2027-2030 Area Plan

CLALLAM-GRAYS HARBOR-JEFFERSON-PACIFIC

FINAL DRAFT

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Olympic Area
Agency on Aging
d/b/a
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

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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.

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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

OUR MISSION

To empower older adults, adults with disabilities, and families across coastal Washington to live safely, independently, and with dignity in the communities they choose.

WHO WE ARE & HOW WE WORK

As the local Agency on Aging for Clallam, Grays Harbor, Jefferson, and Pacific counties, we lead our region in advocating, funding, and coordinating aging and disability services. We partner with healthcare providers, community groups, Tribal Nations, and local governments to secure daily support, home care, and public benefits. By strengthening our rural health systems, supporting the WA Cares program, and addressing essential needs like food, housing, and transportation, we ensure everyone has fair access to a healthier, better life.

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 Services 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 agency'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.

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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

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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.

Compassionate Care in the Final Days: The Power of Presumptive Eligibility (LTSS PE)

When a vulnerable individual needs immediate help to stay safely at home, every day counts. For one Clallam County resident, a rapid response from AASCW made all the difference in her final weeks of life. At the end of July 2026, the client was referred to the Long-Term Services and Supports Presumptive Eligibility (LTSS PE) Program – an initiative to bypass traditional bureaucratic delays for those in urgent need. Under standard procedures, the client would have faced a devastating five-week waitlist just to receive an initial assessment.

Recognizing the urgency, the case management team moved into action immediately:

- Day 3: A case manager coordinated the case and scheduled initial assessment.
- Day 4: The case manager completed the evaluation, officially qualifying the client for the program.
- Week 2: A local home care agency accepted the referral, and professional caregiving services officially began alongside home visits from a contracted nurse.

Thanks to Presumptive Eligibility, a process that normally takes over a month was compressed into just days. This rapid coordination granted the client expedited access to professional care during her last two weeks of life. Because of this vital safety net, she was able to spend her final days exactly where she wanted to be resting peacefully and with dignity in the comfort of her own home.

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 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 WA 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

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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. Expanding dementia supports and screening to isolated individuals and their care givers.
- 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.

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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
Congregate Nutrition	Contracted (OAA)	X	X	X	X
Senior Farmers Market	Contracted	X	X	X	X
Family Caregiver Support	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)*	-	-	X	-
MoCA	Direct (RHT Funding)*	X	X	X	X
Health-Related Social Needs (HRSN)	Hybrid (Direct/Contracted) *	X	X	X	X
Minor Home Repair/Senior Emergency	Direct (OAA)	X	X	X	X
Mobile Assistance Van	Contracted	X	-	-	-
ElliQ Smart Companion	Direct Pilot	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
***New Service**					

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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 24, 2026	South County Public Hearing
August 27, 2026	North County Public Hearing
September 2, 2026	Advisory Council review and recommendation for approval

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September 9, 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

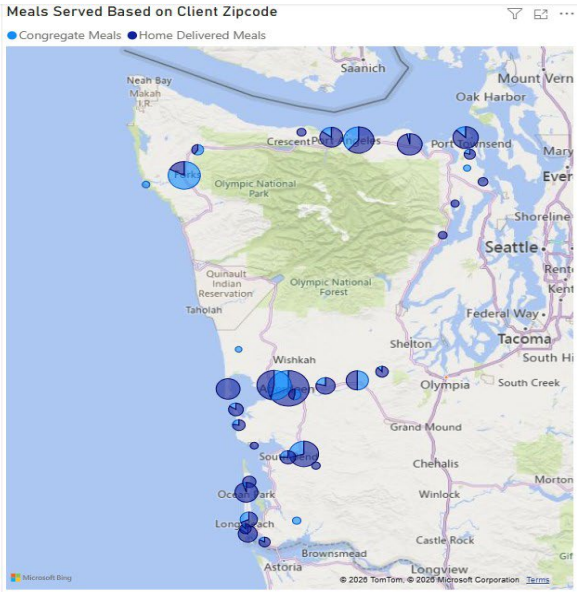
Several data sources were reviewed to best understand the demographics of who we serve and how the population is expected to change, as well as how our current service delivery may need to be adapted. Primary sources included:

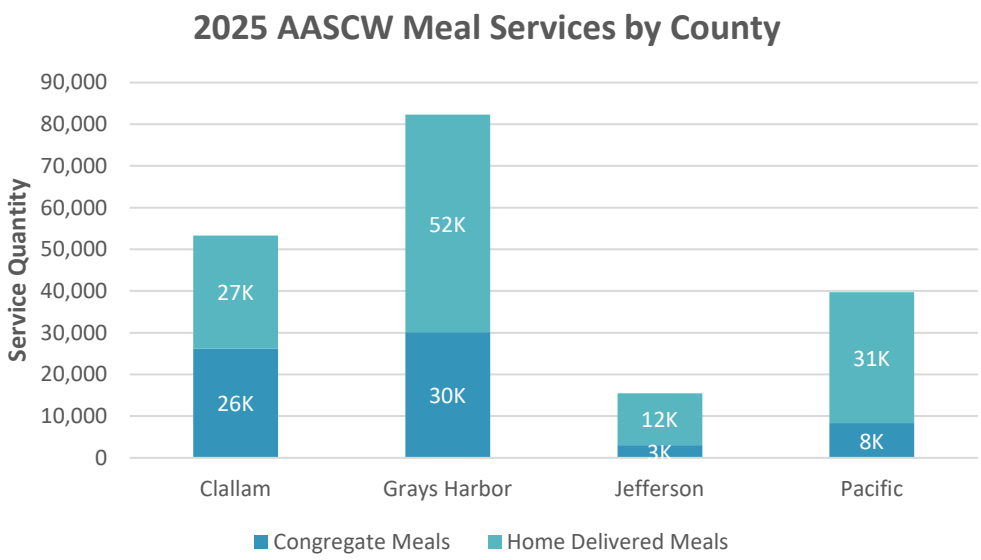
- AASCW service data collected through CLC (Community Living Connection) and DataMart to understand current service use and review year-over-year trends.
- Demographic data from the U.S. Census Bureau, Department of Social and Health Services (DSHS) Research and Data Analysis Division (RDA), Washington 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 2025 senior nutrition services utilization for home-delivered and congregate meals by county, based on CLC Service data. Mobile Assistance Van (MAV) services are not included because they are not funded through the Older Americans Act. The MAV serves remote coastal communities, including areas considered "food deserts."

Congregate meal participation has returned to pre-pandemic levels and continues to increase month over month. If current growth continues, we anticipate a funding shortfall by 2028 that

may limit our ability to meet growing demand. Grays Harbor and Pacific counties may be particularly affected given their consistently high levels of food insecurity and socioeconomic need.

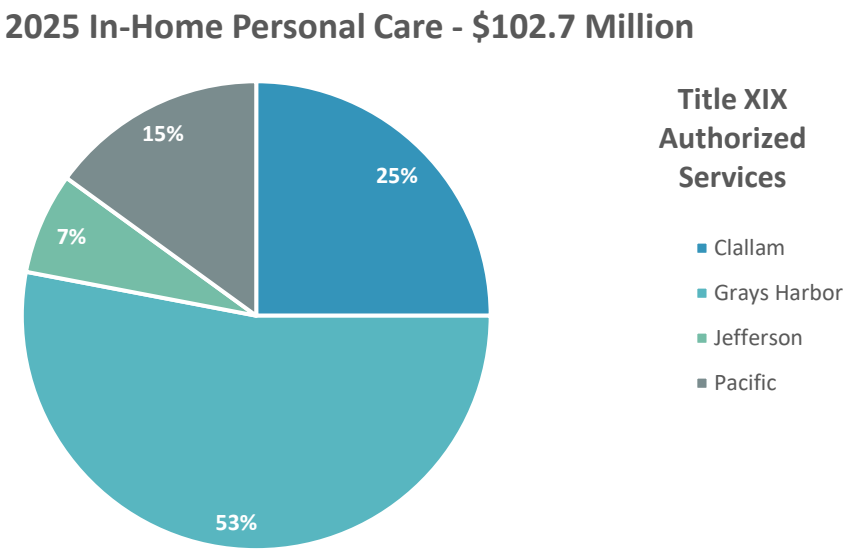




In 2025, AASCW case managers authorized more than $102.7 million in Medicaid-funded In-Home Personal Care services, helping older adults and adults with disabilities remain safely and independently in their homes and communities across Coastal Washington. As one of the region's largest long-term services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

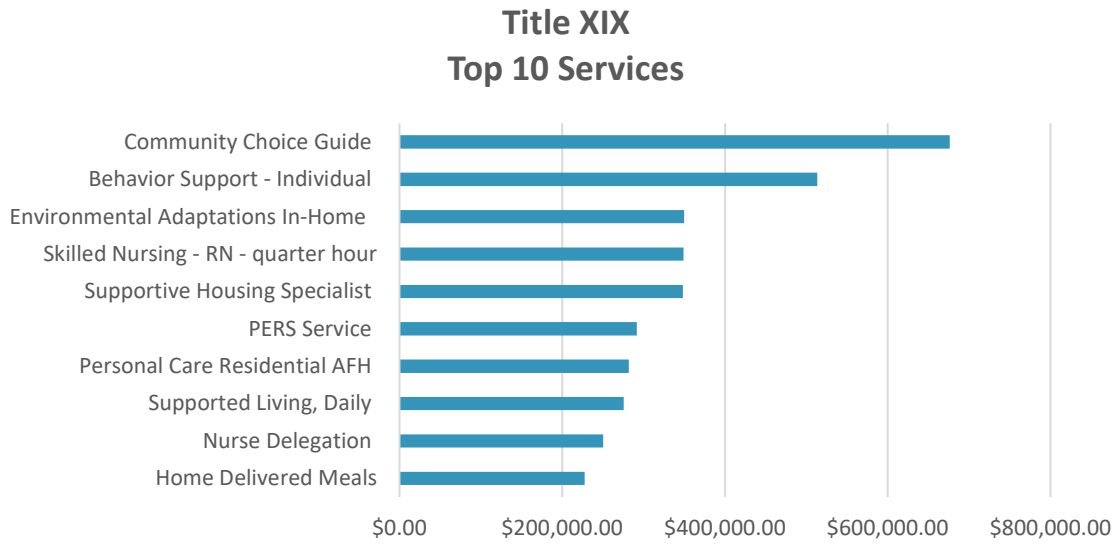
more costly institutional care. The value of authorized services varies across the four-county region, reflecting differences in demographics, economic conditions, and access to care.

- **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.

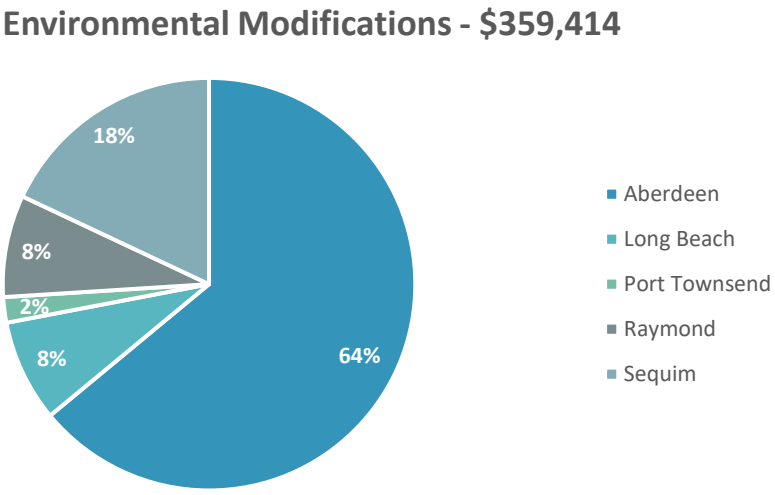


In addition to Medicaid-funded In-Home Personal care services, AASCW case managers authorized $3.6 million in specialized services designed to support individuals in remaining safely in their homes and communities and to provide alternatives to institutional care when appropriate. The largest share of 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.



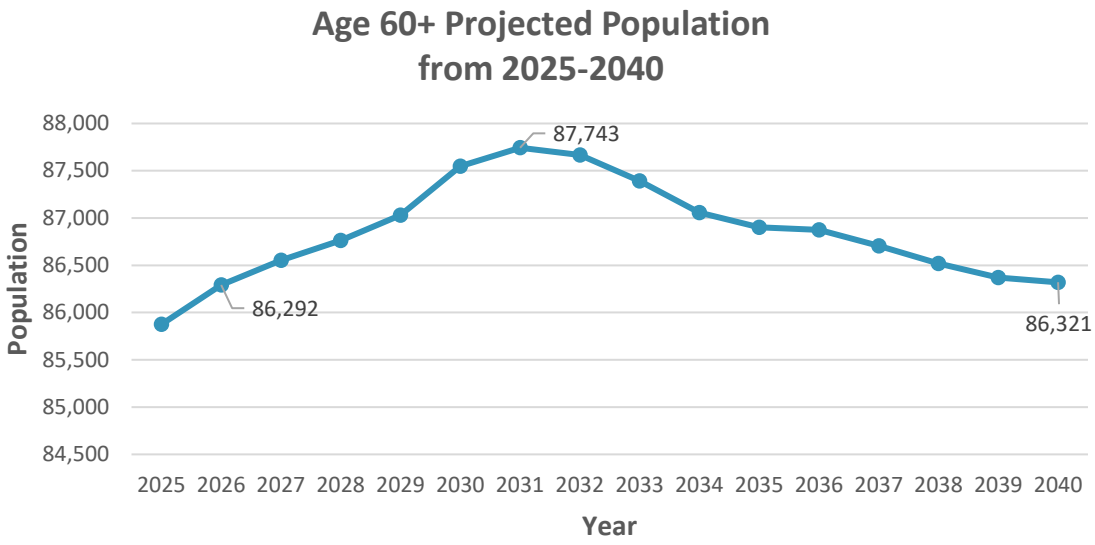
Case managers also authorized $359,414 in home modifications—including wheelchair ramps, walk-in showers, and grab bars—to improve safety, accessibility, and independence for older adults and individuals with disabilities in their homes. These authorizations were highly concentrated in Aberdeen, which 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.



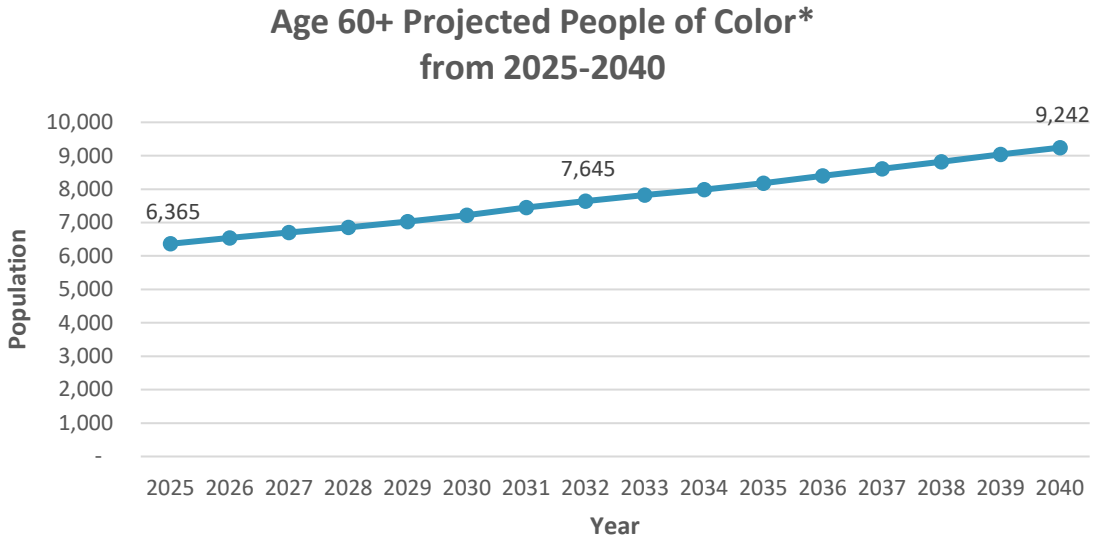
3.2 DEMOGRAPHICS: PSA PROFILE, DATA TRENDS

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.

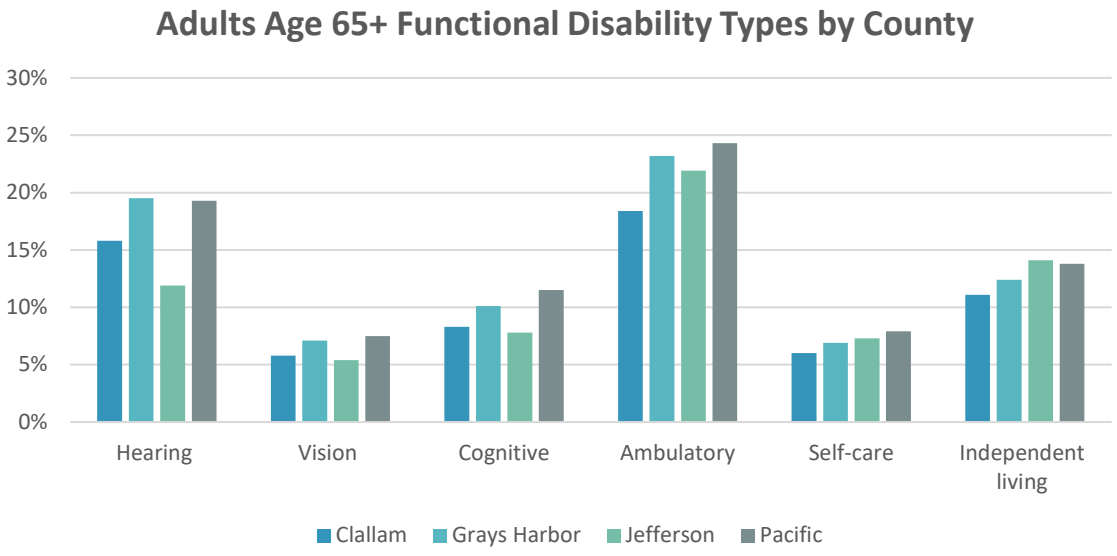
Data from the 2022 Behavioral Risk Factor Surveillance System (BRFSS) highlights the connection between disability and health outcomes, showing that adults with disabilities experience significant health disparities and are more likely to report conditions such as depression, obesity, diabetes, heart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



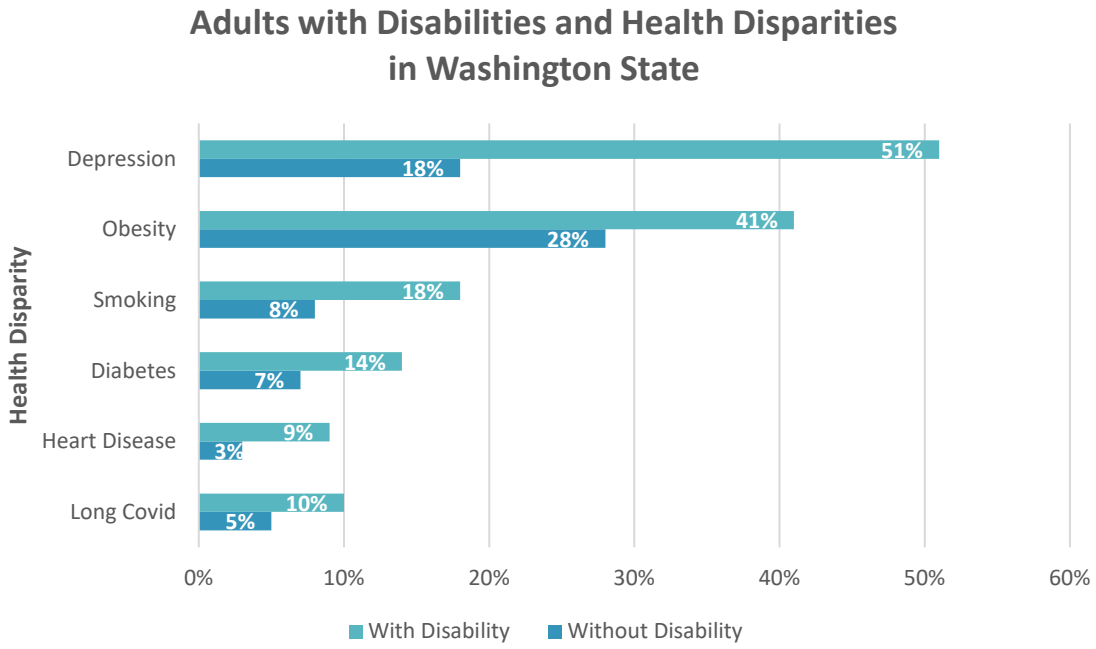
Source: Washington State Office of Financial Management, 2025.



**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.

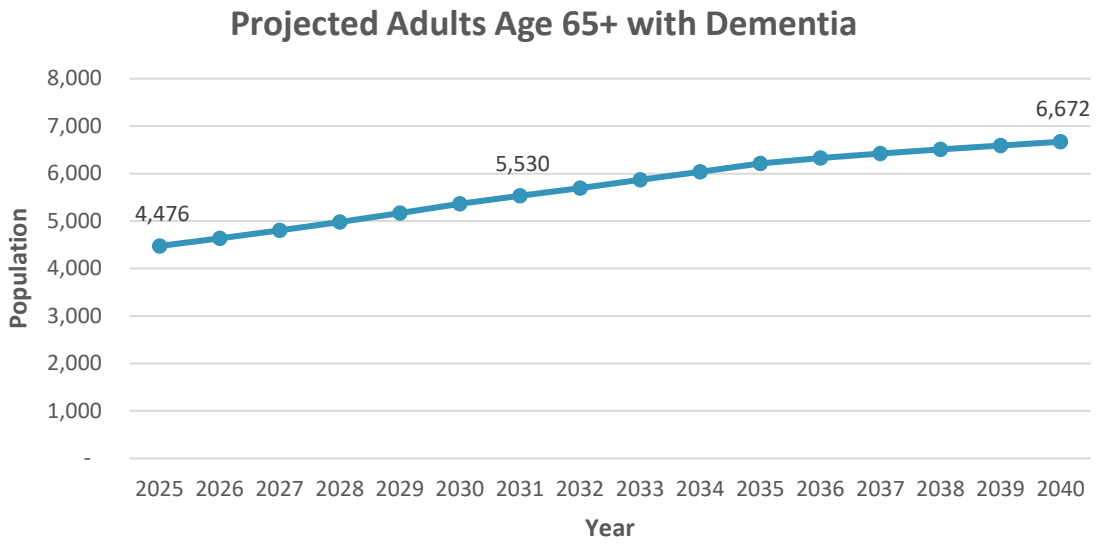


Source: 2022 Behavioral Risk Factor Surveillance System (BRFSS).

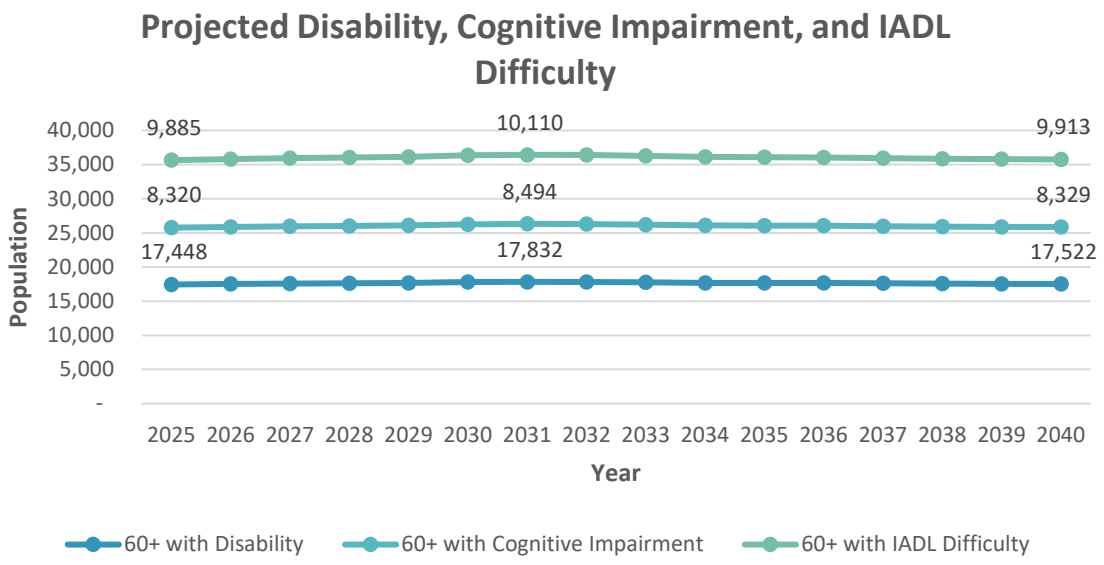
By 2030, as more members of the Baby Boomer generation enter their 80s, the complexity of long-term care needs across the region is expected to increase. State projections indicate that AASCW should prepare for an estimated 20% to 25% increase in the number of people living with dementia over the next 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	2026 Baseline	2030 Mid-Plan Outlook	2040 Long-Range Outlook	Planning Implications
Cumulative Population Change	Baseline	~ 0.5% Change	~ 1.0% Cumulative Change	Continued focus on service capacity and targeted supports.
Adults Age 85+	Growth underway	Increasing	Continued growth	Greater need for personal care, caregiver support, and services for higher functional needs.

Dementia Prevalence	Current prevalence baseline	+ 20% to 25%	+ 49%	Increasing need for dementia-capable services and caregiver supports.
Caregiver Workforce	Existing shortages	Continued pressure	Increasing gap	Continued investment in workforce development, technology solutions, and innovative service delivery.
Financial Vulnerability	Existing strain	Continued pressure	Increasing demand	Strong benefits navigation and access to affordable services.

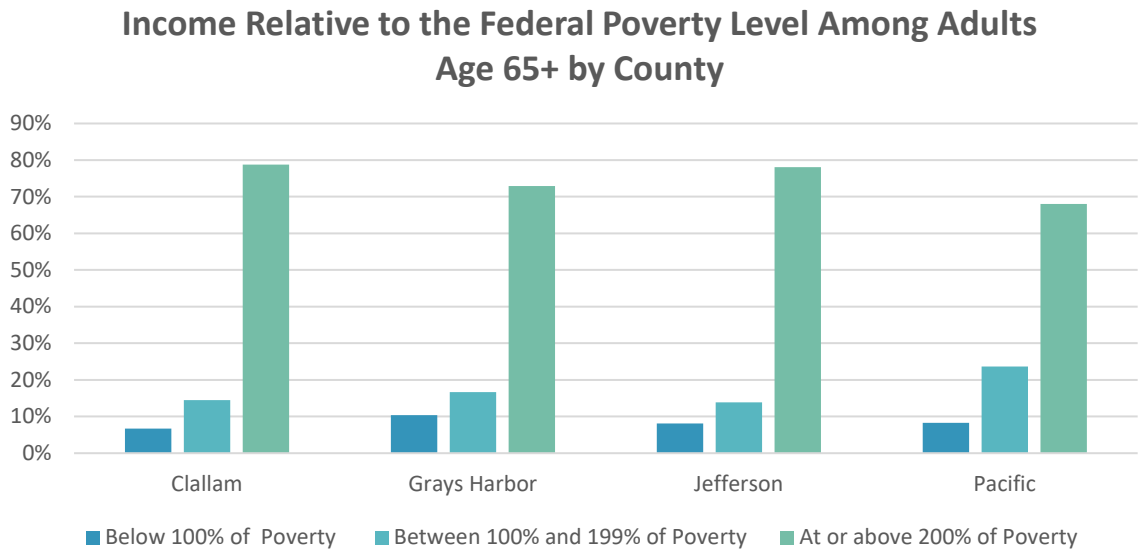
Although overall population growth is expected to remain relatively stable, the region's aging profile will drive increasing demand for aging and long-term services and supports. The continued growth of adults age 85 and older, combined with projected increases in dementia prevalence and ongoing caregiver workforce shortages, is expected to increase demand for community-based services and caregiver support. These trends underscore the importance of maintaining service capacity, strengthening dementia-capable and caregiver supports, expanding workforce strategies, and ensuring access to benefits and other safety-net resources for older adults experiencing financial vulnerability.

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.

Program data demonstrate broad reach across AASCW's four-county service area. From October 1, 2024, through June 30, 2026, beneficiary contacts reached 8.47% of the Medicare population in Clallam County, 10.29% in Jefferson County, 10.2% in Grays Harbor County, and 4.2% in Pacific County. Across statewide SHIBA performance measures, AASCW recorded the highest performance during this reporting period. These results demonstrate the program's capacity to connect Medicare beneficiaries with unbiased information, benefits assistance, and resources that can help reduce health care costs.

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.

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 temporarily prevented her from visiting the pantry, where she regularly picked up milk and a favorite treat – usually chocolate.

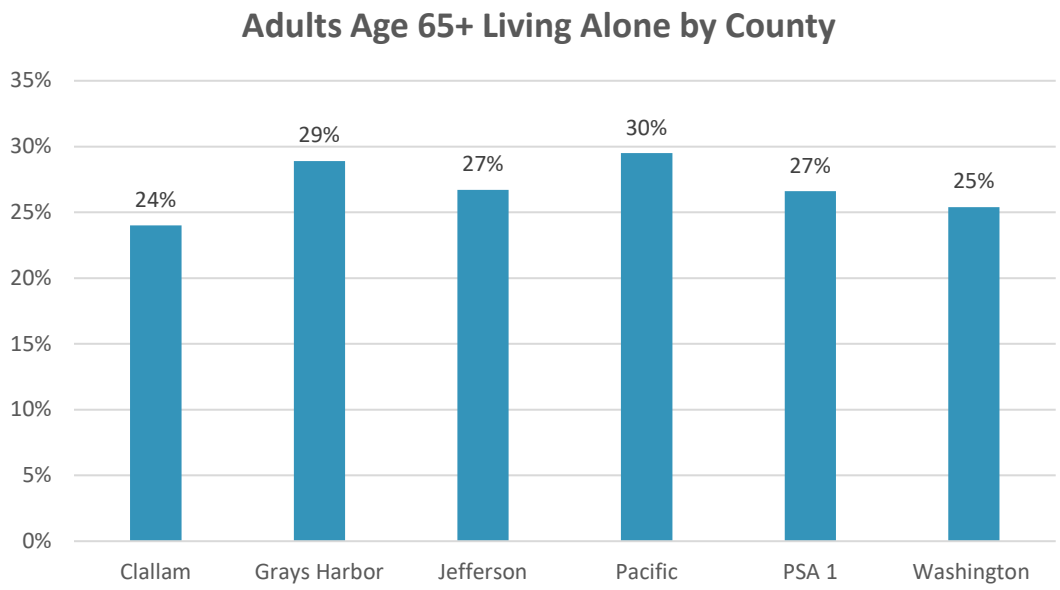
When she was unable to make the trip, her neighbor picked up a bag of groceries we prepared for her. By her second week of recovery, our coordinator was able to deliver the food directly to her apartment.

The joy she expressed made it clear that the visit meant far more than the groceries. It provided comfort, connection, and reassurance during a difficult time of recovery- and helped ensure that she continued to have access to nutritious food while she was unable to leave home.

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.

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

**Name changed to protect privacy.*

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. 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 October 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 one of the highest-ranking issues. 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.

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

[4] Ibid

Ratio of Population to Providers by County					
	Clallam	Grays Harbor	Jefferson	Pacific	WA State
Primary Care Physicians	1,080:1	2,660:1	1,120:1	4,020:1	1,170:1
Mental Health Providers	200:1	190:1	170:1	190:1	180:1
Dentists	1,050:1	1,930:1	1,980:1	4,840:1	1,130:1

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

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:

- Care Transitions: A program 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) recipients. 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

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>
</table>

Increase access to core services, HRSN interventions, and contracted programs to optimize health, prioritizing those with the greatest social and economic need.	• 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. • 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.
Expand regional Brain Health and Dementia Supports to build a dementia-capable community infrastructure.	• Clinical Screening: Administer 60 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.

A Coordinated Response: One Call Can Change Everything

ADRC specialists are often the first point of contact for individuals experiencing sudden health change or who can no longer safely manage on their own. Many callers have significant care needs but are unsure what resources are available or how to navigate the systems designed to support them.

Recently, a man undergoing chemotherapy for cancer contacted AASCW for assistance. Treatment had left him extremely weak and struggling to manage personal care at home. As the ADRC specialist explored his needs, they also identified an urgent concern: he did not have enough food. He was managing a serious illness while also struggling to meet basic needs such as preparing meals and maintaining his strength.

The ADRC specialist responded by coordinating immediate food assistance while helping him apply for state programs and establish long-term services and supports. This process ultimately provided the funding needed for in-home

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 residents. 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.

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

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:

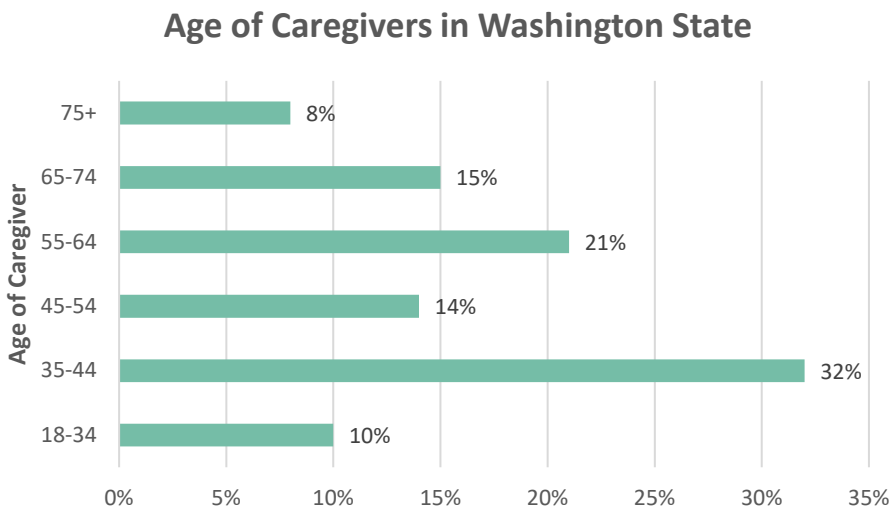
1) Deliver high-quality, person-centered case management through a skilled and well-trained workforce.
2) Connect individuals and families to information, services, and supports that maximize independence and quality of life at home and in the community; and in making successful transitions home following 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, sustainable funding, and accessible benefits to strengthen the aging and disability network.	• Collaborate with Advisory Council, W4A, and coalitions to monitor, evaluate, comment on and advocate for policies, programs and 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]



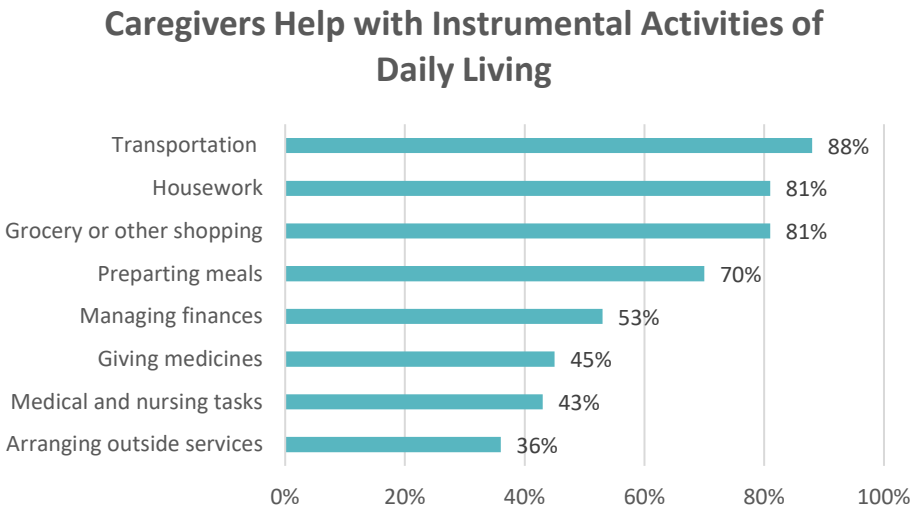
Source: AARP and National Alliance for Caregiving. Caregiving in the US 2025: Caring Across States. Washington, DC: AARP. October 28, 2025.

[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."



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

Client Story: Jack and Lyla* Receive Caregiver Support

Jack and Lyla spent decades building a life together and looked forward to retirement – a 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 and heart disease and eventually became paraplegic. Lyla became his primary caregiver, providing nearly all his daily support for almost five years. Over time, 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.*

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 provide an estimated 49.5 billion hours of care annually, valued at more than $1.01 trillion. Unpaid caregiving carries significant economic, physical, and emotional costs, including lost wages, reduced employment opportunities, financial strain, stress, declining health, social isolation, and limited personal time.

These challenges are particularly pronounced in AASCW's rural four-county service area, where family caregivers often travel long distances for medical appointments and provide care that might otherwise be delivered by paid providers. Shortages of in-home care workers, healthcare professionals, transportation services, and other community-based supports can further increase the responsibilities placed on family caregivers.

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. Nearly all respondents cared for someone with one or more chronic health conditions, and more than half supported a person living with Alzheimer's disease or another form of dementia.

Survey findings demonstrated substantial impacts on caregivers' well-being and economic stability. Nearly all respondents reported increased stress, with many experiencing declines in their physical and mental health. Caregivers described taking on unfamiliar household responsibilities, managing increasingly complex medical and behavioral needs, and balancing caregiving with employment and other family responsibilities. Approximately half reported social isolation and financial strain, more than one-third reported lost work time, and one-quarter had left the workforce because of caregiving responsibilities.

Caregivers also identified resources that helped them sustain their caregiving role, including peer support groups, counseling, respite services, hospice, and caregiver education. Many described developing deeper relationships with the people they cared for and finding meaning and purpose in their caregiving experience.

AASCW's four-county service area has a higher proportion of older adults than Washington State as a whole, contributing to a greater prevalence of Alzheimer's disease and related dementias. Combined with persistent shortages of healthcare professionals and direct care workers, these demographic trends are likely to increase reliance on unpaid caregivers and the need for accessible, comprehensive caregiver supports.

AASCW 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 that support both caregivers and individuals living with dementia.

The implementation of the WA Cares Fund presents an additional opportunity to strengthen the long-term care system by expanding options for individuals who need care, including allowing eligible spouses to be compensated for providing care. While WA Cares will not address every caregiver need, it may provide greater financial flexibility and expand access to long-term care supports for eligible Washington residents.

Over the next four years, AASCW will focus on strengthening caregiver education, respite and dementia supports, and access to community-based services while expanding partnerships and system coordination. These efforts will support caregiver well-being and help older adults and adults with disabilities remain safely and independently in their homes and communities.

Key Issue Area 4: Caregiving

Profile of the Issue: Family caregivers provide essential support to older adults and adults with disabilities, but many face significant challenges in accessing information, respite, and affordable paid care. Washington has approximately 1.33 million unpaid caregivers, nearly one-third of whom provide care to someone experiencing memory loss. In AASCW's rural service area, cost, workforce shortages, limited provider availability, and geographic distances can make paid care and intermittent respite particularly difficult to access, leaving many family caregivers with limited opportunities for relief.

The implementation of the WA Cares Fund beginning in 2026 presents an opportunity to expand access to long-term care services and strengthen supports for family caregivers, including provisions that allow eligible family members to be compensated for providing care. AASCW will support implementation through outreach, education, provider network development, and collaboration with community partners.

Strengthening the caregiver support system is essential to sustaining community-based long-term care and helping older adults and adults with disabilities remain safely in their homes and communities. Access to reliable information, respite, and other supports can reduce caregiver strain, strengthen caregiver capacity, and help delay or prevent unnecessary institutionalization.

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.

Major Objectives	**Key Tasks and Benchmarks**
Increase awareness of caregiver services throughout the four-county region**.**	• 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.
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; to 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.

Key Issue Area 5: 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.

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.

Major Objectives	**Key Tasks and Benchmarks**
Strengthen government-to-government relationships with tribal nations.	• 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.
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.

5. APPENDICES

APPENDIX A: EMERGENCY RESPONSE PLAN

AASCW EMERGENCY OPERATIONS & CONTINUITY PLAN

This Emergency Operations and Continuity Plan establishes the framework for response, recovery, and service continuity for **Aging & Adult Services of Coastal Washington (AASCW)**. This plan applies directly to all AASCW personnel across all branch offices and establishes emergency performance expectations for contracted service providers within **Clallam, Jefferson, Grays Harbor, and Pacific** counties.

1. Plan Governance, Training & Decentralized Leadership

Due to the geographical layout across four distinct, rural coastal counties, this plan establishes a decentralized management hierarchy to preserve branch office autonomy during prolonged communications or physical isolation.

Staff Preparedness & Training

- **Disaster Alert Enrollment:** All AASCW staff are encouraged to sign up for local disaster alerts and utilize the Washington Emergency Management Division preparedness site for personal emergency plan development and training videos.
- **Regional Exercises & Representation:** Leadership assigns one employee as the designated **Key Disaster Lead** for each AASCW office. These leads maintain in-depth plan knowledge, periodically attend local preparation meetings hosted by County Emergency Management, and share regional conference insights back with local offices.
- **Annual Practice Drills:** AASCW will conduct **one mandatory practice drill each year**. Learnings from these drills, alongside mandatory after-event feedback loops following *real-world activations, will be used to review and adjust this plan.*

Incident Command System (ICS) Structure

- **Incident Commander (Executive Director, Port Townsend Office):** Holds final authority over region-wide asset deployment, state-level reporting, and emergency fund activation.
- **Operations Lead (Case Management Director):** Directs vulnerable client tracking and physical wellness check deployment. Prioritizes critical care delivery.
- **Logistics & Infrastructure Lead (IT Director & Administrative Manager):** Manages physical branch structures and backup power. Ensures off-grid emergency database access.
- **Local Office Coordinators (Local Office Supervisors - Forks, Sequim, Aberdeen, Raymond, Long Beach):** Act as fully autonomous Incident Commanders for their

localized catchment areas if communications with the Port Townsend office fail completely.

Multi-Tiered Activation Matrix

The **Executive Director** (or designated alternate) has sole authority to formally activate this plan. Once activated, the Leadership Team will convene physically or virtually to execute coordinated responses. Regional supervisors and directors from unaffected areas will step in to provide both on-site and remote operational support to impacted zones.

Activation Tier	Triggering Event	Authority and Scope
Tier 1: Localized	Single-county storm, isolated utility outage, local bridge/road washout.	**Local Office Supervisor** directs the immediate branch response. No changes to regional staffing levels or structural operations.
Tier 2: Multi-County	Severe winter coastal windstorms, major highway blockages (US-101) affecting two or more counties, widespread power grid failures.	**Executive Director** assumes regional control. Regular non-essential case management is paused; staff shifted strictly to emergency triage and provider coordination.
Tier 3: Catastrophic	Cascadia Subduction Zone earthquake, regional tsunami, widespread infrastructure and communications collapse.	**Immediate Decentralization.** Every branch office operates under standalone survival protocols. Local Office Supervisors assume total command over local assets and client triage loops.

2. Staff Support, Safety & Accountability Protocols

AASCW cannot ensure the safety of its consumers without first ensuring the safety and accountability of its workforce. The following protocols must be enacted immediately upon plan activation:

Personnel Accountability Protocols

- **The 2-Hour Check-In Rule:** In a Tier 2 or Tier 3 event, all staff (including remote and field workers) must check in with their direct Local Office Supervisor or via the emergency check-in line within **two hours** of the event to report their safety and operational availability.
- **Supervisor Reporting Loop:** Local Office Supervisors must compile a staff status roster and attempt to relay it to the HR Manager via phone, satellite text, or radio as soon as feasible.

Staff Safety & Field Work Restrictions

- **Travel Discretion:** Employees must use strict professional discretion when determining whether it is safe to transport themselves to a client's home or to an agency branch office during hazardous conditions.

- **Field Visit Suspensions:** All routine in-home assessments and field visits are automatically suspended during a Tier 2 or Tier 3 activation, or during an active **Level 2 (Be Ready)** or **Level 3 (Leave Now)** Evacuation Order in their travel zone.
- **"Go-Bag" Preparedness:** All field staff traveling through rural corridors (such as Hwy 101, Hwy 12, or Hwy 4) are required to maintain an agency-approved winter/emergency vehicle kit containing emergency blankets, water, non-perishable food, and a backup power bank.
- **Secondary Branch Reporting:** If a major disaster occurs during working hours and a staff member cannot safely return home or reach their assigned office, they are authorized to report to the nearest accessible AASCW office or local County EOC to seek shelter and assist with operations.

Employee Assistance & Post-Disaster Support

- **Emergency Scheduling & Pay Continuity:** If an office is forced to close physically due to structural damage, power failure, or unsafe environmental factors, the agency will follow the established "Payment During Office Closure" policy to ensure staff pay continuity while operations transition to a virtual or secondary site.
- **Critical Incident Stress Management (CISM):** Following any Tier 3 catastrophic event or severe localized trauma, the HR and Administrative Manager will coordinate peer-support debriefings and activate the Employee Assistance Program (EAP) to support staff mental wellness.

3. Client Vulnerability Triage & Care Continuity

Routine Case Management Planning

AASCW Case Managers review disaster planning with all clients during routine assessments. This plan must cover:

- Developing a home disaster kit.
- Documenting emergency contacts, highlighting a local contact who can assist immediately.
- Creating an easily accessible list of important emergency contact numbers.

The Weekly Client Vulnerability Spreadsheet

To ensure immediate readiness, a spreadsheet of all active AASCW case management clients is compiled and sent to the **Leadership Team** and **Case Management Supervisors weekly**. This database must track:

- Client Name and Physical Address
- Inbound/Outbound Telephone Numbers

- Assigned Case Manager
- Specific Emergency Evacuation Needs (e.g., oxygen dependency, mobility limitations, transportation gaps).

High-Risk Client Contact Plan

Upon plan activation, Case Management Supervisors will divide the weekly vulnerable client list and coordinate staff assignments to execute the following triage loop:

- **Telephone Outreach:** Case Managers will call high-risk clients to verify their safety, assess their immediate well-being, and advise them on when a resumption of care services can be expected.
- **Natural Support Activation:** High-risk clients will be prompted to contact immediate family, extended family, or neighbors for local, immediate support.
- **Critical Care Coordination:** Staff will directly contact care providers for highest-priority clients, as well as equipment vendors responsible for maintaining life-sustaining medical equipment in client homes.
- **911 Escalation:** High-risk clients requiring immediate medical attention will be instructed to call 911. If the client is incapacitated or unable to do so, AASCW staff will call 911 on their behalf.
- **EOC Referrals:** High-risk clients requiring non-medical emergency assistance will be reported directly to the local county Office of Emergency Management EOC.
- **Welfare Check Activation:** If AASCW or the home care vendor cannot successfully reach a high-risk client via phone, or if communications are entirely down, AASCW will coordinate with local Emergency Management staff to deploy physical welfare checks to the client's home address.

4. Business Continuity & Infrastructure Recovery

Facility Safety Assessments

Following a disruptive event, Leadership or Supervisory staff will evaluate whether branch facilities are safe for occupancy.

- **Professional Inspection:** Staff will determine if an assessment can be safely handled internally, or if local fire departments, structural engineers, or building inspectors must be brought in first.
- **Temporary Relocation:** If an AASCW facility is deemed unfit for occupancy, the Executive Director will coordinate with county offices to identify temporary sites- or designate remote work.

IT and Communications Continuity

- **VOIP Phone Networks:** AASCW utilizes Cloud VOIP technology. In a disaster, staff can maintain full inbound and outbound phone functionality seamlessly while working remotely or out of alternative facilities.
- **Server Relocation & DSHS WAN Access:** If physical office servers must be relocated due to structural hazards, IT staff will coordinate directly with Washington DSHS IT personnel to establish a secure alternative placement that preserves client data access via the DSHS Wide Area Network (WAN).
- **Records Safeguarding:** Staff will immediately assess the physical status of paper records and specialized equipment required to maintain minimal regulatory functioning of all agency programs.

5. All-Hazards Response Protocols

Cascadia Subduction Zone & Tsunami Framework

- **Immediate High-Ground Evacuation:** Coastal branch offices in Raymond, Long Beach, Aberdeen, and Forks must immediately evacuate on foot to designated local high-ground geographical collection zones upon sensing prolonged seismic activity. Staff must not wait for formal sirens, radio notices, or administrative approval.
- **Post-Earthquake Assembly:** Once high ground is successfully reached and life-safety is established, staff will activate emergency check-in procedures, identify public disaster shelters to update local staff units, and prepare to pivot to community-based elder relief assistance if safe to do so.

Highway 101 Landslide & Physical Isolation Event

- **Mutual Aid Activation:** When physical washouts, mudslides, or tree falls close key segments of US-101, local branch supervisors will automatically activate local coordination agreements with adjacent fire districts and county emergency services to pool resources.
- **Shelf-Stable Food Logistics:** The Contracts & Planning Director will immediately coordinate with the Senior Nutrition and Home Delivered Meals provider network to authorize the distribution of pre-staged, multi-day emergency shelf-stable meals to isolated consumers in cut-off communities.

Active Shooter

- In the event of an active shooter or violent threat, our priority is the safety of everyone on site. Staff will evaluate immediate surroundings to evacuate if a safe path is clear or secure themselves in place.

6. Communications, Providers & External Coordination

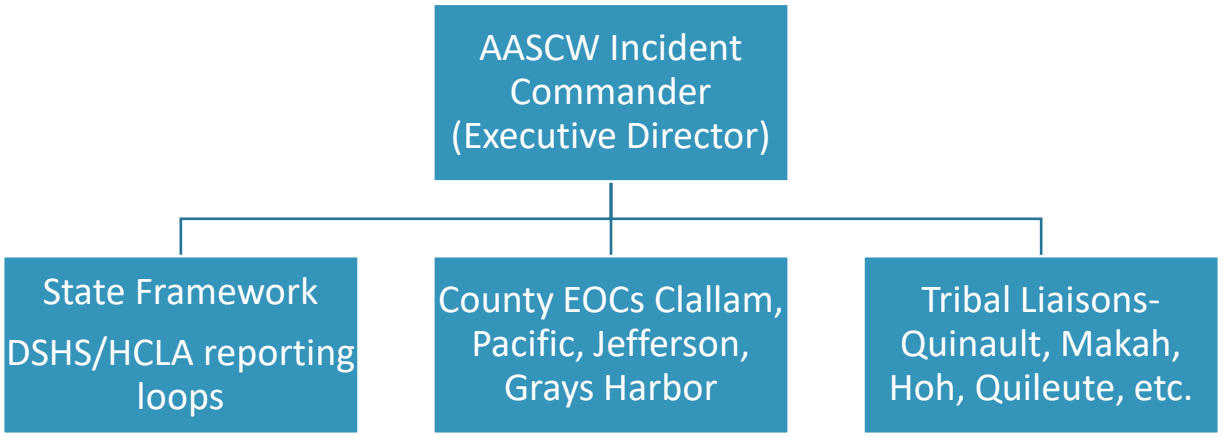
AASCW will maintain direct communication links with state, local, and sovereign partners to report regional status updates, resource gaps, and client vulnerabilities.

Provider Emergency Requirements

AASCW Contracts staff will periodically review emergency protocols with contracted service providers to ensure accountability across our network, emphasizing:

- Dynamic triaging of client care needs during local outages.
- Verified agency capacity to provide services during staffing shortages.
- Multi-agency service coordination to plug service gaps.
- Maintaining uninterrupted communication loops with AASCW regional staff.

External Interagency Mapping



- **State Frameworks:** The Executive Director or designee will serve as the primary conduit to report operational status directly to the Washington State Department of Social and Health Services (DSHS) and the Home and Community Living Administration (HCLA).
- **County Emergency Management Agencies:** Local Coordinators will maintain an active directory of county emergency resources (Emergency Management, Police, Sheriff, EMS, and Fire Departments) and communicate unmet community needs directly to the following hubs:

County Agency	Dedicated Emergency Management Phone
Clallam County Emergency Management Division	360-417-2305
Grays Harbor County Emergency Management	360-249-3911
Jefferson County Department of Emergency Management	360-385-9376
Pacific County Emergency Management Agency	360-875-9338

- **Tribal Nations Liaison Desks:** AASCW recognizes the sovereignty and unique emergency structures of local tribal nations—including the Quinault, Makah, Hoh, Quileute, Lower Elwha Klallam, Jamestown S'Klallam, Chehalis, Chinook, and Shoalwater Bay tribes. AASCW will coordinate resource sharing, communications redundancy, and vulnerable elder tracking directly with tribal emergency management personnel and health clinics.

Sample Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING

BETWEEN

AGING & ADULT SERVICES OF COASTAL WASHINGTON

AND

_____ COUNTY DEPARTMENT OF EMERGENCY MANAGEMENT

This MEMORANDUM OF UNDERSTANDING is hereby made and entered into by and between Aging & Adult Services of Coastal Washington, hereinafter referred to as AASCW, and _____ County Department of Emergency Management, hereinafter referred to as DEM.

1. Purpose:
   The purpose of this agreement is to promote a partnership between AASCW and DEM to help coordinate assistance efforts for AASCW clients during an emergency.
2. Problem:
   A. Each individual client is first and foremost responsible for him or herself. However, high priority clients (already frail) may be particularly vulnerable in the event of an emergency and may need special assistance to meet their needs.

B. AASCW and the DEM will need to have points of contact in order to facilitate emergency communications about the extent of the emergency and urgent, crisis needs of vulnerable clients in the impacted areas.

3. Rules:
   A. On an ongoing and regular basis,

      AASCW SHALL:

      a) Maintain current point of contact lists of the designated AASCW staff to communicate with the command centers of the counties including their names, titles, cell phones, email addresses, work phones, home phones, and any other means of communication with the DEM.

      DEM SHALL:

      a) Maintain and deliver current point of contact lists of the designated DEM staff to communicate with AASCW including their names, titles, cell phones, email addresses, work phones, home phones, and any other means of communication to the points of contact for AASCW.
      b) Respond as necessary during emergencies and disasters to the assigned AASCW staff to coordinate with the client contact health and safety checks as needed.

   B. During an event, the role of each entity in performing health and welfare checks will largely be dependent upon the available resources, priorities and direction of the overall response. Health and welfare checks should, as appropriate, follow the suggested general structure of questions as attached to this agreement.

4. Responsibilities of the parties. AASCW and DEM and their respective agencies and offices will handle their own activities and utilize their own resources, including the expenditure of their own funds, in pursuing these objectives. Nothing in this agreement shall obligate AASCW or DEM to obligate or transfer any funds. Each party will carry out its separate activities in a coordinated and mutually beneficial manner.

5. Commencement/Expiration/Termination. This agreement is in effect from _____ 2026 until amended or terminated by written request of either party and the subsequent written concurrence of the other. Either AASCW or DEM may amend or terminate this agreement with a 30-day written notice to the other party.

6. Principal Contacts. The principal contacts for this agreement are:

Aging & Adult Services of Coastal Washington	**County Department of Emergency Management**
Executive Director: Laura Cepoi laura.cepoi@dshs.wa.gov (360) 379-5064 Mobile – (360) 301-5426	
IT Director: Karin Beard karin.beard@dshs.wa.gov	

(360) 538-2450 Mobile – (360) 986-8910	
Case Management Director: Ann Peterson ann.peterson@dshs.wa.gov (360) 538-2449 Mobile: (360) 581-6945	
Case Management Supervisor: _____	

Authorized Representatives. By signature below, the parties certify that the individuals listed in this agreement as representatives of the parties are authorized to act in their respective areas for matters related to this agreement.

THE PARTIES HERETO have executed this agreement.

_____ _____

Aging & Adult Services of Coastal Washington Date
Laura Cepoi, Executive Director

_____ _____

County Emergency Management Department Date
Printed name: _____

Title: _____

ATTACHMENTS INCLUDED:

- Attachment 1 – Prioritization of AASCW Case Management Clients
- Attachment 2 – AASCW Case Manager Emergency Phone Script Check Questions for Clients
- Attachment 3 – Local Supervisor Cheat Sheet

ATTACHMENT 1: PRIORITIZATION OF AASCW CASE MANAGEMENT CLIENT FOR USE IN DECLARED EMERGENCIES

AASCW maintains a client list in the event that we or the local County Department of Emergency Management need to contact our clients to determine their safety.

Criteria for Assessing Client Risk

The following are guidelines for each of the classifications:

High Priority Client Lists

Solely:

- Is medically fragile and needs daily tasks to survive
- Has critical medical equipment that is dependent on electricity (i.e., oxygen, nebulizer)
- Is located in close proximity to disaster (based on some degree of judgement of type and severity of disaster)
- Has cognitive issues
- Has inadequate housing

-OR-

Two or more:

- Lives alone
- Is non-ambulatory
- Is geographically isolated
- Lacks functioning or close informal support systems
- Has a non-family independent provider

Low Priority Client for Contact

- Lives with family
- Lives in a senior or disabled housing complex
- Has a strong, local informal support system
- Has an Agency Provider

Note: Some High Priority Clients (HPC) may be at less risk based on their support systems – e.g., a medically fragile client living with a daughter who is a nurse by training, or a client with oxygen who is known to have an electrical generator. There is also a human element in assessing need, based on the case manager's and/or supervisor's knowledge of a client's circumstances.

The contact list includes the following:

Client Name

Physical Address

Phone Number(s)

Emergency Contact Name and Phone Number

Summary care needs/issues

AASCW maintains a master list of clients by zip code. This list is emailed to Leadership Team and Case Management Supervisors weekly and county specific lists are stored at _____, _____ and _____. Lists will be used solely to perform health and welfare checks on high priority clients.

PHASE 1: INTRODUCTION & SAFETY CHECK

*"Hello **[Client Name]**, this is **[Your Name]** from **Aging & Adult Services of Coastal Washington**. We are currently experiencing a widespread emergency **[insert event: e.g., storm / power outage / highway closure]** in our area. I am calling to check on your immediate safety. Are you doing okay right now, and do you have a safe shelter?"*

PHASE 2: RESPONSE TRIAGE PATHWAYS

PATH A: Immediate Medical Emergency

- **Trigger:** The client is injured, experiencing a medical crisis, or in immediate danger.
- **Script:** *"Please hang up right now and dial **911**. I am going to stay on the line with you if I can, or I will call them on your behalf right now to ensure help is on the way."*
- **Action:** If the client cannot call, **dial 911 immediately**. Give the dispatcher the client's verified physical address from your weekly spreadsheet.

PATH B: Client is Safe but Lacks Essentials (Power, Heat, Food, Water)

- **Trigger:** The client is not in medical danger but is isolated, freezing, or running out of food/water.
- **Script:** *"We are coordinating with our local county networks. Your routine home care services may be temporarily delayed due to road conditions, but we want to make sure you are safe. Do you have a family member, neighbor, or friend close by who can come over to assist you right now?"*
- **Action:**
    1. Encourage them to activate their natural local supports (family, friends, neighbors).
    2. Note their specific gaps (e.g., "needs water," "no heat") on your tracking sheet.
    3. Log the client's name with your Supervisor for an **Emergency Operations Center (EOC) referral** or **shelf-stable meal distribution**.

PATH C: Client Relies on Life-Sustaining Medical Equipment

- **Trigger:** The client utilizes an oxygen concentrator, dialysis machine, or other critical life-sustaining devices.
- **Script:** *"I see you have life-sustaining equipment at home. Do you currently have backup power, or has your equipment switched to its emergency battery?"*
- **Action:**
    1. If they have no backup power, instruct them to call family/neighbors immediately to help them relocate to a public shelter, or contact their equipment vendor.

2. Immediately escalate this client's name and address to your **Local Office Supervisor** to initiate a priority emergency responder intervention.

PHASE 3: WRAP-UP & REASSURANCE

*"Thank you for speaking with me, **[Client Name]**. Please stay indoors and stay off the roads if you can. If our phone lines go down completely and you cannot reach us, please remember that we are working directly with **County Emergency Management** to look out for you. Do you have your emergency contact list nearby just in case?"*

IMMEDIATE ACTIONS REQUIRED UPON EMERGENCY ACTIVATION (TIERS 2 & 3)

1. Staff Safety & Accountability (First 2 Hours)

- **Enforce the 2-Hour Check-In Rule:** Log all inbound check-ins from your office staff (including remote workers).
- **Compile the Roster:** Document who is safe, who is operationally available, and who is unaccounted for.
- **Report Upward:** Send your completed branch status roster to the HR Manager in Port Townsend via phone, satellite text, or radio as soon as humanly possible.
- **Halt Field Work:** Confirm that all routine in-home assessments and field visits are officially suspended for your office.

2. Client Triage & Welfare Operations

- **Deploy the Database:** Pull the most recent *Weekly Client Vulnerability Spreadsheet* for your area.
- **Divide and Conquer:** Distribute the list of high-risk clients among your available Case Managers.
- **Initiate Phone Calls:** Instruct Case Managers to begin the telephone triage script to check on client safety, home equipment power status, and natural support networks.
- **Coordinate Welfare Checks:** For any high-risk clients who cannot be reached by phone, log their details and prepare to request physical welfare checks through local Emergency Management.

3. Facility & Infrastructure Operations

- **Assess the Building:** Visually inspect your office structure for safety, power, and utility status if safe to do so.
- **Determine Fit for Business:** If structural integrity is compromised, notify the Executive Director immediately to coordinate temporary relocation or remote cloud VOIP routing.
- **Safeguard Essential Elements:** Secure or assess the status of physical client records and specialized equipment needed for minimal operations.

4. External Interagency Links

- **Connect with Your EOC:** Establish a direct line with your local County Emergency Operations Center to report unmet community needs or request welfare checks.
- **Engage Tribal Liaisons:** If your area borders or serves tribal nations, establish direct contact with tribal emergency personnel and clinics to sync elder tracking.

EMERGENCY CONTACT QUICK DIRECTORY

Jurisdiction / Office	Agency Hub	Emergency Management Phone
Clallam County *(Forks, Sequim)*	Clallam County Emergency Management Division	**360-417-2305**
Grays Harbor County *(Aberdeen)*	Grays Harbor County Emergency Management	**360-249-3911**
Jefferson County *(Port Townsend)*	Jefferson County Dept. of Emergency Management	**360-385-9376**
Pacific County *(Raymond, Long Beach)*	Pacific County Emergency Management Agency	**360-875-9338**

APPENDIX B: ADVISORY COUNCIL

Member	Geographic Representation
Lisa Law	Clallam County
Leah Rathwell	Clallam County
Marsha Melnick	Clallam County
Joseph Sharkey	Clallam County
Ginny Adams – Vice Chair	Jefferson County
Eileen Svoboda – SCOA representative	Jefferson County
Robert “Steve” Browning	Jefferson County
Jeanette Siburg	Jefferson County
Alice Sharp	Grays Harbor County
Sherry Ainsworth	Grays Harbor County
Vacant	Grays Harbor County
Vacant	Grays Harbor County
Beth Tripp	Pacific County
Darian Sheldon	Pacific County
Jeannine Grey	Pacific County
Elise Chayet	Pacific County
Vacant	Disability Representative
Vacant	Minority Representative
Vacant	Tribal Representative
Nancy Gorshe - Chair	Elected Official Representative

1. A regional survey of older adults, the Community Needs Survey, was distributed May-July 2026 in paper and electronic formats. It was widely distributed via email lists, the Advisory Council, a press release, website and social media, and paper copies with a QR code for electronic option distributed to libraries, senior centers, and health departments.
2. AASCW staff were surveyed in May 2026 to identify the top three needs observed for their clients. Fifty-four responses were received. Staff identified affordable housing (N=28), access to healthcare (N=27), and cost of food (N=23). Other responses in order were transportation (13), caregiver support (8), social isolation (7), Internet access (5), and in-home care and services (2).
3. After reviewing survey data and demographic data from a variety of sources (see below), the planning team developed goals and sought input from the leadership team.
4. The Advisory Council Planning Committee reviewed the draft plan in July 2026 and approved it for presentation at a series of public hearings.
5. The draft plan was presented to staff in August and they were invited to provide feedback.
6. Public Hearings were held in August 2026 in two locations, one in Aberdeen for Grays Harbor and Pacific County residents and one in Sequim for Clallam and Jefferson County residents. The draft plan was also available online and printed copies were available in AASCW's six offices for review.
7. Suggestions from staff and the public were reviewed and incorporated into the plan in September 2026.
8. The Advisory Council accepted the plan and recommended that the Council of Governments approve the plan for submission to the Aging and Long-Term Support Administration in September 2026.
9. The Council of Governments approved the plan on October 1, 2026, and it was submitted to HCLA.

Public Hearing Locations

- **Grays Harbor/Pacific Counties- August 24, 2026, 3-4:00 pm (Hybrid: Zoom option)**
  Coastal Community Action conference room
  101 E. Market St.
  Aberdeen, WA 98520

- **Clallam/Jefferson Counties-August 27, 2026, 2-3:00 pm (Hybrid: Zoom option)**
  AASCW office
  609 W. Washington St., Suite 16
  Sequim, WA 98362

Survey questions and responses from the Community Needs Survey and Caregiver Survey are included below.

ATTACHMENT 1: COMMUNITY NEEDS SURVEY

For Older Adults, People with Disabilities, and Caregivers

Help Shape Services in Your Community

We want to hear from you. Your responses will help improve services for older adults, people with disabilities, and caregivers in our region. This survey takes about 5 minutes. Your answers are confidential, and you may skip any question. (You may also complete the survey at o3a.org or use the QR code to access the survey.)

Thank you for sharing your experience.

I am: (check one): Age 50-59 □ Age 60-74 □ Age 75-84 □ Age 85+

□ Under 50 □ Adult with a disability □ Caregiver

I live in: □ Clallam County □ Grays Harbor County □ Jefferson County □ Pacific County □ Tribal community

ZIP Code:

How did you complete this survey?

□ QR Code □ Paper (in person) □ With help □ Online

What are the biggest challenges you are facing right now? (Select up to 3)

☐ Affordable housing
☐ Cost of food
☐ Transportation
☐ Access to healthcare
☐ In-home care/services

☐ Social isolation
☐ Internet access
☐ Caregiver support
☐ Other:

In the past 12 months, have you had trouble paying for:

Housing □ Yes □ No

Utilities □ Yes □ No

Food □ Yes □ No Medical care □ Yes □ No

What is the hardest cost for you to manage right now?

☐ Housing □ Healthcare □ Food □ Transportation □ Other

HEALTHCARE ACCESS

How easy is it to get the healthcare you need?

☐ Very easy □ Somewhat easy □ Difficult □ Very difficult What are the biggest barriers? (Select up to 2)

☐ Long distance to providers

☐ No transportation

☐ Cost

☐ Long wait times

☐ Lack of specialists

☐ Internet/telehealth issues

Have you used telehealth in the past year? □ Yes □ No □ Tried but could not access it

If a mobile health clinic could come to your area, which of the following services, if any, would you use?

☐ Blood pressure screening

☐ Blood glucose screening or A1C testing

☐ Mental health screening and referral to telehealth

☐ Chronic disease self-management education

☐ Vaccines

☐ Foot care

☐ Naloxone and opioid prevention

☐ Dementia screening and resources

☐ Telehealth for primary or urgent care:

In a typical week, how many times do you go somewhere other than medical appointments?

Less than once a week

1-3 times a week

More than 3 times a week

Do you have any of the following close to home that you can easily get to? (check all that apply)

Senior center (if you are 55+)

Community center

Gym

Accessible parks and/or walking trails

Other public places where you can exercise or socialize (please list)

COMMUNITY NEEDS SURVEY

For Older Adults, People with Disabilities, and Caregivers

SERVICES

Have you used local aging or disability services at O3A?

□ Yes □ No □ Not sure what is available What would help you most right now?

□ Help paying for basic needs

□ Transportation services

□ Healthcare access

□ In-home support

□ Social activities

□ Information about services

□ Other:

What is one change that would most improve your quality of life?

What services are missing in your community?

Thank you for your input!

SURVEY RESULTS

What are the biggest challenges you are facing right now?(Select up to 3)

Greatest Needs	Clallam	Grays Harbor	Jefferson	Pacific	Overall
Cost of Food	50	30	10	9	102

Affordable Housing	**32**	**18**	**11**	**6**	**69**
Access to Healthcare	**22**	**26**	**13**	**7**	**69**
Transportation	**18**	**16**	**7**	**6**	**48**
In-home care/services	**13**	**10**	**3**	**2**	**26**

What are the biggest challenges you are facing right now?(Select up to 3)

Answer Choices	**Responses**	
Affordable housing	**40.59%**	**69**
Cost of food	**60.00%**	**102**
Transportation	**28.24%**	**48**
Access to healthcare	**40.59%**	**69**
In-home care/services	**15.29%**	**26**
Social isolation	**15.29%**	**26**
Internet Access	**11.76%**	**20**
Caregiver support	**13.53%**	**23**
Other:		**32**
	Answered	**170**
	Skipped	**25**

In the past 12 months, have you had trouble paying for Housing?

Answer Choices	Responses	
Yes	22.70%	42
No	77.30%	143
Answered		**185**
Skipped		**10**

I am: (Choose one):

Answer Choices	Responses	
Age 50-59	14.87%	29
Age 60-74	35.38%	69
Age 75-84	21.54%	42

Age 85+	3.59%	7
Under 50	13.85%	27
Adult with a disability	6.67%	13
Caregiver	4.10%	8
	Answered	**195**
	Skipped	**0**

I live in:

Answer Choices	Responses	
Clallam	41.27%	78
Grays Harbor	31.22%	59
Jefferson	15.87%	30
Pacific	11.11%	21
Tribal Lands	0.53%	1
Answered		**189**
Skipped		**6**

How did you complete this survey?

Answer Choices	Responses	
QR Code	35.75%	69
Paper (in person)	37.31%	72
With help	1.55%	3
Online	25.39%	49
Answered		**193**
Skipped		**2**

In the past 12 months, have you had trouble paying for Utilities?

Answer Choices	Responses	
Yes	27.17%	50
No	72.83%	134
Answered		**184**
Skipped		**11**

In the past 12 months, have you had trouble paying for Food?

Answer Choices	Responses	
Yes	39.89%	75
No	60.11%	113
Answered		**188**

Skipped	**7**

In the past 12 months, have you had trouble paying for Medical care?

Answer Choices	Responses	
Yes	33.89%	61
No	66.11%	119
Answered		**180**
Skipped		**15**

What is the hardest cost for you to manage right now?

Answer Choices	Responses	
Housing	22.75%	38
Healthcare	16.17%	27
Food	22.16%	37
Transportation	14.37%	24
Other (please specify)	24.55%	41
Answered		**167**
Skipped		**28**

How easy is it to get the healthcare you need?

Answer Choices	Responses	
Very easy	15.87%	30
Somewhat easy	46.56%	88
Difficult	29.10%	55
Very difficult	8.47%	16
Answered		**189**
Skipped		**6**

What are the biggest barriers? (Select up to 2)

Answer Choices	Responses	
Long distance to providers	48.89%	88
No transportation	11.67%	21
Cost	27.22%	49
Long wait times	40.56%	73
Lack of specialists	52.78%	95
Internet/telehealth issues	5.56%	10
Answered		**180**
Skipped		**15**

Have you used telehealth in the past year

Answer Choices	Responses	
Yes	33.52%	61
No	60.99%	111
Tried but could not access it	5.49%	10
	Answered	**182**
	Skipped	**13**

If a mobile health clinic could come to your area, which of the following services, if any, would you use?

Answer Choices	Responses
Blood pressure screening	32.93%
Blood glucose screening or A1C testing	28.05%
Mental health screening and referral to telehealth	26.83%
Chronic disease self-management education	31.10%
Vaccines	40.24%
Foot care	
Naloxone and opioid prevention	
Dementia screening and resources	
Telehealth for primary or urgent care	

In a typical week, how many times do you go somewhere other than medical appointments?

Answer Choices	Responses
Less than once a week	21.05%
1-3 times a week	27.89%
More than 3 times a week	51.05%
	Answered
	Skipped

Do you have any of the following close to home that you can easily get to? (check all that apply)

Answer Choices	Responses

Senior center (if you are 55+)	64.20%	104
Community center	38.27%	62
Gym	48.15%	78
Accessible parks and/or walking trails	83.33%	135
Other public places where you can exercise or socialize (please list)		35
	Answered	**162**

Have you used local aging or disability services at O3A

Answer Choices		Responses	
Yes		22.28%	41
No		61.96%	114
Not sure what is available		17.93%	33
	Answered		**184**
	Skipped		**11**

What would help you most right now?

Answer Choices	Responses	
Help paying for basic needs	14.55%	24
Transportation services	9.09%	15
Healthcare access	12.73%	21
In-home support	7.27%	12
Social activities	13.33%	22
Information about services	18.18%	30
Other (please list)	24.85%	41
Answered		**165**
Skipped		**30**

What is one change that would most improve your quality of life?

Medical Services	18
Housing Costs	13

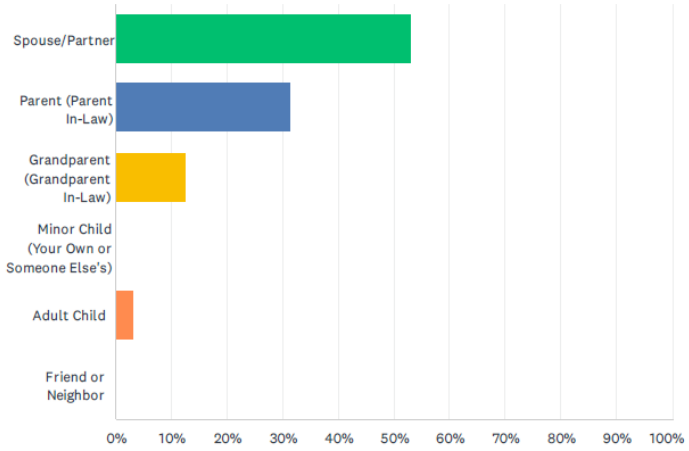
Financial Assistance	11
Transportation	8
Recreation/Social	7
Social	7
General	7
Personal health	6
In Home Care	6
Employment/wages	5
Food Access	3
Mental Health	3
Home Repairs	3
Food Costs	3
Medical Insurance	3
Help with Cleaning	3
Home Delivered Meals	2
Neighbor issues	2
Housing	2
Law Enforcement	2
Nothing	2
Yard Work	2
Dental Services	2
Improved Health	1
Family Proximity	1
Financial Educaiton	1
Internet Costs	1
I'm good	1
Insurance Costs	1
Training and support for Caregiving	1
Back Pain	1
Medication costs	1
Medical Costs	1
Grand Total	**130**

What services are missing in your community?

Medical Services	38
Recreation	15
Transportation	14
Housing	9
General Services	7
Adult Day Services	7
In home Health Care	7
Mental Health	6
Dental Services	4
Human Services	3
Food	2
Technology Education	2
Employment	2
Childcare	2
Internet Access	2
PACE	2
Senior Services	2
Unknown	2
Library Access	1
Food Costs	1
Walking	1
Many	1
Food Access	1
Education	1
Discounts	1
Grand Total	**133**

Q1 Who were you providing care for?

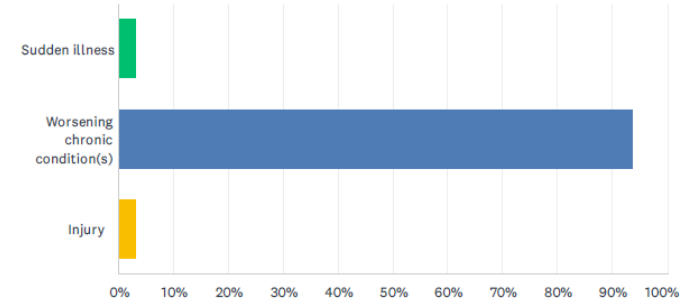
Answered: 32 Skipped: 1



ANSWER CHOICES	RESPONSES	
Spouse/Partner	53.13%	17
Parent (Parent In-Law)	31.25%	10
Grandparent (Grandparent In-Law)	12.50%	4
Minor Child (Your Own or Someone Else's)	0.00%	0
Adult Child	3.13%	1
Friend or Neighbor	0.00%	0
TOTAL		32

Q2 Briefly, what were the circumstances—why did that person need help? (for 3 months or longer)

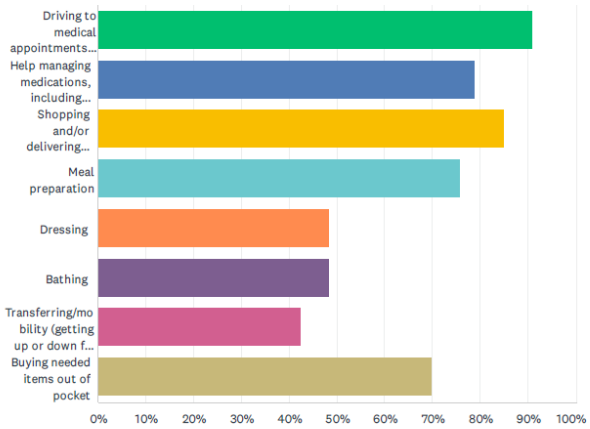
Answered: 32 Skipped: 1



ANSWER CHOICES	RESPONSES	
Sudden illness	3.13%	1
Worsening chronic condition(s)	93.75%	30
Injury	3.13%	1
TOTAL		32

Q3 What kinds of support did you provide or are you currently providing? (check all that apply)

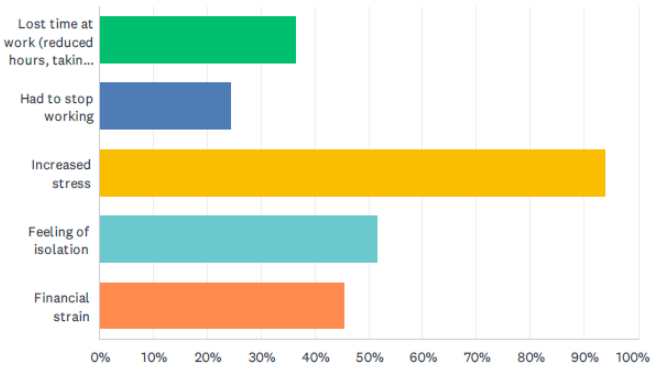
Answered: 33 Skipped: 0



ANSWER CHOICES	RESPONSES	
Driving to medical appointments and/or helping navigate treatment	90.91%	30
Help managing medications, including getting refills or providing reminders	78.79%	26
Shopping and/or delivering groceries	84.85%	28
Meal preparation	75.76%	25
Dressing	48.48%	16
Bathing	48.48%	16
Transferring/mobility (getting up or down from chairs, bed, etc.; transferring to a wheelchair; pushing a manual wheelchair or walker with a seat; etc.)	42.42%	14
Buying needed items out of pocket	69.70%	23
Total Respondents: 33		

Q4 How did this impact you? (Check all that apply)

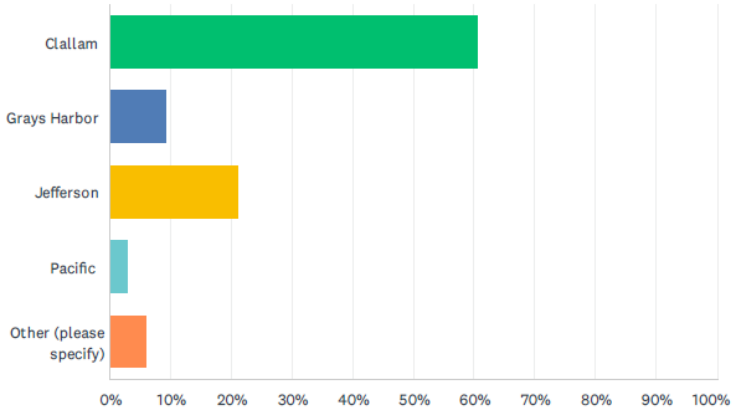
Answered: 33 Skipped: 0



ANSWER CHOICES	RESPONSES	
Lost time at work (reduced hours, taking leave)	36.36%	12
Had to stop working	24.24%	8
Increased stress	93.94%	31
Feeling of isolation	51.52%	17
Financial strain	45.45%	15
Total Respondents: 33		

Q5 Which county do you reside in?

Answered: 33 Skipped: 0



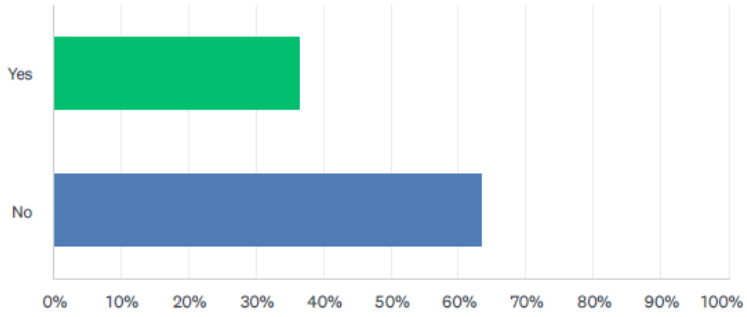
ANSWER CHOICES	RESPONSES	
Clallam	60.61%	20
Grays Harbor	9.09%	3
Jefferson	21.21%	7
Pacific	3.03%	1
Other (please specify)	6.06%	2
TOTAL		33

Q6 Is there anything else you want to tell us about your experience?

Answered: 22 Skipped: 11

Q7 Are you willing to be contacted for an interview to possibly share your story on social media to help people understand the impact of caregiving?

Answered: 33 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	36.36%	12
No	63.64%	21
TOTAL		33

Issue Area 1: Healthy Aging	
Goal: Older adults and adults with disabilities are supported in their health-related social needs through direct and contracted services, partnerships, and advocacy. (2) Affected Individuals and their families will have access to Brain Health resources & Dementia Support. (3) Older adults and their families will have the knowledge and support to make informed choices about chronic disease prevention and management.	
Measurable Objectives	**Accomplishments**
a. Increase access to services and supports by contracted programs that will optimize health, ensuring those in greatest social need are prioritized.	Congregate delivered meals increased significantly from 2023 to 2024 (29%) after the previous contractor in Clallam and Jefferson Counties was replaced with Coastal Community Action Program, which had been serving only Grays Harbor and Pacific Counties. From 2024 to 2025, congregate meals increased by another 11%. During the same periods, HDMs increased by 10% and then dropped by 4% in 2025. As of the end of Q1 in 2026, combined nutrition services were up another 17% over the previous year. National providers offer a broad choice of HDMs, including meals that are medically tailored. The Senior Farmers Market Nutrition Program has also expanded with the addition of the Port Townsend Farmers Market. In 2025, AASCW contracted with the Sequim Food Bank to provide Mobile Assistance Van (MAV) services in Clallam County; in 2026, we also contracted with the PA Food Bank. They are currently serving over 20 sites per month, most of them weekly, with approximately 2,000 individuals served per month (including duplicated guests). These services are wholly funded by agency fund balance.
b. Establish Dementia Action Catalyst Program in region	AASCW's dementia program launched in early 2024 as one of three AAAs in the state to provide dementia services. Staff provide professional training which is now certified by the Alzheimer's Association; free caregiver training; advanced planning for those with early memory loss; in-home behavioral consultation; community Dementia Friends training; and supports the development and operation of Memory Cafes and other community-based programs. Training for American Indian/Alaskan Native is also available and has been offered to tribes in the region. All staff are now certified to conduct MoCA assessments to screen for early signs of memory loss.
c. Facilitate implementation of evidence based (Title IIID) programs.	Title IIID funding supports Jefferson Healthcare's Tai Ji Quan workshops annually through 35 scholarships. In Pacific County, AASCW previously funded the Pacific Coast Senior Center to train SAIL trainers. Free SAIL classes continue. Ocean Beach Hospital was also funded to train staff on the Otago program. Other evidence-based programs are also funded in Clallam and Grays Harbor.
d. Reducing loneliness and Social Isolation	AASCW's three-year-old pilot project with the ElliQ Smart Care Companion has evolved into several areas. In 2025-26, we had partnership with a John A. Hartford Foundation fellow from the Mayo Clinic, who has presented at conferences and submitted academic papers examining how different states' Medicaid waiver rules may allow or limit such devices and looking at our pilot project and other data to learn which features participants use and self-reported data on loneliness and health outcomes. AASCW also shared information and feedback with DSHS, which initially approved ElliQ for RCW clients and then in 2026 expanded it to Community First Choice clients statewide.We continue to promote volunteer opportunities, congregate meal sites, and other community-based programs to encourage older adults and adults with disabilities to have meaningful social interaction and contribute to their communities via our Trending Healthy newsletter, website, and social media.

Issue Area 2: Expanding and strengthening services and supports that prevent or delay entry into Medicaid funded Long Term Services and Supports	
Goal: 1) Provide unpaid caregivers the opportunity to engage with healthy activities and benefit from community-based services and supports. 2) Reduce risks that lead to injuries and exacerbate medical conditions that require hospitalization and/or admission to short- and long-term facilities. 3) Ensure individuals can make informed choices about the care and supports they receive.	
Measurable Objectives	**Accomplishments**
a. Provide unpaid caregivers the opportunity to engage with healthy activities that support their wellbeing.	Community outreach occurred throughout the year at multiple venues, such as health fairs, printed and electronic articles, social media, etc. Caregivers and care recipients received timely needs assessment, case management services, and access to support groups and were supported to remain in their own homes/communities when they chose to do so. Contracted services were expanded with addition of new homecare providers. Executive Director participated in WA Cares workgroup and legislative advocacy for spousal caregiver pay.
b. Reduce risks that lead to injuries that lead to hospital admissions.	Fall prevention outreach materials are forwarded to partner agencies and first responders to share with people who may benefit from these services, SAIL programs are offered in Pacific and Jefferson Counties. Since 2024, three additional MOUs have been signed for the Care Transitions program, including Jefferson Healthcare, Olympic Medical Center, and North Olympic Health Network. Referrals have increased steadily, from 98 in 2024 to 196 in 2025 and 140 through the first half of 2026.
c. Individuals can make informed choices about the care and services they receive.	Senior Information & Assistance has been transitioned over to an Aging & Disability Resource Center (ADRC) with staff trained to assist individuals with additional programs, assessing eligibility and enrolling participants for some programs and providing more comprehensive, robust services. There were 3,389 SHIBA beneficiary contacts in 2025. Health Homes continues to serve clients with complex chronic conditions, despite the challenges presented by geographic distance in our rural region.
d. Elder abuse prevention and protection	AASCW terminated in-office SLAC clinics after a program review determined that services were heavily focused on wills and POAs, which was not aligned with program funding priorities, and significant staff time was required. AASCW redirected those funds to the Northwest Justice Project. The Long-Term Care Ombudsman Program was also discontinued and is now managed by the state. AASCW staff continue to make referrals for legal assistance and ombudsman services as appropriate, along with APS referrals, to prevent abuse and neglect of vulnerable adults. AASCW has continued to provide outreach for the WA Cares Fund through weekly social media posts, articles, paid advertising, presentations, and tabling at events.
e. Promote and support WA Cares access to prevent or delay entry into Medicaid enrollment.	AASCW has contracted with providers to expand the network for WA Cares eligible services. ADRC staff have received training to assist beneficiaries with navigating the application process and accessing benefits.

Issue Area 3: Person-centered home and community-based services	
Goal: 1) Case Management services are person-centered and provided by well trained staff. 2) Ensure that those with the greatest need have access to services that they can understand.	
Measurable Objectives	**Accomplishments**
a. Case Management services are provided by well trained staff who support complex care needs through plans that are person-centered, maximizing independence and the ability to engage in self-direction of services.	In addition to CORE training for Case Managers and certification as Community Resources Specialists for Aging/Disabilities, all-staff trainings have included dementia training for professionals (now certified by the Alzheimer's Association) and trauma-informed care. Staff also have access to Inform USA trainings on a variety of topics. AASCW clients receive person-centered planning or options counseling that reflects their goals, values, and preferences for available services and supports.
b. Increase access and equity.	AASCW responds to clients who request materials in alternate formats in a timely manner to ensure they are able to understand the information provided. Tribal outreach continues with regular participation in health fairs, elder events, and other activities as well as program presentations on request. Hispanic/Latinx outreach was attempted via a contract for bilingual outreach for the MAV but the contract was terminated for convenience. One current MAV contractor has bilingual staff onsite at some events.
c. Provision of optional Health Homes care coordination to individuals.	Health Home continues to enroll eligible individuals who choose to participate. Services include at least one monthly contact, in person, when possible, to support clients in improving health outcomes.

Issue Area 4: Coordination of Community Service Access with Tribal Nations	
Goal: 1) Ensure service access and coordination to Tribal members. 2) Support the development of Tribal service contracts to support Tribal Elders.	
Measurable Objectives	**Accomplishments**
a. Strengthen partnerships and services to elders and adults with disabilities by increasing outreach and providing more opportunities for tribal input.	Five tribes received Social Isolation grants to address elders' isolation stemming from the pandemic. Funds were used to increase technological access and literacy and support community outings for elders. Staff participated in 7.01 planning, including Program Managers, who shared information about new programs and opportunities for funding. Staff also participated in many tribal health fairs, elder events, and other events to share program information. The Tribal Liaison and Elder Program Manager from the Quileute tribe presented at a national Title VI chat about Mobile Assistance Van services. The Dementia Program Manager provided training to medical staff at the Jamestown S'Klallam tribe, is working with the Makah, and offered a training to all tribes in the region developed specifically for AI/AN.
b. Encourage participation in AASCW opportunities.	A Tribal Representative from the Jamestown tribe joined the Advisory Council in 2024. He resigned in 2026, and AASCW sent notice to tribes and OIC of the opening. Tribes are notified of AASCW job openings and grant opportunities.

APPENDIX E: STATEMENT OF ASSURANCES AND VERIFICATION OF INTENT

For the period of January 1, 2027, through December 31, 2030, the Olympic Area Agency on Aging D/B/A Aging & Adult Services of Coastal Washington (AASCW) accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (as amended through P.L. 116-131) and related state law and policy. Through the Area Plan, AASCW shall promote the development of a comprehensive and coordinated system of services to meet the needs of older individuals and individuals with disabilities and serve as the advocacy and focal point for these groups in the Planning and Service Area. The AASCW assures that it will:

- Comply with all applicable state and federal laws, regulations, policies and contract requirements relating to activities carried out under the Area Plan.

- Conduct outreach, provide services in a comprehensive and coordinated system, and establish goal objectives with emphasis on older individuals and unpaid family caregivers who have the greatest social and economic need.

All agreements with providers of OAA services shall require the provider to specify how it intends to satisfy the service needs of older individuals and unpaid family caregivers who have the greatest social and economic need within the Planning and Service Area.

Provide information and assurances concerning services to older individuals who are American Indians, including:

- Information concerning whether there is a significant population of older American Indians in the planning and service area, and if so, an assurance that the Area Agency on Aging will pursue activities, including outreach, to increase access of those older American Indians to programs and benefits provided under the Area Plan.

- An assurance that the Area Agency on Aging will, to the maximum extent practicable, coordinate the services the agency provides with services provided under title VI of the Older Americans Act; and

- An assurance that the Area Agency on Aging will make services under the Area Plan available, to the same extent as such services are available to older individuals within the planning and service area, to older American Indians.

Provide assurances that the Area Agency on Aging, in funding the State Long Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of

Title III funds expended by the agency in the base fiscal year 2019 on the State Long Term Care Ombudsman Program.

The [AAA] has received approval from the State Unit on Aging, Home and Community Living Administration to directly provide certain Title III services using OAA funding consistent with sections 307(a)(8)(A) of the OAA and 45 CFR 1321.65(b)(7).

Obtain input from the public and approval from the AAA Advisory Council on the development, implementation and administration of the Area Plan through a public process, which should include, at a minimum, a public hearing prior to submission of the Area Plan to DSHS/HCLA. The AASCW shall publicize the Hearing(s) through legal notice, mailings, advertisements in newspapers, and other methods determined by the AAA to be most effective in informing the public, service providers, advocacy groups, etc.

Laura Cepoi — 9/24/2026

Laura Cepoi, Director, AASCW — Date

9/25/2026

Nancy Gorshe, Advisory Council Chair, AASCW — Date

Lisa Olsen — 9/24/2026

Lisa Olsen, Pacific County Commissioner, COG Chair — Date