbers in the table reflect percentage point changes from 2020-2021. The asterisks denote statistical significance at the following levels: *** p<0.01; ** p<0.05; * p<0.1

[1]Disabled employment status means the person is out of the labor force because of a disability or other reason.

[2]Disability status refers to those with limitations on select activities of daily living.

Appendix Table 4. The Extent of Senior Food Insecurity in 2021 by Combined Race/Ethnicity Categories

	Food Insecure	Very Low Food Secure
Asian American, Pacific Islander, Native American, and people who identify as multi-racial, non-Hispanic	9.7	3.9
Black, non-Hispanic	17.3	6.8
Hispanic	13.8	4.5
White, non-Hispanic	4.6	1.8

Source: Authors' calculations from 2021 December Current Population Survey. The numbers in the table show the rates of food insecurity under two measures for various groups.

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Attachment I - 2023 Fact Sheet Community Living Connections

Aging and Long Term Support Administration
Washington State Department of Social and Health Services

Fact Sheet

Transforming Lives

Attachment I - Community Living Connections

Overview	Washington state's Community Living Connections (CLC) network is part of the Federal Aging and Disability Resource Center (ADRC) No Wrong Door (NWD) initiative. The CLC concept is a network of state and community organizations that coordinate to provide consumers of all ages and disabilities with seamless access to private pay and/or publicly funded long-term services and supports (LTSS) options in their local community; regardless of what program or organization they may contact or currently utilize. They do this using person-centered concepts and skills. Aging and Long-Term Support Administration (ALTSA), under the Department of Social and Health Services (DSHS), supports the statewide network through the long-standing infrastructure of Area Agencies on Aging. This work braids funding for information and access assistance services for older adults (ages 60 and over); unpaid caregivers (ages 18 years and older); unpaid kinship and grandparent caregivers; options counseling for 1115 Medicaid Alternative Care (MAC)/Tailored Supports for Older Adults (TSOA); and screening/assisting for Medicaid LTSS. CLC network partners are highly visible and trusted organizations and places where consumers can learn about and access the full range of LTSS available in the local community, and tailor these options to meet the personal preferences, goals, and health and safety needs of each consumer. Local CLC networks expand the populations served through collaborative partnerships with organizations that have expertise in providing information and access assistance to those populations. Occasionally, grant funding helps support the network to better serve individuals. As funding and staff resources allow, Area Agencies on Aging continue to build capacity through planning and development, and through the expansion and formalization of community partnerships. The COVID-19 Pandemic shifted local CLC networks' focus to supporting improved access to additional resources for those affected by the pandemic. One large focus of this work has been additional partnerships with community agencies and organizations to provide education and access to vaccines in the community. The Community Living Connections website www.waclc.org provides Washington state residents and others with information on the full range of LTSS options and how to access local, statewide, and nationwide services and supports. A toll-free number is available at 1-855-567-0252.

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2023

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Washington State Department of Social and Health Services

Fact Sheet

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Eligibility Requirements	Individuals who: Are older adults (ages 60 and over), unpaid family and kinship caregivers, legal representatives, family members and other loved ones, professionals, and the community at large. Also, persons of all ages, with a disability, from all economic circumstances (as local networks expand), and who may be veterans, who are seeking: ▪ To learn about and understand the full range of public and/or private-pay LTSS options for both present and future needs. ▪ Assistance to access LTSS options that meet their personal preferences and goals, as well as health and safety needs.
Authority	**Statutory Authority:** ▪ Older Americans Act (OAA), Titles II and IV (42U.S.C. 3032), as amended by the Older Americans Act Amendments of 2006, P.L. 109-365. (Catalog of Federal Domestic Assistance 93.048, Title IV Discretionary Projects) ▪ Title XIX of the Social Security Act (SSA), Section 1903(a)(7), CFR 433.15(b)(7), and CFR 433.15(b)(1)-(6) ▪ Senior Citizens Services Act, Chapter 74.38 RCW ▪ Prescription Drug Education For Seniors, Chapter 74.09 RCW, Section 74.09.660 ▪ State Family Caregiver Support Program (FCSP), Chapter 74.41 RCW
Rates	This service is provided at no cost to consumers.
Partners	Collaborative partnerships support high quality, responsive and accountable service delivery. Listed are just a few of our robust partnerships providing services and working toward our goal of a No Wrong Door system within the Community Living Connections as they expand across the state: Centers for Independent Living/Washington State Independent Living Council (WSILC), Brain Injury Association of WA, Statewide Health Insurance Benefit Advisors, Legal Advocacy Organizations, Veterans Services, Tribal Governments, 211s, National Alliance of Mental Health, Alzheimer's Dementia Organizations, WA State Services for the Blind, Department of Vocational Rehabilitation, and Long-Term Care Ombudsman.
Oversight	**External:** ▪ United States Department of Health and Human Services ▪ Administration for Community Living ▪ Centers for Medicare and Medicaid Services

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Washington State Department of Social and Health Services

Fact Sheet

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	Internal: ▪ Aging and Long-Term Support Administration, Home & Community Services, State Unit on Aging

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2023

Attachment J - 2023 Fact Sheet Family Caregiver Support Program

Aging and Long Term Support Administration
Washington State Department of Social and Health Services

Fact Sheet

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Attachment J - Family Caregiver Support Program

Overview	The Family Caregiver Support Program (FCSP), established in 2000, through legislative action (SHB 2454), provides needed supports and services to unpaid caregivers throughout the state. Family caregivers, totaling more than 860,000, are the backbone of our state's long-term care system. In 2001, federal funding was authorized for the National Family Caregiver Support Program (NFCSP) through Title IIIE of the Older Americans Act. Present funding is enough to serve less than 1% of Washington's caregivers. A Department of Social and Health Services Research and Data Analysis evaluation showed a statistically significant improvement in depression and burdens for participating caregivers and a delay in use of Medicaid long-term services and supports (LTSS). The COVID pandemic necessitated service delivery in new ways. With COVID funding, Area Agencies on Aging rallied to deliver meals to an increased number of family caregivers and their care receivers. The state provided increased mental health services including geriatric depression screening, care transitions, access assistance to mental health services and telephone reassurance to assist with isolation, anxiety, and depression. Hospital discharge support was provided virtually to support medication management and help with post hospitalization goals to prevent re-hospitalization. Assistive technology, durable medical equipment, face masks and other PPE and personal emergency response systems were provided to maintain safety. TCARE® is the screening and assessment tool used as it provides an objective and reliable way to assess the stress, depression and burdens of unpaid family caregivers and recommends strategies and services that can best help those caregivers to cope with their unique caregiving responsibilities. The caregiver population served through the FCSP is both a vulnerable and resilient one. Four out of five caregivers reported that the FCSP helped them understand the importance of taking care of themselves. In FFY 2021, a total 13,623 caregivers received Information and Assistance regarding long-term care and caregiver support services and/or evidence-based screening of caregiver needs. A total of 4,035 caregivers received one or more of the following services: ▪ Evidence-based assessment of caregivers' needs and care planning tailored to meet individuals' needs;

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	▪ Caregiver training and education to increase skill building and self-care, including more than three evidence-based models; ▪ Caregiver support groups (disease-specific or general); ▪ Counseling/consultation services to cope with challenges; ▪ Respite care services (in and out-of-home settings) to provide breaks; ▪ Supplemental services such as bath bars and incontinent supplies; and ▪ Health/wellness referrals to cope with depression and medical issues.
Eligibility Requirements	An eligible caregiver is a spouse, relative, or friend who has responsibility for the care of an adult with a functional disability and does not receive financial compensation for the care provided. Individuals previously eligible for this program, but now eligible for Medicaid Alternative Care (MAC) or Tailored Supports for Older Adults (TSOA) will have the option of transitioning to MAC or TSOA or remaining on FCSP.
Authority	Chapter 74.41 RCW
Budget	State Fiscal Year 22 Expenditures ($14.9M): ▪ State Family Caregiver Support Program 11.7M (78.5%) ▪ OAA Federal Funding Expenditures: $3.2 M (21.5%) Average annual cost per caregiver client: $ 1094
Rates	The 13 Area Agency on Aging (AAA) contract with a wide variety of providers, including home care agencies, adult day services, mental health therapists, educational workshop leaders, nursing homes, durable medical equipment suppliers among others. Where an established Medicaid provider rate exists (e.g. nursing homes, home care agencies, etc.) the AAAs reimburse services at that rate (unless an exception has been established). For all other services, a negotiated rate is established between the AAA and the provider.
Partners	ALTSA partners with the 13 AAAs that employ 167 licensed TCARE Assessors and other support staff, plus local community service providers.
Oversight	**External** ▪ State Auditor's Office ▪ AAAs monitor their subcontracted providers **Internal** ▪ ALTSA's Home and Community Services Division, State Unit on Aging ▪ ALTSA, Management Services Division

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Attachment K - 2023 Fact Sheet Health Homes

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Attachment K - Health Homes

Overview	The Health Home (HH) program helps to empower clients to take charge of their own health care, bridge the systems of care between providers, and identify potential gaps in care. This is accomplished through health action planning and better coordination between the client and their providers using Care Coordinators (CC). Clients receiving HH services are assigned a CC who will partner with them, their families, and providers to ensure coordination across systems of care. The primary role of a Health Home Care Coordinator is to make in-person visits with the client to develop a Health Action Plan that is person-centered. The state contracts with designated Health Home Lead Entities to provide Health Home services directly, or through contracted Care Coordination Organizations. These organizations hire qualified Care Coordinators who must complete required Health Home training. Health Home benefits are available to Medicaid eligible (and dual eligible) individuals who meet certain eligibility criteria. The six services provided by Health Home Care Coordinators are: • Comprehensive care management • Care coordination • Health promotion • Comprehensive transitional care and follow-up • Individual and family support • Referral to community and social support services Medicaid eligible clients enrolled in both Apple Health and Medicare are known as “dual eligible clients”, and many are eligible to participate in Washington’s Health Home demonstration project approved by the Centers for Medicare & Medicaid Services (CMS). New analysis from CMS shows the Health Home demonstration has saved the Medicare program more than $293 million over six years through better care coordination while transforming the lives of thousands of Washingtonians.

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Eligibility Requirements	Medicaid beneficiaries of all ages are eligible for Health Home services if they: • Are on active Medicaid, includes dually eligible (Medicaid and Medicare); and • Have one identified chronic condition; and • At risk for a second chronic condition (**P**redictive **R**isk **I**ntelligence Syste**M** (PRISM) score of 1.5 or higher)
Authority	State Plan Amendment Final Demonstration Agreement
Fee for Service Rates	For each client service the following rates will be paid: • When Initial engagement, and Health Action Plan is completed (one time): $870.38 • Intensive HH Care Coordination: per Participant per Month: $244.60 • Low-Level HH Care Coordination: per Participant per Month: $ 200.94 Note: Apple Health managed care services may have a modified rate structure
Shared Savings	• Total shared savings to date = $87.3 million • Total Medicare savings = $293 million
Oversight	**External** • Centers for Medicare and Medicaid Services **Internal** • Department of Social and Health Services • Health Care Authority

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Attachment L - 2023 Fact Sheet High School

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Attachment L - High School Home Care Aide (HS HCA) Course Fact Sheet

Overview	The High School Home Aide (HS-HCA) course, a collaboration between Washington State **Department of Social and Health Services** (DSHS) and **Office of Superintendent of Public Instruction** (OSPI), is designed to prepare students for employment as a home care aide while earning credits toward high school graduation. The content of this course includes, but is not limited to, person-centered caregiving, safety habits, mobility, and client rights. Using the academic foundation of medical terminology and knowledge of the life sciences, they will demonstrate technical skill competency in real-life caregiving situations. The program criteria are dictated by DSHS Home Care Aide (HCA) program requirements and OSPI's National Healthcare Foundation Standards and Accountability Criteria. For secondary high school programs, the 90-hour course covers the core foundational knowledge and skills for Health Science-National Healthcare Foundation Standards from the National Consortium for Health Science Education as well as DSHS requirements. These standards are the critical knowledge and skills that students should demonstrate to be successful in the home and health care industries. Once students display evidence of competency in a classroom laboratory setting, they may participate in a practicum experience, learning under the supervision of a home care professional. This supervisor will provide mentorship in an adult family home or assisted living facility demonstrating person-centered care of clients while students analyze and synthesize information to solve problems, make decisions, and record information in the form of charts, graphs, and reports. Alternatively, this practicum may consist of job shadowing, practice interviews, and attending facility marketing or recruiting events. From this training, students may sit for a proctored test that, if passed, will allow them to apply for licensure with the Washington State Department of Health (DOH) and have a work-ready credential (must be 18 in order to work).

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Eligibility Requirements	**Requirements to be a Home Care Aide** To **work** as a paid home care aide, individuals must: • Be at least 18 years of age • Pass a background check • Complete the home care aide training • Pass skills and knowledge testing • Apply for and retain a home care aide credential (issued by WA State Department of Health) **Requirements to offer the High School Home Care Aide course** To offer the High School Home Care Aide course, schools must: • Hire an instructor who meets both DSHS requirements for High School Instructors and OSPI requirements for the Career and Technical Education (CTE) certificate • Provide a suitable training location that accommodates the necessary equipment and meets safety and square footage requirements • Provide the equipment and supplies required to teach the course content • Submit a DSHS contract to deliver training
Partners	Office of Superintendent of Public Instruction Department of Health Prometric
Oversight	**Internal** Aging and Long-Term Support Administration/Home and Community Services Division/TCWD (Training, Communications, and Workforce Development)

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Attachment M - 2023 Kinship Caregivers Support Program

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Attachment M - Kinship Caregivers Support Program

Overview	The Kinship Caregivers Support Program (KCSP), authorized by the Washington State Legislature in 2004, covers the cost of urgent needs incurred by grandparents or other relatives (kinship caregivers) who are raising children whose parents are unable to care for them. Basic needs—clothing, rent, and fuel, for example—are the most frequent service requests. The KCSP can be accessed in every county in Washington. The KCSP staff confirm that alternate payment sources have been exhausted prior to authorizing kinship caregiver financial support. For other needs, staff also refer caregivers to the available Kinship Navigator Program who can provide information regarding other local and state resources. The relatives who apply for the program have very high financial needs and support is needed to make ends meet. About 72% of the caregivers served have incomes below 100% of the federal poverty level. For every child in the formal child welfare system, there are an estimated 19 children living with their relative caregivers informally. Children with relatives have significantly better outcomes than those in the formal system. In 2021, the KCSP served a total of 1,014 kinship caregivers who were raising 1,607 children. The ethnic/racial make-up of the kinship caregivers served included: 59% White/Non-Hispanic, 13.67% African American/Black, 11% Hispanic, 8% American Indian/Alaskan Native and 1.4% Asian, Native Hawaiian/Pacific Islander. About 63% of the KCSP funding supports basic necessities of the children (e.g., beds, food, clothing), about 29% of the funding supports housing needs (e.g., rent, utilities) and 8% supports needs such as transportation. To address challenges during the COVID epidemic, Kinship programs throughout the state were able to offer electronic forms of service delivery to assist families and address their needs.
Eligibility Requirements	An individual who is a grandparent or other relative: ▪ Raising a child age 18 or younger; ▪ At risk of not being able to continue kinship caregiving without additional financial support services; and ▪ Raising a child who does not have an open case in the child welfare system.
Authority	ESHB 2459, Section 206, Chapter 276, Laws of 2004

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Budget	▪ SFY23 Budget: $1.3M
Rates	The Area Agencies on Aging (AAA) either directly provide the KCSP service or contract it out to a community organization, such as a child or family service agency. Each organization administering the program reimburses eligible businesses based on approved costs (e.g., utilities, beds, clothing and supplies, housing, etc.) determined to meet the specific need(s) of each kinship care family within established program limitations.
Partners	▪ Each of the 13 AAAs and their subcontracted community service organizations and Kinship Navigators ▪ Department of Children, Youth and Family Services ▪ Washington State Kinship Care Oversight Committee
Oversight	**External:** ▪ AAAs are responsible for monitoring their community subcontracted agencies. **Internal:** ▪ ALTSA State Unit on Aging Kinship Program Manager ▪ ALTSA AAA Specialists ▪ ALTSA Management Services Division
Examples of How KCSP Helps Kinship Care Families	A Kinship Navigator staff member tells about working with a grandmother we will call Kim. Kim is raising her two granddaughters who are eight and ten years old. Kim has taken care of these two granddaughters off and on since they were born due to heavy drug use by both parents. The father showed up on this grandmother's door one winter night with the girls in a double stroller with a blanket wrapped around them. Their mother, Kim's daughter, had taken off a week before; the father, who could not take care of the girls, abandoned them. Kim is on social security, and KCSP funding is desperately needed. The Kinship Specialist used the KCSP funding at Walmart to purchase clothes, shoes, boots, personal items, backpacks, OTC meds, as well laundry detergent and cleaning supplies. Because Kim's microwave is no longer working, the Navigator also purchased a new microwave for the girls so they can cook/heat up meals. As a result of KCSP funding, this family will have stability and be able to thrive. In addition, the Specialist also referred the family to Serve Wenatchee, Salvation Army, and The Hope chest and provided four buckets of emergency food to this family that will provide up to one month of meals for each family member in an event of an emergency. Without the assistance of KCSP funding, this family would be struggling and would have to go without the essential needs which are so very important for the growth and wellbeing of the children. Kim is very grateful for the KCSP funding as well as referrals to community services through the KCSP program. The trained Kinship Specialist says that unfortunately the family need depicted in this story is typical of the grandparents with whom she works—but so is the happy ending possible with help from KCSP funding.

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Attachment N - 2023 Kinship Caregivers Support Program

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Attachment N - Kinship Navigator Program

Overview	The **Kinship Navigator Program (KNP),** authorized by the Washington State Legislature in 2005, serves grandparents and other relatives (kinship caregivers) who are raising children because their parents are unable to do so. Kinship Navigators provide services in 30 counties. **Tribal Kinship Navigator Program** was funded in 2016 enabling eight Tribes to begin implementing services to meet the specific needs of their kinship caregivers. Kinship Navigators serve as a one-stop shop; providing resources, assistance, problem solving and emotional support to kinship caregivers who are overwhelmed and do not know where to turn for support. Caregivers regularly need help to apply for state and federal benefits and to learn what services are available related to financial needs, health care, educational advocacy, counseling, legal and other needs. Kinship Navigators also assist these families to locate housing, connect to local support groups, apply for urgent need funds and act as advocates. This critical service helps relatives establish and maintain greater self-sufficiency and stability for the children they are caring for, typically outside the formal child welfare system. For every child in foster care, there are 19 children living with their kinship caregivers. Area Agencies on Aging (AAA) and tribes administer programs where staff either deliver the service directly or contract with local community service agencies. Three AAAs are piloting a first in the nation case management model for informal kinship caregivers. DSHS hopes to achieve evidence based status in 2024, unlocking new federal funding to leverage state funds. In 2021, the KNP served a total of 1,054 caregivers and to 1,607 children through 7,931 navigator assistance contacts. Through the Tribal KNP, a total of 515 kinship caregivers and 811children received a total of 3,558 tribal navigator assistance contacts.
Eligibility Requirements	Kinship caregivers who are raising a child(ren) and are in need of resources, services and support.

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Authority	The Kinship Navigator Program was created by ESSB 6090, Chapter 518, Section 206, Laws of 2005. The Tribal Kinship Navigator Program was created by ESHB 2376, Chapter 36, Laws of 2016.
Budget	▪ FY23 KNP Budget: $662,000 ▪ FY23 Tribal KNP Budget: $400,000
Rates	▪ Nine AAAs manage a KNP with a budget to partially support either a full or part-time Kinship Navigator staff person. ▪ Each of the seven Tribes are allocated $50,000-$58,333 per year.
Partners	▪ AAAs ▪ Community service organizations providing kinship care support ▪ DSHS Economic Services Administration ▪ Department of Children, Youth, and Families ▪ DSHS Office of Indian Policy Washington State Kinship Care Oversight Committee
Oversight	**External** ▪ The AAAs are responsible for monitoring their subcontracted community agencies. ALTSA and the DSHS Office of Indian Policy monitors the Tribes. **Internal** ALTSA: Home and Community Services Division, State Unit on Aging and Management Services Division
Examples of program success	▪ A Kinship Navigator staff member shares about working with a tribal elder who lost their home in a fire. They lost everything and were in dire need. The tribal kinship navigator assisted this family as a prevention measure to keep the family together. The family was initially provided with emergency food/hygiene basket and then they were assisted with food, clothing, and hygiene supplies. ▪ Another Kinship Navigator staff member received a call from a distraught caregiver taking care of her three grandchildren. The caregiver lived in a home in need of repair, but one that she owns and desperately did not want to leave. She lived on a fixed income of $1,000 a month and raises three school aged children. She had been unable to pay her property taxes for over three years. The caregiver was told that her home would be sold if she could not pay the County over $4,400. The Kinship Navigator Program spearheaded collaboration with several non-profit agencies and a local credit union to supplement the resources of the Kinship Navigator Program. Together we were able to stop the auction of her home. This

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…success continued…	grandmother would not have been able to find an alternative place to live with such limited income. She may have become homeless and unable to care for her grandchildren. There are no other relatives that could step up to care for the girls and both parents are in legal trouble and using drugs. The family was able to stay in the home, the girls were able to stay with their grandmother and they were able to stay in their home school and not be uprooted. Stability is as crucial for kinship children as it is for foster children. We know that children do better with relatives and when they are not uprooted. Every day, the oldest grandchild would come home from school and ask grandma, "Can we stay in our home?" Children should be able to focus on school and not where they are going to live. Thanks to the help of the Kinship Navigator and community allies, they can stay put. ▪ A grandma and her grandson came to Washington from out of state. They could never get enough money together to move into permanent housing and were living in unsafe motels. The cost of the motels was preventing them from gathering enough money to be able to get stable housing. Grandma was very concerned with the unsafe environment of the motels. Through kinship navigator services, she was able to get resources to pay the first month's rent and deposit to they could gain stable living arrangements. The navigator was also able help find resources to help the family go back to their previous out of state home and gather up their belongings and bring them to Washington. Without the support of a kinship navigator, they would have been stuck in a cycle of motel living and exposure to dangerous situations.

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Attachment O - 2023 Fact Sheet Medicaid Alternative Care and Tailored Supports for Older Adults

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Attachment O - Medicaid Transformation Waiver– Initiative 2
Medicaid Alternative Care (MAC)
Tailored Supports for Older Adults (TSOA)

Overview	Washington has achieved a rebalanced system where individuals have a community care entitlement for Long-Term Services and Supports (LTSS). Our LTSS system has earned the ranking of second in the nation by AARP for its high performance in supporting seniors, adults with disabilities and their family caregivers. Washington is building on the successes of our current system and creating a "next generation" system of care focused on outcomes, supporting families in caring for loved ones, delaying or avoiding the need for more intensive Medicaid-funded LTSS where possible, creating better linkages to a reformed healthcare system and continuing its commitment to a robust Medicaid LTSS system for those that need it. Initiative 2 of the Medicaid Transformation Waiver allows the Department to test new and innovative approaches to providing LTSS using two programs, Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA). MAC creates a benefit package for individuals who are eligible for Medicaid but choose not to access traditional Medicaid-funded long-term services and supports (LTSS). TSOA creates a new eligibility category and benefit package for individuals at risk of future need for Medicaid LTSS but who currently do not meet Medicaid financial eligibility criteria. Both MAC and TSOA support dyads, which is the term used to define the combination of a care receiver and an unpaid family caregiver. In addition to dyads, TSOA provides supports to a care receiver who does not have an unpaid family caregiver available. Both TSOA and MAC programs are mirrored after the state-funded Family Caregiver Support Program (FCSP) which was established in the year 2000. Research demonstrates that it is critical to understand how a caregiver is feeling about their role in order to better tailor support to their individual needs. The FCSP has shown

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	that the majority of caregivers (84%) show significant improvements on key outcomes when their stresses and burdens are addressed. The MAC and TSOA programs were implemented in September 2017. As of March 31, 2022, ALTSA has served over 13,000 people in these two programs.
Eligibility Requirements	**MAC eligibility:** Care Receiver (client) must meet all of the following criteria: ▪ Be age 55 or older; ▪ Currently receiving categorically needy (CN) or alternative benefit plan (ABP) Medicaid coverage group (Apple Health); ▪ Meets nursing facility level of care (NFLOC) but has chosen not to receive Medicaid long-term services and supports through the state's other programs; ▪ Resides in their own home or a family member's home; and ▪ Has an unpaid family caregiver who is age 18 or older. **TSOA eligibility:** Care Receiver (client) must meet all of the following criteria: ▪ Be age 55 or older; ▪ Be a U.S. citizen or have eligible immigrant status; ▪ Not currently eligible for categorically needy (CN) or alternative benefit plan (ABP) Medicaid coverage group (Apple Health); ▪ Meets nursing facility level of care (NFLOC); ▪ Meets financial requirements: o Income up to 300% of the Supplemental Security Income (SSI) Federal Benefit Rate (as of 1/2022, $2523/month) o Has countable resources below $53,100 for a single or $112,990 for a married couple; and ▪ Has an unpaid family caregiver who is age 18 or older; or ▪ Does not have an unpaid family caregiver available. An unpaid family caregiver is a spouse, relative, or friend who has responsibility for the care of an adult with a functional disability and does not receive financial compensation for the care provided.
Authority	This is a federal Centers for Medicare and Medicaid Services (CMS) 1115 demonstration waiver. An 1115 waiver allows the state to "waive" certain Medicaid requirements in order to test innovative, sustainable and systematic changes that will help improve the overall health of Washingtonians. During the six years of the waiver, the state must demonstrate that it will not spend more federal dollars on its Medicaid program than it would have spent without the waiver. Chapter 74.39 RCW and WAC 388-106-1900 through 1990.
Budget	The total budget for the six-year demonstration period (January 2017 to December 2021) is $163.2M.

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Rates	The 13 statewide Area Agencies on Aging (AAA) contract with a wide variety of providers, including home care agencies, adult day services, mental health therapists, educational workshop leaders, nursing homes, adult family homes, assistive technology and equipment suppliers, among others. Where an established Medicaid provider rate exists (e.g., nursing homes, home care agencies, etc.) the AAAs reimburse services at that rate (unless an exception has been established). For all other services, a negotiated rate is established between the AAA and the provider.
Partners	Area Agencies on Aging Health Care Authority Centers for Medicare and Medicaid Services
Oversight	**External** ▪ Centers for Medicare and Medicaid Services ▪ Health Care Authority ▪ State Auditor's Office **Internal** ▪ Home and Community Services Division Quality Assurance Unit monitoring ▪ Area Agency on Aging monitoring

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Attachment P - 2023 Fact Sheet Plan to on Alzheimer's Disease and Other Dementias

Aging and Long Term Support Administration
Washington State Department of Social and Health Services

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Attachment P –
A State Plan to Address Alzheimer's Disease and Other Dementias

Overview	Alzheimer's disease is the third leading age-adjusted cause of death in Washington state. While death rates of cancer, stroke and heart disease have declined, the death rate for Alzheimer's is on the rise. In 2020, about 120,000 people in Washington had Alzheimer's or other dementias. By 2025, that number is expected to be over 140,000. Implementing a state plan, particularly one that coordinates across sectors, is an opportunity for Washington state to improve quality of care, create efficiencies and potentially impact the trajectory of the illness itself as we strive to achieve better health outcomes.
Eligibility Requirements	The plan targets persons who may be at risk of developing dementia and individuals and families living with memory loss, Alzheimer's disease, or other dementias.
Authority	In March 2014, Substitute Senate Bill 6124 charged the Department of Social and Health Services (DSHS) to convene a prescribed membership for an Alzheimer's Disease Working Group (ADWG) to develop a Washington State Plan to address Alzheimer's disease. This work resulted in the first Washington State Plan to Address Alzheimer's Disease and Other Dementias (Jan 2016). The Washington state plan has 7 high-level goals. Each goal identifies strategies and recommendations to move towards these goals. The comprehensive and complex nature of this implementation work requires a phased approach. The plan identifies varied timeframes for each of the many recommendations. The high-level goals are to: 1. Increase public awareness, engagement and education; 2. Prepare communities for significant growth in dementia population; 3. Ensure well-being and safety of people living with dementia and their family caregivers; 4. Ensure access to comprehensive supports for family caregivers; 5. Identify dementia early and provide dementia-capable, evidence-based health care; 6. Ensure dementia-capable services and supports are available in the setting of choice; 7. Promote innovation and research for causes of and effective interventions for dementia.

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	The plan's implementation, including action planning, next steps, and policy changes, depends upon the ongoing participation and contributions of a broad group of committed partners. That is why the plan implementation is envisioned as a public-private partnership and called for the formation of a next generation workgroup to implement the recommendations. In 2016, this group became the Dementia Action Collaborative (DAC), a voluntary, statewide collaboration of organizations and individuals committed to preparing our state for the future. The Assistant Secretary of Aging and Long-Term Support Administration (ALTSA), has acted as Chairperson of the DAC, which includes a range of members – people living with dementia, family caregivers, advocates, aging network providers, Alzheimer's organizations, long-term care providers, health care professionals, legislators and governmental agencies. House Bill 1646, passed in the 2022 session. The bill continues and codifies the work of the Dementia Action Collaborative, to be convened by the DS HS. The bill specifies a roster of members to be appointed by the Governor, requires a review and update of the Washington State Plan to Address Alzheimer's Disease and Other Dementias due by October 1, 2023, and requires annual recommendations by the Dementia Action Collaborative for legislative and executive branch agency action to the Governor and legislature each October 1st, beginning October 1, 2024.
Budget	As of July 1, 2018 - $160,000 per year is split among three agencies to support part-time positions in each of four state agencies to help implement state plan recommendations: • $80,000 to DSHS to support DAC/dementia work at ALTSA and DDA • $40,000 for Health Care Authority • $40,000 for Department of Health As of July 1, 2019 – around $1 million per biennium spread to varied DAC partners to work on three initiatives: • University of Washington - $226,000 per year ongoing • Department of Health - $150,000 per year ongoing • Aging and Long-Term Support Administration $113,000 per year ongoing As of July 1, 2021 - $1.5 million was authorized for FY22 and FY23 to pilot and demonstrate the building of more dementia-capable communities in two Area Agency on

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	Aging (AAA) service areas. After procurement, contracts were awarded to AAAs based in Spokane and Bellingham, each serving multiple surrounding counties. As of July 1, 2022 - $100,000 per year was allocated to University of Washington's Memory and Brain Wellness Center for a staff position to expand the Dementia Friends, global public awareness program, statewide.
Partners	Senate Bill 6124 in 2014 prescribed internal and external groups and individuals to be represented on the ADWG. Transitioning to the voluntary Dementia Action Collaborative, most of the original ADWG members or assigned designees remain involved with some new members added to address specific recommendations. HB 1646 passed in 2022, adds a few new members/partners. See linked bill for detailed list of participant types.
Oversight	Broad membership of contributing experts will ensure quality. DAC Steering committee provides guidance.
Accomplishments	In its first five years the DAC has done as much possible on recommendations that could be addressed within existing resources and/or through heightened collaboration. DAC advocates were successful in garnering state funds as of state FY 2019 to bring part-time staff into four state agencies – Aging and Long-Term Support Administration (ALTSA), Department of Health (DOH), Developmental Disabilities Administration, and Health Care Authority. These staff support the work of DAC subcommittees and work together to raise awareness of dementia and state plan recommendations that might be addressed within their respective agencies. DAC advocates were successful again for FY 2020, gaining around $1 million per biennium to address three priorities related to identifying and supporting people with dementia early in the disease process. These state-funded initiatives launched to the public and providers in 2020, and include those to: ▪ **Train primary care practitioners in best practice dementia care** The University of Washington began hosting the new Project ECHO Dementia launched in May 2020. As of June 2022, this has reached 118 individual providers and 43 clinics. ▪ **Increase public awareness of dementia/the value of early diagnosis** Building on early exploratory work, DOH contracted in 2021 with marketing professionals to investigate, develop and audience-test health messages around dementia and diagnosis with the African American community. This work

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www.dshs.wa.gov/altsa/stakeholders/alzheimers-state-plan
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	resulted in creation of culturally-tailored messages and identification of strategies to promote early and accurate diagnosis in this population. See: www.doh.wa.gov/memory. Work in 2022 continues to create materials for the Latino/a/x community. ▪ **Promote early legal and advance care planning** A Dementia Legal Planning Toolkit was created for the public along with webinars, Continuing Legal Education opportunities to increase attorney knowledge, and a virtual clinic (May 2021) offering local pro bono legal services to complete legal and advance care planning documents. In 2022, the WA Pro Bono **Council** launched the Dementia Legal Planning project in which adult 60+ or people with dementia of any age can get free assistance in completing powers of attorney for finances and health care documents and health care directives. DAC advocates next succeeded in attaining $1.5 million for the next biennium (FY22/FY23) to support the development of two pilot programs in Area Agencies on Aging (AAAs), intended to build more dementia-capable communities. ▪ Each AAA employs Dementia Resource Catalyst staff (resource developer/planner) to enhance dementia-capability in the aging network, foster dementia awareness and partnerships across sectors, and develop plans that optimize existing resources while enhancing the array of dementia-capable services. ▪ New direct services funds will fill gaps in dementia-capable services such as: early stage programming, specialized supports that promote safety and/or help manage behaviors, services that address complex care needs of dementia, and culturally accessible dementia-capable support services. In 2022, projects were launched, have been providing trainings to aging network staff and began providing direct services. *Other accomplishments of note include:* ▪ Created a Washington State-specific "road map" for family caregivers providing information about what to expect over time to help plan for the future. Have disseminated more than 80,000 booklets across the state. Was published in Spanish in 2019. This document is also made available online at https://www.dshs.wa.gov/altsa/dementia-action-collaborative. ▪ Enhanced a statewide webpage for Washington state information and local services, see www.memorylossinfowa.org. ▪ Two *"Collaborating for a Dementia-Friendly Washington"* statewide conferences to promote dementia-friendly programs and communities. Offered virtually in September 2020 and September 2021, these conferences attracted hundreds of participants each year from more than 24 counties in Washington. See more on dementia-friendly communities here: Dementia Friendly Fact Sheets. ▪ Promoting the implementation of early stage memory loss groups and dementia friendly programs through guidance documents for community-based organizations interested in learning how to develop Alzheimer's Cafés and Dementia Friendly Walking groups. In 2021, partners together launched the

	Dementia-friendly Washington Learning Collaborative, through the Project ECHO Dementia platform, to promote learning/sharing around dementia-friendly programs and communities across the state. ▪ UW Healthy Brain Research Network developed evidence-based messages around promoting healthy aging and brain health in Asian-American and Pacific Islander communities, see Action Guide: Connecting with Asian-American and Pacific Islander Communities Around Dementia. ▪ Department of Health (DOH) launched a new webpage on dementia; and created an optional online training for Community Health Workers on the topic of memory loss and dementia, available through DOH. ▪ Preparedness, and home safety assessments. See Dementia Safety Info Kit.

Information Contact
Lynne Korte, Dementia Program Manager, Home & Community Services
(360)725-2545; Lynne.Korte@dshs.wa.gov
www.dshs.wa.gov/altsa/stakeholders/alzheimers-state-plan

Attachment Q - 2023 Fact Sheet Wellness Education

Aging and Long Term Support Administration
Washington State Department of Social and Health Services

Transforming Lives

Fact Sheet

Attachment Q - Wellness Education

Overview	The goals of the Wellness Education (WE) service are to increase client health literacy, engagement with healthcare providers, engagement with community resources, and support individuals to be empowered to achieve their own health and well-being goals. WE uses existing data from the Comprehensive Assessment and Reporting Evaluation (CARE) client assessment system to develop individualized health and well-being indicators for each client on the service. This enables individuals to receive Wellness Education as a customized monthly newsletter, with new information every month, about health and well-being topics relevant to them. Wellness Education newsletter articles are written to health literacy standards and contain actionable information on health and well-being topics. Articles are matched to each individual's health and well-being profile from the CARE assessment. Newsletters are translated into 25 languages. In addition, Large Print and Braille transcriptions are available for the visually impaired. Wellness Education addresses all aspects of health and well-being. Indicators include a variety of topics related to health diagnosis, health risk factors, social and emotional factors, and lifestyle. The CARE assessment provides 110 indicators on which each copy of WE is custom-built for each client. Examples of indicators include diabetes, depression, Cerebral Palsy, traumatic brain injury, smoking, falls risk, grieving a recent loss, interest in employment, or conflict management needs. Approximately 47,000 individuals are currently enrolled in this service. **Sample Newsletters** Sample January 2022.pdf Sample February 2022.pdf Sample March 2022.pdf Sample May 2022-Chinese.pdf

Washington State Department of Social & Health Services
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Information Contact
Debbie Blackner, Ancillary Services Program Manager, Home and Community Services Division
(360) 725-3231; Debbie.blackner@dshs.wa.gov
https://www.dshs.wa.gov/adult-care
2023

Eligibility Requirements	The Wellness Education service is available to clients enrolled in the following waivers: **Aging and Long-Term Support Services Administration** • Community Options Program Entry System (COPES) • Residential Support Waiver (RSW) **Developmental Disabilities Administration** • Basic Plus, Core, or Individual and Family Services (IFC)
Authority	Title XIX federal funding through a 1915(c) home and community-based services waiver and state funding. (Chapters 74.39 and 74.39A RCW and WAC 388-106-0015, 388-106-0300 , 388-106-0305, and 333-106-0336)
Budget	FY22 Expenditure: $1.7M
Rates	$3.95 per client per month
Partners	Developmental Disabilities Administration Health Care Authority
Oversight	**External** • Centers for Medicare and Medicaid Services • Health Care Authority • State Auditor's Office **Internal** • Home and Community Services Division Quality Assurance Unit monitoring
Partners	Health Care Authority Developmental Disabilities Administration
Oversight	**External** • Centers for Medicare and Medicaid Services • Health Care Authority • State Auditor's Office • Department of Health **Internal** • Home and Community Services Division Quality Assurance Unit monitoring

Attachment R - 2023 Fact Sheet Workforce Development

Aging and Long Term Support Administration
Washington State Department of Social and Health Services

Fact Sheet

Transforming Lives

Attachment R - Workforce Development Fact Sheet

Purpose	The purpose of the workforce development (WD) program is to build a robust, well-trained workforce of direct care professionals to provide quality care to Washingtonians who need long term services and supports. To serve individuals with disabilities and older adults, recruiting and retaining direct care professionals is crucial. Long-term services and supports has a long history of workforce shortages and high turnover rates driven by low wages and benefits, poor job quality, and a lack of recognition for the value of the work performed and the demonstrated competencies gained in the field. Several factors contribute to the need to deploy effective workforce strategies that will increase the numbers of individuals entering and staying in the direct care workforce. Those factors include: • The demand for services could increase by 150% due to the aging of the state's population. • A new long-term care public insurance model will begin in January 2026, further increasing demand for services. • High number of the direct care workforce will be nearing retirement age within the next 15-20 years. • High turnover of direct care professionals across all settings, including skilled nursing facilities, assisted living, adult family homes, and in-home.
Goals	**Goal 1**: Increase the number of high schools, skills centers, tribal and compact schools delivering a Home Care Aide training to students, summer programs, community programs, and community colleges. **Goal 2**: Design and deploy resources that increase retention of the direct care workforce across all settings. **Goal 3**: Increase the visibility of the direct care workforce by educating workforce boards, centers, and health care providers about the competencies and values of the work.

Washington State Department of Social & Health Services
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Contact Information
Christine Morris, Office Chief
Training, Communications & Workforce Development unit
Home and Community Services Division
morrimc@dshs.wa.gov
2023

Fact Sheet

External Partners	Office of Superintendent of Public Instruction Department of Health Prometric
Internal Oversight	ALTSA Home and Community Services Division

Contact Information
Christine Morris, Office Chief
Training, Communications & Workforce Development unit
Home and Community Services Division
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2023

Attachment S - Tribal Health Home Fact Sheet

Washington State Department of Social and Health Services

Transforming Lives

Aging and Long-Term Support Administration

Tribal Health Home Fact Sheet

Overview
The Health Home program is a set of services offered to individuals living with chronic medical conditions that can have a lasting negative impact on their quality of life. It consists of a set of six services that are tailored to promote person-centered health action planning and empower participants to take charge of their own health care. This is accomplished through better coordination between the participant and all their health care providers. Health Homes encourages participants to take an active role in their health care and is designed to ensure participants receive culturally competent care, when it is needed, and with the best providers for each individual's needs.

Goals
○ Increase the health and quality of life for each participant and reduce the stress and strain for their family and supports. ○ Increase confidence and skills for self-management of health goals ○ Establish person-centered health action goals designed to improve quality of life and health-related outcomes ○ Prevent or slow the decline in functioning that comes from living with a chronic condition ○ Bridge gaps in services and ensure there is a cross-system care coordination across the full continuum of services including medical, behavioral, substance use, and long-term services and supports

Eligibility
○ Meet Apple Health (Medicaid) eligibility criteria ○ Participants must be diagnosed with at least one chronic condition ○ Participants must have a PRISM risk score of 1.5 or greater predicting higher than average healthcare costs in the next 12 months ○ Eligibility can begin at birth or during any stage of life

Structure
The Health Care Authority contracts with designated "Health Home Lead Entities" to provide Health Home services directly, or through contracted Care Coordination Organizations. The Health Home program emphasizes person-centered care with the development of the Health Action Plan (HAP). The HAP includes routine screenings such as the Patient Activation Measure (PAM). The PAM is an assessment that gauges the knowledge, skills, and confidence essential to managing one's own health and healthcare. The HAP also includes screenings for body mass index, depression, level of independence in accomplishing activities of daily living, risk of falls, anxiety, chemical dependency, and pain. The HAP and assessment screenings are updated on a 4-month cycle or as needed. The centerpiece of the HAP is the participant's self-identified short and long-term health related goals, including what action steps the participant and others will do to help improve his or her health. With participant consent the HAP can be shared with care providers in order to foster open communication, support, and encouragement to reach their health goals.

Washington State Department of Social & Health Services Transforming lives

Washington State Health Care Authority

Tribal Health Home Fact Sheet

Role of the Care Coordinator
A Care Coordinator is an individual who works with eligible participants, their families, and providers to: o Coordinate services for participants with chronic and complex medical and social needs o Identify gaps in care and help remove barriers o Connect participants to a broad range of benefits and culturally competent community resources o Support successful transitions from inpatient facilities to other levels of care o Help establish primary and specialty care relationships o Communicate and coordinate with the participant's providers o Support and assist participants to reach their identified health goals

As defined by the Centers for Medicare and Medicaid, and authorized by the Affordable Care Act, Health Home Care Coordination provides the following services beyond the traditional Medicaid or Medicare benefit package.

Comprehensive Care Management
Initial and ongoing assessment and culturally competent management aimed at integration of physical, behavioral health, substance use, long-term services and supports and community services using a person-centered Health Action Plan (HAP) which addresses clinical and non-clinical needs. o Conduct outreach and engagement activities o Develop the HAP including health goals and action steps to achieve the goals o Complete comprehensive needs assessments/screenings and the Patient Activation Measure o Support the participant to live in the setting of their choice o Identify possible gaps in services and secure needed supports
Care Coordination and Health Promotion
Facilitating access to and monitoring of progress toward goals identified in the HAP to manage chronic conditions for optimal health and to promote wellness. o Encourage and support progress towards HAP short- and long-term goals o Coordinate with service providers, case managers, and health plans o Conduct or participate in interdisciplinary teams o Assist and support the participant with scheduling health appointments and accompany if needed o Provide individualized educational materials according to the needs and goals of the participant o Promote participation in community educational and support groups
Comprehensive Transitional Care
The facilitation of services for the participant, family, and caregivers when the participant is transitioning between levels of care. o Follow-up with hospitals/emergency departments upon notification of admission or discharge o Review post-discharge instructions with the participant, family, and caregivers to ensure they are understood o Assist with access to needed services and equipment, and ensure they are received o Provide education to the participant and providers located at the setting from which the person is transitioning o Ensure follow-up with Primary Care Provider (PCP) o Review and verify medication reconciliation post discharge is completed
Individual and Family Supports
Coordination of information and services to support the participant and their family or caregivers to maintain and promote quality of life, with particular focus on community living options. o Provide education and support of self-advocacy including referral to Peer Support specialists o Access resources to improve self-management, socialization, and adaptive skills o Educate the participant, family or caregivers of advance directives, participant rights, and health care issues o Share information with consideration of language, activation level, literacy, and cultural preferences

Tribal Health Home Fact Sheet

Referral to Community and Social Supports
Providing information and assistance for the purpose of referring the participant and their family or caregivers to community-based resources when needed. ○ Identify, refer, and facilitate access to relevant community and social services ○ Assist the participant to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services ○ Follow-up with referral resources to ensure appointments and services were established and the participant engaged in Health Home services

Attachment T - DSHS-AP-09-11

Washington State Department of Social & Health Services
Transforming lives

Administrative Policy No. 9.11

Subject: Emergency Management

Information Contact: Director, Emergency Management Services
MS: 45021
(360) 902-8159

Authorizing Sources: Chapter 38.52 RCW, Emergency Management
Directive by the Governor 13-02 Continuity of Government Operations Preparation

Additional Information: AP 09.15 Continuity of Operations
AP 09.16 Closures and Suspension of Operations
DSHS Emergency Operations Plan, as revised
DSHS Emergency Management SharePoint

Effective Date: November 1, 2010

Revised: September 5, 2019

Approved By: Original signed by Lori Melchiori
Senior Director, Office of Policy and Rules

Sunset Review Date: September 5, 2023

Purpose

To provide guidance, direction, and standards that promote DSHS organizational and individual employee preparedness to respond effectively to emergencies and disasters. Adherence to this policy supports the well-being and life safety of DSHS employees, protects state property, and supports the department's ability to continue its mission essential functions during emergencies and disasters to quickly resume normal business operations.

Scope

This policy applies to all DSHS administrations and employees at all locations statewide.

Further guidance

This policy, and any procedures or guidelines referenced herein, is intended only for internal department use. It is not intended, nor can it be relied on, to create any substantive or procedural rights enforceable by any party involved in matters with DSHS.

Definitions

The terms below are among those commonly used in emergency management; many of them are derived from federal definitions and adapted for use within DSHS. Additional commonly used terms may be found in the DSHS Emergency Operations Plan, Annex C. The terms defined below are used in this policy.

Capitol campus includes government buildings and grounds shown on this map. DSHS headquarters in Capitol View 1 and 2, Blake Office Park, and any other facilities are excluded from Capitol Campus.

Continuity plan is the written document describing the capability of each administration and residential program to support the continued performance of its mission essential functions during a wide range of emergencies or disasters. Continuity plans are developed using a standardized approach based on guidance from the Federal Emergency Management Agency (FEMA) and as required by RCW 38.52.030 (11) and the Directive by the Governor 13-02.

Emergency coordination center (ECC) is a DSHS headquarters function activated by the director of emergency management services (EMS) or designee to provide centralized guidance, information sharing, and support to DSHS regional and field services offices, and residential services operations responding to an emergency or disaster. The ECC is staffed by employees representing each administration who are trained by EMS.

Emergency or disaster is defined under RCW 38.52.010 (6) (a) as "an event or set of circumstances which: demands immediate action to preserve public health, protect life, protect public property, or to provide relief to any stricken community overtaken by such occurrences, or reaches such a dimension or degree of destructiveness as to warrant the governor declaring a state of emergency pursuant to RCW 43.06.010.

Emergency operations plan (EOP) is maintained by DSHS EMS for DSHS. It provides overarching guidance and procedures describing how DSHS responds as an organization to emergencies and disasters. There is only one EOP for DSHS. All emergency response plans and continuity plans must align vertically and not conflict with the DSHS EOP. The EOP is reviewed annually and revised, as needed.

Emergency response plan describes in writing the actions that management and employees must take immediately during an emergency or disaster to protect life-safety. Emergency response plans address incidents that are generally short term and do not interrupt DSHS' ability to continue its mission essential functions. Each DSHS location should have a single, integrated emergency response plan incorporating all DSHS programs at that location and in the same building.

GETS/WPS is the Government Emergency Telecommunications Service/Wireless Priority Service. It is funded by the Department of Homeland Security – FEMA. This program allows subscribers enhanced routing of government related calls during emergencies and disasters when lines may otherwise not permit calls to reach their destination. Further information is available at GETS/WPS

and DSHS EMS.

Headquarters is all DSHS offices in the Olympia, Lacey, and Tumwater area that includes the primary work location for the executive leadership of each administration, their staff, and supporting systems, and resources. Note that only the DSHS Office Building 2 (OB2) is on capitol campus.

Incident command system (ICS) is a method of organization used for the command, control, and coordination of an emergency response developed and promulgated by FEMA. It is the nationally standardized approach for incident response and for all levels of government. The ICS organization is flexible, scalable, and arranged in a hierarchy to facilitate communication and collaboration. DSHS uses a modified version of ICS adapted to its business needs.

Location includes DSHS headquarters, regional and field offices, state hospitals, residential habilitation centers, state operated living alternatives, the Special Commitment Center, and other DSHS operated residential programs.

Mission essential functions are the limited set of organization level functions that must be performed continuously, or resumed as soon as possible after a disruption of normal actions. Mission essential functions are required by federal or state statute, a funding source, or direction from the secretary. Some DSHS services must be continued without interruption.

Residential program means the responsible state hospital, child study and treatment center, competency restoration center, residential habilitation center, state operated living alternative, or similar program in which DSHS clients are under the agency's direct care and supervision by DSHS employees.

Policy Requirements

A. Emergency management services

DSHS EMS is in the facilities, finance, and analytics administration (FFAA) and the director of EMS reports to the assistant secretary. During emergencies and disasters, the director may report directly to the secretary or other designated member of the DSHS cabinet. EMS is the emergency management policy, planning and training, and exercising authority for the department and employs the department's related subject matter experts.

1. Delegation of authority

   The director of EMS has delegated authority to represent and act on behalf of the DSHS secretary on all matters pertaining to emergency management.

2. Employee and organizational readiness

   EMS maintains a comprehensive emergency management planning and response approach for DSHS that promotes preparedness at the organizational and individual employee levels by providing:

a. DSHS agency level standards for emergency and disaster preparedness, emergency operations, and continuity planning;
b. Technical assistance, training, and exercises for DSHS headquarters, regional offices, and residential operations; and
c. Planning resources, tools, and materials.

3. Emergency coordination center

The emergency coordination center (ECC) is organized based on incident command principles and is led by a DSHS manager trained by EMS. This position may assume the role of incident commander when the incident is directly impacting DSHS headquarters. During activations, the ECC emergency manager reports directly to a DSHS cabinet designee, typically the deputy chief of staff, office of the secretary. The ECC follows procedures established by DSHS EMS, which are included in the DSHS EOP.

a. EMS is responsible for training and completing drills with the ECC, which convene either in OB2 in Olympia or virtually, or both.
b. Each assistant secretary must designate at least two employees to serve as liaisons to the ECC. Liaisons must participate in training, drills, and activations in response to actual incidents.
c. Administration liaisons are responsible for updates to the DSHS toll-free employee emergency information line and the internet duty station status report (or successor systems) during incidents that impact DSHS operations.
d. Assistant secretaries must designate additional representatives, if requested by the director of EMS, to meet the needs of a response.
e. DSHS locations (as defined by this policy) must develop and maintain procedures for emergency coordination at each campus.
f. EMS must provide training, exercises, and other technical assistance to DSHS regional offices and locations (as defined by this policy) to support the implementation and maintenance of continuity plans.
g. The ECC will occupy the OB2 computer training room for the duration of response activities as necessary.

4. Capitol campus planning and response coordination

a. EMS is responsible for DSHS agency level coordination with other state agencies in response to any incident on the Capitol Campus. This includes participation on the Washington Interagency Security Committee, convened by the Department of Enterprise Services and the Washington State Patrol.
b. The Department of Enterprise Services is responsible for coordinating the immediate facilities response to any incident impacting multiple facilities on the Capitol Campus.
c. The DSHS EOP is written to scale up to incidents that extend beyond the capabilities of DSHS resources.

5. State, tribal, and federal level coordination

a. EMS represents DSHS on matters pertaining to emergency management with local

jurisdictions, other state agencies, tribes and tribal agencies, and federal agencies. Any other DSHS representation must be coordinated through the director of EMS. However, this requirement is not intended to preclude local, direct coordination by DSHS offices and locations (as defined by this policy) with local jurisdictions' emergency management for planning purposes or during a response.

b. Within available resources, EMS coordinates the provision of DSHS staff with subject matter expertise to the state EOC to support a response.
c. DSHS organizations and employees must not deploy to the State EOC without advanced coordination with the DSHS director of EMS.
d. During state level activations DSHS response actions must be coordinated through EMS using the procedures established in the DSHS EOP for the emergency coordination center. DSHS programs and individual staff must not deploy to the incident location or in proximity to it without prior coordination with EMS.
e. The director of EMS is responsible for overseeing DSHS compliance with the Directive by the Governor 13-02 and any subsequent requirements, and submitting quarterly reports summarizing the continuity planning, and training and exercise actions taken by all DSHS programs during the previous quarter.

B. Emergency response plan

1. When an emergency occurs that impacts DSHS operations and requires immediate action to protect the well-being and safety of employees and clients, every affected DSHS manager and employee must understand their role in the response.

2. Every DSHS location must have a written emergency response plan that aligns with the EOP.

3. Locations shared by two or more DSHS administrations must collaborate in developing an emergency response plan that incorporates the needs of each program in an integrated response plan. Plans must be approved by the responsible manager for each program at that location, reviewed annually, and updated as needed.

4. Management at locations that also house non-DSHS tenants are responsible for working with those tenants and to include them in planning, where feasible. Plans must describe how DSHS services may be impacted by other tenants during an emergency or disaster.

5. Training in accordance with each location's emergency response plan is necessary for employees to understand their role during emergencies and disasters. Training will be provided by qualified staff identified by each administration and in coordination with the preparedness training manager located in DSHS EMS.

C. Continuity planning

Continuity plans are developed at the administration and location (as defined by this policy) level and must align vertically with the EOP as much as practical. Plans are activated when an emergency or disaster significantly disrupts normal operations requiring temporary relocation, reassignment of staff, implementation of alternate care standards, or other actions that must be sustained for 72 hours

or longer. (Note that the specific period may be less than or greater than 72 hours depending on the mission essential function(s) that are impacted.) Please refer to AP 09.15 - Continuity of Operations for additional guidance.

D. Training and exercise coordination

1. DSHS EMS oversees and administers preparedness and response training and exercises at the administration and location (as defined by this policy) levels, providing review, technical assistance, direct training, training resources, and other assistance. EMS will incorporate other federal or state emergency preparedness training requirements, as they are developed and promulgated.

2. As a requirement of the Directive by the Governor 13-02, each administration and location (as defined by this policy) must have a written training plan that describes how employees on all shifts will be oriented to their roles in an emergency or disaster, and that specifies timelines for completing training.

3. Completion of training may be recorded in the learning management system.

4. EMS is authorized to make specific training and exercise recommendations to administrations and locations (as defined by this policy) to improve DSHS organizational and individual employee readiness.

5. EMS provides training resources and assistance at the administration and location (as defined by this policy) level. Within available resources, EMS will support regional offices as well.

6. When requested by an appointing authority, EMS will assist each administration and location (as defined by this policy) in determining what training is necessary for their staff to prepare them to carry out their duties during emergencies and disasters.

7. Administration and location (as defined by this policy) emergency preparedness training plans must be submitted to the preparedness training manager located in DSHS EMS by January 15 of each year.

E. Local jurisdiction coordination

All counties and larger cities are required under Chapter 38.52 RCW to have an emergency manager. DSHS management at every location are encouraged to acquaint themselves with their local jurisdiction's emergency managers for the purpose of mutual support.

F. Government Emergency Telecommunications Service/Wireless Priority Service (GETS/WPS)

EMS manages the GETS/WPS program for the DSHS cabinet and FFAA. Other administrations wishing to participate in the program may set up and manage separate accounts below the assistant secretary or senior director level. Enrollment information is available through GETS/WPS.

Attachment U - 2024-2027 Area Plan Instructions

Attachment U

2024-2027 AREA PLAN INSTRUCTIONS
FOR AREA AGENCIES ON AGING

GENERAL INSTRUCTIONS

These are the instructions for the 2024-2027 Area Plan per 42 USC 3026. This Area Plan covers the period from January 1, 2024, through December 31, 2027.

The Area Plan is due to the Department of Social and Health Services/Aging and Long-Term Support Administration (DSHS/ALTSA) on November 2, 2023.

1. Please submit an electronic copy of the Area Plan with original or electronic signatures on the Verification of Intent and Statement of Assurances page to:

   Susan Engels, SUA Office Chief
   State Unit on Aging
   Susan.engels@dshs.wa.gov

2. Send one electronic copy of the Area Plan via e-mail to your AAA Specialist. AAAs are not expected to send electronic copies of documents in the Plan that were not created in electronic format by the AAA, such as notices in newspapers. The 7.01 Plan Matrix must be submitted in Microsoft Word format.

3. Organize the Area Plan according to the table of contents and corresponding sections that follow these general instructions per 42 USC 3027 (a)(1)(A). At a minimum, the content detailed in each section must be included, unless noted as optional. Additional information or sections may be provided at the option of the AAA.

4. Type the year, section number and page number at the bottom corner of every page.

5. A copy of these instructions and the budget forms will be e-mailed to the AAA chief fiscal officer so the proper budget forms can be used. The instructions and forms will also be on the DSHS/ALTSA Intranet as attachments to the corresponding Management Bulletin.

6. Inquiries on Sections A, B, C and the appendices should be directed to Aime Fink (360) 725-2554. Inquiries on Section D should be directed to Julia Mosier at (360) 725-2275.

[NAME OF AREA AGENCY ON AGING]
2024-2027 AREA PLAN

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G Statement of Assurances and Verification of Intent

[1]This issue area may be incorporated into existing issue areas as applicable, however, COVID services and supports and/or plans for the unwinding of the Public Health Emergency should be specifically addressed.

SECTION A – AREA AGENCY PLANNING AND PRIORITIES

A – 1 Introduction:

This section should introduce the reader to your Area Agency on Aging (AAA) and the Area Plan. Briefly describe your agency, sponsoring organization, and other pertinent introductory information applying to your Planning and Service Area (PSA), the nature of the programs you provide, and the client population you serve (e.g., older adults, vulnerable and disabled adults, etc.). Discuss the purpose of the Area Plan and indicate how the reader may contact your agency with questions or comments.

A – 2 Mission, Vision, Values:

This section should reflect the mission of your agency consistent with 45 CFR 1321.53. It may be an excerpt of the mission statement from your sponsoring organization and should incorporate your agency's vision and values in a way that provides the reader with a summary of the guiding principles under which your AAA operates.

A – 3 Planning and Review Process:

In this section, please describe your approach to assess the needs and strengths in your PSA, develop your Plan, and review draft(s) prior to adoption. Identify and include relevant stakeholders, partnerships, data, and tools used to determine your approach for serving the target population. Appendix E. (an optional template is available in the attachments of the MB) Public Process may be used in lieu of narrative in this section.

A – 4 Prioritization of Discretionary Funds:

This section describes your 2024-2027 priorities for programs for which you have discretionary funding. Describe your process for determining priority services, including the criteria established, the basis for your criteria, factors influencing your prioritization, and the methods employed in weighting individual elements.

Describe how you would implement these priorities in the event of funding reductions or increases. Discretionary funds are normally those that come from Title IIIB, Senior Citizens Services Act (SCSA), and local sources. Consider how use of discretionary funds could be used in relation to reducing services in the community.

SECTION B – PLANNING AND SERVICE AREA PROFILE

Provide an update in the event of any significant changes in Section B.

B – 1 Target Population Profile:

This section introduces the reader to the scope of the target population your Area Agency on Aging (AAA) serves and should describe the current demographics of the PSA and emerging trends over the

course of the plan period. This section should include local analysis of the demographic shifts in your PSA and the associated impact on the AAA and providers within the aging network.

This section must list, at least, the following required target population demographic characteristics in your PSA, not necessarily in this order:

- Number of persons 60 and over
- Number of minority persons 60 and over and minority
- Number of persons 60 and over with income at or below the federal poverty level
- Number of persons 60 and over and minority with income at or below the federal poverty level
- Number of persons 60 and over living in rural areas[2]
- Number of adults aged 18 and over with disabilities
- Number of persons 60 and over with limited English proficiency
- Number of Native American Elders
- The Native American Tribes represented in the PSA, indicating which have Title VI programs.
- Number of individuals with Alzheimer's disease, dementia, or other cognitive impairment
- Number of persons 60 and older at risk for institutional placement

Some of the categories will be subsets of others. For example, the number of minority persons 60+ would be counted in the number of persons 60 and over, and any other category they may fit into, such as low income, Native American Elders, etc.

Census data and any related data should be used, but reliable locally developed data can also be included your profile. You may use the data provided by ALTSA through the Research and Data Analysis Division of DSHS in lieu of census or local data. Updated RDA data is posted online at: https://www.dshs.wa.gov/altsa/stakeholders/aging-demographic-information. Please cite the data sources used as the basis of your planning efforts. You may choose to describe the population using narrative, tables, charts, graphs, or maps, or any combination of these methods. A chart may be used in lieu of narrative for this section.

B – 2 AAA Services and Partnerships:

List all the services provided by or through the AAA either directly or through contracts with community partners. Briefly describe the service as it is provided in you PSA. Indicate in which counties the services are available, either in the narrative, by chart or by utilizing the optional B-2 template provided as an attachment with this MB. Also describe if the service has been affected by budget reductions and if there are other resources available to provide similar services. Also include partnerships that support the AAAs efforts to create a comprehensive, coordinated community-based system for older adults, if desired.

[2] Rural refers to any area that is not defined as urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census designated place with 20,000 or more inhabitants. DSHS RDA data will delineate rural areas by county only. PSAs that include rural areas within a mostly urban county will include data to identify rural towns, cities, or territories in the county to coincide with targeting efforts to serve rural residing adults.

B – 3 Focal Points:

Per 42 USC 3026 (3)(A) and 45 CFR 1321.53(c), list designated focal points in the Area Plan. According to the Older Americans Act (OAA), the term focal point means a facility established to encourage the maximum collocation and coordination of services for older individuals. AAAs are required to designate, where feasible, a focal point for comprehensive service delivery in each community. List a focal point for each county in the PSA. If the AAA has not formally designated a community-based focal point, designate the ADRC/CLC or Information & Assistance location(s) as a focal point in the Area Plan. Include the name of the organization, address, phone number for the public, and county for which the focal point is designated. List additional services coordinated at this focal point if desired, for example, if the focal point is also a congregate meal site, indicate that detail in the list. An optional template is included in the attachments of the Management Bulletin for these instructions.

SECTION C – ISSUE AREA THEMES

This section is designed to address emerging trends impacting the target population of your AAA over the four-year planning period. Use a local process to identify goals and objectives, for each of the Issue Areas listed below or for the Issue Area themes identified by your AAA, and list these goals and objectives in the format listed below. Goals and Objectives should identify how your PSA's plan targets those in greatest economic and social need[3]. Include how individuals of hard to reach/target groups are identified, engaged, and served. Identify how the AAA will serve low-income minority individuals, limited English speaking persons and older adults residing in rural areas. Include engagement strategies for older Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Two Spirit, Plus (LGBTQIA2+) individuals and persons under sixty (60) with disabilities.

The first four (4) Issue Areas (C-1 through C-4) must be completed while Issue Area C-5, COVID 19 Response Services and Support, can be filled out as an independent issue area, or the content can be incorporated into the first four (4) issue areas.

When formatting the Issue Areas, AAA should utilize the structure outlined below or use the optional C-Issue Area templates attached to the MB. An example of an Issue Area has been provided in the optional C-Issue Area Template for reference.

Format your selected Issue Areas using C – 1, C – 2, C – 3, etc. for each identified issue area with goal/s and objectives identified within each issue area. Include the following three (3) sections for each issue area.

Profile of the Issue: This profile should help the reader to understand the issue and its impact to the target population. It should include a description of the services available to meet an identified need and enhancements necessary to expand or enhance the benefits of those services. It could include

[3] The term "greatest economic need" means the need resulting from an income level at or below the federal poverty line. The term "greatest social need" means the need caused by non-economic factors, including: (A) physical and mental disabilities; (B) language barriers; and (C) cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that-(i) restricts the ability of an individual to perform normal daily tasks; or (ii) threatens the capacity of the individual to live independently.

information about the applicable history and significant trends and include information about federal or state policies which affect the choice of the issue area by the AAA.

Goal/s: Clearly identify the direction the AAA will take to enhance services, enhance access for target populations, or achieve cost-effectiveness over the next four years. Goals should be broad in nature and should describe the major outcomes expected.

Objectives: Specific and measurable actions or activities that will occur within the four-year planning period that link to the AAAs selected focus and goals. These should include methods of achievement or key tasks and benchmarks (means of measuring progress), and month-specific timeframes for completion. The AAA may set one or several goals per issue area and one or several objectives per goal.

The Issue Areas are as follows:

- **C-1. Healthy Aging:** Healthy aging programs are designed to improve the health and well-being and reduce disease and injury in older adults. Evidence-based disease prevention and health promotion programs reduce the need for more costly medical interventions. **The AAA must include goals that address healthy aging services and evidence-based programs for Title IIID funds.** Include efforts to develop dementia-friendly communities as appropriate. Services that may fit well with this theme include:
  - ✓ Brain health and dementia supports
  - ✓ Evidence-based health promotion programs
  - ✓ Nutrition
  - ✓ Senior centers/avoiding isolation/social participation
  - ✓ Transportation
  - ✓ Universal design & community planning feedback for aging populations
  - ✓ Mental health, counseling
  - ✓ Volunteering and civic engagement
  - ✓ Advocacy
  - ✓ Equity, diversity, inclusion

- **C-2. Expanding and strengthening services and supports that prevent or delay entry into Medicaid funded long-term services and supports (LTSS):** Supports that prevent or delay entry into Medicaid funded LTSS are tailored to community strengths and promote an interdependence of natural supports and paid services. **The AAA must include goals that address family caregiver support and person-centered counseling that empowers people to make informed choices about their care.** Include efforts to support hospital to home care transitions as appropriate. AAAs can address the needs of formal and informal caregivers and strengthening of the direct care workforce. Services that may fit well with this theme include:
  - ✓ Community Living Connections/Aging and Disability Resource Centers
  - ✓ Information and Assistance

- ✓ Care Transitions
- ✓ State Family Caregiver Support Program
- ✓ Kinship Caregiver Support Program
- ✓ Evidence-based caregiver programs
- ✓ Medicaid Alternative Care
- ✓ Tailored Supports for Older Adults
- ✓ Advanced planning, guardianship, protection from abuse, neglect, exploitation
- ✓ Advocacy

- **C-3. Person-centered home and community based services:** Person-centered home and community based systems are designed to allocate resources and provide the necessary supports and coordination to be responsive to the person-centered needs and choices of older adults and people with disabilities in ways that maximize their independence and ability to engage in self-direction of their services, and achieve a more consistent and coordinated approach to the administration of policies and procedures across public programs. **The AAA must include goals that support building a person-centered home and community-based system.** Include case management and community living connections/aging and disability resource network development as appropriate. Services that may fit well with this theme include:
  - ✓ Case Management (Medicaid and non-Medicaid)
  - ✓ Health homes
  - ✓ Person-centered counseling/Options counseling
  - ✓ Personal in-home care services
  - ✓ Supportive housing
  - ✓ Supported employment
  - ✓ Equity, diversity, inclusion
  - ✓ Advocacy
  - ✓ State Family Caregiver Support Program
  - ✓ Kinship Caregiver Support Program

- **C-4. 7.01 Planning with Native American Tribes and Tribal Organizations.** *This theme does not apply to PSA 10 or PSA 12. An alternative fourth theme has been identified for Yakama Nation and the Confederated Tribes of the Colville Reservation.* DSHS Administrative Policy 7.01 requires Area Agencies on Aging to develop a formal plan that outlines their coordination with individual tribes within their PSA. **The AAA must incorporate goals to engage tribes and recognized tribal organizations in planning discussions and include a completed 7.01 plan as agreed upon by the federally recognized tribe or federally recognized tribal organization.**

- **C-4. Serving non-tribal members living on tribal lands.** *This theme only applies to PSA 10 and PSA 12.* An Area Agency on Aging is required by the OAA to serve all elders regardless of tribal affiliation within their designated planning and service area. **The Area Agencies on Aging of Yakima Nation and Colville Confederated Tribes will include goals that address serving non-tribal members residing in the designated planning and service area.**

- **C-5. COVID-19 Response Services and Supports** Washington State was the United States epicenter of the pandemic in January 2020 and on February 29, 2020, Governor Jay Inslee declared a state of emergency in response to the COVID-19 outbreak. As a trusted local community resource, [name of the AAA] anticipated needs in the community and responded by pivoting crucial services to maintain compliance with the Major Disaster Declaration orders while engaging their local community with new services and supports to meet needs such as food scarcity and social isolation. The Area Agencies on Aging may include goals that continue to support the unique needs of their communities during the COVID-19 pandemic and/or strategies in place to support the unwinding of the Public Health Emergency.

SECTION D - AREA PLAN BUDGET INSTRUCTIONS

General Instructions

1. The Area Plan Budget workbook contains the following worksheets:
   A. Area Plan Budget Summary (D-1 Summary tab)
   B. Expenditure/Revenue Detail by Funding Source (D-2 Expenditure-Revenue tab)
   C. Area Plan Formula Worksheet (D-3 Formulas tab)
   D. Staff Full Time Equivalent (FTE) Breakout (D-4 Staff FTE Breakout tab)
   E. AAA Individual Direct Services Worksheets (D-5 DS Admin {Begin}, DS {To Copy}, and DS {End} tabs)
   F. AAA Total Direct Services Worksheet Including Subcontracted Costs (D-6 Reconciliation tab)
   G. Family Caregiver Support Program – Number of Units and Persons Served (D-7 FCSP Services tab)
   H. Example – Staff Full Time Equivalent (FTE) Breakout (D-8 EXAMPLE Staff FTE Breakout tab)

2. The budget forms and instructions can be accessed on the ALTSA Intranet as attachments to the corresponding Management Bulletin or at https://fortress.wa.gov/dshs/adsaapps/contractors/aaa/forms/. If you cannot access these forms, please contact Julia Mosier (360)725-2275.

3. The worksheets have been formatted for ease of data entry. **Only enter amounts in cells with blue font. Cells with black font or shaded cells are either not applicable or contain formulas.** If you should have problems with the worksheets or formulas, please notify ALTSA so the problem can be corrected, and all AAAs notified.

4. The completed budget forms, staffing plan and organization chart must be submitted electronically to your AAA Specialist, and to Julia Mosier, Julia.Mosier@dshs.wa.gov, by the due date stated within the corresponding Management Bulletin.

D – 1 Area Plan Budget Summary (Summary tab)

This worksheet summarizes the detail found on the Expenditure/Revenue Detail by Funding Source. This worksheet was designed to provide a complete financial picture to all AAA stakeholders, the public, and clients.

AAAs will only need to enter information in the bottom section titled 'AAA Non-Budgeted Services'. The AAA Budgeted Services section of this worksheet is linked to the Expenditure/Revenue Detail by Funding Source worksheet, so data entry is not required. The AAA Non-Budgeted Services section is used to record expenditures that flow through the AAA and are not part of the formal budget. These expenditures include but are not limited to Caregiver Training and Agency Workers' Health Insurance. Please note, the admin portion of Caregiver Training should not be reported in this section. Please report those costs in the Expenditure/Revenue Detail By Funding Source worksheet, on the Administration line of the Other-ALTSA Funding column.
This sheet is not protected, but the data submitted to ALTSA must be consistent to allow for comparability and statewide summarization. Please contact Julia Mosier at Julia.Mosier@dshs.wa.gov to request any changes.

D – 2 Expenditure/Revenue Detail by Funding Source (Expenditure-Revenue tab)

1. General Information

- This worksheet provides expenditure detail by service delivery and funding source. (Areas of the budget that are greyed out should not be filled in.)
- Each column identifies a specific revenue source, and each row identifies a service. Please note line .12 'Interfund Payments for Services' under Administration. This allows the option for reporting administration expenditures charged by the grantee's central services, if applicable.
- AAAs must ensure that they have sufficient match for all funding sources when completing their budget.
- Expenditures under the State Long-Term Care Ombudsman program must not be less than the total amount of Title III and Title VII funds expended by the agency in calendar year 2019, per 42 USC 3027(a)(9).
- Budgeted expenditures are summarized by funding source.

Refer to Chapter 9-Fiscal Operations of the AAA Policy and Procedures Manual, located at http://adsaweb.dshs.wa.gov/docufind/AAAPPManual/, for additional information on funding sources and budgets.

This sheet is not protected, but the data submitted to ALTSA must be consistent to allow for comparability and statewide summarization. Please contact Julia Mosier at Julia.Mosier@dshs.wa.gov to request any changes.

2. Budget Expenditure Information

All information should transfer automatically to the Area Plan Budget Summary if nothing is altered on the worksheets. (Information should only be entered in the areas that are **not** shaded gray.)

a. AAA: Enter the name of your Area Agency on Aging. Entering your name on this sheet will also enter the information on all other tabs in the workbook.

b. Budget Period: The budget period, January 1, 2024 – December 31, 2024 has been entered.

c. BARS Code Number: The BARS Code Numbers have been entered on the worksheet. Please note: ALTSA no longer issues a BARS Supplement. However, the old BARS Code numbers are used by ALTSA to identify specific programs and activities. Additions or changes to the BARS Code numbers must not be made without first contacting Julia Mosier at Julia.Mosier@dshs.wa.gov to request changes.

d. Contract or Direct: Enter "C" if the service is contracted or "D" if the service is provided directly by the AAA. If the service is both contracted and direct, enter "C/D".

e. Number: Enter the estimated number of units of service you plan to deliver over the budget period. Due to the transition to Older Americans Act Performance System (OAAPS) reporting, service lines for the Family Caregiver Support Program are shown at a more detailed level for planning purposes. Budget projections are required at the highest level, with the planning awareness that data reporting and billing will be required at the more detailed level.

f. Unit: OAAPS or OAA-designated unit for the service has been entered. **Do not change the unit of service; these are needed for comparability purposes.**

g. Persons Served: Enter the estimated number of persons you expect to serve under each service line for this budget period. When applicable, enter both number of units and number of persons served.

h. Older Americans Act (OAA): Enter the budget projections for each funding source of OAA by service line. Include both the new and carryover federal dollars in these columns. Do not include match dollars in these columns. The applicable match should be entered in the appropriate funding source column or “Non-ALTSA Funding Sources” column.

i. OAA Total: No entry is required; a formula summarizes the OAA expenditures.

j. Nutrition Service Incentive Program (NSIP): Enter the projected expenditures on the appropriate service line.

k. DSHS Allocated - Title XIX/MFP/Chore: Enter the funding as reflected in your SFY25 State/Federal contract by service line. Case Management/Nursing Services and Core Services Contract Management should be based on the ALTSA Projected Caseload Revenue.

l. Title XIX/MFP- AAA Requested: Enter the federal funding as reflected in your SFY25 State/Federal contract. Do not enter the corresponding SCSA or local match in this column. The match should be entered in the appropriate SCSA or Non-ALTSA Funding Sources column.

m. SCSA: Enter the total budget projection for SCSA funds by service line.

n. State Family Caregiver Support Program (SFCSP): Enter the total budget projection for SFCSP funds by service line. Due to the transition to OAAPS reporting, service lines for Family Caregiver Support Program are shown at a more detailed level for planning purposes. Budget projections are required at the highest level, with the planning awareness that data reporting and billing will be required at the more detailed level.

o. Kinship Caregiver Support: Enter the total budget projection for the Kinship Caregivers Support Program (KCSP) by service line. Combined Administration and Service Delivery expenditures cannot exceed 20% of the total funding. Administration alone cannot exceed 10% of the total funding.

p. Kinship Navigator: Enter the total budget projection for the Kinship Navigator Program by service line.

q. Medicaid Transformation Demonstration: Enter the total budget projection for the Medicaid Transformation Demonstration by service line.

r. Senior Farmer's Market Nutrition Program (SFMNP): Enter the projected expenditures on the appropriate service line by State and Federal funding sources. The projected expenditures should represent a full market season.

s. Other ALTSA Funding: Enter miscellaneous funding received from ALTSA. Enter the projected expenditures on the appropriate service lines along with the funding title in the .90 Other Activities section. If necessary, provide further information in the Description column; at a minimum, if the admin amount entered in this column is applicable to more than one funding source, the description column must reflect the breakdown, (i.e. $2,000 – Volunteer Services, $1,000 - Caregiver Training Admin)

   The following activities must be budgeted under Other ALTSA Funding:

   - Volunteer Services (Northwest Only): Enter funding for administration on lines .11 and .12, and services on line .59
   - Senior Drug Education: Enter the projected services expenditures on line .74 Senior Drug Education
   - Home Delivered Meal Expansion: Enter the projected services expenditures on line .64 Home Delivered Meals.
   - Other funding sources, such as T3B Admin funding provided for special projects, conferences, etc. should also be included when the AAA anticipates having such funding.

t. Total ALTSA: No entry is required; a formula computes the total ALTSA funding expenditures.

u. Non-ALTSA Funding Sources: Enter the total other funds the AAA expects to expend to support the AAA. Include all expenditures funded by local funds, private pay, donations, in-kind match, other

Federal and State funds, etc (not received from ALTSA). **Use the Description column to identify the source of the other funding.**

v. Grand Total: No entry is required; a formula computes all columns. Please do not change these formulas.

w. Description: This column is used to enter all pertinent descriptive information either requested above or considered necessary for complete understanding of the budget entries. At a minimum, there must be sufficient information presented so any outside party can ascertain the source of other funds, as well as the source and amount of any match.

D – 3 Area Plan Formula Worksheet (Formulas tab)

This worksheet computes the required match for Title III and Title XIX grants, the minimum funding levels required by Title IIIB and maximum funding allowances (lids).

1. Match Requirement Computation:

Administration Match and Services Match lines: Enter the amounts of administrative and services match for each funding source.

OAA Total & Total Match columns: OAA Total - This is the total of the entered administrative and services match for OAA. Total Match - This is the total of the entered administrative and services match from all funding sources. Both of these columns contain formulas; do not enter data in these cells.

2. Required Match:

% of Match Budgeted (lines 19-21 on the worksheet): Computes the percentages of reported match to the percentages required by the terms of the grant. The match reported in the Match Requirement Computation section must meet or exceed the required percentages. **This section contains formulas; do not enter data in this section.**

3. Administration Expenditure LIDS:

T3E (Column C) – must not exceed 10%

% of Administration to Total Grant Dollars, OAA Total (Column D): This percentage cannot exceed 10%. **The percentage must be exactly 10% if coordination is budgeted under Title 3B. These percentages are all calculated by formulas; do not enter data into these sections.**

4. **OAA Minimum Funding Level (New Funds Only):**

This section computes the percentage of new funds budgeted under Title 3B for categories of services with minimum funding levels as required by the Older Americans Act. **These are formulas; please do not enter data in these cells.**

5. **Lids:**

SCSA, State & Federal Family Caregiver Support Programs, Kinship Caregiver Support, and Kinship Navigator are subject to administrative and services lids. The maximum percentages are shown, and formulas calculate the percentages budgeted. **These are formulas; please do not enter data in these cells.**

D – 4 Staff Full Time Equivalent (FTE) Breakout (Staff FTE Breakout tab)

The purpose of this worksheet is to assist in reconciling the AAA's staffing plan, organization chart and the Individual Direct Services worksheets.

FTE Distribution Section (green): This section summarizes the information entered in the Cost Pools and Direct Charge Sections by position title.

1. Enter Position Title: List all positions within the AAA. Add additional lines if necessary.

2. Total FTE: **Do not enter information into this column.** The cells contain formulas, which sum the information entered in the Cost Pools and Direct Charge Sections.

Cost Pools Section (purple): List all cost pools within in the AAA. Add additional columns if necessary.

1. Enter Pool Name: Enter the name of each of the AAA's cost pools. At minimum, the AAA must have at least one cost pool to accumulate costs that benefit the AAA as a whole and that allocates to the various funding sources of the AAA.

2. For each position, enter the portion of FTE that will be charged to each pool. If a position is 100% direct charged the line for this section would be left blank.

3. Non-ALTSA Pool (yellow): For each position, enter the portion of FTE that will be charged to the pool(s) not associated with ALTSA funding.

4. Subtotal Pools: This column contains formulas, which total all the FTE that are allocated by cost pools.

Direct Charge (salmon): List all AAA cost centers that have time direct charged to them. Add additional columns if necessary

1. Enter Cost Center Name: Enter the name of each cost center. At minimum, most AAA's will have a cost center for information and assistance, case management, nursing services and contract management.

2. For each position, enter the portion of FTE that will be charged to each cost center. If a position is charged 100% to a cost pool the line for this section would be left blank.

3. Non-ALTSA Cost Center (yellow): For each position, enter the portion of FTE that will be direct charged to cost center(s) not associated with ALTSA funding.

4. Subtotal Direct Charge: **This column contains formulas,** which total the amount of direct charge time.

Ensure that all Column D cells contain the word "ok". If the word "error" appears, it is likely that the formula in Column C, under Total FTE has been deleted or overridden. If this should occur, copy a formula from a cell in Column C that has not been corrupted and paste into the damaged cell.

Ensure that cell C54 contains the word "YES". The formula in this cell compares the total FTE in cell C51 to the total FTE reported on the AAA Total Direct Services Worksheet Including Subcontracted Costs, (D-6 Reconciliation tab). If the word "ERROR" appears, these two worksheets do not reconcile.

For an example of a completed worksheet, see the D-8 EXAMPLE Staff FTE Breakout tab in the workbook.

D – 5 AAA Individual Direct Services Worksheets (DS Admin {BEGIN}, DS {TO COPY} and DS {END} tabs

A worksheet is required for each cost pool and cost center. These worksheets must tie to the cost pools and cost centers described in the AAA's written cost allocation plan and that are listed on the Staff FTE Breakout. The direct service worksheet must encompass the entire program; for example, the AAA may submit one worksheet for Nursing Services, which may include budgeted expenditures under Title 3B, SCSA, TXIX/MFP/Chore, DDD Nursing and HCS Nursing.

1. Make the number of direct services (DS) worksheets needed by copying the DS {TO COPY} tab in the workbook. This is done by placing your cursor on the DS {TO COPY} tab; hold down the Ctrl key and the left mouse button at the same time. Drag the cursor to the right. This will copy all formatting as well as content. Make sure each new tab (worksheet) is placed between the DS Admin {BEGIN} and the DS {END} tabs. This will allow the formulas on the D-6 Reconciliation tab to sum all of the direct services worksheets. Rename each tab to correspond with cost pool or cost center name.

2. On each worksheet, list the appropriate cost pool or cost center name in the space provided.

3. Each worksheet must encompass all activities allocated though the same cost pool or methodology and must include all funding sources supporting the activity. For example, a worksheet for Information and Assistance should contain all applicable funding such as Title 3B, Title 3D, Title 3E, TXIX, SCSA, Senior Drug Education, State Family Caregiver Support, and Non-ALTSA Funding Sources, if applicable.

4. Enter the total number of Full Time Equivalent (FTE) positions dedicated to the cost pool or cost center. FTEs do not need to be broken out by each funding source (each column). Use fractions of positions when applicable. For example, if two full time staff each spend one-third of their time providing the service, .67 FTE would be entered.

5. Enter the direct services budget projections by object line (e.g. 10 - Salaries & Wages, 20 – Personnel Benefits, etc.) and by funding source. BARS object codes 30 thru 80 have been combined into one

line on the form. Submit the information only at the level shown. No further breakdown of object line detail is required.

6. Please note – object line 90 – Interfund Payments for Service should be used to report the AAA's portion of administrative expenditures charged by your sponsor agency; for example, professional services, insurance, indirect overhead, etc. If the AAA does not have a sponsoring agency, nothing should be reported on line 90.

7. An ALTSA/Non-ALTSA Breakout Section is located at the bottom of each AAA Individual Direct Services Worksheet. This is to determine the breakout between ALTSA and Non-ALTSA FTE based upon the amount of ALTSA and Non-ALTSA funding reported on each individual worksheet. **This section is formula driven therefore no entries are required.** A comment will appear in cells I32 and I33 stating whether the information in the worksheet is correct or if an error has occurred. If the word error appears, the AAA has probably inserted a column(s) to report additional Non-ALTSA funding and the formula did not capture the additional column(s). This can be avoided by inserting needed columns in-between the Non-ALTSA (specify) columns opposed to inserting them at the end.

D – 6 AAA Total Direct Services Worksheet Including Subcontracted Costs (Reconciliation Tab)

This worksheet is used to summarize all direct services worksheet tabs, to report all subcontracted expenditures, to reconcile to the Expenditure/Revenue Detail by Funding Source worksheet and to reconcile the FTE reported on the Staff Full Time Equivalent (FTE) Breakout worksheet.

1. The FTEs and Direct Services expenditures are automatically linked from the AAA Individual Direct Services worksheets**.**

2. Enter all subcontract expenditures on the Total Subcontracted Expenditures line by funding source.

3. Enter all other resources provided by subcontractors (subcontractor match, program income, etc.) on the Total Other Subcontracted Resources line by funding source.

4. Total FTEs must match the number of FTE on the agency's Organizational Chart, Staff Full Time Equivalent (FTE) Breakout (D-4 Staff FTE Breakout tab) and the Appendix B - Staffing Plan

5. The Total Expenditures line must equal the Grand Total line on the Expenditure/Revenue Detail by Funding Sources worksheet. The reconciliation section located at the bottom of the worksheet indicates whether this has occurred. **This section contains formulas; do not enter data in this section.**

D – 7 EXAMPLE Staff Full Time Equivalent (FTE) Breakout

This worksheet shows an example of a correctly completed Staff Full Time Equivalent (FTE) Breakout worksheet. See Staff Full Time Equivalent (FTE) Breakout section above **D – 4**.

APPENDICES

Please update appendices to reflect the 2024-2027 planning years.

Appendix A Organizational Chart

The Organization Chart should show the relationship of the AAA to the sponsoring body and show the reporting relationships of AAA staff. The minimum required is a structural chart showing the chain of command with a box for every type of position. If several staff have the same classification under the same supervisor, a single box may be used but must show the number of positions represented. The organizational chart should reconcile with the Staff FTE Breakout in the budget.

Appendix B Staffing Plan

The Area Agency Staffing Plan requires a description of each unique position along with the number of staff who perform the functions described under that position. Include names of staff currently filling the position and indicate vacancies where the position is not currently staffed. If there are concerns about security, the AAA can omit the names of current staff in the staffing plan for the public document and instead send to DSHS/ADS under separate cover a staffing plan complete with names. Please indicate staffing for the Medicaid Transformation Demonstration.

The number of full-time and part-time staff as well as the total number should be provided. Totals are also required for the number of minority staff reporting in each race/ethnicity category, staff over age 60, and those that have self-indicated a disability. Indicate the number of hours considered as full-time at the AAA, i.e., 40, 37.5, etc.

Appendix C Emergency Response Plan

The Emergency Response Plan includes the following elements from the Area Agency on Aging Policy and Procedures Manual Chapter 1: Policies:

- A designated staff person to oversee planning tasks and determine how emergency management is carried out in the local jurisdiction.
- Letters of agreement between the AAA and local emergency operations leadership that identify responsibilities.
- Preparedness activities done by the AAA.
- Criteria for identifying high risk clients in the community.
- Plan for contacting high-risk clients and referring to first responders as necessary.
- Local partners such as the American Red Cross
- Cooperation with the appropriate community agency preparedness entities when areas of unmet need are identified.
- A system for tracking unanticipated emergency response expenditures for possible reimbursement.
- An internal Business Continuity Plan that emphasizes communications, back-up systems for data, emergency service delivery options, and transportation
- Policy and procedures developed and/or implemented due to the COVID-19 pandemic.

Appendix D Advisory Council

The name of each Advisory Council member must be listed on this appendix along with a demographic count. The AAA may also include the geographic or other affiliation of any or all members.

Appendix E Public Process

This appendix should include simple documentation of planning activities, such as notices for or a list of the dates and locations of the community forums, focus groups, surveys or public hearings held to assess need and obtain community input. Describe roles played by Advisory Council and County/Council of Governments/Tribal Government in the local approval process of the final Area Plan. (An optional template is attached to the MB for Appendix E.)

Appendix F Report on Accomplishments from the 2020-2023 Area Plan

This appendix should include goals, objectives and accomplishments described in your 2020-2023 Area Plan. Indicate progress make toward the goals, for example, whether objectives have been met or continue in your current Area Plan. This can be done in a brief chart form to address the major accomplishments within your PSA. An optional Appendix F template is attached to the MB.

Appendix G Statement of Assurances and Verification of Intent

For the period of January 1, 2024 through December 31, 2027, the _____[AAA]_____accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (as amended through P.L. 116-131) and related state law and policy. Through the Area Plan, _____[AAA]_____ 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. The _____ _____[AAA]_____ 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 the _[AAA]_____ 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/ALTSA. The _____[AAA]_____ 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 Director, [AAA]

_____ _____
Date Advisory Council Chair

_____ _____
Date Legal Contractor Authority

_____
Title

Attachment V - WA State Plan on Aging Public Comments

	Affiliation	Comment	Response
1	DSHS/ALTSA Constituent	Hi Pg 36 objectives column near bottom. Up one Talks about finding ways to avoid more intense services That is what we are facing now! I got nerve tests in January and can't get to a dr till August. Can't delay much more than that We need help getting drs and nurses instead of bandaiding the issues. Going back to tye real issue My thoughts Thx We can't wait this long as seniors.	This comment may be in reference to workforce shortage issues. ALTSA recognizes the need to strengthen the direct care workforce to better support the growing population of older adults in Washington. The State Plan on Aging aims to address this concern through several strategies throughout the Caregiving topic area.
2	DSHS/ALTSA Constituent	We feel this is wrong, we should be able get long-term care insurance WHEN WE WANT TO and not have it mandated by the state. As it is, what we will pay into it we will only qualify for 10% of the value, if we need to use it. This isn't right. If we move out of state, then we can't use it in another state. We are against the government basically taking our hard-earned money and we have nothing for it.	This comment may be in response to the WA Cares Fund, a first in the nation long term care benefit for Washingtonians. ALTSA is currently working to address concerns around near retirees eligibility, portability, and other concerns prior to the benefit becoming available in 2026. The WA Cares program offers frequent information sessions open to the public as well, which may serve as an opportunity to voice these concerns and improve the program.
3	DSHS/ALTSA Constituent	it's my adult family home license going to increase I mean the payment of my services that I do for the clients am I going to get an increase this year thank you for letting me know…	This comment may be more specific to an individual concern rather than to a State Plan on Aging specific topic area. Resources for Adult Family Home may be found here: https://www.dshs.wa.gov/altsa/residential-care-services/about-adult-family-homes
4	DSHS/ALTSA Constituent	The clients need more help with personal information on medical medical supplies poe gear and how to get it and more transportation more medical money	This comment may be in relation to person centered approaches to client case management. ALTSA supports a person-centered approach to help identify the needs and barriers that better support clients. Additionally, the Washington Community Living Connections aims to connect individuals with the local long-term services and supports they need. ALTSA has worked to improve resource accessibility through this consumer website and is continuing to enhance it directory.

5	Caregiver	You have noted that the state has contracted with cdwa who now handles all of our caregiver payrolls, etc. I hope that you know that it's because of the switch to cdwa that many caregivers have quit the past year and a half. Cdwa has not been a good employer for caregivers. In the year and a half to two years that I have been employed I have never been able to access a pay stub and there are multiple steps to have to go through to get any information at all. The people assigned to handle calls have been very rude and not helpful at all. I don't know how many times that I have received a message in my mail that I have gone over time with my client because I am a live in caregiver. I am not a live in caregiver. Nor have I ever been a live in caregiver. It is because of cdwa mainly that I am quitting my 13-year profession as a caregiver in Washington State. It has been a horrible experience. This is my main concern for responding to your proposal. The state cannot hire the cheapest firm to take charge of the caregivers in the state. Spend a little more money and get better service and retain your caregivers! Not only is there a problem with cdwa, there is also a problem with living wages for caregivers. I have been a caregiver for over 13 years and I'm now receiving less than $1 an hour more a caregiver just beginning in the field. This is not acceptable. In all the time that I have worked as a caregiver I have accumulated a retirement fund of less than $6,000. I could go to work at McDonald's and have less stress, a higher retirement, and more income. How can we be proud of our jobs, our training, and hold our heads high? Another reason that I am leaving the caregiving field is because of the continuing education. Last year I was not able to access continuing education even though I begged for it. Then I began classes with SEIU and chalkboard which were so full of errors that it took twice as long to get through the classes that it should have taken. Finally, caseworkers do not evaluate their clients well enough. In my last 13 years of employment as an Individual Provider/ caregiver I have had the opportunity of seeing many clients	This comment covers several topics including the transition to a Consumer Directed Employer (CDWA), barriers to being a caregiver, livable wages, and client care. It is important to recognize the transition to CDWA has been a challenging experience. While this transition has come with challenges, the goal of creating greater capacity to support the goals of increasing the capacity of DSHS/AAA case management, customer service, and other social services staff to focus on core case management activities. Additionally, ALTSA recognizes the significant challenges caregivers face, and addresses these concerns throughout the Caregiving topic area section in the Plan. Client care is a critical priority of ALTSA. Through a person-centered approach, ALTSA aims to support older adults and individuals with disabilities live healthy, independent lives in their settings of choice.

		getting up to 160 hours of care each month who don't need that amount of care, and the disabled people who are covered just let their caregivers work whatever hours they want and then let them go for the day. For a long time caseworkers never came out to the house to even visit with the client. They just took the clients information directly from the client over the phone and gave them the hours that they thought they should have. This was all based on the clients word. This year I have noted that one case worker in particular has come out to visit with my client. But this was without any input from me regarding my client's situation. In addition, 2/3 of the clients that I have worked for have misused their medical supplies. They order pee pads so that their dog can pee on them. They order depends so that their family can use them and then they give them all away. Much of the supplies end up at thrift stores. It's been ridiculous that no one is checking on this and that the companies that handle the medical supplies just ship what the client asks for. There is no oversight here and it is costing the state quite a bit of money in the long run. I have been in homes where there are rats everywhere, spiders everywhere, overflowing toilets and leaking sinks and mold. There is no warning to caregivers that the house could be their death trap. They do this without telling the caregiver that the house is unfit to live in or is dangerous for the caregiver and they allow caregivers to work in those conditions. I have worked in homes where they had holes in the middle of the floor which I at one time fell into and had to be on L&I for a year. I hope with all the money that you are planning on spending that you are taking into consideration all of the waste, the well-being of caregivers, and better care for the seniors and other disabled that you are covering.	

6	DSHS/ALTSA Constituent	Hello, Though I appreciate receiving this document, especially via email and not printed matter format, I am not inclined to offer any comment on its content. To me it reads simply as a formulaic business plan for ALTSA. As a "senior citizen" my interest in the topic of services to support aging in place caused me to open and scan the document. Sadly, I found it to be too long and too much about what is already in place to be of much interest. I scanned the document through to page 34 before finding anything resembling an action plan but even that didn't reveal anything new about new challenges or how to achieve goals already in place. If the document contains specific new action items I missed them as not highlighted. I did hope to read about something new that's being planned or considered to support "Aging in Place" via support for services offered etc. I would like to take this opportunity to say that I fully support the WA Cares Fund as something that's sorely needed. Also, I think much more effort is needed for public education about what benefits a person who's paid into the fund could receive. I've read so much misinformation about the Fund on local social media sites such as NextDoor that I'm convinced the majority of workers paying into the fund just don't get it. I have no idea what kind of info is provided in the workplace about this 'contribution' from paychecks but it seems to be viewed as a tax. The amount of benefit the Fund is projected to provide is only a drop in the bucket for what will be needed by average person in need of any kind of aging services. I am one of the minority who has a personal Long Term Care insurance policy and which premium has more than tripled over the past 4 years. We have reduced the coverage afforded in the policy in order to keep our premiums affordable but are still paying close to $8k annually for a policy that started out 13 years ago at about $3k. So, yes, I'm fully in support of the WA Cares Fund and also think it needs to grow coverage - educate the public and offer different levels of coverage. Thank you for this opportunity to comment.	This comment provides gratitude and support for the WA Cares Fund. Resources for the WA Care Fund can be found here: https://wacaresfund.wa.gov/.

7	Former CM	Thank you for doing this work As a former case manager & case manager supervisor with over 25 years experience and a Master's degree related to the field (but I'm not a CPN or RN or MSW) I was dismayed to find I still had to take all the trainings to be a paid caregiver for the IP program when my business partner got cancer & i needed to start providing in home supports. I do not fit any other criteria to be excused from trainings I'm qualified to teach & have supervised for years!!! Please add this to the "to do list" because training criterias were just tweaked, but I'm still not able to present my experience & education to the Dept of Health for a waiver for on-going CEUs the way I'm reading the changes in standards. If I'm a trainer for a CEU I can't even use that as a waiver!!! I'd have to take the class I've been certified to teach! Please add a process to ask for a training waiver for people like me, who might end up becoming a caregiver again after retiring from being a supervisor in that same field. Thank you.	This comment relates to the training requirements for home care aides in WA state. Though stringent, WA's training requirements are designed to provide HCAs with the education and training needed to support client's needs while creating a strong foundation to learn and develop throughout their careers in this workforce.
8	DSHS/ALTSA Constituent	Hello and thank you for this opportunity to give thoughts and feedback. I am a soon 68-year-old taking care of my disabled 42-year-old disabled son. His sister is just getting trained to step in and help me and take over if I am no longer able. We live in a 2-story home with all bedrooms and baths on the 2nd floor. I own my home and have been looking for 55+ community homes where we could transition. There are not many available in Snohomish County. An apartment would not work for us as my son can get very loud with his music and his "happy noises". Very much presents itself as a one plan does not fit all with atypical family needs. There are some nice housing areas in other places, Lacey, Sequim, Lake Chelan, Spokane I am aware, but I will need to be close to my daughter. Thus, I am advocating for more 55+ housing opportunities for those who are not ready for an assisted living facility yet wanting to not be isolated in neighborhoods of families and without peers with our same interests and needs of socialization. Thank you for listening,	This comment addresses one of the top concerns noted in the Plan's Trends and the Needs Assessment Activities sections -- this issue is housing that is affordable. ALTSA recognizes this concern and continues to support housing needs of clients, as well as other long term services and supports through a variety of programs and practices noted throughout the Plan.
9	DSHS/ALTSA Constituent	Those employees 64 years or older should be exempt from the tax. People of this age will never be eligible to receive a benefit for this care. The State of Washington will collect this tax and use the amounts collected to pay the benefits of other younger people. This is a form of Age Discrimination, an unfair tax on our older work force.	This comment may be in response to the WA Cares Fund, a first in the nation long term care benefit for Washingtonians. ALTSA is currently working to address concerns around near retirees' eligibility, portability, and other concerns prior to the benefit becoming available in 2026. The WA Cares program offers frequent information sessions open to the public as well, which may serve as an opportunity to voice these concerns and improve the program.
10	Stakeholder	To Whom It May Concern: The WA State Hospice and Palliative Care Organization (WSHPCO) would like to express our concerns that the plan does not seem to incorporate palliative care or hospice options at the end-of life. Advanced directives are not included as well. It would seem like a State Plan on Aging should include some preparation and planning for end of life care! From the report : Alzheimer's disease (AD) is the fourth leading age-adjusted cause of death in Washington State, and from 2020-2040 the number of people with AD or other dementias is expected to grow from 125,000 to over 270,000. Thank you for your consideration. Sincerely,	This comment has been addressed through the addition of Legal Services Program, as well as the inclusion of the Palliative Care Road Map as a resource noted in the Plan.

11	Stakeholder	Hello, I'm reaching out today to comment on the state plan for aging 2023-2027. I'm commenting not only as a board-certified music therapist who works with seniors, memory care, and hospice, but also as the guardian of a parent with dementia who uses COPES. So I've been on both sides here. As a music therapist in memory care for 10 years in Snohomish and King counties I can attest to the incredible difference that it makes for seniors who are living increasingly isolated lives. Music allows them to connect with their loved ones, peers, their communities, and themselves. In group settings, as well as one-on-one therapy, people benefit from a medium that is accessible, motivating, and incredibly beneficial. Primarily, I work on non-musical goals with my clients from helping people with aphasia sing and speak again, to maintaining fine and gross motor skills through dance and instrument play, to giving them a way to communicate and express themselves in a supportive musical environment. I work with between 80-120 clients weekly in the Puget Sound region, but my clients are able to attend my sessions because the communities they live in support my services through private pay. It is not lost on me that there are many more people who would benefit from this service if there weren't financial barriers to their access. My dad is one of those individuals who does not have the extra funds to spend on things like this and even budgeting a haircut can be a challenge when it's 1/3 of his discretionary income. He was a musician in his youth and highly motivated by music. So much of his identity, and so many of his core memories are wrapped up in the songs of the 60s and 70s. Now that he's in Assisted Living he stays in his apartment most of the time, only leaving for meals, watching Seattle sports in the living room, or for live music. While the live music is certainly enriching, I know that he and many of his neighbors would benefit from music therapy opportunities in his community.	This comment relates to music therapy as a service option. While not specific to Older Americans Act programs/services, other administrations withing DSHS may support music therapy for its clients, such as the Developmental Disabilities Administration: https://manuals.dshs.wa.gov/sites/default/files/DDA/dda/documents/DDA%20Eligibility%20and%20Services%20Guide.pdf.
		I urge you to continue to support access to professional music therapy services in a population where this type of connection and care is crucial to a fulfilling and enriched life. Thank you for your work, time, and consideration.	

12	DSHS/ALTSA Constituent	I am a 76- year- old Master Fitness trainer, sports nutritionist, author and speaker on health and wellness. I live in Vancouver, WA. I actively train people of all ages but do considerable training of seniors, including rehab of injuries and stroke recovery. I read your state plan on aging and have the following comments: I understand the need to help people in need- especially seniors and those who are not mobile or cannot do all of the daily activities of living by themselves. The issue as I see it is where do you spend taxpayer dollars? Do you spend the majority of dollars allocated to aging on assisting the sick, financially needy, disabled or people who are old and weak? Or, do you spend more money on prevention? True, we cannot prevent getting old, but we can (and I believe should) spend more dollars on educating our citizens on proper nutrition and exercises that can prevent premature aging, many degenerative diseases, some forms of cancer and sarcopenia (age related loss of muscle mass), and even Alzheimer's and dementia. Here's the worst part of your spending plan: without addressing the root causes and downsides of aging, all you are doing is spending more and more dollars that can only increase (with the aging population) placing additional burden on taxpayers. It's no different than buying fancy fire-fighting equipment but ignoring the real problem- how to prevent fires in the first place. As a trainer for many years, I know the results of proper nutrition and exercise for older adults. The results are astounding. My older clients function at a level that is actually hard to imagine for most. Seeing 70 and 80 somethings living fully functional lives does not happen by chance. True, these people can afford proper nutrition and trainers who specialize in older adults, but the results speak for themselves.	This comment relates to the healthy living habits for older adults to promote healthy aging. In addition to several measures noted throughout the Plan (Senior Nutrition, CDSME, Addressing Alzheimer's Disease and other dementias), ALTSA, through its State Plan to Address AD and Other Dementias promotes healthy aging through education, training, and ongoing public-private partnerships.

		My recommendation to spend more dollars on education (even for our younger citizens) probably doesn't fit with what I see is recommended in your study document: social services, caregiving, emergency preparedness, housing, hunger, assistive technology and mobility transportation to name a few. Many of these "issues" are certainly a direct result of aging, but they do nothing to help our citizens age better with fewer diseases and conditions that can be prevented to a large extent. I do note you are spending some funds on prevention (Falls and TBI to name one), but it is clearly not enough. If given an opportunity to speak to the panel who crafted the state plan, I can show them how I would propose to create a more robust educational council that would seek to provide targeted fitness training and nutritional solutions for long term benefit to our citizens. Please consider the following. I know there are many theories about the causes and potential cures for Alzheimer's and dementia but please explain this if you can: I've personally known about 30 people in my lifetime who have clearly had Alzheimer's or dementia. All of them, to one extent or another were either sedentary or engaged in very limited daily exercise activities. I don't know of anyone who has contracted these conditions who have routinely exercised and practiced reasonably healthy nutrition (although there are certainly some). There are many studies indicating exercise and nutrition have a positive effect on these conditions, but I believe the connection is much stronger. The problem is proper nutrition and exercise need to start earlier in life rather than later but so far it is unknown when it becomes too late. Another reason to educate our citizens. Perhaps it too late for the Dept to change its recommendations, but I am convinced that while the proposed plan will probably help those in acute need, it will do little to help with the longer-term problem and thus only create the need for more dollars to be spent in support in the	

		future. Motivating citizens to adopt healthy living patterns is no easy task. Change is difficult for many, and as an experienced trainer, I know motivation is either there or it's not. Getting into people's heads to eat healthy and exercise is special skill that doesn't work on everyone. What seems to work is having a message that is consistent and energizes people to adopt new habits. Still, not perfect, but the right education platform can work. Finally, the one topic that doesn't seem to get attention but desperately needs to be addressed is obesity. So many of our older adults suffer from this condition and is the root cause of cardiovascular disease, diabetes and certain forms of cancer. We must spend money on educating our citizens. Please feel free to contact me. I would be more than willing to come to Olympia and address the panel that created this plan. My perspective may be different than theirs, but I think I have credible arguments for modifying support and assistance to aging citizens of Washington.	
13	DSHS/ALTSA Constituent	I appreciate having the opportunity to comment. Arguably the most significant issue facing Washingtonians close to or in retirement is the cost of living. Without addressing policies that support seniors, most of which are on a fixed income, all of the strategies in this document will be in peril. If aging Washingtonians are to "age in place", the state must keep as many costs as possible frozen. Here are two general examples: 1. Property taxes need to be frozen so seniors are not taxed out of their homes. Proposition 51 in CA is an example. 2. Promoting and adopting fiscal policies that hold inflation in check. Inflation, especially when it occurs due to legislative actions functions as a backdoor tax. Bottom Line: ALTSA needs to promote strategies such as the two above to our legislature if any real or sustained progress is made. Thank you	This comment aligns with the concerns addressed in the Plan's Needs Assessment Activities. ALTSA continues to support the programs and services that aim to delay more costly, intensive care by rebalancing funding and services to promote home and community-based services/supports.

Washington State
Department of Social
& Health Services

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