# Stakeholder Review Draft

# Area Plan 2027-2030

The Area Plan 2027–2030 for Seattle and King County is the Aging and Disability Services (ADS) roadmap for a comprehensive system of services that promote quality of life, independence, and choice for older people, adults with disabilities, caregivers, and their family members. Draft goals, objectives and strategies were informed by engagement with community members, staff and stakeholders; as well as research and data analysis across multiple sources.

**We want to hear from you!** Please take a moment to share your thoughts**.** Learn more at AgingKingCounty.org/areaplan/.

## our vision & mission

**ADS Vision:** Black, Brown, Indigenous, Latin, and Asian communities of color experience equitable health and quality of life, so all people thrive at every stage of life.

**ADS Mission:** ADS builds and strengthens systems that ensure equity, mutual respect, and access to resources for older adults, people with disabilities, and their caregivers.

## our partners

As the Area Agency on Aging (AAA) for Seattle and King County, ADS priorities are guided by the Seattle-King County Advisory Council on Aging & Disability Services and by AAA partners—Seattle Human Services Department, King County Department of Community and Human Services, and Public Health—Seattle & King County. In addition to our contracted, intergovernmental, and advisory partners, ADS works with a vast network of non-profit, public and private partners spanning housing, education, transportation, legal, and other health and human services sectors.

## our services

ADS invests federal, state, and local funds to deliver more than 20 different services to older people, adults with disabilities, and caregivers. Services for 2027-2030 will include:

- Adult Day Services
- Age Friendly Communities
- Brain Health and Dementia Support *new*
- Caregiver Support
- Care Transitions
- Case Management
- Community Living Connections
- Elder Abuse Prevention
- Health Promotion
- Health Related Social Needs (HRSN) *new*
- Legal Services
- Mental and Behavioral Health *new*
- Mobile Integrated Health
- Minor Home Repairs
- Nutrition Services
- Nursing Services
- Senior Centers
- Senior Drug Education
- Transportation
- WACares *new*
- Workforce Enhancement Program

# Issue Area 1: Greatest Economic and Social Need[1]

## *Communities in greatest economic and social need experience equitable health and quality of life*

### Goal 1: Ensure that services and decision making are accessible to communities in the greatest economic and social need.

Objective: Coordinate with and support outreach of aging network providers as representatives of the AAA in the community.

a. Update a suite of user-friendly and translated materials (brochures, social media posts, one-pagers) to support partner agencies in their outreach efforts.
b. Develop a workflow for sharing and coordinating outreach with various community partners.
c. Provide materials and training on program specifics to community partners.

Objective: Prioritize language access in all outreach materials, events, and staff representation.

a. Create an inventory of existing public-facing materials and communications assets and identify gaps.
b. Translate materials into languages of communities in greatest economic and social need.
c. Create a policy and ongoing budget for providing in-person interpretation services at events.

Objective: Strengthen recruitment and engagement for ADS's Advisory Councils as representatives to the community.

a. Establish best practices for recruiting, compensating, and retaining Advisory Council members.
b. Conduct targeted outreach to recruit Advisory Council members who represent the diversity of the communities served.

[1] The Older Americans Act requires Area Agencies on Aging (AAA) to prioritize specific criteria in the planning and coordination of services. Greatest economic need is need resulting from an income level at or below the Federal Poverty Level and based on local and individual factors such as cost-of-living expenses. Greatest social need is need caused by non-economic factors, including but not limited to disability; language barriers; and cultural, social and geographic Isolation. Black, Indigenous and People of Color (BIPOC) communities continue to be identified as particularly vulnerable to economic and social disparities. This lens is applied across all Area Plan Issue Areas.

# Issue Area 2: Healthy Aging

## *People enjoy optimal health and longevity in a vibrant, age-friendly community*

### Goal 1: Improve the social, physical, mental, and emotional wellbeing of older adults, people with disabilities and caregivers.

Objective: Ensure older adults have access to nutritious, culturally relevant meals.

a. Increase awareness about congregate meals.
b. Deploy creative methods to keep pace with evolving needs and new vulnerable populations.
c. Expand access to culturally relevant food services.
d. Support the integration of nutrition programs with Washington's local food system.

Objective: Strengthen community connection to trusted, culturally appropriate gathering spaces for healthy meals, social engagement opportunities, and social services.

a. Invest in and support Senior Centers to offer programming and access to services to meet the increasingly complex needs of clients.
b. Collaborate with King County and others to create stability across the network of senior centers.
c. Support community-based organizations and partners offering gathering spaces and activities to be accessible and culturally inclusive through sponsorship, technical assistance, promotion and similar approaches.

Objective: Ensure that people living with memory loss and their caregivers receive adequate support in a welcoming community.

a. Align local investments with state dementia goals and strategies.
b. Expand programs and services for people living with memory loss and their caregivers.

### Goal 2: Improve the affordability, accessibility, and livability of Seattle and King County for older adults and people with disabilities.

Objective: Support the advancement of age-friendly initiatives within our region.

a. Advocate for better housing affordability for both homeowners and renters.
b. Encourage the availability of homes and public spaces designed for age-inclusivity.
c. Engage business communities with age-friendly initiatives, including offering discounts to older adults and people with disabilities.
d. Support transportation options that promote safe, effective and inclusive access to essential services and social activities.
e. Support community education and dissemination of funding opportunities addressing digital access, digital literacy and scam prevention.

# Issue Area 3: Aging in Place

## *People have the services and supports they need to age in their home or community of choice*

### Goal 1: Strengthen availability and coordination of in-home and community-based services and supports.

Objective: Facilitate community-informed and community-driven housing adaptability and support.

a. Expand CAPABLE program capacity to support the functionality, mobility, and capacity of older adults to age in place.
b. Work with community partners to implement new home modification, remediation and adaptation services available to older adults and adults with disabilities through Health-Related Social Needs (HRSN) services and WACares.

Objective: Support vulnerable patients through hospital transitions to prevent readmission

a. Conduct an evaluation of local hospital needs.
b. Establish referral and caseload goals that match local program operation capacity to local hospital needs.
c. Integrate Presumptive Eligibility in Care Transitions program to support streamlined client access to Long Term Services and Supports (LTSS).

Objective: Improve the ability of housing and shelter providers to serve older adults and adults with disabilities

a. Work with regional housing authorities, supported housing providers and King County Regional Homelessness Authority to coordinate delivery of supportive services to older adult and adult with disability tenants in need or at risk of homelessness
b. Coordinate training and resource sharing with shelter provider staff on aging and disability related needs and support.

Objective: Increase awareness of elder abuse among community providers, including what to look for, referral resources, and how to help clients prevent being victimized.

a. Develop a comprehensive elder abuse outreach plan, including both prevention and victim referrals.

Objective: Strengthen capacity to support clients with complex medical and behavioral health needs.

a. Work with a Behavioral Health consultant to develop and deliver training and case staffing on advanced behavioral health topics.
b. Partner with the University of Washington Geriatrics Workforce Enhancement Program (GWEP) to host regular training for AAA and partner staff on complex health topics.

c. Advocate for easier identification and transfer of 911 calls to Mobile Integrated Health (MIH).
d. Deliver outreach and education to community providers who are frequently in contact with existing or potential MIH clients about how to request help.

### Goal 2: Advance the development of unified systems that support people to make informed choices about aging in place.

Objective: Improve communication and resource sharing across systems serving older adults, adults with disabilities, and their families.

a. Support statewide adoption of service models and technology solutions that promote cross-system coordination and visibility of resources.
b. Establish and maintain strategic partnerships with organizations serving adults with disabilities and justice-involved organizations to improve coordination with Community Living Connections and other aging and disability network programs.
c. Deliver training, education and consultation to healthcare professionals and clinical trainees.

Objective: Strengthen processes to ensure a coordinated, comprehensive service delivery network.

a. Research network adequacy tools used by funders, health plans, and governments to inventory and identify service gaps.
b. Develop a tool, criteria and corresponding process that can be applied regularly across AAA programs to inventory and identify service gaps, including BIPOC-led/owned service providers, language access and geographic coverage.

### Goal 3: Strengthen AAA ability to meet rising demands and sustain operations.

Objective: Establish practices that maintain high-quality service, maximize resources and streamline operations.

a. Implement alignment of caseloads across ADS and partner agencies to achieve sustainable caseloads at or below Home and Community Living Administration (HCLA) standard.
b. Implement geographic case assignments where clients are densely located, where possible limiting assignments to only one agency to support elements of the Coordinated Personal Care (CPC) model.
c. Continue efforts to adopt process improvement and evaluation practices across AAA units and investments.

Objective: Develop a strong workforce through training, mentorship and external system partnerships.

a. Develop a leadership academy program to prepare AAA staff for leadership and advanced skill roles.
b. Deepen and solidify partnerships with schools of medicine, social work, nursing, law, and public health, as well as geriatrics fellowship programs. Integrate trainees into AAA programs, including the Elder Abuse Multidisciplinary Team (MDT).

Objective: Advocate for vital policies, funding and benefits that support dignity, health and wellbeing.

a. Collaborate with AAA Councils and Legal Services partners to monitor, evaluate and comment on policies, programs, levies and community actions that affect older adults, people with disabilities and caregivers.
b. Coordinate with local and regional aging advocacy groups and coalitions to amplify community voices.
c. Support provider networks in funding advocacy and sustainability, with particular emphasis on Nutrition, Caregiver and Senior Center services.

# Issue Area 4: Caregiving

## *A thriving caregiver workforce maintains their own well-being while providing support for others*

### Goal 1: Support direct care providers to deliver and sustain timely, quality in-home care services.

Objective: Promote innovative service delivery models and statewide policies that address care worker recruitment, training, retention and service provision.

a. Participate in a state workgroup to promote the adoption of a coordinated-personal-care (CPC) model in which home health aides have client assignments in geographic clusters.
b. Increase the visibility of direct care workforce value, issues and opportunities through advocacy and active engagement in regional groups, events, and initiatives.

Objective: Optimize utilization of all appropriate care delivery models.

a. Develop resources to support AAA staff in sharing options with clients, including remote caregiving, adult day services, etc.
b. Deliver regular training to AAA and partner staff on the types of support that can be received.
c. Maintain awareness of emerging cooperative and village development organizations and support dissemination and listings in local directories as appropriate.

### Goal 2: Improve coordination and dissemination of support for family and kinship caregivers.

Objective: Implement service delivery improvements for FCSP and MAC/TSOA that ensure family caregivers can access timely and culturally responsive support.

a. Work with Mayor's Council on African American Elders (MCAAE) and other partners to ensure continuity of caregiver services tailored to African American caregivers following the African American Elders program transition.
b. Partner with Family Caregiver Support Program Tailored Caregiver Assessment and Referral (TCARE) and Respite Coordination agencies to establish new workflows that maximize system capacity and ensure caregivers experience seamless transition of services.

c. Actively participate in state-led meetings and workgroups related to Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) future planning (including waitlist, waiver renewal, and coordination with HRSN) and to represent the interest of the AAA and its contracted agencies.

Objective: Expand educational opportunities available to help caregivers with coping, skill-building and awareness of services and supports available.

a. Recruit and maintain a strong base of diverse, culturally relevant community partners to provide caregiver training and peer support across ADS caregiver programs.
b. Partner with community organizations to sponsor, promote or host community events, with particular focus on caregivers of color.
c. Identify and coordinate with employers to support resource sharing with employees who are also caregivers.

Objective: Utilize communications and branding designed to reach family and kinship caregivers

a. Update communications materials to better reflect caregiver needs including images and tailored in-language messaging
b. Evaluate current web-presence and update web-based hubs to ensure that caregivers can easily find information about resources, services, and upcoming events
c. Coordinate AgeWise King County articles that provide information about issues relevant to caregivers and support services.

# Issue Area 5: Partnerships with Tribes and Urban Native Organizations

## *Collaborative intergovernmental relationships and partnerships center the experiences of Tribal members and urban Native communities*

### Goal 1: Ensure services are accessible and culturally relevant through strengthened relationships with Tribal and urban Native communities.

Objective: Strengthen internal capacity to support culturally responsive, Tribal- and Native-informed and coordinated engagement, planning, and service delivery.

a. Provide ongoing training for AAA staff on Tribal history, values, priorities, sovereignty, government-to-government relationships, and culturally respectful engagement. Support staff to integrate learnings from the training and Tribal-led guidance into their work, engagement, and service practices.
b. Identify and connect appropriate staff with Tribal and urban Native partners to support their priorities and help them access needed services and resources for Native elders.

c. Enhance awareness, accessibility, and cultural relevance of AAA services for Tribal and urban Native communities through partnership-based, Tribal/Native community-informed outreach and engagement.

Objective: Strengthen cross-departmental and cross-system coordination and alignment.

a. Participate in the City of Seattle's Tribal Coordination Workgroup and collaborate with other City partners to align approaches, reduce fragmentation, and integrate Tribal and urban Native community priorities into broader City and department initiatives.
b. Support continued connections between ADS Advisory Council and Indigenous Advisory Council

### Goal 2: Ensure ongoing, accountable collaboration and coordination with Tribal Nations, Washington Department of Social and Health Services, and other Washington State AAAs through 7.01[2] planning.

Objective: Align Tribal priorities with AAA programs, maintaining compliance with planning and reporting requirements, and integrating continuous improvement through progress tracking and Tribal feedback.

a. Sustain consistent, relationship-centered collaboration with Tribal Nations (Cowlitz, Muckleshoot, and Snoqualmie) and partners through regular communication and participation.
b. Strengthen coordinated emergency preparedness and referral systems between AAA and Tribal services.
c. Improve cross-jurisdictional coordination to address service access and gaps for Tribal members (Cowlitz, Snoqualmie) across counties.

[2] Washington State Administrative Policy 7.01 requires Area Agencies on Aging (AAAs) to develop formal plans that outline coordination with recognized Tribes within their Planning and Service Area. Completed 7.01 plans address concerns identified by Tribal members, identify Tribal leads and AAA staff, establish action steps to address each concern, and provide a yearly summary of the program.