Section C-1: HEALTHY AGING

Introduction

"Quality is never an accident; it is always the result of intelligent effort," John Ruskin

Most everyone's goal is to live a quality life that is long and healthy. However, the United States is losing some ground in that arena. The average life expectancy of Americans is 78.6 years of age, this is slightly lower than that of other developed nations with similar economics to the United States. According to the Organization for Economic Cooperation and Development – Health Statistics 2017, other similarly developed nation's life expectancy is around 81 years of age.

In the article, "*Americans are Dying at a Faster Rate*," featured in the November 29, 2018, issue of the **Atlantic Monthly,** author Olga Khazan cites statistics by the Center for Disease Control and other studies performed by, for example, the University of Washington. These indicate part of the decreased life expectancy is due to higher rates of drug overdoses and suicides within the United States, but it also highlights a slight rise in prevalence and lethality of Alzheimer's disease, diabetes and the flu.

The fastest growing demographic in the US is individuals age 80 and over. Like our counterparts around the world, we are an aging demographic, which brings with it a lot of implications. Healthy aging is something that people can start at any age, and the sooner one starts, the more likely a positive outcome will occur.

Dan Buettner, in his role as an explorer, researcher and author for National Geographic and New York Times, started to notice some communities around the world with larger numbers of centenarians and older people in general who were living long and healthy lives. He saw a trend in these communities. He noted they have less chronic disease and live longer than average life spans. He started working with researchers to document what these communities had in common. They researched five such communities and he found multiple things in common. These findings came to be known as "Blue Zone" communities and he, along with the National Geographic, started to develop an approach to apply these same concepts to help transform communities around the world to mirror these Blue Zone communities. The five Blue Zone communities venerate older people, and they found that this attitude also assists with all generations within that community. The Blue Zone communities shared other things that lend themselves to longer, healthy aging communities.

These findings were:

- People are not isolated, including older adults. They have meaningful family and social networks within their communities. They are connected to their community and belong to other "healthy people," described as "tribes." These are generationally mixed communities.
- They have a meaningful life and have a sense of purpose, also known as, "the reason to wake up in the morning."
- They have active spiritual beliefs with life activities around those beliefs.
- They eat a largely plant-based diet with moderate amounts of meat. They practice the "80% rule," which means they stop eating when they feel 80% full. They have diets rich in vegetables, legumes, grains, nuts and omega 3 fats. They tend to have lower calorie restrictions and may practice intermittent fasting. They drink only moderate levels of alcohol.
- Exercising is built into daily life. They don't typically have purposeful exercise but had communities that emphasized natural movement such as gardening, walking, taking stairs, cooking without a lot of mechanized tools.

A culmination of these activities, within other settings, is to transform communities which help change individual behaviors. However, until communities embrace Blue Zone concepts, there are elements that individuals and planning organizations can utilize to help promote some of these same concepts within their communities.

Issue: Age and Dementia Friendly Communities

Dementia is the 3rd leading cause of death (age adjusted) in Washington State. While many chronic diseases are decreasing, dementia is on the rise. Currently 107,000 Washingtonians are living with dementia and this number is projected to grow by 181% over the next 30 years. Dementia is long in duration and one of the most costly chronic conditions in our society. The backbone of the care is provided by unpaid family caregivers, often at the expense of their health and wellbeing and with significant financial strain. Early detection of the diagnosis is lacking, leading to missed opportunities to help those with the diagnosis. This lack of early diagnosis, impacts the ability of unpaid family caregivers and individuals with dementia to prepare for the disease. We often help unpaid family caregivers late in the diagnosis, when we could have helped them earlier with good service delivery options for both the person with the diagnosis and the unpaid family caregivers.

Southeast Washington Aging and Long Term Care is trying to make an impact in this area through:

- Enhancing awareness of the disease, engaging the public and educating them.
- Helping build dementia responsive communities
- Provide comprehensive supports to unpaid family caregivers
- Ensure legal strategies are employed to help the decision making process as the disease progresses
- Encourage the medical community to emphasize early diagnosis for treatment interventions which should include referrals to Washington State's service delivery system for unpaid family caregivers
- Get upstream of the disease by promoting healthy aging and brain health.

What ALTC has embarked and built upon:

- ALTC conducted "Leadership Community Forums," to raise the awareness of dementia and a call to action to prepare our communities for this epidemic. These community forums included leaders from public works, first responders, recreation departments, aging and disability network, libraries, physicians, hospital staff, social and health services, to name a few.
- For the last two years ALTC has contracted with the Alzheimer's Association to have a navigator to develop support groups, conduct more Early State Memory Loss classes, Brain Health Classes, Powerful Tools for Caregivers classes and to find and train volunteers to lead these efforts.
- ALTC has implemented a demonstration program called MAC/TSOA and has increased services to more unpaid family caregivers getting upstream.
- ALTC has grown our State Family Caregiver Program with additional people served and an increased network of services.
- ALTC, in conjunction with community partners, has developed one or more memory cafes in Kittitas, Yakima, Benton, Columbia and Asotin counties.

Some of ALTC's Challenges and Barriers:

ALTC still works to bridge the gap between medical providers and social service networks, a challenging effort. ALTC is in the initial stages of working to enhance the awareness of the benefit of early diagnosis, treatment, and referral to our service delivery network for both unpaid caregivers and those with a dementia diagnosis. The communities within ALTC's Planning and Service Area (PSA) have planted some seeds

with regard to age friendly and dementia friendly communities. This still needs to grow to truly transform into dementia friendly communities, capable of responding to the growing epidemic. Funding for many of the efforts remains a challenge and is not sustainable without additional funding sources.

Issue: Evidence Based and Health Promotion Services

The number of older individuals in the population is increasing with each decade and, as a result, chronic diseases and falls have increased to where they are now the leading causes of death and disability among older adults, according to the National Council on Aging. However, both chronic disease and falls are highly preventable. Evidence-based programs can help turn the tide and lift the quality of life for older adults, along with improving health, functional status and overall well-being.

Evidence-based programs (EBP) offer proven ways to promote health and prevent disease among older adults. They are based on research and provide documented health benefits, allowing confidence in their outcomes. EBPs are based on rigorous study of the effects or outcomes of specific interventions or model programs. They demonstrate reliable and consistently positive changes in important health-related and functional measures. EBPs are programs that can be modeled and carried out with multiple populations in a variety of settings, making them more likely to produce positive changes and outcomes. EBPs offered by ALTC meet the threshold established by the Administration for Community Living/Administration on Aging criteria for evidence-based program funding. The biggest benefit of EBPs is that they work!

Benefits of EBPs include:
- More efficient use of available resources.
- Facilitation of partnerships between community and clinical entities.
- Improved health outcomes and a more positive health care experience.
- Fewer hospital and doctor visits and lower or decreased health care costs.
- Ease of replicating and spreading programs.
- Greater opportunity for varied funding sources, as programs get proven results.

Older adults who participate in EBPs can lower their risk of chronic diseases and falls or improve long-term effects of chronic diseases or falls. Specific benefits of EBPs for Older Adults include:
- Improved quality of life.

- Increased self-efficacy in managing one's health.
- Increased or maintained independence, positive health behaviors, or mobility.
- Reduced disability (fewer falls, later onset or fewer years of disability, etc.)
- Reduced pain
- Improved mental health (including delays in loss of cognitive function and positive effects on depressive symptoms).

Based on the benefits listed above and ALTC's commitment to Healthy Aging, we partner with local entities to offer the following EBPs for our communities.

The Bridge Model (Bridges)/No Wrong Door – The hospital experience is taxing and confusing for patients and their families. This complexity often leads to disengagement, poor adherence to the plan of care, and high readmission rates. The Bridge Model is a person- centered social work-based, interdisciplinary transitional care intervention that addresses these challenges as it helps adults safely transition from the hospital back to their homes and communities. The Bridge Model combines four key components—patient engagement and self-efficacy, primary care integration, appropriate use of community resources, and coordinated care that is woven throughout effective clinical case management.

Chronic Disease Self-Management Education program(s) (CDSME) – CDSME, also called Living Well with Chronic Conditions, is a six-week workshop that provides tools for living a healthy life with chronic conditions, including diabetes, arthritis, asthma and heart disease. CDSME was designed by Stanford University. Through six weekly sessions, the 2.5 hour workshop provides support for continuing normal daily activities and dealing with the emotions that chronic conditions may bring about. Kadlec Regional Medical Center implements this service in the Tri-Cities area.

Early Stage Memory Loss Workshops (ESML) – Staying Connected is an ESML health promotion and social support program developed for individuals experiencing memory loss and their care partner. Staying Connected consists of four weekly 90-minute discussion sessions in which participants learn methods for coping with memory loss, communication, and staying engaged in social and pleasant activities. Upon completion of the program, individuals feel empowered, armed with new information and strategies for success. The series is facilitated by the Alzheimer's Association.

Health Home Program – A Health Home is not a place. It is a set of services to support people with serious chronic conditions and more than one medical or social service need. Health Home services can make things go more smoothly between medical and social service supports. This can help reduce visits to hospitals and emergency rooms as well as support overall well-being and self-care.

Powerful Tools for Caregivers – Powerful Tools for Caregivers is an evidence-based class series over six weeks designed to help caregivers take better care of themselves while caring for a family member or friend. The series is facilitated by the Alzheimer's Association.
Topics include:

- Identifying and reducing personal stress
- Communicating feelings, needs, and concerns
- Communicating in challenging situations
- Taking care of you
- Problem solving and goal setting
- Mastering tough caregiving decisions

Star-C Program – STAR-C is a program designed to help caregivers who are caring for and living with someone with dementia. Field tested by the University of Washington, this six-week program has been shown to reduce depression in caregivers and decrease unwanted behaviors in the person with dementia.

Reducing Disability in Alzheimer's disease Program (RDAD) –RDAD is another evidence-based caregiver education program developed by the University of Washington to help caregivers caring for someone with dementia. It combines exercise training with teaching caregivers how to manage dementia-related behavior problems in person with Alzheimer's or other related dementias. The program consists of 12 sessions over 11 weeks; each session is an hour in length.

Stay Active and Independent for Life (SAIL) – SAIL is a strength, balance and fitness program for adults 60 and older. Performing exercises that improve strength, balance and fitness is the single most important activity adults can do to stay active and reduce their chances of falling. The activities in the SAIL Program can help improve strength and balance, if done regularly.

Some of ALTC's Challenges and Barriers to providing EBPs:

Funding remains a challenge for many of our programs, not just EBPs. These programs are not sustainable without additional and stable funding sources. EBPs do present some unique challenges, such as keeping to a fidelity model and retaining instructors. Often the most costly portion of an EBP is initial training and oversight of instructors, when a new instructor is needed often training opportunities are limited and require extensive travel. Lastly, recruitment of participants to attend EBPs, especially during limited grant funded windows, can be a challenge as often the limited marketing we are able to do does not fully demonstrate their benefits and success.

Issue: Falls Prevention

According to the Department of Health, in Washington State, falls were the leading cause of fatal and non-fatal injuries for adults ages 65 and older from 1999 to 2016. In 2015, three-quarters of all injury-related deaths in adults ages 85 and older were from falls. While many factors increase the risk of fall for older adults, falls are not a normal part of the aging process, and most falls can be prevented. Solutions for preventing falls are complex, requiring collaboration with older adults, their families, and with many types of elder care and health care providers. Improving the health of older adults includes helping with safety and mobility.

Washington State has a variety of evidence-based falls prevention programs. In September 2018 all but four counties in our PSA had evidence-based fall prevention programs. Those counties are Yakima, Benton, Walla Walla and Asotin counties.
The Department of Health partnered with ALTC in the fall of 2018 to address this gap in falls prevention services. Through the three-year duration of the grant, and with the support of Department of Health, ALTC will be implementing the following evidence-based falls prevention programs and specifically targeting the four counties currently without services.

EnhanceFitness – This is an evidence-based group exercise class designed by Sound Generations, Group Health, and University of Washington. The class improves balance, flexibility, bone density, endurance, coordination, and mental sharpness and decreases the risk of falling. The classes are for one hour, three times per week. The focus is on dynamic cardiovascular exercise, strength training, balance, and flexibility. Data is collected at the start of the program and again after 4 months of participation. Improvement is tracked in upper and lower body strength, stamina, and balance. Key components older adults need to maintain health and function as they age.

A Matter of Balance - A Matter of Balance is an 8-week, structured group intervention that emphasizes practical strategies to reduce fear of falling and increase activity levels. Participants learn to view falls and fear of falling as controllable, set goals to increase activity, change their environment to reduce fall risk factors, and exercise to increase strength and balance.

The Otago Exercise Program – The Otago Exercise Program (OEP) is a series of 17 strength and balance exercises delivered by a physical therapist or a physical therapy assistance in the home, outpatient, or community setting that has reduced falls between 35 and 40% in frail older adults. The program calls for physical therapists to assess and progress participants through an 8-week clinic phase and then the participant is transitioned to a self-management phase for four to 10 months. During the self-management phase the participant is supported by phone calls.

What ALTC has embarked and built upon:

- Participated in the creation process of the Washington State Action Plan for Older Adults Falls Prevention – 2018
- Partnered with the Department of Health on a grant to bring evidence-based falls prevention classes to Yakima, Benton, Franklin and Walla Walla Counties
- Implemented three classes of Enhance Fitness in Benton County and one bi-lingual class in Yakima County with additional classes in Yakima, Franklin and Walla Walla counties in process
- Local direct services offices at ALTC have had training on information regarding Falls Prevention, and have a check off list for falls risks to review with clients.
- Some of ALTC's direct service offices have developed a working relationship with local Fire Departments to make referrals to the ADRC for the at-risk older adults they encounter.

Some of ALTC's Challenges and Barriers to providing falls prevention services:
We need to build strong and effective community relationships between collaborating agencies such as community resources for falls prevention and primary care screening. There is a need to educate older adults to help increase motivation to participate in falls prevention classes. Then lastly, there is a need for falls prevention classes, which cannot

take place without partnerships for host locations, instructors and a commitment to finding sustainable funding.

ISSUE: Linking Primary Care with Community Resources in the Aging Services Network

The Affordable Care Act (ACA) was built around the idea that the right service, at the right time, in the right place would help deliver better and less expensive health outcomes. The ACA acknowledges that the Social Determinants of Health model indicates that health outcomes are not based exclusively on healthcare but are more highly influenced by social determinants of health. The World Health Organization defines social determents of health as "the conditions in which people are born, grow, live and age." These conditions are not equal and the complexity of these social factors become the determinants to health, good or poor.

Studies indicate that the larger the inequities in social determents the higher incidence in poor health. Social determents are the underlying cause of many major health issues such as obesity, diabetes, heart disease and mental health issues. Without resolving some of these inequities, good health outcomes are hard to achieve.

Social determinants of health are identified as income, educational opportunities, occupation, employment factors, gender, race, food insecurity, childhood trauma, social support, community inclusion, crime rates, public transportation, physical environmental conditions, food, water, and air quality and recreational and leisure activities. (NEJT Catalyst, "Social Determinants of Health (SDOH)," December 1, 2017)

The University of Washington Medical School's arm called the "Northwest Geriatric Workforce Enhancement Center," (GWEC) embarked on a project to help bridge the gap between the medical providers and the social and health service delivery community. A partnership between these two communities will heighten the awareness of and the continuity between the social and health worlds of patients/clients with a focus on geriatrics. This is an approach to better address the social determinants of health of older adults. In conjunction with this, GWEC is attempting to enhance the primary care practitioner's geriatric medicine expertise.

With the growing age wave, there is a shortage of geriatric physicians. Geriatric medicine is a medical specialty that requires one to two years more of additional training (residency) than a generalist in medicine. It is the lowest ranking specialty in part because even with the specialty and additional training, a geriatrician is paid on average $20,000 less per

year than a general practitioner. (The New York Times, “As Population Ages, Where Are the Geriatricians,” January 25th, 2016).

What ALTC has embarked and built upon:

Geriatric Workforce Enhancement Center
ALTC is embarking on a partnership with the NW GWEC in Yakima, Benton, and Franklin counties within the first years with optimism of expanding to the other counties. This partnership entails a full time Primary Care Liaison, who will be embedded in ALTC and work with GWEC to engage and train primary care providers, those studying in the health care field, patients, families, caregivers, and social services to enhance their knowledge of geriatric medicine and care for persons with Alzheimer’s disease and related dementias. The Primary Care Liaison will be responsible for facilitating primary care awareness of the aging services networks, enhancing communication and referrals of older adults and caregivers with primary care clinics within the service delivery region.

Some of ALTC’s Challenges and Barriers:
Our society has a medical bias, with medicine being viewed as the singular solve. The expertise and credibility of social services and their workforce are not nearly as highly valued. Moving this bias for both the client/patient, as well as the medical and social service community will be a challenge. Bringing a multi-pronged solution will entail getting the attention of a medical community that is already resource-stressed and having them carve out time and resources to learn about and make referrals to social services. This will be a barrier to overcome. Bringing a liaison with a social service background into the medical world where they are out-ranked in terms of societal value and obtaining credibility will take time, persistence and courage. In addition, marketing the UW Medical School’s geriatric seminar to the medical community who have so many demands on their time will be a steep goal to achieve but a worthy endeavor that will help bridge the educational gap many primary care practitioners may have in the field of geriatrics.

Issue: Nutrition Services

The Congregate Meal Program successfully targets seniors who are older, low income, and more likely to live alone, live in rural areas, be minorities and be medically vulnerable. The meal programs are offered in community centers, churches and sites such as Grange Halls. Congregate nutrition services improve the health of participants and prevent more costly interventions. The congregate meal programs also provide

older people with positive social contacts at the group meal sites and physical activity programs.

Home-delivered nutrition services enable older adults to avoid or delay costly institutionalization, enabling them to stay in their homes and communities. Recipients of home-delivered meals are typically older persons living alone, have annual incomes below $12,500, and have multiple chronic health conditions.

Adequate nutrition is essential for healthy aging and the prevention or delay of chronic disease and disease-related disabilities. The cost of a one-year supply of home-delivered meals equals about the cost of one day in the hospital.

In 2018, the Older Americans Act (OAA) nutrition program served 3.9% of the entire senior population in Southeast Washington. Home delivered and congregate meals are an important part of the weekly nutrition for seniors in our PSA.

The need for adequate food and nutrition services by at-risk older adults currently exceeds the resources of the existing programs. Funding has yet to keep up with the demand of the growing senior population.

As well, national funding sources have not kept pace as food, transportation, and labor costs continue to rise. Currently, several of our nutrition contractors are faced with dilemma of finding ways to best serve our aging population with less funding. They implemented cost-saving measures that include: cutting back on the number of days that hot meals can be delivered or served, eliminating meal sites and moving meal sites that are located in Senior Centers to locations that better serve our targeted populations.

Some congregate meal sites cut back on days of service temporarily to continue serving the home bound senior with the limited funds available.

ALTC's PSA has high poverty levels, large populations of limited English speaking persons and individuals with less than a 12th grade education. To adequately serve these populations, there must be adequate education about nutrition. This information needs to be disseminated in multiple languages and through multiple media.

Senior Farmers Market Nutrition Program (SFMNP):
SFMNP provides resources in the form of fresh, nutritious, unprepared, locally grown fruits, vegetables, herbs and locally produced honey from authorized farmers' markets, farm stores and Certified Sellers to low-income seniors. SFMNP also provides nutrition related educational materials including recipes, nutrient values, food preparation and

storage information to increase the effectiveness of the program and improve the health of the participant. In our PSA seniors purchase produce from the above mentioned markets through checks/vouchers received from ALTC's contracted senior nutrition providers. Homebound seniors are offered the same vouchers and are able to send a proxy for the purchases. There is no cost to the senior to participate in this program.
Seniors who may participate in this program are defined as individuals who are at least 60 years old, and who have household incomes of not more than 185% of the federal poverty income guidelines (published each year by the Department of Health and Human Services). For 2019, this amount was $1,926 for a single person and $2,607 for a married couple. In 2018, 2,069 seniors, in our PSA, received vouchers for a total of over $82,760 in produce.

Some of ALTC's Challenges and Barriers to providing nutrition services:
With the OAA re-authorized and signed into law in April 2016, ALTC has the opportunity to continue serving the senior population. However, our PSA has had challenges with increased fuel and transportation costs. With much of our region being rural (38%), ensuring equal access to our services has been expensive. A forum participant remarked, "Our rural areas have few transportation options, volunteer drivers are needed to take home delivered meals or fill the transportation gap and offer a ride to a meal site."

Southeast Washington is rich in diversity. This challenges providers to integrate seniors of ethnic backgrounds with meals sites that have not historically been ethnically diverse. There is the challenge of meal planning to accommodate all tastes and textures and overcoming social barriers that are further complicated by the inability for different language groups to communicate fluently with one another. Often, these challenges have been addressed by creating ethnic meal sites.

Nutrition providers have had to make some difficult decisions in the past as funding decreased. There has been a reduction of the number of days congregate meals are served in some areas and closing of some meals sites, which include ethnic meal sites, where a lower volume of clientele may come. There has been a decrease in the number of hot home delivered meals that are able to be served.

As home delivered meals serves the most vulnerable population, ALTC has made this a priority. According to nutrition providers, home delivered meals are much more costly than congregate meals due to transportation costs and the limited numbers of volunteers to deliver meals. Providers also indicate that individuals receiving home delivered meals donate at a much lower rate than for Congregate Meals, thereby reducing the number of meals that may be served. With the Nutrition Program for Older Adults – Expansion

(Senate Bill 5736), ALTC used the additional funding to expand home delivered meal service to eligible home-bound seniors and/or expand the home delivered service area. In September of 2017, ALTC also began utilizing Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) funds to serve HD meals to newly eligible persons throughout our PSA.

Nutrition providers are making efforts to educate seniors on nutritional health and physical activity. Presentations are conducted at the congregate sites by the nutrition provider at least twice a year. Most senior centers hosting congregate meals offer some kind of physical activity session once or twice a week.

Issue: Transportation Services

The eight counties in ALTC's PSA are for the most part vast and rural. ALTC contracts for transportation services in their PSA communities that have limited or no public transportation available. Services are provided for seniors sixty years of age and older, who have no car, are unable to drive, cannot afford to drive and public transportation is not available or accessible. Persons with disabilities access the same service via other funding sources.

Transportation is a critical part of accessing services that maintain health and wellbeing. Seniors, especially those who are rurally isolated, need rides to buy groceries, clothing, attend medical appointments, meal sites or simply go to a social gathering.

What may seem like simple tasks of daily living to the able person can become major challenges when seniors have lost their ability to maneuver a vehicle safely in urban and rural areas where distance, weather and traffic are factors.

Benton, Franklin, Walla Walla, and Asotin counties are four of the eight counties that enjoy a Public Transportation Benefit Area (PTBA). Garfield County is an Unincorporated Public Transportation Benefit Area (UPTBA). Most community residents are opposed to a public transportation system because of the additional local taxes needed to fund such a service. The city of Yakima has a transit system that operates within the city limits and also serves the Selah area. Columbia County Public Transportation serves the communities of Dayton, Waitsburg, and Dixie with rides into Walla Walla.

Lack of awareness of and support for public transportation hinders the development of a service needed for the increasing number of seniors who remain in their communities without adequate transportation.

Contracted Transportation Services:
The provision of contracted transportation service is provided by HopeSource in Kittitas County, People For People in Yakima County, and InterLink in Asotin County.

Collectively the transportation contractors operate with buses/vans with an average of 1,336.75 boards per month. A total of 457 unduplicated persons were served in 2018. Of those served, 36.75% are low income, 51.87% are over the age of 75 and 50.98% live alone.

The contractors transport seniors to meal sites, medical facilities, grocery stores, senior centers and other facilities that provide services to seniors. Some of these other services available to seniors are falls prevention exercise programs such as EnhanceFitness and SAILS, hospital-based programs for Diabetes Self-Management, and Life Transitions Intensive Outpatient Program intended for older adults that focuses on restoring daily functioning and improving quality of life. The contractors make efforts to continue the service via applications for state, federal and county funds.

Some of ALTC's Challenges and Barriers to providing transportation services:
ALTC transportation services have limited funding and therefore cannot meet all of the needs. These providers do their best to coordinate transportation services and augment budgets with other transportation dollars beyond ALTC funds. Additional funding has been requested and obtained for Rural & Special Needs Public Transportation Programs through Federal Transit Administration (FTA) 5310 Elderly & Disabled Transportation, FTA 5311 Rural Public Transportation, State Rural Mobility and State Para transit/Special Needs Grants.

With the lack of a PTBA in Kittitas, Yakima and Garfield counties ALTC provides significant funding for transportation as compared to the AAAs in urban areas where public transportation options are more readily available.

Requests for Transportation to non-medical services are on the rise for seniors who demand to keep "in touch" with their communities. Non-medical services include transportation to religious services, exercise sessions and social activities. Rural towns in ALTC's service area have limited or no transportation options due to lack of funding. Pahto Public Passage provides transportation services to all persons living on the

Yakama Reservation. The system coordinates with People For People Community Connector to connect folks with a ride from and to the Yakama Reservation.

With the limited funding resources in Washington State, agencies are continuing to experience funding shortfalls. Volunteers are a major resource for transporting seniors who are unable to utilize existing transportation or where no transportation services are available.

With that thought in mind, Yakima has formed a Mobility Public Access to Countywide Transportation (MPACT) coalition whose goal is to coordinate transportation services and develop intercity routes in the community. The transportation meetings take place periodically in Yakima.

ALTC is also taking part in the People for People (PFP) Valley Shuttle Steering Committee which is working towards improving transportation in the rural areas of lower Yakima County, specifically Sunnyside, Grandview, and Mabton. These areas historically have had limited transportation services and the steering committee is working with PFP to maximize transportation benefits in this area. These transportation services will benefit all people in this rural area that includes a high population of low-income minority individuals, limited English speaking people, older adults and people under age 60 with disabilities.

ISSUE: Legal Services

The legal assistance service program targets seniors who are 60 years of age and older, low income, and more likely to live alone, be minorities and be limited or non-English speaking. Seniors are served by providers who have multi-cultural, bilingual staff who can meet with the seniors either in their homes or at accessible office locations. Legal service providers publicize the program. They explain the program to other service providers and how referrals can be made.

The program intent is to foster cost-effective high quality service that is integrated in the aging services network, is accessible throughout the planning service area, and develops and maximizes the use of other resources.

Coordinated Legal Education, Advice and Referral for Senior’s (CLEAR *Sr) is the primary gateway for seniors seeking legal help. It is available, toll-free, throughout the state.

Northwest Justice Project also has access to regional volunteer lawyers and Pro Bono programs operated by county Bar Associations to assist with cases.

Contracted Legal Services:
ALTC contracts with Northwest Justice Project (NJP) for legal services in ALTC's eight county area. In our PSA, NJP's main office is located in Yakima with satellite offices in Kennewick and Walla Walla.

Legal assistance services provide access to the system of justice by offering representation by the legal service provider who acts as an advocate for the socially and economically needy older individual experiencing legal problems. Issues are prioritized to reflect local needs. As resources are limited, clients with problems in the following areas receive services: income maintenance, health care, long term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse & neglect, age discrimination, and other related matters.

Some of ALTC's Challenges and Barriers to providing legal services:
Having this legal aid available to assist our AAA's vulnerable senior population is critical for seniors calling for help when they are in imminent risk of losing their homes, are victims of fraud, or have been treated unjustly.

Comparing the 2010 US Census to the 2018 OFM estimate, the senior population in ALTC's region has grown by 36.16%, making it imperative that the funding for legal services be continued and preferably be increased. Knowledge of the existing legal advocacy program is limited for the public and legislators.