DRAFT 2018-2019 UPDATE

Section C:
Issue Areas, Goals and Objectives

C-1: Long-Term Services & Supports

Aging and Disability Services (ADS) has a goal of maximizing current program, funding and staff capacity to meet the needs of complex long-term services and supports (LTSS) clients.

Background
Washington is a national leader in offering home and community-based LTSS for people with significant disabilities under the Medicaid program. Washington residents can choose to receive support in adult family homes, in assisted living, in their own homes, or in a nursing home. As expected, about 75 percent choose to receive care in their homes, either from an agency or an individual provider of their choosing.

Not only is in-home care the preferred LTSS option, it is the most cost-effective. It costs less than $2,000 per month, on average, for in-home care compared to over $5,000 per month for care in a nursing home. In-home care makes efficient use of funding. Rather than assuming the cost of full, 24/7 complete care, it supplements what individuals and families can do for themselves with intermittent, paid, gap filling services and supports. To ensure success and safety, plans of care must be tailored to each situation because every individual and family differs widely in what they can do for themselves.

The number of people 65 and older is growing, and people with disabilities of all ages are living longer with multiple chronic conditions. In response to this demand, Washington's in-home program has developed capacity and expertise to support people with moderate to severe physical limitations as well as those who are medically complex, including clients with significant behavioral and cognitive challenges.

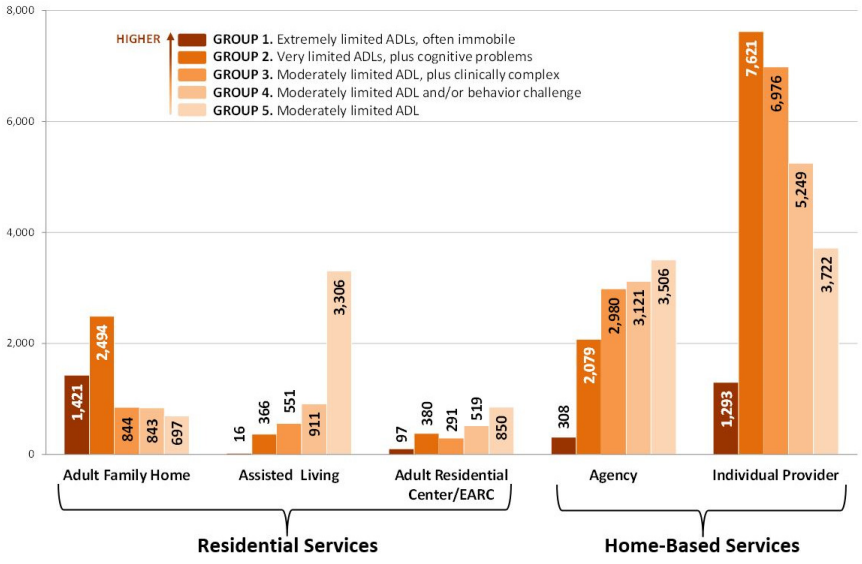


Figure 22. Long-Term Care Assessment by Setting and Acuity

As the Figure 22, above, demonstrates, statewide there are approximately 38,000 people in the home and community-based portion of Washington's LTSS system who face a broad range of challenges to their health and independence. All need assistance to accomplish daily activities such as bathing, dressing, preparing meals, personal hygiene and moving about.

About 30 percent (11,300 people) of those have very little ability to accomplish daily activities (e.g., eating, dressing, bathing) due to physical mobility and cognitive limitations. That is roughly equal to the number of Washington's nursing home residents with similar conditions who are covered by Medicaid. Another 30 percent are slightly more able to accomplish daily activities but are challenged by a complex combination of difficult to manage diagnoses and health conditions.

The levels of acuity among LTSS clients have continually increased over the past decades and require increasingly sophisticated service planning, coordination, and monitoring to maintain independence, health, and safety.

Case Management of In-home Long-term Services and Supports

In any given month, the AAA manages around 10,500 in-home LTSS clients, and 12,000 individuals over the course of a year. Clients receive a comprehensive assessment of their functional and health support needs. After assessment, they receive an individual service plan that authorizes personal care help with activities of daily living such as bathing, personal hygiene, ambulation and meal preparation. In addition, the case manager can authorize other supportive services such as personal emergency response systems and medication management. On average, Case Managers authorize about $2,000 per month in supportive services.

Beyond what is directly authorized for payment, the case management team (which includes nursing and social services professionals) helps people access healthcare and other services in the community. To monitor care and maintain safety of this very vulnerable population the case manager does home visits and maintains contact with family and providers to monitor the effectiveness of the plan of care.

As clients increase in complexity, the responsibility of helping them meet health outcomes will also shift in the next four years. Legislation passed in 2013 (HB 1519) directs DSHS and Health Care Authority (HCA) to establish accountability measures for service coordination agencies such as Behavioral Health Organizations (BHOs) and Area Agencies on Aging (AAAs). Within the next four years, outcome measures will be added to AAA contracts.

For the first time in many years, the 2015–2017 state budget included an increase in maintenance level funding for the Medicaid Case Management program. The additional $10.5 million statewide translates to a nine percent increase in reimbursement rates and will enable AAAs to better balance revenue and expenditures through the next biennium. Unfortunately, following years of flat funding and increases in both client complexity and operational costs, the nine percent increase is still significantly short of what is needed to restore the program to pre-recession capacity and quality levels.

Figure 23, below shows the number of new clients to the AAA has continued to increase with a net increase of 391 more clients served during 2016.* Caseloads remained high for case managers throughout 2016. The Case Management Program has been preparing for two new programs, Health Homes and the Medicaid Transformation Demonstration Project, and worked on transferring approximately 1,300 clients from one case management subcontractor to two new case management subcontractors. This period of growth has lead ADS to examine areas needing efficiency improvements while maintaining the quality of services for clients.

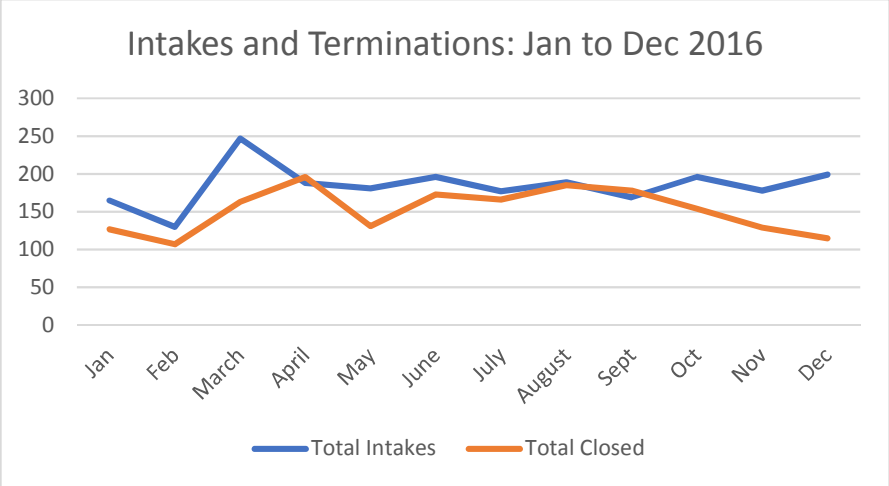


Figure 22. Long-Term Care Assessment by Setting and Acuity

While these efforts will keep the program operational, more funding is needed to maintain these critical services and to ensure quality of care, minimize risk for staff and clients, and support positive health outcomes. In-home monitoring of care, inclusion of nurse expertise on the care team, supervisory quality control and quality of care planning will continue to challenge the AAA at current levels of funding. If not rectified by FY2017, it will be necessary to reduce or eliminate related quality assurance benchmarks.

C-1: Long-term Services and Supports: Goal

Maximize current program, funding and staff capacity to meet the needs of complex Long-Term Services and Supports (LTSS) clients.

Long-term Services and Supports: 2018–2019 Objectives

1. Address the increase in medical complexity of LTSS clients by participating in the Health Home Program.
    a. Expand pilot medication management program to housing providers in south King County.
    Goal: Provide 84 hours of consultation and education
2. Advocate for full funding to maintain quality in-home case management so that individuals receive stabilized care that allows them to stay in home as long as that is their choice.
    Goal: Ongoing advocacy
3. Implement Lean Process for hiring and preparing Individual Providers
    Goal: Improve the IP hire rate and compliance measures
4. Fully launch new Medicaid Transformation Demonstration Project.
    Goal: Meet average number of new clients by end of year.

C-2: Health Promotion, Disease Prevention, and Delay of Medicaid-funded Long-Term Services and Supports

Aging and Disability Services (ADS) has a goal of delaying Medicaid-funded long-term services and supports by encouraging health promotion and disease prevention.

Pre-Medicaid services help delay entrance into more expensive Medicaid-funded long-term services, such as nursing homes and in-home care. These upstream efforts focus on providing information and connecting older adults, people with disabilities and family caregivers to programs and services that help them stay healthy, active and engaged in their communities.

ADS pre-Medicaid strategies focus on the following program areas:

- Community Living Connections & Family Caregiver Support
- Alzheimer's, Dementia and Memory Care
- Health Promotion
- Falls Prevention

C-2-1: Community Living Connections & Family Caregiver Support

Access services help people understand what options and resources are available to meet their needs and assist people in connecting to these resources. In King County, access services are provided through a strong network of provider agencies that comprise Community Living Connections and Family Caregivers Support programs.

Community Living Connections

Across the country, Aging & Disability Resource Centers (ADRCs) are a key component in strategies to reach people upstream to prevent or delay more costly services later in life. In Washington state, these centers are part of Community Living Connections, a network of access services delivered through each of the state's 13 Area Agencies on Aging. The system employs a "no wrong door" approach, connecting people of all ages and abilities seamlessly and efficiently to the services they need, regardless of how or where they enter the system.

A new service of Community Living Connections—Person-Centered Options Counseling—was pilot-tested with three agencies in 2014 and will be implemented throughout King County. Detailed description of this service as well as all other Community Living Connections services are described in B-3: AAA Services.

In King County, Community Living Connections launched in the fall of 2015, integrating existing access services (Information & Assistance, Disability Access Services, and non-Medicaid Case Management) into one comprehensive service delivery system. The service delivery system was developed in response to community input in which staff from over 100 agencies

participated in more than 30 community engagement activities. Place-based services was the salient theme that emerged, that services need to be accessible in the community where people reside.

The geographic hub model was designed to be a coordinated effort with network agencies that contract with Aging and Disability Services to deliver specific Community Living Connections services, as well as partner agencies that participate through letters of agreement. Following are access points and roles:

- **Central Access**—The main phone line responds to information calls and links people to needed services. Staff also follow-up as needed and refer people to other agencies if they need more hands on assistance.
- **Region Leads**—To make it easier for people to access services in their communities and neighborhoods, Community Living Connections has identified lead agencies that will be responsible for developing and expanding the network in three geographic service regions—South, East and North King County/Seattle. Region lead roles include identifying new partners, formalizing partnerships roles through letters of agreement, convening partner agencies for training and information sharing, and conducting outreach and marketing specific to their region. They are considered the local expert and primary point of contact for providers in their respective regions. They also bring the unique perspective of their region, including service gaps and emerging trends, to the larger Community Living Connections network.
- **Network Agencies** are contracted providers that deliver a range of Community Living Connections services, including Information & Assistance/Referral, Person-Centered Options Counseling and Care Coordination that are responsive to the cultural and language preferences and needs of the communities they serve.
- **Partner Agencies**—Partner agencies are non-contracted providers that participate in the Community Living Connections network through letters of agreement, referrals, information sharing, meetings and trainings. Partner agencies are essential to the Community Living Connections network.

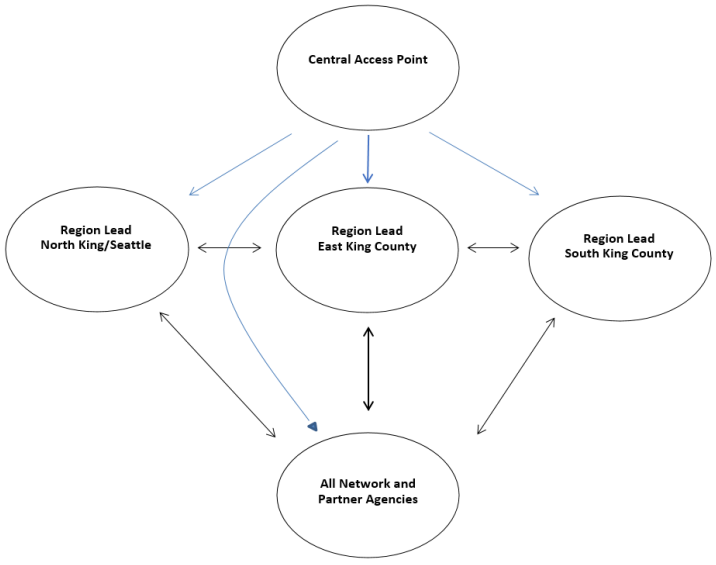


Figure 23. Community Living Connections Structure

To help facilitate seamless service delivery, the State of Washington ~~is implementing~~has a client management and resource directory information system called GetCare. The system includes a public portal where consumers can search for resource information, complete an assessment, and self-refer to programs and services. Agencies using GetCare can access client service history and case notes and are able to seamlessly refer clients throughout the network. ADS launched a marketing campaign in the fall of 2015 to raise awareness for Community Living Connections. The goal is to make sure people know where to go or who to call to find information.

Family Caregiver Support Program

As the "front door" long-term supportive services, Community Living Connections helps connect family caregivers with the King County Caregiver Support Network for services that are tailored to their caregiving needs. Contracted providers in this coordinated network offer a range of family caregiver support programs and services than ensures caregivers receive the right services, at the right time, and in a way that meets their needs.

All providers in the network have staff who are trained in administering the Tailored Caregiver Assessment and Referral (TCARE®) protocol. This evidence-based tool assesses caregiver burden and identifies what services and supports are needed to reduce that burden. TCARE® has demonstrated significant success in improving well-being and mental health outcomes for caregivers.

Network Expansion

Aging and Disability Services conducted Request for Proposal (RFP) processes in 2015 to identify providers for both Community Living Connections and Family Caregiver Support. The processes expanded the scope of services and the reach to new populations and communities that will be served through Community Living Connections and King County Family Caregiver Support Network. Combined, these networks will be able to provide cultural and language appropriate services to the following populations: African American; homeless; Adults with disabilities including intellectual disabilities, deaf and hard of hearing, and deaf-blind; people with limited English proficiency including Asian, Pacific Islander, East European, Spanish speaking, and East Africans.

Through 2016, King County is receiving additional funding from the State Unit on Aging to develop and expand these networks and implement Community Living Connections. The funding is from a federal ADRC implementation grant to Washington State. At this time, funding is used for planning, coordination, marketing and other implementation related efforts. Should additional funding become available, ADS will direct those funds to subcontracted network providers to increase their capacity to serve more clients.

C-2-2: Alzheimer's, dementia and memory care

Alzheimer's disease is the largest unrecognized public health crisis of the 21st Century. It is the sixth leading cause of death in the United States and the third leading cause of death in King County. The disease is a significant driver of increasing healthcare and long-term care costs, and it takes a devastating toll on the health and wellbeing of families and caregivers -- financially, mentally and physically.

In Washington state, an estimated 110,000 individuals have Alzheimer's disease or a related dementia. This number is projected to increase significantly with the age wave – over the next 30 years, the number of people age 65 and older with Alzheimer's and dementia will increase by 181 percent.

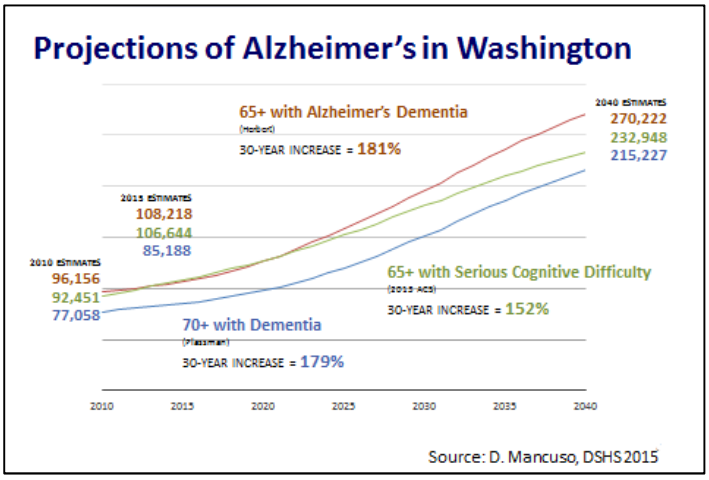


Figure 24. Projected Increase of Individuals with Alzheimer's in Washington, 2010–2040

Alzheimer's disease is similar to other diseases in prevalance and disportionately impact certain populations by race, ethnicity and gender:

- The most frequently cited national estimates show that older African Americans are about two times more likely than whites to have Alzheimer's disease.
- Hispanics age 60 and older are about 1.5 times more likely than non- Hispanic whites to have Alzheimer's disease or related dementias.
- In King County, deaths per year for women, as a result of Alzheimer's disease, almost double the counts for men.

As the U.S. population ages and minorities become a higher proportion of the older population, a higher percentage of people with Alzheimer's disease will be minorities.

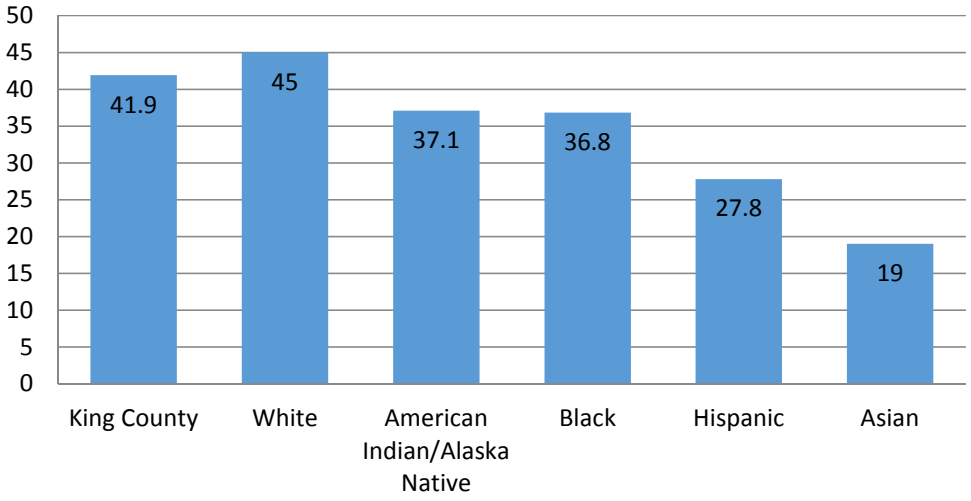


Figure 25. King County Alzheimer's Death Rates, by Race/Ethnicity, 2008–2012
Rate = Death per 100,000, All Ages

Preparing for Crisis

In 2016, the Washington State legislature created an Alzheimer's Disease Working Group (ADWG) that developed the first State Plan to Address Alzheimer's Disease and Other Dementias. The group later evolved into the Dementia Action Collaborative (DAC) to provide oversight on implementation of the plan. The plan identifies goals, strategies and recommendations to enhance the dementia-capability of systems of care and support for people

with memory loss and/or dementia and their caregivers. Recommendations in the plan are consistent with ADS goals for King County, including: promoting dementia-friendly communities; strengthening and expanding dementia-capability through Community Living Connections; improving services and supports for caregivers and families; and providing ongoing public outreach and education about healthy aging and brain health. ADS participates in multiple DAC committees.

Dementia-friendly communities

Creating dementia-friendly communities is about breaking down stigma to actively accept and value people with dementia. Alzheimer's Disease International states that dementia friendly communities, "not only seek to preserve the safety and wellbeing of those living with dementia, [but] also empower all members of the community to celebrate the capabilities of persons with dementia, and view them as valuable and vital members of the towns, cities, villages and countries in which they reside."[1]

Dementia friendliness is largely about training, education, awareness, and dismantling stigma.

In Seattle and King County, many opportunities already exist for people with memory loss or dementia, including Alzheimer's Cafes; Memory Loss Zoo Walks; Library Book Clubs for people with memory loss; Taproot Theater; Frye Art Museum gallery and studio program for persons with dementia; and Early Stage Memory Loss workshops.

The 2016 pioneering group of the Our Time Has Come workshop culminated in a community action project to raise dementia awareness in the younger generation. Photo by UW Medicine Memory Brain & Wellness Center.

In creating dementia friendly community, ADS has three strategies. 1) Work with the Community Living Connections network to increase the dementia-capability through education and training 2) Integrate with the Age Friendly Initiative; 3) Support existing programs and connect with new partners. For example, in 2017 ADS co-hosted the Changing Aging Tour that featured workshops on disrupting dementia.

[1] Alzheimer's Disease International. 2015. Dementia Friendly Communities (DFCs): New domains and global examples. https://www.alz.co.uk/adi/pdf/dementiafriendly-communities.pdf.

C-2-3: Health Promotion

Health promotion programs help people manage their chronic conditions and live healthier lives, and are a key strategy in delaying more expensive long-term care services. Aging and Disability Services supports these programs directly by administering federal funds, and indirectly through advocacy and facilitation.
In 2016, Aging and Disability Services conducted an investment process for Health Promotion services, which are funded under Title III-D of the Older Americans Act. The goals for this investment are to:

- Facilitate access to a menu of evidence-based health promotion programs available for community-dwelling older adults and adults with disabilities, and
- Expand opportunities for high-need populations to participate in evidenced-based Chronic Disease Self-Management Programs (CDSMP), Chronic Pain Self-Management (CPSMP) workshops, and Tai Ji Quan: Moving for Better Balance®.

Evidenced-based health promotion programs in King County

A Matter of Balance

Chronic Disease Self-Management Program

Diabetes Self-Management Program

EnhanceFitness

EnhanceWellness

PEARLS (Program to Encourage Active and Rewarding Lives)

These programs—CDSMP and CPSMP—were initially funded through a state pilot grant that ended in August 2015.

In addition to direct investments, ADS is working to raise awareness among public health, community clinics, and other healthcare professionals about health promotion programs to increase the number of patients referred to and participating in these programs. This is the first step toward a long-term strategy of embedding health promotion programs in the healthcare system. ADS has been engaging with managed care organizations and other healthcare systems to further this work.

Aging and Disability Services also supports and facilitates quarterly network meetings made up of organizations that coordinate CDSMP workshops. The network works to ensure that workshops are offered throughout King County and are also accessible to cultural and ethnic communities.

C-2-4: Falls Prevention

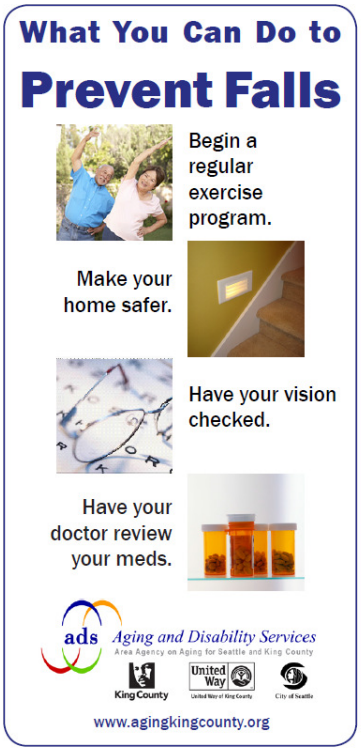
Falls are a preventable public health concern impacting quality of life, health care costs, and premature institutionalization.

Fall rates increase sharply with advancing age

- In Washington State, one in every three people age 65 and older living in the community falls each year, and fall rates increase sharply with advancing age.[2]
- In King County, 21 percent of adults 60 and older reported having fallen in the previous three months, and about 20 percent of those falls resulted in an injury that limited activities or made them see a doctor.[3]

Impact on Hospitals and Emergency Response Systems

- In 2012, falls were the leading cause of all injury-related hospitalizations in Washington State leading to over 14,000 hospitalizations.[4]
- Fall hospitalization rates among older adults are significantly higher in urban and large town rural areas, like King County, compared to other areas of Washington.[5]
- In King County, 18 percent of Emergency Medical Services 911 calls from older adults are fall related incidents.[6]
- For adults 60 and older in King County, falls accounted for 72 percent of all injury hospitalizations in this population.[7]



ADS distributes magnets to elders at high risk of falling.

[2] Washington State Department of Health - The Health of Washington State, 2008.
[3] **Behavioral Risk Factor Surveillance Survey 2009-2013.**
[4] Washington State Department of Health - Research, Analysis & Data, November, 2013.
[5] Washington State Department of Health, Hospital Discharge, July 2013.
[6] Public Health: Seattle & King County, Division of Emergency Medical Services, 2013.
[7] Washington State Department of Health, Office of Hospital and Patient Data Systems, Hospitalization Discharge Data: 2008-2012.

- Although the rate of hospitalizations due to falls has declined in King County for adults age 60 and older since 2000, the number of hospitalizations for this age group increased 17 percent between 2000 and 2012, reflecting larger number of adults age 60 and older.[8]

Falling can lead to premature institutionalization

- Among Washington State older adults who were hospitalized for a fall in 2008, 53 percent were discharged to skilled nursing facilities for additional care.[9]
- In 2013, the total direct medical costs of fall injuries for people 65 and older, adjusted for inflation, was $34 billion.[10]
- In Washington State, the estimated costs for fall hospitalizations for adults 65 years and older was $473 million.[11]

ADS has successfully reduced falls among Russian and Ukrainian speaking SHAG residents.

Partnerships to Prevent Falls

Developing partnerships and supporting programs to prevent falls are key strategies in reducing healthcare and long-term care costs, promoting healthy aging, and supporting independence and aging in place.

Creating linkages and partnerships is critical to strengthening community responses to falls. Older adults need to be aware of their fall risk before a fall occurs, while healthcare providers need to be informed about available community programs and resources for patient referrals. At the same time, community systems and organizations must work together to increase awareness, coordination and support for vulnerable adults. Work is well underway to increase access and awareness of availability of evidence-based interventions. For more information, visit B-4: Non-AAA Services.

[8] Washington State Department of Health, Office of Hospital and Patient Data Systems, Hospitalization Discharge Data: 2008-2012.
[9] Washington State Injury and Violence Prevention Guide, January 2013, DOH 530-090.
[10] Stevens JA, Corso PS, Finkelstein EA, Miller TR. The costs of fatal and nonfatal falls among older adults. Injury Prevention 2006a;12:290–5.
[11] Washington Office of Financial Management, 2013.

C-2: Health Promotion, Disease Prevention, and Delay of Medicaid-funded Long-Term Services and Supports: Goal

Delay Medicaid-funded long-term services and supports by encouraging health promotion and disease prevention; increasing awareness about Alzheimer's disease, memory care and wellness **for older adults and adults with disabilities; and reducing the incidence of falls.**

C-2: Health Promotion, Disease, Prevention, and Delay of Medicaid-funded Long-Term Services and Supports: 2018–2019 Objectives

C-2-1: Community Living Connections & Family Caregiver Support Program

1. Integrate Community Living Connections marketing and communications plan into Age-Friendly communications planning.
   Goal: **2018–2019**—Marketing and communication plans are integrated.

2. Develop geographic hubs delivering Information Assistance/Referral, Options Counseling and Care Coordination in Seattle/North King County, South King County, and East King County.
   Goal: Region leads will conduct 6 networking meetings each year

3. Provide Person-Centered planning to individuals needing assistance with long-term support service planning.
   Goal: **2018**—400; **2019**—425

4. Provide cross-system training and meeting opportunities for CLC and FCSP providers to improve referral network, including resources for and working with priority populations (LGBTQ elders, rural elders, adults under 60 with disabilities).
   Goal: One event per year

5. Provide Family Caregiver Support Services to caregivers of African or African descent.
   Goal: Provide services at least 1.5 the rate of King County population of African or people of African descent annually

6. Provide TCARE® assessment and care plan to family caregivers who show moderate to significant caregiver burden.
   Goal: 800 per year

C-2-2: Alzheimer's, dementia, and memory care

7. Provide STAR-C training to caregivers to help caregivers manage behavioral symptoms of their care recipient with Alzheimer's disease or dementia.
   Goal: **2018**—5 clients; **2019**—5 clients

8. Partner with the Mayor's Council on African American Elders to conduct outreach on Alzheimer's and related dementias, and promote brain health and the importance of early detection.
   Goal: At least one community forum per year

9. Coordinate with partners, such as Public Health and Alzheimer's Association on implementing the Alzheimer's state plan with a focus on communities of color.
   Goal: **2018**—Develop an action plan with partners to increase awareness of Alzheimer's in King County. **2019** – Monitor and implement plan

C-2-3: Health Promotion

10. Conduct Chronic Disease Self-Management Education (CDSME) trainings for lay leaders in King County.
    Goal: One training per year

11. Coordinate quarterly network meetings for organizations offering CDSMP workshops in King County.
    Goal: **2018**—Four network meetings; **2019**—Four network meetings

C-2-4: Falls prevention

12. Increase awareness of fall risk, prevention, resources and access to fall prevention programs.
    Goal: At least one article per year and at least three falls prevention presentations annually.

13. Collaborate with fire departments, Emergency Medical Services, healthcare, and housing providers to strengthen the community infrastructure and ensure coordinated support for vulnerable adults.
    Goal: Make five presentations and/or trainings per year.

14. Provide falls prevention training for case managers and health care professionals on the recognition/identification of older adults at fall risk and appropriate referrals to programs and services.
    Goal: One training per year

Sources

- Behavioral Risk Factor Surveillance Survey, 2009–2013.
- Developing a Washington State Plan to Address Alzheimer's Disease, presentation by Lynne Korte, MPH, DSHS/ALTSA, to the Seattle-King County Advisory Council on Aging & Disability Services, accessed 6/26/15 at www.agingkingcounty.org/docs/2015_Focus-on-the-Future_WA-State-Alzheimers-Plan.pdf.
- Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2020 in Washington State, David Mancuso, PhD, August 2011, accessed 6/26/15 at www.wowonline.org/documents/ADSAAgeWave.pdf.
- Projections of Alzheimer's Dementia in Washington State, presentation by David Mancuso, PhD & Irinia Sharkova, PhD, Alzheimer's Working Group Meeting, November 12, 2014, accessed 6/26/15 at www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/AD/Forecasting%20Dementia%20-%20ADWG%20Meeting%20Presentation%20Nov%2012%202014.pdf.
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- Washington State Department of Health, Center for Health Statistics, Death Certificate Data.
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C-3: Service Integration & Systems Coordination

Health care reform in Washington

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 created opportunity for innovation in achieving the triple aim: Better Health. Better Care. Lower Cost.

In 2012, the State of Washington received Centers for Medicare and Medicaid Services (CMS) funding to develop an innovative integrated service delivery plan for beneficiaries who are eligible for Medicare and Medicaid ("dual-eligible"). The Washington State Health Care Authority and DSHS collaborated on two strategies for dual integration: Health Homes and Health Path Washington, a fully-integrated capitation model delivered through managed care organizations. While Health Homes was launched throughout the state, King County chose to participate in Health Path Washington. From 2013–2015, Aging and Disability Services (ADS) participated in planning sessions with the managed care plans and King County Regional Support Network and Public Health—Seattle & King County.

In 2015, the state discontinued implementation of Health Path Washington when one of the two managed care plans withdrew their participation; however, the collaboration and partnership-building provides a base for future integration efforts.

AAA experience with managed care

In 2006, ADS partnered with Harborview Medical Center and four community health systems to form King County Care Partners, a managed care pilot program that provided specialized intensive chronic care management for Medicaid fee-for-service clients. The goals of the program were to improve health outcomes, support health home development, and prevent avoidable medical costs by improving self-management skills.

In 2012, the Health Care Authority moved all Medicaid-only SSI blind and disabled clients to five managed care organizations (MCO) under the Healthy Options program (now called Apple Health). ADS was able to continue King County Care Partners by contracting with one MCO—Community Health Plan of Washington. ADS staff visit clients in the hospital and then in the community to prevent re-hospitalization. Transitional care services include post-discharge service coordination, medication reconciliation, problem-solving, care plan development, and follow-up to support self-management. Care coordination services include comprehensive assessment, ongoing consultation, cross-system coordination, individual and family support, referral to community and social support services, and help connecting to primary care.

ADS plans to continue working with MCOs through Apple Health and other new health reform initiatives or pilots.

Local health reform efforts

The state revealed the Washington State Health Care Innovation Plan in December 2013. The plan is guided by three core strategies: improve how we pay for services, ensure health care

focuses on the whole person, and build healthier communities through a broad collaborative regional approach. In 2015, the Center for Medicare and Medicaid Innovation awarded the State $65 million to implement their innovation plan, now called Healthier Washington.

As the State devised the Healthier Washington plan, King County also charted its course for health and human services transformation by 2020. The King County Transformation Plan looks at affecting both the individual/family and the community through strategies designed to improve access to person-centered, integrated, culturally competent services and improve community conditions where people live, work, learn, and play.

A strategy of both Healthier Washington and King County Transformation Plan is creating an Accountable Community of Health (ACH). The State recognized that innovation and collaboration are already occurring in local communities with public and private entities working together on shared health goals. During the span of this Area Plan, ADS will collaborate and align with Accountable Community of Health goals, ensuring that AAA initiatives such as Community Living Connections and Chronic Disease Self-Management are integrated into the structure. ADS has a seat on the ACH governing board and participates in workgroups..

Care transitions and beyond—complex client coordination

Coordination of care and services is vital to Seattle-King County older adults and those with disabilities who are discharged from the hospital or skilled nursing facility to the community. Medical facilities are penalized for unnecessary readmissions while most of a person's care is in the community. ADS works with community partners to provide an overview of services and supports, and to help integrate the services and supports into the transitions across settings. ADS supports person-centered planning so patients are empowered to be active members of their health care team.

ADS' experience with chronic care management, managed care, caring for over 10,500 complex clients in-home, and coordinating an aging and disability network positions the AAA to coordinate activities between the health care system and community. ADS is active in a variety of groups convened to address coordination, including:

- **Mobile Integrated Health-Community Paramedics**: This statewide group led by Department of Health includes more than 25 healthcare industry organizations and community partners—fire chiefs, health plans, Home Care Association of Washington, King County Medic One, University of Washington School of Medicine, Washington Ambulance Association, Washington State Council of Firefighters, Washington State Department of Health, Washington State Health Care Authority, Washington State Hospital Association, and Washington State Nurses Association.
- **King County Vulnerable Population Strategic Initiative**: Work is underway to ensure that King County residents receive the best possible emergency services regardless of age, race, ethnicity, socioeconomic status, gender, culture, or language spoken. The initiative focusses on three EMS components: dispatch service, on-scene service, and after-care community service. Under this initiative, ADS has pilot-tested a collaboration with Seattle Fire Department (SFD) to work with older adults experiencing abuse and neglect. During a nine-month period ending in June 2015, the AAA responded to 223 referrals and followed up with feedback to the SFD referents.
- **Caring Beyond Healthcare**: in partnership with Qualis Health, ADS is working with local hospital such as Harborview, MultiCare, and Valley Medical to address the social

determinants of health (SDOH). The hospitals will screen for SDOH to help make referrals to Community Living Connections.

These groups work to improve EMS services and transitions of care among hospital, skilled nursing facility, and community providers and caregivers. Recent data indicates that the South King County community is improving their hospital admissions and re-hospitalizations. Since 2012, the data show a 10 percent improvement in all-cause re-hospitalizations for Medicare recipients. Although the trend lines look positive, continued effort and coordination is needed to continue reduction of avoidable hospitalizations.

More than 300 participated in Care Transitions: We're All In It Together Conference on May 10, 2017. Photo by Lorraine Sanford.

In addition to participating in workgroups and pilots, ADS plays a convening role in the community. For example, since 2011, ADS has coordinated six community-based care transitions conferences and expects to facilitate annual conferences in the future. The conferences relate to health care quality as well as issues related to care transitions. Community partners, family caregivers, patients, professionals providing direct care services, leaders of community-based agencies, including hospitals, skilled nursing facilities, home health care agencies, and home care provider agencies attend the conferences. The 2016 conference drew nearly 250 participants from more than 75 organizations. The 2017 conference saw continued growth; 300 participants from over 80 organizations attended this one day conference.

In King County, the biggest challenge the AAA has in implementing strategies for change is working with vast health and community systems and a multitude of initiatives. King County has 12 hospitals and health systems, several with multiple campuses; more than 60 skilled nursing facilities; and hundreds of community-based health and human services provider organizations. Challenges in this environment include accountability, alignment of ongoing initiatives, staff continuity in planning meetings, and constant education of services and supports.

Strategies to address the challenges include active participation in bigger health care reform efforts such as the Accountable Communities of Health. The AAA can also continue to be a convener of health and community organizations. Last, the AAA can use its Community Living Connections network to educate the health system on community-based services and create competency within the network on health outcomes. In 2015, ADS collaborated with the University of Washington on the Northwest Geriatric Workforce Enhancement Center grant. A component of the grant is to establish a new community-based role (primary care liaison) and function to link primary care to the community.

Elder justice coordination

Preventing elder abuse is an important issue to consider in systems coordination and health reform. A startling number of elders continue to face abusive conditions. Every year an estimated five million older adults (one in ten individuals age 60-plus) experience abuse, neglect, or exploitation, and many experienced it in multiple forms.

The incidence of elder abuse in America is so pervasive that the Centers for Disease Control and Prevention now consider it a major public health problem. Elders who experience abuse have a 300 percent higher risk of death when compared to those not abused. In addition, abused elders have more health care issues, including increased bone or joint problems, digestive problems, depression or anxiety, chronic pain, high blood pressure, and heart problems. Elder abuse is also associated with increased rates of hospitalization. Those who had experienced abuse are twice as likely to be hospitalized as other elders.

The AAA has played a significant role in supporting elder abuse prevention and awareness for the community. In 2011, the AAA partnered with the King County Prosecuting Attorney's Office to pilot a much-needed program that filled a gap of advocacy and service coordination for survivors of elder abuse, neglect and exploitation. A designated case manager provided safety planning, information and assistance, service referrals, court accompaniment, coordination of services, and personal advocacy. The pilot ended in 2013, but the ADS Advisory Council has continued to support the work by allocating 1.0 FTE in the base budget. In 2014, the elder abuse program served 81 older adults experienced abuse.

Although King County has one of the finest elder abuse prosecuting teams and many trained law enforcement partners, there is still a need for awareness and training. Lack of training affects community-wide response to elder abuse. Law enforcement, first responders, city prosecutors, judges, social service providers, and medical professionals need training and re-training to understand the nature and scope of elder abuse in order to recognize signs, report appropriately, and coordinate effectively with victim services.

C-3: Service Integration & Systems Coordination: Goal

Integrate Aging and Disability Network services with other health and human services systems for better health and better care at a lower cost.

C-3: Service Integration & Systems Coordination: 2018–2019 Objectives

1. Participate in the King County Accountable Communities of Health.
   Goal: **2018**—2019: a) Attend monthly governing board meetings and report key information back to ADS leadership and Advisory Council; b) keep community partners informed about ACH activities at least four times per year.

2. Coordinate with health care providers, hospitals, and community partners on an annual event or forum.
   Goal: 2016–2019: One annual conference

3. Participate in multi-stakeholder collaborations that strive to improve health outcomes and reduce unnecessary EMS and Emergency Department use.
   Goal: **2018**—Provide case management to 60 clients involved in the low-acuity alarm program.

4. Increase county-wide access and awareness of elder abuse, neglect, and financial exploitation.
   Goal: **2018—2019** a) Provide case management to 100 elder abuse clients; b) Help develop an online training module for first responders for continuing education program and train two fire departments.

5. Strengthen connections with prosecutors, law enforcement, and first responders to better coordinate a response for older adult victims of abuse and neglect.
   Goal: **2018**—Develop a strategy to fund a multi-disciplinary team who meets regularly to staff cases; **2019**—Formalize a multi-disciplinary team to staff cases.

6. Increase awareness of Community Living Connections in the primary care health system.
   Goal: **2016–2018**—Primary care liaison will complete four outreach visits to clinics per month.

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C-4: Native Americans

Muckleshoot elder
Doris Allen.
Photo by John Loftus.

Aging and Disability Services is working to address the health and social needs of Native Americans age 60 and older—including Indians, Eskimos and Aleuts—who live in King County.

Of the 1.9 million people living in King County, 39,117 (two percent) identify as American Indian/Alaskan Native (AI/AN) alone or in combination with another race. It is estimated that 1.4 percent (5,174) of the King County population age 60 and older is all or part American Indian/Alaska Native, though this population has been shown to be undercounted. See B-1: Population Profile and Trends.

The American Community Survey (2009–2013) estimates that 669 individuals speak a Native North American language in King County, including American Indian and Alaska Native languages. Of those individuals, seven percent speak English less than "very well." Persons 65 years of age and older account for 5.8 percent of AI/AN in King County, compared to 10.9 percent of the general population.

Urban Native Americans


Statue of Chief Seattle at Tilikum Place, a small park at 5th & Denny in downtown Seattle. City of Seattle Archives photo.

Beginning with the federal relocation program and continuing through the decades following, AI/ANs from more than 100 tribes and Alaska villages migrated to King County, primarily Seattle. In addition, there are a large number of Canadian Indian or First Nations people who are part of the urban Indian community.

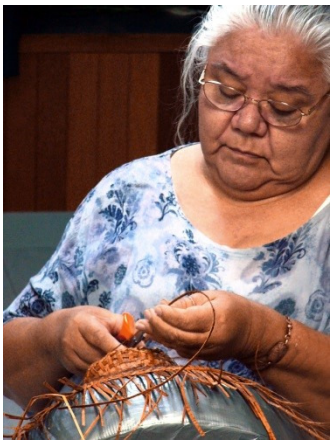
In 1970, two organizations were formed to provide social and health services—United Indians of All Tribes and the Seattle Indian Health Board. During the 1990s, the Seattle Indian Health Board served individuals from more than 200 tribes.

AI/AN people in King County are more likely to be poor, with 24 percent living in poverty, as compared to just 10.2 percent of the general population. American Indians and Alaska Natives living in cities face poverty, unemployment, disability and inadequate education at rates far above other populations. These and other risk factors have contributed to a health crisis in this population despite an ongoing effort to eliminate health care disparities across all races and ethnicities.

Duwamish Tribe
The people known as the Duwamish Tribe are descendants of Chief Seattle. Their ancestral homeland includes the cities of Seattle, Mercer Island, Renton, Bellevue, Tukwila, and much of King County. The Duwamish have about 600 enrolled members.

For decades, Duwamish tribal members have fought for federal recognition but courts have denied their petitions. In the absence of federal recognition, funding, and human services, Duwamish tribal services have struggled to provide social, educational, health and cultural programs. Recognized status would provide access to many federal benefits, including fishing rights and healthcare.

7.01 Implementation Plans



Muckleshoot elder Leah Moses. Photo by John Loftus.

In addition to a large urban Indian population in the greater Seattle area, there are also two federally recognized tribes within King County: the Muckleshoot Indian Tribe and the Snoqualmie Indian Tribe.

In compliance with the Washington State 1989 Centennial Accord and current federal Indian policy, 7.01 plans are created in collaboration with Recognized American Indian Organizations in the planning of the Washington Department of Social and Health Services and Area Agencies on Aging (AAA) service programs, to ensure quality and comprehensive service delivery to all American Indians and Alaska Natives in Washington state. **The plans address concerns identified by tribal members, identify tribal leads and AAA staff, action steps to address each concern, and provide a yearly summary of the progress.**

Muckleshoot
The Muckleshoot Indian Tribe comprises descendants of the Duwamish and Upper Puyallup. The 2000 Census reported a resident population of 3,606 on reservation land, of which 29 percent reported solely Native America heritage. Of these, approximately 600 are age 60 and older. Aging and Disability Services has collaborated with Muckleshoot tribal members on 7.01 Implementation Plans since 2005.

Policy 7.01 Implementation Plan (Muckleshoot Indian Tribe)

Snoqualmie
The Snoqualmie Indian Tribe comprises approximately 500 members. Of these, approximately 125 are age 60 and older. The tribe lost federal recognition in 1953, but regained Bureau of Indian Affairs recognition in 1999. This allowed the tribe to develop the Snoqualmie Casino, which financially supports services and resources for tribal members and the local community. Today, many live in Snoqualmie, North Bend, Fall City, Carnation, Issaquah, Mercer Island and Monroe.

Policy 7.01 Implementation Plan (Snoqualmie Nation)

Both 7.01 Implementation Plans are available among the Appendices to this plan.

C-4: Native Americans: Goal

Ensure greater success for Native American elders in King County.

C-4: Native Americans: 2018–2019 Objectives

1. Strengthen ADS ability to serve community groups that have not been served previously (i.e., urban Native Americans)
   Goal: **2018–2019**—Connect the Seattle Indian Health Board to the Community Living Connections network, with at least one meeting per year.

2. Collaborate with social and health services organizations that serve Native American elders on yearly in-service trainings.
   Goal: Participate in at least one in-service training per year.

3. Continue 7.01 Implementation Plan collaboration with federally recognized tribes in King County.
   Goal: **2018–2019**—Conduct at least two 7.01 update meeting annually.

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C-5: Medicaid Transformation Project Demonstration

The Medicaid Transformation Demonstration (MTD) is part of Healthier Washington and will transform the delivery system for the 25% of Washington's population served by Medicaid, engaging and supporting Apple Health clients, providers, and communities in achieving improved health, better care, and lower costs.

The demonstration has two main long term services and supports components:

1. Medicaid Alternative Care (MAC) – will assist unpaid caregivers in getting supports needed to avoid or delay the need for more intensive Medicaid-funded services. This is a benefit package for individuals who are eligible for Medicaid, but not currently enrolled in Medicaid-funded long term services and supports (LTSS).

2. Tailored Supports for Older Adults (TSOA) – is a new eligibility category and benefit package for people "at-risk" of future Medicaid LTSS use, but do not meet Medicaid financial eligibility criteria. It will provide a limited set of services an supports to help individuals avoid or delay the need for Medicaid-funded services.

MAC and TSOA include the following benefits:

1. Caregiver Assistance Services
2. Training and Education
3. Specialized Medical Equipment & Supplies
4. Health Maintenance & Therapies
5. Personal Assistance Services (TSOA only)

ADS contracts with a network of eleven Community Living Connections & nine Family Caregiver Support Program agencies who represent the diversity of communities throughout King County. These agencies represent over twelve various languages and cultures and are valuable resources for their communities. The network staff will serve as a front door service providers where individuals will be pre-screened for MAC, TSOA, as well as Family Caregiver Support Program services. Individuals who appear eligible will be referred to ADS where the Medicaid Transformation Demonstration (MTD) Program case managers will determine presumptive eligibility. The ADS Discretionary Case Management programs will also serve as an entry point for MAC & TSOA.

C-5: Medicaid Transformation Project Demonstration

Delay Medicaid-funded long-term services and supports by offering new services to support family caregivers, help people to stay at home, and delay or avoid the need for more intensive care.

C-5: Medicaid Transformation Project Demonstration: 2018–2019 Objectives

1. Implement the Medicaid Transformation Demonstration by engaging new family caregivers and other individuals who are potentially eligible for the new programs and services.
   Goal: 2017: 94; **2018**: 696; **2019**: 1,408

C-6: Livable Communities

In devising this Area Plan, ADS conducted a wide variety of community outreach and engagement events and activities in 2014 and early 2015 (see A-3: Planning and Review Process). The most frequent themes heard were:

- Health and wellness
- Housing
- In-home assistance
- Income/financial assistance
- Safety
- Socialization
- Transportation

These can be summed up as the desire for "livable communities."

The greater Seattle region has many strengths. It is acknowledged by the general population as a great place to grow up and live. By reducing physical and social barriers to aging in place; promoting creative ways for older adults to maintain, share, and grow their talents, skills, and experiences; and ensuring livable communities for all ages, Seattle-King County can also be a great place to grow old.

Characteristics of a livable community

According to the World Health Organization (WHO), cities that encourage active aging and enhanced quality of life share eight domains of livability:

1. Outdoor spaces and buildings
2. Transportation
3. Housing
4. Social participation
5. Respect and social inclusion
6. Civic participation and employment
7. Communication and information
8. Community support and health services

In 2016, the City of Seattle joined the AARP Network of Livable Communities, an affiliate of the WHO Global Network of Age-Friendly Cities and Communities. In 2017, Seattle's Mayor and City Council passed Age Friendly Seattle Resolution 31739, which formalized Seattle's commitment to become a more age-friendly city in each of the domains of livability listed above.

Aging and Disability Services has been charged with managing Age Friendly Seattle—carrying out the early actions outlined in the resolution and crafting an action plan through the year 2021. Aging and Disability Services is a resource for any community in King County wishing to become more age-friendly.

Related AAA Programs, Services & Partnerships

Coordinated Response to Abuse, Neglect & Exploitation

Housing Development Consortium

King County Mobility Coalition

Northwest Universal Design Council

Older Americans Month

Puget Sound Regional Council Special Needs Transportation Committee

Senior Centers

Senior Coffee Hours

Senior Community Service Employment Program

For more information, visit:

Age-Friendly Communities

www.agingkingcounty.org/what-we-do/age-friendly-communities/

Age Friendly Seattle

www.seattle.gov/agefriendly

Trends and challenges

The Green Way to Travel in Your Neighborhood (AgeWise King County, May 2015). Seattle Department of Transportation photo.

- The need for affordable housing in King County greatly surpasses the supply. An additional 936 subsidized housing units need to be created each year until 2025 just to maintain the current ratio of affordable housing to less-affluent older adults.
- A higher percentage of King County residents age 65 and older pay more than 30 percent of their income for housing, as compared to U.S. residents of the same age.
- A higher percentage of King County residents age 65 and older use public transportation than U.S. residents of the same age.
- Older adults outlive their ability to drive safely by an average of 7–10 years.
- Older adults will choose to age in place rather than relocate to retirement facilities or communities where access to services is more convenient.
- Individuals with limited mobility have difficulty accessing basic needs, including food, employment and health care, and face inactivity, social isolation, and exclusion.
- The monthly housing costs for elder homeowners without a mortgage in King County typically exceeds $600/month. On average, elders with a mortgage pay $1,617/month.
- Social Security is the only source of income for about three in ten Washingtonians age 65+.
- The Elder Economic Security Standard Index for Seattle-King County shows that monthly household expenses greatly exceed the average Social Security benefit. Elders in poor health have even more difficulty meeting the cost of living in the greater Seattle area.
- Many Seattle-King County residents will not have the resources they need to cover basic needs and healthcare expenses in their retirement.
- Loneliness and social isolation are a threat to longevity. Lack of social relationships influences the risk of death comparable to well-established mortality risk factors such as smoking and alcohol consumption, and exceeds the influence of other risk factors such as physical inactivity and obesity.

C-5: Age-Friendly Communities: Goal

Promote/develop a regional framework to increase awareness about the aging population; and influence municipalities, stakeholders, policy and decision makers, and consumers to prepare their communities for the aging population; and encourage people of all ages to keep moving and stay connected.

C-5: Livable Communities: 2016–2019 Objectives

C-5-1: Housing

1. Update existing housing data and reports to advocate for expansion of affordable, accessible housing including development of alternative housing for aging in place.
   Goal: Update Quiet Crisis: Age Wave Maxes Out Affordable Housing, King County 2008-2025 by 2017

2. Provide education about the benefits of Universal Design (UD) and promote the inclusion of UD principles in capital construction programs by facilitating the Northwest Universal Design Council and coordinating public program meetings.
   Goal: 4+ events per year

3. Utilize websites, newsletter, and social media to promote community-based options for home repair, weatherization, and conservation that can help older adults live more comfortably and save money.
   Goal: 12+ posts per year

C-5-2: Community Mobility

2. Advocate/work to increase options and funding for older adult transportation programs such as the Hyde Shuttle.
   Goal: Ongoing

3. Promote community design that supports mobility, such as public transportation, walking, and bicycling.
   Goal: 1+ forums each year

C-5-3: Economic Security

1. Participate in public education and marketing campaigns to promote individual savings for later life.
   Goal: Ongoing

2. Encourage hiring and retention of older workers, allowing them to work and save longer, by promoting age 55+ employment programs and training opportunities.
   Goal: a) 2 employment fairs per year; b) 200 older adults employed through ADS funded employment programs

C-5-4: Social and Civic Engagement

1. Advocate for increased funding for senior centers and related services to reduce social isolation.
   Goal: Ongoing

2. Utilize current technology to enhance access to aging information, programs and services as well as social and civic engagement for older adults.
   Goal: 50+ posts per year

New Objectives

1. Provide leadership for age-friendly communities throughout King County.
   Goal: 2018-2019 - One city or community added to the network of age-friendly cities.

2. Implement the Age Friendly Action plan.
   Goal: Regular reports on progress to key stakeholders including Advisory Council, City Council, and the Ag Friendly Taskforce.

3. Develop materials and training to support best practices for communication, events, and meetings.
   Goal: 2018-2019 a) 2 publications posted online and shared with local government and community partners; b) 2 trainings for staff and partners.

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