SECTION B – PLANNING AND SERVICE AREA PROFILE

B–3 AAA Services:

Service	Asotin	Benton	Columbia	Franklin	Garfield	Kittitas	Walla Walla	Yakima
Congregate Meals	X	X	X	X	X	X	X	X
Home Delivered Meals	X	X	X	X	X	X	X	X
Ethnic Sites		X		X			X	X
Transportation	X				X	X		X
Emergency Funds/Donations (Advisory Council)	X	X	X	X	X	X	X	X
Case Management	X	X	X	X	X	X	X	X
Aging and Disability Resource Center (ADRC)	X	X	X	X	X	X	X	X
Adult Day Health		X		X				
Adult Day Care		X		X			X	X
Dementia-specific Daycare								X
Legal Services	X	X	X	X	X	X	X	X
Foot Care	X		X	X		X		X
Medication Management	X		X				X	X
Ancillary Services	X	X	X	X	X	X	X	X
Respite	X	X	X	X	X	X	X	X
Family Caregiver Services	X	X	X	X	X	X	X	X
Kinship Navigator	X	X	X	X	X	X	X	X
Kinship Caregiver Services	X	X	X	X	X	X	X	X
Home Care Referral Registry	X	X	X	X	X	X	X	X
Nursing Services	X	X	X	X	X	X	X	X
Senior Center Dental			X		X	X	X	X
Health Home	X	X	X	X	X	X	X	X
Chronic Disease Self Management Program (CDSMP)	X				X		X	X
Care Transitions Intervention (CTI)		X		X				X
Bathing Assistance (OIPC)	X	X	X	X	X	X	X	X
Title V	X	X	X	X	X	X	X	X
Elder Abuse	X	X	X	X	X	X	X	X

Service Definitions:

Congregate Meals: is the provision of a meal which complies with USDA guidelines to an eligible client at a nutrition site, senior center or a congregate meal site.

Meal Sites: Cle Elum Senior Center, Ellensburg Adult Activity Center, Selah Civic Center, Harman Center in Yakima, Union Gap Ahtanum Youth Park, Southeast Yakima Community Center (ethnic/African American), Sunnyside Senior Center, Grandview Community Center, Benton City, Prosser Senior Center, Pasco Senior Center, Richland Community Center, Parkside Center in Pasco, Connell Community Center, Walla Walla Senior Center, Burbank Grange Hall, Waitsburg Presbyterian Church, Garfield County (Pomeroy) Senior Center, Valley Community Center in Clarkston, Asotin Methodist Church and Columbia County (Dayton) Senior Center. Ethnic sites for Hispanic seniors are provided in Yakima, Walla Walla, Benton and Franklin counties.

Meals on Wheels/Home-Delivered Meals is the provision of a meal which complies with dietary guidelines of USDA to an eligible client. This is provided in all eight counties.

Transportation services are designed to transport older persons to and from social services, medical and health care services, meal programs, senior centers, shopping and recreational activities to enable such services to be accessible to eligible individuals who have no other viable means of transportation. Personal assistance for those with limited physical mobility is provided.

ALTC funds transportation in counties that do not have funding through the Public Benefit Transit Administration. Rides are funded in Kittitas County through a contract with HopeSource; Yakima County through People For People; and with Interlink Transportation for Asotin County seniors. Garfield County is an Unincorporated Public Transportation Benefit Area which ALTC supports.

Adult Day Health services are provided to eligible individuals in a group setting and on a regular recurrent basis in order to prevent or delay entrance into 24-hour care or reduce the length of stay in 24-hour care. Services are designed to address the physical, emotional and cognitive needs of participants and include rehabilitative nursing, health monitoring, occupational therapy, personal care, social services, activity therapy and a noon meal.

The only Adult Day Health (ADH) program in ALTC's service area is contracted with Benton Franklin Elder Services (BFES) in Benton County with administrative support from Trios Health Hospital. Participants from Pasco, Connell and other smaller cities and towns nearby are also welcomed.

Adult Day Care enables families of older persons to obtain relief from constant care and provide isolated older persons with opportunities for socialization. Services are designed to address the social needs of participants and the need of families for a safe, comfortable place to leave an adult 18 years or over with functional disabilities on a regular or irregular basis.

Adult day care is provided at the Walla Walla Senior Center, the Harman Center in Yakima (City of Yakima Contract/Parks and Recreation) and through Catholic Family and Child Services for specialized dementia care, also in Yakima. BFES also provides adult day care services to participants from Benton and Franklin counties.

Ancillary Services (Title XIX) provides additional services to assist Medicaid individuals who qualify for Community First Choice (CFC) to remain at home. ALTC has over eighty contracts throughout its eight counties to provide COPES ancillary services to individuals who need assistance staying at home for their long term care. These may include home modification, a personal emergency response (PERS) unit, pain management, wheelchairs, walkers and other services that may come up from time to time.

Geriatric Preventative Foot Care is the provision of foot care through either clinics or senior centers where a registered nurse provides the service. Each county has access to foot care through ALTC's funding, another agency or church. Counties funded by ALTC include Kittitas, Yakima, Franklin, Burbank area of Walla Walla, Asotin, and Columbia.

Information and Assistance (I&A)/Aging and Disability Resource Center (ADRC) is a public access point for long term supports and services. This is a free service for older individuals, adults with disabilities and family caregivers to access a wide range of community-based resources. Functions of this component include information giving, service referral, client advocacy, and screening to determine whether or not an individual should be referred for a comprehensive assessment and case management. The ADRC is also responsible for community outreach, program publicity, and developing and maintaining community resources in the statewide Washington Community Connections resource database.

Emergency Funds/Donations are maintained by individual ALTC Advisory Councils for special circumstances that might arise. The source of all funds is private donation from individuals, groups and United Way (in some counties). Funds are provided for prescription medications, utilities, rental assistance and other emergencies. Applications for funds may come from other community agencies, walk-ins to the ADRC offices or through home visits.

General Case Management is assistance either for access or care coordination in circumstances where older or disabled persons and/or their caregivers are experiencing diminished functioning capacities, personal conditions, or other characteristics which require the provision of services by formal service providers. Activities of case management include assessing needs, developing care plans, authorizing services, arranging services, coordinating the provision of services among providers, follow-up and reassessment as required.

Title XIX Case Management assists functionally impaired adults at risk of institutionalization in accessing, obtaining, and effectively utilizing the necessary services that will enable them to maintain the highest level of independence in the least

restrictive setting. Activities to achieve this goal include a comprehensive assessment of individual needs, development of a detailed plan of services, authorization of services, and ongoing monitoring of health and long term care.

Home Care Referral Registry (HCRR) is a web-based database designed to enhance the quality of home care through maintenance of a list of qualified individual providers who are ready and available to work. Potential caregivers are recruited, interviewed, have a background check completed, and are contracted to provide care to consumers who use publicly funded in-home care services (Aging Services, Developmental Disabilities, and Children's Services). As both consumers and their case managers can access the Home Care Referral Registry, both parties are able to find matches to the consumer's needs. The registry serves to further the image of the caregiver as an employee in the community.

Nursing Services is one of ALTC's contributions supporting clients' independence in the community. Registered Nurses may review the clients comprehensive assessments, provide nursing assessment or reassessment, provide instructions to clients and caregivers and evaluate health-related care needs affecting service planning and delivery. ALTC Nursing Services has a diverse client list that includes clients of the Division of Developmental Disabilities Medicaid Personal Care program, clients of the Home and Community Services Medicaid Personal Care and COPES programs, clients of the ALTC Family Caregiver program, CFC or Medicaid Personal Care programs.

Social Workers, Resource Care Managers and Case Managers may make referrals following program guidelines for a client home visit or request a consult with Registered Nurses. Registered Nurses are housed throughout the eight-county region, providing reasonable accessibility for services and knowledge of local resources.

Health Home Care Coordination

The Health Home Program was created by Affordable Care Act (ACA) section 2703. It provides Health Home Services and care coordination to high cost high risk Medicaid and Medicare/Medicaid (dual) eligible clients. Its purpose is to reduce duplication of services and provide smoother transition and more personalized care to help reduce the progression of chronic disease, reduce inappropriate emergency department utilization and preventable hospital readmissions, and improve health and self-management of conditions.

Health Home Care Coordination provides six specific services beyond the services offered by a typical provider:

- Comprehensive care management
- Care coordination
- Health promotion and education
- Comprehensive transitional care
- Patient and family support
- Referral to community and social support services

Chronic Disease Self Management Program (CDSMP)

Another special project led by ALTC's is the Chronic Disease Self Management Program designed by Stanford University. It is an evidence based model of six 2.5 hour workshops, designed to help individuals self-manage their health.

ALTC has participated in two grants, the first with NCOA and the second grant with AOA to promote the six week workshop throughout our eight county region. The grant funding have ended however, ALTC is still committed to this evidenced based model. ALTC continues to fund our partners in this area, Yakima Valley Memorial Hospital, Kadlec Regional Medical Center and Community Health Associated of Spokane.

Medicare Improvements for Patients and Providers Act (MIPPA) provides outreach and assistance services for individuals residing in targeted zip codes throughout ALTC's service delivery area. The funds provide valuable support at the state and community levels for organizations involved in reaching and providing assistance to people likely to be eligible for the Low-Income Subsidy program (LIS), Medicare Savings Program (MSP), the Medicare Part D Prescription Drug Program (Med D) and in helping beneficiaries to apply for benefits.

Bathing Assistance (Over Income Personal Care)

This program is a limited in-home care service that provides up to 15 hours of care per month for individuals who have activities of daily living needs, to include bathing, but are slightly over income or resistive to Title XIX Medicaid in-home care. This service is funded with SCSA funds and is on a sliding fee scale and contingent upon allocation priorities, largely established by ALTC's Advisory Council and reviewed yearly. This program is closed to new enrollment.

Elder Abuse

Our Title III-D Elder Abuse funding is used to help augment contracted legal services to provide legal assistance to elders age 60 and over around legal issues of abuse, neglect and exploitation.

Senior Drug Education Program

The dollars that support this program are used to increase knowledge of individuals sixty-five years of age and older in the safe and appropriate use of prescription and non prescriptions medications. These dollars support care transitions work through the Care Transitions Intervention (CTI) model or the Bridges Model to reduce rehospitalization which occur most predominantly due to misunderstandings related to medication management post hospital discharge.

Disease Prevention and Health Promotion

These services are designed to assist older persons in helping to prevent the onset of serious diseases through promoting good health habits to help older persons enhance their lives and prevent premature institutionalization.

Dental Outreach Program

Washington State Dental Association (WSDA) Outreach Program is a reduced fee dental care program for low-income elderly, disabled, and Alzheimer's patients. Dental services and laboratory charges are discounted by 25% and provided by participating members of the WSDA and the Washington State Dental Laboratory Association. As the local Area Agency on Aging, ALTC's ADRCs determine the eligibility of seniors and Alzheimer's patients. The Washington Oral Health

Foundation determines the eligibility of disabled patients.

Veteran Directed Home Services Program (VDHS) offers eligible veterans who have functional disabilities more choices about how to get help at home. Specifically, it gives elders and adults with disabilities the option to manage a flexible budget and decide for themselves what mix of services/goods will best meet their care needs. VDHS participants may use their service budgets to hire their own personal care aides as well as purchase items or services that help them live independently.

Dementia Capable Options Counseling is a person-centered process holding the vision of providing the highest quality of life for all Washington state residents with memory loss. This person centered approach holds the absolute value of all human lives regardless of cognitive ability and recognizes the uniqueness of each individual and aims to create an understanding of the world from the perspective of the person with memory loss. Dementia capable options counseling promotes a living environment that supports the individual's health and safety needs while balancing their psychological needs including security, connectedness, meaningful life experiences, and joy.

STAR-C is an evidence-based, in-home consultation service to help the caregiver with their loved ones behavioral challenges related to Alzheimer's disease. Developed by the University of Washington (UW), this model includes four home visits with two phone sessions in between (over six weeks) plus four monthly follow-up phone calls.

Early Stage Memory Loss Groups
This 4-week group is based on an evidence-based program developed by the UW. The program engages individuals in the early stages of Alzheimer's and their caregivers by facilitating social support and engagement through positive, pleasant activities.

Reducing Disability in Alzheimer's Disease (RDAD) has been developed by the UW. This is an evidence-based, individualized exercise and caregiver education program designed specifically for individuals with dementia and their family caregiver. RDAD is a six-week intervention that includes home visits and follow up telephone calls.