2027-2030 Area Plan

CLALLAM-GRAYS HARBOR-JEFFERSON-PACIFIC

DRAFT

Aging & Adult Services OF COASTAL WASHINGTON

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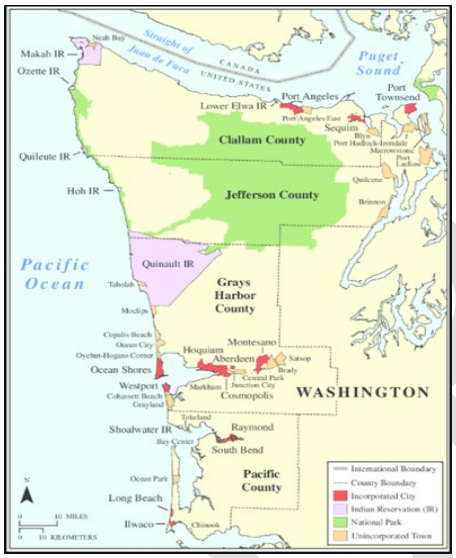
AREA PLAN 2027-2030

1. EXECUTIVE SUMMARY

Across Coastal Washington, people share a common hope as they age—to remain connected to their communities, make their own choices, and live safely and independently in the place they call home. For more than 50 years, Aging & Adult Services of Coastal Washington (AASCW), formerly the Olympic Area Agency on Aging, has partnered with older adults, adults with disabilities, family caregivers, Tribal Nations, local governments, healthcare providers, nonprofit organizations, and community partners to help make that vision a reality. Designated in 1976 by the Washington State Unit on Aging as one of Washington's 13 Area Agencies on Aging (AAAs), AASCW serves as a trusted convener, planner, and advocate, bringing people and resources together to strengthen the network of services that helps individuals age with dignity, purpose, independence, and connection.



AASCW serves a diverse and predominantly rural four-county region stretching along Washington's Pacific Coast, from the Strait of Juan de Fuca to the Columbia River. The region is defined by remarkable natural beauty, resilient communities, and a strong tradition of neighbors supporting one another. At the same time, its geography presents unique challenges. Long travel distances, limited transportation infrastructure, severe weather, flooding, and communities connected by a single highway can make access to essential services difficult. Many communities are designated by the U.S. Department of Agriculture as food deserts, while the entire region experiences federally designated shortages of primary, dental, and behavioral healthcare providers. These overlapping challenges make strong community partnerships and coordinated local services essential to supporting residents where they live.

Our region is also home to the oldest population served by any Area Agency on Aging in Washington. More than half of all residents (51.2%) are age 50 or older, and 34.5% are age 65 or older, above the national average of approximately 18%. Three of Washington's five oldest counties are located within AASCW's service area, including Jefferson County, where 44% of residents are age 65 or older, the highest proportion in the state and among the highest in the nation. Several communities, including Brinnon, Ocean Shores, Sequim, and Long Beach, have evolved into naturally occurring retirement communities (NORCs), reflecting the region's

longstanding appeal as a place to live and age. Unlike many areas that are preparing for an aging population, Coastal Washington is already experiencing this demographic reality. As a result, AASCW's focus is on strengthening systems of care that support an established older population with increasingly complex health and social needs.

Alongside these demographic trends, many residents face persistent barriers to health and well-being. Higher rates of poverty, disability, chronic disease, and social isolation intersect with limited access to affordable housing, transportation, healthcare, and nutritious food. Healthcare workforce shortages often delay preventive care, increasing reliance on emergency services and institutional care while highlighting the critical role of coordinated community-based supports.

Recent changes to federal and state safety-net programs have intensified these challenges. Reductions in food assistance and healthcare programs, combined with state budget constraints, are expected to continue through at least 2030. The effects are already visible across the region, with participation in the Emergency Food Assistance Program (EFAP) increasing by 10.92% and distributions through The Emergency Food Assistance Program (TEFAP) increasing by 11.36% between 2024 and 2025. Food insecurity remains one of the most significant drivers of health outcomes in our communities. At the same time, growing recognition of Health-Related Social Needs (HRSNs) and rural health equity at both the state and national levels present new opportunities to better integrate healthcare with community-based services and improve outcomes for older adults and families.

Meeting these evolving needs requires innovation, adaptability, and strong partnerships. AASCW delivers services through a combination of direct programs and a network of contracted providers. Where workforce shortages or geography limit traditional service delivery, we continue to expand innovative approaches, including mobile services, technology-enabled supports, workforce development, and collaborative community solutions that increase access and strengthen local capacity.

The 2027–2030 Area Plan provides the strategic framework that will guide this work over the next four years. Informed by extensive community engagement, public input, service data, and qualitative and quantitative research, it establishes regional priorities in programs, partnerships, and resources. More than a planning document, it reflects our shared commitment to building an equitable, coordinated, and sustainable system of services that empowers older adults, adults with disabilities, family caregivers, and working-age adults to live healthy, independent, and meaningful lives in the communities they call home.

For additional information about our 2027-2030 Area Plan, please contact Laura Cepoi, Executive Director, at laura.cepoi@dshs.wa.gov.

2. STEWARDSHIP AND OVERSIGHT

2.1 MISSION, VISION, VALUES

MISSION

Aging & Adult Services of Coastal Washington (AASCW) helps older adults, adults with disabilities, and family caregivers live safely and independently. We work across our rural communities to make sure everyone has fair access to the daily support, home care, and public benefits they need to stay in the homes and neighborhoods they choose with dignity.

As the local Area Agency on Aging for Clallam, Grays Harbor, Jefferson, and Pacific counties, we lead the region in planning, funding, and organizing aging and disability services. We partner with healthcare providers, community groups, Tribal Nations, and local governments to meet basic everyday needs like food, housing, and transportation. Together, we work to strengthen our rural health systems, support the WA Cares program, and create personal solutions that help people live healthier, better lives.

VISION

Healthy, connected rural communities where every person has equitable access to the services and support, they need to live independently, with dignity, purpose, and choice.

VALUES

Aging & Adult Service of Coastal Washington is guided by a set of core values that shape our decisions, strengthen our partnerships, and define how we serve the people and communities we support. These values are reflected in our daily work and our commitment to advancing the Association's mission.

- **Inclusion** – We foster a welcoming environment where diverse perspectives are valued**,** and everyone can contribute.
- **Respect** – We treat all individuals with dignity, professionalism, and consideration.
- **Service Excellence** – We are committed to providing responsive, high-quality service that meets the evolving needs of our members.
- **Integrity** – We act ethically, honestly, and transparently in all that we do.
- **Accountability** – We take responsibility for our actions, steward resources wisely, and strive for continuous improvement.

2.2 AAA SERVICES AND PARTNERSHIPS

Aging & Adult Services of Coastal Washington provides services to older adults, adults with disabilities, caregivers, and others utilizing a hybrid service delivery model, combining a robust network of contracted community providers with targeted direct agency services. The tables at the end of this section detail these services by county and list our core network partners.

DIRECT SERVICES

AGING & DISABILITY RESOURCE CENTER (ADRC): Serves as the region's trusted access point for information, assistance, and referral to community resources and long-term services and supports. ADRC Specialists help older adults, adults with disabilities, caregivers, and families understand available options and connect with appropriate services.

CARE TRANSITIONS: Supports individuals transitioning from hospitals or skilled nursing facilities back to their homes by promoting a safe and seamless recovery. Services focus on medication reconciliation, follow-up care, self-management, and reducing avoidable hospital readmissions.

CAREGIVER SUPPORT: Provides education, consultation, respite, and other supportive services for unpaid caregivers who provide ongoing care, supervision, or assistance with daily living activities to eligible family members or friends. Eligibility varies by program.

FAMILY CAREGIVER SUPPORT PROGRAM (FSCP): Supports unpaid family members and friends – including spouses, adult children, relatives, and neighbors – who provide care to an eligible adult.

KINSHIP CAREGIVER SUPPORT PROGRAM (KCSP)/RELATIVES AS PARENTS (RAP): Assists grandparents, relatives (by blood, marriage, or adoption), and other suitable caregivers who are raising related children.

KINSHIP NAVIGATOR: Provides a single point of access to information, resources, and navigation assistance for grandparents, relatives, and other caregivers raising children, helping them access legal, financial, healthcare, education, and community supports.

MEDICAID ALTERNATIVE CARE (MAC): Supports unpaid spouses, relatives, and friends (age 18 and older) who care for an individual age 55 or older with a diagnosed memory loss condition or significant functional needs. The care recipient meets Medicaid financial eligibility but chooses community-based supports rather than traditional Medicaid long-term care services.

TAILORED SUPPORTS FOR OLDER ADULTS (TSOA): Provides supportive services for unpaid caregivers (age 18 and older) caring for an adult age 55 or older, or directly to eligible older

adults without an unpaid caregiver who need assistance to remain safely at home. Participants are not currently eligible for Medicaid long-term services and supports.

CASE MANAGEMENT (MEDICAID LTSS, MAC/TSOA): Provides person-centered assessment, care planning, service coordination, and ongoing case management for individuals eligible for Medicaid Home and Community-Based Services (HCBS), Medicaid Alternative Care (MAC), and Tailored Supports for Older Adults (TSOA). These programs help individuals remain safely in their homes and communities as an alternative to institutional care. Beginning in July 2026, Long-Term Services and Supports **Presumptive Eligibility** (LTSS PE), authorized under Washington's Medicaid Transformation Project (1115 Waiver), provides expedited access to selected home and community-based services and temporary Medicaid medical coverage while full functional and financial eligibility is being determined.

DEMENTIA SERVICES: Provides early identification, education, caregiver training, care planning, evidence-based interventions, support groups, and community-based social engagement opportunities for individuals living with dementia and their care partners.

- *The Montreal Cognitive Assessment (MoCA):* Provides a validated cognitive screening tool to help identify mild cognitive impairment and early-stage dementia, supporting timely referral for further evaluation and services. (Rural Health Transformation Funding)
- *STAR-Caregivers (STAR-C):* Delivers an evidence-based training and consultation program that equips family caregivers with practical strategies to manage behavioral and communication challenges associated with Alzheimer's disease and related dementias.
- *Dealing with Dementia*: Offers an evidence-based educational program that provides family caregivers with practical skills, resources, and confidence to support a person living with dementia.
- *Memory Café:* Creates welcoming, stigma-free social gatherings where individuals living with early- to moderate-stage dementia or mild cognitive impairment and their care partners can connect, socialize, and build supportive relationships.

HEALTH HOME: Provides individualized care coordination for people living with multiple chronic conditions, helping them navigate healthcare and community services, improve self-management, and achieve better health outcomes.

HEALTH RELATED SOCIAL NEEDS (HRSN): Provides care coordination to eligible Medicaid beneficiaries whose unmet social needs affect their health and well-being. ADRC Specialists connect participants to services such as nutrition support, home accessibility modifications, environmental remediation, assistive adaptations, and caregiver respite to help individuals remain healthy and independent in their homes and communities.

STATEWIDE HEALTH INSURANCE BENEFIT ADVISORS (SHIBA): Provides free, unbiased, and confidential counseling to help individuals understand Medicare, compare health and prescription drug plans, access financial assistance programs, and make informed health insurance decisions.

WA CARES (NEW): Provides education, navigation, and individualized support to help eligible Washington Cares participants understand available benefits and access approved long-term services and support that promote independence and quality of life.

CONTRACTED SERVICES

PROVIDER CAPACITY & SYSTEM CHALLENGES

While community partnerships remain our highest priority, expanding the number of rural providers continues to be an important area of focus. In many underserved communities, provider shortages—and in some categories, the absence of available vendors—create opportunities for innovative solutions to ensure continued access to care. To address these needs, AASCW actively recruits new contractors, strengthens and supports existing contractors, and implements creative direct service delivery models that help connect individuals with the services they need.

NETWORK EXPANSION

Over the past year, AASCW successfully expanded its contracted provider network by leveraging new state and federal initiatives:

- WA Cares Fund: Recruited new providers to expand capacity for upcoming long-term services and supports (LTSS).
- Rural Health Transformation Funding: In open procurement process to build rural partnerships to deploy equity-focused care models in isolated communities using Mobile Health Vans.
- Specialized Care Scaling: Expanded contracts for dementia-specific care (Respite Day Model) and Health Related Social Needs (HRSN) to address rising complex health and nutrition and housing modification/safety demands.

CONTRACTED PILOT PROJECTS & INNOVATION

AASCW invests agency fund balances and targeted grants to pilot innovative models that bypass traditional provider shortages and reduce social isolation:

- ElliQ Smart Companion Initiative (Launched 2023): Funded initially by regional community foundations and sustained via agency fund balance, this pilot supports 20 to 30 isolated individuals annually. The AI companion mitigates loneliness, assists with health management (medication, hydration, and appointment reminders), and facilitates video/voice communication with family and caregivers.

- Mobile Assistance Van (MAV) Program (Launched 2022): Established via federal Rural Health Equity grants and sustained through agency fund balance after grant expiration in 2024, the MAV program drives rural health equity. AASCW expanded the program in 2026 to a second provider, broadening coverage from the Sequim School District to the Clallam County West End. The two contracted providers now serve over 20 sites weekly, recording more than 2,200 monthly guest visits for food distribution and resource navigation.

The following table shows direct and contracted services by county.

Service Category	Provider Model	Clallam	Grays Harbor	Jefferson	Pacific
Case Management	Direct (AASCW)	X	X	X	X
MAC/TSOA	Direct (AASCW)	X	X	X	X
Medicaid Waiver Services	Contract				
Personal Care		X	X	X	X
Adult Day					
Home Delivered Meals		X	X	X	X
Community Choice Guiding		X	X	X	X
Behavior Supports		X	X	X	X
Client Training		X	X	X	X
Community Transition and Stabilization Services		X	X	X	X
Environmental Modifications			X		X
PERS (personal Emergency Response System)		X	X	X	X
Skilled Nursing		X	X	X	X
Transportation					
Aging & Disability Resource Center (ADRC)	Direct (AASCW)/OAA	X	X	X	X
Care Transitions	Direct (AASCW)	X		X	X
Home-Delivered Meals	Contracted (OAA)	X	X	X	X
Health Home Services	Direct (AASCW)	X	N/A	X	X
Congregate Nutrition	Contracted (OAA)	X	X	X	X
Senior Farmers Market	Contracted	X	X	X	X
Family Caregiver Support (FCSP)	Hybrid (Direct/OAA)	X	X	X	X
Kinship Navigator	Direct (AASCW)	X	X	X	X
Kinship Caregiver Supports	Direct (AASCW/OAA)	X	X	X	X
Dementia-Specific Services (Memory Café, Star-C, Dealing with Dementia)	Direct (AASCW Expanded-BDCC & RHT Funding)	X	X	X	X
Creative Aging	Contracted (BDCC Funding)	-	-	X	-
MoCA	Direct (AASCW- RHT Funding)	X	X	X	X

Health-Related Social Needs (HRSN)	Hybrid (Direct/Contracted) (New)	X	X	X	X
Minor Home Repair/Senior Emergency	Direct (OAA)	X	X	X	X
Mobile Assistance Van (MAV)	Contracted (fund balance)	X	-	-	-
ElliQ Smart Companion	Direct Pilot (Fund Balance)	X	X	X	X
Legal Assistance	Contracted (OAA)	X	X	X	X
Transportation	Contracted (OAA)	X	X	X	X
Statewide Health Insurance Benefits Advisors (SHIBA)	Direct (OIC)	X	X	X	X
WA Cares Beneficiary Support	Direct	X	X	X	X
Senior Drug Education	Contracted (OAA)	X	X	X	X

AASCW partners with a variety of providers and organizations throughout our region to share information and resources, coordinate care, and deliver the services needed in our communities. Partners in our region include:

- Accountable Communities of Health
- Adult Family Homes
- Alzheimer's Association
- Assisted Living Facilities
- Behavioral Health Services
- City and County Governments
- Community Action Programs
- Community Health Clinics
- Dental Programs and Services
- Disability Access Programs
- EMS
- Energy Assistance
- Faith-based Organizations
- Food Banks and Pantries
- Healthcare Networks
- Home Health Services
- Home Repair and Weatherization
- Hospice Services
- Legal Services
- Local Chambers, Coalitions, and Councils
- Public Health Departments
- Public Housing Authorities
- Senior Centers
- Skilled Nursing Facilities
- Tribal Clinics and Services
- Transportation Services
- Utility Providers
- Veteran's Services
- Volunteer Programs
- WA Department of Health
- WA Department of Social & Health Services

3. CONTEXT

3.1 PLANNING AND REVIEW PROCESS: NEEDS ASSESSMENT, SURVEYS, PUBLIC REVIEW

The 2027-2030 Area Plan is based on community input and data from multiple sources, including public and staff surveys, needs assessments, and population data. The plan is reviewed and approved by our Advisory Council and governing body, the Council of Governments (COG).

ACTIVITY TIMELINE

November 2025	Distribute Family Caregiver Survey – newspaper, phone-in, and electronic formats
May-July 2026	Community Survey distributed in paper and electronic formats
May 12, 2026	North Counties: All Staff, Advisory Council & COG Community Needs Assessment Review
May 15, 2026	South Counties: All Staff, Advisory Council & COG Community Needs Assessment Review
July 21, 2026	Advisory Council review of Community Survey, Service Utilization Data
July 31 – August 30, 2026	Area Plan Draft posted to agency website
August 18, 2026	Advisory Council review and recommendation for approval
August 24, 2026	South County Public Hearing
August 27, 2026	North County Public Hearing
September 3, 2026	Council of Governments approves Area Plan for submission

COMMUNITY SURVEY

To identify regional needs, AASCW conducted a community survey using digital networks, paper copies, and QR code posters across 35 community sites. The survey assessed cost-of-living stressors, healthcare barriers, social isolation, and local interest in mobile clinic services ahead of potential Rural Health Transformation funding.

KEY FINDINGS: PRESSING NEEDS AND SYSTEMIC BARRIERS

The survey revealed four primary challenges facing residents:

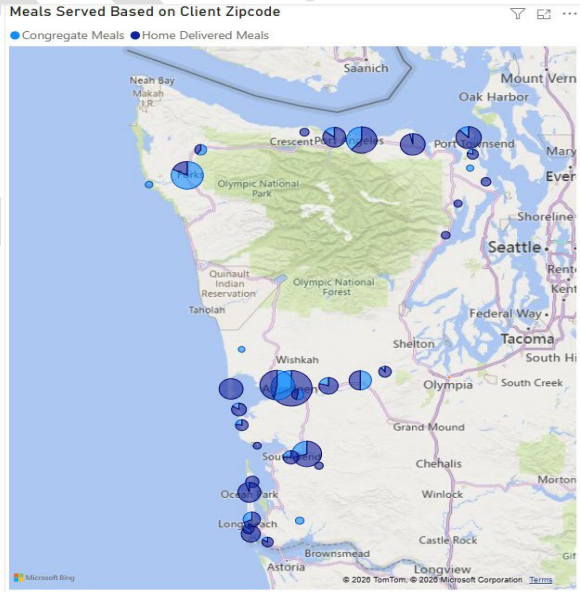
- Affordability: High costs of essential necessities remain difficult for people on fixed income to manage, especially food and housing (including utilities).
- Healthcare Barriers: Physical, geographic, and provider shortages create severe bottlenecks to timely care.
- Social Isolation: Minimal local opportunities exist for meaningful community connection.
- Caregiver Support: Limited respite resources and geographic isolation.

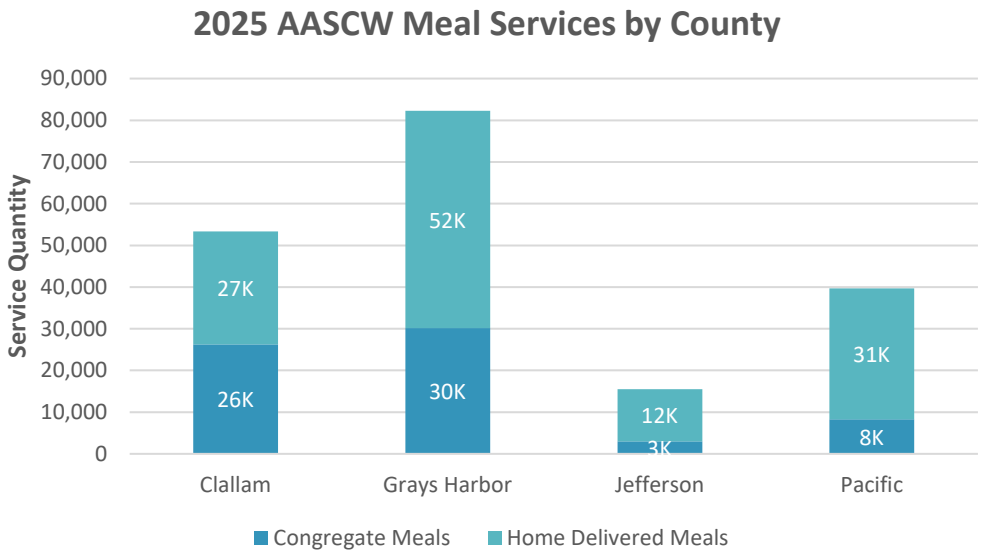
DEMOGRAPHIC AND SERVICE DATA REVIEW

Several data sources were reviewed to best understand the demographics of who we serve and how the population is expected to change, as well as how our current service delivery may need to be adapted. Primary sources included:

- AASCW service data collected through CLC (Community Living Connection) and DataMart to understand current service use and review year-over-year trends.
- Demographic data from the U.S. Census Bureau, Department of Social and Health Services (DSHS) Research and Data Analysis Division (RDA), Washington State Department of Health, Elder Economic Index, Washington State Geospatial Open Data Portal, Feeding America's *Map the Meal Gap* study.
- Reports from the Washington State Department of Health and Washington State Department of Agriculture.
- AARP and National Alliance for Caregiving survey of family caregivers.

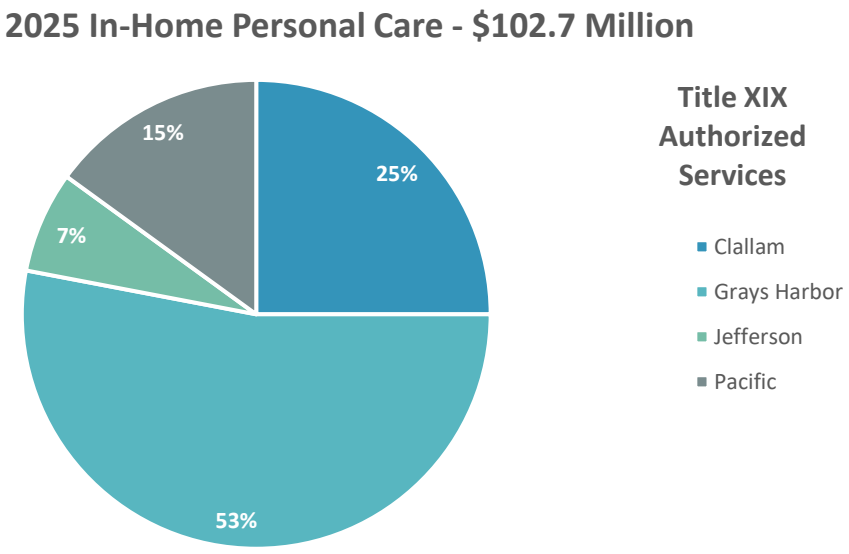
The graphic below depicts senior nutrition services utilization for home delivered and congregate meals by county for the year 2025 from our CLC Service data. The Mobile Assistance Van (MAV) data is not reflected in this chart as it is not funded by Older Americans Act funding; the MAV aims to serve the most remote areas along coastal WA that is considered a "food desert." A review of the data showed an increase in congregate meal participation, which has returned to pre-pandemic levels. We continue to observe monthly increases in participation and, if current growth rates continue, we anticipate facing a funding cliff in 2028 that will affect our ability to meet demand. Within our service area, Grays Harbor and Pacific counties may be the most impacted as both consistently rank among the highest in Washington State for rates of food insecurity and overall socioeconomic need.



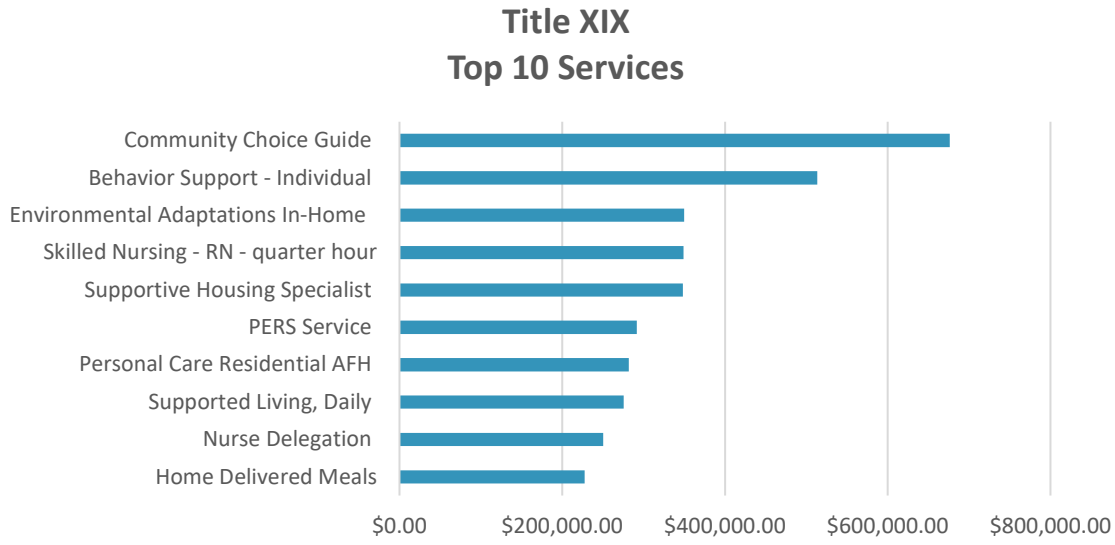


In 2025, AASCW case managers authorized more than $102.7 million in Medicaid-funded In-Home Personal Care services, helping older adults and adults with disabilities remain safely and independently in their homes and communities across Coastal Washington. As one of the region's largest long-term services and supports programs, Medicaid In-Home Personal Care plays a vital role in supporting individuals with complex care needs while reducing reliance on more costly institutional care. The value of authorized services varies across the four-county region, reflecting differences in demographics, economic conditions, and access to care.

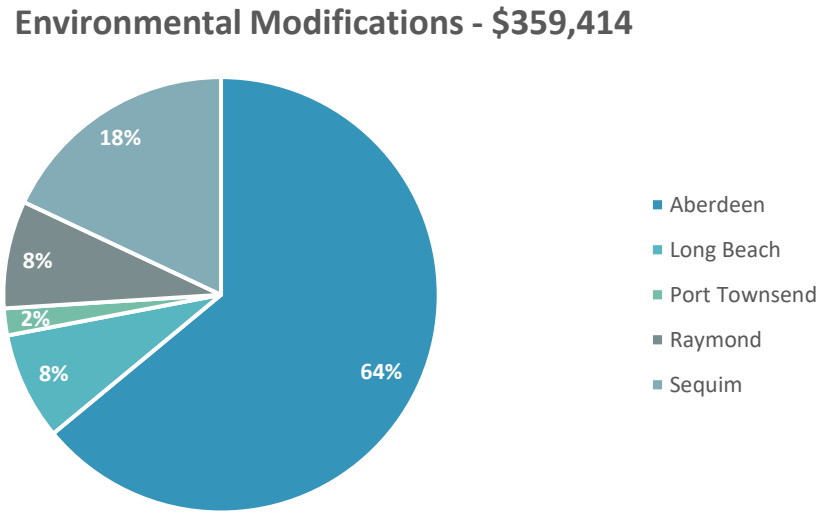
- **Grays Harbor County:** 53% of all authorized services ($54.43 million), reflecting the county's larger population, higher rates of Medicaid eligibility, and greater prevalence of complex long-term care needs.
- **Clallam County**: 25% ($25.68 million), driven in part by the continued growth of its older adult population and increasing demand for home and community-based services.
- **Pacific County:** 15% ($15.41 million), representing one of the highest per-capita levels of authorized services in the region – a reflection of its rural geography, limited access to institutional care, and reliance on home- and community-based services.
- **Jefferson County**: 7% ($7.19 million). While Jefferson has the oldest population in the region, its comparatively lower level of authorized services likely reflects higher household assets and incomes that place many older adults above Medicaid financial eligibility thresholds despite ongoing long-term care needs.



In addition to Medicaid-funded In-Home Personal care services, AASCW case managers authorized $3.6 million in specialized services designed to support individuals in remaining safely in their homes and communities and to provide alternatives to institutional care when appropriate. The largest share of these authorizations was for Community Choice Guides, who assist individuals transitioning from institutional settings back into community living or help sustain individuals safely in their current homes. AASCW also authorized services such as Individual Behavior Support and Supportive Housing to assist vulnerable individuals in maintaining stability, addressing complex needs, and securing safe, appropriate housing. Additionally, AASCW authorized $630,000 in Skilled Nursing and Nurse Delegation services to support individuals with medical needs, including assistance with complex health tasks and medication-related care, allowing them to receive necessary supports in their homes.



Case managers also authorized $359,414 in home modifications—including wheelchair ramps, walk-in showers, and grab bars—to improve safety, accessibility, and independence for older adults and individuals with disabilities in their homes. These authorizations were highly concentrated in Aberdeen, which accounted for 64% ($230,025) of the total authorized value in this category, likely reflecting a combination of local accessibility needs and available service capacity. The remaining authorizations were distributed across the region, with Sequim accounting for 18% ($64,695), Long Beach and Raymond together representing 16% ($57,506), and Port Townsend accounting for 2% ($7,188). This distribution highlights geographic variation in the need for accessible home environments and identifies opportunities to strengthen contractor networks and expand access to home modification services throughout northern and southern coastal communities.

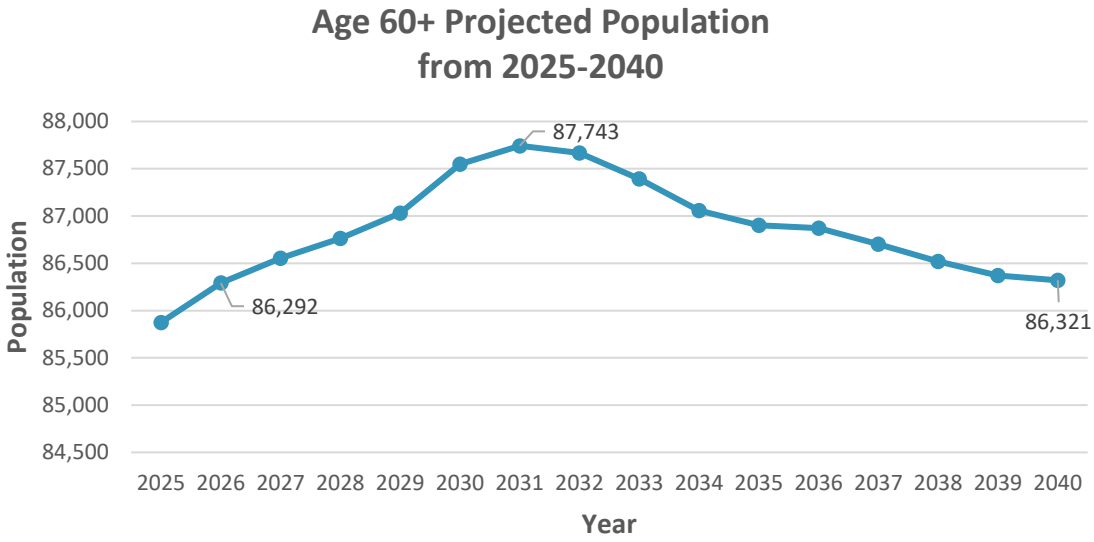


3.2 DEMOGRAPHICS: PSA PROFILE, DATA TRENDS

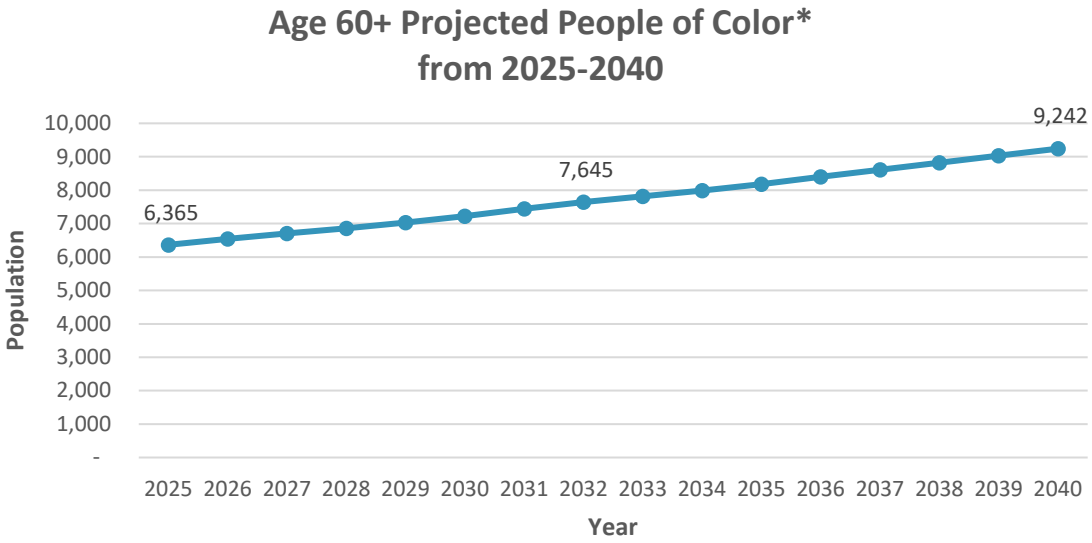
Projected demographic trends from 2026 through 2040 point to a steady evolution in the service needs of our region, requiring AASCW to adapt its program strategies, partnerships, and resource planning over time. While the overall number of residents age 60 and older is expected to remain relatively stable over the next 15 years, with projected growth of approximately 1%, the complexity of support needs within this population is changing. As the region's older adult population ages, a growing share of individuals age 65 and older are expected to experience disabilities and functional limitations—key indicators of the types of assistance and services needed to support independence.

Data from the 2022 Behavioral Risk Factor Surveillance System (BRFSS) highlights the connection between disability and health outcomes, showing that adults with disabilities experience significant health disparities and are more likely to report conditions such as

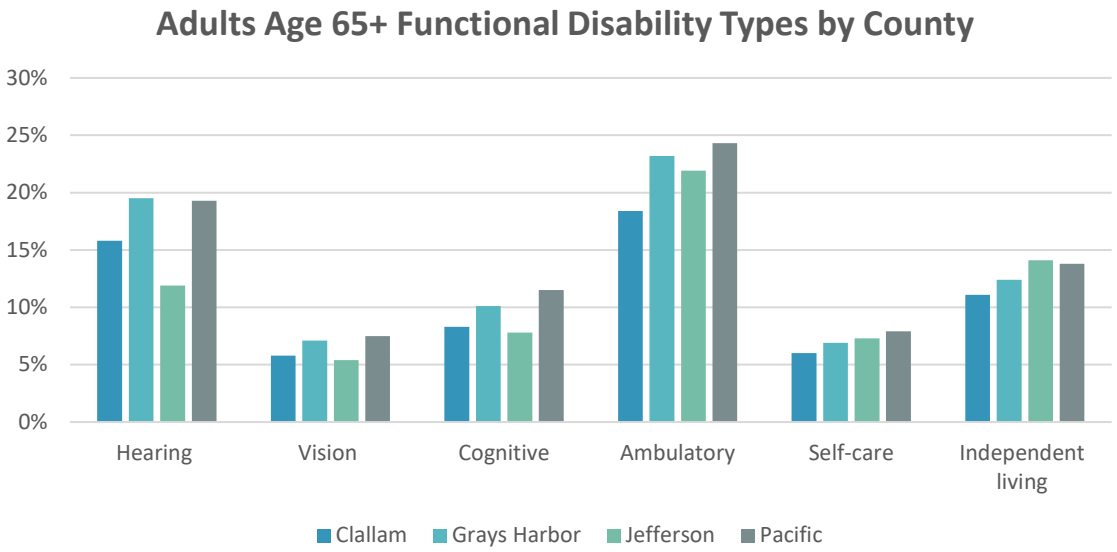
depression, obesity, diabetes, heart disease, and tobacco use. These intersecting factors reinforce the importance of long-range planning that focuses not only on maintaining a broad network of services, but also on expanding targeted, person-centered supports for older adults with more complex health and functional needs.



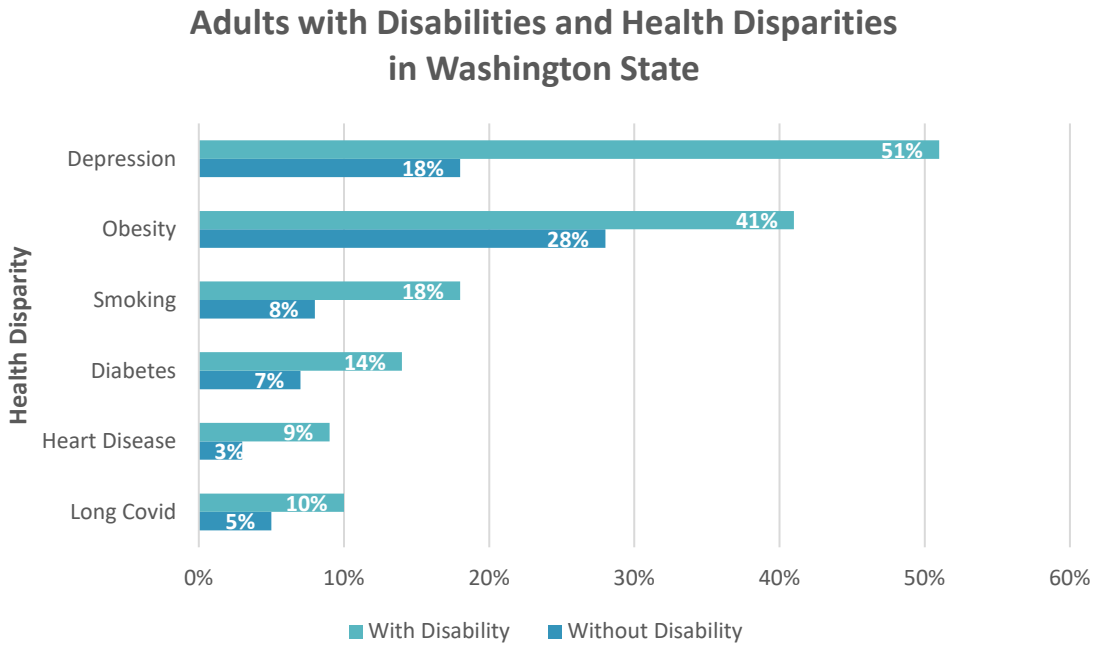
Source: Washington State Office of Financial Management, 2025.



**People that identify as Hispanic, Latino, American Indian, Alaskan Native, Asian, Pacific Islander, Black, or multi-racial.*
Source: Washington State Office of Financial Management, 2025.



Source: U.S. Census Bureau. "Disability Characteristics" American Community Survey, ACS 5-Year Estimates Subject Tables, Table S1810, 2024.

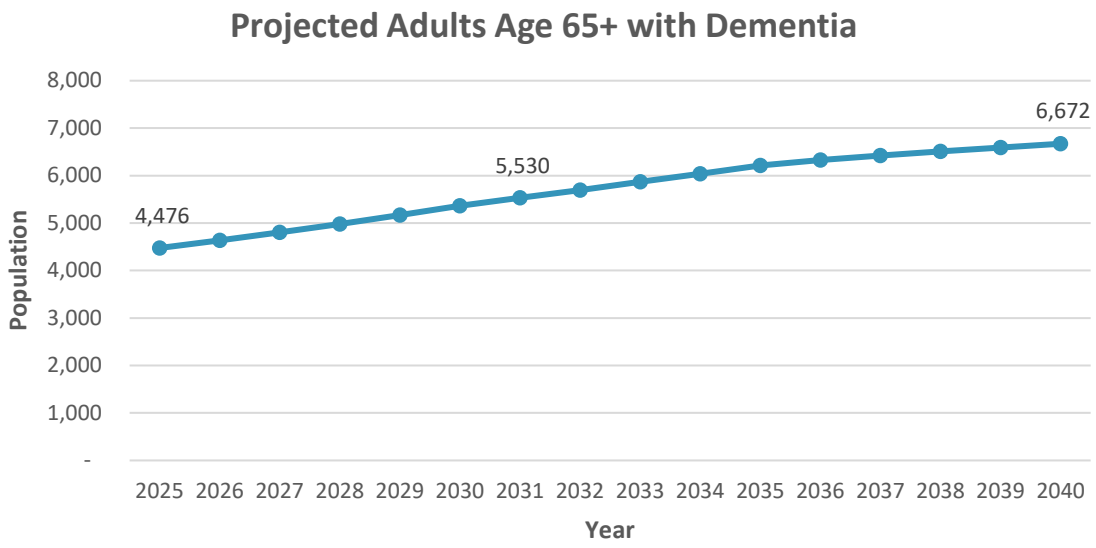


Source: 2022 Behavioral Risk Factor Surveillance System (BRFSS).

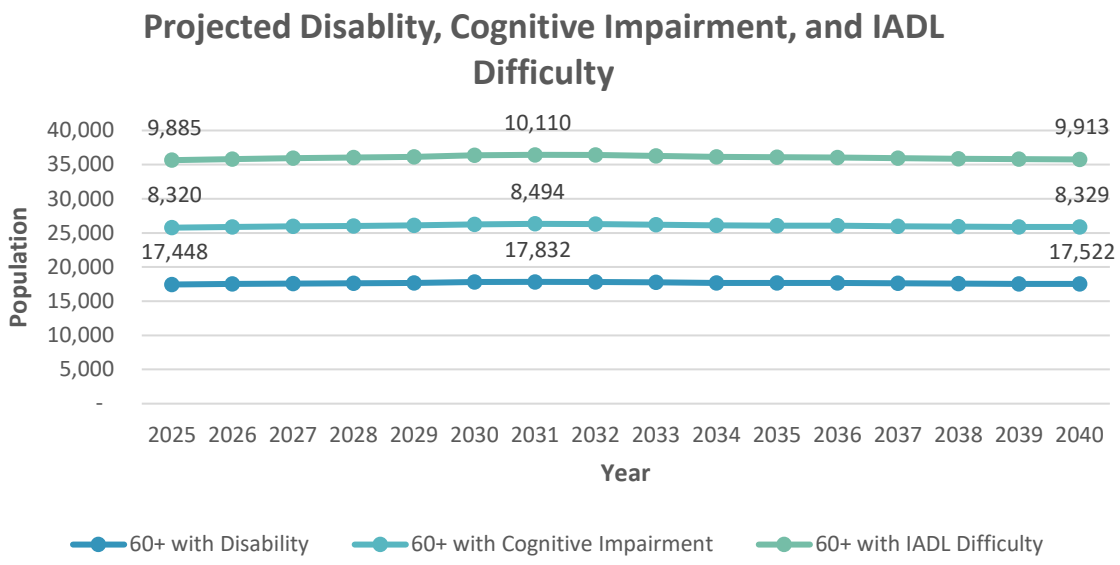
By 2030, as more members of the Baby Boomer generation enter their 80s, the complexity of long-term care needs across the region is expected to increase. State projections indicate that AASCW should prepare for an estimated 20% to 25% increase in the number of people living with dementia over the next four years. This trend will occur alongside continued changes to state and federal safety-net programs, reinforcing the importance of coordinated, localized

community supports. As fixed retirement incomes continue to face pressure from rural living costs, ensuring consistent access to affordable, accessible home and community-based services will remain a key priority for AASCW and its case management teams.

By 2040, dementia prevalence across the region is projected to increase by approximately 49%, further emphasizing the need for specialized cognitive supports, caregiver resources, and a well-prepared workforce. These trends will unfold within a population that is already among the oldest in Washington, creating increased demand for services at a time when the availability of healthcare and direct care workers remains a significant challenge. Statewide projections show the ratio of working-age adults to older adults continuing to decline, a trend that is often experienced even more acutely in rural coastal communities. These demographic shifts reinforce the need for innovative approaches, strong partnerships, and sustainable models of care that support individuals and caregivers throughout the aging journey.



Source: Source: U.S. Census. American Community Survey 5-Year Public Use Microdata Sample (PUMS) Files, 2019-2023.



Source: Source: U.S. Census. American Community Survey 5-Year Public Use Microdata Sample (PUMS) Files, 2019-2023.

To address persistent vacancies in traditional caregiving roles, AASCW is integrating alternative service models into its long-term strategy. This approach includes continued investment in assistive technologies, flexible outreach models such as the Mobile Assistance Van (MAV), Remote Day Programming, and Respite for All. Rather than serving as temporary solutions, these approaches are designed to extend the reach of the existing workforce, strengthen community connections, and support reliable access to care for the region's growing population of older adults and individuals with complex needs.

DEMOGRAPHIC PROJECTION TIMELINE: 2026 TO 2040

The following table highlights projected demographic trends across the current planning year (2026), the midpoint of the 2027–2030 Area Plan period (2030), and the long-range planning horizon (2040). These projections illustrate how changing population characteristics will influence AASCW's service strategies, partnerships, and resource planning over time.

Metric / Milestone	2026 Baseline	2030 Mid-Plan Outlook	2040 Long-Range Outlook	Planning Implications
Total Regional Growth	Baseline	Approximately 0.5% Change	Approximately 1.0% Cumulative Change	A stable population size requires continued focus on strengthening service capacity, improving coordination, and targeting supports for individuals with higher needs.

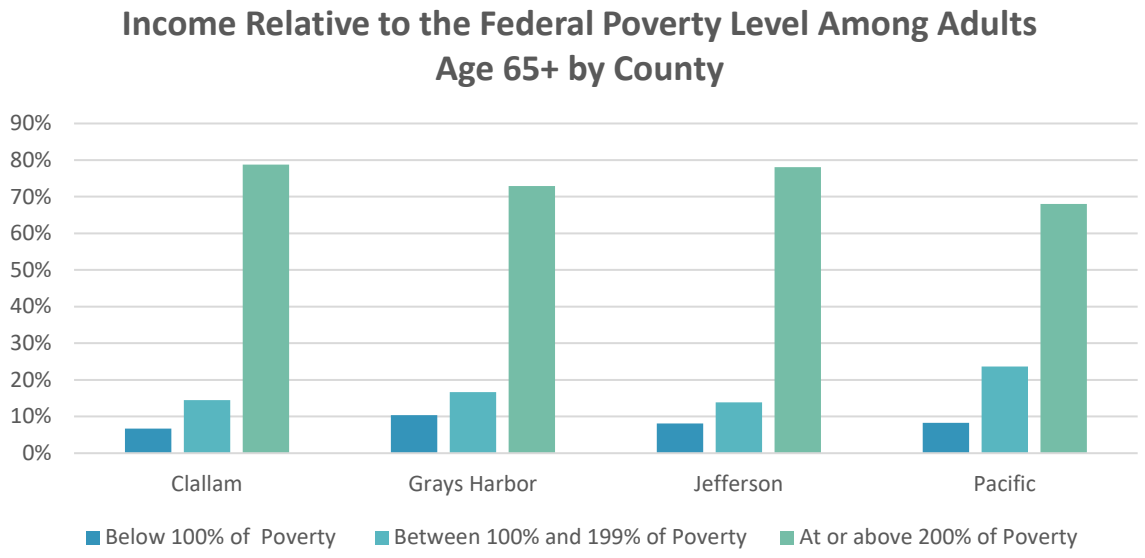
Adults Age 85+	Gradual increase underway	More Baby Boomers entering 85+ age group.	Continued growth of this age group.	Assume increasing demand for personal care, caregiver support, and services addressing higher levels of functional need.
Regional Dementia Prevalence	Current prevalence baseline	Projected 20% to 25% increase from baseline.	Projected 49% increase from baseline.	Growing need for dementia capable services, caregiver supports, and community-based resources.
Paid & Unpaid Caregiver Labor Supply	Existing workforce shortages and caregiver strain	Continued pressure on available care workforce.	Increasing gap between demand and workforce availability.	Continued investment in workforce development, technology solutions, caregiver supports, and innovative service delivery models.
Primary Safety-Net Financial Strain	Existing financial pressures among vulnerable households.	Continued impact from policy changes and economic pressures.	Increased demand for affordable long-term services and supports.	Strengthening access to benefits, supportive services, and Medicaid-funded programs will remain essential.

4. KEY ISSUE AREAS

4.1 GREATEST SOCIAL AND ECONOMIC NEED

The Older Americans Act (OAA) directs Area Agencies on Aging to prioritize services for older adults experiencing the greatest economic and social need, with particular attention to individuals facing low income, disability, limited access to services, social isolation, and other barriers that affect their ability to remain independent. Across the Aging & Adult Services of Coastal Washington (AASCW) planning and service area, these factors intersect with the realities of rural living, an aging population, and limited access to healthcare, transportation, and other essential supports.

Poverty rates throughout the four-county region remain higher than the Washington State average, ranging from approximately 10% to 16% by county. The region also experiences higher rates of disability and chronic disease across many measures compared with statewide averages. These factors, combined with the region's older population, contribute to increased demand for home and community-based services that promote safety, independence, and quality of life.



Source: Census Bureau. "Age by Ratio of Income to Poverty Level in the Past 12 Months" American Community Survey, ACS 5-Year Estimates Detailed Tables, Table B17024, 2024.

Food insecurity continues to rise in all four counties and reflects the community survey results, naming this as the top concern for serving older adults in our community. The table below contrasts the actual number of individuals enrolled in the Supplemental Nutrition Assistance Program (SNAP) with the overall estimated percentage of all residents facing food insecurity:[1]

County	SNAP Recipients (% of Population)	Food Insecurity Rate[2]	Community Context
Grays Harbor	15,461 (**20.0%**)	**14.7%**	Among highest SNAP reliance statewide, reflecting significant economic need and health equity challenges.
Pacific	3,682 (**15.4%**)	**15.2%**	Highest estimated food insecurity rate in the region, influenced by rural geography and transportation barriers
Clallam	10,627 (**13.5%**)	**~11.0%**	Large older adult population, including many retirees living on fixed incomes.
Jefferson	3,328 (**9.9%**)	**13.2%**	Demonstrates **"Eligibility Gap"** (hunger outpaces federal assistance participation).

[1] https://www.cantwell.senate.gov/news/press-releases/county-by-county-data-where-in-wa-will-snap-cuts-hit-hardest

[2] https://www.feedingamerica.org/about-us/press-room/Map-the-Meal-Gap-2025

These findings reinforce the need for nutrition, benefits enrollment, transportation, and other supportive services that help older adults remain healthy and independent.

Jefferson County illustrates the complexity of addressing food insecurity among older adults. In some communities, individuals experiencing hunger may not qualify for federal nutrition assistance due to income thresholds, despite continuing financial challenges. Statewide research from the University of Washington and Feeding America indicates that many individuals' experiencing food insecurity earn too much to qualify for SNAP benefits. Conversely, Grays Harbor County's high SNAP participation highlights the significant level of economic need present in parts of the region. Together, these trends demonstrate the importance of a coordinated approach that includes nutrition assistance, benefits navigation, and broader supportive services.

To help older adults access affordable healthcare coverage and benefits, AASCW provides the Statewide Health Insurance Benefits Advisors (SHIBA) program, a service of the Washington State Office of the Insurance Commissioner (OIC). SHIBA volunteers provide confidential, unbiased counseling to help Medicare beneficiaries understand coverage options, identify programs that reduce healthcare costs, and protect themselves from fraud and abuse through education, claims review, and reporting assistance.

Economic barriers are closely connected with social needs. Geographic isolation, limited transportation options, fewer community gathering spaces, and healthcare workforce shortages can contribute to social isolation, delayed care, and declining physical and mental health.

AASCW prioritizes individuals with the greatest economic and social need through programs with financial and functional eligibility requirements while also offering services designed to reach vulnerable populations throughout the region. Each month, more than 2,100 individuals receive Medicaid-funded long-term services and supports through Community First Choice and related programs. Eligibility includes ongoing financial and functional assessments to ensure services are directed to individuals with significant support needs. Services include in-home personal care, environmental modifications, home-delivered meals, caregiver support, and other assistance that enables individuals to remain safely in their homes.

Programs such as Medicaid Alternative Care (MAC), Tailored Supports for Older Adults (TSOA), and Health-Related Social Needs (HRSN) similarly focus resources on individuals and families with identified needs. Senior nutrition services, while not income-based, prioritize older adults experiencing social isolation, food insecurity, or limited access to resources. Together, these programs reflect AASCW's commitment to ensuring that older adults, adults with disabilities, and caregivers have access to the support they need to remain healthy, connected, and independent.

AASCW recognizes that healthy aging extends beyond access to healthcare and basic supports—it also depends on connection, purpose, and meaningful engagement within the community. Through social engagement, caregiver support, health promotion, and community connection programs, AASCW helps older adults remain connected and supported throughout the aging journey. Congregate meal programs, home-delivered meals, and Mobile Assistance Vehicle (MAV) services provide nutritional support while creating opportunities for regular social interaction and relationship-building. Caregiver support groups, Memory Cafés, and dementia education programs help reduce caregiver isolation while strengthening informal networks of support.

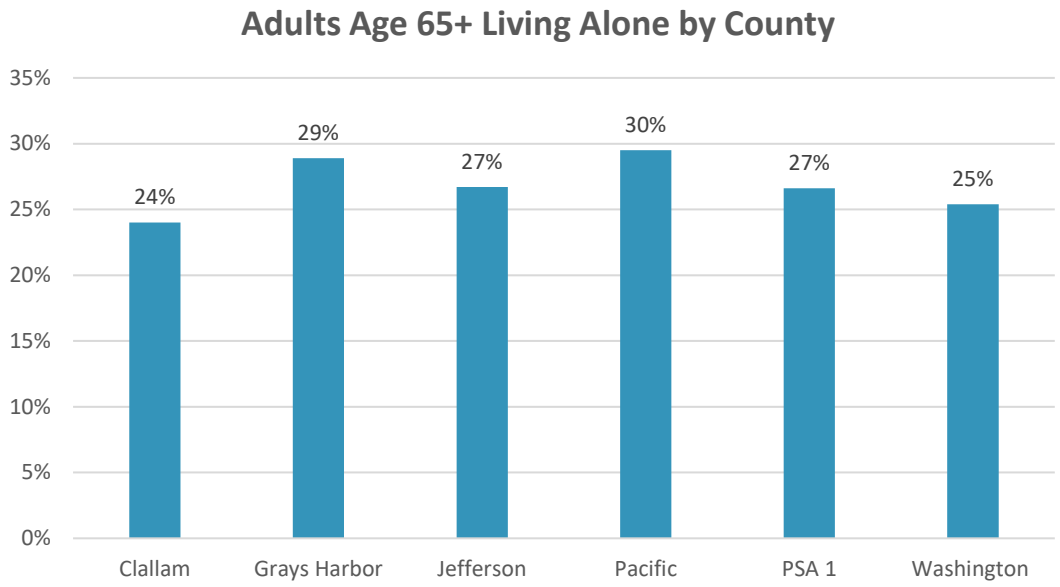
Client Story: The Mobile Assistance Vehicle Provides Nutritional Support

A 98-year-old woman fell out of bed, breaking her nose and sustaining other injuries that prevented her from visiting the pantry, where she regularly picked up milk and a sweet treat- usually chocolate.

When she couldn't make it down, her neighbor picked up a bag of groceries we prepared for her. By her second week of recovery, our coordinator was able to deliver the food directly to her apartment.

The joy she expressed made it clear that the visit meant far more than the groceries- it also brought comfort, connection, and reassurance during a difficult time.

AASCW continues to explore innovative approaches to reducing social isolation, particularly as three counties within the service area have higher proportions of adults age 65 and older living alone compared with Washington State. The ElliQ companion technology project has offered an additional tool for supporting older adults who live alone, with participants reporting reduced loneliness and improved emotional well-being. Beyond technology, AASCW also helps older adults stay connected through meaningful volunteer opportunities, including SHIBA and the Advisory Council, where they can remain engaged, share their expertise, and contribute to their communities.



Source: U.S. Census Bureau. "Relationship by Household Type (Including Living Alone) for the Population 65 Years and Over" American Community Survey, ACS 5-Year Estimates Detailed Tables, Table B09020, 2024.

Client Story: ElliQ helps Barbara* Overcome Social Isolation

After a partial foot amputation severely limited her mobility, Barbara requested an ElliQ companion robot. Unable to leave home except for medical appointments, she spent most of each day alone, aside from visits from her caregiver. The isolation contributed to depression and anxiety.

ElliQ provided companionship through conversation and activities, while also guiding Barbara through relaxation and mindfulness exercises that helped her sleep better.

As Barbara recovered, she regained her independence and began leaving home regularly to go swimming and grocery shopping. Today, she continues to use ElliQ every day for encouragement, entertainment, and health reminders. - ElliQ Project Lead

Key Issue Area 1: Greatest Social Need and Greatest Economic Need

Profile of the Issue: The Older Americans Act requires service prioritization for individuals experiencing the greatest social and economic needs, including those affected by low income, disability, geographic isolation, and limited access to essential resources. In AASCW's predominantly rural service area, many older adults experience overlapping barriers related to financial stability, healthcare access, transportation, nutrition, housing, and social connection. AASCW addresses these challenges through programs that prioritize individuals with the greatest need while providing broad access to supportive services that promote independence.

Community data and feedback demonstrate that some local older adults face major daily challenges. These include chronic health issues, housing instability, food insecurity, transportation limitations, social isolation, and difficulty accessing healthcare. It is also often hard for people to get medical care. When these challenges occur together, they significantly reduce an individual's ability to maintain health, perform daily activities, and remain safely at home.	
Goal/s: Improve equitable access to essential services and supports for older adults with the greatest economic and social need by reducing barriers that affect health, independence, and quality of life.	
Major Objectives	**Key Tasks and Benchmarks**
Increase access to Medicare counseling and benefits enrollment.	• Recruit five SHIBA volunteers for full regional coverage • Increase completed Medicare counseling in Pacific County by 10% • Reduce wait times for counseling • Continue providing consumer education through in person outreach events and digital platforms across all counties.
Expand food security by delivering mobile food pantries and ADRC resources to rural and low-income communities.	• Increase the number of older adults in rural and underserved communities accessing nutrition or supportive services. • Maintain mobile food pantry locations to a minimum of 20 sites in Clallam County and support expansion into Jefferson County. • Seek potential partners to establish mobile food pantry program in Grays Harbor and Pacific Counties.
Increase engagement with underserved populations through community outreach events.	• Increase referrals to AASCW programs generated through outreach events. • Maintain or improve participant-reported knowledge of available services after outreach or education events. • Increase the proportion of clients from priority populations served by AASCW programs. • Maintain participation in at least 30 outreach events annually, consistent with current performance.
Develop and implement a remote Adult Day Services pilot program for geographically isolated older adults, promoting social connection, lifelong learning, and strategies to support health and independent living.	• Launch a remote Adult Day Services pilot by July 2027. • Enroll 20 geographically isolated older adults during the pilot period. • Provide at least 10 virtual group sessions each month. • Provide programming that includes chronic disease self-management, health education, current events, music, cognitive engagement, and social activities. • Achieve 80–90% participant satisfaction based on post-program surveys. • Evaluate participant outcomes related to social connectedness, engagement, and program accessibility to determine feasibility for ongoing implementation.
Develop and implement Mobile Assistance Vans through Rural Health Transformation funding to expand access to preventative health services in geographically isolated communities.	• Conduct monthly Mobile Assistance Vehicle visits in each county beginning December 2026. • Provide preventive health screenings and health navigation services at each scheduled visit. • Track the number of participants receiving screenings, referrals, or care coordination. • Measure participant-reported improvements in access to health services through post-visit surveys.

4.2 HEALTHY AGING AND OLDER AMERICANS ACT CORE PROGRAMS

Healthy aging is a continuous process of optimizing opportunities to maintain and improve mental and physical health, independence, and quality of life throughout the life course. In the recent community survey, residents identified health and well-being as the highest-ranking issue. Accordingly, AASCW provides services and programs designed to improve health outcomes, reduce disease, and prevent injuries among older adults in the service area.

Determinants of Healthy Aging

Several interconnected factors influence an individual's capacity for healthy aging within the community. AASCW monitors and addresses these key areas:

- Regular physical exercise
- Access to healthy nutrition and oral health care
- Consistent medical and mental health care
- Availability of support services and social connections
- Safe, affordable housing environments
- Reliable access to transportation

Regional Health Care Access Challenges

Access to health care remains a significant structural challenge throughout the rural region. Data indicates that approximately 80% of rural America is medically underserved[3], resulting in longer travel distances for medical care and persistent shortages of health care providers. On average, rural residents live two years less than urban residents and experience higher mortality rates from heart disease, cancer, and unintentional injury. [4]

Locally, shortages of primary care providers, specialty clinics, behavioral health services, and providers accepting Apple Health combine with transportation barriers to frequently delay preventative care and the management of chronic conditions.

Ratio of Population to Providers by County				
	Clallam	Grays Harbor	Jefferson	Pacific
Primary Care Physicians	1,080:1	2,660:1	1,120:1	4,020:1
Mental Health Providers	200:1	190:1	170:1	190:1
Dentists	1,050:1	1,930:1	1,980:1	4,840:1

Source: University of Wisconsin Population Health Institute, County Health Rankings, 2025.

[3] https://nihcm.org/publications/rural-health-addressing-barriers-to-care

[4] Ibid

Current Service Delivery and Interventions

AASCW addresses these localized challenges through integrated care coordination, evidence-based health promotion, transportation services, and formal partnerships with health care systems and community organizations. Current core programs include:

- Health Homes & Care Transitions: Programs designed to help individuals navigate complex health systems, manage chronic conditions, and reduce unnecessary hospitalizations.
- Building Dementia Capable Communities: Initiatives that establish local support structures for individuals experiencing cognitive decline and their caregivers.
- Contracted Transportation: Targeted transit services to ensure individuals can attend necessary medical appointments and access community resources to support independent living.
- Title III-D Evidence-Based Program Delivery: Evidence-based wellness frameworks designed to improve chronic disease self-management, prevent falls, and mitigate cognitive decline. These structured interventions provide measurable, non-pharmacological health stabilization.

Integration of New State Long-Term Care Initiatives

To expand the safety net beyond traditional OAA funding, AASCW is aligning its core infrastructure with two major Washington State long-term care programs:

- Health-Related Social Needs (HRSN) Services: AASCW provides evidence-based, non-medical interventions for qualifying Apple Health (Medicaid). This includes connecting individuals to vital non-medical resources like short-term nutrition support, and environmental accessibility or home modifications to address adverse social conditions affecting health.
- WA Cares Fund Infrastructure: As Washington launches benefits under the nation's first public long-term care insurance program, AASCW serves as a vital local point of access. AASCW supports the WA Cares framework by assisting eligible beneficiaries who require help with activities of daily living to navigate and coordinate their lifetime benefits—such as professional in-home care, adaptive technology, home-delivered meals, and family caregiver respite.

Strategic Initiatives and Future Expansion

To address ongoing service gaps, AASCW will utilize Rural Health Transformation funding during this Area Plan period to deploy mobile resources and expand regional program capacity:

- Mobile Assistance Vans: AASCW will launch mobile service units to deliver health education, chronic disease self-management programming, health screenings, benefits counseling, and resource connections directly to rural and underserved communities.

This initiative aims to lower barriers to preventative care, improve self-management of chronic conditions, and reduce avoidable emergency department visits.

- Dementia Service Expansion: AASCW will expand dementia-capable services into Pacific and Grays Harbor counties. This expansion will increase local access to education, caregiver support, structured care planning, and cognitive screening, addressing documented resource gaps in these rural sectors.
- Targeted Operations: Over the next Area Plan period, AASCW will focus on expanding equitable access to core OAA and state-funded programs through targeted outreach, benefits counseling, nutrition assistance, and initiatives designed to reduce social isolation for individuals with the greatest social and economic need.

<table>
<tr><td colspan="2">Key Issue Area 2: Healthy Aging Goals and Objectives

Profile of the Issue: AASCW serves the highest per capita population of older adults in Washington State. Because social determinants of health—income, housing, nutrition, and transit—heavily impact rural longevity, AASCW coordinates care across complex systems using Older Americans Act (OAA) and state funds. This plan integrates Washington's Health-Related Social Needs (HRSN) initiative to connect Medicaid enrollees with non-medical health stabilizers, alongside the WA Cares Fund to provide local options counseling and benefit navigation for public long-term care insurance and Building Dementia Capable Community funding to address rising needs.</td></tr>
<tr><td colspan="2">Goal/s:
1) Older adults and adults with disabilities are supported in their health-related social needs through direct and contracted services, partnerships, and advocacy.
2) Expand the local dementia support infrastructure by offering a structured pathway of early cognitive screening, evidence-based care planning, and community-based social engagement to maximize independence for individuals living with dementia and their care.
3) Older adults and their families will have the knowledge and support to make informed choices about chronic disease prevention and management.</td></tr>
<tr><td>Major Objectives</td><td>Key Tasks and Benchmarks</td></tr>
<tr><td>Increase access to core services, HRSN interventions, and contracted programs to optimize health, prioritizing those with the greatest social and economic need.</td><td>• Ensure nutrition contracts meet target population needs, prioritizing home-delivered meal services that offer choice, consistency, and strict nutritional standards.
• Establish and support congregate meal services tailored to local community needs and resource availability.
• Partner with contractors to implement the Senior Farmers Market Nutrition Program, ensuring access for economically vulnerable seniors.
• Maintain food distribution and support via the Mobile Assistance Van (MAV) to 20 remote and/or economically underserved sites per month.
• Contract with volunteer transportation providers and advocate for expanded transit infrastructure in rural areas.
• Deliver direct support and resource connections to low-income mobile home parks and long-term RV campgrounds to address acute social and economic needs.
• Partner with regional Community Care Hubs to identify Apple Health enrollees with qualifying health-related social needs, coordinating direct referrals for nutrition and environmental home modifications.</td></tr>
</table>

Expand regional Brain Health and Dementia Supports to build a dementia-capable community infrastructure.	• Clinical Screening: Administer 30 MoCA Screenings annually to facilitate early detection, tracking, and referral pathways. • Enroll 25 care dyads in the evidence-based SHARE program for early-stage care planning. • Enroll 12 STAR-C clients for behavioral management support. • Host 24 Memory Café sessions annually, providing safe, stigma-free environment for peer-to-peer connection. • Develop 2 new Memory Cafés in unserved areas. • Deliver 24 art program classes per year designed to facilitate non-verbal communication and shared positive experience between individuals with dementia and caregivers. • Launch the brain-healthy chef demonstrations and expand Dementia Friends training to local business and hospitality sectors.
Facilitate implementation of evidence based (Title IIID) programs.	• Deploy highest-tier wellness programs across the service region, including Chronic Disease Self-Management workshops, Staying Active and Independent for Life (SAIL) fitness classes, Powerful Tools for Caregivers, Tai Ji Quan: Moving for Better Balance, and Savvy Caregiver. • Promote class registration via agency newsletters, website, and outreach.
Provide structured education and pathways for volunteering, civic engagement, and social participation.	• Continuously promote AASCW and localized community volunteer pathways via the agency website, newsletters, social media, and community networks. • Mobilize SNAP-eligible individuals into volunteer tracks in support roles to increase community disaster resilience and senior outreach capacity, ensuring participants receive documented hours, vocational skills, and workforce readiness mentoring.
Support legal services and abuse prevention through contracts and referrals.	• Contract with Northwest Justice Project for legal assistance. • Staff make referrals to the state Ombudsman program, APS, and other resources for concerns about abuse, neglect, and exploitation.

4.3 EXPANDING ACCESS TO HOME AND COMMUNITY BASED SERVICES (HCBS)

Most people want to remain in their homes and communities as they age, maintaining their independence, social connections, and quality of life. Washington State has long been a national leader in providing home and community-based services (HCBS) that help older adults and people with disabilities live safely and independently in the setting of their choice.

National research consistently demonstrates that older adults prefer to receive services and support in their homes and communities whenever possible. According to AARP's 2024 Home and Community Preferences Survey, 75% of adults age 50 and older want to remain in their current home, and 73% want to remain in their community for as long as possible. These preferences highlight the importance of accessible, coordinated HCBS systems that provide individuals with the services and supports needed to maintain independence and avoid unnecessary transitions to residential care settings.

Case management is a critical component of a strong HCBS system. Through assessment, person-centered planning, service coordination, advocacy, and connections to community resources, case managers help individuals identify their needs, access available supports, and develop coordinated plans that promote independence and well-being. By connecting people to the right services at the right time, including caregiver supports, nutrition, transportation, housing resources, and in-home assistance, case managers help individuals remain safely in their homes while ensuring supports are responsive to each person's unique circumstances.

AASCW provides multiple HCBS options that address social, personal, and health-related needs in home and community settings rather than institutional or clinical environments. Throughout AASCW's community needs assessment process, residents identified the importance of having supportive services available as their needs change and emphasized the need for a seamless pathway to access assistance. The continued expansion of services, including Health-Related Social Needs (HRSN) and WA Cares, provides new opportunities to meet the evolving needs of older adults, adults with disabilities, and working-age adults.

Case management is increasingly serving individuals with more complex needs. Client stabilization often requires additional time, coordination, and collaboration due to challenges related to housing instability, behavioral health needs, chronic health conditions, mental health support needs, and other social determinants of health.

As individuals experience increasingly complex circumstances, timely access to case management and supportive services is essential. Delays in eligibility determinations, assessments, or service initiation can create additional barriers for individuals at risk of declining health, reduced safety, or housing instability. To address these challenges, AASCW has implemented presumptive eligibility processes that allow individuals to receive guidance, service coordination, and needed supports as quickly as possible.

The Aging and Disability Resource Center (ADRC) is a trusted entry point for information about long-term services and supports, community resources, health programs, and public benefits. Services are available by phone and in person at each AASCW office. ADRC Specialists provide information, assistance, and options counseling to help individuals understand available resources, evaluate long-term care choices, and connect with services that support independence and quality of life.

Growing demand for case management services has increased pressure on workforce capacity, with current caseloads reaching 80 individuals per case manager. These demands can affect the time available for intensive, person-centered support required by individuals with complex needs. AASCW recognizes the importance of investing in workforce development, operational improvements, and community partnerships to ensure case managers have the capacity and support necessary to provide high-quality, person-centered services.

AASCW supports ongoing professional development opportunities that strengthen case management expertise in areas critical to effective service delivery, including dementia-informed practices, trauma-informed care, falls prevention, and other specialized areas of practice. Through partnerships with universities and local healthcare systems, AASCW expands opportunities for workforce development and interdisciplinary collaboration including serving as a clinical rotation site for Community Health Medicine students. These partnerships help prepare future healthcare professionals to better understand and respond to the needs of older adults and adults with disabilities living in community settings.

A Coordinated Response: One Call Can Change Everything

As an ADRC specialist, I am often the first person people reach out to when they are feeling overwhelmed and unsure where to turn. Many calls come from individuals facing a sudden health change or a point where they can no longer manage safely on their own. They have significant care needs, but they don't know what resources are available or how to navigate the systems designed to help them.

Recently, someone contacted our office during a very difficult time. He was undergoing chemotherapy for cancer, and the treatments had left him extremely weak. He was struggling to manage personal care at home and needed help, but he wasn't sure where to start. As we talked through his situation, we discovered another urgent concern – he did not have enough food. He was managing a serious illness while also trying to meet basic needs like preparing meals and maintaining strength.

I knew we needed to build a support system around him quickly. We started by connecting him with immediate food assistance, so he had access to nutritious meals. Then, I helped him apply for state programs and worked through the process of establishing long-term services and supports. This connection to services provided the funding needed for in-home caregiving assistance and connected him with a case manager who could help coordinate his ongoing care.

Often, people do not need just one service – they need someone to help connect the pieces. By listening, identifying needs and linking individuals to the right supports, AASCW helps people remain safely at home and ensures they do not have to navigate complex systems alone.

Through early engagement strategies, workforce investment, and strong community collaboration, AASCW remains committed to ensuring individuals receive timely, person-centered supports that promote independence, safety, and quality of life in the communities they call home.

Key Issue Area 3: Expanding Access to HCBS Goals and Objectives

Profile of the Issue: Access to timely information, person-centered planning, and coordinated home and community-based services is essential to helping individuals remain safe and independent in the setting of their choice. As needs become more complex, many older adults, adults with disabilities, and family caregivers require assistance navigating long-term care options, public benefits, and community resources.

Limited service availability for individuals who are not yet financially eligible for Medicaid long-term services remains a significant gap, particularly for middle-income households without long-term care insurance. Through comprehensive case management, options counseling, and the Aging and Disability Resource Center, AASCW helps individuals make informed decisions, access available resources, and develop plans that promote independence, dignity, and quality of life.

Goal/s:

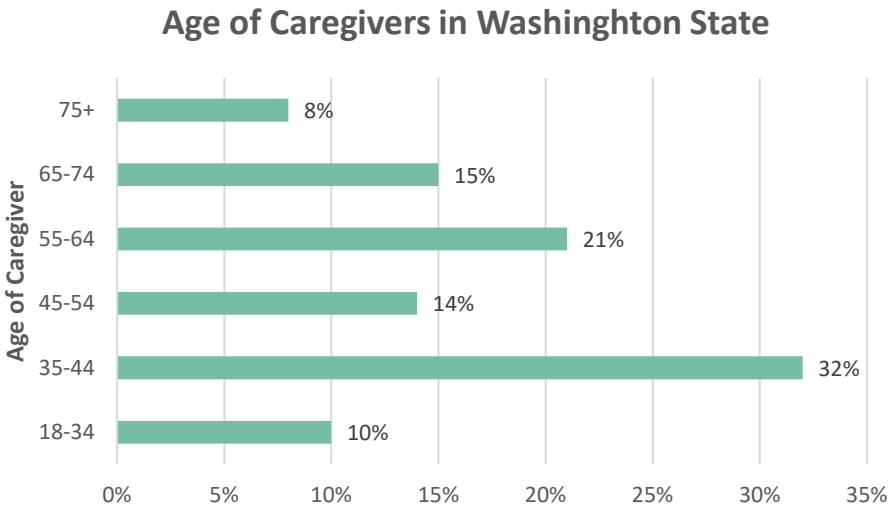
1) Deliver high-quality, person-centered case management through a skilled and well-trained workforce.
2) Connect individuals and families to information, services, and supports that maximize independence and quality of life at home and in the community; and in making successful transitions home following a hospital or nursing home stay.
3) Provide person-centered options counseling that empowers individuals to make informed long-term care decisions.

Major Objectives	Key Tasks and Benchmarks
Case Management services are provided by well trained staff who support complex care needs through plans that are person centered.	• Provide annual training on dementia, trauma-informed care, falls prevention, HRSN, and other emerging topics. • Clients are supported by program staff to access the services, programs, and interventions necessary to promote quality of life and independence of choice, and that meet their individual needs assessment. • Train staff to implement home modification, remediation, and adaptation services available through HRSN and WA Cares. • Ensure new ADRC Specialists complete Options Counseling, WA Cares, HRSN, and Care Transitions training within six months of hire.
Ensure that those with the greatest need have access to services that they can access easily	• Integrate Presumptive Eligibility in Care Transitions program to support streamlined client access to LTSS. • Provide local benefit counseling and public education on navigating WA Cares Fund benefits. • Sustain and expand partnership with hospitals, clinics, and facilities to provide Care Transitions Services. • Support older adults, people with disabilities, and family caregivers who are not eligible for or choose not to access Title XIX services by providing high-quality case management for all MAC/TSOA clients.
Advance advocacy efforts that promote equitable policies,	• Collaborate with Advisory Council, W4A, and coalitions to monitor, evaluate, comment on and advocate for policies, programs and

sustainable funding, and accessible benefits to strengthen the aging and disability network.	community actions that affect older adults, people with disabilities and caregivers.

4.4 CAREGIVING

Family caregivers are the foundation of the nation's long-term services and supports system. Caregivers represent a diverse population spanning multiple roles across the lifespan, reflecting multigenerational family dynamics and a wide range of household configurations. They include spouses and partners, adult children caring for aging parents, grandparents raising grandchildren, grandchildren caring for grandparents, members of the "sandwich generation" who simultaneously care for children and aging parents, and extended family members, friends, and neighbors who support individuals with disabilities or chronic health conditions.[5]



Source: AARP and National Alliance for Caregiving. Caregiving in the US 2025: Caring Across States. Washington, DC: AARP. October 28, 2025.

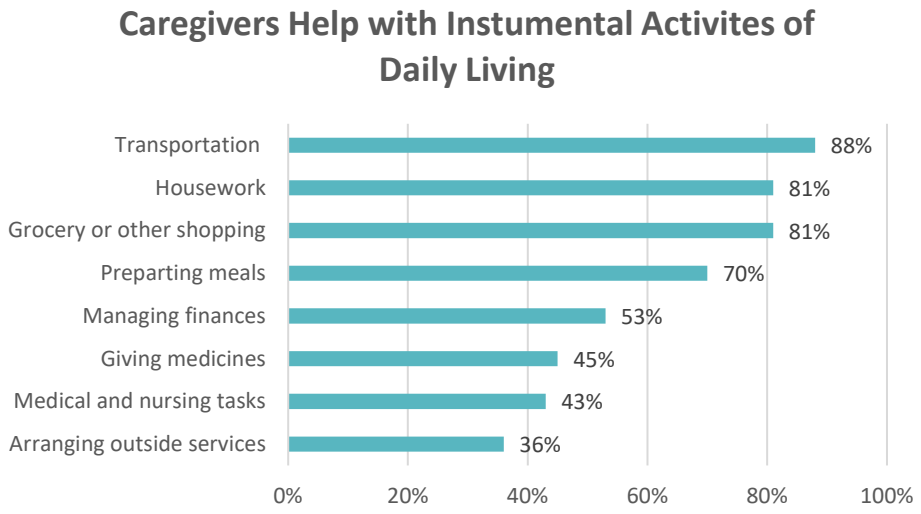
[5] Haley WE, Elayoubi J. Family caregiving as a global and life-span public health issue. Lancet Public Health. 2024;9(1):e2-e3. doi: 10.1016/S2468-2667(23)00227-X

Client Story: Kinship Caregiver Support Program

"I am a 79-year-old woman who has been raising [my] great grandboys for the past two years, as well as their father, my grandson, since he was two years old. He is now 38 years old, unable to work, and is awaiting a disability decision. I worked until very recently but was laid off and now have my grandson and his two boys living in my two-bedroom mobile home.

Without the assistance of the Kinship Caregiver Support Program, I would not be able to feed and house these boys on my Social Security check. This program is a godsend and has provided us with an annual shop at Walmart where groceries are much less expensive and I can buy in bulk."

Across Washington, an estimated 1.33 million adults provide unpaid care to a family member, friend, or neighbor, and approximately 94% care for an adult.[6] Many do not identify themselves as "caregivers" because the assistance they provide—preparing meals, managing medications, providing transportation, assisting with personal care, coordinating medical appointments, or helping with household tasks—is viewed simply as part of caring for someone they love. Yet these unpaid caregivers provide essential support that enables older adults and people with disabilities to remain safe in their homes and communities.



Source: AARP and National Alliance for Caregiving. Caregiving in the US 2025: Caring Across States. Washington, DC: AARP. October 28, 2025.

[6] Caregiving in the US 2025:Washington, October 2025, AARP and National Caregiving Alliance

Nationwide, family members are the primary source of care for older adults and individuals with disabilities or chronic conditions. According to a recent AARP report, approximately 59 million unpaid caregivers provided an estimated 49.5 billion hours of care valued at more than $1.01 trillion annually. Although unpaid, this care is far from free. Caregivers often experience significant economic, physical, and emotional consequences, including lost wages, reduced employment opportunities, financial strain, stress, declining health, social isolation, and limited personal time.

Client Story: Jack and Lyla* Receive Caregiver Support

Jack and Lyla spent decades building a life together and looked forward to retirement – time to enjoy slower mornings, evenings with friends, and experience the years they had worked so hard to reach.

As Jack's health declined, he developed diabetes, heart disease and eventually became paraplegic. Lyla became his primary caregiver, providing nearly all his daily support for almost five years. Overtime, the demands of caregiving left her feeling isolated, exhausted, and disconnected from many of the activities and relationships she once enjoyed.

When Jack and Lyla enrolled in the TSOA (Tailored Supports for Older Adults) program their experience began to change. Within a month, Lyla called to say the services had "changed their life." With regular respite support, she was able to leave the house again, reconnect with friends, go dancing, and enjoy time for herself without worrying about leaving Jack unsupported.

TSOA provided more than services — it provided relief, connection, and renewed quality of life. By supporting Lyla as a caregiver, the program also helped Jack remain at home with the person who knows him best.

**Names changed to protect privacy.*

These challenges are particularly pronounced in AASCW's rural four-county service area. Family caregivers often travel long distances for medical appointments, provide care that might otherwise be delivered by paid providers, and assume increasing responsibilities because of

shortages of in-home care workers, healthcare providers, transportation services, and other community-based supports.

To better understand local caregiver experiences and identify service gaps, AASCW conducted a regional caregiver survey. More than half of respondents were caring for a spouse or partner, while approximately one-third cared for a parent. Others were supporting grandparents or adult children. Nearly all respondents cared for someone with one or more chronic health conditions, and more than half were supporting a person living with Alzheimer's disease or another form of dementia.

Survey findings highlighted the significant personal, emotional, and financial impacts of caregiving. Nearly all respondents reported increased stress, with many describing declines in their own physical and mental health. Caregivers also reported taking on unfamiliar household maintenance tasks, managing increasingly complex medical and behavioral needs, and balancing caregiving with employment and other family responsibilities. Approximately half experienced social isolation and financial strain. More than one-third reported lost work time, and one-quarter had left the workforce altogether because of caregiving responsibilities.

Despite these challenges, caregivers also identified important sources of resilience. Peer support groups, counseling, respite services, hospice, and caregiver education were frequently cited as valuable resources that helped them sustain their caregiving role. Many also described developing deeper relationships with the person they cared for and finding meaning and purpose despite the challenges.

As the region's population continues to age, the demand for family caregiving will continue to increase. AASCW's four-county service area has a higher proportion of older adults than Washington State as a whole, resulting in a greater prevalence of Alzheimer's disease and related dementias. These demographic trends, combined with persistent shortages of healthcare professionals and direct care workers, will continue to increase reliance on unpaid caregivers and underscore the need for comprehensive caregiver supports.

AASCW currently provides a continuum of caregiver services through the Family Caregiver Support Program, Medicaid Alternative Care (MAC), Tailored Supports for Older Adults (TSOA), Dementia Catalyst services, caregiver education, behavioral consultation, respite care, support groups, and evidence-informed dementia training for family caregivers and community partners. Since 2024, AASCW has expanded dementia-specific programming to include Memory Cafés, arts-based engagement opportunities, and social respite programs designed to support both caregivers and individuals living with dementia.

The implementation of the WA Cares Fund represents an important opportunity to strengthen caregiver supports by expanding options for individuals who need long-term care, including

allowing eligible spouses to be compensated for providing care. While this benefit will not meet every caregiver's needs, it represents an important step toward reducing financial hardship and increasing flexibility for Washington families.

Supporting family caregivers remains a critical priority for AASCW because they are essential partners in helping older adults and adults with disabilities remain independent, healthy, and connected to their communities. Over the next four years, AASCW will continue to strengthen caregiver education, respite services, dementia supports, and access to community-based services while advancing policies and partnerships that reduce caregiver burden, improve caregiver well-being, and enable individuals to age in place with dignity, choice, and the highest possible quality of life.

<table>
<tr><td colspan="2">Key Issue Area 4: Caregiving

Profile of the Issue:
Older adults and adults with disabilities need access to comprehensive, reliable information to understand the aging and long-term care system. Of the 1.33 million unpaid caregivers in Washington, almost one-third of these unpaid caregivers help a person with memory loss. Most people cannot hire a private caregiver due to cost or availability. Requests for intermittent respite are hard to fulfill, as paid caregivers try to limit travel between multiple jobs in one day, leaving many unpaid family caregivers without a break.

Implementation of the WA Cares Fund beginning in 2026 provides an important opportunity to strengthen caregiver supports by expanding access to long-term care services and allowing eligible spouses to be compensated caregivers. AASCW will support successful implementation through outreach, education, provider network development, and collaboration with community partners.

Supporting family caregivers is essential to maintaining community-based long-term care, delaying or preventing unnecessary institutionalization, reducing avoidable hospitalizations, and improving quality of life for both caregivers and care recipients.</td></tr>
<tr><td colspan="2">Goal/s:
1) Family caregivers have timely access to information, education, and support services that improve their health, well-being, and ability to sustain their caregiving role.
2) Family caregivers have access to respite and community-based services that reduce caregiver burden and delay institutional care.
3) Strengthen the long-term caregiver support system through partnerships, workforce development, and advocacy.</td></tr>
<tr><td>Major Objectives</td><td>Key Tasks and Benchmarks</td></tr>
<tr><td>Increase awareness of caregiver services throughout the four-county region.</td><td>• Conduct outreach annually in all four counties through health fairs, senior centers, libraries, Tribal communities, first responders, healthcare providers, faith communities, and community organizations.
• Increase referrals to Family Caregiver Support Program (FCSP), Kinship Care Support Program (KCSP), and related caregiver services.
• Expand culturally responsive outreach and educational materials.
• Support advocacy efforts for spousal pay.</td></tr>
</table>

Increase caregiver access to education, counseling, and evidence-based support.	• Provide caregiver assessments and person-centered care planning. • Expand caregiver education, dementia training, support groups, and evidence-based caregiver programs. • Increase participation in Memory Cafes, caregiver workshops, and behavioral consultations. • Monitor caregiver satisfaction and reported reductions in stress and caregiver burden.
Expand access to respite and supplemental caregiver supports.	• Maintain and expand provider contracts for respite services. • Increase availability of supplemental services such as counseling, massage therapy, acupuncture, wellness programs, and caregiver coaching.
Increase enrollment in caregiver support programs.	• Enroll eligible caregivers in FCSP, MAC, TSOA, and Dementia Catalyst services. • Provide case management and ongoing reassessment. • Connect individuals awaiting services with available community resources and maintain active waitlist management.
Expand the caregiver support network.	• Recruit and support additional contracted providers. • Provide technical assistance to agencies interested in becoming qualified providers. • Develop partnerships with healthcare systems, Tribes, community organizations, university research and behavioral health providers. • Explore technological and AI tools that can reduce the caregiver burden.
Support implementation of WA Cares and policies that strengthen family caregiving.	• Educate consumers and provers regarding WA Cares benefits. • Assist eligible individuals in accessing benefits. • Support expansion of caregiver options, including spousal pay and other family caregiver supports. • Monitor implementation barriers and communicate system issues to WA Cares team.

4.5 PLANNING WITH NATIVE AMERICAN TRIBES AND TRIBAL ORGANIZATIONS

Aging & Adult Services of Coastal Washington (AASCW) honors the sovereignty of Tribal Nations and is committed to maintaining strong government-to-government relationships with Tribes throughout our service region. AASCW works collaboratively with the eight federally recognized Tribes in the region as well as the Chinook Indian Nation, which is recognized by the State of Washington. Our shared goals are to ensure Tribal communities are aware of and have access to AASCW programs and services; increase awareness of employment, Advisory Council, and grant opportunities; to provide technical assistance and support when requested; and to respond respectfully and effectively to Tribal priorities and concerns.

The 7.01 plans that follow reflect formal planning efforts conducted with participating Tribal Nations. Because participation in the planning process is voluntary and formal plans are not typically updated annually, these documents represent one component of AASCW's broader

and ongoing Tribal partnerships. Throughout the year, AASCW staff participate in Tribal health fairs, elder events, TANF events, and other community gatherings to share information, build relationships, and support access to available programs and services.

AASCW staff also provide presentations and training at the request of Tribal staff and community members on programs such as family caregiver support, dementia services, and other aging and disability resources. A culturally responsive dementia training designed for American Indian and Alaska Native communities is available upon request and has been shared with all Tribal partners. Dementia program staff have provided training to clinical staff at the Jamestown S'Klallam Tribe and, as of 2026, are working collaboratively with the Makah Tribe to expand dementia education and support.

Mobile Assistance Van (MAV) services are expanding into Tribal and surrounding communities in western Clallam County through AASCW's contracted provider, the Port Angeles Food Bank. The first event was held in Forks in June 2026. Additional mobile service locations are being developed with the goal of providing services at least quarterly. These efforts represent AASCW's continued commitment to improving access to resources in rural and Tribal communities.

<table>
<tr><td colspan="2">Key Issue Area 4: 7.01 Planning

Profile of the Issue: AASCW acknowledges the Tribal Nations whose ancestral and contemporary homelands are located within our service region and values the longstanding contributions of Native peoples to our communities. We are committed to strengthening partnerships that improve access to culturally responsive services for Tribal elders, adults with disabilities, family caregivers, and their families while fully respecting Tribal sovereignty and self-determination. Eight federally recognized Tribes are located within the AASCW planning and service area. AASCW also works with the Chinook Indian Nation and the Bay Center community to identify and address the needs of older adults and caregivers.</td></tr>
<tr><td colspan="2">Goal/s:
1) Improve access to AASCW programs and coordinated services for Tribal elders, adults with disabilities, caregivers, and families.
2) Strengthen partnerships with Tribal Nations through collaboration, outreach, technical assistance, and support for Tribal-led aging services.
3) Support opportunities for Tribal participation in planning, advisory activities, and service development.</td></tr>
<tr><td>Major Objectives</td><td>Key Tasks and Benchmarks</td></tr>
<tr><td>Strengthen government-to-government relationships with tribal nations.</td><td>• Conduct regular outreach and consultation with Tribal partners.
• Participate in Tribal health fairs, elder fairs, TANF events, and other community activities.
• Maintain regular communication with Tribal staff to identify emerging needs and opportunities for collaboration.</td></tr>
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Improve access to AASCW services for Tribal members	• Expand coordination of nutrition services, Home Care Services, Family Caregiver Support, Dementia programs, and other AASCW services. • Coordinate referrals between Tribal programs AASCW services as appropriate. • Continue expanding MAV services to Tribal and surrounding communities.
Increase on-site access to AASCW programs	• Schedule visits by family caregiver support, kinship navigator, dementia catalyst, and other program staff to Tribal centers and community events. • Provide presentations and educational workshops at the request of Tribal staff or Tribal communities.
Support all Tribal communities within the service area	• Continue outreach and technical assistance to Tribal Nations that choose not to participate in the formal 7.01 planning process. • Continue outreach to the Chinook Indian Nation and other Tribal communities within the service area.
Increase Tribal participation in AASCW planning	• Recruit and support Tribal representation on the AASCW Advisory Council. • Share Advisory Council vacancies, employment opportunities, grant opportunities, and other partnership information with Tribal Nations.