New Partners for New Times

AREA PLAN ON AGING

2014–2015 UPDATE

Seattle-King County Washington

ads Aging and Disability Services
Area Agency on Aging for Seattle and King County

King County | United Way of King County | City of Seattle

AGING AND DISABILITY SERVICES (ADS)

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Key Funding Partners

City of Seattle/General Fund
King County Community and Human Services/Veterans and Human Services Levy
U.S. Department of Health & Human Services / Administration for Community Living
UW Health Promotion Research Center
Washington State Department of Health
Washington State DSHS/Aging and Long Term Care Services Administration
Washington State Health Care Authority

October 2013

Dear Friends:

During the past few years, our communities have experienced one of the most challenging periods in history. The state and federal budget uncertainties have had an impact on all Washingtonians, including older adults. In addition, the number of older adults in our region has increased, and is expected to increase dramatically as the baby boomer generation continues to cross the threshold into retirement age.

Although this significant demographic shift poses many challenges, it also brings many new opportunities for advocacy, creativity, leadership, education, healthy aging, and community engagement.

The Aging and Disability Services 2014–2015 Area Plan Update, is a guide to help us meet the challenges and opportunities that are before us, by focusing on five goals:

- **Improve Health Care Quality for Older Adults and Adults with Disabilities**
- **Address Basic Needs**
- **Improve Health and Well Being**
- **Increase Independence for Frail Older Persons and Adults with Disabilities**
- **Promote Aging Readiness**

As we strive to achieve these goals, we will do our best to maintain the range of services we provide, and ensure that our services are culturally diverse and culturally competent, to meet the needs of our region's increasingly diverse population, especially those who are the most vulnerable. We will rely on evidence-based models that have been shown to produce successful results. We will track our progress using nationally recognized data indicators that will measure trends and help us assess our work.

Each of us takes pride in being a part of the three-sponsor organizational model of Aging and Disability Services, which is the designated Area Agency on Aging for King County. Together, the City of Seattle Human Services Department, United Way of King County, and King County Department of Community and Human Services coordinate our planning and investments to create choices for elders and people with disabilities in the Seattle-King County region.

We are confident that our seamless system will continue to make the Seattle-King County region a great place to live for people of all ages.

We look forward to hearing from you with your thoughts and suggestions as we strive to provide and promote high-quality services to elders and people with disabilities around the region.

Sincerely,

Catherine Lester, Interim Director
Seattle Human Services Department
City of Seattle

Jackie MacLean, Director
Department of Community & Human Services
King County

Sara Levin, Vice President
Community Services
United Way of King County

AGING AND DISABILITY SERVICES
2014–2015 AREA PLAN

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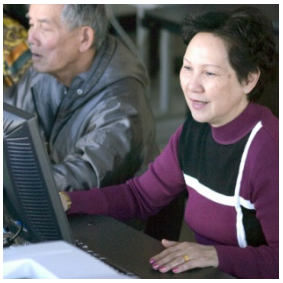
AREA AGENCY PLANNING AND PRIORITIES

Sound Steps Half-Marathon

"There is no more important 'prescription' to write, individualize and assure compliance with than regular physical activity for all patients, whether robust or frail, living independently or in nursing homes."

~ Christine (Himes) Fordyce, MD, Group Health

INTRODUCTION



We are delighted to present this update to the 2012–2015 Area Plan on Aging for the King County region, Planning and Service Area 4 (PSA 4).

The plan provides updated population profile information as described in Section B; updated information about planned accomplishments, as described in Section C— Issue Areas, Goals and Objectives; and information regarding 2012–2013 accomplishments, found in Appendix G. In addition, the plan provides information about the planning process, plans for the next two years, and new and revised issue area goals and objectives.

The Area Plan Update will guide the work of the local Area Agency on Aging and Disability Services (ADS) for the next two years. It reflects the needs of our community and highlights goals for developing elder-friendly communities. Our major goals are to:

- **Improve health care quality for older adults.**
- **Address basic needs.**
- **Improve health and well-being.**
- **Increase the Independence for frail older adults and people with disabilities.**
- **Promote aging readiness.**

The Older American's Act (OAA) requires the Area Agency on Aging to establish a volunteer Advisory Council to assist in identifying unmet needs, advise on needed services, and advocate for policies and programs that promote quality of life. As required by the OAA, our plan incorporates suggestions from the Advisory Council as well as numerous partners in the community. We engaged community members in several activities to understand local needs better, by conducting several focus groups, forums and workshops as described in Section A-3 Planning Process.

The Area Plan also highlights key trends in King County's aging population, including:

- **The rising number of seniors living in poverty.**
- **The shortage of housing for low-income seniors.**
- **Disparities in disability rates by race.**
- **Challenges faced by women as they age.**
- **Challenges faced by family, friend and neighbor (unpaid) caregivers.**

Besides describing updated information on new issues, goals and objectives, the plan also provides updated staffing information, and a new budget summarizing our annual budget of approximately $40 million in federal, state, and local resources. We hope you will continue to be as inspired, as we are, by our vision to create elder-friendly communities in the Seattle-King County region.

Jesse Eller
Director, Aging and Disability Services
Seattle Human Services Department

Tony Provine
Chair, Seattle-King County Advisory
Council on Aging & Disability Services

MISSION AND VALUES

The mission of Aging and Disability Services (ADS) is to develop a community that promotes quality of life, independence, and choice for older people and adults with disabilities in King County.

To accomplish our mission, we will:

- Work with others to create a complete and responsive system of services.
- Focus attention on meeting the needs of older people and adults with disabilities.
- Plan, develop new programs, educate the public, advocate with legislators, and provide direct services that include the involvement of older adults and others representing the diversity of our community.
- Promote a comprehensive long-term care system.
- Support intergenerational partnering, planning, and policy development.

In fulfilling our mission, we follow these values:

- Older people, adults with disabilities, and their families have a right to be treated with respect and dignity and to make decisions affecting their lives.
- Diversity brings richness to our community and within our agency and supports a wealth of ways to capitalize on this strength.
- The support and nurturing provided by family, domestic partners, and friends are important, and we seek to strengthen this capacity.
- Community partnerships are central in bringing together funders, providers, consumers, and community members to develop solutions that address changes in housing, education, health, long-term care, and advocacy needs.
- The concerns of low-income older people, adults with disabilities, and traditionally underserved groups are recognized, as well as the needs and potential of every member of the community.
- Efforts that encourage independence and enable individuals to remain in their community for as long as possible provide our focus.
- It is important that older people, adults with disabilities, and those having cultural and language differences within our community have knowledge of and access to the services for which they are eligible.
- Accountability to the public trust means the programs we oversee are consumer-guided, responsive, and useful.
- Leadership is shared with our regional, state, and federal partners and other city institutions as they develop ways to serve older people and adults with disabilities.

PLANNING AND REVIEW PROCESS

A six-month planning and outreach process informed the development of the Area Plan on Aging, which incorporates input from community members, local experts, providers, staff, and key partners.

During 2013, ADS received input regarding Area Plan updates from the following sources:

Aging and Disability Services Advisory Council (April–June 2013)
The Advisory Council Planning and Allocations (P&A) Committee spearheaded the process for updating the 2014–2015 Area Plan objectives and developing the 2012 Report on Accomplishments. Reviews were conducted in committee and by the full Advisory Council. The P&A Committee also hosted the public hearing held on August 5, 2013.

Mayor's Town Hall Meeting at Horizon House (April 2013)
Approximately 150 Horizon House (retirement community) residents attended a town hall meeting with Mayor Mike McGinn. ADS staffed a resource table, answered questions, and provided recommendations for town hall meetings in other senior facilities. Issues raised by audience members included:

- Economic issues, including a proposed felon employment program and unemployment rates, especially among African Americans
- Education issues, including follow-up on Youth & Families Day
- Environmental issues, including coal trains, urban forestry, and climate change
- Housing issues, including homelessness, shelter and affordable housing
- Infrastructure issues, including aging roads, seawall, electrical, water and sewer systems
- Land use planning issues, including neighborhood density, scale, green space, loss of view corridors, and sports arenas
- Public safety issues, including Seattle Police Department excessive force
- Transportation issues, including discontinued bus routes, advantages of trolleys over buses, and parking rate increases

Presentations and Group Discussions (April–June 2013)
ADS staff facilitated input sessions with Advisory Council members, the ADS Sponsors, ADS Management and Supervisory Leaders, and providers.

Aging & Disability Resource Centers (ADRC) Meeting (June 2013)
ADS staff hosted a meeting with nine individuals representing six King County 211 and Senior Information & Assistance programs. The meeting included a review of the proposed Area Plan Update on how ADS will meet the ADRC Fully Functional Core Components as defined by the ACL in order to achieve statewide goals.

Area Plan Public Hearing (August 2013)
The public review period for the 2014–2015 Area Plan and the draft 2014 discretionary allocation recommendations was July 22 to August 5, 2013, and concluded with a public hearing held in the city of Bellevue on August 5. Fourteen individuals attended the hearing representing older adults, Advisory Council members, community members, staff and providers. Public comments on the draft documents appear in Appendix E.

Prioritization of Discretionary Funds

Aging and Disability Services is designated by the State of Washington as the Area Agency on Aging for Seattle-King County, and part of the Aging Network that was established in 1965 with the passage of the Older Americans Act.

ADS sub-contracts with over 60 agencies to provide a network of in-home and community services, support programs and assistance to older adults and qualified disabled adults. In 2012, over 37,620 older adults, family caregivers and adults with disabilities in King County received services from the local Aging Network.

The 2013 budget totals $40 million. Of this funding, $34 million is “non-discretionary” and earmarked for specific services, such as Medicaid Title XIX case management, U.S. Department of Agriculture meals, and state-funded caregiver support and respite care.

The budget also includes $6 million of “discretionary” funds from the federal Older Americans Act, the state Senior Citizens Services Act, and the Seattle General Fund. Discretionary funding has some flexibility and can be directed to meet priority needs in King County.

The Advisory Council’s Planning and Allocations (P&A) Committee recommends strategies to increase or decrease discretionary funding to service areas. The committee consists of the Advisory Council chair and six members from the three ADS sponsor organizations (City of Seattle, King County, and United Way).

For 2013, automatic federal budget cuts of 7.4 percent (also known as sequestration) began March 1. Federal sequestration reduced the 2013 ADS budget by $442,700 for services. Approximately $390,388 was reduced from Older Americans Act discretionary funding. In addition, there was a direct services reduction of $24,979 from the federal family caregiver program and $27,333 from the federal nutrition incentive program.

When developing their recommendations, the P&A Committee considered the following:

- All ADS Service Areas
- Revised allocation guidelines from ADS Sponsors
- The P&A Committee’s 2012 service area priorities (Information & Assistance, Elder Abuse Prevention, Volunteer Transportation, Case Management and Nutrition Services)
- The 2013 Discretionary Allocations approved by Sponsors in 2012

Following public review process, the ADS Sponsors approved the committee’s recommended reductions to mitigate 100 percent of reductions to the priority service areas of Information and Assistance, Elder Abuse Prevention, and Volunteer Transportation; and reduce discretionary allocations to the following: Case Management, Nutrition Services, Adult Day Services, Client Specific Fund, Health Promotion & Senior Wellness and In-Home Care. In addition, approximately $80,000 of 2012 ADS carryover dollars was approved to lessen the 2013 sequester impact.

For 2014, the Seattle Human Services Department and Aging and Disability Services were significantly impacted by federal sequester reductions. In addition, the Washington

State Department of Social and Human Services (DSHS) allocates the Senior Citizens Service Act (SCSA), the Older Americans Act (OAA), Family Caregiver Support and other funds annually to the 13 WA Area Agencies on Aging (AAA). A funding formula, based on local Census data (such as the number of adults age 60 and over; the number of individuals with a disability; and the number of individuals who speak limited English) is used to determine how much funding each AAA will receive.

Beginning in 2014, DSHS issued an updated funding formula, resulting in a loss of $148,062 to ADS. The loss was based on growth in other areas and population shifts throughout the state. King County's share of the state funding was 28.1% using the 2000 Census data, but will be 26.98 percent based on the 2010 data. DSHS will phase in the updated formula over the next three years — 2014 to 2016 — for a total impact of $448,668 in lost revenue.

The P&A Committee's recommended strategies for the 2014, included additional discretionary reductions to Adult Day Services, Case Management, Client Specific Fund, Health Promotion & Senior Wellness, Information & Assistance, and Nutrition Services. Following a public review process, ADS Sponsors adopted the recommendations.

Should funding in 2014 increase or decrease, the P&A Committee will re-convene and examine the most updated global revenue picture for services for older residents in King County, as well as existing funding principles, and make recommendations which will be subject to public review and Sponsors' approval.

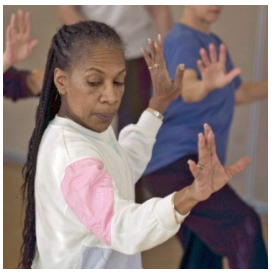
SECTION B
PLANNING AND SERVICE AREA PROFILE

PEARLS counselor Carl Kaiser

"Aging and Disability Services is particularly adept at connecting clients to community-based services, and coordinating service delivery. ADS also has a history of collaborating in the development, evaluation and dissemination of innovative and effective clinical practices that focus on the needs of its homebound clients."

~ Daniel S. Lessler, MD, MHA,
UW Medicine/Harborview Medical Center

POPULATION PROFILE



The "age wave" is already lifting the tide. The 2010 Census indicates that 312,624 people age 60 and above now live in King County, up 30 percent since 2000. By 2025, the number of King County residents over age 60 will exceed 496,000. Nearly one in four county residents will be age 65 or older.

As increasing numbers of baby boomers—born between 1946 and 1964—get swept up by the age wave, individuals and organizations need to ask, "Are we ready to catch the wave? What will it take to build an elder-friendly community?"

Aging in King County

A snapshot of King County's population over age 60 shows that 16.2 percent of King County's population is now age 60 or older, but this only tells a portion of the story.[1] Over the past decade, average life expectancy in King County climbed approximately four years (to 77.8 years of age).[2]

Age	Population	% total	Male	% total	Female	% total
60 to 69 years	169,262	8.8%	81,612	8.5%	87,650	9.0%
70 to 79 years	80,630	4.2%	36,415	3.8%	44,215	4.6%
80 and older	62,732	3.2%	22,611	2.4%	40,121	4.1%
Total age 60+	**312,624**	**16.2%**	**140,638**	**14.7%**	**171,986**	**17.7%**

Table 1. King County population age 60+ snapshot.[3]

The so-called Baby Boomer generation (born 1946–1964, hereafter called "boomers") has begun to swell the ranks of older adults throughout the U.S., and King County holds no exception. The oldest boomers now collect Social Security. Figure 1, below, illustrates the current population pyramid for King County, with a clear "bulge" in the 45 to 69 age groups.

[1] Information that was available from the decennial U.S. Census when this Area Plan went to print is included, along with the Census Bureau's most recent American Community Survey. Detailed information about age, gender, race, households, families, housing tenure and occupancy, population density, and area measurements will be released by the U.S. Census Bureau in mid- and late-2012.
[2] Public Health–Seattle & King County, presentations by director David Fleming, MD (2010–2011).
[3] U.S. Census (2010).

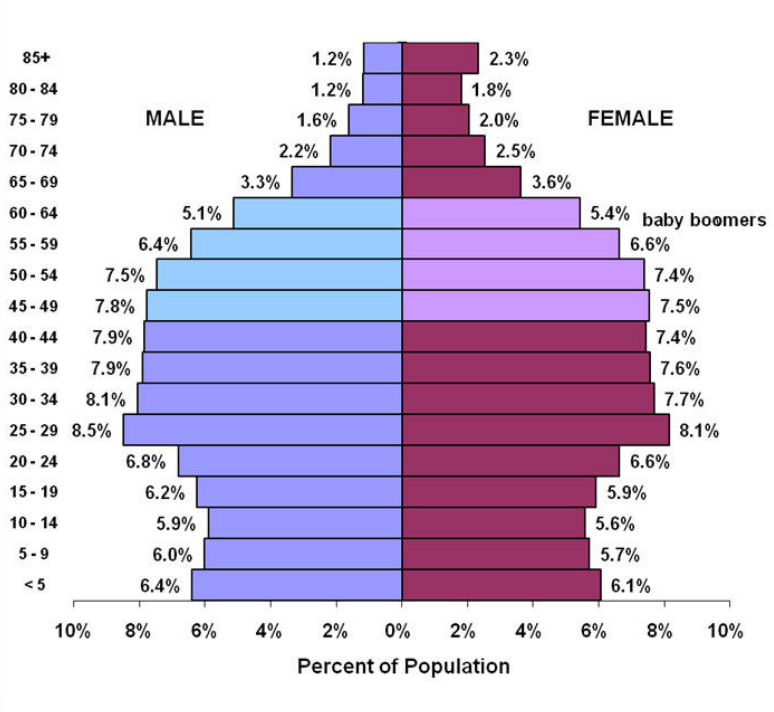


Figure 1. King County Baby Boomers compared to other age cohorts.[4]

Figure 2, below, further illustrates the age wave, as the baby boomer generation ages by 10 years (2000 to 2010). The 2010 bump in the age 25–29 cohort is sometimes referred to as the baby boom's "echo" (children of baby boomers).

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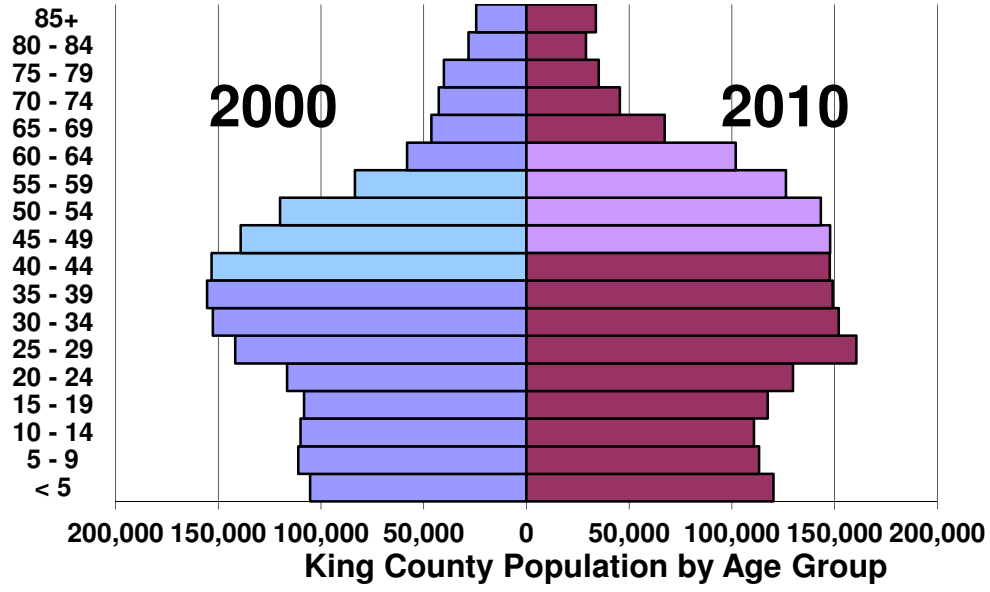


Figure 2. King County Baby Boomers compared to other age cohorts, 2000 and 2010.[5]

[4] Ibid.
[5] Ibid.

Current Census projections are illustrated in Figure 3, showing that King County's elder population (age 60+) will near 25 percent of the total population by 2035.

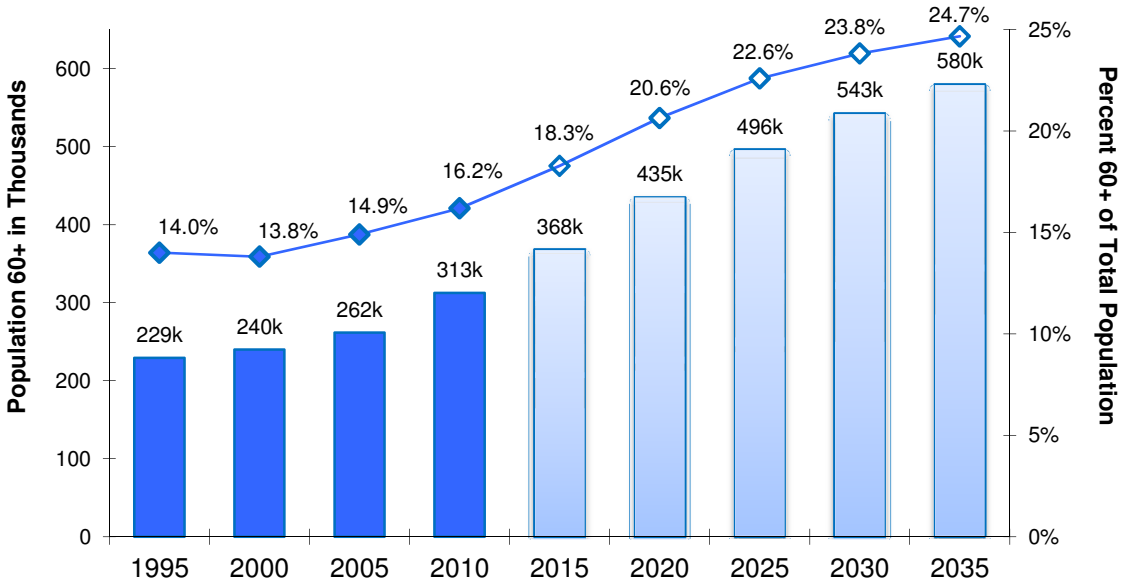


Figure 3. King County 60+ Population, Number and Percent of Total Population.[6]

A similar increase is expected among the oldest-old in King County. Since 1995, the number of residents 85 and older has almost doubled, and by 2035 will almost quadruple.

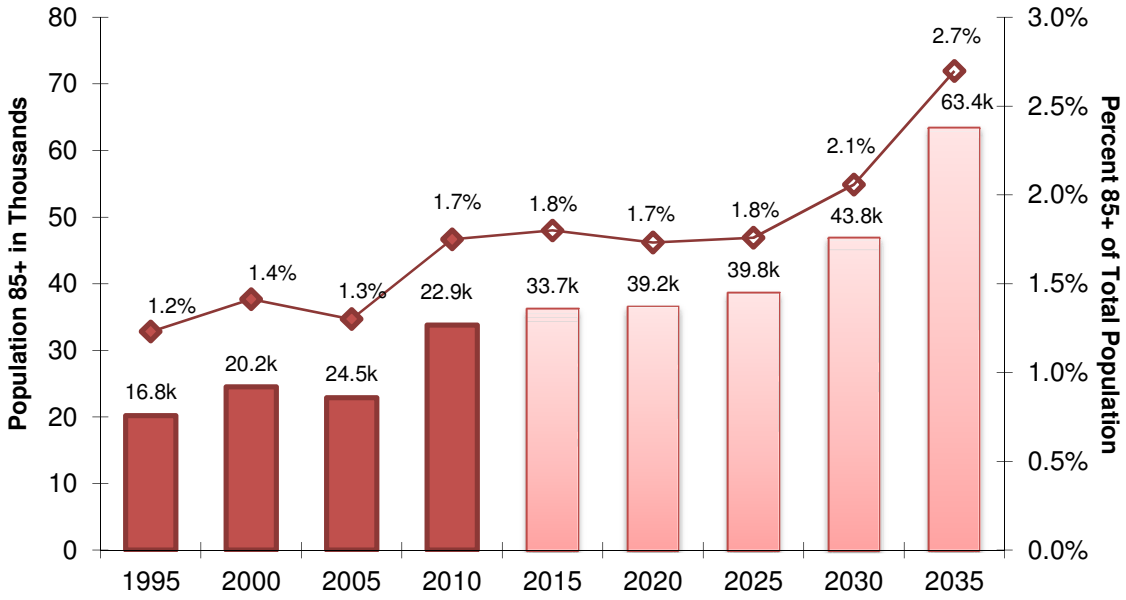


Figure 4. King County 85+ Population, Number and Percent of Total Population.[7]

[6] Washington State Office of Financial Management 'medium' 2012 population projections, plus American Community Survey (1995 & 2005) estimates and decennial Census (2000 & 2010) counts.
[7] Ibid.

Although small in number, Vashon Island has the largest percentage of older adults of any sub-region in King County, followed by the largest sub-region, Seattle. The South Urban and East Urban sub-regions follow Seattle in total number and percentage of older adults.

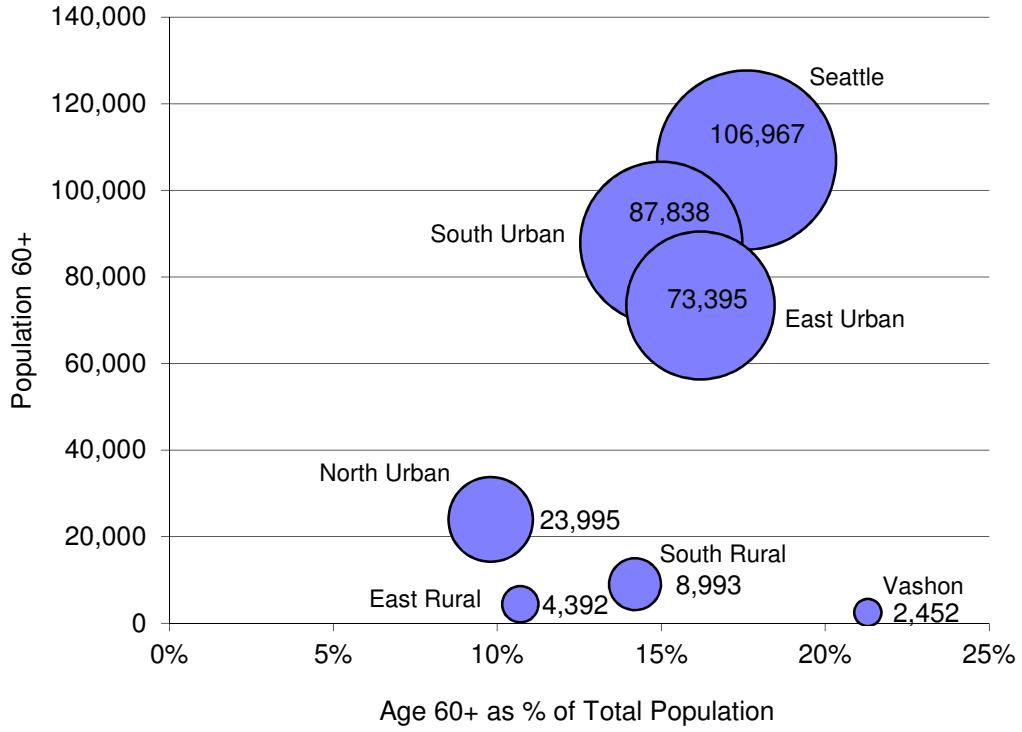


Figure 5. Age 60+ by Sub-Region.[8]

[8] American Community Survey (2009).

Overall, King County's older adult population grew by more than 28 percent[9], much faster than the total population (11.2 percent[10]). Table 6 indicates that the East Urban sub-region experienced the most growth in adults age 60 and older from 2000 to 2009 (39.1 percent), followed by Vashon (36.5 percent) and South Rural (36.1 percent).

	2000		2009		Growth 2000–2009	
Sub Region	**N 60+ 2000**	**60+ % of Total Pop.**	**N 60+ 2009**	**60+ % of Total Pop.**	**N**	**%**
Seattle	84,969	15.1%	106,967	17.6%	21,998	25.9%
South Urban	69,996	12.6%	87,838	15.0%	17,842	25.5%
East Urban	52,753	14.2%	73,395	16.2%	20,642	39.1%
North Urban	20,069	14.3%	23,995	9.8%	3,926	19.6%
South Rural	6,606	12.4%	8,993	14.2%	2,387	36.1%
East Rural	3,667	8.8%	4,392	10.7%	725	19.8%
Vashon	1,797	17.8%	2,452	21.3%	655	36.5%
Total King County	**239,857**		**308,032**			**28.4%**

Table 2. Growth in Age 60+ Population, by Sub-Region.[11]

King County's demographic composition is changing rapidly—not only by age but also by race and ethnicity. Nearly the entire general population increase consisted of persons of color. Asian Americans accounted for nearly half the increase, while Hispanic/Latino residents account for more than one-third. There were also small increases in the African American, Pacific Islander and Native American populations, as well as persons who reported more than one race. Persons of color now make up more than one-third of King County's population.

King County residents of color comprise 19 percent of the population age 60 and older. Figure 6, below, illustrates the overall racial composition of King County's elders.

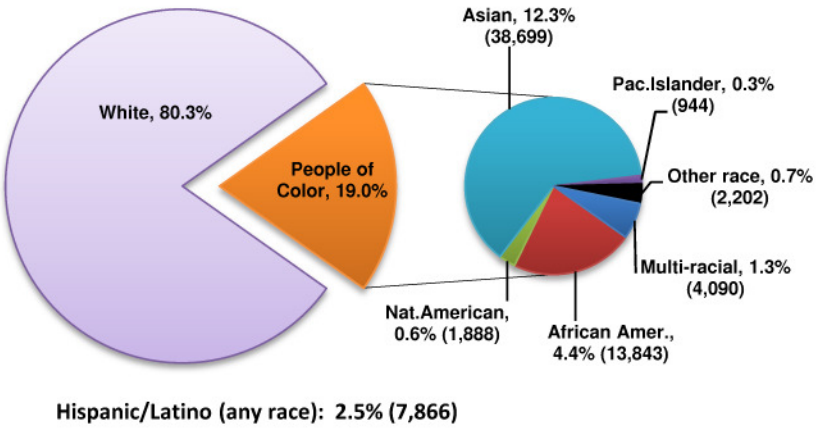


Figure 6. King County Population Age 60+ by Race.[12]

[9] U.S. Census and American Community Survey (2000–2009).
[10] U.S. Census (2000–2010).
[11] American Community Survey (2009).
[12] American Community Survey (2009-2011 three-year estimates).

Census data show that the percentage of people of color in Seattle remained flat, while the percentage of people of color in suburban cities south of Seattle—Kent, Renton, SeaTac, and Tukwila—grew much larger and now represent a majority of those populations. Throughout South King County, the white population declined by more than 14 percent, while communities of color increased 66 percent. The Hispanic/Latino population doubled, and even tripled, in some cities.

Life expectancy at age 65 is the number of years a person aged 65 can expect to live if the current age-specific death rates stay the same for his or her life. Life expectancy at birth for Whites is 82 years, in contrast to African Americans (76.2 years) and Native Americans (73.2 years).

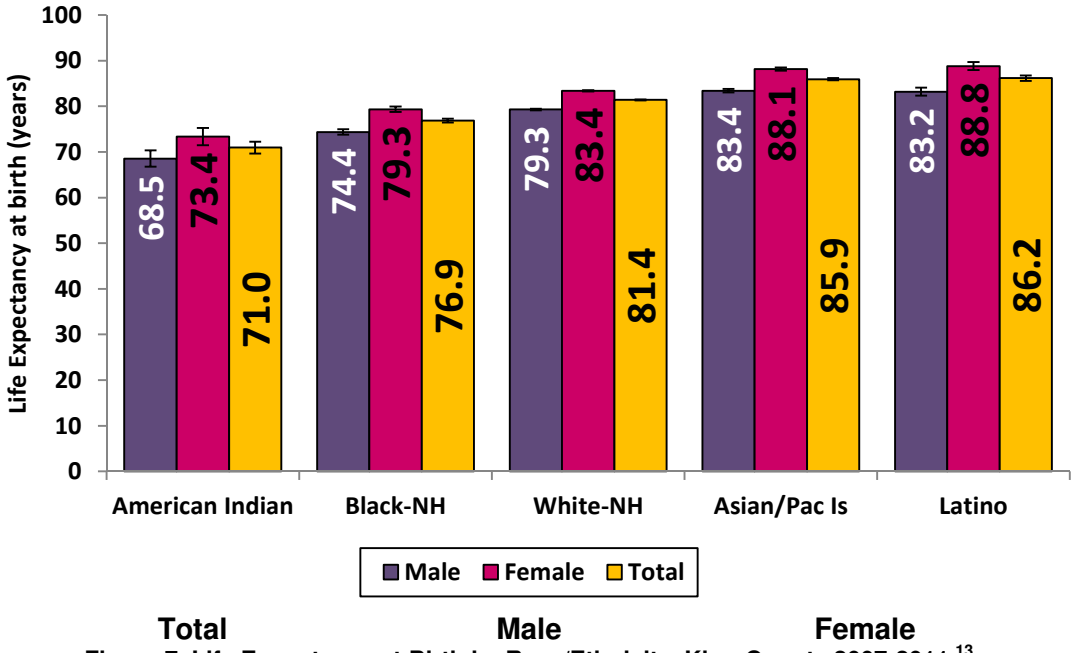


Figure 7. Life Expectancy at Birth by Race/Ethnicity, King County 2007-2011.[13]

Life expectancy is based on a number of factors, notably chronic disease and disability rates. The U.S. Census Bureau defines disability as a long-lasting physical, mental, or emotional condition that can make it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering. This condition can impede a person from being able to go outside the home alone or to work at a job or business.

Table 3 shows the proportion of older King County residents who have disabilities, by race and ethnicity. Disparities exist among Native American (66.6 percent), Multi-racial (48.4 percent) African American (40.0 percent), and Hispanic/Latino (38.1 percent) elders, compared to the overall proportion of older adults with disabilities (35.6 percent) in King County. Pacific Islander elders report a much lower disability rate than other groups.

[13] Death Certificate Data, Washington State Department of Health, Center for Health Statistics, 2011.

Racial Group	Total 65+	65+ With Disability	% With Disability
African American	8,377	3,349	40.0%
Asian	25,321	9,198	36.3%
White	168,491	59,042	35.0%
Native American	937	624	66.6%
Other Race	1,477	397	26.9%
Multi-racial	2,566	1,243	48.4%
Pacific Islander	479	123	25.7%
TOTAL	**207,648**	**73,976**	**35.6%**
Hispanic/Latino*	4,724	1,801	38.1%

**Overlaps with other categories*

Table 3. Disability Status by Race/Ethnicity, King County.[14]

Figure 8, below, demonstrates how disability rates increase with age. Physical limitations are most prevalent.

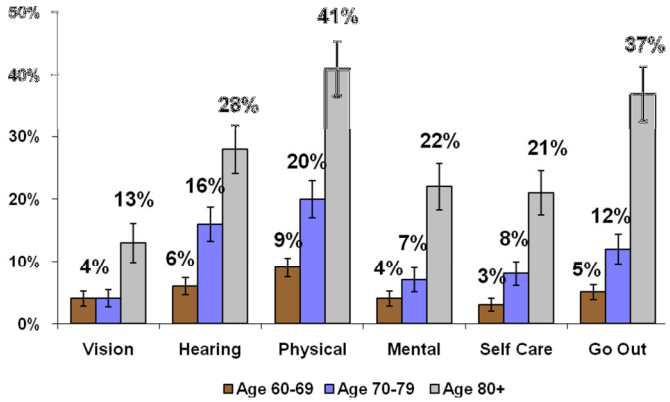


Figure 8. Rates of Disability by Type and Age, King County, 2005–2009.[15]

[14] American Community Survey (2009-2011 three-year estimates).
[15] American Community Survey (2005–2009 five-year estimates).

Figure 9 shows that cancer and heart disease remain the leading causes of death among all age groups in King County.

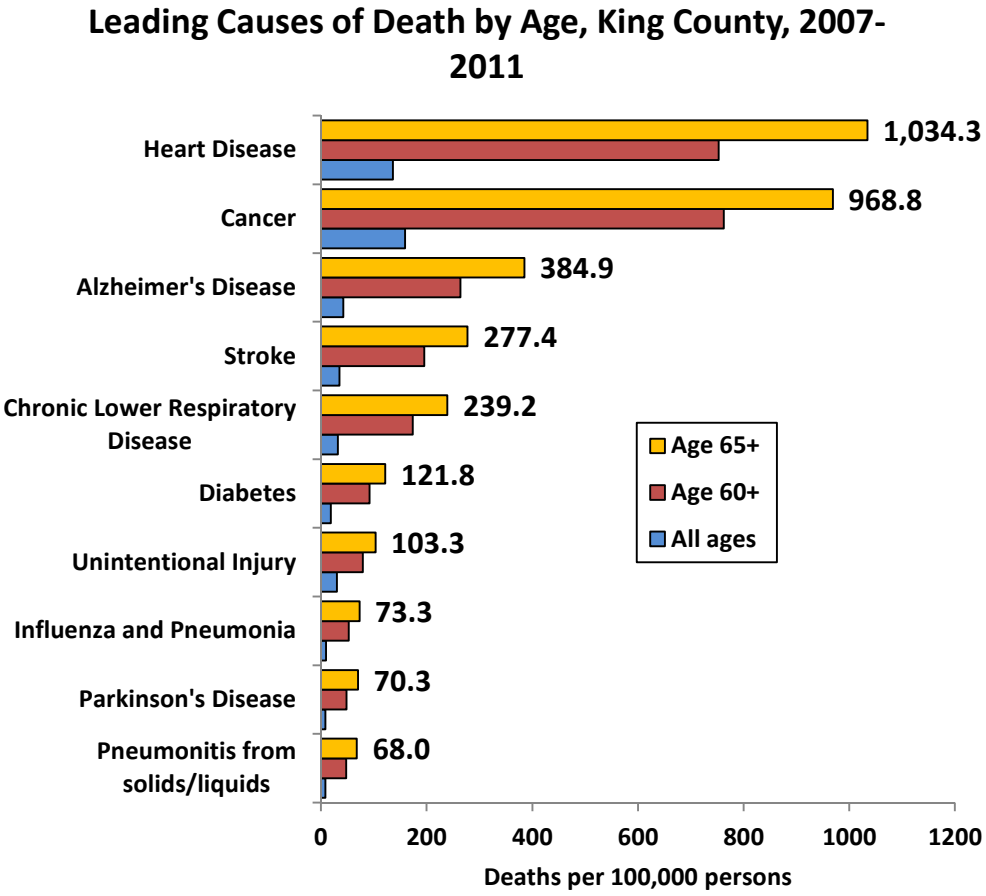


Figure 9. Leading Causes of Death by Age in King County, 2007–2011.[16]

[16] Death Certificate Data, Washington State Department of Health, Center for Health Statistics, 2011.

Figure 10 illustrates the leading causes of death for older adults, by race, with the highest incidence of deaths due to cancer or heart disease among Native American, African American, and White residents, and the highest incidence of deaths due to diabetes among Native Americans and African Americans.

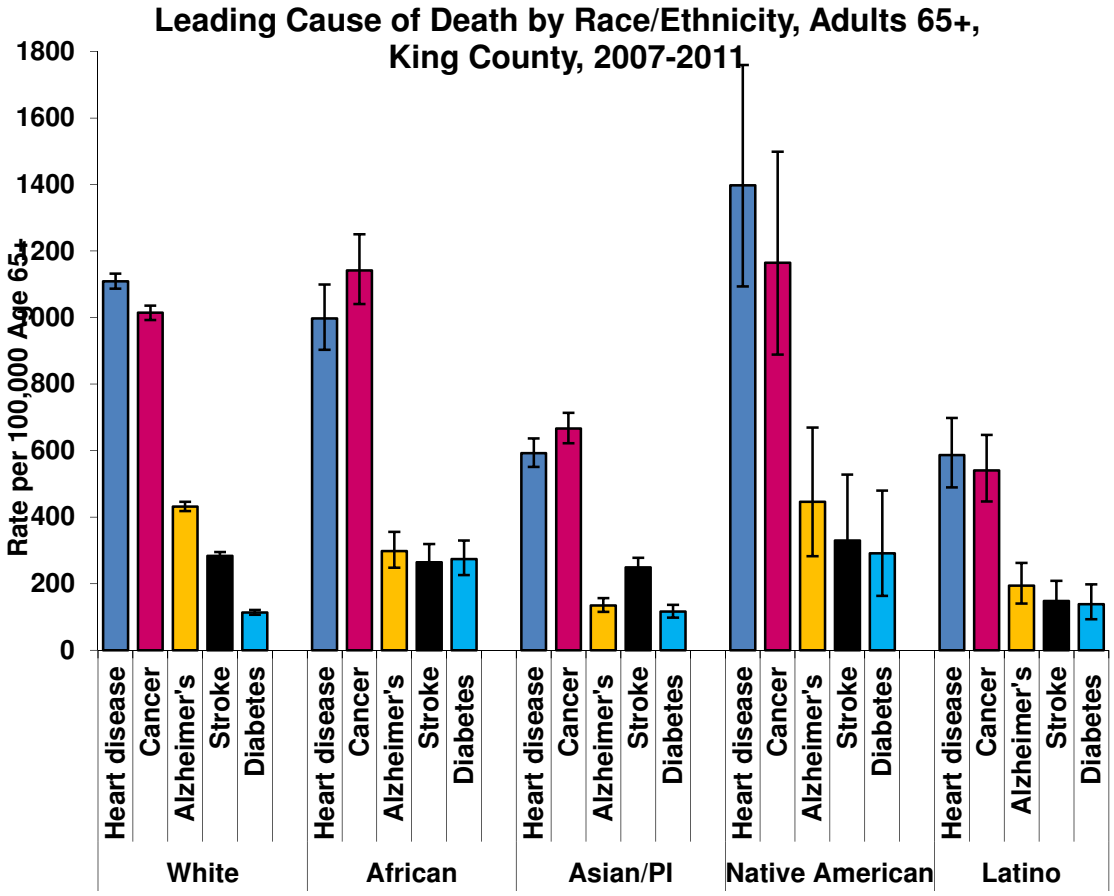


Figure 10. Leading Cause of Death, by Race, Age 65 and Older, King County, 2007-2011.[17]

[17] Ibid.

Nationwide, the most common chronic conditions for people age 75 and older are arthritis, hypertension, hearing impairments, heart disease, and cataracts.[18]

Figure 11, below, represents the increase in the incidence of chronic conditions, by age.

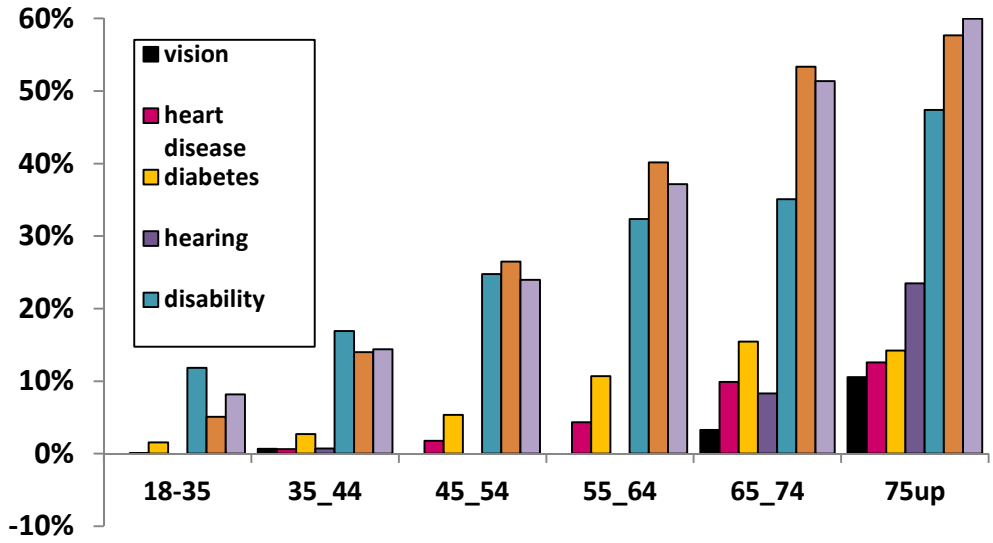


Figure 11. Rates of Chronic Conditions by Age, King County, 2007-2011.[19]

In King County, the rate of hospitalization for unintentional falls rises sharply with age, as indicated in Figure 12, below. Sharp rises occur after age 75 for men and women, and unintentional falls are much more prevalent among older women than older men.

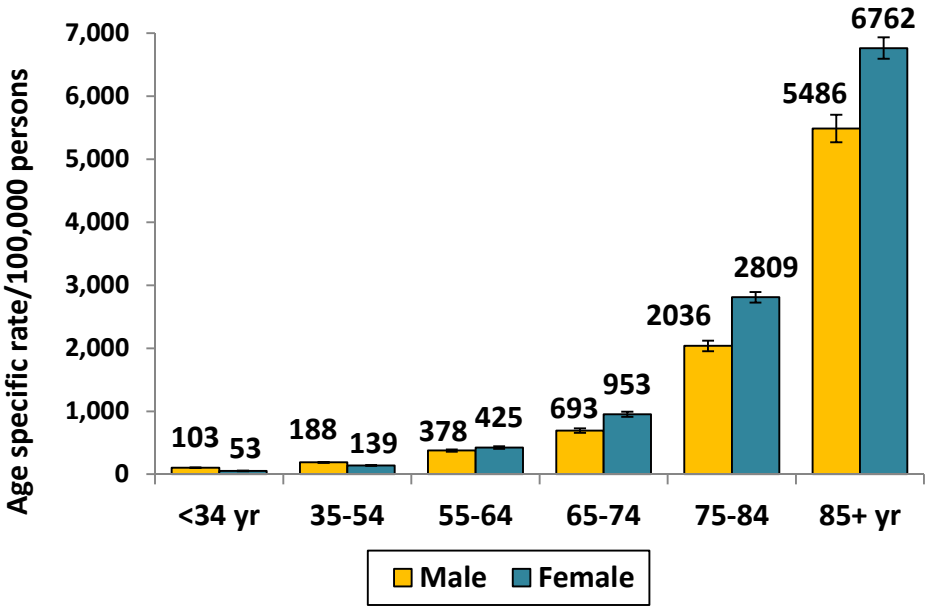


Figure 12. Rates of Hospitalization for Unintentional Falls by Age and Gender, King County, 2007-2011.[20]

[18] "Chronic Conditions: A challenge for the 21st century," *National Academy on an Aging Society (*November 1999), accessed at www.agingsociety.org/agingsociety/pdf/chronic.pdf.
[19] Behavioral Risk Factor Surveillance System, King County (2007–2011); American Community Survey (2009-2011).
[20] CHARS, Center for Health Statistics, Washington State Department of Health (2011).

The obesity rate has increased among all age groups over the past decade.[21] A majority of King County's adults are overweight, contributing to increasing rates of diabetes and heart disease. The obesity rate has increased significantly among all age groups over the past decade.

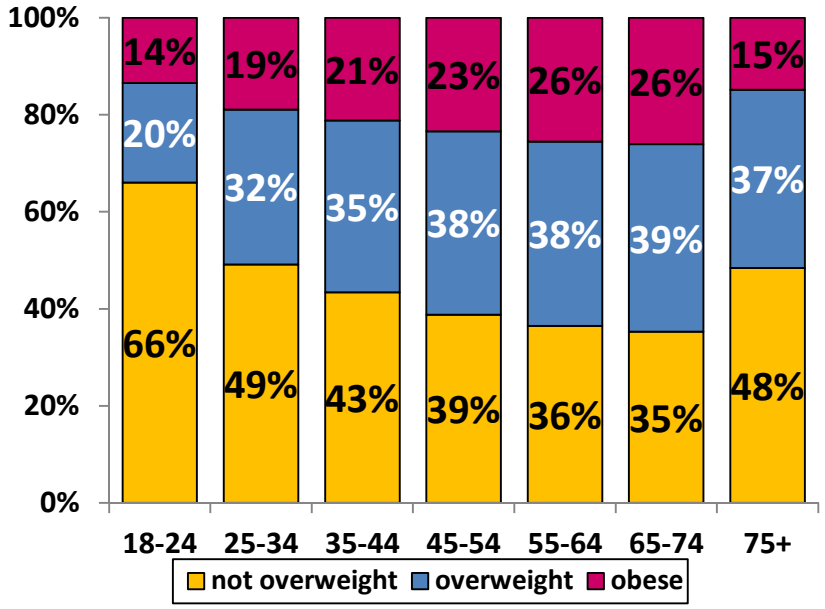


Figure 13. Weight Status by Age, King County, 2006-2010.[22]

Tobacco use is the single most avoidable cause of disease, disability, and death in the United States.[23] Figure 14 shows that smoking in King County is most prevalent among younger adults; however, a significant number of older adults also smoke.

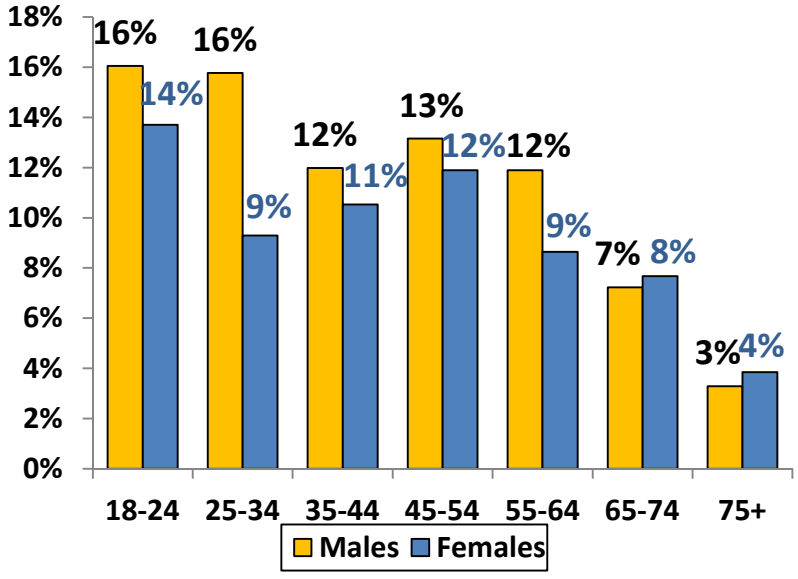


Figure 14. Smoking Among Age Cohorts, King County.[24]

[21] Behavioral Risk Factor Surveillance System, King County (2007-2011).
[22] Ibid.
[23] "Smoking and Tobacco Use," Centers for Disease Control: www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/
[24] Behavioral Risk Factor Surveillance System, King County (2007-2011).

Here and nationally, older adults are at greatest risk of suicide. In 2009, the suicide rate in King County topped rates from each of the previous nine years, and older adults appear disproportionately impacted. A total of 253 suicide deaths occurred in 2009—25 percent committed by people 50–59.[25]

Figure 15 shows that, over five years, 20 percent of suicides were committed by people over age 60, who made up 15 percent of the population during that period.

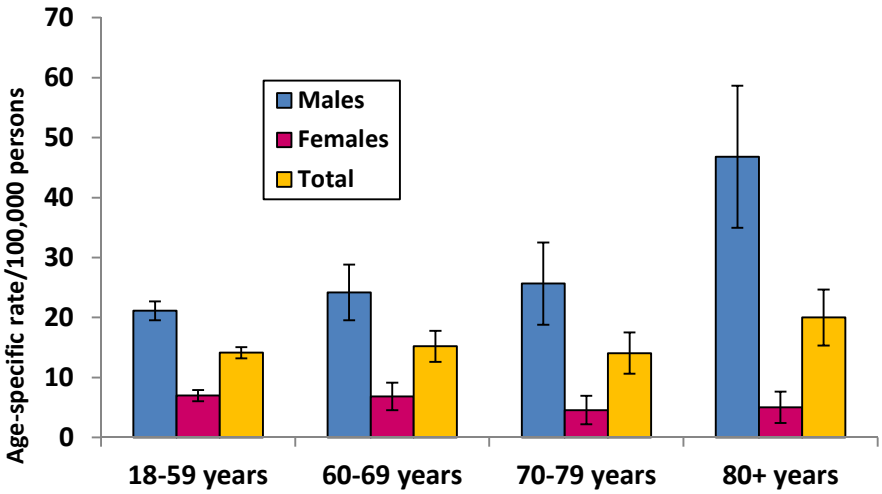


Figure 15. Suicide Rate by Age and Sex, King County, 2007-2011.[26]

[25] King County Medical Examiner's Office, "2009 Annual Report," accessed at www.kingcounty.gov/healthservices/health/~/media/health/publichealth/documents/examiner/2009MedicalExaminerReport.ashx.
[26] Death certificates, Center for Health Statistics, WA State Dept of Health (2011).

In King County, 9.3 percent of residents age 65 and older live in poverty. As shown in Figure 16 below, Native Americans are much more likely to be living below poverty compared with the average King County older adult, followed by Hispanics/Latinos, African Americans, and Asians. Data is based on the Federal Poverty Level. In 2011, this included a one-person household living at or below $10,890.[27]

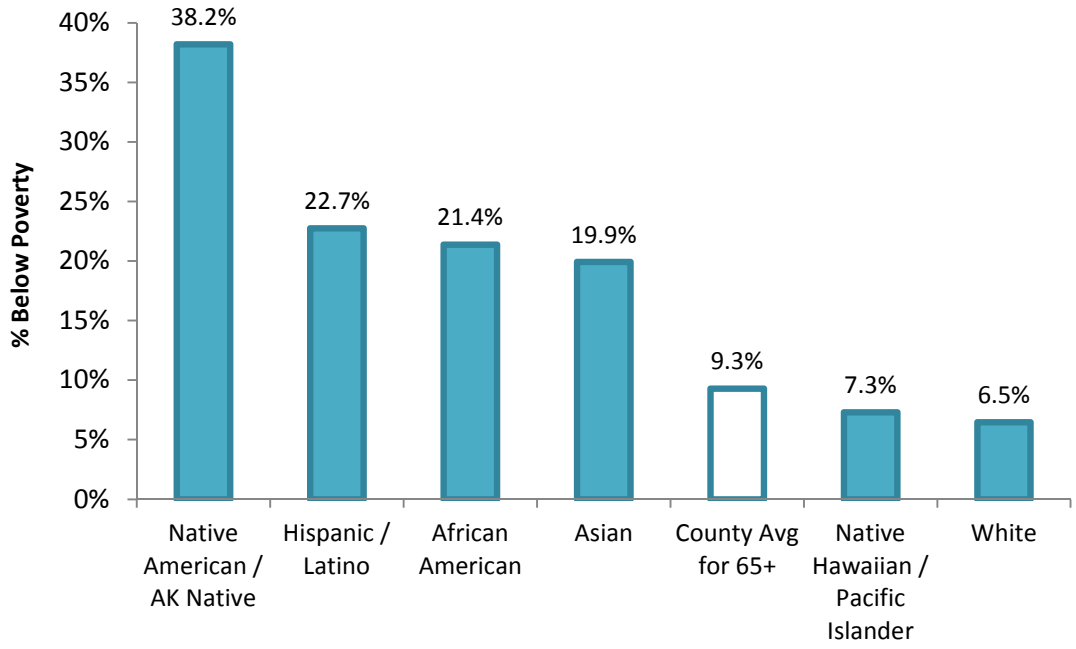


Figure 16. Poverty Rate by Age & Race, King County residents age 65+.[28]

Sub-regional differences in poverty rates exist. Table 4 shows that the poverty rate among the 65+ population is highest in Seattle and the South Rural and South Urban sub-regions and lowest on Vashon Island.

Sub-region	Total 65+	65+ Below Poverty	% of Total
East Rural	2,565	120	4.7%
East Urban	38,952	1,835	4.7%
North Urban	15,319	752	4.9%
Seattle	67,804	6,709	9.9%
South Rural	4,679	359	7.7%
South Urban	51,126	3,132	6.1%
Vashon	1,327	30	2.3%
TOTAL	**181,772**	**12,937**	**7.1%**

Table 4. Residents age 65+ living in poverty, by sub-region.[29]

[27] The 2011 HHS Poverty Guidelines, accessed at http://aspe.hhs.gov/poverty/11poverty.shtml.
[28] American Community Survey (2009-2011 three-year estimates).
[29] American Community Survey (2005–2009 five-year estimates).

Twenty-four percent (49,985) of King County residents age 65 and older are veterans.[30] Figure 17 shows heavy concentrations of veterans in Federal Way, Covington, and parts of Kent.

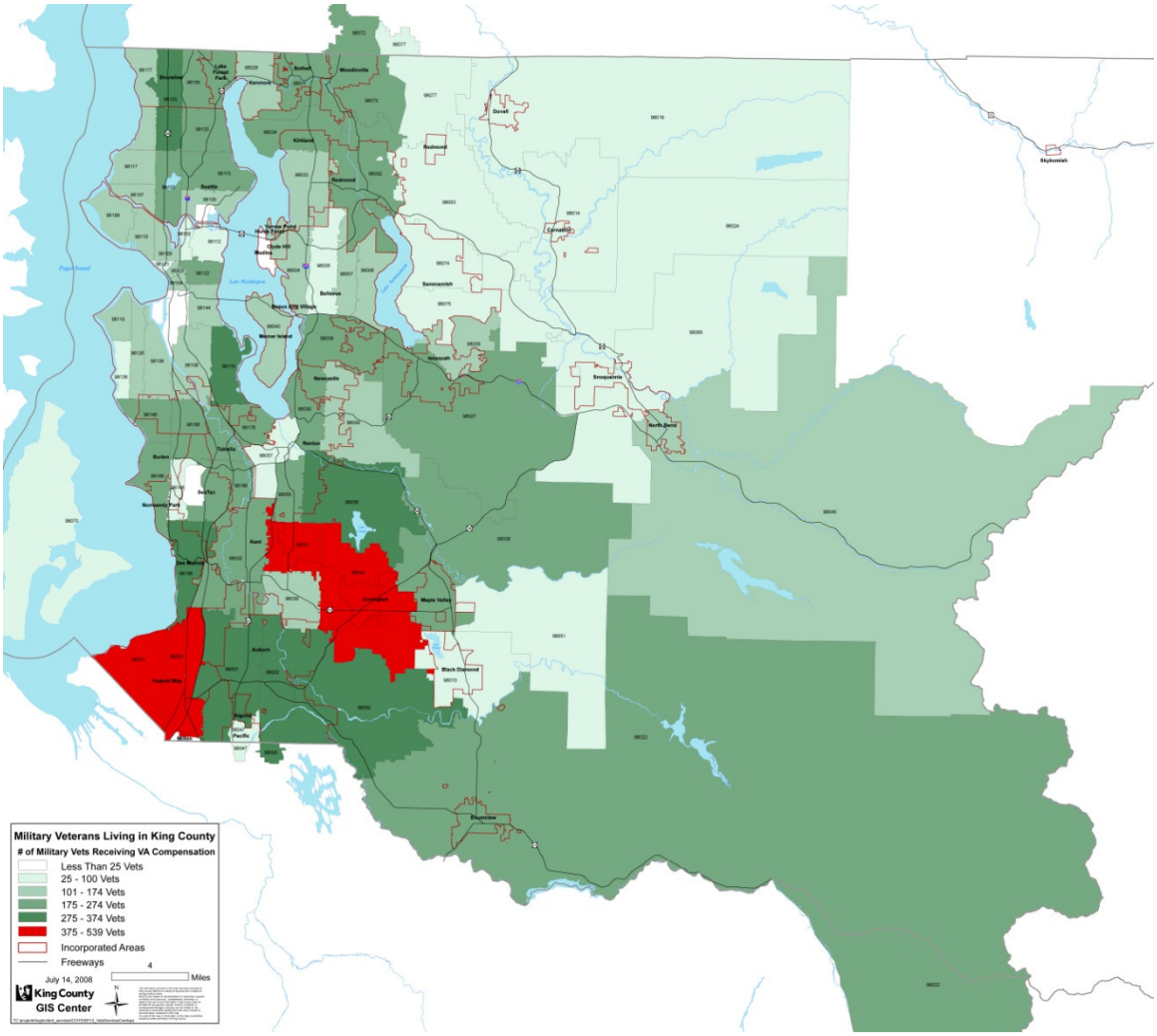


Figure 17. Percentage of residents with veteran status, King County.[31]

[30] 2009 American Community Survey.
[31] King County Department of Community and Human Services/King County GIS Center, Veterans Services Overlays.

Figure 18 shows a similar geographic pattern among low-income veterans with disabilities.

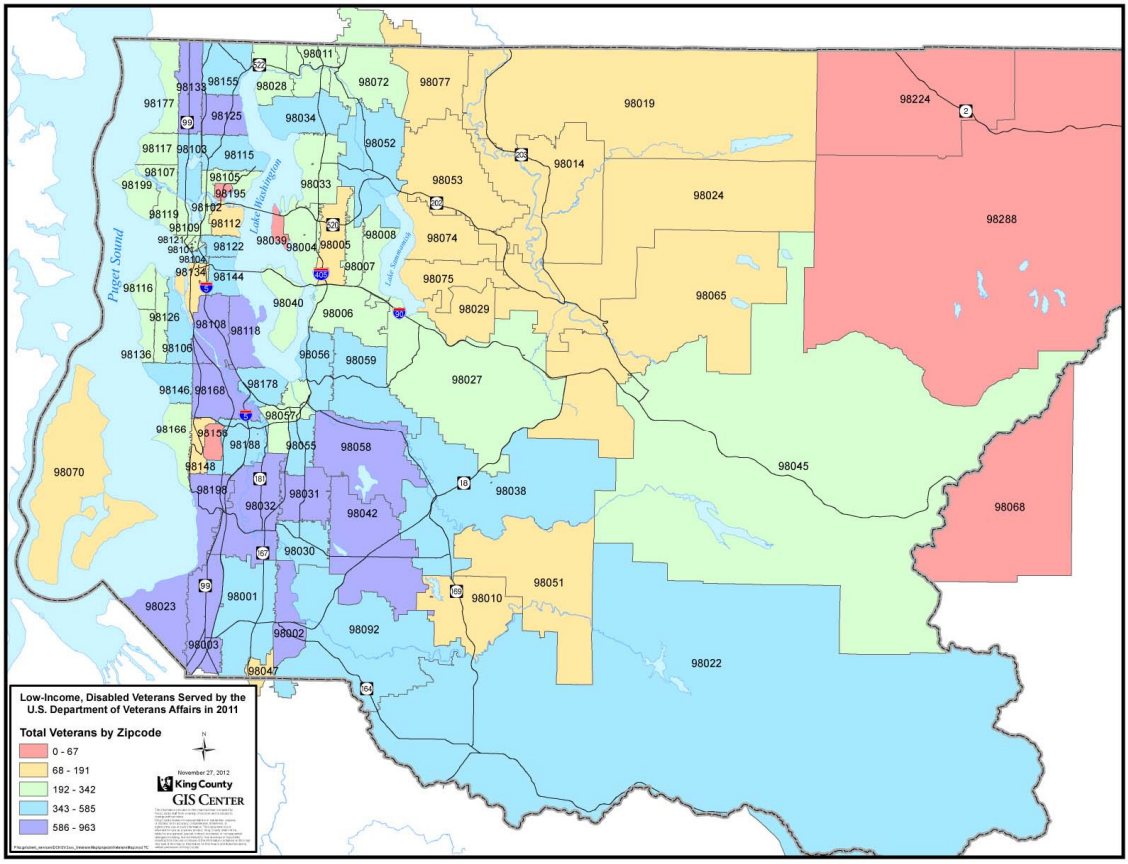


Figure 18. Low-income veterans with disabilities served by the U.S. Department of Veterans Affairs, 2011.[32]

[32] Status of Veterans and Veterans Services in King County, King County Department of Community and Human Services, February 2013 (King County GIS Center, 11/27/12).

TARGET POPULATION

Elders in communities of color and Native American, lesbian/gay/ bisexual/transgendered, rural, immigrant, and refugee elders need better access to services. ADS is committed to serving each of these population groups. Specific outreach objectives are listed under Aging Readiness/Public Outreach.

Native Americans

According to the 2010 Census data, the number of American Indian/Alaska Natives (AIAN) age 55 and older living in King County increased from 1,972 to 2,835 (43 percent) between 2000 and 2010. This represents 23 percent of the total number of AIAN people living in King County. However, studies show that the American Indian population is undercounted in the Census data.[33] The number of Native American elders is expected to increase steadily by the year 2025, just as the overall King County population.

Of the 2,835 Native American residents of King County who are age 55 or older, 369 received ADS services in 2010. These services primarily included case management, community information and assistance, congregate and home-delivered meals, senior centers, and transportation.

American Indians and Alaska Natives living in cities suffer from some of the worst health problems in the nation. Parallel to poor health outcomes, urban Indians experience high rates of poverty, single parenthood, unemployment, disability and inadequate education far above those of other Americans. Many believe limited or no access to comprehensive health care services is a major contributor to poor outcomes for this population.[34]

Passage of the Patient Protection and Affordable Care Act (ACA) marked two significant changes for urban Indian health. First, the law alters the way direct medical care services are provided and how these services will be financed. Second, lawmakers embedded a permanent reauthorization of the Indian Health Care Improvement Act that includes authorization of Title V, health care for urban Indians, making urban Indians a permanent part of the Indian Health Service for the first time.[35]

Urban Indian health organizations and their partners are now required to become informed, engaged and active in health care reform. In an effort to support these aims, the Seattle Indian Health Board hosted an Urban Indian Health Summit on January 13, 2011, in Washington, D.C. Urban Indian health organizations, policy-makers, federal partners, community advocates, private foundations, researchers and leaders in the field all gathered for this important event, which was sponsored by the Robert Wood Johnson Foundation. They addressed issues tied to the success of health care reform and its

[33] John Robert, "Aging Among American Indians: Income Security, Health, and Social Support Networks," *Minority Elders: Five Goals Toward Building a Public Policy Base* (The Gerontological Society of America: 1994), 66.
[34] Urban Indian Health Institute, Seattle Indian Health Board, *Actualizing Health Care Reform for Urban Indians: An Action Plan From the Urban Indian Health Summit*, (Seattle: April 2011).
[35] Ibid.

promise to help urban Indians who experience severe health disparities.[36] ADS recognizes the importance of engaging native elders in health care reform and will collaborate with urban Indian organizations in future discussions about accountable care.

There are two recognized tribes in King County—the Muckleshoot Indian Tribe and the Snoqualmie Nation. Since 2005, Area Agencies on Aging are required to adhere to the Department of Social and Health Services Administrative Policy 7.01, which requires a formal plan outlining coordination of services provided for older Native Americans. ADS coordinates with each tribe to provide services, including case management, training, and family support. See 7.01 Implementation Plans in Appendix F.

In an effort to improve the health of older adults in the Muckleshoot Indian Tribe, the Muckleshoot Senior Center participates in a Farm to Table pilot project to bring fresh produce straight from local farms to the Senior Center for the senior's daily lunch program. The Farm to Table program, funded by the King County Public Health Department through a federal economic stimulus grant, focuses on building connections between local farms and meal programs to make the best quality food available for the senior meal program. The Farm to Table program strengthens the tribe's connection with traditional foods, makes the most of our local agricultural system, and increases the nutritional value of the food served at the Senior Center, thereby helping to improve the health of the Muckleshoot senior community. (Additional information about Farm to Table can be found in the Improve Health and Well-Being section.)

LGBT Elders

Lesbian, Gay, Bisexual and Transgender (LGBT) older adults are a largely invisible population. Not only are they undercounted and underserved, they are understudied. While there have always been LGBT elders, relatively few have been open about their sexual orientation until recent years.[37] Nationally, current estimates of LGBT elders 65 and older number 1.5 million and are expected to grow to nearly three million by 2030—a significant share of the larger 65 and older population.[38]

Aging service providers will face challenges in addressing the needs of LGBT elders. For social, cultural, and legal reasons, the needs of older LGBT people differ from heterosexual and/or non-gender variant people. The social stigma associated with being lesbian, gay, bisexual or transgender continues to stand in the way of full participation in community and society for many LGBT elders, and full and equal access to important services and opportunities. About one-third of lesbian and gay male Baby Boomers (26 percent of lesbians and 32 percent of gay men) identify discrimination due to sexual orientation as their greatest concern about aging.[39]

It is difficult to age well without social support.[40] Compared to other older people, LGBT elders rely far more heavily on non-traditional caregivers. For example, LGBT elders rely less on spouses, children, parents, siblings, nieces, nephews, cousins and in-laws, since

[36] Ibid.
[37] LGBT Movement Advancement Project and Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders, *Improving the Lives of LGBT Older Adults* (2010).
[38] Ibid.
[39] MetLife Mature Market Institute, *Out and Aging The MetLife Study of Lesbian and Gay Baby Boomers* (November 2006).
[40] Rose and David Kimmel (2006).

most over age 60 are single, compared to only a third of heterosexual elders nationwide[41], and may be estranged from family members.[42]

LGBT elders as a group are less financially secure than older Americans as a whole. A lifetime of employment discrimination translates into earnings disparities, reduced life-long earnings, smaller Social Security payments, fewer opportunities to build pensions, and more limited access to health care.[43]

Knowledge of a client's sexual orientation in a health or social service setting is crucial to provide appropriate, sensitive, and individualized care in order for LGBT elders to experience "successful aging" (a term used by gerontologists to describe life satisfaction and a sense of well-being in the face of growing older). Providers who lack awareness of the LGBT clients overlook their specific needs, sacrificing care without even knowing it. If health and social service agencies are not sensitive to the social, cultural, and legal needs of LGBT seniors, there is a high risk that clients will be alienated from seeking needed services. If LGBT seniors avoid service providers because they feel misunderstood and unwelcome, their health and well-being will be compromised.

Immigrant and refugee elders

Immigrant and refugee elders want to lead active lives as they age. Nearly a quarter of King County's population speaks a language other than English, and about half of those have limited English proficiency. During the 2011 ADS community conversations held with Chinese, Eritrean, Ethiopian, Ukrainian, Hispanic, Native American, and Somali older adults—among the top concerns expressed by each ethnic group, including immigrants and refugees, was difficulty speaking, reading, writing or understanding the English language.

Ability to speak English is one of the key measures of immigrant integration – limited English speaking immigrants tend to hold less desirable jobs, earn lower wages, and generally fare worse on most indicators of well-being.[44] Nearly one quarter (23 percent) of King County residents do not speak English as first language. There are many implications as a result, ranging from access to services including public transportation. Another concern identified from ADS community conversations was the inability to utilize library services, computers, maps, etc.

[41] According to the U.S. Department of Health and Human Services, Administration on Aging (2008), 30 percent of heterosexual elders nationwide are single.
[42] LGBT Movement Advancement Project and Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders, *Improving the Lives of LGBT Older Adults* (2010).

[43] Ibid.
[44] The Urban Institute, Research of Record, www.urban.org

Figures 19, below, shows the major languages other than English spoken in King County by residents over age five.[45]

Language	King County Residents Age 5+
Spanish	102,000
Chinese	51,000
Vietnamese	30,200
Somali, Amharic	23,400
Tagalog	22,900
Korean	21,100
German, French	20,400
Hindi, Punjab	18,400
Russian	17,700
Japanese	11,300
Ukrainian	10,000
Other	73,500
Total	**401,900**

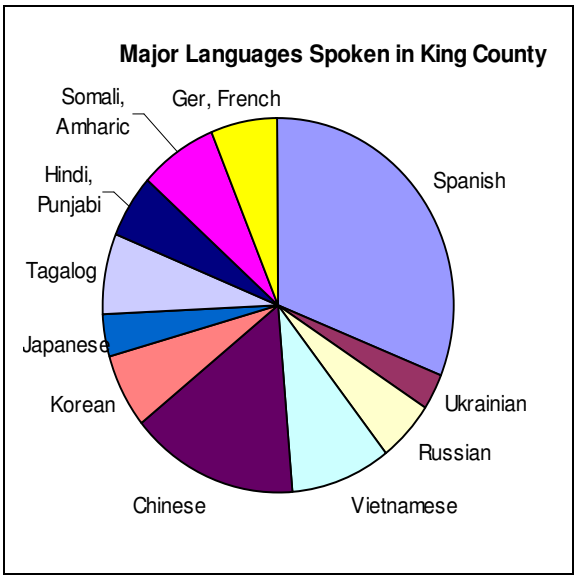


Table 5 and Figure 19. Major Languages Spoken by King County Residents Age 5+.

Figure 20 shows the language spoken at home by ability to speak English for older adults age 65 and older. Among the approximately 212,705 King County residents age 65 or older, 40,181 speak a language other than English at home, and 7,624 of these residents do not speak any English.

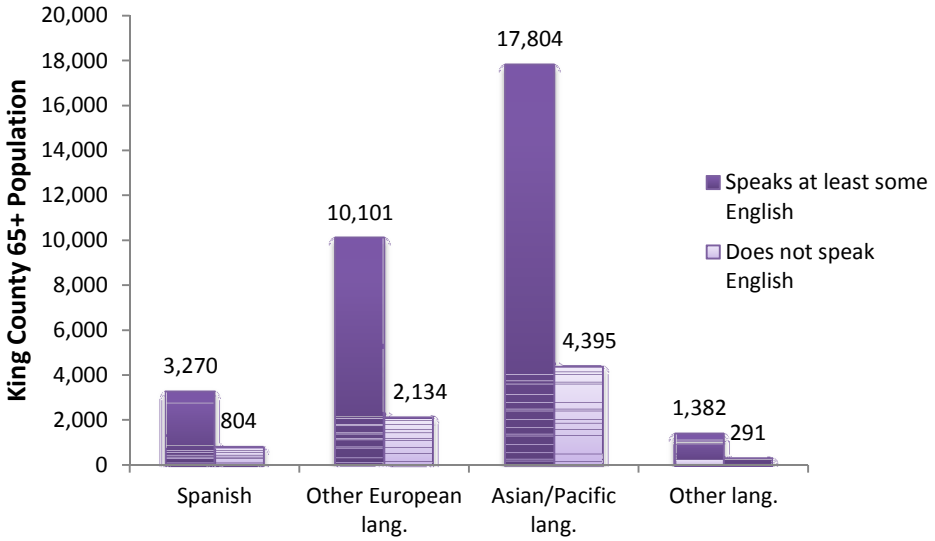


Figure 20. King County Population Over 65 Who Speak Other Language at Home.[46]

Of King County's 196,000 persons over age 65, almost 34,800 (18 percent) speak a language other than English at home. Two-thirds of those experience limited English

[45] U.S. Census Bureau and American Community Survey (2005–2009).
[46] American Community Survey (2005–2009).

proficiency (LEP). Among the 22,000 older residents who do not speak English very well, the largest group speaks an Asian language.

During 2012, 13,737 limited English speaking older adults received ADS services ranging from adult day care and Alzheimer's support to disability services and transportation.

For most of this decade, the numbers of immigrant and refugee populations in King County have remained steady at nearly 28,000 with a slight decrease in the last two years. Most of the county's refugee population is located in South King County—Federal Way, Kent, and Tukwila—although Seattle has the highest refugee population of any city in King County.

Figure 21 shows the distribution of refugees in King County.

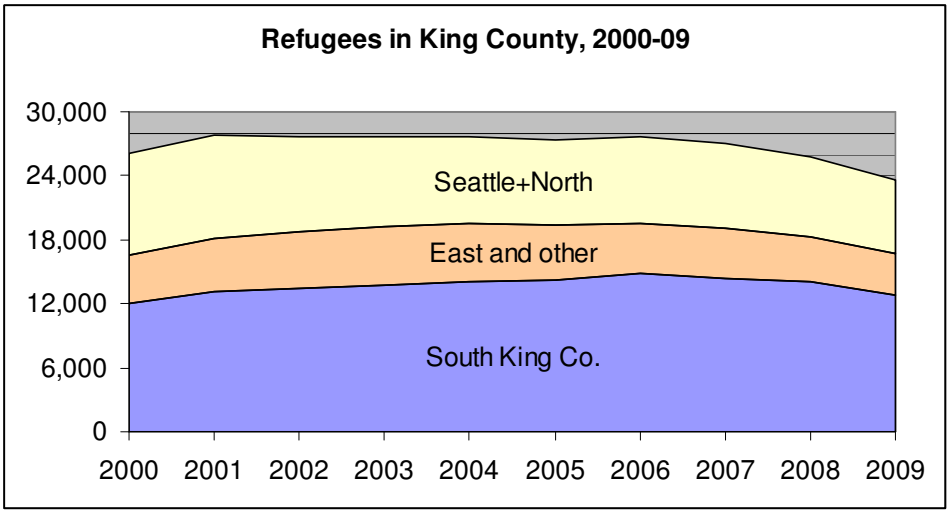


Figure 21. Refugees in King County, 2000-2009, by Area

As the aging services network continues to meet the needs and expectations of increasingly culturally and ethnically varied populations, a better understanding of cultural differences and their relationship to the hallmarks of quality service—respect, inclusiveness, and sensitivity—becomes essential. Serving diverse populations is not a "one size fits all" process. Diversity includes all differences, not just those that indicate racial or ethnic distinctions. Addressing the needs and concerns of specific service populations—African American, Asian American, American Indian, Hispanic, as well as older adults with disabilities, immigrant elders, and LGBT older adults—begins with asking appropriate questions.[47]

Rural Elders

Between 2000 and 2010, the population over 60 years of age in the greater-rural area increased from 15,600 to 24,400 (56.4 percent), while the total rural population (all ages) increased by 7 percent.[48] Total population growth continues to be limited within the greater rural areas of King County (both unincorporated areas outside of the Urban Growth Boundary and the seven towns within those areas), except for Snoqualmie and Duvall, which grew rapidly. This means that the increase in seniors is due to aging within

[47] Administration on Aging, A Toolkit for Serving Diverse Communities (2010).
[48] U.S. Census Bureau, 2010 and the Washington State Office of Financial Management

the community, and not migration. The very old (over 85) increased moderately and the numbers of persons age 70–85 changed slightly. Most of the growth occurred among older baby boomers (age 60–70).

Rural elders age 75 or older who live alone and/or on fixed incomes are particularly isolated. The 2010 Census data indicate that the total number of people age 75 or older who live alone in the greater rural areas of King County increased from 1,331 to 1,631 (22.5 percent). Some low-income elders in rural areas do not have phones and others do not have cars, which may further increase their isolation and vulnerability in emergencies. In addition, housing developers seldom consider rural areas for cost-effective projects, limiting affordable and safe housing.

Many rural elders face difficulties getting to medical appointments or to outpatient clinics. According to case managers who have clients in East Rural King County, typically caregivers transport their clients to medical appointments. There is limited public transportation in the rural areas and the Volunteer Transportation program (operated by a subcontractor, in which volunteers use their own cars to provide rides to essential appointments) has difficulty finding volunteer drivers in rural areas.

Climate change, rising transportation costs, projected population growth, increasing pressure on rural and natural resource areas, food safety, and preserving high-quality recreational opportunities are concerns of many King County residents.[49] We must all work together to ensure King County will remain a healthy, vibrant place to live well into the future.

Low-income Communities of Color

As of 2008, the number of older adults age 65 and older who live below poverty is 12,937 (7.1 percent of the senior population in King County). Many types of disability relate to income level. Older adults in all communities of color are disproportionately affected by poverty. Prior to 2000, King County experienced 30 years of improvements in the number of elders living in poverty; then, the percentage of residents age 65 and older who live in poverty increased, first to 7.39 percent and then to 8.6 percent. On average, Native Americans, African Americans, Asian/Pacific Islanders, and Hispanic/Latinos fare considerably worse.

Sub-regional differences in poverty rates are also a reality. The poverty rate among the 65+ population is highest in Seattle and the South Rural and South Urban sub-regions and lowest on Vashon Island.

[49] Partnership for Rural King County, www.prkc.org.

SERVICES PROVIDED THROUGH THE AAA

Aging and Disability Services funds nearly two dozen different services for older adults and adults with disabilities in King County. ADS invests a mixture of federal, state and local funds in services provided by a network of organizations located throughout King County, who provide services to people within their communities. ADS served 37,620 older adults, adults with disabilities, and caregivers in 2012.

Adult Day Services

These programs are designed to meet the needs of functionally and/or cognitively impaired adults in a community-based group setting. Programs are structured and comprehensive and provide a variety of health, social, and other related support services so adults who need supervised care are in a safe place outside the home during the day.

Adult Day Care programs include core services, such as personal care (eating, positioning, transferring, toileting, etc.), social services, routine health monitoring (vital signs, weight, etc.), general therapeutic activities (recreational activities, exercises, etc.), general health education (nutrition, disease management, etc.), a nutritious meal and snack, supervision, assistance with arranging transportation, and first aid as needed.

Adult Day Health programs include the core services mentioned above, as well as skilled medical services—skilled nursing, physical therapy, occupational therapy, or speech therapy, and psychological or counseling services.

Case Management

The ADS **Case Management** program offers in-depth assistance to frail elders and adults with disabilities who have significant health and social needs. Case managers conduct in-home assessments and collaborate with their clients to develop and implement an individualized service plan. The service plan for clients with medically unstable health conditions may include consultation with a nurse who can provide referrals and coordination with health care professionals.

Case managers monitor the service plan, with regular follow-up contact with clients and service providers to track progress on meeting service plan goals. Short-term counseling is provided if needed. Screening and referral for case management services is provided through Information & Assistance programs and, for Medicaid-funded clients, through DSHS Home and Community Services.

The **Amy Wong Client Fund** is a charitable fund available to Case Management clients. The fund provides services individually tailored to meet a client's specific needs so that the client can remain in his or her own home. These services are authorized by case managers and provided by ADS service providers and outside vendors.[50]

ADS targets **Mental Health** funds to Case Management clients who may be resistant to receiving services, by offering mental health consultation support to case management staff.

[50] Amy Wong Fund: www.amywongfund.org

The **Nursing Services Program** provides nursing expertise to high-risk case management clients upon referral from case managers. RN Consultants focus on medically complex clients with unstable health conditions providing services including case reviews, home visits, coordination with health care professionals, and valuable nursing input into the plan of care.

Chronic Care Management—King County Care Partners

ADS, Harborview Medical Center and four community health centers formed **King County Care Partners** to provide chronic care management for Medicaid fee-for-service adult patients.[51] Care Partners members work together to improve clinical outcomes and decrease unnecessary utilization by providing community-based RN care management and enhancing coordination, communication and integration of services across safety-net providers. The goals of the program are to:

- Identify Medicaid clients who need care management, using predictive modeling.
- Support development of "health care homes" for Medicaid clients.
- Improve health outcomes for enrollees, using evidence-based science.
- Intervene with enrollees to prevent avoidable medical costs by improving self-management skills.

Chronic Disease Self-Management Program

The **Chronic Disease Self-Management Program** (CDSMP) is a community-based self-management program that assists people with chronic illness. A six-week series of workshops are held in community settings such as senior centers, churches, libraries and hospitals, where people with different chronic health problems attend together. Two trained leaders facilitate the workshops, one or both of whom are non-health professionals with chronic diseases themselves. The program is especially helpful for people with more than one chronic condition, as it gives them the skills to coordinate all the things needed to manage their health and helps them keep active.

COPES/Personal Care and Ancillary Services

COPES/Personal Care services are provided to Medicaid Case Management clients with disabilities, many of whom live alone. **Personal care services** might include help with walking, bathing or eating. A person must need personal care services to receive household services. Examples of **COPES/Ancillary services** include:

- Client training by a skilled professional (e.g., medication management by a pharmacist, occupational therapy by a registered therapist, nutrition education by a dietician). Adult day care at a licensed facility that provides personal care, routine health monitoring, and other general therapeutic services.
- Home environmental modifications by licensed, bonded construction companies (i.e., construction or installation of minor physical adaptations and devices).
- Home-delivered meals for housebound clients who lack the ability to prepare meals and do not have help.
- Home health aide services to provide intermittent health and other incidental services beyond what a regular caregiver can provide.
- PERS services, which include the installation of devices and in-home monitoring and response to personal emergency requests for help.

[51] King County Care Partners: www.kccarepartners.org

- Skilled in-home nursing services to meet needs that are beyond the capacity of non-licensed staff.
- Specialized medical equipment that allows the client to function better in the home and community (e.g., wheelchairs, special shoes, aids to assist with standing).

Disability Access Services

Services provided include case management, sign language and tactile interpretation services, and advocacy for people who are deaf, deaf-blind, or hard of hearing. ADS also contracts for call-in information and referral services for people with disabilities. Other services include providing training to community agencies and other groups, and advocacy and technical assistance to help make facilities and programs accessible to people with disabilities.

Elder Abuse Prevention

The **Gatekeeper Training Program** trains community members to recognize signs that may indicate that a vulnerable adult is at risk of abuse, neglect, or exploitation; and shows them how to report their concerns. The residential **Long-Term Care Ombudsman Program** is designed to improve the quality of life for residents of nursing homes, congregate care facilities, boarding homes, and adult family homes. With the assistance of trained volunteers, the Ombudsman investigates and resolves complaints made by or on behalf of residents, and identifies problems that affect a substantial number of residents. The Ombudsman may also recommend changes in federal, state and local legislation. In 2011, ADS received an **Elder Abuse grant** from the King County Prosecutor's Office to provide advocacy and service coordination for survivors of abuse in later life (King County residents age 50 and older). The funding ended in April 2013; however, with support from its Advisory Council, ADS has allocated funding for this program into 2014.

Family Caregiver Information and Support

Caregiver information and support focuses on the informal family caregiver and the system that supports the caregiver. It includes in-home and out-of-home respite care services for unpaid caregivers of adults with functional disabilities. ADS administers funds for:

- Caregiver information and assistance.
- Support groups.
- Caregiver training.
- Translation and interpreter services.
- Specialized transportation.

Additional services include **Kinship Care** to support relatives (often grandparents) who are raising grandchildren and **Respite Care**, addressing the needs of caregivers by providing them time away from the responsibilities of ongoing care of a disabled adult, ranging from companionship and supervision to skilled nursing care. Respite care is available in the home and in the community.

Health Maintenance

Health Maintenance services were provided to a small number of Vashon Island residents, in their own homes, by visiting home health aides. A registered nurse supervised the home health aides. ADS Case Managers assessed clients annually. This service area was phased out in 2011.

Health Promotion

Enhance Wellness and **Enhance Fitness** provide low-cost, high quality, comprehensive health promotion programs for older adults at local community locations. These evidence-based programs include an exercise program that focuses on strength, balance, aerobics, and flexibility through one-hour supervised classes; a seven-session course on healthy living with chronic conditions; and a health enhancement program that provides personal guidance and support to maintain and/or improve health.

Information and Assistance (I&A)

Primary I&A provides information to older adults and their family members over the telephone, in-person, and through the internet. Assistance to access services is also provided for clients who are unable to do so themselves. Trained I&A Advocates screen clients to determine whether they need referrals to more extensive services, which may include Case Management.

Community I&A services are provided to older persons and family members who are not able to use the primary I&A program due to language, cultural, racial or social barriers. Currently, ADS funds Community I&A services for Chinese, Southeast Asian, Pacific Islander, Russian, East European, Latino, East African, and African American populations.

Legal Services

Legal Services provides group legal representation – including class action lawsuits, advocacy training and information – to service providers, private attorneys and volunteer advocates, and individual client legal services. Legal Services helps older people secure rights, benefits, and entitlements under federal, state and local laws. It also seeks to effect favorable changes in laws and regulations that affect older people. In addition, Legal Services strives to maintain public and private resources that benefit low-income older people.

Memory Care and Wellness Services

Memory Care and Wellness Services (MCWS) is a specialized day program for people with dementia and their caregivers. MCWS provides a safe, social and therapeutic environment with meaningful services and activities, including a structured, evidence-based fitness program and health assessments by RNs and occupational therapists. Family caregivers receive support and service coordination as they strive to maintain their own health, wellness, and optimal functioning.

PEARLS

The **Program to Encourage Active, Rewarding Lives (PEARLS)** is a community-based program that treats adults with disabilities who also have minor depression. PEARLS is available to ADS-funded case management clients in King County and to veterans and community members through King County levy support. PEARLS was created through a research project conducted in collaboration with the University of Washington's Health Promotion Research Center (HPRC), which showed that home-based depression management counseling significantly reduced depression symptoms and improved the health status of program participants.

Nutrition

The **Congregate Nutrition Program** helps meet the social and dietary needs of older people by providing nutritionally sound meals in a group setting. Ten agencies manage 45 nutrition sites, located throughout King County. Nineteen of the sites tailor meals to the language and cultures of immigrant and refugee seniors once a week. Another four contractors provide meals at 24 senior centers. Some senior centers provide special meals to serve African American, Hispanic, Native American, or Asian American elders. Seattle Parks and Recreation partners with local congregate meal programs by providing gathering space for **Food and Fitness** programming for the elders at local community centers.

The **Home Delivered Nutrition Program**, often known as **Meals on Wheels**, provides nutritious meals to older people who are homebound and unable to prepare meals for themselves. Two agencies provide frozen meals delivered to individuals throughout Seattle and King County, including rural communities. A third contractor delivers hot meals to clients' homes in a limited area (primarily Latinos). ADS subcontracts with a registered dietician to consult with the contractors who serve immigrant and refugee elders, to ensure that their meals and service comply with program requirements.

The **Senior Farmers Market Nutrition Program en**hances access to fresh fruits and vegetables for seniors and supports local sustainable agriculture. Baskets of fresh produce are delivered to homebound seniors, along with newsletters and other information about unfamiliar foods, recipes, and information about the farmers. Each summer, one-time Senior Farmers Market Program vouchers are provided to low-income older adults. The vouchers can be redeemed at farmers markets throughout King County.

In cooperation with Public Health—Seattle & King County, Seattle Human Services Department/Youth and Family Empowerment division, and other partners, ADS is piloting a **Farm to Table** program that connects farming and meal programs through a cooperative buying model. Three senior nutrition programs, eight childcare centers, and the Muckleshoot Indian Tribe currently benefit from fresh, nutritious, and affordable produce provided by this program.

Senior Centers

ADS administers local funds that support nine **Senior Centers** within the city of Seattle. Senior centers are community resource centers that meet the physical and emotional needs of older adults by offering access to services and resources on site, including immunization, health screening, nutrition, and exercise and fitness programs.

Senior Employment

The **Age 55+ Employment Resource Center** in the Seattle Mayor's Office for Senior Citizens, a unit of Aging and Disability Services, helps Seattle residents age 55+ find jobs to support their basic needs and helps local employers find experienced, dedicated and reliable employees. Services are free to both job seekers and employers.

The **Pike Market Senior Center** coordinates day labor positions for individuals age 55 and older who are homeless or living in the downtown Seattle low-income corridor.

Transportation

Nutrition and Volunteer Transportation is provided through a subcontracted agency. The **Nutrition Transportation Program** provides transportation within King County to ADS

congregate nutrition sites, focusing on access to ethnic and rural meal sites. **Volunteer Transportation** provides rides, by volunteers using their own cars, to medical and other essential appointments.

NON-AAA SERVICES

Human service providers in King County also offer community resources for older adults and those with disabilities.

Table 6 lists the types and location of non-AAA services in the Planning & Service Area. The list is not all-inclusive. These services may be funded by private or public fund sources.

SERVICES	South King County	East King County	North King County	Seattle	Serves all of County
Case Management Programs	X	X	X	X	X
Computer Training				X	X
Dementia, Alzheimer's Services	X	X	X	X	X
Developmental Disabilities-focused	X	X	X	X	X
Disability/Issue Groups	X	X	X	X	X
Elder Abuse	X	X	X	X	X
Employment Services	X	X	X	X	X
Education & Counseling Programs	X	X	X	X	X
Energy Assistance Programs				X	X
Food Banks	X	X	X	X	
Homeless Programs	X	X	X	X	X
Hospitals/Medical Centers, Medical & Dental Clinics	X	X	X	X	X
Housing (includes King County and Seattle Housing Authorities)	X	X	X	X	X
Geriatric Mental Health & Alcohol / Substance Abuse Services	X	X	X	X	X
Older Gay, Lesbian, Bi-Sexual, and Transgender Programs				X	X
Refugee/Immigrant Services	X	X	X	X	X
Senior Centers, Senior Fitness and Social Programs	X	X	X	X	X
Senior Employment				X	X
Senior I&A Services (211, SHIBA, Benefits CheckUp)	X	X	X	X	X
Services to Ethnic Groups	X	X	X	X	X
Spiritual/Faith-based Organizations	X	X	X	X	X
Transportation	X	X	X	X	X

Note: There are no gaps in service due to county-wide coverage by most services.

Table 6. Services Available in King County

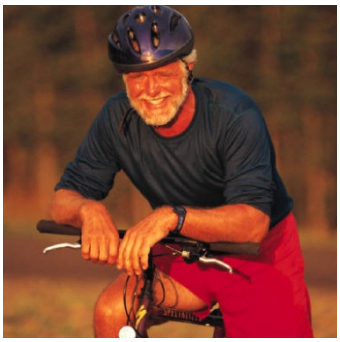
SECTION C
ISSUE AREAS, GOALS & OBJECTIVES

Lifelong Recreation Program Participants

"Our goal is for all residents, regardless of where they live in the county, to have access to healthy choices and opportunities for healthy living."

~ Dow Constantine, King County Executive

BUILD AN ELDER-FRIENDLY COMMUNITY



Increasing numbers of baby boomers and changing expectations highlight the need to create elder-friendly communities that provide affordable and accessible opportunities for people to age in place by making resources available for day-to-day living. Elder-friendly communities address basic needs, optimize health and well-being, promote social and civic engagement, and increase independence for all people, but especially people who are frail or have disabilities.[52] An elder-friendly community is a livable community for all ages.[53]

Aging boomers

Born after World War II, baby boomers grew up in an era of optimism, opportunity and progress. Boomers dominated policy decisions for decades, as federal and local governments built thousands of hospitals, suburbs and schools to accommodate them. Heavily influenced by social and political activism surrounding the Vietnam War, the assassinations of President John F. Kennedy, and the civil rights movement, boomers have different needs, desires and experiences than previous generations.[54]

Figure 22. Changing Life Expectancy in King County.

Public Health—Seattle & King County refers to the "good news, bad news" scenario:

- Boomers expect to live longer than their parents do and, due to increased life expectancy, on average, they will do so.[55]
- The number of unhealthy years each person can expect (on average) has also climbed (now 8.6 years).[56]
- Many boomers are overweight, contributing to chronic yet preventable conditions such as heart disease and diabetes.[57]

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[52] Center for Home Care Policy and Research/Visiting Nurse Service of New York, *The AdvantAge Initiative*.
[53] National Association for Area Agencies on Aging and Partners for Livable Communities, *A Blueprint for Action: Developing a Livable Community for All Ages (*May 2007).
[54] The MetLife Study of Boomers in the Middle: An In-Depth Look at Americans Born 1952–1958 (March 2010).
[55] Ibid.
[56] Public Health–Seattle & King County presentations by director David Fleming, MD (2010-2011).
[57] Behavioral Risk Factor Surveillance System (2009).

National and local research on boomers tells us to expect changing needs, wants, and ways of doing business:

- Boomers expect to work longer, enjoy better health, travel more, and have more money in retirement than their parents.[58]
- Boomers acknowledge the digital revolution and are becoming increasingly knowledgeable about technology.[59] Significantly more Boomers than people over age 65 use the Internet. Tomorrow's seniors will use far more technology than the generations before them, and expect information at their fingertips 24/7, much as younger generations.[60]
- Boomers may be more "high maintenance" than older generations, having grown up to expect comfort, convenience and fun.[61]
- Boomers do not identify with traditional aging terminology (e.g., "senior citizen").[62]
- Boomers may be healthier and wealthier than their parents, and live longer, but many are poor savers and will have more financial difficulty as they age. A majority of boomers report they are behind in retirement savings, and nearly one in four reports being significantly behind where they hoped they would be at this point in their lives.[63]
- Boomers expect to work. More than 60 percent of boomers expect to work in retirement, often "reinventing" themselves in a second or more rewarding career.[64]
- Boomers are not a homogenous group. In fact, immigration has played a large role in shaping the baby boom generation, particularly increasing the percentages of Latino and Asian Americans. Boomers did not come of age at the same time or in the same place.[65]

As boomers age, the Aging Network will adapt to meet many of their needs; however, cities and communities will need to change, too. And boomers themselves will find—out of necessity—that healthy aging strategies must be infused into every part and all stages of life.

[58] AARP Bulletin Survey on Perceptions of Boomers (November 2010).
[59] Ibid.
[60] Generations 2010, Pew Research Center (12/16/2010) and Information Technology Access and Adoption in Seattle Report (Technical Report), Seattle Department of Information Technology, City of Seattle (2009).
[61] AARP Bulletin Survey on Perceptions of Boomers (November 2010).
[62] Ibid.
[63] The MetLife Study of Boomers in the Middle: An In-Depth Look at Americans Born 1952–1958 (March 2010).
[64] AARP Bulletin Survey on Perceptions of Boomers (November 2010).
[65] Mary Elizabeth Hughes and Angela M. O'Rand, *The Lives and Times of the Baby Boomers* (Russell Sage Foundation and the Population Reference Bureau, 2004).

IMPROVE HEALTH CARE QUALITY FOR OLDER ADULTS AND ADULTS WITH DISABILITIES

Health care reform is a pivotal issue in Washington, DC, but also in King County. Area Plan Questionnaire respondents indicated that affordable health care is the highest priority for older adults, and second only to mobility concerns for adults with disabilities.

New health care reform laws have significant impact on chronic care management and long-term care services and supports (LTSS) provided through the Aging Network. With Duals Integration beginning in 2014, the service delivery system for medical, mental, behavioral, and LTSS aims for more coordination and effectiveness in serving Medicare and Medicaid recipients.

ADS contributes to health reform savings and improvements to the community. Adults with multiple chronic conditions such as diabetes, cardiovascular disease, mental health and/or substance abuse are very high users of expensive pharmacy services, emergency rooms and other hospital care. Case management services, chronic care management, and partnerships that emphasize effective patient-centered communications and accountability among health care providers are important keys to successful health care reform.

ADS joined the Partnership for Patients early in 2011, shortly after it was announced.[66] The Partnership for Patients has pledged to decrease preventable hospital-acquired conditions (injuries and illness) by 40 percent and prevent complications during transition from one care setting to another, and therefore decrease hospital readmissions by 20 percent, both by the end of 2013 (as compared to 2010).

During the span of this Area Plan (2012–2015), AAAs will collaborate with King County and local health care organizations to establish, expand, and sustain hospital care transition models, chronic care management models and incentives, and other programs and services affecting health care quality for older adults and adults with disabilities.

Chronic Disease Self-Management Program

With the aging of the baby boom generation, the number of older adults who live with chronic conditions will increase dramatically in the years to come. The first boomers turned 65 in 2011 and, of these, more than 37 million—or 6 out of 10—will manage more than one chronic condition by 2030.[67] Fourteen million boomers will live with diabetes while almost half of the boomers will live with arthritis (that number peaks to just over 26 million in 2020).[68]

[66] Partnership for Patients: www.healthcare.gov/center/programs/partnership.
[67] First Consulting Group & American Hospital Association. (2007). *When I'm 64: How boomers will change health care*. Chicago, IL.
[68] Ibid.

Chronic diseases kill. For years prior, they negatively affect quality of life and threaten the ability of older adults to remain independent within their homes and communities. The more chronic illnesses an individual has, the more likely that individual will become hospitalized. Two-thirds of Medicare spending is for beneficiaries with five or more chronic conditions.[69]

To address the growing prevalence of chronic conditions, many of the nation's leading experts recommend that our care systems include a combination of health care and community-based interventions, such as community-based chronic disease self-management programs. One example is The Stanford University Chronic Disease Self-Management Program that was developed with funding from the Agency for Healthcare Research and Quality. The Stanford program emphasizes the patients' role in managing their illness and building their self-confidence so they can be successful in adopting healthy behaviors.

The Chronic Disease Self-Management Program (CDSMP) is a community-based self-management program that assists people with chronic illness. A six-week series of workshops are held in community settings such as senior centers, churches, libraries and hospitals, where people with different chronic health problems attend together. The workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.

The way in which the program is taught makes it effective. Classes are highly participative, where mutual support and success build each participant's confidence in their ability to manage their health and maintain active and fulfilling lives. The program is especially helpful for people with more than one chronic condition, as it gives them the skills to coordinate all the things needed to manage their health and helps them keep active.

Aging and Disability Services recently received a three-year grant from the Department of Health and Human Services and Public Health Funds to collaborate with King County CDSMP-licensed agencies and provide workshops throughout King County. Over the next three years, ADS will:

1. Improve coordination of the local network of CDSMP providers and create a seamless tracking and information system.
2. Update CDSMP training for Master Trainers and Lay Leaders in King County and coordinate cross-trainings to incorporate CDSMP for diabetes.
3. Conduct targeted outreach activities in South King County to recruit older adults from groups experiencing health disparities.
4. Increase workshops in King County by expanding to Chinese-speaking and Russian and Ukrainian-speaking older adults.
5. Monitor and track CDSMP fidelity.

Chronic Care Management/King County Care Partners

In 2006, ADS partnered with UW Medicine/Harborview Medical Center, Community Health Centers, HealthPoint, NeighborCare Health and SeaMar Community Health Centers to form King County Care Partners (KCCP), which provided specialized care management for Medicaid fee-for-service adult patients. KCCP also

[69] Anderson, Gerard, *Analysis of the Medical Expenditure Panel Survey, 2004*, Johns Hopkins University (2008).

participated in a national learning network committed to advancing Medicaid's capacity to serve high-need and high-cost populations. (http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=676169)

KCCP goals are to:

- Improve health outcomes for program enrollees using evidence-based medicine.
- Support health care home development and coordination for Medicaid clients.
- Intervene with enrollees to prevent avoidable medical costs by improving self-management skills.

KCCP nurses and social workers coach participants to set personal goals, using evidence-based protocols, and create their personal health action plans. RNs provide education and support for the self-management of chronic illnesses, including pain and medication management; advocate for participants; and coordinate care across multiple health providers.

KCCP also worked closely with King County Mental Health, Washington State DSHS Health Care Authority and Patient Review & Coordination Program. KCCP is committed to helping clients and patients establish a "health home" that embraces client, health provider, nurse, social worker and mental health professional involvement as well as, when appropriate, the client's family and caregivers. Each partnering organization seeks to provide services, advocacy, support, and treatment intervention in a culturally and linguistically appropriate manner.

"It won't be enough just to change payment and give practices incentives to change. It will require a national infrastructure that can guide and support practices through the transformation to the patient-centered medical home." ~ Ed Wagner, MD, MPH, Director, MacColl Institute, Group Health Research Institute

A good example of these connections and partnerships is through KCCP's efforts to promote tobacco cessation among its clients. The KCCP team may refer clients to WA Quit Line as well as provide printed materials, including self-management behavior goals around tobacco cessation. The KCCP team also coordinates with clinic partners to obtain medications/nicotine replacement therapy when appropriate. Success is possible when a client is supported throughout the entire health home.

Evaluations show promise in controlling health care costs and improving health outcomes[70] through:

- Good, trusting relationships with an RN or MSW.
- Personal empowerment
- Lower psychiatric inpatient costs.
- Fewer total arrests and charges.
- Higher odds of receiving inpatient alcohol/drug treatment.
- Achievement of at least one health care goal.
- Improved health condition, living environment and access to treatment.
- Decreased mortality rates.

[70] Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations (CHAMMP) and Department of Health Services, University of Washington School of Public Health. All evaluations are available online at www.kccarepartners.org.

In July 2012, HCA began moving all Medicaid-only SSI blind and disabled clients to five managed care organizations under its Healthy Options program. Through Healthy Options, HCA will require plans to provide community-based care management services to high-risk individuals. Although the fee-for-service payment wound down in December 2012 KCCP continues to provide chronic care management and care transition services to a limited number of dual-eligible clients and to one Healthy Option health plan – Community Health Plans of Washington. By 2015, ADS hopes to contract with more health plans to provide these critical services.

Care Transitions

Effective "care transitions" programs make it easier for older adults who leave the hospital to return home, get the care they need in the community, and stay independent longer. Care transitions programs empower patients to be active members of their transition team, by providing coaches to assist patients with goal setting, ongoing self-management, follow-up care arrangements, and provider communication.

Hospitals refer patients to community partners that can:

- Link patients to community services to help them stay independent at home.
- Offer evidence-based programs, such as the Chronic Disease Self-Management Program, to empower patients to manage their own health.
- Teach patients how to communicate effectively with health care providers to ensure their needs are met.

In 2011, ADS studied six care transitions models:

- BOOST (Better Outcomes for Older [adults through] Safe Transitions)[71]
- Bridge[72]
- Care Transitions ("Coleman Model")[73]
- GRACE (Geriatric Resources for Assessment and Care of Elders)[74]
- Guided Care[75]
- Transitional Care Model ("Naylor Model")[76]

In addition, Whatcom County's Stepping Stones, a care transitions program involving multiple health, hospital and social service providers—including the Northwest Regional Council (AAA)—provided a local model of coordination, communication and information exchange around the needs of each patient and family, particularly when patients are leaving the hospital.[77]

CMS data on the rates of Medicare beneficiary readmissions resulting from heart attack, congestive heart failure, and pneumonia led ADS to focus on south King County, where two hospitals exceeded state averages. Starting in 2011, ADS has convened care transitions meetings with administrators from four south county hospitals as well as health and human services providers in south King County, participated in root cause analyses, and coordinated community conferences that emphasize the importance of eliminating avoidable hospitalizations.

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[71] BOOST: www.hospitalmedicine.org/BOOST
[72] Bridge: http://hmprg.org/programs-projects/illinois-transitional-care-consortium/
[73] Care Transitions: www.caretransitions.org
[74] GRACE: www.medscape.com/viewarticle/541536_2
[75] Guided Care: www.guidedcare.org
[76] Transitional Care Model: www.transitionalcare.info

[77] Stepping Stones: Care Transitions Project of Whatcom County: www.steppingstoneswhatcom.org.

To strengthen relationships with area hospitals and health care providers, ADS briefs hospital discharge planners and nurses on Aging Networking Services on a regular basis.

In 2012, eight ADS case management staff (RNs and case managers) were trained as care transitions coaches under the Care Transitions Intervention (Coleman) model, supporting recovery of hospitalized case management clients with chronic conditions. An additional 11 RNs and case managers from ADS and subcontractors were trained in 2013.

In 2013, ADS began receiving referrals from Community Health Plan of Washington (CHPW) to coach Seattle-King County residents at high risk for re-hospitalization.

Duals Integration

Washington State is one of fifteen states funded by Centers for Medicare and Medicaid Services (CMS) to develop an innovative service delivery implementation plan that integrates care for beneficiaries who are eligible for both Medicare and Medicaid services, often referred to as dual eligible (or "duals"). Approximately 115,000 duals reside in Washington. Duals account for a disproportionate share of spending in Medicare and Medicaid programs due to their complex set of health challenges. Our current system of care for dual eligible individuals is fragmented, requiring individuals to access multiple service providers and payment systems in order to manage their physical and mental health.

Through this CMS funding, Washington is planning an integrated care model that aligns incentives to provide the right care at the right time for the right person in the right setting. The goal is to improve quality and coordination while reducing costs. This requires DSHS/ALTSA to work closely with Health Care Authority to provide services that allow choice and control for dual eligible individuals.

Washington is planning two strategies for duals integration:

1. **Health home services for high cost/high risk duals embedded in all systems**
   The Health Home Strategy 1 will provide integration and coordination of primary, acute, behavioral health and long-term care services and supports for high cost, high-risk persons with chronic illness across the lifespan. Services include comprehensive care management, transitional care, referral to community and social supportive services. Health homes will be qualified through the state and require community-based partnerships. There are approximately 39,000 high risk/high cost duals statewide. All counties will implement strategy 1 except for King and Snohomish.

2. **Full integrated model purchased through health plans**
   The Full Capitation Strategy 2 will work through health plans to provide medical, behavioral health and long-term services and supports through capitation. Health plans will get one rate to provide both Medicare and Medicaid services regardless of cost of care or quality of service. King County has authority to approve participation in strategy 2 and will vote in late fall whether to participate. Strategy 2 will enroll clients beginning July 2014.

In King County, approximately 36,000 clients are dual eligible and 8,000 receive long-term case management by the AAA. Our biggest opportunity is to redesign the delivery

system to integrate medical, behavioral health, and long-term services and supports. ADS, King County Department of Community and Human Services and Public Health are collaborating to design the optimal model by addressing infrastructure issues, service access and quality, and measurable outcomes while keeping the client's needs at the center. The City/County collaborative will work with the apparently successful bidders – United Healthcare and Regence on seamless service delivery.

The three-year demonstration does have risks especially if not well designed and implemented. According to an article by the Community Catalyst[78], there are 10 priorities for shaping a well-designed dual demonstration plan. The priorities we are most concerned about are:

- Provider Networks – maintain a robust network that utilizes longstanding relationships including small agencies that target rural and ethnic populations
- Long-Term Services and Supports – conduct conflict-free assessment and maintain current levels of service
- Financing and Payment – ensure there are no incentives for denying or minimizing services
- Cultural Competency – ensure services are culturally and linguistically appropriate

PEARLS

Untreated depression is the leading cause of suicide, and a wide variety of life experiences can lead to depression.[79] Depression is not a normal part of aging. Most older adults feel satisfied with their lives; however, depression in older adults is often overlooked. Though highly treatable, even health care professionals find it difficult to diagnose depression (and suicide risk) because older adults are more likely to talk about physical symptoms than emotional concerns. [80]

"Dissemination of the PEARLS program within existing community social service organizations has the potential to significantly improve the well-being and function of depressed older adults served by these organizations." ~ Mark Snowden, MD, MPH, University of Washington Health Promotion Research Center

ADS assists veterans and others in addressing minor depression. With support from the King County Veterans and Human Services Levy, ADS recruits 112 veterans and/or spouses to participate in PEARLS each year, enrolls60, and targets a minimum of 48 program completions.

[78] http://www.communitycatalyst.org/doc_store/publications/Top_Ten_Duals_Projects_Guide_Advocates.pdf
[79] Suicide.org: www.suicide.org/suicide-causes.html
[80] National Institute of Mental Health, *Depression*: www.nimh.nih.gov/health/publications/depression/complete-index.shtml#pub5.

GOAL: Improve Health Care Quality for Older Adults and Adults with Disabilities

ADS is committed to improving health care quality for older adults and adults with disabilities. We propose to carry out the following objectives:

OBJECTIVES

Chronic Care Management

1. Expand access to chronic care management (CCM) through the King County Care Partners network.
   a. Expand to Medicaid/Medicare (duals) in LTSS
      2011 Baseline: 0 dual clients
      2012 Goal: 100 dual clients (39 actual)
      2013 Goal: 25 dual clients
      2014 Goal: 25 dual clients
      2015 Goal: 25 dual clients
   b. Provide CCM services to Healthy Options high-risk clients.
      2014 Goal: 50 clients
      2015 Goal: 75 clients

Reducing Disabilities for People with Alzheimer's Disease

2. Participate in a translational study of the Reducing Disabilities for people with Alzheimer's Disease (RDAD) in-home exercise and problem-solving therapy model for Alzheimer's patients and their family caregivers.
   2011 Baseline: 0 clients
   2012–2015 Goal: 13 dyads per year

PEARLS

3. Maintain the number of older adults, including veterans/spouses, who show improvement in their level of minor depression as measured by the PHQ-9 assessment tool.
   Annual Goal: 80 clients, including 40 veterans/spouses

Care Transitions (New)

4. Strengthen relationships with area hospitals and health care providers, and provide care transitions coaching and other interventions, to support reduction of unnecessary hospital readmissions.
   a. 2014 & 2015 Goal: 4 Hospital briefings and 1 Community meeting
   b. 2014–2015: Serve 240 Healthy Options clients per year
   c. 2014–2015: For ADRC referred and AAA clients receiving CT, reduce hospital readmission within 30 days by 40%

Chronic Conditions (New)

5. Expand CDSMP workshops in King County to include limited English-speaking immigrant communities. Coordinate and support local CDSMP providers network.
   2014 Goal: 10 workshops;
   2015 Goal: 14 workshops

Duals Integration (New)

6. Participate in HealthPath Strategy 2 by providing health home and long-term care services, network management, and other negotiated services.
   2014–2015 Goal: Contract with at least two managed health care organizations

Falls Prevention (New)

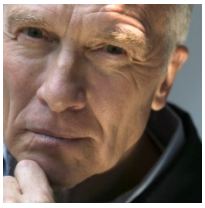
7. Increase awareness about fall risk among community-dwelling older adults by conducting falls prevention presentations to ADS staff and other relevant healthcare professional groups.
   2014 Goal: One presentation per year
   2015 Goal: One presentation per year

8. Partner with the Harborview Falls Prevention Clinic to conduct monthly consultations about clients with a six month or greater history of falls.
   2014 Goal: 10 to 12 consultations
   2015 Goal: 10 to 12 consultations

Oral Health (New)

9. Partner with the Mobile Dental Clinic to target eligible case management clients at-risk for poor oral hygiene.
   2014 Goal: 6 dental clinics in SHA buildings and serve 38 clients
   2015 Goal: 3 dental clinics in Senior Centers and serve 24 clients

ADDRESS BASIC NEEDS



Most U.S. residents wish to remain in their own homes and communities as they grow older, and in fact, most do; however, quality of life depends first on having basic needs met, and many elders struggle. In an effort to create vibrant and elder-friendly communities in King County, ADS will address the basic needs of older people in the following areas:

- Access to information and assistance about services in the community.
- Affordable housing designed to accommodate mobility and safety over the course of life.
- Mobility for shopping, social, and medical visits.
- Financial empowerment, with a goal of self-sufficiency.
- Food security.

Aging & Disability Resource Centers: Washington's Community Living Connections

Information & Assistance (I&A) services are the core of King County's Aging Network. These programs open the door to benefits and services, directly impacting each of our five priority issue areas: basic needs, health and well-being, aging readiness, independence, and health care reform.

Professional staff in King County I&A programs provide older adults, their families, and caregivers with information on available services and assistance in accessing services. Over the phone, on-line, and in person, I&A staff assess needs, connect clients with services that meet those needs, and follow up to ensure that services were received and needs were met.

Because of the strength and depth of our I&A network and its close relationships with the 211 system, King County is well positioned to participate in national and state initiatives aimed at expanding senior I&A programs into **Aging & Disability Resource Centers** (ADRCs). In Washington State, these programs will be part of the **Community Living Connections** (WA-CLC) network, a coordinated system that provides comprehensive information on a full range of available public and private long-term care services, personal counseling to assist individuals of all ages in assessing and planning for their long-term care needs, and assistance in accessing needed services.

Washington is one of eight states to receive a grant from the Administration on Community Living (ACL) to strengthen and expand ADRCs as part of the WA-CLC network. The grant will provide training and other supports to assist ADS and other AAAs in becoming fully functional in each of the core ADRC components:

- Information, Referral, and Awareness
- Options Counseling and Assistance
- Streamlined (Access to) Eligibility for Public Programs
- Person-Centered Transition Support
- Consumer Populations, Partnerships and Stakeholder Involvement
- Quality Assurance and Continuous Improvement

ADS has initiated a strategic planning process to transition King County's I&A network to a fully functional ADRC. This effort will also inform the investment plan and competitive bid process for ADRC services (tentatively scheduled for 2014). For each of the

following core ADRC components, we have identified current and planned efforts, including successes and anticipated challenge, to prepare for full implementation:

Information, Referral and Awareness (I&R/A)
King County has a strong I&A network that includes a telephone-based Senior I&A program; Community I&A programs that provide culturally competent services to elders in ethnic communities, including Asian, African, Eastern European, and Spanish-speaking older adults; an on-line resource database for public use, as well as more than a dozen consumer guides and directories.

Among the challenges to fully implementing the I&R/A component will be increasing staff understanding of the range of services, both public and private, available for people of all ages and abilities, as well as marketing the I&R services to a broader base. I&A/ADRC providers have been working to expand their knowledge of services for people with disabilities but there is concern about the ability to serve new populations without an increase in funding.

In summer 2014, a few King County I&A/ADRC providers will participate in a pilot test of a new statewide resource database and client management system. As we gain a better understanding of the system, ADS will develop plans to migrate existing resource and client data and support ongoing maintenance.

Options Counseling and Assistance
I&A/ADRC staff in King County are highly skilled at helping older adults, their families, and caregivers navigate the complex array of public benefits and long-term care options. With funding provided by the state's ADRC grant, staff will receive training in Options Counseling and will pilot test service delivery models. Anticipated challenges include: identifying options to meet the needs of the broad client base (all income levels and abilities), including culturally appropriate options and resources; and the ability to sustainably fund staff time required for both ongoing training and a more intensive service delivery model.

Streamlined (Access to) Eligibility for Public Programs
King County's I&A/ADRC providers are designated community partners for Washington Connections, DSHS's online benefit application portal. They directly assist clients with the eligibility and application process for DSHS services and program. ADS is beginning to review enrollment data in order to track usage rates by older adults and our community partners, with the goal of increasing the number of older adults who access benefits. In addition to pilot testing the new WA-CLC data system, ADS staff and providers will participate in statewide discussions to inform policies and procedures to improve client access to enrollment programs. One potential challenge for staff is the lack of integration across multiple state screening and enrollment systems.

Person-Centered Transition Support
I&A/ADRC providers will play an important role in Care Transitions, by identifying clients/patients in need of formal supports; conducting related referrals and follow-up; and connecting health care and human service providers to support patient recovery. See Section C-2, Care Transitions.

Consumer Populations, Partnerships and Stakeholder Involvement
The transition to ADRCs means King County's I&A network will serve new populations, including people under 60 and people with disabilities. To prepare for

this change, I&A/ADRC programs have been using flexible funds (non-OAA) to serve people under age 60, and they have invited disability organizations to present at their bi-monthly professional development meetings. Family Caregiver Support programs have developed partnerships with four major disability organizations and have implemented a cross-program referral process through 2-1-1. Seattle's walk-in" senior I&A program at the Mayor's Office for Senior Citizen's has partnered with SHIBA (Statewide Health Insurance Benefits Advisors) to provide onsite services. An ongoing challenge as we continue to bring in new partners will be effective and efficient coordination on behalf of clients across systems.

Quality Assurance and Continuous Improvement
Eligible I&A/ADRC staff are Alliance of Information and Referral System (AIRS) certified, and are trained in de-escalation and crisis intervention. I&A/ADRC program managers will be participating in a state sponsored Quality Improvement and Assurance Training in the summer of 2013. Through the expansion grant, AAAs will partner with the state on development of national ADRC standards and best practices.

Affordable Housing

Assessing possible housing options for ourselves, an aging parent, relative, or friend, is a daunting task given shortage of affordable housing in King County. What kind of assistance or living arrangement might we need? What might our health—or the lack of good health—require in terms of our housing decisions?

Which of our options can be supplemented with health insurance coverage? What can we afford if we stay where we are? What if we need to remodel? What if we move? Will a part-time or full-time caregiver be required? Is assisted living appropriate? Is there an appropriate place available if a move is required or a higher level of care needed? What financial assistance resources and guides are available to help make these decisions?

In 2008–2009, ADS collaborated with local housing authorities to assess the supply of affordable senior housing in King County, and determined that the demand for affordable and accessible housing with services for older adults and people with disabilities exceeds the existing housing stock in King County. The study report, *Quiet Crisis: Age Wave Maxes Out Affordable Housing, King County 2008–2025*, serves as a guide: King County needs to create an additional 936 subsidized units each year just to maintain the current ratio of affordable housing to low-income older adults.[81]

Affordable housing is defined as mortgage or rent and utilities that do not exceed 30 percent of a household's gross income. In the 2011 HUD update of Affordable Housing Needs 2009: Report to Congress, households with "worst case needs" are defined as unassisted renters with very low incomes who have one of two "priority problems," defined as either paying more than half their income for housing ("severe rent burden") or living in severely substandard housing. Renters are classified by income using three income levels:

- **Low Income** renters earn 80 percent or less of the area's median income (AMI);
- **Very Low Income** renters earn 50 percent or less of AMI; and
- **Extremely Low Income** renters earn 30 percent or less of AMI.

[81] Cedar River Group, *Quiet Crisis: Age Wave Maxes Out Affordable Housing, King County 2008–2025* (February 2009).

A major finding in the report found a dramatic increase of 20 percent in worst-case needs during 2007–2009. The numbers jumped from 5.91 to 7.10 million including 1.33 million households with elders. This means that older adults make up about 18.7 percent of the "worst case needs" in our country. Younger adults with disabilities accounted for 990,000 (13.9 percent) of those renters in worst-case needs. The report cited three major causes of the increase in worst-case needs: shrinking incomes, lack of rental assistance, and competition for affordable units.

The report went on to note that in 2009 there were only 60 affordable units available for every 100 very low income renter households, a decrease from the 77:100 ratio in 2005. For extremely low-income rental households, the ratio in 2009 was worse: 32 units per 100 households, down from 40:100 in 2005.[82]

People with very low incomes can be at-risk of becoming homeless. According to *King County 2010 One Night Count Survey Data,* 6187 live in shelters and transitional housing programs. 703 or 11.4 percent were people 55 and older. Of those, 135 were 65 and older.

Racial disparity is very apparent among the homeless population. While African American, American Indian/Alaska Native, and Hispanic people represent 14.9% of the adult population in King County, they comprise 57% of the homeless population surveyed in shelters and transitional housing programs.[83]

Several factors are anticipated to contribute to a growing gap between the demand and supply for affordable housing and needed support services for elders over the next four years:

- An increasing population of older adults and people with disabilities who are living longer.
- A shortage of Section 8 rental assistance vouchers and other rental subsidy programs.
- Significant loss of housing available to low income renters, due to condominium conversions, rent increases, and renovations.
- New "affordable" housing targeted to 80 percent of median income, which, at $45,100 for a single person in King County (in 2011), is higher than most low-income people earn.
- High housing costs in the Puget Sound area.

"The challenge for King County is great. An additional 936 subsidized units each year will need to be created until 2025 just to maintain the current ratio of affordable housing to poor seniors." ~ Quiet Crisis: Age Wave Maxes Out Affordable Housing, King County 2008–2025

Transportation

Affordable transportation is a great concern for King County residents.[84] Transportation links people with goods and services as well as social and community activities. Current infrastructure supports mobility via personal automobiles. Older people and persons with disabilities need better mobility options to stay active, involved, and independent, remaining in their own homes and the communities of their choosing. Mobility is crucial for older persons to remain socially connected later on in life.[85]

[82] U.S Department of Housing & Urban Development, *Affordable Housing Needs 2009: Report to Congress 2011 Update*, accessed at www.huduser.org/portal/publications/affhsg/wc_HsgNeeds09.html
[83] Committee to End Homelessness, *King County 2010 One Night Count Survey Data*, accessed at www.cehkc.org/DOC_reports/2010ONC.pdf
[84] Aging and Disability Services, 2011 Area Plan Questionnaire results.
[85] Mezuk, B., Rebok, G.W., "Social integration and social support among older adults following driving cessation," *The Journals of Gerontology* 63B(5), S298-S303 (2008).

More than one in five drivers in the nation and in Washington state is over age 60.[86] Driver safety is a concern as older adults have a higher risk of mortality due to an accident for which they are responsible.[87]

As people outlive their ability to drive, alternative transportation options need to be available.

Persons over 65 spend between 14 percent and 16 percent of their annual income on transportation costs, more than they spend on food or health care[88]. Transportation options must be affordable, accessible, and safe.

Note: Mobility issues related to the built environment, universal design and "walkability" are referenced in the **Promote Aging Readiness** section of this plan.

Financial Empowerment

Nationwide, the percentage of all workers age 55+ who work full time throughout the year has increased steadily.[89] By 2018, more than one-third of men and one-quarter of women age 65-74 will be in the labor force.[90]

Table 7 illustrates the increase in both the total number of older adults who work and the larger increase in the number of older women who work.[91]

	1993	1995	2000	2002	2004	2006	2007	2008
Men	60.5%	63.3%	66.2%	68.2%	69.2%	70.7%	71.7%	69.2%
Women	46.6%	48.2%	53.3%	56.3%	57.1%	59.6%	59.7%	58.0%

Table 7. Work Status of Workers Age 55 and Older, by Gender (full time, full year)

The benefits of recruiting, training and retaining mature workers are well documented:

- Stronger attendance, and greater availability and willingness to work different schedules.
- Ability to mentor less experienced staff.
- Valuable experience.
- Stronger loyalty, reliability, and work ethic.
- Diversity of thought and approach.
- Established network contacts and clients.
- Fewer accidents, with a tendency to be more careful on the job.
- Fewer job changes, higher retention rate, and lower employee replacement costs.
- More productive in their work, with steadier production rates, than younger co-workers.
- Lower training costs.[92,93]

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[86] U.S. Department of Transportation, Federal Highway Administration, *Highway Statistics* (2008), accessed at www.fhwa.dot.gov/policyinformation/statistics/2008/dl22.cfm.
[87] Tefft, B.D., "Risks older drivers pose to themselves and to other road users," *Journal of Safety Research*, 39 (6), 577–582 (2008).
[88] Federal Interagency Forum on Aging-Related Statistics, *Older Americans 2010: Key Indicators of Well-Being* (Washington, DC: July 2010).
[89] Employee Benefit Research Institute estimates from the 1988–2009 March Current Population Surveys.
[90] Stanford Center on Longevity, *New Realities of an Older America: Challenges, Changes and Questions (*2010).
[91] Employee Benefit Research Institute estimates from the 1988–2009 March Current Population Surveys.

Despite these advantages to employers, an increasing number of older jobseekers encounter ageism in hiring. The Workforce Development Council of Seattle-King County hosts Employ Experience, a Web site devoted to helping employers keep a competitive edge by hiring the wisdom and experience of older workers, and supporting experienced workers currently in the job market.[94]

The biggest concerns about retirement among Middle Boomers are being able to afford health care (25 percent) and staying productive and useful (18 percent). Being able to afford health care and staying productive and useful also tied for the top two biggest concerns among Oldest Boomers, while outliving retirement money and having to work full- or part-time in retirement were the top two biggest concerns among the Youngest Boomers. More than half of the boomers age 53–59 feel that they are behind in their retirement savings.[95] Fewer than half the employers in King County provide retirement plans.[96]

Older adults who are lucky enough to retire, in the traditional sense, often seek productive encore careers. How we support and encourage workers across the lifespan, especially through career transitions, and help them maintain financial stability is important.

Of particular concern is the financial stability of older women. In the US, on average, women outlive men by five to seven years. Nationwide, older women outnumber older men at 22.7 million older women to 16.8 million older men. Forty-two percent of older women in 2009 were widows. Half of women age 75+ (49 percent) live alone. Older men were much more likely to be married than older women—72 percent of men vs. 42 percent of women—and men are more likely than women to remarry if they are widowed or divorced. [97,98]

Women are more likely to be poor. The median income of older persons in 2009 was $25,877 for males and $15,282 for females. Older people are more likely to live alone, and older women are more likely than older men to live alone. Although older people are experiencing lower rates of disability now, in general older women are more likely than older men to face certain health problems, such as mobility impairments and chronic conditions such as arthritis, asthma, depression, and obesity.[99,100,101]

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[92] Society for Human Resource Management, National Older Worker Career Center & Committee for Economic Development, *Older Workers Survey* (June 2003), accessed at www.shrm.org/Research/SurveyFindings/Documents/SHRM%20NOWCC%20CED%20Older%20Workers%20Survey.pdf.

[93] Council for Adult and Experiential Learning and the Council on Competitiveness, *Bridging the Skills Gap: Why Mature Workers Matter* (July 2009), accessed at http://hrqmc.com/Planning%20Materials/12%20Bridging_the_Skills_Gap.pdf

[94] Employ Experience: www.employexperience.com

[95] The MetLife Study of Boomers in the Middle: An In-Depth Look at Americans Born 1952–1958 (March 2010).

[96] Communities Count (2008).

[97] Administration on Aging, *A Profile of Older Americans* (2010).

[98] U.S. Census Bureau, *65+ in the United States* (December 2005).

[99] *MetLife Report on Early Boomers: How America's Leading Edge Baby Boomers will Transform Aging, Work & Retirement* (September 2010).

[100] U.S. Department of Commerce, *Women in America: Indicators of Social and Economic Well-Being* (March 2011).

[101] Stanford Center on Longevity, *New Realities of an Older America: Challenges, Changes and Questions* (2010).

Food Security

Food security is a crucial measurement of well-being. Food insecurity is defined as limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.[102] In the United States alone more than 50 million Americans do not have dependable, consistent access to enough food due to limited finances or resources, and more than 2 million rural households experience food insecurity.[103]

> "Malnutrition costs. It costs older people by exacerbating disease, by increasing disability, by decreasing their resistance to infection, and by extending their hospital stays. It costs caregivers by increasing worry and caregiving demands. The entire country pays for health care costs related to this increase in complication rates, increasing hospital stays, and increasing mortality rates." ~ Fernando M. Torres-Gil

Poverty is closely associated with hunger. Food insecurity among elderly households with incomes below the federal poverty line was more than 12 times greater than that of elderly households with incomes above 185 percent of the poverty line.[104] According to the 2005–2009 American Community Survey Report, 7.1 percent of older adults age 65 and older live below the poverty line in King County—almost 13,000 older King County residents.[105]

Specific groups are at higher risk of food insecurity. Hispanic and African American elders are more likely to live in food-insecure households compared to non-Hispanic white older adults. Nearly half of all the differences between these groups can be accounted for by lower incomes among minority households.[106] Older women living alone have higher than average poverty rates and are at risk of food insecurity.[107]

Numerous health consequences are attributed to food insecurity and hunger among older adults, such as malnutrition, which can exacerbate disease, increase disability, decrease resistance to infections, and extend hospitals stays.[108]

Local demand for congregate meals is increasing. For the first time in several years, senior nutrition providers in King County have reported that the numbers of meals served per month are rising. In some cases there is even fear they may exceed their budgets due to the increase in demand. In 2010, the total number of congregate mals served in King County was 10,442. In 2012, the number of meals served was 15,479—an increase of 48 percent.

Note: See also Healthy Eating in the following section.

[102] S.A. Anderson, "Core indicators of nutritional sate for difficult-to-sample populations," *Journal of Nutrition* 120 (11s) 1557–1600 (1990)
[103] Feeding America, *Senior Hunger*, accessed at www.feedingamerica.org
[104] M. Nord, "Food Security Rates Are High for Elderly Households," *Food Review* 25(2): 19-24 (2002).
[105] U.S. Census Bureau, *American Community Survey Report: 2005–2009*.
[106] M. Nord, "Food Security Rates Are High for Elderly Households," *Food Review* 25(2): 19-24 (2002).
[107] U.S. Department of Health and Human Services, Administration on Aging.
[108] Bryan Hall & J. Larry Brown, "Food Security Among Older Adults in the United States," *Topics in Clinical Nutrition* Volume 20, Issue 4: 329–338 (2005).

GOAL: Address Basic Needs

ADS is committed to addressing basic needs. We propose to carry out the following objectives:

OBJECTIVES

Information & Assistance/Aging & Disability Resource Network

10. Expand existing Information & Assistance (I&A) service delivery system to implement core components of ADRCs: 1) Information, Referral, and Awareness; 2) Options Counseling and Assistance; 3) Person Centered Transition Supports; 4) Streamlined Eligibility (Access) Determination; 4) Consumer Populations, Partnerships and Stakeholder Involvement; and 5) Quality Assurance and Continuous Improvement.
    2011 Baseline: 20% of core components implemented.
    2014 Goal: 60% of components implemented; expansion of pilot projects to ADRC network.
    2015 Goal: 80% of components implemented.

11. Increase the number of King County older adults and people with disabilities who use Washington Connection, either directly or with the help of I&A/ADRC advocates, to complete applications for benefits.
    2012 Baseline: Applications for benefits for ages 60+ - 6,996 direct and 1,165 community partner
    2014: Increase access by 10% from 2012
    2015: Increase access by 10% 2014

Housing

12. Increase access to housing with services for low-income residents to age in place. (2014)
    a. Advocate at the federal and state levels to maintain funding for low-income housing and to reduce barriers to providing services to seniors in subsidized housing (Ongoing)
    b. Advocate increasing access to affordable housing for old adults and people with disabilities. **(New)**

13. Maintain the percentage of eviction prevention services that result in maintaining SHA residency for seniors and adults with disabilities. **Annual Goal**: 80 percent

Transportation

14. Advocate maintaining funding for neighborhood transportation options, including community shuttles and volunteer transportation, to keep pace with population growth.
    2011 Baseline: $3,069,075
    2015 Goal: $3,222,529

Financial Empowerment

15. Partner with the King County Asset Building Collaborative (KCABC) to promote financial literacy education for people of all ages to build financial literacy, promote economic self-sufficiency, and prepare for retirement. (**Ongoing**)

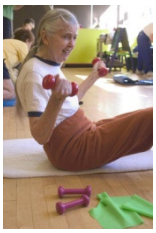
16. Advocate for the reauthorization of the Older Americans Act and advocate for improved economic security in King County, especially among older women. (**Ongoing**)

17. Increase awareness of the Elder Economic Security Standard Index for Washington, and specific data that details how much income an older adult needs for self-sufficiency in Seattle & King County. (**Ongoing**)

Food Security

18. Partner with other jurisdictions in King County to develop strategies for increasing meal programs for older adults. (**Ongoing**)
    2011 Baseline: 322,782 congregate meals

IMPROVE HEALTH AND WELL-BEING



The research is clear and compelling. Regular physical activity positively affects overall health for older adults and increases life expectancy.[109] Adopting a balanced diet that focuses on fruits and veggies (even later in life) promotes longer life expectancies and better quality of life in older adults.[110] In short, physical activity and healthy eating can have a profound impact on the lives on older adults.

Active Aging

Older people who exercise regularly generally have stronger bones, lower blood pressure, better balance, better sleep, better mood, fewer aches and pains, more energy, healthier heart and lungs, and reduced risk for diabetes and some types of cancer. Older adults who maintain their abilities in balance and strength through exercise fall less often than those who are less active. Even moderate exercise and physical activity can have a dramatic positive effect on physical and mental health. Health issues related to lack of exercise include stiff joints, heart disease, diabetes, weight gain, low energy and depression.

With high (and increasing) rates of heart disease, diabetes and obesity in King County, aging readiness must include opportunities for regular exercise. More than 20 percent of adults over age 65 are obese.[111] The number of King County residents with diabetes has doubled in the past decade. Obesity and diabetes lead to numerous other chronic diseases.[112] Many chronic conditions are preventable. Physical activity has a great bearing on health and quality of life.[113]

> "Although no amount of physical activity can stop the aging process, there is evidence that a moderate amount of regular physical activity can minimize the physiological effects of aging and increase active life expectancy by limiting the development and progression of chronic disease and disabling conditions." ~ Wojtek Chodzko-Zajko, et al., "Successful Aging: The Role of Physical Activity," *American Journal of Lifestyle Medicine*

Most cases of diabetes can be prevented by decreasing obesity and increasing physical activity.[114] Regular physical activity actually increases average life expectancy through its influence on chronic disease development.[115] Regular exercise also improves mood in people with mild to moderate depression.[116,117] Unfortunately, in 2008, more than 19 percent of adults in Washington state had no leisure time physical activity or exercise.[118]

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[109] Wojtek Chodzko-Zajko, Andiara Schwingel and Chae Hee Park, "Successful Aging: The Role of Physical Activity," *American Journal of Lifestyle Medicine* (2008), accessed at http://ajl.sagepub.com/content/3/1/20.full.pdf.
[110] Amy L. Anderson, "Dietary patterns and survival of older adults," *Journal of the American Dietetic Association* (January 2011).
[111] Behavioral Risk Factor Surveillance System (2009).
[112] Public Health–Seattle & King County, *Public Health Data Watch: Diabetes in King County* (April 2007).
[113] Wojtek Chodzko-Zajko, Andiara Schwingel and Chae Hee Park, "Successful Aging: The Role of Physical Activity," *American Journal of Lifestyle Medicine* (2008), accessed at http://ajl.sagepub.com/content/3/1/20.full.pdf.
[114] Ibid.
[115] American College of Sports Medicine, *Position Stand on Exercise and Physical Activity for Older Adults*, among others.
[116] Harvard Medical School, *Exercise and Depression* (2008).

The rate of depression is high among older adults. In 2007, adults age 45 to 64 had the highest suicide rate in King County, followed closely by adults age 65 and over (17.4 deaths per 100,000 people and 17.0 deaths per 100,000, respectively). The five-year average for hospitalizations due to suicide attempts was 44.9 per 100,000 people for the younger group and 15.8 per 100,000 for the older group.[119] In older adults, depression is often misdiagnosed and undertreated, thought by health care providers and older adults themselves to be a natural reaction to illness or aging and not a treatable condition; however, depression can be treated successfully.[120]

"If you stay physically active, you're buying protection for your brain." ~ Eric B. Larson, MD, Center for Health Studies, Group Health Cooperative

Exercise helps older adults maintain balance and prevent falls, which are a major threat to the health and independence of people age 65 and older. Each year, nearly one-third of older adults experience a fall. Approximately one in ten falls among older adults results in a serious injury that requires hospitalization and long convalescence. Falls are the leading cause of injury deaths among older adults.[121]

ADS has expanded funding for **Enhance Fitness** programs with six immigrant/refugee senior groups. In 2012, services will be revised to meet the needs of these populations more effectively.

In response to a request in 2010 by the Seattle City Council (Statement of Legislative Intent 38-2-A-1), ADS conducted a planning process to identify the City's policy goals for older adults; the role of senior centers and other City-funded programs and initiatives in meeting these goals; and effective and sustainable approaches to implementing programs and services in support of these goals.

The final report, **Seattle for a Lifetime: City Goals for Older Adults**, included recommendations to improve coordination between City-funded senior centers and other municipal programs for older adults.[122] Efforts include regular meetings to share information between senior center staff and Seattle Parks Lifelong Recreation Program staff, and the development of memoranda of agreement between programs to identify areas for coordination and opportunities for partnerships or joint programming.

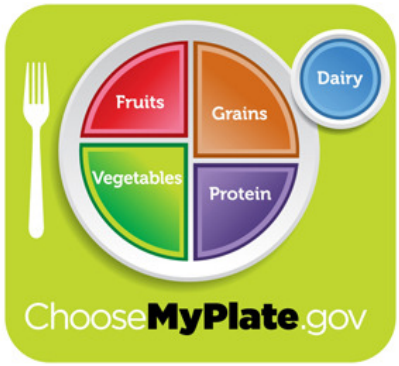
Healthy Eating

A healthy diet supports active aging, yet barriers for some seniors include cost of quality fresh fruits and vegetables, lack of interest in preparing a well-balanced meal for one, and inability to get out shopping regularly.

Healthy eating can control or prevent Type II diabetes, maintain cardiovascular health, and limit disability. Older adults who adhere to healthy nutritional guidelines and

[117] "Prospective Study of Cardiorespiratory Fitness and Depressive Symptoms in Women and Men," *Journal of Psychiatric Research* (10/8/2008).
[118] Behavioral Risk Factor Surveillance System (2008).
[119] Center for Health Statistics, Washington State Department of Health (2007).
[120] Centers for Disease Control, *Enhancing Use of Clinical Preventive Services Among Older Adults* (2010).
[121] Public Health–Seattle & King County Web site.
[122] Seattle for a Lifetime: City Goals for Older Adults, accessed at www.agingkingcounty.org/docs/SLI_38-2-A-1_Older_Adults.pdf.

consume relatively high amounts of vegetables, fruit, whole grains, low-fat dairy products, poultry and fish may have a lower risk of mortality.[123]



In June 2011, the USDA launched the *My Plate* campaign to encourage U.S. residents to make healthier food choices, addressing epidemic rates of overweight and obesity nationwide. Among their recommendations: fill half of every plate with fruits and vegetables.[124] The My Plate graphic image has replaced the USDA's Food Pyramid.

Although My Plate replaces the USDA's long-time *5 A Day* campaign, which encouraged five servings of fruits and vegetables each day, the USDA's emphasis on eating more fruits and vegetables has not changed. Recommended quantities can be personalized by age and activity level, with interactive tools available at www.fruitsandveggiesmatter.com.

People who eat generous amounts of fruits and vegetables, as part of a healthy diet, tend to have reduced risk of chronic diseases.[125] Older adults with limited incomes often find it difficult to purchase more expensive fruits and vegetables.

In 2002, ADS created a **Senior Farmers Market Program** to support local, sustainable agriculture and to increase intake of fruits and vegetables for homebound seniors with limited incomes. Participants received bi-weekly market baskets filled with local, in-season fruits and vegetables and a newsletter with recipes and nutritional advice keyed to the produce of the week. In 2010, 665 seniors received delivery of 2,660 baskets.

The program also includes the distribution of Farmer Market vouchers. Each recipient receives $40 worth of $2 vouchers, which can be used to purchase local produce at authorized farmers markets or roadside stands from June through October 31. With the addition of market vouchers, participation in the Senior Farmers Market Program has increased from 1,450 participants in 2002 to 6,547 participants in 2010. ADS will continue to promote the expansion of the Senior Farmers Market Program to improve the diet of a greater number of low-income mobile and homebound older adults

Throughout King County, senior meal and childcare programs are benefiting from **Farm to Table**, a new program that is providing them with more fresh, locally grown produce. By directly connecting local farmers with meal providers, Farm to Table's goal is to help meal programs serve fresher, nutritious foods at prices they can afford. An added benefit is support for local farmers and the local economy.

Farm to Table is funded by Public Health—Seattle & King County through a federal grant from Communities Putting Prevention to Work (CPPW), a Centers for Disease Control and Prevention project. As part of the federal economic stimulus program, CPPW projects focus on systems change—improving how things work. Farm to Table connects two systems—farming and meal programs—that had limited interactions, but

[123] Amy L Anderson, "Dietary patterns and survival of older adults," *Journal of the American Dietetic Association* (January 2011).
[124] USDA ChooseMyPlate.gov: www.choosemyplate.gov
[125] U.S. Department of Health and Human Services and U.S. Department of Agriculture, *Dietary Guidelines for Americans* (January 2005).

which have a shared mission of feeding people. Farmers want to see their food eaten and appreciated, while senior meal and childcare providers want to provide the best quality food possible for their participants.

ADS is piloting the program with three sub-contracted senior nutrition programs in an effort to develop cooperative buying or other purchasing models that will enable providers to keep farm fresh produce on their menus for the long term. The Muckleshoot Indian Tribe and eight childcare centers are also participating in the pilot.[126]

In addition to this section of the Area Plan, see goals and objectives related to aging, the built environment, physical fitness, and fall prevention under the heading of Promote Aging Readiness. Changes communities make to inspire adults to get moving, stay active, and protect themselves will increase their opportunity to age in place successfully.

"With our local and state partners we are increasing access to fresh fruits and vegetables for residents with the greatest need in our County. At the same time, we are supporting our local farmers so they can bring healthy foods to our neighborhoods for years to come." ~ Dr. David Fleming, Director and Health Officer for Public Health–Seattle & King County

Health Promotion and Disease Prevention

The U.S. Administration on Aging (AoA) highlighted ADS' health promotion efforts in a report, "Case Studies of Health Promotion in the Aging Network," published in January 2006.[127] ADS continues to promote evidence-based health promotion and disease prevention programs outlined in the report, including Chronic Disease Self-Management, Sound Steps, and Congregate Meals. ADS staff participate in monthly Healthy Aging Partnership meetings. Strategies for health promotion and prevention of chronic diseases are woven throughout this plan, in each of the five goal areas. New and continuing initiatives include:

1. **Improve health care quality for older adults and adults with disabilities.**
   - King County Care Partners
   - PEARLS (Program to Encourage Active, Rewarding Lives)
2. **Address basic needs.**
   - Financial empowerment
   - Food security
3. **Improve health and well-being.**
   - Enhance Fitness
   - Senior Farmers Market Program
   - Farm to Table
4. **Increase the independence for frail older adults and people with disabilities.**
   - Family and Kinship Caregiver Support
5. **Promote aging readiness.**
   - Community engagement
   - Technology, including social marketing tools such as Silver & Gold–Seattle & King County, a nimble Facebook page that features daily posts, and Seniors Digest, a monthly e-newsletter, promote healthy, active aging.

[126] Puget Sound Food Network/Farm to Table: http://psfn.org/blog/category/farm-to-table/
[127] Available online at www.agingkingcounty.org/docs/AoaCaseStudyHealthPromotion.pdf.

GOAL: Improve Health and Well-Being

ADS is committed to improving health and well-being. We propose to carry out the following objectives:

OBJECTIVES

Active Aging

19. Increase the number of people who participate in evidenced-based health promotion programs and show positive health behavior change.
    2012 Baseline: 1,223 (includes participants of color and immigrants/refugees)
    2014 Goal: 1,480
    2015 Goal: 1,730

20. Seek funding and community partners for outdoor fitness stations geared towards older adults and adults with disabilities.
    2011 Baseline: 0
    2015 Goal: 1 senior fitness facility

21. Advocate for social and recreational programming adapted to support people as they age. (Ongoing)

INCREASE INDEPENDENCE FOR FRAIL OLDER ADULTS AND ADULTS WITH DISABILITIES

Disability takes many forms. Loss of physical or mental ability (e.g., energy, emotional control, flexibility, hearing, memory, movement, stamina, vision) can result in limited ability to care for oneself. Loss of independence can be frustrating and/or lonely and can limit one's ability to complete necessary activities of daily living, like grocery shopping and laundry.

Most older people remain in their own homes but their quality of life depends on receiving care and support, often from family and friends. Types of care include dressing, meal preparation, getting in and out of bed or chairs, personal hygiene, and getting around the house.

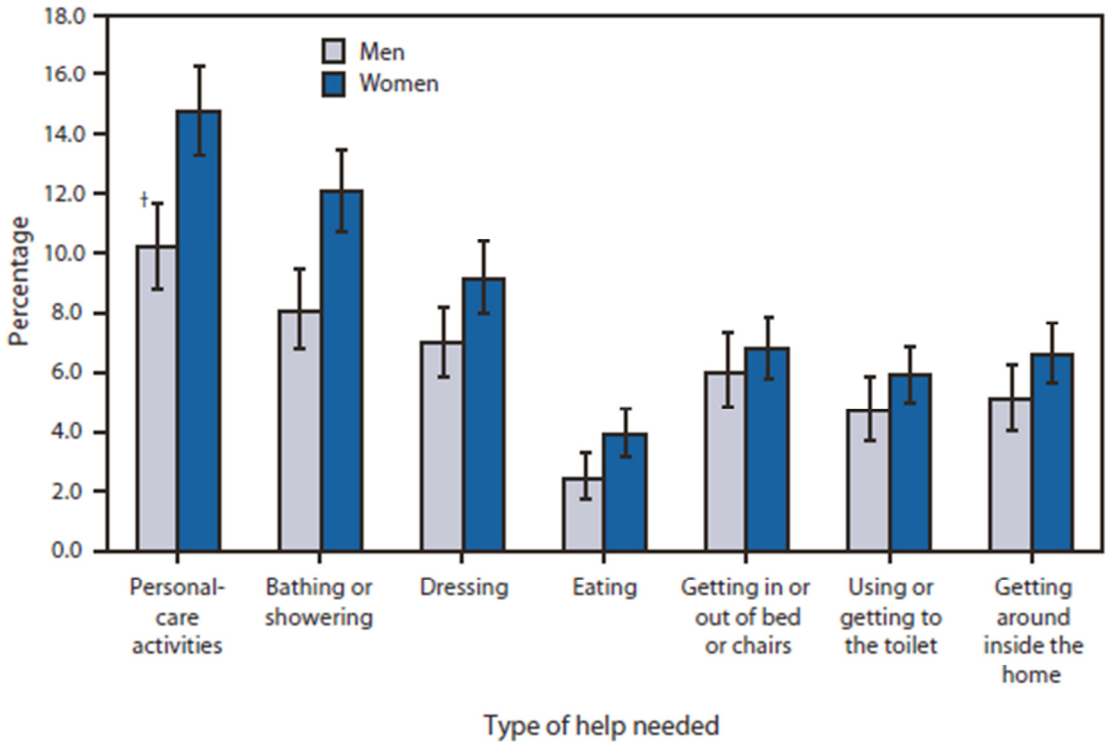


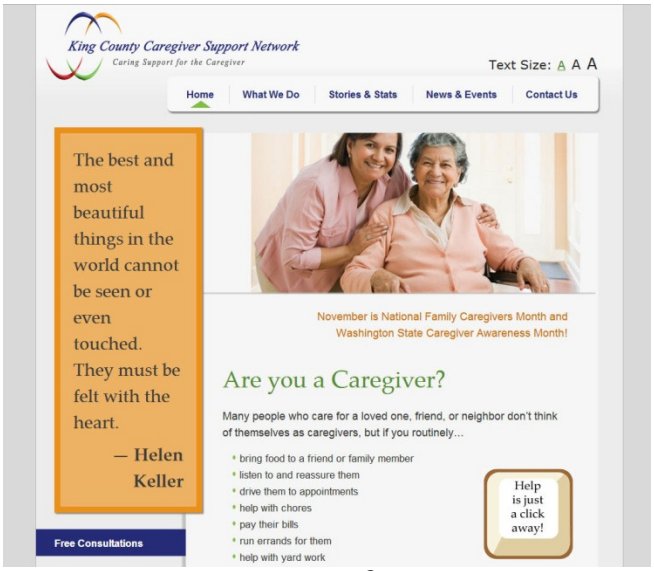
Figure 23. Percentage of Non-institutionalized Adults Age 80+ Who Need Help with Personal Care, by Sex (U.S., 2008–2009)[128]

[128] Centers for Disease Control, *Morbidity and Mortality Weekly Report*, accessed 6/24/11 at www.cdc.gov/mmwr/preview/mmwrhtml/mm6024a5.htm?s_cid=mm6024a5_e&source=govdelivery

Family and Kinship Caregiver Support

In early 2011, a Request for Investments (RFI) was issued that resulted in an increase in the number of contracted providers for both the Family Caregiver Support Program (FCSP) and Kinship Caregivers Support Programs (KCSP). The RFI planning process included literature reviews of the latest caregiver research, analysis of service and population data, surveys of local caregivers, and focus groups with caregivers from a variety of ethnic and economic backgrounds.

An ongoing priority of the King County FCSP and KCSP has been to improve service to at-risk communities, especially those identified in the Older Americans Act. RFI respondents were required to identify how they would serve these priority populations, and which groups they had specific expertise and/or interest in targeting. The last column in Table 9 (see Appendix A—Family Caregiver Support Programs) summarizes these priorities by provider. The list is not meant to be comprehensive: all contracted providers serve a diverse mix of clients, and may not deny services based on race, gender, ethnicity, or sexual orientation.



Thanks to additional state funding and growing interest in caregiver services, ADS has increased community outreach to raise awareness of the King County FCSP and KCSP. New program brochures and flyers have been developed and are being distributed to FCSP providers, hospitals, and community groups. A new website (www.kccaregiver.org) was created as a gateway to local FCSP and KCSP resources, including caregiving tips and research, links to providers, and other relevant information. The goal is to create a more cohesive network of services, with the electronic "TCARE®" caregiver screening and assessment system as a common standard for helping FCSP caregivers find the "right services at the right time" in their caregiving journey.

With the lingering effects of the Great Recession still felt, serving low-income caregivers and those in financial distress is a high priority. Improved collaboration with DSHS' Home and Community Services—where a new referral system to FCSP has been developed—will help ADS target those with greatest economic need even more effectively. Outreach through King County Care Partners and other programs serving low-income populations is planned.

The addition of Neighborhood House and Jewish Family Services as FCSP providers will significantly expand the program's capacity to serve limited- and non-English-speaking caregivers. Neighborhood House has expertise serving immigrant and refugee populations, with a focus on Southeast Asian and East African populations, and their program also has a Kinship component. Jewish Family Services will significantly improve the FCSP's ability to serve Russian and Eastern European caregivers. Kin On, Chinese

Information & Service Center, and Alzheimer's Association will continue their expertise serving Asian, Spanish-speaking, and African American clients.

Implementation of the TCARE protocol has been a significant enhancement to FCSP services, but it has presented challenges as well. The assessment process and wording of the questions has been problematic for some ethnic and racial groups. Therefore ADS has convened the "TCARE Cultural Issues Subgroup" consisting of several providers, ADS staff, and occasionally ALTSA's and Dr Rhonda Montgomery's staff as well. The group is working on translating versions of TCARE for different groups and further tailoring the process so it is more culturally appropriated.

Similarly, it was discovered through discussions with the statewide Lifespan Respite group that many "patient advocacy organizations" (e.g. the Parkinson's Foundation, MS Society, and similar groups) were either unaware of the services available through the FCSP or felt the services offered were not suited to the needs of their members. To address this, ADS staff convened several meetings with these groups and two trainings were held: one to educate ADS and FCSP provider staff on the services offered by these groups, and another to educate the patient advocacy groups on the services available through the FCSP. Crisis Clinic has agreed to serve as the main point of FCSP entry for clients of these groups, due to their experience working with younger caregivers.

Caregivers of same-sex partners face eligibility barriers in accessing entitlement systems, while the FCSP is much more flexible. Through the RFI process two providers—Northshore Senior Center and Jewish Family Service —expressed interest in reaching out to and serving LGBT populations. These providers have been conducting outreach to these populations with mixed results. Jewish Family Service plans to increase the resources devoted to reaching LGBT caregivers starting in July 2013.

All FCSP providers have the capacity to serve caregivers of people with severe and/or developmental disabilities. Jewish Family Service in particular will collaborate with the Arc of King County to serve adults with cognitive disabilities. Likewise, all providers have the capacity to serve caregivers of loved ones under age 60 using State Family Caregiver Support Program funds. Crisis Clinic has developed particular expertise in this area.

Most FCSP agencies have the ability to serve caregivers of loved ones with Alzheimer's disease and other dementias, but the Alzheimer's Association Western and Central Washington Chapter provides local expertise in this area. Services include in-home, dementia-specific consultations; support groups; and trainings on the latest Alzheimer's research. The Chapter also hosts a yearly conference for African American Caregivers.

Full Life Care offers Memory Care and Wellness Services—a type of adult day health program tailored to care receivers with dementia—at two locations. This service is available through the FCSP Respite Care Program, and is described in more detail elsewhere in this plan.

Although the King County FCSP serves Native American caregivers at a rate slightly above their population density, no RFI applicants described specific expertise in serving this community. ADS will therefore focus some of its own outreach on building bridges to local tribes and Native American groups. Recently a connection was made with the Muckleshoot tribe resulting in two of their social workers being trained as Powerful Tools for Caregiving trainers. These tribe members have been invited to future FCSP provider meetings and ADS hopes this results in many fruitful collaborations going forward.

The KCSP provides information and services to grandparents and relatives raising children. According to the Census Bureau, more than 35,000 children are being raised by kinship caregivers in Washington. The 2011 RFI resulted in an expansion from two contracted KCSP providers to three.

Neighborhood House and Renton Area Youth and Family Services are new (to the KCSP) providers who bring expertise serving ethnically diverse areas of south Seattle and south King County. They will offer a range of services, including support groups, outside activities, and training opportunities. Encompass is an existing KCSP provider based in the Snoqualmie Valley. Among other things, they provide case management and home visits to help kinship caregivers access counseling, parenting classes, health care, and various government entitlement and support programs.

The Kinship Navigator Program is a state-funded information and assistance service for grandparents and other relatives raising children whose own parents are unable to do so. A Request for Investment (RFI) process was completed in 2013 and Catholic Community Services – the previous contractor – submitted the winning proposal. Kinship Navigators can make referrals to a wide variety of programs helpful to kinship caregivers, and can also help them receive or maintain childcare, navigate the educational system, and obtain legal assistance. A half-time position funded by the Children's Administration was included in the RFI. This position, called the Kinship Collaboration Coordinator, helps coordinate the King County Kinship Collaboration, and networks with local providers, support groups, and advocates.

FCSP Expansion: ADS recently expanded its capacity largely thanks to a significant increase in state funding for the FCSP. This funding was used to train more TCARE® assessors and increase service levels. The goal of the expansion was to demonstrate that appropriately targeted caregiver services can prevent or delay costly Medicaid enrollment among care receivers. It is hoped the state will continue to fund the program at this higher level; at the time of this writing, it appears the legislature will do so.

With the expansion phase completed, ADS staff are spending more time consolidating local FCSP policies and procedures, training providers in a variety of FCSP-related topics, monitoring TCARE outcomes and documentation, and increasing the qualitity and quantity of referrals to other providers (inside and outside of the FCSP network).

One of the most important FCSP goals to target caregivers who serve loved ones at risk for institutionalization. ADS has long believed that appropriately targeted caregiver services create a "triple win" scenario: caregivers have lower stress and burden, care receivers are able to stay home and independent, and taxpayers see reduced public spending on nursing facilities.

As a result of increased funding, ADS has moved to a "no wrong door" model for TCARE® and away from a "single entry point" model. More providers have the ability to conduct the TCARE® screenings and assessments, meaning more caregivers get TCARE® care plans.

Core Elements: Eight core elements have been identified for a robust FCSP service menu:

1. Information services and group outreach
2. Specialized family caregiver information
3. Specialized family caregiver assistance, including TCARE®

4. Caregiver counseling
5. Caregiver Training
6. Caregiver Support Groups
7. Respite care services (in-home and out-of home)
8. Supplemental services

All of the FCSP Core Elements are provided through the King County Family Caregiver Support Program. FCSP-contracted agencies provide multiple core services, with a range of three to six per agency. Respite Care Services are administered by ADS, Evergreen Care Network, and Chinese Information and Service Center. In home care, adult day care/health, and brief nursing home stays are available. Supplemental Services are administered by ADS, but accessible to all FCSP-contracted agencies.

The KCSP provides all of the Core Elements except TCARE®, counseling, and respite.

The two Family Caregiver Support Programs tables in Appendix A summarize how the eight core elements are organized in King County for both Family Caregiver and Kinship programs, with information about geographic areas served and special target populations served.

Caregiver training has been an important component of the King County FCSP since the beginning of the program. Northshore Senior Center offers several group trainings such as Powerful Tools for Caregiving, Living Well with a Chronic Condition, A Matter of Balance, and—in collaboration with Alzheimer's Association—Early Stage Memory Loss. Alzheimer's Association also provides an annual African American Caregivers Forum in King County, and ongoing training for African American and other caregivers.

ADS recently hosted a series of Powerful Tools for Caregiving "Train the Trainer" trainings for service providers, thereby increasing our capacity to offer this service throughout King County. Thanks to these efforts our providers will also be able to offer this training to Chinese- and Cambodian-speaking caregivers.

The Geriatric Regional Assessment Team (GRAT) of Evergreen Healthcare is the main provider of mental health counseling for the King County FCSP. GRAT provides up to six sessions of (often) in-home solution-focused therapy for depressed and overburdened caregivers. The program was developed using an evidenced-based program called the New York University Spouse-Caregiver Intervention Study. Jewish Family Service and Kin On also provided mental health counseling services. Kin On serves primarily Chinese-speaking caregivers.

Counseling is one of the most frequently recommended services through TCARE®, and through the recent RFI GRAT was able to add an extra .5 FTE caregiver counselor. Another FTE was added in 2012 due to continuing strong demand. GRAT counseling is limited to six sessions per year, with "on-demand counseling" phone support available in between sessions.

GRAT is also starting a new support group in Kent, at the Kent Library. The group will target "baby boomer" African Americans in the area, though anyone eligible can attend. Support groups with an Asian community focus are offered by the Chinese Information & Service Center and Kin On Community Health Care.

Chinese Information and Service Center, Senior Services, Neighborhood House, and Alzheimer's Association all offer support groups for caregivers. They rely on trained

volunteers, typically social workers, health care providers, or former family members. Alzheimer's Association has established specialized groups for LGBT and Spanish speaking caregivers. They have offered some groups via teleconferencing, due to the difficulty some caregivers have getting away from home.

In late 2012 ADS added a new service called "Housekeeping and Errands." This was done in response to an analysis of TCARE data that showed "chore services" as one of the top care plan recommendations generated by the TCARE system. So far 29 clients have received this service.

Supplemental services fall into two categories in King County: emergency respite, and other goods and services. Emergency respite is provided through the Crisis Clinic for caregivers in acute distress who need an immediate break from caregiving. The requirement for a TCARE assessment is waived, at least until the immediate crisis has passed.

The purchase of "other goods and services" for items to help decrease caregiver stress currently happens through ADS, where we are able to rely on an existing database and protocols to authorize quickly the purchase of goods and services while maintaining appropriate audit controls. Other FCSP providers can access this system for their clients through a referral to ADS. The Nursing Home Diversion Program demonstration project, complete in early 2011, clearly demonstrated the value of these purchases, which can make a big difference in keeping their loved ones at home and independent.

The King County Respite Care Program is administered through ADS. ADS contracts with 19 in-home and adult day providers to offer this service. The program offers caregivers short breaks of (typically) four to eight hours, by providing substitute caregiving. Three agencies schedule respite: ADS, Evergreen Care Network, and Chinese Information and Service Center.

In-Home Services

Changing in-home services population

Clients have many choices when receiving services including choice of setting—nursing home, assisted living, adult family homes or in-home. Over the past 25 years Washington state policymakers have successfully expanded the community-based services available to clients and decreased the nursing home population resulting in more choice for clients and lower Medicaid expenditures given the growth of the population. Despite an increasing older population, King County's nursing home population remained relatively stable at about 3,000 clients per month during 2010 (1,200 fewer individuals than in 1997). The Medicaid in-home services population in King County is growing in number, diversity, and medical complexity.

As medical advances and supportive services allow individuals with greater medical complexity to live safely at home, the number of clients who receive Medicaid in-home personal care services continues to grow, from 7,800 in 2002 to over 10,000 in 2010. In 2012, four case management agencies served a total of 13,719 older adults and adults with disabilities who live at home with Medicaid and discretionary case management services:

- Aging and Disability Services (Seattle and Renton offices)
- Evergreen Care Network (serving eastside residents)
- Asian Counseling and Referral Services
- Chinese Information and Service Center

King County is one of the most ethnically and linguistically diverse counties in the nation. This rich mix of cultures and languages is also reflected in the Medicaid long-term care service population case management programs serve. Of the current overall total of 10,000 COPES and Medical Personal Care clients served, 62 percent speak a primary language other than English for a total of 70 languages. Emerging language groups include Punjabi, Bosnian, Farsi, and Hindi. Over 75 case managers speak a language other than English. As new immigrant and refugee families settle in our area and require long term care services, it is important for case management programs to focus hiring and program training objectives on providing culturally relevant services to more diverse client populations.

Case Management Program Challenges

Case managers assess client needs, consult with clients to set up a comprehensive care plan, and authorize Medicaid in-home personal care support for activities of daily living (e.g., bathing, dressing, meal preparation) for older adults and adults with disabilities. RN consultants offer health-related assessment and consultation to Medicaid clients, home care providers, and case managers in order to enhance the development and implementation of the client's plan of care. The goal of nursing services is to help promote the client's maximum possible level of independence and contribute nursing expertise by performing the following activities:

- Comprehensive Assessment Reporting Evaluation (CARE) review
- Nursing assessment/reassessment
- Instruction to care providers and clients
- Care and health resource coordination
- Evaluation of health-related care needs affecting service planning and delivery.

Increasing workload. In late 2010, the case management reimbursement rate was reduced by three percent, one of many service impacts implemented by the state legislature to balance the state budget. Due to reduced revenue and increasing costs of running the program, case management programs cannot hire staff as quickly as warranted by caseload growth resulting in increased caseload sizes. The loss of other Medicaid services such as purchasing dental care and eyeglasses has further impacted clients' ability to get the services they need. Some services have been restored for 2014.

A client's selection of an individual provider as their caregiver is an integral part of client choice available in Washington's long-term care systems. Recent legislation prohibits family members from working for a home care agency to take care of a relative who is receiving Medicaid in-home services, although the family member may work for a relative as an individual provider. As a result, approximately 1,000 agency caregivers in King County transitioned to individual providers. Now individual providers make up 65 percent of the caregivers providing care for in-home clients, and additional oversight is required by case managers to ensure the clients' needs are being met and the IP continues to meet state contract requirements. One outcome of the greater number of individual providers is the large increase in workload for administrative hearings due to challenges to payment termination when training or character, competency, and suitability requirements are not met.

New requirements for IP contractors have increased the amount of time it takes before an IP is "qualified" to work, thereby delaying clients' receipt of services.

Increasing medical complexity of clients. Because case managers commonly serve clients with increasingly complex health issues who transition to home from hospitals and nursing homes, they spend more time and resources establishing and maintaining a

stable plan of care. Some clients experience difficulty making their medical appointments for dialysis treatment or are reluctant to follow through with their wound care plans. Other medically complex clients experience high caregiver turnover due to the difficulty of meeting their care needs. Clients with mental health or substance use problems sometimes exhibit behaviors that, without mental health intervention, may result in eviction and an unstable living condition and difficulty in keeping care providers.

The Case Management and planning staff have studied various Care Transitions models to determine which could be most effective for Case Management clients. Meetings with local hospitals have strengthened relationships and explored methods of improving communication about Case Management client utilization of hospital services. Several Case Management staff have been trained in the Care Transitions Intervention model and have begun working with clients to ensure a smoother transition between the hospital and the in-home setting. For more information, see Care Transitions in the Improve Health Care Quality section, above.

Person-Centered Care

Maintaining high-quality in-home services is imperative during this period of shrinking budgets. Comprehensive assessments and service plans for complex long-term care clients must address consumer needs and respond to the increasing focus on person-centered care. A quality service:

- Meets consumer needs and preferences (including service content and timeliness).
- Meets service standards.
- Is provided in a safe, caring, and reliable way.
- Is user-friendly.
- Is flexible to meet consumer preferences.
- Respects consumer rights.
- Is widespread and available to all who need it, including information about the service.
- Is adequately funded.
- Makes effective use of funding in order to achieve service outcomes.
- Is evidence-based, where possible.

Person-centered planning is important so that consumers feel a part of their health care plan and health outcomes. Case managers and RN consultants trained in Motivational Interviewing[129] support person-centered care by involving the client in realistic health-care and home-care goal setting.

In addition, three innovative in-home care models give clients more choice in types of services provided in King County:

- PACE—a model funded by a blend of Medicare and Medicaid funding that integrates medical and long term care services for 345 clients who are nursing home eligible.
- New Freedom—a participant-directed model for 550 clients who can direct their own care and are interested in flexible service options.
- Veterans-Directed Home Services (VDHS)—a participant-directed model in which as many as seven clients have had budgets based on their needs and have made spending choices, within established parameters, in consultation with a case manager.

[129] Motivational Interviewing: www.motivationalinterview.org

Seattle Housing Authority Building-Based Case Management
The ADS case management program, Asian Counseling and Referral Service, and Chinese Information and Service Center provide building-based case management services to older adults and adults with disabilities living in 52 Seattle Housing Authority (SHA) buildings. Case managers maintain regular building hours for building residents. They provide access to psychiatric consultations when appropriate and RN consultation to review the care needs of Medicaid clients. In the event of a crisis situation, case managers work with residents to avoid the exacerbation of issues. They provide training for building management and staff on a wide variety of topics including: domestic violence, substance abuse, disability or aging issues, and how to handle difficult client situations.

The three agencies perform the following early-intervention activities as part of their contract with SHA, in addition to the Medicaid-funded case management functions:

- Outreach
- Information and referral
- Assistance
- Eviction prevention
- Client assessment, evaluation and service planning
- Ongoing client monitoring and follow-up
- Supportive counseling

Elder Abuse

While statistics vary, in a national study that interviewed a representative sample of adults ages 60 and over, one in ten older adults reported emotional, physical, or sexual mistreatment (abuse) or potential neglect by others in the past year. Since turning 60 years of age, 13.5 percent reported experiencing emotional abuse or neglect, 1.8 percent reported physical abuse, and 0.3 percent reported sexual abuse. Low social support significantly increased the risk for the above forms of elder mistreatment by trusted others, as well as the risk for financial or material exploitation by family members.[130]

According to the 2009 U.S. Census estimates, 10.7 percent of King County's population (approximately 205,000) was age 65 or older. Assuming that past-year abuse estimates above are correct, an estimated 20,500 community-residing adults ages 65 or older were emotionally, physically or sexually abused or potentially physically neglected by trusted others in 2009.[131]

Estimates of elder abuse incidence and actual reports differ considerably. In 2009, there were 3,076 actual reports of vulnerable adult abuse to Adult Protective Services in King County, over two times the number of

"According to the best available estimates, between 1 and 2 million Americans age 65 or older have experienced abuse; and for each reported case about five more cases go unreported. Unfortunately, as the number of older individuals increases, so does the number of potential victims of elder abuse."
~ First World Elder Abuse Awareness Day press release, U.S. Department of Justice, 6/15/10

[130] Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the "United States: the National Elder Mistreatment Study," by R. Acierno, M.A. Hernandez, A.B. Amstadter, H.S. Resnick, K. Steve, W. Muzzy, et al., *American Journal of Public Health* 100(2), 292-297.
[131] U.S. Census Bureau, *State & County Quick Facts* (Thursday, 04-Nov-2010), accessed 5/11/11 at http://quickfacts.census.gov/qfd/states/53/53033.html.

reports received by any other county in Washington state. Approximately three-quarters of the reported victims were 60 and older, and one-quarter were age 18–59. Of the total reports, 837 were for physical and emotional abuse, 809 were for financial exploitation, 772 were for neglect (not including self-neglect), and 76 were for sexual abuse.[132]

Many cases of elder mistreatment are never reported. A national study estimated that, for every reported case, approximately 5.3 cases go unreported.[133] A New York state study estimated that only one in 23 cases of elder abuse, neglect, or exploitation ever comes to light.[134]

Elder abuse comprises the following:

- **Physical abuse—**Use of force to threaten or physically injure a vulnerable elder.
- **Emotional abuse—**Verbal attacks, threats, rejection, isolation, or belittling acts that cause or could cause mental anguish, pain, or distress to a senior.
- **Sexual abuse—**Sexual contact that is forced, tricked, threatened, or otherwise coerced upon a vulnerable elder, including anyone who is unable to grant consent.
- **Exploitation—**Theft, fraud, misuse or neglect of authority, and use of undue influence as a lever to gain control over an older person's money or property.
- **Neglect—**A caregiver's failure or refusal to provide for a vulnerable elder's safety, physical, or emotional needs.
- **Abandonment—**Desertion of a frail or vulnerable elder by anyone with a duty of care.[135]

In addition, while not elder abuse, **self-neglect**—the inability to understand the consequences of one's own actions or inaction, which can lead to harm or endangerment—is particularly challenging to address. Examples include not eating enough food (to the point of malnourishment), wearing filthy or torn clothing, living in unsanitary or hazardous conditions, and not getting necessary medical care.[136]

Elder financial abuse is involved in at least 20 percent to 30 percent of all reported elder abuse, and has huge short- and long-term effects, including "health care and health care costs, living situations, filings for bankruptcy, and costs for its recuperation passed along in service industries. It may even exacerbate or cause mental and physical illness, including an untimely death for the victim." It affects elders at all income levels, and all races and ethnicities."[137]

When compared to older community-residing adults who are not mistreated (physically or psychologically abused, physically neglected, or financially or materially exploited) by trusted others, mistreated older adults have a three times higher risk of death. The higher risk of death is not due to the elder mistreatment itself. Scientists think that the

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[132] Adult Protective Services (APS), *Reports of Abuse, Neglect, Self-Neglect, Exploitation of the Person, Financial Exploitation or Abandonment* (January 1–December 31, 2009), accessed at www.aasa.dshs.wa.gov/APS/documents/2009.doc.
[133] T. Tatara, *The National Elder Abuse Incidence Study: Executive Summary* (New York City, 1997).
[134] New York State Elder Abuse Prevalence Study.
[135] National Center on Elder Abuse, Administration on Aging, "Why Should *I* Care About Elder Abuse?" factsheet, accessed 5/12/11 at www.ncea.aoa.gov/ncearoot/Main_Site/pdf/publication/NCEA_WhatIsAbuse-2010.pdf
[136] DSHS/Aging and Disability Services Administration, *Self Neglect*, accessed 5/12/11 at www.aasa.dshs.wa.gov/pubinfo/selfneglect/#what
[137] MetLife, *Broken Trust: Elders, Family, and Finances* (March 2009).

higher risk of death may be due to factors such as the prolonged and significant distress that elder mistreatment victim's experience.[138]

The King County Prosecuting Attorney's elder abuse unit—one of the first such units in the country—has committed to prosecuting "cases of neglect, financial exploitation, and sexual assault of the elderly and disabled; to work collaboratively with police, social service agencies, and medical professionals to improve the referral, investigation and , ultimately, prosecution of cases of abuse and neglect of vulnerable adults; and to provide training to first responders so they can better recognize and react to such cases."

Lack of training affects community-wide response to elder abuse. Law enforcement personnel, prosecutors, judges, social service providers (including mandatory reporters), and medical professionals need training and re-training to understand the nature and scope of elder abuse in order to recognize signs of elder abuse, report appropriately, and coordinate effectively with victim services personnel.

In 2001, the King County Prosecuting Attorney's Office and King County Medical Examiner's Office convened the King County Elder Abuse Council, comprising representatives from a number of other public and nonprofit sector agencies. The Council meets regularly to discuss collaboration and systemic response to the critical issue of elder abuse.

Beginning in 2011, the King County Prosecuting Attorney's Office granted $100,000 (from the federal Department of Justice/Office on Violence Against Women) to the Seattle Human Services Department (HSD) to provide advocacy and service coordination to survivors of elder abuse, neglect and exploitation, age 50 and older. During a one-year pilot program, a designated ADS Case Manager provided safety planning, information and assistance, supervised referrals, court accompaniment, coordination of services, and one-to-one advocacy. This funding ended in April 2013.

With support from its Advisory Council, ADS has continued to allocate funding into 2014, supporting 1.0 FTE to serve individuals age 60 and older. From February 2012 through May 2013, ADS' designated case manager served 118 elder abuse victims.

[138] M.S. Lachs, C.S. Williams, S. O'Brien, K.A. Pillemer & M.E. Charlson, "The mortality of elder mistreatment," *Journal of the American Medical Association* 280(5), 428-432 (1998).

GOAL: Increase Independence for Frail Older Adults and People with Disabilities

ADS is committed to increasing independence for frail older adults and people with disabilities. We propose to carry out the following objectives:

OBJECTIVES

Family Caregiving

22. Provide a TCARE assessment and care plan to family caregivers who show moderate to significant caregiver burden.
    2011 Baseline: 600
    2012 Goal: 650
    2013 Goal: 700
    2014 Goal: 750
    2015 Goal: 750

23. Develop training curriculum for family caregivers who have loved ones with mental illness and difficult behaviors.
    2011 Baseline: 0 2015 **Goal**: 1 curriculum

In-Home Services

24. Advocate to increase language capacity and class schedules and to reduce class size for home care independent provider training to better meet the language needs and training requirements of the independent provider workforce. (**Ongoing**)

25. Advocate with Aging and Long-Term Support Administration (ALTSA—formerly called Aging and Disability Service Administration) and the state legislature to match required tasks (e.g., frequency of client contact) for Medicaid case management with available Medicaid case management resources. (**Ongoing**)

26. Conduct cultural competence staff trainings on emerging immigrant and refugee populations.
    Goal: 1 training per year

27. Advocate for ALTSA to implement Web portal improvements, efficiencies and better reporting for the participants and care consultants. (**Ongoing**)
    a. Work with ALTSA to standardized SSPS processes outside the portal when efficiencies can be realized for the care consultant, consumers and providers.
    b. Work with ALTSA to require new consumer staffing before transfers to address the consequences of not having personal care in place and the ability to accumulate funds while unstaffed.

28. Advocate with the Veteran's Administration to increase the number of clients referred to the Veterans-Directed Home Services. (**Ongoing**)

Elder Abuse

29. Work with the Elder Abuse Council to increase coordination among service and criminal justice agencies. (Ongoing)

a. Seek funding to expand support for victims of elder abuse to navigate the system.
b. Completed in 2013
c. Increase training for domestic violence support, staff capacity to respond and mandatory reporters on resources available for abused elders, using methods such as webinars, Web-based training videos and in-service training.
   2011 Baseline: $0
   2014 Goal: $50,000

PROMOTE AGING READINESS

For many, King County is a wonderful place to live. Our temperate climate, beautiful scenery, plentiful natural resources, and rich history, arts and culture are extraordinary. At the same time, like other metropolitan areas across the country, our region faces a variety of socioeconomic challenges. The age wave places a higher percentage of our resident population in a vulnerable position.

Prior area plans on aging for King County (2004-2007 and 2008-2011) have addressed social and civic readiness as a primary goal. This plan embraces social and civic engagement as one component of aging readiness. Planning for the future should:

- Build on current strengths of our region and our people.
- Reduce physical and social barriers to aging in place, ensuring livable communities for all ages.
- Promote creative ways for older adults to maintain, share and grow their talents, skills, and experiences.
- Utilize current technology to enhance access to aging information, programs and services as well as social and civic engagement for older adults.

Aging Your Way, a series of asset-based community planning forums conducted by the nonprofit Senior Services, has provided a broad spectrum of opportunities for collaboration on the arts, built environment, communication-connection, community meeting places, healthcare access, housing, intergenerational places and activities, lifelong learning, mixed-use buildings, multicultural activities and events, non-denominational/interfaith places of worship, outdoor plazas, physical activity, sustainability/environment, sustainability/local economy, technology, transportation, urban farming, volunteerism, and walkability.

Recent forums resulted in a wide variety of transportation, housing and built environment recommendations. Meetings summaries developed by Senior Services for 2010–2011 are available on their website at www.seniorservices.org.

Aging in place is a goal that should be incorporated into every initiative to build livable or sustainable communities as well as every government and nonprofit effort to build transportation systems, create universal urban design, bolster the economy and/or plan for growth. When communities offer affordable and appropriate housing, supportive community features, and mobility options, people of all ages and abilities can thrive.

"As long as older adults can stay independent, they need an environment that allows them to flourish." ~ Basia Belza, PhD, RN, Aljoya Endowed Professor in Aging, University of Washington School of Nursing

Land use policies should incorporate the Smart Growth strategies, as defined by the Environmental Protection Agency: "development patterns that create attractive, distinctive, walkable communities that give people of varying age, wealth, and physical ability a range of safe, affordable, convenient choices in where they live and how they get around."

Built Environment

Universal Design is a concept for designing all aspects of the built environment—homes, as discussed in previous sections, but also mobility routes, landscapes, commercial developments, products and life space, including equipment and architecture—with the goal of making them accessible to every person, regardless of age or ability. Developers of housing funded with public dollars have begun to incorporate elements of universal design into new construction, thus enabling residents to stay in their units with minimal modification as they age.

Incorporating Universal Design at the outset of publicly funded housing developments contributes to sustainable development goals. Using the flexible and open principles of universal design also means that people with disabilities are no longer marginalized in our society. They can own or rent whatever is built, because the unit and the entire built environment are designed to meet their needs as a rule rather than an exception.

Another area of concern in the housing arena is the growing need for **supportive services** for older residents as their needs change. The fastest growing part of the aging population is people who are age 85 or older. People in this age group will increasingly need more assistance and may have critical mobility issues. ADS will continue to work with housing and community partners to create more options for support of aging residents in public sector housing in an effort to help people remain at home as long as possible.

Aging in place requires safe, reliable, accessible and affordable **mobility**. Older adults are most comfortable and supported when they have safe and easy access to services, amenities, and support networks (such as friends and family). Residents of all ages must have access to everyday activities, which may include commuting to work or volunteer sites, visiting family members, recreation, shopping and/or traveling to medical appointments.

What makes a neighborhood walkable?

- **A center:** Walkable neighborhoods have a center, whether it's a main street or a public space.
- **People:** Enough people for businesses to flourish and for public transit to run frequently.
- **Mixed income, mixed use:** Affordable housing located near businesses.
- **Parks and public space:** Plenty of public places to gather and play.
- **Pedestrian design:** Buildings are close to the street, parking lots are relegated to the back.
- **Schools and workplaces:** Close enough that most residents can walk from their homes.
- **Complete streets:** Streets designed for bicyclists, pedestrians, and transit.

Source: WalkScore (www.walkscore.com)

In 2008, Seattle was ranked sixth among American cities for "walkability". Several suburban cities in King County have similar high scores; however, some neighborhoods have very low walkability scores, partly due to terrain but also due to planning and development patterns that do not support pedestrian mobility. Walking benefits our environment (reducing the use of carbon-emission vehicles), our health (supporting healthy weight and ability), our finances (increasing home value), and our communities (for every 10 minutes spent in a car, community activity is reduced by 10 percent). In a typical metropolitan area, a one-point increase in "WalkScore" is associated with an increase of housing value from $700 to $3,000.[139]

[139] WalkScore (www.walkscore.com). Joseph Cortright, "Walking the Walk," CEO's for Cities (2009).

In communities across the country, a Complete Streets movement is growing—policymakers are increasingly aware that road networks must be safer, more livable, and welcoming to everyone.[140] Instituting a complete streets policy ensures that transportation planners and engineers consistently design and operate the entire roadway with all users in mind, including bicyclists, public transportation vehicles and riders, and pedestrians of all ages and abilities.

In 2006, the City of Kirkland became the first city in Washington to adopt a Complete Streets ordinance, ensuring that pedestrian and bicycle ways were incorporated into city planning and development.[141] Kirkland's Walkable Community Profile illustrates their commitment to designing streets that will enable safe access for all users. Juanita Drive and Slater Avenue are designated as "complete streets."[142]

Seattle passed a Complete Streets ordinance the following year, which provides "guiding principles and practices so that transportation improvements are planned, designed and constructed to encourage walking, bicycling and transit use while promoting safe operations for all users."[143] Thanks to a city voter-approved transportation levy the previous year, the City of Seattle has been able to repair sidewalks, rehabilitate stairways, install new readable signs, restripe sidewalks, install pedestrian countdown signals, make safety improvements, and implement a Bicycle Master Plan, although much work remains.[144]

Note: Mobility issues related to transit options are addressed in the Address Basic Needs section of this plan.

Community Engagement

"Without careful planning and without the infusion of new resources, there is a real danger that we as a nation may squander the opportunity that is offered by this cadre of aging boomers that is heading our way." ~ Jay Winsten, Harvard School of Public Health

The knowledge, talent and skill of Seattle and King County residents age 50 and older enrich our communities, and individuals find meaning in contributing to the greater good. Individual and community benefits to aging readiness are tremendous. Organizations benefit from the time, talent, skills and resources that older adults can share. Local shops and restaurants benefit from the older people who frequent them for food, goods and services. Older adults bring neighborhood and community stability. Communities benefit from maintaining the knowledge, wisdom and talent of older adults.

Communities Count 2008 reported that 85 percent of all King County adult residents were active in at least one community organization (i.e., a neighborhood, political, civic, youth, cultural, educational, or religious group) and 84 percent of King County adults

[140] National Complete Streets Coalition: www.completestreets.org/
[141] City of Kirkland, Kirkland Complete Streets Ordinance, accessed at www.kirklandwa.gov/Assets/CMO/CMO+PDFs/Complete+Streets+Ordinance.pdf
[142] City of Kirkland, *Walkable Community Profile*, accessed at www.kirklandwa.gov/Assets/CMO/CMO+PDFs/AL+Walkability.pdf
[143] City of Seattle, Complete Streets ordinance #122386 , accessed at http://clerk.ci.seattle.wa.us/~scripts/nph-brs.exe?d=CBOR&s1=115861.cbn.&Sect6=HITOFF&l=20&p=1&u=/~public/cbor2.htm&r=1&f=G
[144] City of Seattle Department of Transportation: www.seattle.gov/transportation/

were very or somewhat active in at least three life-enriching activities; however, this percentage was higher among people younger than age 65.[145]

The Seattle Foundation released a report in 2009 that analyzed the vast opportunities facing nonprofit and other organizations in tapping the talents of older adults—noting that two-thirds of Seattle area residents age 50 to 54 are interested in taking jobs now or in the future to help improve the quality of life in their communities—and considerations in motivating and optimizing those talents (e.g., identifying appropriate roles, providing project work, high degree of independence, training opportunities, flexibility).[146]

"Having a reason to get up in the morning is associated in numerous scientific studies with better mental and physical health and greater longevity. Purpose can add not only years to your life but life to your years!" ~ Richard Leider, The Power of Purpose

Older people focus more on meaningful activities (e.g., spending time helping others and participating in community activities) than younger people, who spend more time on activities related to generating, managing, and accumulating money.[147]

Individuals' expectations are changing. For many, retirement is a time to begin anew, start new activities, take new risks and set new goals. Boomers and older adults want to use the skills and experience they've developed over time to serve their communities directly and take leadership roles. A large percentage of boomers will only engage in volunteer work if it is meaningful.[148]

Nonprofit organizations have not changed their views of volunteer utilization accordingly and have shown reluctance to try new and innovative volunteer management approaches.[149] The Rose Community Foundation surveyed nonprofit groups in Denver and found they gave themselves higher marks on volunteer management than the boomers did.[150] Coming of Age, a program developed by Temple University, determined that nonprofit organizations across the country are largely unprepared to utilize the professional skills of new retirees. Coming of Age designed trainings to build volunteer management capacity within nonprofit organizations and government agencies.[151]

"Community-based cultural programs for older adults appear to be reducing risk factors that drive the need for long-term care." ~ Gene Cohen, MD, PhD

A groundbreaking longitudinal study measuring the effects of **participatory arts** on older adults in Washington, DC, Brooklyn and San Francisco found that professionally-conducted arts and cultural programs resulted in higher overall rating of physical health, fewer doctor visits, less medication use, fewer instances of falls, better morale, less loneliness and fewer other health problems that in comparison groups. Furthermore, older arts participants experienced an increase in total number of activities while the comparison

[145] Communities Count (2008).
[146] Seattle/King County Community Experience Partnership Community Assessment Report, Seattle Foundation (6/1/2009).
[147] Meaning Really Matters: The MetLife Study on How Purpose Is Recession-Proof and Age-Proof (July 2010).
[148] AARP Bulletin Survey on Perceptions of Boomers (November 2010).
[149] Helping Communities Solve Critical Social Problems by Engaging Adults 55+, RespectAbility/National Council on the Aging (March 2008).
[150] Rose Community Foundation Survey of Volunteers (Denver, 2007).
[151] Coming of Age: www.comingofage.com.

group evidenced a significant decline.[152] Numerous studies support the importance of arts to aging adults—decreased anxiety and stress, lower blood pressure, and increased memory recall, mood, sense of control over life, self-awareness, non-pharmacological pain management, and social interaction.

In King County, arts and culture (e.g. participation, funding, and employment) are among the social and health indicators measured by Communities Count. In 2008, three-quarters of King County residents reported substantial direct participation in artistic, cultural and literary activities (e.g., reading, crafts, music and dance) and a majority of residents attended artistic, cultural or literary events; however, residents age 65 and older were less likely than younger community members to be active in arts and crafts activities.[153]

Libraries play a vital role in offering **lifelong education**. Libraries offer free reading materials, videos, music, community information, and Internet access, and serve as a community gathering place. Collections include an increasing number of large print and audio materials for people with vision and hearing impairments.

Colleges and universities offer a wide variety of learning programs for older adults. State colleges and universities continue to offer college tuition exemptions to Washington state residents aged 60 and older, who may audit academic courses on a space-available basis, taking advantage of extraordinary faculty and campus resources. Most community colleges offer low-cost continuing education classes and workshops designed for older adults.

The Osher Lifelong Learning Institute at University of Washington (OLLI-UW) offers classes to people age 50+ who pay an annual membership plus small class fees to study among peers in a collegiate learning community. Classes are offered at multiple sites, including downtown, Trilogy at Redmond Ridge, Carl Gipson Center (Everett), and the UW campus. In 2009-2010, Aging and Disability Services supported expansion of OLLI-UW programs to Horizon House, on Seattle's First Hill, with support from neighboring Exeter House, Summit, Skyline and Mirabella retirement communities. Programming can be expanded to additional sites, given sufficient public support.

Lifelong learning also occurs naturally, through doing. Lifelong learning in inextricably tied to other activities discussed in this section.

Technology

The Internet provides the ability to access information more quickly than by traditional media. Web portals, social networking sites (e.g., Facebook, Twitter), and e-mail are some of the methods that Aging and Disability Services and other aging network providers can use to contact older adults, provide access to aging services, and help older adults stay connected.

[152] The Impact of Professionally Conducted Cultural Programs on Older Adults, Gene D. Cohen, MD, et al. (2006).
[153] Communities Count (2008).

Table 8 shows the percentage of adults who go online, by generation.[154]

	Millennials Ages 18-33	**Gen X** Ages 34-45	**Younger Boomers** Ages 46-55	**Older Boomers** Ages 56-64	**Silent Generation** Ages 65-73	**G.I. Generation** Age 74+	**All adults**
% who go online	95	86	81	76	58	30	**79**

Table 8. U.S. Adults Who Use the Internet

The vast majority of adults in King County use the Internet, including 73 percent of Seattle residents age 65 and up, a much higher percentage than older adults nationally.[155] Nationally, Internet use drops off significantly for adults over age 65: only 58 percent of adults ages 65-73 (the Silent Generation) and 30 percent of adults age 74 and older (the G.I. Generation) go online.[156] Nationally and locally, the "digital divide" is closing as boomers age.

Despite higher Internet use, the City of Seattle's 2009 Information Technology Access and Adoption report, the Department of Information Technology determined that many older people need assistance in acquiring basic computer skills, including accurate information about Internet viruses, scams and identity theft in order to protect themselves and that people with limited mobility can benefit from Internet use, helping them retain independence and family connections.[157]

Assistive technology enhances personal independence and helps persons with disabilities avoid institutional care. The Washington Access Fund makes assistive technology affordable, through loans for assistive devices, services and modifications to homes and vehicles. Examples of assistive technology include hearing aids, mobility equipment (scooters, vans, wheelchairs), vision-related equipment (CCTVs, Braille notetakers, screen magnification, reading software), exercise equipment, computers, and business equipment.

Public Outreach

Aging and Disability Services utilizes technology—including social networking media—to stimulate discussion about aging issues and promote aging programs and services:

- **Aging King County**, the ADS Web site, provides an overview of the Area Agency on Aging, Area Plan on Aging, trends, strategic initiatives and events for seniors and adults with disabilities.[158]

[154] Pew Research Center, *Generations 2010* (12/16/2010).
[155] Seattle Department of Information Technology, *2009 Information Technology Access and Adoption report* (City of Seattle, 2009), accessed at www.seattle.gov/tech/indicators/.
[156] Pew Research Center, *Generations 2010* (12/16/2010).
[157] Seattle Department of Information Technology, *2009 Information Technology Access and Adoption report* (City of Seattle, 2009), accessed at www.seattle.gov/tech/indicators/.
[158] Aging King County: www.agingkingcounty.org

- **Encore** is a City of Seattle Web portal to hundreds of local, regional and national resources for people age 50 and older, developed and maintained by the Seattle Department of Information Technology in collaboration with ADS. In 2010, Encore pages received 20,335 hits.[159]

- The **Mayor's Council on African American Elders** maintains a Web site and a Facebook page, supporting their advocacy for improving the quality of life for African Americans residents of Seattle and King County who are 60 years of age and older.[160]
- **AgeWise King County** (previously Seniors Digest) is a monthly online newsletter currently distributed to 1,480 individuals.[161]
- **Silver & Gold—Seattle & King County** is a new Facebook page promoting healthy aging and personal empowerment for older adults, created by Aging and Disability Services in 2011.[162]
- The **Northwest Universal Design Council**—an ADS Advisory Council committee with participation by non-Council members who advocate for Universal Design—maintains a Web site and a Facebook page.[163]

NW Universal Design Council
Environments for All

- **Twitter (/AgingKingCounty)** is a nimble way to send and receive information from aging network collaborators and friends.
- **Pinterest (/AgingKingCounty)** provides a visual connection to issues and resources for Aging and Disability Services and followers, much like an online bulletin board. Pinterest requires graphic images.

Current outreach priorities include building awareness of resources available for aging in place, including family caregiver resources, long-term care support, and end-of-life care and support.

King County enjoys broad religious diversity. Most faith communities provide support for older members and help prevent social isolation for homebound elders. Many support human services in the broader community as well. Targeted outreach to places of worship would help weave aging programs and services into the fabric of the community.

Negative perceptions of aging

Personal and community perceptions of aging influence how we live as well as social, economic and political priorities. A simple thesaurus search on "aging" produces mostly pejorative terms associated with decline. Myths and stereotypes on aging include: frail, weak, fragile, sick, physically impaired, eyesight and hearing problems, dependent, associated with death, declining physical appearance, lacking sexual desire, mental decline, extreme dispositions (i.e., difficult and pessimistic, warm and kind), lonely, isolated, disrespected, and undervalued.

[159] Encore: www.seattle.gov/encore
[160] Mayor's Council on African American Elders: www.seattle.gov/MCAAE/ and www.facebook.com/MCAAE
[161] King County: www.agewisekingcounty.org
[162] Silver & Gold—Seattle & King County: www.facebook.com/Silver.and.Gold.SKC
[163] Northwest Universal Design Council: www.environmentsforall.org and www.facebook.com/NWUDC

Negative perceptions of aging carry a high cost to society: ageism in health care and employment, social exclusion, and elder abuse and neglect.[164] Two-thirds of boomers find "senior" program and service identification of little appeal.[165] Many senior centers are aware of a stigma associated with their name.[166,167,168,169] New approaches must be used to create a new and authentic perception that the wisdom, talents, and experience of older adults are community assets.

[164] National Centre for the Protection of Older People, *Public Perceptions of Older People and Ageing*, (Ireland, 4/27/2010).
[165] AARP Bulletin Survey of 1,507 adults age 18 and older conducted by GfK (November 26-28, 2010).
[166] "Act II Scene II," *The Senior Center Movement Blog* (January 23, 2010).
[167] Presentation by Dr. Manoj Pardasani, Professor of Social Work at Fordham University, Senior Center Stakeholder Forum, California Commission on Aging (February 4, 2009).
[168] Robbyn R. Wacker, et al., *Community Resources for Older Adults: Programs and Services in an Era of Change* (2008).
[169] *BoomerANG Project Final Report* (Montgomery County, PA, January 2006).

GOAL: Promote Aging Readiness

ADS is committed to promoting aging readiness. We propose to carry out the following objectives:

OBJECTIVES

Built Environment

30. Advocate for transportation, pedestrian, street and land use policies and projects that promote walkable communities and pedestrian safety, and support people as they age. (Advisory Council) (**Ongoing**)

31. Educate policy makers and community members about the advantages of incorporating Universal Design (UD) principles into standards for all types of housing development.
    Annual Goal: 2 presentations

Technology

32. Support technology that enhances access to aging information, programs and services as well as social and civic engagement for older adults. (**Ongoing**)
    a. Increase public awareness of resources available for aging in place, including family caregiver resources, long-term care support, and end-of-life care and support. (**Ongoing**)
    b. Celebrate positive aging and the powerful impact that people age 50+ have on their community, utilizing social networking media.
       2011 Baseline: n/a
       Goal: 50 posts to social sites per year.

Public Outreach

33. Conduct at least one community conversation per quarter, with an emphasis on target populations (communities of color, rural, immigrant and refugees, LGBT).
    2011 Baseline: n/a
    2014 Goal: **2 meetings/year**
    2015 Goal: 2 meetings/year

34. Collaborate with faith-based communities to support successful aging to increase awareness about the aging network.
    2011 Baseline: n/a
    Goal: 1 workshop per year

35. Increase outreach to target populations in order to achieve a five percent (5%) increase in participation within ADS-funded services. (**Ongoing**)

36. Conduct outreach activities within diverse communities by coordinating at least one ADS Advisory Council meeting a year with a focus on older people and adults with disabilities who reside in East and South King County areas. (**Ongoing**)
    Goal: One meeting per year.

AREA PLAN INDICATORS

How will we know if we have succeeded? The Area Plan on Aging includes indicators to measure community progress in each of our five priority issue areas.

Using measures such as program outcomes will help us evaluate the benefits ADS-funded programs provide; however, our work extends beyond providing and funding services for clients to include advocacy, education, and collaboration as we work to develop a community that promotes quality of life, independence, and choice in their activities.

- **Improve health care quality for older adults and adults with disabilities.**
- **Address basic needs.**
- **Improve health and well-being.**
- **Increase the independence for frail older adults and people with disabilities.**
- **Promote aging readiness.**

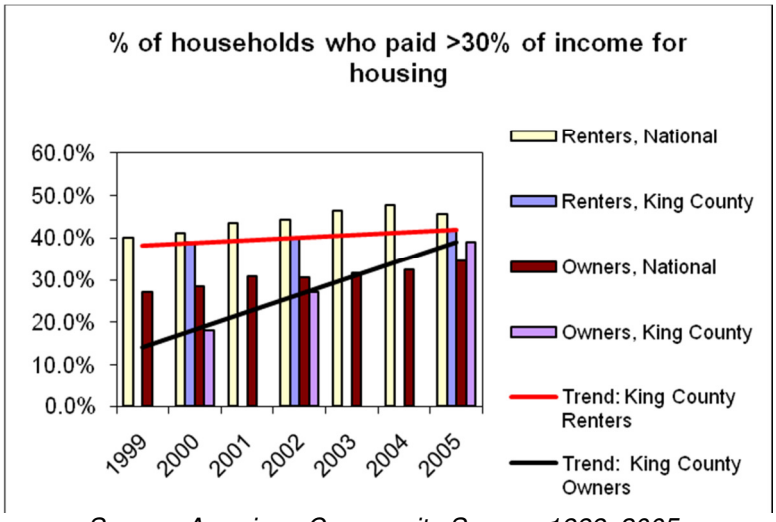
To measure the broader impact of all of these efforts, we use community indicators that provide information on the health and well-being of older adults in King County. We have selected a set of statistically valid and commonly used indicators from local and national data sources that are tracked consistently to allow us to measure trends and progress over time, including American Community Survey, Bureau of Labor Statistics, Communities Count: Social and Health Indicators across King County, Behavioral Risk Factor Surveillance System, and Washington State Population Survey.

Whenever possible, we isolate indicator data for the older adult population. Unless otherwise noted, therefore, data used represent people ages 65 and older.

We want to thank our partners at King County, Public Health—Seattle & King County, and the State of Washington for compiling and analyzing available data in order to provide us with statistically valid data indicators for older adults.

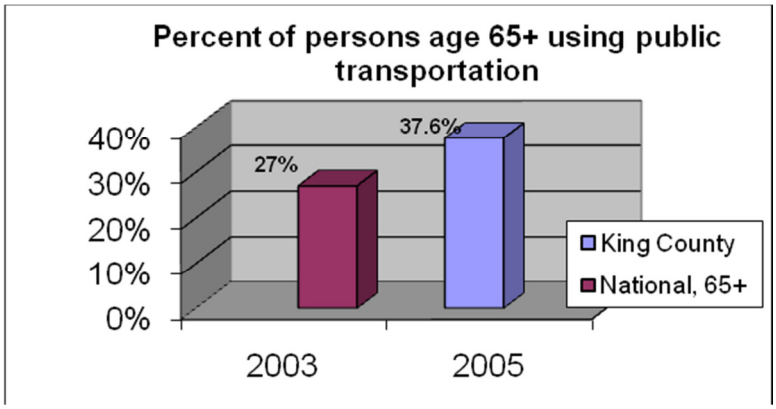
Indicator	King County Baseline	National Baseline	King County Better?
ADDRESS BASIC NEEDS			
Percent of 65+ households that paid >30% of income for housing	32.7% owners 58.5% renters (2009)	28.5% owners 53.6% renters (2009)	N
Percent of persons 65+ who use public transportation	35.1% (2008)	17.0% (2009)	Y
IMPROVE HEALTH AND WELL-BEING			
Percent of people 65+ whose physical or mental health interfered with their activities in the past month	15.8% (2010)	29.5% (2005)	Y
Percent of people 65+ who report being in good to excellent health	82.6% (2010)	75.2% (2010)	Y
Percent of people 65+ who participated in any physical activity during the past month	15.8% (2010)	29.5% (2005)	N
Percent of people 65+ who met recommendations for moderate physical activity	47.1% (2009)	40.3% (2009)	Y
Percent of older adults who report cutting size or skipping meals due to lack of money	2.2% (2010)		
Percent of people 65+ who had a flu shot in the past year	72.1% (2010)	67.5% (2010)	Y
Percent of adults age 65+ who consume 5+ daily servings of fruits and vegetables	30.2% (2009)	27.6% (2009)	Y
INCREASE INDEPENDENCE			
Percent of people 65+ with someone to help with chores if they are sick	89.9% (2008)	52.0% (2003)	Y
Percent of people 65+ who have someone to help if they are confined to bed	91.5% (2008)	52% (2003)	Y
Percent of caregivers who identify stress as their greatest difficulty	39.7% (2007)	29.9% (2005)	N
PROMOTE AGING READINESS			
Percent of people 65+ who are active in three or more life-enriching activities	73.0% (2008)	89% (2003)	N
Percent of people 65+ who volunteer	85.0% (2008)	24.8% (2010)	Y

Table 9. Community Indicators



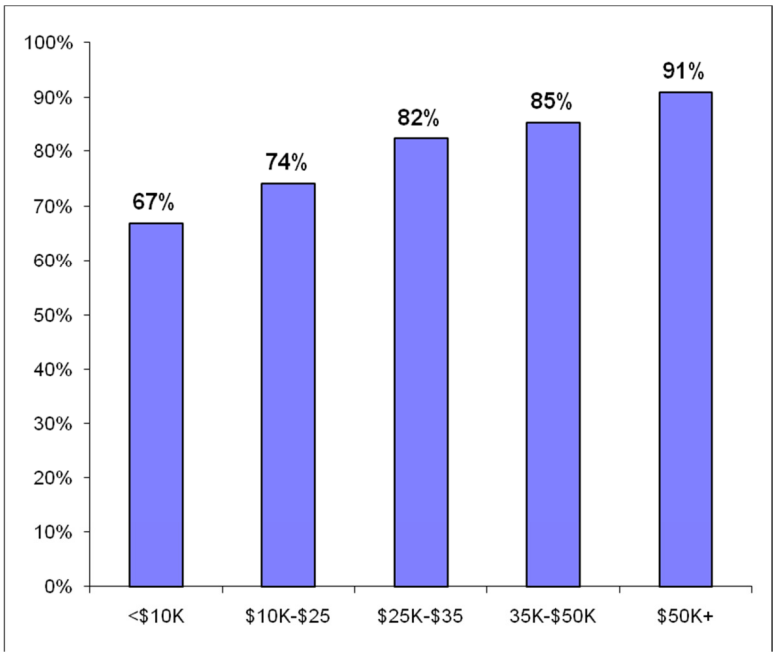
Source: American Community Survey, 1999–2005.

Figure 24. Percent of age 65+ households that paid >30% of income for housing



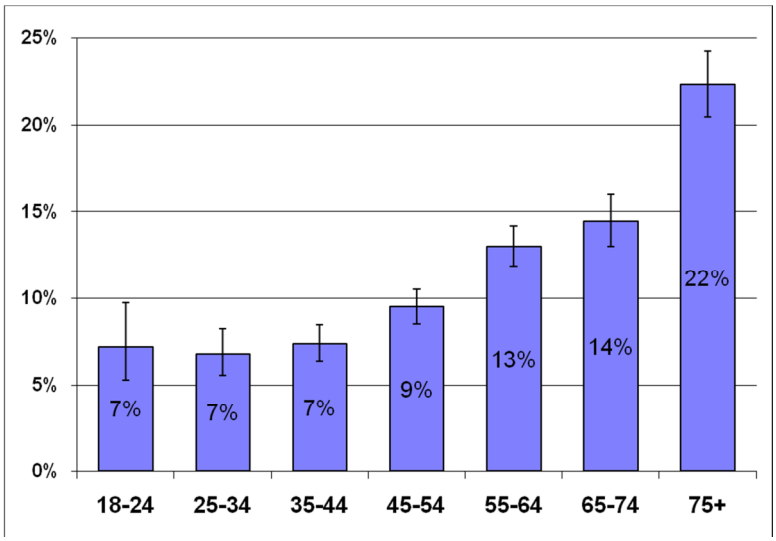
Source: Communities Count 2005 & 2008; National Household Travel Survey, Bureau of Transportation Statistics, October 2009

Figure 25. Percent of persons age 65+ who use public transportation



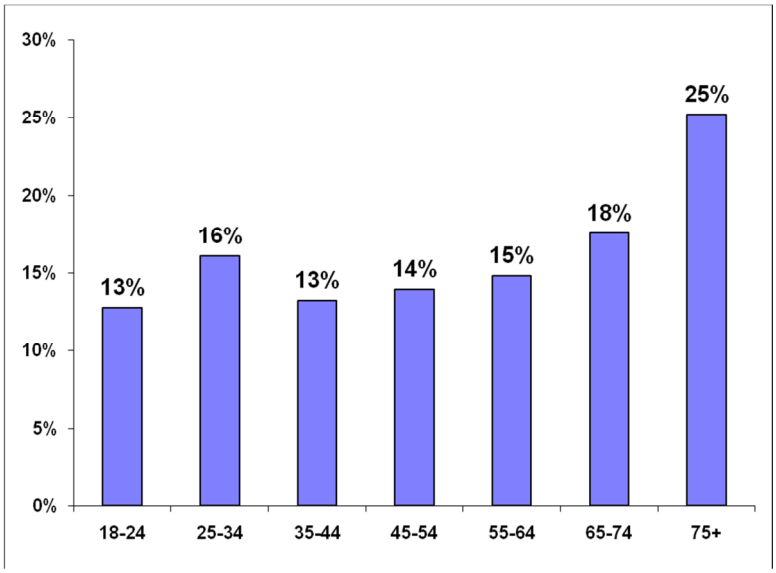
Source: Behavioral Risk Factor Surveillance System, King County, 2006-2010

Figure 26. Percent of adults age 60+ who can usually or always get needed social and economic support, by household income



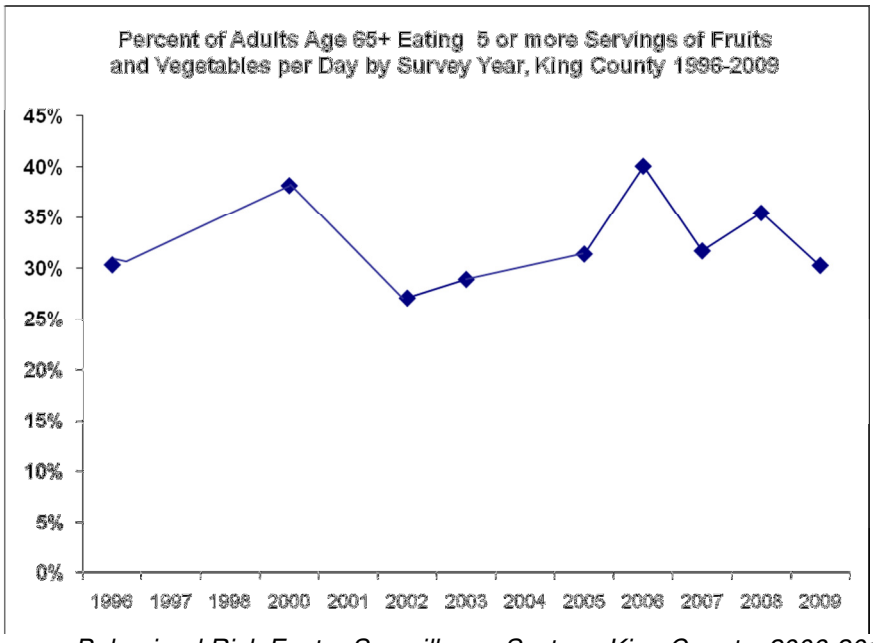
Source: Behavioral Risk Factor Surveillance System, King County, 2006-2010

Figure 27. Percent of adults reporting fair or poor health, by age



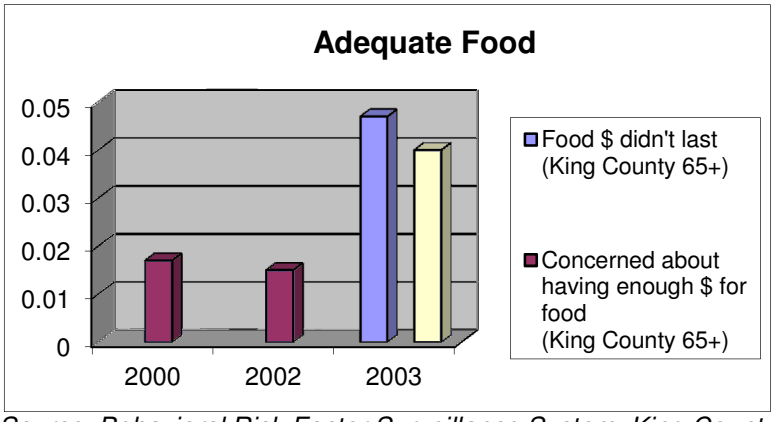
Source: Behavioral Risk Factor Surveillance System, King County, 2006-2010

Figure 28. Percent of adults with no physical activity during the past month, by age



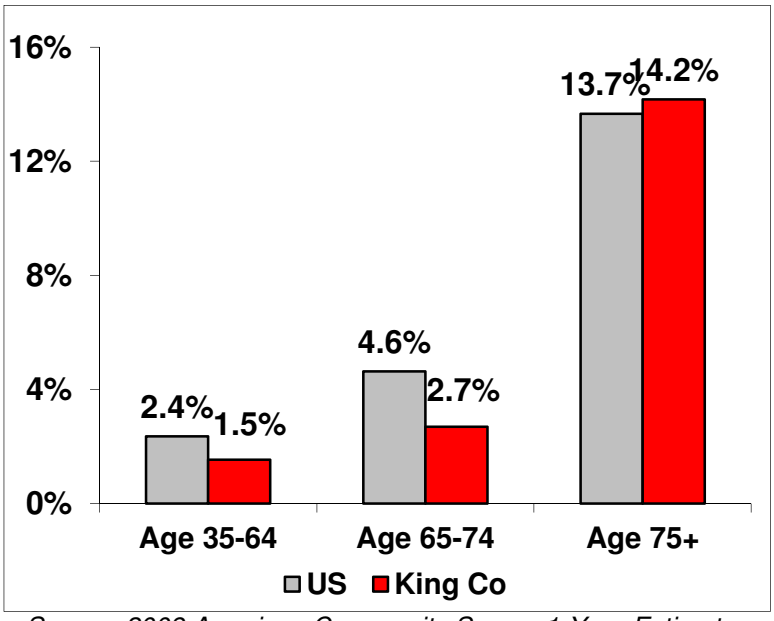
Source: Behavioral Risk Factor Surveillance System, King County, 2006-2010

Figure 29. Percent of adults age 65+ who consume 5+ daily servings of fruits and vegetables



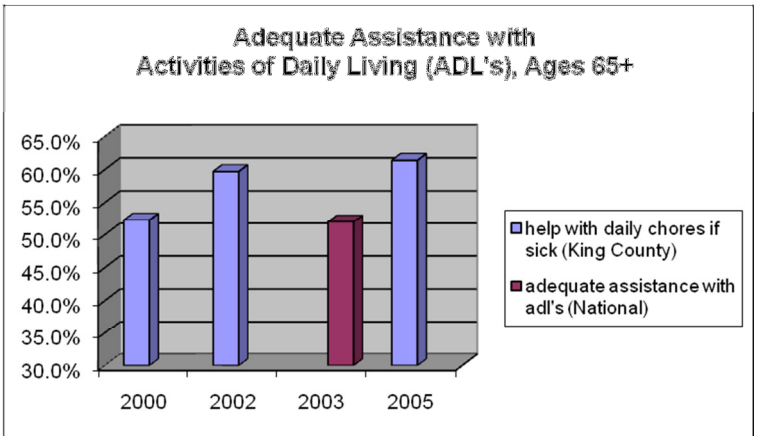
Source: Behavioral Risk Factor Surveillance System, King County

Figure 30. Percent of older adults who report insufficient funds for food



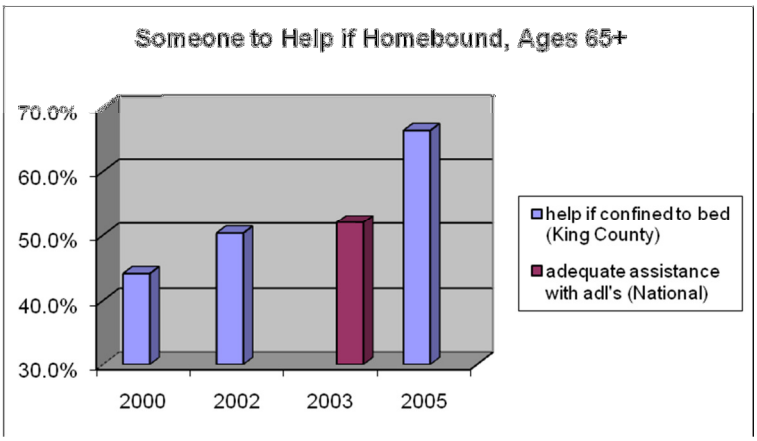
Source: 2009 American Community Survey 1-Year Estimates

Figure 31. Percent of older adults with self care limitations, by age



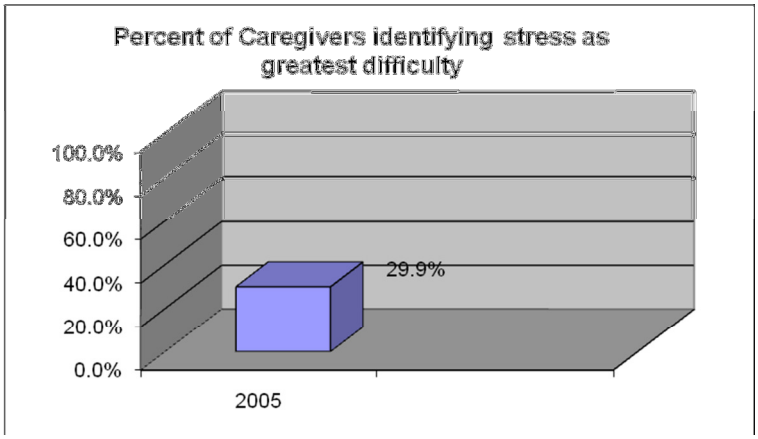
Source: Behavioral Risk Factor Surveillance System, King County, 2005

Figure 32. Percent of King County residents age 65+ with adequate assistance for activities of daily living



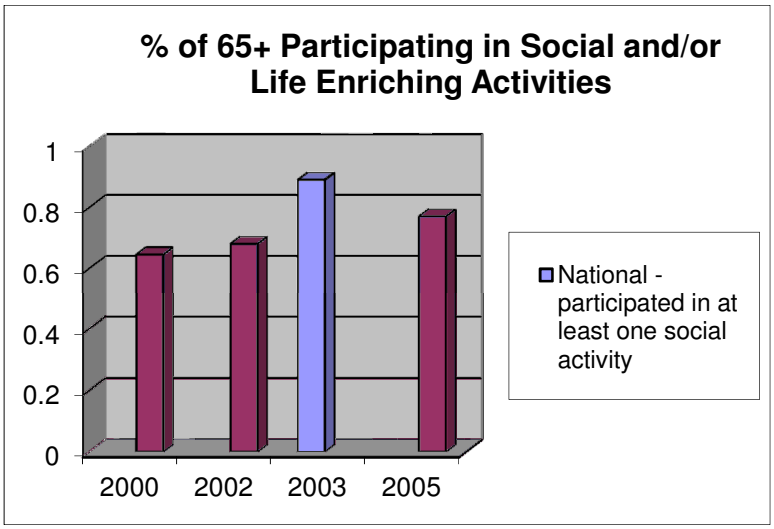
Source: Behavioral Risk Factor Surveillance System, King County, 2005

Figure 33. Percent of King County residents age 65+ with someone to help if homebound



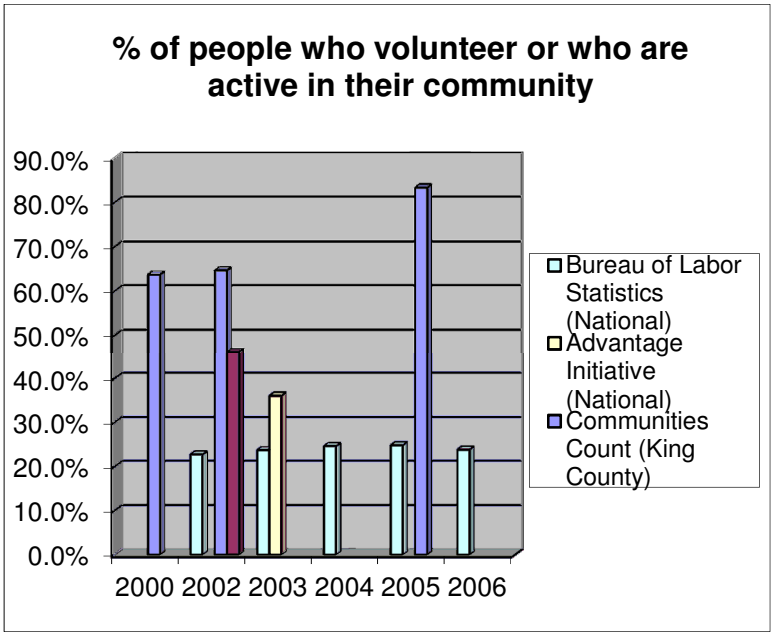
Source: Behavioral Risk Factor Surveillance System, King County, 2005

Figure 34. Percent of caregivers identifying stress as greatest difficulty



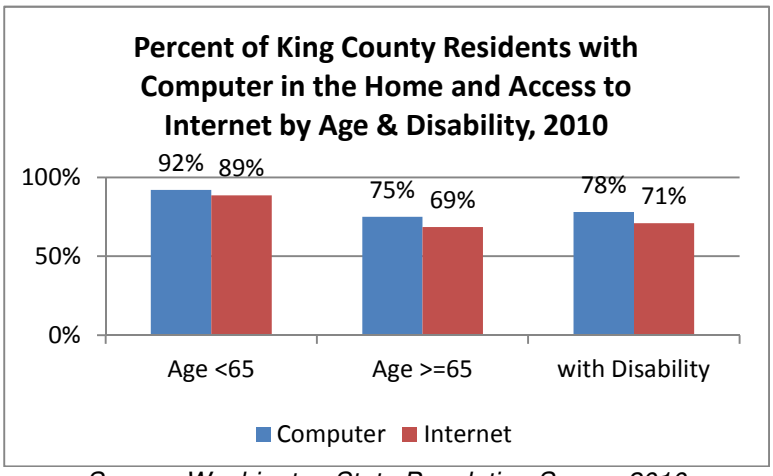
Source: Communities Count 2008

Figure 35. Percent of older adults who participate in social and/or life enriching activities



Source: Communities Count, 2000, 2002, 2005; Bureau of Labor Statistics; and AdvantAge Initiative

Figure 36. Percent of people age 65+ who volunteer or who are active in their community



Source: Washington State Population Survey 2010

Figure 37. Percent of King County residents with computers and Internet access, by age and disability

SECTION D
AREA PLAN BUDGET

Seattle jazz artist Grace Holden

"Our older adult population is passionate and knowledgeable about both quality of life issues and making the city affordable. It is essential that older adults are not merely served by the city, but are integrally involved in charting its course."

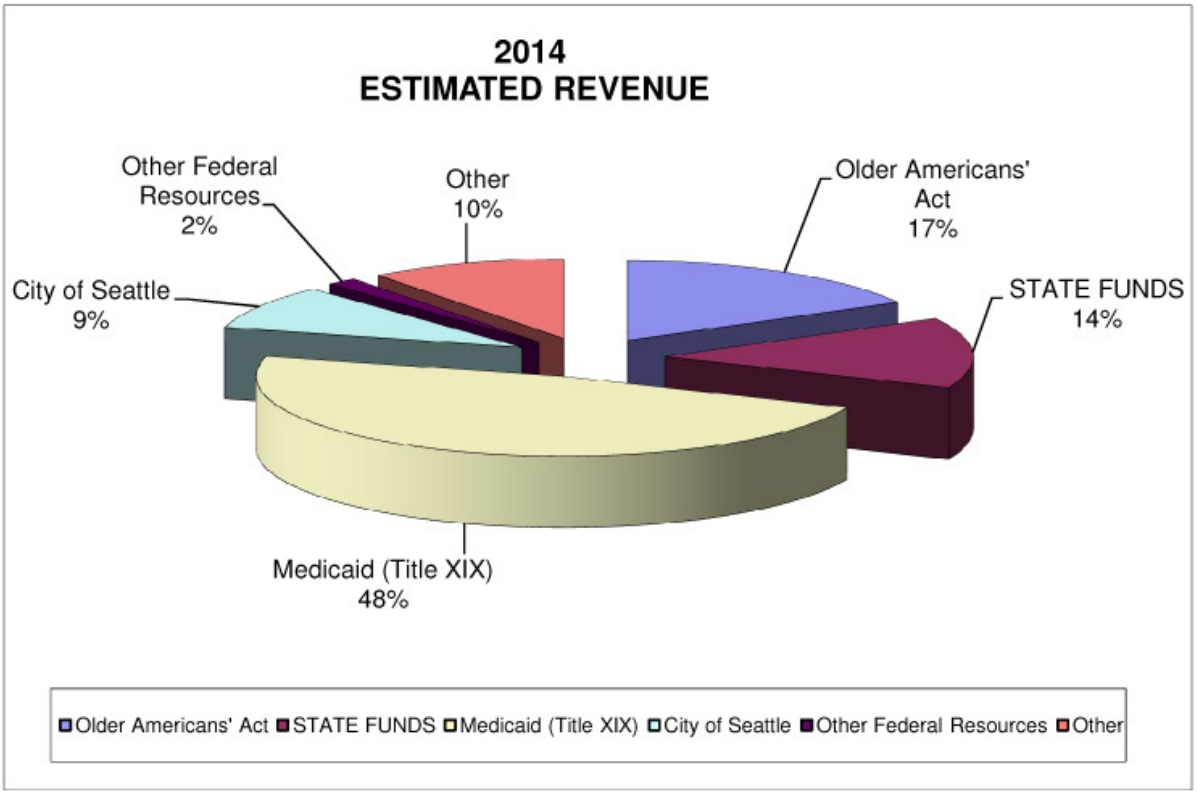
~ Mike McGinn, Mayor of Seattle

AREA PLAN BUDGET SUMMARY
2014 ESTIMATED REVENUE

AREA PLAN BUDGET 2014 ESTIMATED REVENUE			
FEDERAL FUNDS		**STATE FUNDS**	
Older Americans Act (OAA)		Sr. Citizens Services Act	$2,213,474
-Title III-B, III-C, III-D, III-E	$6,312,206	State Family Caregiver	$3,237,633
-Title VII Elder Abuse Prevention	$23,925	Senior Drug Education	$17,560
-NSIP (USDA/Food)	$588,076	Kinship Caregiver	$233,201
		Kinship Navigator	$84,785
		Kinship Collaboration	$39,310
		Veteran Directed Home Services	$20,000
Total OAA	**$6,924,207**	**Total State Funds**	**$5,845,963**
Medicaid (Title XIX)		**City of Seattle**	
Case Mgmt, Nursing Services, Contract Mgmt, & Day Health	$16,705,160	General Fund	$3,123,348
Title XIX Admin. Claiming	$1,207,735	Mayor's Office for Senior Citizens	$498,547
Caregiver Training/Training Training Wages	$1,453,581	Dept of Info Technology Cable Fund	$44,666
Total Medicaid	**$19,366,476**	**Total City Funds**	**$3,666,561**
Other Federal Resources		**Other Local**	
Seattle Housing Authority	$359,745	Contribution, fees, donations, Inkind	$3,146,433
Senior Farmers Market	$162,963	Bequest/Emergency Fund	$89,500
Chronic Disease Self Mgmt Progra	$27,000	Amy Wong Client Fund	$4,500
ADRC Enhanced Option	$84,184	Interest on Aging Advance	$100,000
UW - Reduced Disability Alzh Disease	$17,247	King County (KC) Hospital District	$200,000
		KC Levy (PEARLS)	$356,000
		KC Care Partners (Healthy Options)	$300,000
Total Other Federal	**$651,139**	**Total Other Local Funds**	**$4,196,433**
TOTAL FEDERAL FUNDS	**$26,941,822**	**TOTAL LOCAL FUNDS**	**$13,708,957**
	GRAND TOTAL	**$40,650,779**	

2014 ESTIMATED REVENUE

Older Americans' Act	$6,924,207
STATE FUNDS	$5,845,963
Medicaid (Title XIX)	$19,366,476
City of Seattle	$3,666,561
Other Federal Resources	$651,139
Other	$4,196,433
	$40,650,779



APPENDIX A: FAMILY & KINSHIP CAREGIVER SUPPORT PROGRAMS

Agencies as of Summer 2011	Information Services & Group Outreach	Specialized caregiver information	Specialized caregiver assistance (incl. TCARE)	Counseling	Training	Support Groups	Respite Care Services	Supplemental Goods & Svcs	**Focus Areas Served** (may go beyond these)	**Key Priority Populations** (highlights, not all-inclusive)
Jewish Family Services	X	X	X	X		X	X		Most of County; special focus on S. County	African American; GLBTQ; Russian; low income
Neighborhood House	X	X	X			X			Central & S. Seattle; S. County	Immigrants/refugees; SE Asian and East African focus
Senior Services	X	X	X						All of County	Focus on underrepresented Zip Codes
Chinese Information & Service Center	X	X	X		X	X	X		Most of County, though centered in the intl district	Chinese focus, plus SE Asians, Russians, and Latinos
Alzheimer's Association	X	X	X		X	X			All of County	Caregivers with dementia, Hispanic/Latino; African American
Northshore	X	X	X		X	X	X		Northeast Seattle, Shoreline, Bothell, Woodinville	LGBT, low income, ethnic minorities
Kin On	X	X	X	X	X	X			Mostly Seattle, S County, Eastside (hopes to expand thru collaborations)	Chinese, other Asian communities
Geriatric Regional Assessment Team	X			X		X			All of County	All populations, but new African American focus
Crisis Clinic	X	X	X				X		All of County	Caregivers in crisis; Teleinterpreter service for low-English-Speaking
Evergreen Care Network	X	X	X				X		Eastside: Bellevue, Redmond, Kirkland, etc.	Non-Medicaid caregivers, low income
Aging and Disability Services	X	X	X				X	X	Rest of County not served by Evergreen Care Network	Non-Medicaid caregivers, low income, Nat. American
Contracted In-Home and Adult Day Respite Providers (19)	X	X					X		All of County	Non-Medicaid caregivers, some providers specialize in serving various non-English speaking individuals and ethnic communities

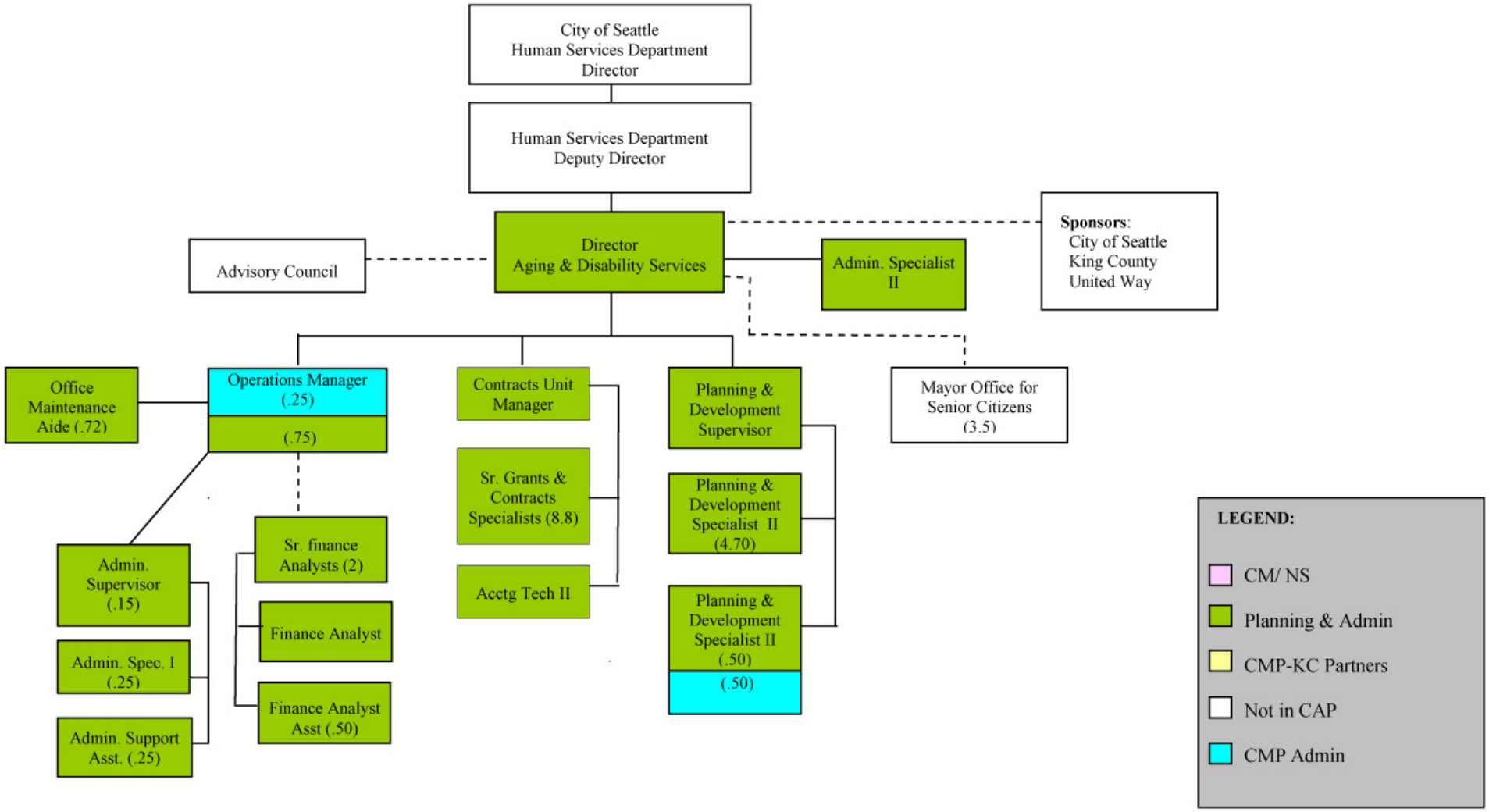
Table 10. Family Caregiver Support Program providers, Fall 2013

Agencies as of Summer 2011	Information Services & Group Outreach	Specialized caregiver information	Specialized caregiver assistance (incl. TCARE)	Counseling	Training	Support Groups	Respite Care Services	Supplemental Goods & Svcs	Focus Areas Served (may go beyond these)	Key Priority Populations (highlights, not all-inclusive)
Neighborhood House	X	X	X		X	X			Central & S. Seattle; S. County	Immigrants/refugees; SE Asian and East African focus
Encompass	X	X	X		X	X			Eastside into Eastern, Rural KC	Low-income, rural. Some Latino. Children w/ dev delays
Renton Area Youth & Fam.	X	X	X		X	X			S Seattle (Skyway) and Renton	African American
Kinship Navigator	X	X	X					X	All of County	All priority populations

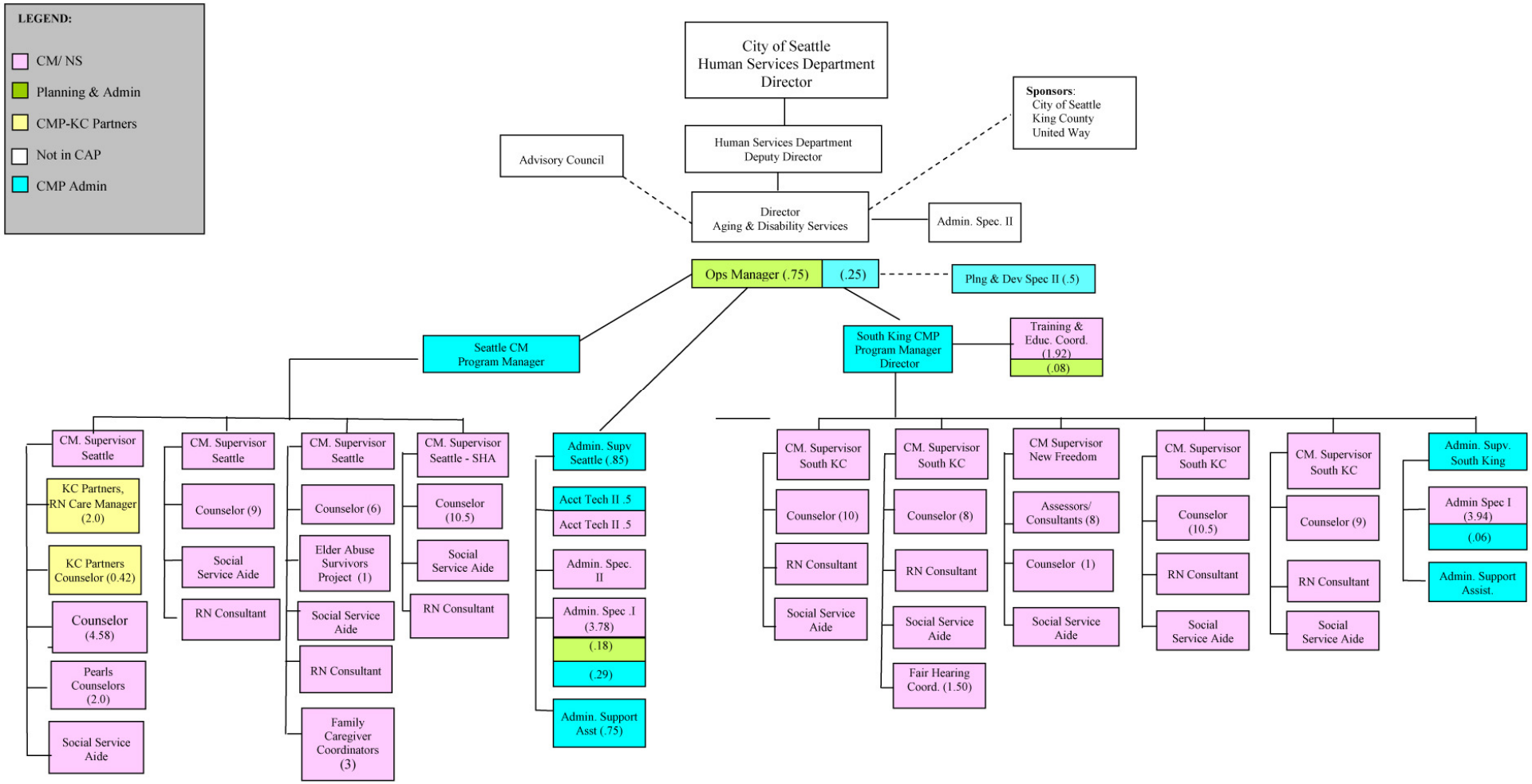
Table 11. Kinship Caregiver Support Program providers, Fall 2013

APPENDIX B: ORGANIZATION CHARTS

Aging & Disability Services — 2014 Planning & Administration



Aging and Disability Services — 2014 Case Management Program



APPENDIX C: STAFFING PLAN

PLANNING AND ADMINISTRATION		
POSITION TITLE	**TOTAL STAFF *(FT & PT)***	**POSITION DESCRIPTION**
Director	1 FTE	Directs and supervises all AAA activities.
Operations Manager	.75 FTE	Oversees agency budget, case management, administrative support. Serves as the HIPAA Privacy Officer.
Planning and Development Supervisor	1 FTE	Oversees all planning functions and data application systems.
Planning & Development Specialist II	5.2 FTE (6 staff)	Conduct planning functions: Area Plan development and implementation, systems coordination, research and analysis, advocacy coordination. Advisory Council support.
Contracts Manager	1 FTE	Oversees all contracted services and Contracts Unit staff.
Sr. Grants & Contracts Specialist	8.8FTE (10 staff)	Conduct program & contract monitoring, negotiation, training & technical assistance to subcontractors, request for investment processes.
Administrative Supervisor	0.15 FTE	Supervises administrative staff
Administrative Specialist II	1.0 FTE	Serves as assistant to AAA director
Accounting Technician II	1.0 FTE	Performs fiscal & budget management support.
Administrative Specialist I	.43FTE (2 staff)	Provides administrative support and troubleshoot SSPS issues.
Administrative Support Assistant	0.25 FTE	Reception
Office/Maintenance Aide	0.72 FTE	Provides clerical support (from the Supported Employment Program).
Training and Education Coordinator	.08 FTE	Troubleshoot SSPS issues
Total	**21.38 FTE**	

CASE MANAGEMENT		
POSITION TITLE	**TOTAL STAFF *(FT & PT)***	**POSITION DESCRIPTION**
ADS Operations Manager	.25 FTE	Strategic oversight of Case Management and Respite Program Coordinators
Case Management Program Manager - Seattle	1 FTE	Directs the in-house Case Management Program, serves as disaster coordinator.
Case Management Program Manager – Renton	1 FTE	Supervises South King County Case Management Teams, program trainers & all administrative support.
CM Team Supervisor	8 FTE	Each supervises a team of case managers.
Case Manager (Medicaid)	65.50FTE	Provide case management services to in home clients; and conduct Day Health assessment.
Case Manager (non-Medicaid)	3.5 FTE	Provide case management services for clients not receiving in-home services.
Case Manager – Elder Abuse Survivors	1 FTE	Provide advocacy/service coordination to survivors of elder abuse
New Freedom Team Supervisor	1 FTE	Supervise New Freedom team
New Freedom Care Consultants	8 FTE	Care Consultants for New Freedom Program
Registered Nurse Consultant	7 FTE	Serve as nurse consultants to the case managers.
Registered Nurse	2 FTE	Provide care management to clients in the King County Care Partners Program
Pearls Counselors	2.0 FTE (3 Staff)	Provide case management services for clients not receiving in-home services.
Administrative Specialist I	8.07 FTE	Provide administrative support.
Administrative Specialist II	1 FTE	Serves as IP coordinator and may assist in administrative support.
Administrative Supervisor	1.85 FTE	Supervise administrative support staff.
Administrative Support Assistant	1.75 FTE	Serve as receptionists and provide administrative support.
Accounting Technician II	1 FTE	Provides fiscal support.
Social Service Aide	9 FTE	Provide support to case managers.
Planning and Development Specialist II	0.50FTE	Planning support for the case management program.
Training & Education Coordinator	1.92 FTE	Provide and coordinate training for CM staff.
Fair Hearing Coordinator	1.50 FTE	Fair hearing activities.
Respite Program Coordinator	3.0 FTE	Perform client assessment and scheduling for Respite services, coordinate with service providers.
Total	**129.84 FTE**	

MAYOR'S OFFICE FOR SENIOR CITIZENS		
POSITION TITLE	**TOTAL STAFF** ***(FT & PT)***	**POSITION DESCRIPTION**
Human Services Program Supervisor	1 FTE	Supervises the Mayor's Office for Senior Center operations and staff.
Program Intake Representative, Senior Employment	2 FTE (3 positions)	Process client applications and enrollment for Title V Community Service Employment Program and provide employment counseling services.
Volunteer Coordinator	0.5 FTE	Coordinates the Senior Training Seniors (computer training) program.

Total Number of full time equivalent 154.72
Total number of staff positions 161
Total number of ethnic minority staff 55
Total number of staff over age 60 18
Total number of staff indicating a disability (not available)

Information on staff indicating disability is not available in the HR database.

APPENDIX D: ADVISORY COUNCIL

The Advisory Council on Aging and Disability Services (ADS) is comprised of 27-community members mandated by the Older Americans Act of 1965. The Council has a significant role in guiding Aging and Disability Services as it administers services for older people in King County. The mission of the Advisory Council is to:

- Identify the needs of older people and adults with disabilities in our community;
- Advise on services to meet these needs; and
- Advocate for local, state and national programs that promote quality of life for these populations.

They advise ADS on issues, services and policies that affect older people and adults with disabilities. As advocates, the council recommends legislation and policy measures, informs the community about critical issues and needs of older persons and adults with disabilities.

Sponsors of ADS and its Advisory Council are:

City of Seattle

United Way of King County

King County

The Advisory Council accomplishes its work through its committees and task forces:

- Advocacy Committee
- Outreach and Communication Committee
- Planning and Allocations Committee

Currently, there are 24 Advisory Council members:

Mary Anderson
Claire Brannan
Katty Chow
George Dicks
Dr. Natalie Ellington
Timmie Faghin
Kris Fredrickson
Hon. Ava Frisinger
Bev Heyden
Molly Holmes
Hon. Nick Licata
Mac McIntosh
Kathe Matrone
Tom Minty
Kaylene Moon
Suzanne Pak
Dr. Elizabeth Phelan
Tony Provine
Dave Rogers
Berta Seltzer
Diane Snell
Lorna Stone
Daphne Tomchak
Cathy VonWald

* Elected official
Total Age 60 Years of Age or Over: 16
Total People of Color: 4
Total Self-Indicating a Disability: 1

APPENDIX E: PUBLIC PROCESS

The public review period for the 2014–2015 Area Plan and the draft 2014 discretionary allocation recommendations was July 22 to August 5, 2013. A public hearing was held on August 5, in the city of Bellevue. Fourteen individuals attended the hearing representing older adults, Advisory Council members, community members, staff and providers. Comments and responses are summarized below.

Agency	Questions	ADS Response
	Does the ADS Elder Abuse Service Area include funding for caregiver training?	Response: No. Funding for elder abuse prevention supports an Elder Abuse Survivors Advocate (a designated ADS Case Manager).
	Given Secretary Kathleen Sebelius' comments prioritizing elder abuse, was there any additional funding provided?	Response: No
Senior Services	Given the recent cuts to nutrition services, how will the funding be allocated?	Response: The 2013 budget cuts were embedded in the awards resulting from the recent Request for Investment process. The 2014 budget cuts are under review.
Senior Services	Regarding Health Promotion – Does the funding also support the Chronic Disease Self-Management Program (CDSMP)?	Response: No. Funding for health promotion comes from the Older Americans Act, Title III-D. Funding for CDSMP comes from the 2012 Prevention and Public Health Funds.
Kin On Community Health Care	Our concern is regarding the proposed cut to the Senior Citizen Services Act (SCSA) and Older Americans Act - Title III-B funding for the Alzheimer's and Chronic Care Program. The program teaches families how to recognize signs of memory loss and helps them navigate the network of aging services. This is especially important for the Asian/Chinese-speaking population. Kin On is also unique in providing individualized and timely services, and budget cuts would jeopardize the program's viability and ability to serve the Seattle-King County Asian community.	

Agency	Questions	ADS Response
Sno-Valley Adult Day Health	Please reconsider proposed cut to Adult Day Services. The Sno-Valley Adult Day Health program has dual purposes: 1) It helps adults who have functional or cognitive challenges (e.g. Alzheimer's disease) get the medical care they need to maintain a higher level of functioning and continue living at home; 2) It gives family caregivers time to recharge and continue providing quality care. Without the program, many of the clients served would be unable to remain in their own home and community.	
Senior Services	Emphasized how health promotion and senior wellness programs have reduced older adult's utilization of health care services. Their programs (Matter of Balance; Enhanced Fitness; and Enhanced Wellness) offer a menu of options that allow older adults to focus on issues that matter most to them, while targeting older adults in public housing and communities with the greatest health disparities. In order to maintain the health and well-being of as many older adults served in the past, and decrease medical care utilization, funding must continue at the current level.	

APPENDIX F: POLICY 7.01 IMPLEMENTATION PLAN

MUCKLESHOOT INDIAN TRIBE
SEE PP. 113–119

SNOQUALMIE NATION
SEE PP. 120–121

Policy 7.01 Implementation Plan (Muckleshoot Indian Tribe)

Seattle Human Services Department
Aging and Disability Services
Biennium Timeframe: January 1, 2014 to December 31, 2015

Implementation Plan				Progress Report
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the previous year - 2013
Medicaid Case Management 1. Improve communication between ADS, HCS and Muckleshoot Tribal staff re case transfers, and CARE Plan development. 2. Assign one ADS Case Manager for all Muckleshoot CMP clients for continuity. 3. Increase focus on non-tribal members on the reservation and in the community. 4. Follow all persons referred by ADS to HCS to confirm that they are set up on services based on eligibility. 5. ADS will encourage Tribal staff to communicate directly w/ HCS/ADSA re: offering New Freedom Program to CMP clients during initial assessments.	(1) Modify consent form to identify Tribal Affiliation for case management clients. (2) Assign all Muckleshoot CMP clients to one ADS Case Manager. (3) ADS Case Manager will receive referrals for all discretionary clients 60 yrs old and older from Tribal staff. (4) ADS Case Manager will encourage Tribal staff to refer all clients under 60 years old directly to HCS, assist clients with the benefits application process, and notify ADS Case Manager once application is sent to HCS. (5) ADS Case Manager will contact Tribal staff to coordinate home visits with a tribal representative for all initial home visits and as preferred by CMP clients and/or staff.	• Improved communication and coordination between ADS, HCS and Tribal staff re all Muckleshoot client cases. • Coordinated joint case staffing with ADS & HCS RE: tribal members and non tribal community member clients bi-monthly or whenever APS or court-ordered cases are involved. • Tribal staff will help ADS Case Manager establish rapport with CMP clients so that Case Manager will be able to provide services for CMP clients if Tribal staff is not required for each home visit. • Increased referrals and coordination of LTC services for Tribal and non-Tribal community members.	December 31, 2014 **Hilary Cross**, CMP Deputy Director **Hiroko Evans**, CMP Supervisor **Keith Rapacz,** Case Manager **Interim**, Division Director Muckleshoot Human Services **Wendy Burdette**, Program Manager Muckleshoot Senior Services	Joint case staffing every monthly with: a) ADS; b) APS/Muckleshoot Tribal Police; c) Interdisciplinary meetings. 1st Quarter Caseload Core Cases - 9 Discretionary Cases - 32 New Referrals - 19 Initial Assessments - 3 Care Transitions - 0 Referrals to CDSMP - 0 Family Meetings - 6 Special events for tribal elders - MIT staff delivered monthly meals to homebound elders, served hot lunches at the Elder Complex, and provided chore services and transportation. - May 2013 – Elders Luncheon honored 800 elders - May 2013 – Cedar Weaving Community Event - June 2013 - MIT staff visited homebound elders to enroll them into the "Walk after Lunch" every Wednesday. - July 2013 - MIT staff and elders did

Policy 7.01 Implementation Plan (Muckleshoot Indian Tribe)

Seattle Human Services Department
Aging and Disability Services
Biennium Timeframe: January 1, 2014 to December 31, 2015

Implementation Plan				Progress Report
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the previous year - 2013
	(6) Tribal staff will coordinate client releases. (7) Tribal staff and ADS Case Manager will conduct monthly joint case staffings.			fresh water runs and went to the mountains to gather berries, make jams and pies; made deer jerky and went on fishing trips. - September 2013 - Elders attended luncheon hosted by Suquamish. They also went to a Seahawks Game and the NW Trek, and spent a day at the Washington State Fair.
<u>Medicaid Case Management Continued</u> 6. ADS Case Manager will provide initial eligibility determination and on-going case management for Muckleshoot Tribe and tribal community members residing in-home and who request LTC core services, per the agreement HCS has with the Muckleshoot Tribe and ADS. 7. ADS Case Manager and the Muckleshoot Senior Services Program Manager will work to increase communication and coordination client referrals and services by creating a			December 31, 2014 **Hilary Cross**, CMP Deputy Director **Hiroko Evans**, CMP Supervisor **Keith Rapacz,** Case Manager **Interim**, Division Director	ADS staff participated in a meeting with the Muckleshoot Medical Clinic to assist with coordinating access to health care for tribal members. May 2013 - ADS staff participated in an Elder Living Needs Survey regarding health and long-term care needs of elders, people with disabilities and their tribal community. June 2013 - Tribal members met with DSHS Secretary Kevin Quigley who toured the new Elder Complex discussed tribal partnerships. MIT staff assisted 60 elders Food Market

Policy 7.01 Implementation Plan (Muckleshoot Indian Tribe)

Seattle Human Services Department
Aging and Disability Services
Biennium Timeframe: January 1, 2014 to December 31, 2015

Implementation Plan				Progress Report
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the previous year - 2013
partnership with the Tribal Health & Wellness Program.			Muckleshoot Human Services **Wendy Burdette**, Program Manager Muckleshoot Senior Services	Voucher applications. Only three received vouchers. <u>Other special events for tribal elders</u> - Traditional meals are served every Friday. Year-to-total served – 52. - Hosted 30 visiting Agriculture Trade Policy Kellogg Foundation Fellows, ending with a presentation about the Muckleshoot Food Sovereignty Project. - Farm-to-Table continued with focus on the Muckleshoot Ternstra garden introduced to community members to augment the home-grown vegetables dispersed to elders and various programs. Tribal members are working to expand the garden next year.
<u>Training</u> 1. ADS will identify key training opportunities for Tribal Senior Services staff and caregivers. 2. Plan and schedule a training offered by tribal staff re Native American cultural beliefs and practices	(1) ADS will inform and offer training opportunities to Tribal staff for trainings offered to ADS case managers. (2) Coordinate and schedule training with ADS staff.	• Increased training opportunities for Tribal staff. • Conduct at least one training during 2011.	Dec. 31, 2014 **Keith Rapacz,** Case Manager Dec. 31, 2014 **Interim**, Human Services Division Director	April 2013 – MIT hosted a Taking Care of Yourself caregiver treat. July 2013 – MIT staff attended Powerful Tools for Caregivers. MIT staff will offer PTC at the October conference. October 2013 – Caregiver Conference at Oceans Shores, WA.

Policy 7.01 Implementation Plan (Muckleshoot Indian Tribe)

Seattle Human Services Department
Aging and Disability Services
Biennium Timeframe: January 1, 2014 to December 31, 2015

Implementation Plan				Progress Report
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the previous year - 2013
3. Elder Abuse Training	(1) Develop Memorandum of Understanding (MOU). Reporting requirements regarding elder abuse cases will be spelled out in the MOU	• MOU in place.	Muckleshoot Tribe September 30, 2014 **Gigi Meinig**, Planner	April 2013 – Grant submitted for APS training.
4. Medicare Care Transitions	(1) Involve MIT in the So. County focus group regarding the root causes analysis of hospital readmissions. (2) Even if grant is unfunded, continue to work with MIT in reducing hospital readmissions.	Conduct focus group and coordinate any follow-up activities and planning regarding reducing hospital readmissions.		

Policy 7.01 Implementation Plan (Muckleshoot Indian Tribe)

Seattle Human Services Department
Aging and Disability Services
Biennium Timeframe: January 1, 2014 to December 31, 2015

Implementation Plan				Progress Report
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the previous year - 2013
5. **King County Care Partners** (KCCP) – is a collaboration between health care practitioners and community service providers with a goal of improving health outcomes for high risk patients—people whose health concerns include multiple chronic diseases, mental health issues and a history of substance abuse. A team-based approach to care management helps patients develop self-management skills and encourages them to take personal responsibility for their health care.	(1) Identify South King County clinics. (2) Identify potential eligible Muckleshoot tribal members who are: a. Clinic patients enrolled in the Medicaid fee-for-service program. b. "High-utilizers" of health care services as identified by DSHS. (3) Assess risk factors, health literacy, health status and self management skills. (4) Screen for alcohol and substance abuse, depression and other mental health conditions, diabetes, heart disease, and other chronic conditions. (5) Develop medical treatment and care plans. (6) Help clients address barriers to using health care system. (7) Track measures for evidence-based medicine guidelines for chronic illness.	• Improve health outcomes for program enrollees using evidence-based medicine. • Support health care home development and coordination for Medicaid clients. • Improve self-management and prevent avoidable medical costs. • Personal empowerment and goal achievement.	Dec. 31, 2014 **Keith Rapacz,** Case Manager **Interim**, Human Services Division Director Muckleshoot Tribe **Wendy Burdette**, Program Manager Muckleshoot Senior Services	**ADS CM identified the following training opportunities with MIT staff during 2013:** • June 8th Online Discussion "Responding to Native LGBT/Two Spirit Community Crime Victims" • June 8th ADS Training on Dementia • Informed MIT Staff of diabetes studies and contact information about "Exercise for the body & brain" by Julie Moorer, R.N.; Memory Wellness Program, University of WA & VA Puget Sound Health Care System • Informed MIT Staff of Age 55+ Employment Resource Center Job Search Workshops scheduled for 5/20, 6/16, and 7/21 • Informed MIT staff about "Steps for Living Well in Retirement": Download AARP Resources at www.aarp.org/orderfinancialpubs • Provided MIT staff AARP's Retirement Planning Calculator link at www.aarp.org/retirementcalculator to estimate how much income elder's will need in retirement.

Policy 7.01 Implementation Plan (Muckleshoot Indian Tribe)

Seattle Human Services Department
Aging and Disability Services
Biennium Timeframe: January 1, 2014 to December 31, 2015

Implementation Plan				Progress Report
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the previous year - 2013
6. **Family Caregivers Support Program** (FCSP) – helps unpaid caregivers of adults age 18 and older, by helping to reduce stress, and enable care receivers to remain at home and independent. 7. **Chronic Disease Self Management Program -** is a two & a half hours workshop, once a week, for six weeks, in community settings, involving people with different chronic health problems. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.	(1) Develop strategy to determine who will be conducting the T-Care Assessments. (2) Identify MIT caregivers in need of support. (3) Set goal for number of caregiver referrals. (4) Set goal for number of caregiver assessments to be conducted. (1) Case manager will work with MIT to refer tribal and community members to trainings.	• Referrals to local support groups, counseling and other resources. • Provide advice on use of supplies and equipment. • Caregiver training(s). • Respite care, if needed. --- • Track the number of referrals to CDSMP. • Improvements in exercise and self-management of chronic diseases. • Fewer hospitalizations and days spent in the hospital.	**Doug Ricker** ADS Planner **Karen Winston** ADS Planner	Referrals to CDSMP - 0 2013 CDSMP Workshops: 0

Policy 7.01 Implementation Plan (Muckleshoot Indian Tribe)

Seattle Human Services Department
Aging and Disability Services
Biennium Timeframe: January 1, 2014 to December 31, 2015

Implementation Plan				Progress Report
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the previous year - 2013
Emergency Preparedness 1. ADS & Tribal staff will work to educate and assist CMP clients in preparing for possible increased flood risk to residents residing in Green River Valley & hillsides. 2. Plan for possible alternate worksite for ADS Case Manager.	1. ADS and Tribal staff will discuss client emergency preparedness and work to inform CMP client's of their need to be prepared with adequate emergency supplies, evacuation plans and inform CMP clients about their local jurisdiction's warning and notification systems, evacuation routes, shelters, and flood insurance.	• Increase client preparedness • Reduce impact to MIT tribal & community members & their property. • Reduce disruption of home care services. • Tribal staff develops an alternate work site on the reservation for ADS Case Manager.	Dec. 31, 2014 **Keith Rapacz,** Case Manager Dec. 31, 2014 **Interim**, Human Services Division Director Muckleshoot Tribe	ADS staff and tribal members continue to discuss planning for client emergency preparedness.

Policy 7.01 Implementation Plan (Snoqualmie Nation)

Seattle Human Services Department

Aging and Disability Services

Plan and Progress Report Due Dates: April 2 (Regional Plan submitted to Assistant Secretary) and April 30 (Assistant Secretary Plan submitted to OIP) of each year.

Implementation Plan				Progress Report
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff and Target Date**	**(5) Status Update for the Fiscal Year Starting Last July 1**
HCS 1. Miscellaneous Training opportunities for Tribal Senior Services Staff and Caregivers.	Region 2 HCS will, as available, offer training slots to Tribal staff for miscellaneous Social Services trainings held at Region 2 HCS.	Tribal Senior Services Staff and Caregivers will have training opportunities.	Anita Canonica, Region 2 HCS SS Program Manager	
2. Provide training to the Snoqualmie Tribe on Long Term Care Services Eligibility at the tribe's request	The Social Services Program Consultant and the Financial Program Consultant will provide the training	The information will provide a better understanding of programs and eligibility for Tribal members	Mark Hammond, HCS SS Program Consultant Michelle Joseph, HCS Financial Program Consultant	
3. To ensure that all persons referred for HCS services are assessed appropriately and set up on services based on eligibility.	Persons referred from the Snoqualmie Tribe to Region 2 Home & Community Services will be identified on the referral form at Intake to indicate tribal affiliation. The assigned case manager will inform Anita Canonica, Region 2 HCS Tribal Liaison that they have received a referral where tribal affiliation has been identified.	Eligible clients will receive requested HCS services.	On-going Bronwyn Freer, SS Program Manager HCS, Tribal Staff, HCS staff	
4. HCS will inform clients who are affiliated with Tribes other than the Snoqualmie and the Muckleshoot that they may be eligible for services from the Snoqualmie Tribe	If the client wishes HCS to contact the Snoqualmie to provide them with their contact information, then HCS obtain the client's consent and forwards the information to Snoqualmie Tribal Contact.	Eligible clients will receive all accessible services	Tribal Staff HCS staff Bronwyn Freer, HCS Program Mgr. Anita Canonica, HCS Program Mgr	
ADS 1. Work with Tribal staff to facilitate health promotion trainings and workshops for unpaid caregivers.	ADS staff will work with Tribal members to coordinate Chronic Disease Self Management Program (CDSMP) training sessions.	Implement CDSMP workshop sessions.	Kate Miller, Tribal Staff Terra McCaffree, ADS Karen Winston, ADS	June 2013 – ADS, HCS and Snoqualmie tribal members met to review and discuss 701 Plan.
2. Explore the possibility of implementing care transitions program in East King County.	Conduct a focus group involving Snoqualmie Tribal members and East side providers to identify gaps and ways to improve coordination of patients' transition from hospital to community setting.	• Improved coordination of patients' transition from hospital to home. • Able to address	Kate Miller, Tribal Staff Andrea Yip, ADS Planning Unit Manager Maureen Linehan, ADS	

Policy 7.01 Implementation Plan (Snoqualmie Nation) Seattle Human Services Department Aging and Disability Services Plan and Progress Report Due Dates: April 2 (Regional Plan submitted to Assistant Secretary) and April 30 (Assistant Secretary Plan submitted to OIP) of each year.				
Implementation Plan				Progress Report
(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Fiscal Year Starting Last July 1
		both social and health issues. • Reduce or eliminate unnecessary hospital readmissions. • Increased independence.	Operations Manager Karen Winston, ADS	

APPENDIX G-1: REPORT ON 2012 ACCOMPLISHMENTS— 2012–2014 AREA PLAN UPDATE

HEALTH CARE QUALITY

1. Provide CDSMP trainings to COPES clients residing in subsidized housing buildings through COPES Ancillary client training contracts. **2011 Baseline:** 0 CDSMP providers; 2**012 Goal**: 2 CDSMP Provider
   Three CDSMP trainings were offered to COPES clients in subsidized buildings through a mini-grant received from the State. Full Life Care provided the trainings to 44 participants.

2. Expand access to chronic care management to dually-eligible Medicaid/Medicare ("dual") beneficiaries through the King County Care Partners network.

   2011 Baseline: 0 dual clients
   2012 Goal: 100 dual clients
   2013 Goal: 200 dual clients
   2014 Goal: 300 dual clients
   2015 Goal: 400 dual clients

   March – 15 dual eligible clients; July – 15 dual eligible clients enrolled – limited funding to support effort; October – 39 dual eligible unduplicated count. Note: Due to limited funding this objective was partially achieved.

5. Seek Affordable Care Act Care Transitions funding in partnership with local hospitals to reduce hospital re-admissions for Medicare beneficiaries.

   2011 Baseline: 0 hospitals; **2012** Goal: 1 hospital; **2013** Goal: 2 hospitals
   On April 17, 2012, ADS staff coordinated a South King County Community Meeting on Effective Care Transitions attended by 130 people from 65 organizations. ADS also contracted with Community Health Plans of WA to provide care transition coaching support. Staff provided briefings to hospital nurses, discharge planners, case managers, and social workers at three hospitals.

6. Conduct a focus group with home care providers to identify areas for home care agency intake process improvement to enable quick response to set up services for clients transitioning from hospitals. **2012 Goal**: 1 focus group
   On June 19, 2012, 22 Home Care Directors/Supervisors participated in a focus group discussion on their role in care transitions and improving care delivery to clients. Home care agencies responded positively and are working with hospitals and case managers to reduce hospital readmissions.

7. Expand the evidence-based Memory Care and Wellness Adult Day Services model from one to two providers. **2011 Baseline**: 1 provider; **2012 Goal**: 2 providers
   After this objective was developed, the current provider - Full Life Care - identified a second viable site for providing MCWS services. It was decided to expand service in this manner to avoid the cost/time of an RFQ process. If funding increases there may be an opportunity to identify a 2nd provider.

8. (*if funded*) Participate in a translation study of the Reducing Disabilities for people with Alzheimer's disease (RDAD) in-home exercise and problem-solving therapy model for Alzheimer's patients and their caregivers to serve 40 clients and their family caregivers. **2011 Baseline**: 0 clients; **2012–2015 Goal**: 26 clients per year
   RDAD will begin in 2013 with funding from the University of Washington. A training for coaches will be held in 1st quarter 2013.

BASIC NEEDS

11. Increase the number of King County older adults and people with disabilities who use Washington Connection, either directly or with the help of I&A to complete applications for benefits. 2011 Baseline: n/a; **2013 Goal**: 500; **2014 Goal**: 750; **2015 Goal**: 1,000
    Effective December 31, 2012, HSD is no longer partnering with WA Connections to facilitate eligibility and enrollment for City of Seattle programs. Other access to benefits efforts continue and include: Bi-monthly Information & Assistance provider meetings included status updates on WA Connections, and several I&A providers are community partner agencies; ADS received baseline data on Basic Food/SNAP participates who are age 60+ (27k in June 2012), and have requested data on WA Connection utilization; Enhancements to the WA Connection system in August 2012 may help increase utilization.

12. Increase access to housing with services for low-income residents to age in place. (2014)
    2012 Goal: 1 plan
    The Housing Development Consortium's Senior Affinity Group featured several "housing with services" presentations during 2012. Information gathered from these sessions will help inform development of the plan. In June, ADS submitted a proposal as part of the larger state grant to provide CDSMP in SHA buildings. Successful applicants were notified in August 2012.

13. Educate policy makers and community members about the advantages of incorporating Universal Design (UD) principles into standards for all types of housing development. **Annual Goal**: 2 presentations
    The NW Universal Design Council's (NWUDC) website (www.environmentsforall.org) was updated. Social media (e.g., launched a NWUDC Facebook page) was also utilized. AgeWise King County

included assistive technology and universal design articles in the August 2012 issue. The NWUDC heard presentations on supportive housing; UD designed home case studies; Let's Loop Seattle; BEAMS (Built Environment, Accessibility & Mobility Study); waterfront design committee; and Housing First Apartments; and toured the UW Access Technology Center.

14. Advocate for inclusion in the King County Ten Year Plan to End Homelessness of strategies to prevent and reduce older adult homelessness.
In August 2012, the ADS Advisory Council were briefed on successful programs for people who face homelessness. Bill Block, Committee to End Homelessness and HSD Transitional Living & Support staff were among the presenters.

15. Advocate for a steady increase in affordable housing options to keep up with the growth in the 60+ population (i.e., 936 subsidized units each year).
The ADS Advisory Council also received a presentation in August on the Yesler Terrace Redevelopment project and advocated for minimal impact on residents including families, seniors, people with disabilities and immigrants. ADS staff is also increasing presence in the housing community by becoming a member of the Housing Development Consortium.

16. Maintain the percentage of eviction prevention services that result in maintaining SHA residency for seniors and adults with disabilities. **Annual Goal**: 80 percent
The goal was met for this objective in all four quarters with a non-eviction rate of over 94% for 2012. 4th Quarter - 72/77 or 94%; Annual - 223/232 or 94%

19. Partner with the King County Asset Building Collaborative (KCABC) to promote financial literacy education for people of all ages to build financial literacy, promote economic self-sufficiency, and prepare for retirement
ADS staff distributed financial empowerment information to staff and general public, on a weekly basis. Staff also reviewed and provided edits to Senior & Baby Boomers chapter of Your Money Helpline Resource Guide (SKC-ABC publication).

20. Increase awareness of the Elder Economic Security Standard Index for Washington, and specific data that details how much income an older adult needs for self-sufficiency in Seattle & King County.
The Elder Economic Security Index was mentioned in several discussions, forums and on social media throughout 2012, but there is still more that can be done to raise the awareness of this important tool.

21. Support the One Away Campaign for Elder Economic Security and advocate for improved economic security in King County, especially among older women.
Senior Services was the local representative for the One Away campaign. They developed videos ("stories of struggle") from client

testimonies. ADS Advisory Council will continue to advocate for OAA funding for FY 2013.

22. Seek funding to increase by 10% the number of meals to meet the increase in demand in King County.
2012: 366,325 congregate meals total. HSD/ADS is scheduled to release a Request for Investments for Senior Nutrition Program Services in January 2013.

HEALTH and WELL-BEING

25. Advocate for social and recreational programming adapted to support people as they age.
ADS staff met with Seattle Parks & Recreation Department staff to discuss coordination on activities to date, and to identify focus areas and objectives 2013. The Memorandum of Agreements between Senior Centers and Parks—scheduled to be updated in 2013—will outline roles and responsibilities for each party.

26. Increase older adults with online access to information about walking events that promote physical activity, neighborhood unity, and unique features in the built environment (e.g., art, architecture, cultural history, and public facilities such as libraries, fire stations, and light rail station areas). **2011 Baseline**: n/a; **2012 Goal**: 1 Web portal
A web portal was developed to promote physical activity (www.seattle.gov/walking). ADS staff also hosted a King County Mobility Coalition Livable Communities meeting at ADS three times during 2012.

28. Develop policy recommendations regarding use of fresh local produce in the Senior Meal Program following the formal evaluation of the Farm to Table pilot project.
Grant funded work for Farm to Table was completed in March 2012. System and policy changes resulting from the grant include: development of a food hub/online store where orders from multiple farmers are aggregated into one delivery and one invoice for meal providers; shift to scratch cooking from catered and "frozen, heat and serve" meals; and emphasis on freshly prepared food in 2013 investment process.

30. Work with local food banks and East African community groups to increase capacity to provide healthy, culturally appropriate foods for East African elders. **2011 Baseline**: 0 sites; **2012 Goal**: 2 sites

ADS Planning staff participated in a focus group with East African providers to discuss strategies for increasing cultural appropriate foods with Seattle food banks. Lead staff are in the HSD Transitional Living & Supports division.

INDEPENDENCE FOR FRAIL OLDER ADULTS and PEOPLE WITH DISABILITIES

31. Provide a TCARE assessment and care plan to family caregivers who show moderate to significant caregiver burden.

    2011 Baseline: 600; **2012 Goal**: 650; **2013 Goal**: 700; **2014 Goal**: 750
    During 2012, 637 King County caregivers received a TCARE assessment and care plan.

33. Advocate to increase language capacity and class schedules and to reduce class size for home care independent provider training, to meet the language needs and training requirements of the independent provider workforce.

34. Advocate with ADSA and the state legislature to match required tasks (e.g., frequency of client contact) for Medicaid case management with available Medicaid case management resources.
    HSD/ADS management staff communicated regularly about caseload requirements based on increased caseload size. Staff recommends deletion of this objective due to discussions regarding the impact that managed care will have on the future of the ADS Case Management Program.

36. Conduct cultural competence staff trainings on emerging immigrant and refugee populations. **Goal**: 1 training per year

    Summer 2012, ADS Planning staff participated in a training by the Seattle Office for Civil Rights on the City's Inclusive Outreach and Public Engagement Guide.

37. Train long-term care case managers in Motivational Interviewing (MI) to use as a tool in the development of the service plan that includes self-care goals, in addition to services that address functional limitations. **Goal**: Send all new case management staff to MI training within their first year.
    MI trainings were scheduled for 2012, but CHAMPS no longer conducts these trainings. In 2013, a CMP staff survey on MI will be used to determine the level of training needs. It is also anticipated that MI will be incorporated in to performance evaluations.

38. Advocate with ADSA to expand the New Freedom coaching role of the long-term care case management program. (Ongoing)
    As of July 2012, ADS now administers the New Freedom program. ADS gained seven additional case managers to provide the service to clients.

40. Advocate with the Veteran's Administration to increase the number of clients referred to the Veterans-Directed Home Services. (Ongoing)
    The current contract is status quo based on federal budget.

41. Assist SHA residents and SHA building managers with resolving problems for residents who have received eviction notices to ensure that at least 80 percent are not evicted.
Annual Goal: 80 percent
The goal was met for this objective in all four quarters with a non-eviction rate of over 94% for 2012.

42. Work with the Elder Abuse Council to increase coordination among service and criminal justice agencies.
In December 2012, ADS submitted a grant proposal to the Office on Women's Health to train case managers to recognize and respond to abuse, neglect and exploitation. If funded, 150 case managers will improve skills to report and respond to elder abuse, neglect and exploitation. Partners include the King County Prosecutor's office, the Seattle Police Department, Adult Protective Services and a mental health consultant. Discretionary funds were also approved by the ADS Advisory Council and Sponsors to continue the Elder Abuse case manager position through 2013. Also, several presentations/trainings on elder abuse were provided to the ADS Advisory Council, Eastside Network on Aging; Asian Counseling & Referral Services; Chinese Information & Service Center; LifeWire Domestic Violence Program, Senior Services, City of SeaTac Human Services and Law Enforcement staff and ADS Sponsors. Coordination was also improved with other agencies including Adult Protective Services, and the community's first responders including law enforcement and fire departments.

43. Advocate to strengthen services for elder abuse victims.
ADS staff contributed content to the HSD Life Lines Newsletter special issue on domestic violence.

AGING READINESS

44. Advocate for transportation, pedestrian, street and land use policies and projects that promote walkable communities and pedestrian safety, and support people as they age. (Ongoing)
November 2012, the ADS Advisory Council hosted a Transportation: The Road to Independence forum that featured innovative transportation programs and services offered by the King County Mobility Coalition, Hopelink, Senior Services, and King County Metro Transit, including the Human Services Reduced Fare Bus Ticket Program and Transit Incentives Program. ADS staff participated in BEAMS—Built Environment Accessibility and Mobility Study, Eastside Easy Rider Collaborative, King County Mobility Coalition, Livable Communities Committee, Northwest Universal Design Council, and Puget Sound Regional Council Special Needs Transportation Committee meetings. AgeWise King County articles in 2012 included Wanted: Eastside Transportation Advocates, Universal Design Goes Beyond the Home, Make Sure Your Home Can Change As You Do, Hyde Shuttle Service Begins in Federal Way, SeaTac and Tukwila, and Walk Bike Ride Challenge.

47. Support technology that enhances access to aging information, programs and services as well as social and civic engagement for older adults. (Ongoing)
ADS publishes AgeWise King Co., and maintains 4 websites: www.agingkingcounty.org, www.kccarepartners.org, www.environmentsforall.org, maintains 3 Facebook pages: Silver & Gold-Seattle & King Co; NW Universal Design Council; and the Mayor's Council on African American Elders; Aging King Co Twitter and Pinterest.

48. Use social media tools and Seniors Digest to educate public about assistive technology devices and tools for older adults, persons with disabilities, and their families to support successful aging in place. **2011 Baseline**: n/a; **Goal**: 2 articles per year
AgeWise King County included an article on universal design and technology (February & August 2012). Assistive technology posts on Silver & Gold-Seattle & King County have increased public awareness of local resources.

49. Conduct at least one community conversation per quarter, with an emphasis on target populations (communities of color, rural, immigrant and refugees, LGBT). **2011 Baseline**: n/a; **Goal**: 1 meeting/quarter
ADS staff coordinated four community conversations during 2012 with: a) Older adult at both The Central and the Southeast Seattle Senior Centers; b) Kinship caregivers; and c) East African providers in South Seattle.

50. Collaborate with faith-based communities to support successful aging by providing clergy workshops developed by the Mayor's Council on African American Elders to increase awareness about the aging network. **2011 Baseline**: n/a; **Goal**: 1 workshop per year
ADS staff facilitated a discussion at First AME Church in Seattle about managing diabetes.

51. Increase public awareness of resources available for aging in place, including family caregiver resources, long-term care support, and end-of-life care and support. (Ongoing)
ADS publishes AgeWise King Co., and maintains 4 websites: www.agingkingcounty.org, www.kccarepartners.org, www.environmentsforall.org, maintains 3 Facebook pages: Silver & Gold-Seattle & King Co; NW Universal Design Council; and the Mayor's Council on African American Elders; Aging King Co Twitter and Pinterest.

55. Celebrate positive aging and the powerful impact that people age 50+ have on their community, utilizing social networking media. **2011 Base Goal**: 50 posts to social media sites per year
ADS uses the technology tools outlined in #47 to inspire healthy aging and celebrate examples of success.

APPENDIX G-2: REPORT ON 2013 ACCOMPLISHMENTS— 2012–2014 AREA PLAN UPDATE

HEALTH CARE QUALITY

2. Expand access to chronic care management to dually-eligible Medicaid/Medicare ("dual") beneficiaries through the King County Care Partners network.
   Due to limited funding, the measure for 2013 was modified to include 25 new clients per year. There are 34 unduplicated clients as of August 2013, including 16 new. ADS is on track for meeting the updated 2013 measure.

4. Collaborate with Partnership for Health Input through Shared Information (PHISI) to develop a health information exchange (HIE) in King County.
   PHISI disbanded in 2011. Washington State's Health Care Authority received AARA funding to coordinate a statewide HIE. OneHealthPort is the designated lead agency for the health information exchange.

5. Seek Affordable Care Act Care Transitions funding in partnership with local hospitals to reduce hospital re-admissions for Medicare beneficiaries.
   In 1st & 2nd quarter, ADS care transitions responded to 78 referrals from Community Health Plan of WA (66 of which received services) as well as 28 internal Case Management Program referrals (18 of which received services). ADS coordinated Care Transitions: Whose Job Is It Anyway?, a half-day conference on 5/30/13 that focused on reducing unnecessary hospitalizations (especially re-hospitalizations) in south King County, attended by 115 individuals from 61 organizations. In addition, ADS staff briefed nurses and discharge planners at Valley Medical Center and Virginia Mason Medical Center. ADS staff developed and printed a Care Transitions brochure. ADS continues to promote its Self-Management Plans for eight common chronic conditions, which incorporate warning flags and personal health records. ADS staff developed an ADS Video Portal, with links to online skill development content for staff, chronic condition information for clients, and general healthy aging information.

8. Participate in a translation study of the Reducing Disabilities for people with Alzheimer's disease (RDAD) in-home exercise and problem-solving therapy model for Alzheimer's patients and their caregivers to serve 40 clients and their family caregivers.
   The RDAD intervention employed by ADS consists of nine, one-hour home visits by a specially trained ADS staff over a six-week period. During each session, the "coach" teaches easy-to-follow exercises to both the caregiver and care receiver (i.e., the person with dementia).

Caregivers also learn how to handle some of the problems that occur with older adults who have memory problems or dementia. After the ninth session, the caregiver is contacted once a month for four months. The UW also conducts several phone interviews to help gather the data. The 2013 goal was to serve 26 caregiver-receiver couples this year – 13 couples per coach – in Seattle or south King County.

9. Maintain the number of older adults, including veterans/spouses, who show improvement in their level of minor depression as measured by the PHQ-9 assessment tool.
   There were 37 ADS clients who showed improvement in their depression scores, including 17 veterans and/or veteran spouses.

10. Expand existing Information & Assistance (I&A) service delivery system to fully implement each of the essential service components of ADRCs (Aging & Disability Resource Centers).
    In June 2013, ADS facilitated a planning session for I&A providers to assess readiness for implementing all of the Community Living Connection (CLC)-ADRC components. Providers reported 38% of components were implemented. Note: The ADRC components were expanded to include six categories: 1) Information, Referral & Awareness; 2) Options Counseling & Assistance; 3) Person Centered Transition Supports; 4) Streamlined Eligibility (Access) Determination; 5) Consumer Populations, Partnerships and Stakeholder Involvement; and 6) Quality Assurance and Continuous Improvement. CLC-ADRC providers continue to develop connections and relationships with disability organizations through bi-monthly professional development meetings in July and September.

11. Increase the number of King County older adults and people with disabilities who use Washington Connection, either directly or with the help of Information & Assistance Advocates, to complete applications for benefits.
    Data for 2013 for Washington Connection will not be available until February 2014, however, data from 1st & 2nd quarters indicates that baseline will be maintained and/or exceeded. The Fresh Bucks Program (double EBT/Basic Food Dollars at Farmers Markets) was launched in July 2013 and may generate interest in Basic Food and an increase in Washington Connection utilization by older adults.

13. Educate policy makers and community members about the advantages of incorporating Universal Design (UD) principles into standards for all types of housing development.
    In 2013, NW Universal Design Council quarterly meetings included "The Economics of Design," examining the esthetic and functional benefits of barrier-free design and the economic impact of UD; the Affordable Care Act and how states can expand their Medicaid programs, what Washington state is doing to implement these requirements, and how these coordinated programs will help diverse populations; the Seattle Housing Authority's planned redevelopment of Yesler Terrace; the U.S. Access Board; and Marketing Universal Design to the Masses, a

presentation by AFriendlyHouse.com, with a response panel by local Universal Design advocates. In addition to updating the NWUDC website (EnvironmentsforAll.org) and frequent posts on the NWUDC Facebook page, periodic Twitter posts and MeetUp announcements have attracted design professionals and disability advocates to attend meetings. In 2013, AgeWise King County has carried a number of design and accessibility articles, including Access to Technology for Vision Loss, Insight: A Low Vision Expo 2013, and falls prevention (multiple).

14. Advocate for inclusion in the King County Ten Year Plan to End Homelessness of strategies to prevent and reduce older adult homelessness.
Although no presentations were made to the Advisory Council during 2013, the Advocacy Committee continues to monitor strategies to prevent homeless among older adults.

15. Advocate for a steady increase in affordable housing options to keep up with the growth in the 60+ population (i.e., 936 subsidized units each year).
ADS Advisory Council members supported the Washington State Council on Aging legislative priorities for 2013, which included advocacy to protect funding that helps seniors remain in their home or a community-based setting; expand options for safe, accessible, and affordable housing for older adults and adults with disabilities; protect and preserve existing subsidized senior housing; preserve mobile home communities; and adopt policies and create incentives to encourage sustainable, universal design features in new construction and remodeling projects.

16. Maintain the percentage of eviction prevention services that results in maintaining SHA residency for seniors and adults with disabilities.
The goal of this objective was met in first and second quarters, with a non-eviction rate of over 94 percent for 2012.

BASIC NEEDS

19. Partner with the Seattle King County Asset Building Collaborative (SKCABC) to promote financial literacy education for people of all ages to build financial literacy, promote economic self-sufficiency, and prepare for retirement.
ADS staff receives and distributes information from the SKCABC on a periodic basis, and includes financial empowerment events in AgeWise King County and the weekly MOSC Age 55+ Employment Resource Center Job List. ADS participates in the Seattle Human Services Department's Financial Empowerment Workgroup.

20. Increase awareness of the Elder Economic Security Standard Index for Washington, and specific data that details how much income an older adult needs for self-sufficiency in Seattle & King County.
The Elder Index was referenced in several forums and on social media (AgeWise King County; Silver & Gold—Seattle & King County; Mayor's Council on African American Elders; Twitter; and Pinterest).

21. Support the One Away Campaign for Elder Economic Security and advocate for improved economic security in King County, especially among older women.
Senior Services—the local One Away representative—developed videos ("stories of struggle") from client testimonies. Although advocacy continues, the campaign ended in 2012.

22. Seek funding to increase by 10% the number of meals to meet the increase in demand in King County.
A Request for Investments for Senior Nutrition Program Services was released in January 2013. Funding was awarded to 13 agencies to provide meals at 50 sites throughout King County, including programs targeting rural residents (Maple Valley), East African elders in Lake City, and Korean and Eastern European elders in Federal Way. Congrats for new sites are effective January 1, 2014. Congregate meal data (meal and participant numbers) for the 2013 program year will be available by March 2014.

25. Advocate for social and recreational programming adapted to support people as they age.
AgeWise King County promotes healthy, active and successful aging programs and services. Older Americans Month programming is highlighted in the May issue.

27. Partner with the Seattle Parks and Recreation to expand the Food & Fitness Program to more immigrant and refugee communities.
In 2012, Seattle Parks and Recreation piloted a small Food & Fitness program for the Somali community at the Meadowbrook Community Center in Lake City. Following the pilot, the community found both a new partner and location, and was awarded funding through the 2013 Request for Investment (RFI) for congregate meals. The new meal site in Lake City will begin operating in January 2014 and, although it is not a Parks partnership, it will include the meal and health promotion components of other Food & Fitness sites. During the community engagement process for the Congregate Meal RFI, Cambodian community leaders indicated an interest in pursuing a site at the Delridge Community Center but they did not submit a proposal. In addition to the Food & Fitness partnerships, ADS has facilitated partnership efforts between Seattle Parks and Recreation and the nine senior centers in Seattle. These efforts include Memorandums of Agreement regarding collaboration with the goal of expanding programs to new populations.

HEALTH and WELL-BEING

29. Work with City of Seattle's Food Policy Interdepartmental Team to implement policies that promote a more sustainable, equitable and healthy food system.

The City of Seattle's Food Action Plan was approved by the City Council in March of 2013. Two initiatives that support the action plan objective to "increase access to health food for low income and vulnerable populations" include:

1) Farm to Table: connecting older adults and senior meal programs with local farms to increase access to and affordability of fresh produce. Community Transformation Grant (CTG) funding will include: a) support for training and outreach to senior meal programs to encourage them to purchase local produce (by September 2014, 5 new sites and 10 sites who participated in the CPPW F2T grant will participate); and b) development of a "good food bag" or low cost CSA model (1 site in a senior housing community or other senior community hub (by December 2013).

2) Fresh Bucks: Basic Food recipients double their purchasing power at Farmers Markets when using their EBT card from July through Oct. 2013. In August, ADS will send Fresh Bucks information to all Seattle based applicants for the Senior Nutrition Farmers Market Voucher Program.

30. Work with local food banks and East African Community groups to increase capacity to provide healthy, culturally appropriate foods for East African elders in need.
ADS Planning staff participated in a focus group with East African providers to discuss strategies for increasing cultural appropriate foods with Seattle food banks in 2012. Lead staff are in the HSD Transitional Living & Supports division. During 2013, the Somali Community of Seattle (SCofS) has been getting some food bank products from ACRS, however, storage capacity prohibits the SCofS from expanding to their very own food bank operations. The SCofS continues their partnership with the Yesler Terrace Community Center for the congregate meal program.

31. Provide a TCARE assessment and care plan to family caregivers who show moderate to significant caregiver burden.
2011 Baseline: 600; 2013 Goal: 700 assessments and care plans; 2013 Progress: 712 (as of September 2013)

INDEPENDENCE FOR FRAIL OLDER ADULTS and PEOPLE WITH DISABILITIES

33. Advocate to increase language capacity and class schedules and to reduce class size for home care independent provider training, to meet the language needs and training requirements of the independent provider workforce.
Ongoing

34. Advocate with ADSA and the state legislature to match required tasks (e.g., frequency of client contact) for Medicaid case management with available Medicaid case management resources.

HSD/ADS management staff communicated regularly about caseload requirements based on increased caseload size. Staff recommends deletion of this objective in the 2014–2015 Area Plan Update due to discussions regarding the impact that managed care will have on the future of the ADS Case Management Program.

35. Develop specific disease protocols for long-term care clients who have chronic obstructive pulmonary disease, asthma, diabetes, or congestive heart failure.
ADS staff have completed seven protocols: Asthma; Coronary Artery Disease; Congestive Heart Failure; Chronic Obstructive Pulmonary Obstructive; Diabetes; Pain; and Falls Prevention.

36. Conduct cultural competence staff trainings on emerging immigrant and refugee populations.
During 2013, ADS staff participated on an ongoing interdepartmental work team created to develop a HSD Coordinated Community Engagement Handbook to inform HSD work including Request for Information (RFI) processes. In conjunction with the Office of Civil Rights, the team also coordinated an Inclusive Outreach and Public Engagement Workshop in June. ADS staff also participated in monthly meetings for the Refugee Forum of King County.

37. Train long-term care case managers in Motivational Interviewing (MI) to use as a tool in the development of the service plan that includes self-care goals, in addition to services that address functional limitations.
ADS purchased two sets of Motivational Interviewing training videos: "Updated Motivational Interviewing Evidence-Based Skills to Motivate Clients Toward Change," by Stephen Rollnick, Ph.D.

38. Advocate with ADSA to expand the New Freedom coaching role of the long-term care case management program.
As of July, ADS administers the New Freedom program. During 2013, ADS gained nine additional case managers to provide the service to clients. Approximately 704 clients were served from January to June 2013.

39. Obtain feedback from in-home Medicaid long-term care clients regarding satisfaction with case management services and suggestions for case management service improvements.
Due to limited staff capacity, this objective was placed on hold.

40. Advocate with the Veteran's Administration to increase the number of clients referred to the Veterans-Directed Home Services.
The current contract is status quo based on federal budget.

41. Assist SHA residents and SHA building managers with resolving problems for residents who have received eviction notices to ensure that at least 80 percent are not evicted.

The goal of this objective was met in first and second quarters, with a non-eviction rate of over 95%.

42. Work with the Elder Abuse Council to increase coordination among service and criminal justice agencies.
In collaboration with the King County Prosecutor's Office, the Seattle Police Department, and the WA State, DSHS – Adult Protective Services (APS), ADS conducted an all-day training on recognizing abuse, neglect and exploitation among vulnerable adults. Presentations were conducted on how to work collaboratively with law enforcement, the prosecutor's office, and APS, emphasis on the importance of screening and reviewing the criminal history backgrounds of caregivers. Dr. Janice Edwards, Psychologist, Geropsychiatric Unit at Northwest Hospital, discussed clients cognitive capacity for making decisions during a criminal investigation, court proceeding, safety care plan development. The funding allowed ADS to provide training for 162 staff that provides care and services to 12,733 elders and adults with disabilities throughout King County each month.

43. Advocate to strengthen services for elder abuse victims.
ADS staff contributed content to the HSD Life Lines Newsletter special issue on domestic violence. An Abuse in Later Life webpage was added to the AAA website.

AGING READINESS

44. Advocate for transportation, pedestrian, street and land use policies and projects that promote walkable communities and pedestrian safety, and support people as they age.
In September 2013, the Advisory Council hosted a special transportation forum focusing on transportation and mobility challenges facing our region, including large cuts to transportation funding. A panel of speakers included Kevin Desmond, King County Metro; State Representative Jessyn Farrell; King County Councilman Rod Dembowski; and Katy Wilson, Transit Riders Union. All participants were encouraged to advocate to policy makers.

45. Implement a leadership seminar series for people age 50 and older who want to learn new skills, take on community projects, and transform their futures.
A rough outline has been produced. Implementation is postponed until 2014.

46. Explore new partnerships with arts organizations, public libraries, and local colleges to enhance access to lifelong learning and volunteer opportunities for older adults.
ADS staff met with the director of the Seattle Office of Arts and Cultural Affairs. An inventory of opportunities for senior involvement in the arts is planned. The ADS Pinterest page (agingkingcounty) includes Arts & Aging and also Movies. The July issue of AgeWise King County focused on dance, with contributions from Parkinson's Foundation/Dance for

PD, World Dance Party, Seattle Parks/Lifelong Recreation Program, Freeway Park Association, and others. A feature film (Gotta Dance) was screened as part of Older Americans Month (May 2013), and planning is underway for a film festival in May 2014.

47. Support technology that enhances access to aging information, programs and services as well as social and civic engagement for older adults.
ADS staff advocates for CART (Communication Access Real-time Translation) service to accommodate individuals with hearing loss. In addition, staff maintains four websites ((agingkingcounty.org, environmentsforall.org, kccaregiver.org, kccarepartners.org), three Facebook pages (Silver & Gold--Seattle & King County, MOSC, and MCAAE), Twitter (/agingkingcounty), and Pinterest (/agingkingcounty) pages.

48. Use social media tools and AgeWise King County to educate public about assistive technology devices and tools for older adults, persons with disabilities, and their families to support successful aging in place.
The May 2013 issue of AgeWise King County included "Access to Technology for Vision Loss." ADS staff makes periodic assistive technology posts to Facebook and Twitter.

49. Conduct at least one community conversation per quarter, with an emphasis on target populations (communities of color, rural, immigrant and refugees, LGBT).
In April 2013, ADS personnel staffed Mayor McGinn's town hall meeting held at Horizon House, an independent retirement community. Several issues were discussed including homelessness, affordable housing, neighborhood density, transit and discontinued bus lines, aging infrastructure and parking rate increases.

50. Collaborate with faith-based communities to support successful aging by providing clergy workshops developed by the Mayor's Council on African American Elders to increase awareness about the aging network.
In February 2013, ADS staff participated in a workshop at the First African Methodist Episcopal (AME) Church in Seattle, sponsored by the Western States Health Equity Affiliate of the American Heart Association. The workshop provided information about hypertension including the importance of managing blood pressure. ADS staff shared information about the importance of medication compliance and the impact of sodium and additives in foods. The First AME Health and Wellness Ministry, in partnership with the American Heart Association, will be a site for blood pressure research including a blood pressure kiosk at the church.

51. Increase public awareness of resources available for aging in place, including family caregiver resources, long-term care support, and end-of-life care and support.
ADS staffs the Northwest Universal Design Council, which advocates for good design for all ages and abilities (this accommodates aging in

place). Meetings have included "The Economics of Design—Planning for the Age Wave, by ADS Advisory Council member Tom Minty (January); Yesler Terrace redevelopment and accessibility (April); U.S. Access Board (July); and Marketing Universal Design to the Masses (October). Other public awareness strategies include four websites; social media (Facebook, Twitter, and Pinterest); and coordinated brochures and flyers. The ADS Advisory Council sponsored community forums on hunger (March), health care reform (May), health care insurance (August), transportation (September), and health care (planned for November).

52. Increase outreach to target populations in order to achieve a five percent (5%) increase in participation within ADS-funded services.
    Baseline: 53,403
    2012: 58, 189 (a 9% increase)
    2013: Data not available until the end of the first quarter 2014

53. Add a requirement in all ADS Requests for Investments (RFIs) to conduct outreach activities within diverse communities.
    During 2013, ADS staff participated in a cross-divisional Community Engagement Inclusive Outreach Core Team. The team's task was to develop a high-level view of HSD's community engagement activities; research best practices in the field; and develop a document to help guide staff on all community engagement activities in the future. The plan will be incorporated into the revised HSD Request for Investment (RFI) Manual, to be completed by December 2013.

54. Coordinate at least one ADS Advisory meeting a year with a focus on older people and adults with disabilities who reside in East and South King County areas.
    Among the Advisory Council forums referenced in #51 above, the health care forum was held at the SeaTac Community Center, the health care insurance forum was held at the Kent Senior Activity Center, and the transportation forum was held at the Northshore Senior Center (serving north and northeast King County).

55. Celebrate positive aging and the powerful impact that people age 50+ have on their community, utilizing social networking media.
    ADS celebrates aging in a variety of ways, including social media (see references above to multiple websites, AgeWise King County, multiple Facebook pages, Twitter, Pinterest and MeetUp). Older Americans Month (May) increased in 2013 with the addition of a movie screening (Gotta Dance) and collaboration within the Healthy Aging Partnership to sponsor a film festival in the future.

APPENDIX H: STATEMENT OF ASSURANCES AND VERIFICATION OF INTENT

For the period of January 1, 2014 through December 31, 2015, Aging and Disability Services—the Area Agency on Aging (AAA) for Seattle-King County—accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (P.L. 106-510) and related state law and policy. Through the Area Plan, Aging and Disability Services 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. Aging and Disability Services 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 Aging and Disability Services for providing services to low income minority individuals and older individuals residing in rural areas within the Planning and Service Area.

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

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

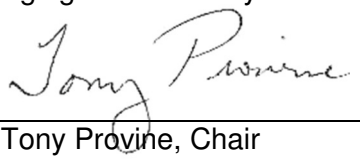
A. Information concerning whether there is a significant population of older Native Americans in the planning and service area, and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits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

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

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

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

Obtain input from the public and approval from the AAA Advisory Council on the development, implementation and administration of the Area Plan through a public process, which should include, at a minimum, a public hearing prior to submission of the Area Plan to DSHS/ADS. Aging and Disability Services 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.

10/15/13	
Date	Jesse Eller, Director Aging and Disability Services
10/15/13	
Date	Tony Provine, Chair Seattle-King County Advisory Council on Aging & Disability Services
10/15/13	
Date	Catherine Lester, Director Seattle Human Services Department
10/15/13	
Date	Jackie MacLean, Director King County Department of Community and Human Services
10/15/13	
Date	Sara E. Levin, Vice-president United Way of King County

COMMENTS AND QUESTIONS

Address comments or questions about the Area Plan to:

Aging and Disability Services
Seattle Human Services Department

Receptionist:
206-684-0660

Fax: 206-684-0689
TTY: 206-684-0702

Street Address:
Seattle Municipal Tower, 51st Floor
700 5th Avenue, Seattle

Mailing Address:
PO Box 34215
Seattle WA 98124-4215

E-mail:
aginginfo@seattle.gov

Web:
www.agingkingcounty.org

QR Codes are a new accessibility tool that allows access to Web sites without using a keyboard. To use the code (at left), download a free QR Reader application on your smart phone, open the application, and then take a picture of the code. This QR Code leads to the ADS Web site.

For information about services, contact:

Senior Information & Assistance
206-448-3110 *or* 1-888-4-ELDERS • www.seniorservices.org

211 Community Information Line
(adults with disabilities & adults under age 60)
Call 2-1-1 *or* 206-461-3200 *(M-F 8-6) or* 206-461-3222 *(after hours) •*
www.resourcehouse.info/Win211/

African American Elders Program
206-328-5639 • www.ccsww.org

Asian Counseling & Referral Service
206-695-7600 *(Asian languages) •* www.acrs.org

Chinese Information & Service Center
206-624-5633 *(Chinese dialects) •* www.cisc-seattle.org

Jewish Family Service
206-861-3152 *(Eastern European immigrants) •* www.jfsseattle.org

Neighborhood House
206-461-4522 *(East African and Southeast Asian languages, and Russian) •*
www.nhwa.org

SeaMar Community Health Center
206-764-4700 *(Spanish) •* www.seamar.org