Area Agency on Aging

2024-2027

Lewis Mason Thurston Area Agency on Aging Area Plan

Enriching lives and supporting people to live fully and with dignity.

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INTRODUCTION

The Lewis Mason Thurston Area Agency on Aging (LMTAAA) serves older adults, adults with disabilities and family caregivers within the 3 counties. The agency is part of a state network of 13 Area Agencies on Aging in Washington State known as the Washington Association of Area Agencies on Aging (W4A) and is part of a National Association of Area Agencies on Aging (USAging), consisting of approximately 622 Area Agencies on Aging across the country.

The aging network was established under federal legislation when the Older Americans Act was signed into law by Lyndon B. Johnson in 1965. The Area Agencies on Aging were established in 1973 when the act was amended. The Lewis Mason Thurston Area Agency on Aging was founded in 1976.

The agency is governed by the Lewis Mason Thurston Council of Governments and is represented by one county commissioner from each county. An inter-local agreement between the counties has been established to support the provision and collaboration of service delivery within Planning and Service Area (PSA) #6. In addition, the agency receives advice on key plans, initiatives, and supports from our advocacy and outreach through efforts of our Advisory Council on Aging. The council is made up of a total of 18 representatives, six from each county within our PSA.

As the aging and disabilities systems, policies and initiatives continue to grow in complexity and the aging population continues to rise, so does the need to be innovative and solution based. We must continue to build our capacity as a network and strengthen our systems in support of our older adult and disabled populations to facilitate aging in place with dignity and with quality of life at the core. Our goal at the Area Agency on Aging is to provide answers through advocacy, action and services. Not only do we have an extensive network of partners who help us do great work in our communities, the LMTAAA staff bring knowledge, experience, and expertise to support our work.

LMTAAA directly provides a variety of services that support individuals, families, and caregivers. We provide case management and nurse consultation for approximately 2,700 consumers receiving Medicaid paid in-home care assistance, assessing individuals' needs and eligibility and ensuring proper service delivery. Thousands of individuals use our Information and Assistance program to gain information about local services and to access support. Our Community Support Programs offers information and assistance, educational opportunities, respite, and other supports to unpaid caregivers providing informal care to an adult family member.

LMTAAA staff work directly with community organizations in developing, managing, and monitoring the delivery of services to seniors and disabled adults. LMTAAA contracts with governmental, non-profit, and for-profit agencies for the delivery of a wide variety of services to eligible individuals. Services provided through contracts include: The Long-Term Care Ombudsman Program, congregate nutrition, home-delivered meals, adult day care, transportation, legal services, respite

care, in-home personal care, kinship and family caregiver support, The Senior Farmers Market Nutrition Program, and a multitude of Medicaid wrap-around services.

In addition, LMTAAA staff is active in many local, regional, and statewide groups and organizations. From advocacy at the national and state levels, to partnering with a local senior center or food bank, we recognize the need to be active and involved in all aspects of our community.

The purpose of the Area Plan and its process is to develop goals and objectives that meet the needs of the population and the communities the agency serves. The Area Plan is developed every 4 years as a mandate under the Older Americans Act and our contractual obligation under our partnership with the Washington Department of Social and Health Services, Aging and Long-Term Support Administration. The Area Plan outlines a considerable amount of information about our communities such as a demographic overview and provider and service systems, as well as some multi-year planning objectives and the current year revenue and expenditure proposals.

For additional information on our Agency and/or resources needed in Lewis, Mason, or Thurston County, please contact us directly, toll free, at (888) 545-0910, or by visiting us at www.LMTAAA.org.

A-2 MISSION, VALUES, VISION

The mission of the Lewis-Mason-Thurston Area Agency on Aging is to help develop, provide, and advocate for quality long term care services and supports emphasizing home and community care options. The agency supports client choice and is a key community-based organization that helps older adults and people with disabilities stay in their homes for as long as possible. It also serves as a community resource with a robust referral network. The agency fulfills its mission through direct service delivery by the agency's professional and dedicated staff and by collaborating with its community partners.

The agency's core values are:

- Service
- Excellence
- Empowerment
- Collaboration

In serving the clients and communities in PSA #6 and in contracting for services on behalf of older adults, adults with disabilities and their caregivers, LMTAAA's values provide guidance on the following principles:

- We value individual choices and efforts to remain in the community, living as independently as possible.
- We value treating individuals with respect and dignity as they make decisions about their lives and care needs.
- We value the growing diversity within our communities and efforts to make planning and programming responsive to all people.
- We value efforts to reach and serve those people whose culture, language, residence, or financial circumstances may limit their ability to easily access services to meet their needs.
- We value the wealth of support that families, friends, and other informal relationships bring to consumers of our services.
- We value a community stewardship model of leadership that builds local capacity to engage and serve older adults and adults with disabilities.
- We value the volunteer efforts of those who work, promote, advise, and act on the needs of our communities and citizens.
- We value strong accountability that safeguards the resources utilized by LMTAAA, the confidentiality of our consumers, and fair treatment of providers doing business with LMTAAA.
- We value the dedicated workforce of LMTAAA and our provider organizations as they seek to fulfill their professional roles within a highly regulated and evolving system.
- We value the ability to advocate and educate on behalf of the communities and populations we serve.
- We value creativity and innovation that allows us to adapt to the evolving and more complex needs of our clients and communities.
- We value collaboration and partnerships that support the maintenance, planning and development of a comprehensive, diverse system of services and supports.

A-3 PLANNING AND REVIEW PROCESS (SEE APPENDIX E)

Through the hard work of our staff and Advisory Council members, 280 individuals across Lewis, Mason, and Thurston counties were surveyed in June through September of 2023. Those surveyed include older adults, adults with disabilities, family caregivers and community partners. Surveys were available in both electronic and paper format.

Community forums were also held in all three counties, as well as one virtual event.

For details of the public process, see Appendix E.

A-4 PRIORITIZATION OF DISCRETIONARY FUNDING

While the majority of our revenue is dedicated to the provision of mandated federal and stated funded services, the agency has a limited amount of discretionary dollars from the State Senior Citizens Services Act and the Federal Older Americans Act Title IIIB.

In prioritizing which programs to support with discretionary funds, LMTAAA considers the following questions:

- Does the program reach those with the greatest economic and/or social need, those with severe disabilities, those with limited English-speaking ability, those residing in rural areas and/or those in minority racial or ethnic populations?
- What is the significance of the program to the larger network of services?
- Does the program enhance an individual's ability to live independently?
- What are the alternative revenue sources available to the program?
- Is the service cost-effective compared with the benefits received?
- What are the expressed preferences of the community?

As a result of program analysis and the public process, LMTAAA will fund the following programs with discretionary dollars:

Adult Day Care – Adult Day Care is not a mandated service; however, it plays an important role in maintaining and/or improving the cognitive and physical abilities of those attending the program and provides much needed respite for the caregivers of participants. Participants receive assistance with activities of daily living while attending the program, which includes socialization activities, light physical activity, nutritious snacks and lunch, and routine health monitoring. Adult Day Care is not a medical service. Participation in Adult Day Care services frequently delays or prevents the need for more costly and restrictive institutional care.

Case Management for Non-Medicaid Consumers – Although LMTAAA is not required to provide case management service to non-Medicaid consumers, we continue to prioritize this service on a relatively small scale for those over the age of 60. A number of consumers just above the Medicaid eligibility requirements present themselves with significant needs. These consumers and families greatly benefit from the service and would otherwise be unable to initiate, coordinate and/or continue support services without the professional help of a Case Manager.

Aging & Disability Resources Connection/Information and Assistance (ADRC) – ADRC is a core competency and a vital part of our local network of services for older adults. LMTAAA has and will continue to prioritize providing access services in our communities. ADRC connects older people with the information and community resources they need or are interested in learning more about. Information is provided on a one-on-one basis and can be provided over the phone, by email or in person. The assistance provided includes information, service referral, advocacy, assistance, and helping with application processes. ADRC staff screen for eligibility for specific services and programs, such as Family Caregiver Support services, Community First Choice and other Medicaid

services. The ADRC program links people to medical services, assists with access to Rx drug coverage and supports a number of other specific activities that promote individual health and disease management. ADRC staff visit regularly with the area Tribes and senior centers and provide outreach at community events. ADRC staff additionally work in conjunction with the Statewide Health Insurance Benefit Advisors (SHIBA) staff and volunteers to provide Medicare Part D education and assistance with enrollment.

Transportation – The provision of transportation services is not a requirement of any LMTAAA revenue source but is critical to providing access to available services and therefore significant in helping to maintain independence for many people within the region. Several other funding sources support transportation, including transit authorities in all three counties, other public and private grants, and the Medicaid brokerage program. However, gaps remain. With input through the planning process, transportation remains a priority use of LMTAAA discretionary funds, with a specific focus on supports to volunteer transportation programs.

Volunteer Support – LMTAAA supports the efforts of volunteers in our communities working in programs that provide needed services and supports to our neighbors who are aging and those with disabilities. Volunteerism helps to stretch limited funding designated for specific programs, as well as provides meaningful social engagement to those providing the work. These efforts will include support of the local Retired Senior Volunteer Program (RSVP), volunteer transportation programs and A Matter of Balance, an evidenced based falls prevention and management program.

In the event of funding reductions or increases, multiple factors and LMTAAA values must be considered in order to determine how to prioritize programs. The following questions would be considered:

- What funding source is being reduced?
- What are the associated legal requirements?
- Which programs protect core functions that are critical to health and safety and limit liability exposure?
- Which programs tend to reach the priority populations?
- What is the impact to the service network if reductions are shared across programs versus reducing one program?
- What is the impact to LMTAAA programmatic staffing?
- What is the status of the other revenue sources for specific programs?
- What are the expressed preferences of the community at that time?

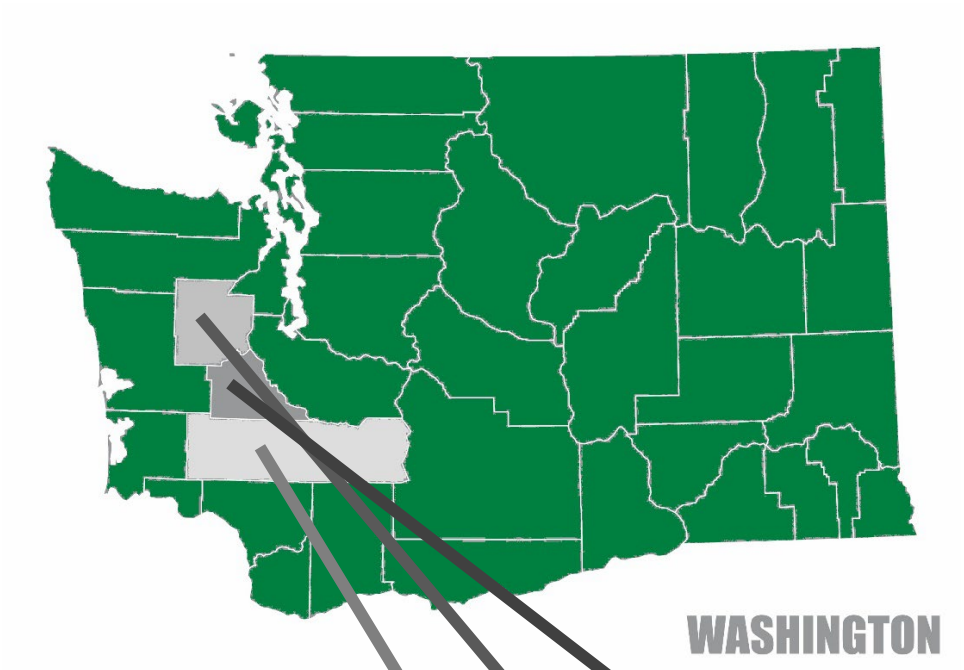
With these questions in mind, we would likely prioritize programs into three categories, with Level 1 being the highest priority. The list in each category below contains both mandated and discretionary programs and the programs are not necessarily in priority order.

Level One	Level Two	Level Three
• Case Management/Nursing • Home and Community Based Service Programs • Home Delivered Meals • Family Caregiver Support • Information & Assistance* • Case Management for non-Medicaid Consumers* • Health Homes • Hospital Transitions	• Adult Day Care* • Congregate Meals • Long Term Care Ombudsman Program • Transportation*	• Health Promotion/Disease Prevention • Kinship Programs • Legal Services • Senior Farmers Market Nutrition Program • Volunteer Support*

*Programs that are funded with discretionary funds.

B-I TARGET POPULATION PROFILE

Through outreach, services and advocacy, Lewis-Mason-Thurston Area Agency on Aging (LMTAAA) targets vulnerable adults with the greatest social and economic need, as well as minority and rural populations. Special efforts are made to ensure that programs are designed, located, and offered in a manner responsive to individuals with special physical, mental, language and cultural needs.



Categories	Projected 2024 #'s				Projected #s by 2027
	LEWIS	MASON	THURSTON	TOTAL	
Number of persons aged 60 or above	24,671	25,105	79,120	128,896	135,317
Number of persons aged 60 or above and at or below 100% FPL	1,891	1,639	3,992	7,522	7,739
Number of persons aged 60 or above and minority	1,443	2,850	9,531	13,825	15,330
Number of persons aged 60 or above and at or below 100% FPL and minority	75	93	710	878	1,002
Number of persons aged 60 or above with limited English proficiency	921	1,061	3,143	5,125	5,632
Number of persons aged 60 or above and Disabled (ACS 18b or 18c)	5,394	5,351	15,832	26,577	28,825
Number of persons aged 18 or above and Disabled (ACS 18b or 18c)	7,621	7,287	23,380	38,288	40,910
Number of persons aged 60 or above with cognitive impairment (ACS 18a)	2,445	2,402	6,688	11,535	12,502

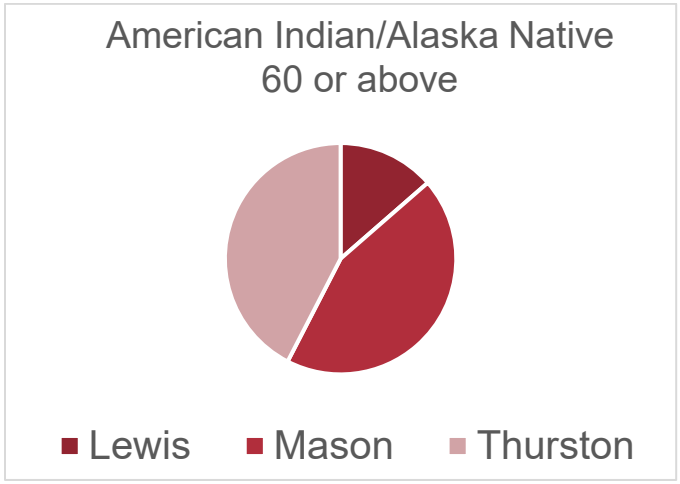
Categories	Projected 2024 #'s			Total	Projected #s by 2027
	Lewis	Mason	Thurston		
Number of persons aged 18 or above with cognitive impairment (ACS 18a)	4,662	4,329	14,248	23,240	24,539
Number of persons aged 60 or above with IADL (ACS 19)	3,365	3,288	9,605	16,258	17,882
Number of persons aged 18 or above with IADL (ACS 19)	4,993	4,726	15,143	24,862	26,739
Number of persons aged 65 or above with dementia	1,926	1,840	5,852	9,618	10,841

In *2024* it is projected that we will be serving approximately **2759** people in their homes, and expected to increase to **2917** by the year *2027*

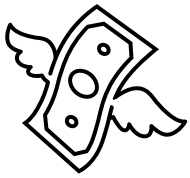
Residential service settings and Skilled Nursing Facilities already have limited space. With current projections of people needing this level of support, the ability to adequately support people in their homes is very important.

American Indian/Alaska Native:

Tribes in this region consist of the Confederated Tribes of the Chehalis Reservation, the Cowlitz Indian Tribe, the Nisqually Indian Tribe, the Skokomish Indian Tribe, and the Squaxin Island Indian Tribe. All five Tribes have their own Title VI Programs. According to the most recent Census information, it is projected to be 1,522 American Indian or Alaska Native persons aged 60 or above living in this region.



*ALTSA Demographics from Census and long-range data obtained from David Mancuso, PhD, Senior Research Supervisor, DSHS Research and Data Analysis Division, Selected Population and Aging Service Utilization Forecast, Lewis/Mason/Thurston AAA, Updated June 3, 2021

Average cost over the 3 counties per person	
	**$1000**
	**$619** (Highest cost in rural counties)
	**$306**
	**$256** (Highest cost in rural counties)
	Miscellaneous costs **$313**

Amount needed to live independently	Single Elder			Elder Couple		
	Owner without mortgage	Renter 1 bedroom	Owner With mortgage	Owner without mortgage	Renter 1 bedroom	Owner With mortgage
Index per month	$2043	$2430	$3002	$3227	$3615	$4186
Index per year	$24,519	$29,164	$36,024	$38,724	$43,376	$50,236

Source: Elderindex.org

B-2 AAA SERVICES AND PARTNERSHIPS

Overview

The Lewis-Mason-Thurston Area Agency on Aging (LMTAAA) provides services to all eligible individuals without regard to race; color; creed; national origin; religion; gender; age; marital status; Vietnam era or disabled veteran status; or the presence of any sensory, mental, or physical handicap. LMTAAA strives to uphold ALTSA's vision to support person centered planning and we turn no one away who seeks our help.

We serve our largest number of clients with disabilities under the age of 60 through our Case Management services. Clients are transferred to us after initially being screened and assessed by Home and Community Services staff. We collaborate with HCS on an ongoing basis to provide seamless services, especially through the Family Caregiver Program Warm Hand Off protocols.

LMTAAA will monitor Census data and engage with community partners to stay abreast of shifts that may impact the population or resource availability. At this time, the cost and availability of affordable housing is a resonating concern as is transportation. Anecdotally the increasing cost of housing appears to be impacting purchasing and rental decisions for lower and fixed income households which in turn impacts available household resources for purchases like gas, further compounding transportation concerns. This is of particular concern for those in the LMTAAA rural service areas with limited to no public transportation to services in more urban settings.

That being said, within our three-county region, Lewis and Mason Counties are considered rural. Within Thurston County, the metropolitan tri-city area of Olympia, Lacey and Tumwater are surrounded by smaller rural communities. Extra efforts are made to provide all services to all of the outlying areas of our counties.

Through our Information and Assistance Program staff, LMTAAA provides widespread distribution of information about community resources. We have published the hard copy *Resource Directory* of Lewis, Mason and Thurston Counties for more than twenty years. Distribution of these directories occurs throughout our region at various service clubs and organizations, senior centers, support groups, health fairs and by individual request. The LMTAAA Community Advisory Council plays an active role in the distribution process using the Resource Guide as a calling card in their communities and networks. The information is also available online at https://www.lmtaaa.org/resource-directory. It should be noted, that due to limited and inconsistent internet connectivity in many parts of the three counties, LMTAAA puts a premium on maintaining hard copy access to the Resource guide.

Direct Services Provided by LMTAAA Staff

Services that may be provided by or through LMTAAA include the following. Availability is noted by county.

Service	Lewis	Mason	Thurston
Aging & Disability Resource Connection/Information and Assistance – Provides older adults with information, advocacy, referral, and other assistance accessing community services. I&A staff also provide outreach and information to community groups and at community events.	X	X	X
Family Caregiver Support – Assessment, ongoing case management, information & assistance, and training for unpaid caregivers caring for family members living in their own homes.	X	X	X
Case Management – Needs assessment and in-depth, on-going assistance for adults with disabilities who have multiple needs and significant social and health issues.	X	X	X
Nurse Consultation – RN Consultation for high-risk adults with disabilities receiving Case Management services.	X	X	X
Health Homes – Comprehensive care management, care coordination, health promotion, transitions planning, individual and family support, and referral to community and social services.	X	X	X
Hospital Transitions - Patients and families work with a Transitions Coach to learn self-management skills during transitions of care.			X
Contracts Management - Procurement and oversight of subcontracted services for seniors and adults with disabilities	X	X	X

Services Provided by Subcontract

LMTAAA provides a multitude of services through subcontracts with other entities that provide important supports to our community, including older adults, adults with disabilities, and family caregivers. These services are provided by for-profit, non-profit, governmental, and private organizations. We consider all to be an important part of the network of services available to those in need in our region. Medicaid contract procurement processes are always open, and non-Medicaid

procurement processes are publicly announced in newspapers in Lewis, Mason and Thurston Counties and specifically mailed to organizations that are identified as women or minority owned.

*Services only provided with Medicaid funding and paid through the State's Provider 1 payment system. Funds for these services do not appear in the Area Plan Budget.

Service	Lewis	Mason	Thurston
Adult Day Care – Day centers for adults with disabilities living in private homes that provide social activities for the participant and may also provide respite for caregivers.		X	X
***Environmental Modifications** – Physical adaptations to a client's own home to ensure safety and facilitate independent functioning.	X	X	X
Family Caregiver Support Program – Support for unpaid family caregivers that includes Respite Care, Counseling, Supplemental Services, Housework and Errands, Yard Work and Snow Removal (MAC & TSOA only), and support to Grandparents raising grandchildren. As part of this program, Medicaid Alternative Care (MAC) provides support to unpaid caregivers who are eligible for Medicaid LTC services but are not yet using them, and Tailored Supports for Older Adults (TSOA) supports caregivers and individuals who are not yet eligible for Medicaid services, but likely will be without support.	X	X	X
Health Promotion – A Matter of Balance Falls Prevention – An evidence-based educational program designed to help reduce the risk of falls by older adults. Expansion to all three counties is planned during the Area Plan timeframe.		X	
***In-home Personal Care** – Help with activities of daily living, such as eating, bathing, dressing, toileting, transferring, walking, and medication management, for adults with disabilities living in their own homes.	X	X	X
Kinship Caregiver Support Program – Provides emergency services for basic needs of grandparents	X	X	X

and other relatives raising children, who are at or below 200% of the Federal Poverty Level.			
Kinship Navigator Program – Provides assistance to grandparents and other relatives raising children, in order to understand and access local support services.	X	X	X
Legal Services – Legal advice and limited representation for older adults.	X	X	X
Long Term Care Ombudsman Program – Recruits and trainings volunteers who protect the rights and advocate on behalf of the residents of long-term care facilities.	X	X	X
Nutrition Services: • Congregate Nutrition – Group meals provided in community-based settings. • Home Delivered Meals – Meals provided to those who are home-bound, unable to provide meals for themselves, and may be at nutritional risk. • Senior Farmers Market – Provides fresh produce to older persons with limited income, through the use of vouchers redeemed at qualifying farmers markets/produce stands. • Nutrition Education and Outreach – Provides individual or group education about healthy meal planning and preparation, and the impact of diet on health.	X	X	X
***Personal Emergency Response System** – Secures help in an emergency through an electronic device that is programmed to signal a response center with staff who immediately summon help.	X	X	X
***Professional Supports Specialist** • Transitional Behavioral Health – Provides mental health services to clients transitioning from residential facilities back into the community. • Challenging Behavior Consultation – Provides services to individuals who need help managing difficult behaviors that interfere with their ability to function in a community setting.	X	X	X

• Substance Abuse Counseling – Provides professional support and substance abuse counseling to individuals who require these services to transition to or live successfully in the community.			
***Skilled Nursing** – Provides RN services in the Medicaid client's home to protect and promote the client's health and welfare.	**X**	**X**	**X**
Transportation – Provides rides to medical appointments, social services, shopping, and other essential errands for adults who do not have alternative ways to access these types of services.	**X**	**X**	**X**
Veterans Directed Health Services – Care consultation to eligible veterans who have functional disabilities and need assistance selecting and managing the mix of services that will best meet their care needs.	**X**	**X**	**X**
Volunteer Support – Support to volunteer programs that provide opportunities for seniors to volunteer in the community.	**X**	**X**	**X**
***Community Transition and Training Services** • Purchasing – Purchasing of services and items that help clients to transition to or live in the community successfully. • Transportation – Provides clients with transportation to essential community services. • Client Training/Music Therapy– Client training teaches skills required to live in a home or community-based setting. Music Therapy is an evidence-based type of training that uses music interventions to achieve training goals. • Dementia Consultation for MAC/TSOA only – Provides education, counseling, medication management, and behavior management for unpaid caregivers, care receivers, and TSOA individuals. • Legal Services/Long Term Care Planning for MAC/TSOA only – Education and services designed to guide unpaid caregivers, care receivers, and TSOA individuals through various aspects of elder law.	**X**	**X**	**X**

Systems Development/Service Coordination Partners

LMTAAA continues the long-held value of working with community, regional, state, and national partners to maintain or enhance the above referral network and to collaborate on issues of long standing or emergent concern. The service delivery system in this area continues to evolve and benefits from the partnerships and collaborations between public and private entities as we strive to meet the needs of the aging and disabled population. Key outcomes from these public-private collaborations have included trainings, shared meeting spaces and resource development.

Topic	Key Partners
Transportation	• Mason Transit • Intercity Transit • Catholic Community Services
Housing	• LMTAAA Senior Housing Alliance
Health Care/Providers	• Valley View Health Center • Providence Health Systems • Morton General Hospital • Home Health Care Providers
Systems Development/Coordination	• Senior Action Network • County based provider groups.
In-home Services and Supports	• Home Care Coalition • Home & Community Services, DSHS • Medical Equipment Banks • Veterans Services • Developmental Disabilities Administration • Translation Services • Light of Hope, Wish List
Nutrition	• Washington Association of Nutrition Services Providers • National Association of Nutrition and Aging Services Programs • Food Banks
Health and Safety	• Mason General Hospital • Public Health Jurisdictions • Senior Games • Adult Protective Services

	• Thurston County Falls Prevention Coalition • Senior-focused publications • Senior Centers • Tribes
Policy/Advocacy	• Washington Association of Area Agencies on Aging • National Association of Area Agencies on Aging • Senior Lobby • AARP

B-3 FOCAL POINTS

AAA: Lewis Mason Thurston Area Agency on Aging

County	Organization or Site Name	Focal Point Address	Public Phone Number
Lewis County	LMT Area Agency on Aging	1651 S. Market Blvd Chehalis, WA 98532	888-545-0910
Mason County	LMT Area Agency on Aging	2008 Olympic Hwy N Shelton, WA 98584	888-545-0910
Thurston County	LMT Area Agency on Aging	2404 Heritage CT SW Olympia, WA 98503	888-545-0910

C - ISSUE AREAS AND THEMES

The Lewis Mason Thurston Area Agency on Aging provides extensive aging and disability services. Our goal is to maintain and establish a comprehensive system of services and supports that reach those that have the greatest economic, social, or service need. We target and engage folks through our Case Management Program, Information and Assistance Program and our Family Caregiver Programs.

The specific targeted issue areas help the agency define and address emerging needs and trends. These specific areas compliment the core competences and programming the agency provides that has been listed above in the AAA services and partnership section.

C-1 HEALTHY AGING

The agency provides an array of services that support the improvement of health and well-being as well as help reduce or maintain chronic conditions or illnesses. Some of the programming specifically focuses on the social determinants of health. The agency supports the provision of nutrition and meal services such as home delivered meals and congregate meals and transportation through our agency partners. The agency also understands the importance of nutrition and the detriments that malnutrition and social isolation have on someone's health and well-being.

Issue Area C-1: Healthy Aging					
Goal 1: Increase awareness and understanding of aging issues and programs that impact the health and wellbeing of older adults, people with disabilities and caregivers.					
Measurable Objectives	**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2024-2027 (By Month & Year)**		**Accomplishment or Update**
			Start Date	**End Date**	
Develop and execute an awareness and advocacy plan.	Define and educate on key issues and challenges.	Executive Director	01/01/2024	1/31/2027	
	Develop and expand on key partnerships (NANASP, DOH)	Executive Director	01/01/2024	1/31/2027	
	Develop an awareness and advocacy toolkit.	Executive Director, Advisory Council, and Executive Assistant	01/01/2024	1/31/2024	
	Develop an agency brochure.	Executive Director	01/01/2024	6/30/2024	
	Host 4 outreach events per year.	Executive Director	01/01/2024	1/31/2027	
	Participate in local, state, and national events appropriate for the specific issues and programs.	Executive Director	01/01/2024	1/31/2027	
	Develop partnerships that can help to provide resources and info to more rural areas.	Executive Director	01/01/2024	1/31/2027	

Goal 2: Increase the effectiveness and viability of key programming that promotes the health and well-being of our clients and communities and that impact the social determinants of health.					
Measurable Objectives	**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2024-2027 (By Month & Year)**		**Accomplishment or Update**
			Start Date	**End Date**	
Raise awareness of senior malnutrition through educational offerings, outreach, and partnerships.	Partner with the National Defeat Malnutrition Coalition for educational opportunities and outreach materials.	Executive Director & Contracts Team	01/01/2024	12/31/2027	
	Partner with the National Association of Nutrition and Aging Services Programs (NANASP) to advocate for community-based senior nutrition programs.	Executive Director & Contracts Team	01/01/2024	12/31/2027	
	Educate seniors on malnutrition through the Older Americans Act congregate and home-delivered meal nutrition programs, as well as the USDA Senior Farmers Market Nutrition Program.	Contracts Team & Subcontracted Senior Nutrition Providers	01/01/2024	12/31/2027	
	Review and evolve menu planning with Older Americans Act senior nutrition meal sites utilizing the subcontracted program Registered Dietician.	Contracts Team	01/01/2024	12/31/2027	
	During the 2025-2028 procurement process for OAA nutrition services, include sections on how meal sites will address malnutrition.	Contracts Team	01/01/2024	12/31/2024	
	Expand partnerships with organizations such as local food banks and Blue Zone Activate	Contracts Team	01/01/2024	12/31/2027	

	and to increase community involvement and engagement regarding senior malnutrition				
Develop and execute a tangible plan to increase access to nutritious meals and/or raw food, targeting rural or underserved senior populations.	Identify rural or underserved senior populations that have limited access to affordable establishments to purchase food.	Contracts Team	01/01/2024	6/30/2024	
	Research and partner with local organizations to provide mobile food options, such as partnerships with area Food Banks and Food Pantries.	Contracts Team	01/01/2024	12/31/2024	
	Partner with Thurston County Food Bank to provide seniors with healthy foods through their Commodity Supplemental Food Program (CSFP) which provides monthly food boxes with shelf stable and fresh food in Lewis, Mason and Thurston Counties.	Contracts Team	01/01/2024	12/31/2027	
Develop and execute a plan to increase awareness of transportation options and explore opportunities for expanded funding and services.	Meet with local subcontracted transportation providers at least annually to evaluate programs and services that can help support and increase operational capacity. This will be implemented at annual monitoring and other opportunities as they arise.	Contracts Manager	01/01/2024	12/31/2027	
	Collaborate with ADRC staff to define key resources and referral points and educate our communities about available transportation services.	Contracts Team & ADRC Team	01/01/2024	12/31/2024	
	Utilize website and social media to educate the community on available transportation services.	Contracts Team and Communications Manager	01/01/2024	12/31/2027	
	Explore grant and programmatic opportunities for new partnerships.	Contracts Team	01/01/2024	12/31/2027	

Advocate with local entities to address affordable housing and homelessness concerns in each county.	Identify partners. Explore needs and funding sources. Advisory Council	Community Supports Director	01/01/2024	12/31/2027	
	Attend partner meetings in each county.	Community Supports Director	01/01/2024	12/31/2027	
	Represent fixed income, affordability, and other related perspectives to our population.	Community Supports Director	01/01/2024	12/31/2027	
Assist in building the capacity of volunteerism within the communities the agency serves	Build awareness through outreach of the programs and partnerships that exist that are volunteer based that support the aging and disability network.	Advisory Council	01/01/2024	01/31/2027	
	Define key strategies and activities for recruitment, recognition and retention of volunteers that support service delivery under the Area Agency on Aging.	Advisory Council	01/01/2024	01/31/2027	
	Participate in one community event per year that supports the local volunteers.	Executive Director, Advisory Council	01/01/2024	01/31/2027	

Goal 3: Foster the development and growth that strengthen the agency's comprehensive system of services and supports.					
Measurable Objectives	**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2024-2027 (By Month & Year)**		**Accomplishment or Update**
			Start Date	**End Date**	
Evaluate current system	Assess access and entry points into LTSS.	Executive Team	01/01/2024	12/31/2027	
	Assess resources and services and the applicability to current system.	Executive Team	01/01/2024	12/31/2027	
	Define current key partnerships.	Executive Team	01/01/2024	12/31/2027	
Implement changes that address the evolution of services and supports that align with future needs	Address the needs of WA CARES.	Executive Director	01/01/2024	01/31/2027	
	Engage in community and partner network discussions.	Executive Team	01/01/2024	01/31/2027	
	Seek feedback from the public and clients via survey every 2 years.	Executive Team	01/01/2024	01/31/2027	
	Advocate and strategize on behalf of the services needed to support the evolving need, demographic positioning the agency to respond appropriately.	Executive Director	01/01/2024	01/31/2027	

C-2 EXPANDING AND STRENGTHENING SERVICES

LMTAAA supports this goal throughout the agency functions, most specifically through the work of the Community Supports unit. The Community Supports unit at LMTAAA consists of the Aging and Disability Resource Connection team providing Information and Assistance and the Family Caregiver Support Program, which includes MAC and TSOA programs as well as a diverse range of classes and outreach activities which occur throughout the three counties. Initial service access may occur through the Information & Assistance Program, or the Family Caregiver Support Program, and may include information, referral, eligibility, determination, and needs assessment. Along the continuum of interaction with LMTAA staff the foundations are grounded in person centered caregiver education, supported decision making, and psychoeducational supports for caregivers. These can occur through one- on-one, one-time conversations, or over a period of time as the care receiver and caregiver needs shift.

Additionally, LMTAAA offers group classes and training, such as the annual family caregiver workshops, the monthly Dementia Study Groups held in each county, Powerful Tools for Caregivers, Normal and Not Normal trainings etc. We also partner with ALTSA staff to provide Person Centered Counseling training for the greater community of care managers, social workers, and direct care providers. Community Supports staff are routinely called upon to present or speak at events such as tribal elder luncheons, faith-based groups, community forums, etc., on topics such as Dementia. Over time, the Community Supports unit is identifying small, yet diverse, populations in the service area. Some of these are readily evident though the natural leaders may not be visible to outsiders. We will use language specific materials such as the Spanish language version of the Dementia Road Map as a vehicle to gain insight into the needs of these language and culture specific groups.

LMTAAA provides a continuum of interactions with families and individual caregivers as well as collaboration with the larger community to address the needs of the elder and disabled population. One outcome of this framing is emergent concerns and conversations about topics which could impact entry into services. An example of this is the participation in the Thurston County Silver Team, an offshoot of Thurston Thrives, which is focused on the housing needs of the elder population. Another example is participating in the Lewis County health system review with the intention of inserting the needs of elders into the conversations about access to health care services in that county. LMTAAA provides a critical perspective for those we serve, from individual interactions with caregivers to community conversations about emergent issues.

Issue Area C-2: Expanding and Strengthening services and supports that prevent or delay entry into Medicaid funded long term services and supports					
Goal 1: Information and services provided through the Community Living Connections and Disability Resources Centers is accessible, accurate, easy to use.					
Measurable Objectives	**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2024-2027 (By Month & Year)**		**Accomplishment or Update**
			Start Date	**End Date**	
Collaborate with community-based organizations which serve LGBTQ+, BIPOC, and immigrant populations as well as organizations that serve adults with disabilities.	Identify and seek out likely partners from within diverse community organizations in each county, to include faith based, service, social organizations, etc.	Community Supports Director and Community Supports Team	01/01/2024	12/31/2027	
	Support organizations in identifying what outreach may be relevant and needed.	Community Supports Director and ADRC Supervisor	01/01/2024	12/31/2027	
	Work with community groups to understand barriers to accessing medical care and human services such as historical trauma.	Community Supports Director and ADRC Supervisor	01/01/2024	12/31/2025	
	Implement changes to outreach plans and service provision based on conversations with community groups about existing barriers.	Community Supports Director, FCSP Supervisor, and ADRC Supervisor	01/01/2025	12/31/2027	
	Develop relationships with organizations that serve those with disabilities to understand services and when to provide referrals.	ADRC Supervisor	01/01/2024	12/31/2024	

	Research demographic data annually to identify any emergent trends or shifts in population identity.	Community Supports Director	01/01/2024	12/31/2027	
Implement at least 40 outreach events and activities annually which reach diverse audiences and are representative of the populations in the LMTAAA service area.	Provide materials translated into languages spoken in our service areas and work with translators to give presentations.	ADRC Supervisor and ADRC Staff	01/01/2024	12/31/2027	
	Thematically frame outreach activities to build on cultural awareness and Social Determinants of Health activities happening at state and national level, for example: Nutrition Awareness Month, Falls Prevention Month, Chinese New Year, Hispanic Heritage Month, ASHHO Cultural Center events, etc.	ADRC Staff	01/01/2024	12/31/2027	
	Participate in Senior Action Network meetings and events (Dementia Conference and Living Well, Living Long)	ADRC Supervisor and FCSP Supervisor	Monthly and annually		
	Present monthly Providers Meetings in collaboration with county-based partners	ADRC Staff	Monthly & On-going		
	Provide outreach to rural areas of our service area with partners such as tribes and senior centers.	ADRC Staff	3+ times a year per county		
	Provide outreach at an LGBTQ event in each county as opportunities arise; to include Capitol City Pride events as possible.	ADRC Staff	Annually		

	Review presentation and outreach material content for language that invites in diverse communities and underserved communities, including underserved geographic areas.	ADRC Supervisor	01/01/2024	12/31/2027	
Maintain ADRC capacity within each county office to assist consumers with information and access to LTSS services.	Ensure each staff providing Medicare orientation and enrollment is adequately trained to meet needs of consumers.	ADRC Supervisor	01/01/2024	12/31/2027	
	Provide Medicare open enrollment supports and referrals as well as Medicare Savings Program (MSP)and Low Income Subsidy (LIS) application assistance.	ADRC Staff	Annually & on-going	12/31/2027	
	Ensure each staff providing WA Cares information is adequately trained to answer questions during outreach, present, and answer calls.	ADRC Supervisor	01/01/2024	12/31/2027	
	Within CLC environment maintain 5% call follow up rate.	ADRC Supervisor	01/01/2024	12/31/2027	
	Ensure existing and new ADRC staff receive orientation and training on Veterans Administration services	ADRC Supervisor	01/01/2024	12/31/2024	
	Ensure staff are trained in services for people who are blind, hard of hearing, and have other disabilities.	ADRC Supervisor	01/01/2024	12/31/2025	
	Attend topical trainings about emergent issues such as fraud and suicide prevention.	ADRC Staff	01/01/2024	12/31/2027	

	Ensure services are provided in a person centered context.	ADRC Supervisor	01/01/2024	12/31/2027	
	Support and promote local health jurisdictions efforts to provide vaccines to older adults, especially those who are homebound.	ADRC Staff	01/01/2024	12/31/2027	
Provide services to reduce social isolation amongst older adults in our service area.	Implement Mon Ami Telephone Reassurance and Volunteer Management System.	Community Supports Director	01/01/2024	12/31/2024	
	Train Volunteer Coordinator to oversee telephone reassurance program.	ADRC Supervisor	01/01/2024	12/31/2024	
	Create kick-off event for Mon Ami including organizations that provide activities for older adults as well as volunteer opportunities.	Community Supports Director, ADRC Supervisor	01/01/2024	12/31/2024	
	Present at least 2 Reach Out and Play intergenerational board game events.	Community Supports Director, ADRC Supervisor	01/01/2024	12/31/2024	
	Assess Mon Ami volunteer management system for additional social isolation uses and volunteer opportunities.	Community Supports Director, ADRC Supervisor	01/01/2025	12/31/2026	
	Seek out and evaluate new tools and programs to combat social isolation amongst older adults.	Community Supports Director, ADRC Supervisor	01/01/2024	12/31/2027	

	Address social isolation in older adults who are still staying home due to COVID concerns.	Community Supports Director, ADRC Supervisor	01/01/2024	12/31/2027	

Goal 2: LMTAAA delivers evidenced based and promising caregiver programs to targeted populations and communities at large.					
Measurable Objectives	**Key Tasks**	**Lead Position & Entity**	**Timeframe for 2024-2027 (By Month & Year)**		**Accomplishment or Update**
			Start Date	**End Date**	
Provide education on dementia to caregivers and community organizations.	Present monthly Dementia Support Group.	FCSP Supervisor	01/01/2024	12/31/2027	
	Distribute dementia educational resources such a Dementia Road Map and Dementia Legal Toolkit	FCSP and ADRC Staff	01/01/2024	12/31/2027	
	Research feasibility of starting a Memory Café in each county	Community Supports Director and FCSP Supervisor	01/01/2024	12/31/2025	
	Provide information and resources at Dementia Conference annually.	FCSP and ADRC Staff	01/01/2024	12/31/2027	
	Promote and present dementia care methods such as Positive Approach to Care.	FCSP Supervisor	01/01/2024	12/31/2027	

Provide evidence based and promising trainings, workshops, and presentations.	Present *Powerful Tools Training* and train more staff to be trainers twice per year.	FCSP Staff	01/01/2024	12/31/2027	
	Provide Advance Care Planning workshop training annually, in partnership with local providers.	FCSP Supervisor	01/01/2024	12/31/2027	
	Research feasibility of providing STAR-Caregivers training.	Community Supports Director and FCSP Supervisor	01/01/2024	12/31/2024	
	Support provision of *A Matter of Balance* trainings through community partnerships.	Community Supports Director and Contracts Team	01/01/2024	12/31/2024	

Goal 3: Family Caregivers experience supported decision making through education, information, and person-centered guidance.

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2024-2027 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
Family Caregivers provide accurate and helpful consultations and assessments to ensure caregivers can access the services they desire,	Maintain staff training and competencies in TCARE survey and assessment, MAC/TSOA intake and FLOC.	FCSP Supervisor	01/01/2024	12/31/2027	
	Utilize TCARE assessment, plan and consultation to inform Caregivers about services for themselves and their care receivers.	FCSP Staff	01/01/2024	12/31/2027	

and/or are eligible for.	Train staff on needs and preferences of caregivers from groups such as LGBTQ, BIPOC, and immigrants.	Community Supports Director and FCSP Supervisor	01/01/2024	12/31/2027	
	Ensure staff are trained in, and are regularly practicing, person-centered care methods.	FCSP Supervisor	01/01/2024	12/31/2027	
	Provide decision-making packet addressing levels of care including in home services, out of home levels of care.	FCSP Staff	01/01/2024	12/31/2027	
	Evaluate and update consultation methods and resources.	FCSP Supervisor	01/01/2024	12/31/2027	
Family Caregiver Resource Managers and MAC/TSOA staff are trained and competent for their roles.	Staff onboarding includes Person Centered counseling and motivational interviewing training.	FCSP Supervisor	01/01/2024	12/31/2027	
	Staff onboarding includes Advance Care Planning training.	FCSP Supervisor	01/01/2024	12/31/2027	
	Attend OSU Geriatrics Training as needed	FCSP Staff	01/01/2024	12/31/2027	
	Staff receive regular cultural competency trainings to serve groups within service area.	Community Supports Director and FCSP Supervisor	01/01/2024	12/31/2027	
	Attend topical trainings as determined by emergent issues, for example, Chemical Dependency, Fraud, Suicide Prevention, etc.	FCSP Supervisor	01/01/2024	12/31/2027	

MAC and TSOA program reach is increased.	Recruit Dyads (MAC and TSOA with Caregiver).	FCSP Supervisor	01/01/2024	12/31/2027	
	Develop and implement targeted outreach plan to home health agencies, hospital social work and medical staff, Federally Qualified Health Centers, diverse populations as appropriate.	FCSP Supervisor, ADRC Supervisor and Community Supports Director	01/01/2024	12/31/2027	
	Maintain WHO protocols and relationship with HCS Intake.	Lead Family Caregiver Specialist and FCSP Supervisor	01/01/2024	12/31/2027	
	Provide county-based Community education specific to MAC/TSOA at LMT sponsored provider meetings, Senior Action Networks, community forums, faith-based groups, service clubs, etc.	FCSP Supervisor, Community Supports Director	01/01/2024	12/31/2027	

C-3 PERSON-CENTERED HOME & COMMUNITY BASED SERVICES

Person-centered home and community-based systems are designed to allocate resources and provide the necessary supports and coordination to be responsive to the specific needs and choices of older adults and people with disabilities in ways that maximize their independence and ability to engage in self-direction of their services. These resources are intended to help achieve a more consistent and coordinated approach to the administration of policies and procedures across public programs. Person-centered services empower clients to identify what is important to them. This approach aids in helping people feel respected and experience healthy control.

Issue Area C-3: Person-Centered Home and Community Based Services

Goal 1: To offer case management services according to State mandates and consumers' needs

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2024-2027 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
Secure adequate funding and sustainability of core case management services.	Work with the State to establish contractual program obligations by increasing funding to support caseload ratios or reducing standards and expectations to match available funding.	Executive Director	01/01/2024	12/31/2027	
	Advocate with DSHS and the Washington State legislature for increased funding to fully implement the case management role.	Executive Director	01/01/2024	12/31/2027	
	Case Management Supervisors will continue to use the QA CARE tool to monitor Case Managers' work and compliance.	Case Management Director	01/01/2024	12/31/2027	
	Case Management Supervisors will participate in monthly ACT Team meetings with Adult Protective Services	Case Management Director	01/01/2024	12/31/2027	
	Lead Case Manager will participate in monthly Vulnerable Task Force meetings.	Case Management Director	01/01/2024	12/31/2027	

Goal 2: To provide Case Management services that embrace person-centered thinking, planning, and practices

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2024-2027 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
Staff will receive training and resources necessary to be knowledgeable on person centered practices.	Case Managers/Family Caregiver Resource Managers will be trained in Person Centered Thinking Training.	Case Management Director/Community Services Director	01/01/2024	12/31/2027	
	Case Managers/Family Caregiver Resource Managers will be knowledgeable in housing resources (Supportive Housing, LMTAAA Housing Alliance, Shared Housing, Emergency Rental Assistance, etc.)	Case Management Director/Community Services Director	01/01/2024	12/31/2027	
	Case Managers/Family Caregiver Resource Managers will be knowledgeable in Supportive Employment resources.	Case Management Director/Community Services Director	01/01/2024	12/31/2027	
	Case Managers/Family Caregiver Resource Managers will be trained on Assistive Technology, Env Mods, SME/DME options and authorizations to support clients staying at home.	Case Management Director/Community Services Director	01/01/2024	12/31/2027	
	Support the growth of Health Home program	Case Management Director/Community Services Director	01/01/2024	12/31/2027	
	Staff will have a good understanding of all residential settings to they can assist and support clients with transitions as appropriate.	Case Management Director/Community Services Director	01/01/2024	12/31/2027	

Goal 3: To create an environment of mutual respect, equity, and acceptance of persons we serve and with whom we serve

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2024-2027 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
Employees will report receiving the training and resources necessary for performing their roles in the agencies Diversity, Equity, and Inclusion Plan.	Staff will participate in DEI training.	Executive Director	01/01/2024	12/31/2027	
	Participate in Government-to-Government training.	Contracted Services Director	01/01/2024	12/31/2027	
	Ongoing support of Staff DEI committee.	Collective Management Sponsor	01/01/2024	12/31/2027	
	Require all new employees to watch DEI introduction video	Executive Director	01/01/2024	12/31/2027	
	Maintain language diversity in staff.	Executive Director	01/01/2024	12/31/2027	

Goal 4: Provide advocacy assistance to in-home clients, and residents of residential facilities

Measurable Objectives	Key Tasks	Lead Position & Entity	Timeframe for 2024-2027 (By Month & Year)		Accomplishment or Update
			Start Date	End Date	
Staff will receive training and resources necessary to be knowledgeable on local advocacy resources; or ensure vulnerable populations have access and support systems to allow them to live in the settings of their choice.	Invite local advocacy resources to staff in-service trainings (Ombudsman, APS, etc.	Case Management Director, Community Services Director	01/01/2024	12/31/2027	
	Participate in ACT Team and Vulnerable Task Force meetings	Case Management Director	01/01/2024	12/31/2027	

C-4 PLANNING WITH NATIVE AMERICAN TRIBES AND TRIBAL ORGANIZATIONS

LMTAAA meets at least annually with each of the recognized tribes in our Planning and Services Area (PSA), for the purpose of developing a DSHS Administrative Policy 7.01 Plan that outlines our coordination with the individual tribes. The five tribes in our PSA are the Confederated Tribes of the Chehalis Reservation, the Cowlitz Indian Tribe, the Nisqually Indian Tribe, the Skokomish Indian Tribe, and the Squaxin Island Indian Tribe. Meetings are arranged by the Regional Manager from the Office of Indian Policy, at the Department of Social and Health Services, who serves as a liaison to LMTAAA. Meetings are typically hosted by each tribe.

These plans contain goals, objectives, and activities that have been mutually agreed upon with each tribe, in order to continually improve our efforts to support tribal elders. Plans are considered to be living documents, and so are updated and adjusted throughout the year, as needs and circumstances change.

LMTAAA remains a resource for the tribes throughout the year and values the sharing of ideas and staff resources with each tribe on behalf of tribal elders. Plans have been updated and distributed with current contact information.

- Confederated Tribes of the Chehalis Reservation
- The Cowlitz Indian Tribe
- The Skokomish Indian Tribe
- The Squaxin Island Indian Tribe
- The Nisqually Indian Tribe

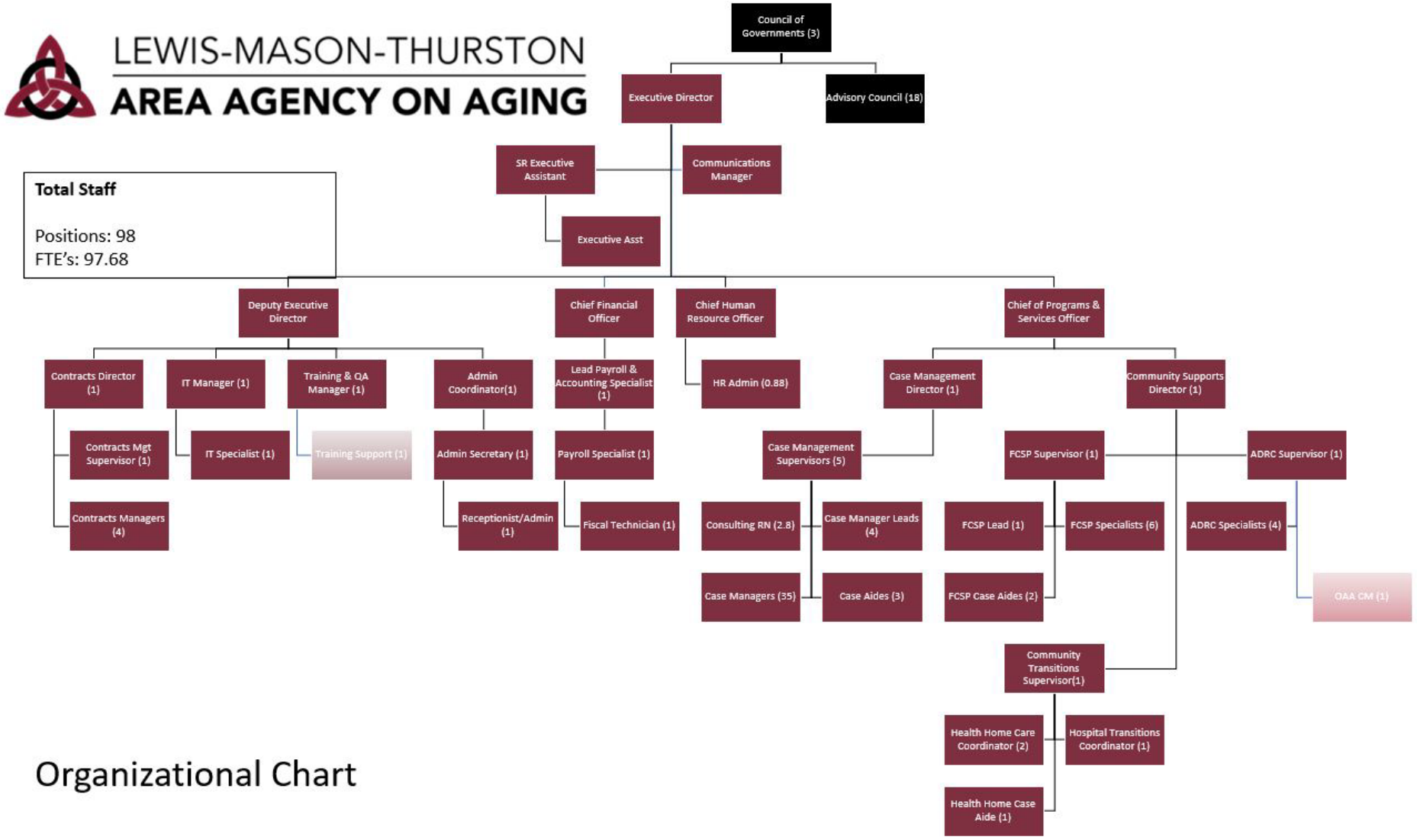
You can see our complete 7.01 plans on our website

D – AREA PLAN BUDGET SUMMARY

Revenues	
Older Americans Act	$2,485,326.00
NSIP	$132,528.00
Title 19	$8,811,076.00
State/Fed Contract	$1,807,931.00
MTD	$951,721.00
Other ALTSA funding	$528,831.00
Non-ALTSA	$2,815,349.00
Total	**$17,532,762.00**

Budgeted Expenditures	
Salaries	$7,538,533.00
Benefits	$2,585,856.00
Operating Costs*	$4,315,962.00
Provider Contracts	$1,568,968.00
Other subcontract Resources	$1,523,343.00
Total	**$17,532,762.00**

APPENDIX A – ORGANIZATIONAL CHART



Organizational Chart

APPENDIX B – STAFFING PLAN

Position Title	Name	Total Staff Full Time & Part Time	Position Description
Executive Director	Nicole Kiddoo	1 FTE	Oversees administration of all agency functions, activities, and personnel. Supervises Program Managers and Fiscal Manager. Provides personnel management and establishes agency policies and procedures. Provides advocacy for the Agency and its clients. Leads disaster and other agency planning activities.
Deputy Executive Director	Jemma Williamson	1 FTE	Oversees the daily operations of the agency. Collaborates with agency departments and applicable partners and stakeholders in meeting the agency's mission, goals, and strategic objectives.
Chief Financial Officer	Sabrina Dean	1 FTE	Responsible for budgeting, financial management, and supervision of Accounting Specialist and Computer System Specialist. Development of agency policies and procedures, personnel management, and participates in disaster and other agency planning activities. Conducts Fiscal monitoring.
Chief Human Resource Officer	Mary Beth Mercer	1 FTE	Program development and oversight include recruitment and selection, policy development and administration, employee compensation and benefits, training and development, employee and labor relations to assure the highest quality of personnel for the organization in compliance with local, state and federal law.
Chief of Program & Services	Donna Feddern	1 FTE	Program planning, development and oversight. Collaborates with agency departments and applicable partners and stakeholders in meeting the agency's mission, goals, and strategic objectives.
Case Management Director	Emily MacFarland	1 FTE	Manages direct services for Case Management & Home Care Referral Registry (HCRR) Support, including supervision of staff for these programs. Development of agency policies and procedures, personnel management, and participates in disaster and other agency planning activities.

Community Supports Director	Vacant	1 FTE	Manages direct services for I&A and Family Caregiver Support, including supervision of staff for these programs. Development of agency policies and procedures, personnel management, and participates in disaster and other agency planning activities.
Contracts Director	Carrie Petit	1 FTE	Supervises Contracts Managers, Administrative staff, provides HR management functions, contract administration, development of agency policies and procedures, personnel management, and participates in disaster and other agency planning activities.
Senior Executive Assistant	Jessica Hodges	1 FTE	Supports the Executive Director and the Executive Leadership Team with meeting their collective goals associated with the agency's various plans, strategies, and operations.
Executive Assistant	Lisa Bachmann	1 FTE	Providing direct high level executive administrative support to the Executive Director and the Executive Leadership Team.
Communications Manger	Becca Frisch	1 FTE	Develops and maintains LMTAAA's internal and external communications and communication plans.
IT Manager	Julie Dasso	1 FTE	Oversees the information technology of the Agency.
QA and Training Manager	Buong Le	1 FTE	Oversees the training and supervision of probationary staff in the Case Management Department. Coordinates and implements Quality Assurance activities. Assess current training and development systems, develop new training programs, organize routine and required trainings, implement measurement tools, and provide feedback.
Family Caregiver Services Supervisor	Kathy Howard	1 FTE	Day-to-day supervision of Information & Assistance (I&A & FCSP staff.

CS ADRC Supervisor	Kyle Sanchez	1 FTE	Provides supervision and oversight of day-to-day activities of Aging and Disability Resources Connection (ADRC) staff
Case Management Supervisor	Emily Palguta Shannon Judy Hannah Sheets Nhi Hoang Vacant	5 FTE	Day-to-day supervision of case management staff and consulting RN's. Responsible for quality assurance, and training of case management staff.
Contracts Supervisor	Val Aubertin	1 FTE	Provides supervision, training, and oversight of day-to-day activities of staff performing contract management functions.
Health Home Supervisor	Adrienne Dorrah	1 FTE	Provides supervision, training, and oversight of day-to-day activities of staff performing Health Home functions.
Consulting Registered Nurse	Terry Worel (1 Jessica Smith (.8) Teresa Cooper (1)	2.8 FTE	Provides Nurse consulting services for AAA and DD Case Managers of Title XIX in-home & community residential programs. Also provides nursing consultation for FCSP clients.
Contracts Manager	Lisa Jolly Alice Cunningham Kane Caren Paintner Chelsea Carter	4 FTE	Develop, monitor and coordinate contracts and provide technical assistance for programs provided outside of the agency. Coordinate with Tribal partners and community providers and participate in agency planning activities
Lead Case Management Leads	Melaine Minson Karen Anderson Liz Fitchett Jennifer Krueger	5 FTE	Back-up & support to CM staff, review of all incoming and outgoing CM files, participates in community meetings, coordinate client services & participate in resolving client concerns. Monitors reports.
Lead Fam CG Res Spec (MTD)	Heather Dretsch	1 FTE	Supports all Resource Managers with TCARE and MAC/TSOA caseloads, helps develop, implement, and maintain the quality assurance processes and helps to develop, implement and oversee central intake for both programs.

Case Managers	Alex Ramstein Amanda Smiley April Michal Beth Babra Brent Bloomfield Deanna DeLancy Debi Prindel Deijah Kaneshiro Demi Williams Erin Seiler Jennifer Lynch Joni Baker Julie Phillips Kaileigh Oliphant Kate Stettler Laura Cook Lawrence Kinnaman Lesona Hartman Lindsey Rios Lindsey LeBret Logan Hill Lynette Richardson Melainie McGee Meridith Thayer Morgan Anderson Nhat Nguyen Nikki Crist Rebecca Roadman Sam Smith Sarah White Sue Kim Tammie Bull Valerie Jackson Vacant (2)	35 FTE	Assessment, service plan development & implementation, reassessment and reauthorization, ongoing case management.
Family Caregiver Specialist	Laurie Lembke Adam Moore April Thomas Jenny McIntyre Matt Davis	5 FTE	Maintains a Family Caregiver case load while working closely with families and Caregivers to determine the need and available resources. Provides education, outreach and training to individuals and the community.
Case Management Case Aide	Mara Matz Joan Hillier Shelby Leota	3 FTE	Assists the Case Management team by monitoring and implementation of client service plans
I&A/FCSP Case Aide	Melissa Thompson Kim Silverthorn	2 FTE	Assist the Resource Managers with client enrollment, phone contacts and monitoring client screenings. Assists I&A staff by documenting, reporting and providing disabled adults with information and resources.

ADRC) Specialist	Laura Dreckman Brandon Humphries Marla Lund Stephanie Mace	4 FTE	Provides Information and assistance services, outreach, and group presentations.
Lead Payroll & Accounting Specialist	Barbara Sadlier	1 FTE	Payroll, accounts receivable & accounts payable.
Payroll Specialist	Seini Uluibau	1 FTE	Perform accounting and clerical tasks for the maintenance and processing of timesheets, accounts payable transactions, general accounting, and clerical duties.
Fiscal Technician	Erica McMellen	1 FTE	Perform accounting and clerical tasks for the maintenance and processing of accounts payable transactions, general accounting, and secretarial and administrative support
HR Assistant	Brooke Bronson	0.88 FTE	Performs a wide range of human resources functions. Provides administrative support for the Human Resources department, as well as help with the day-to-day operations.
IT Specialist	Lex King	1 FTE	Database, personal computer, and local area network support and troubleshooting.
Administrative Coordinator	Chrissy Franklin	1 FTE	Provides an extensive array of clerical and administrative duties, as well as coordinating general administration within the Agency.
Administrative Secretary	WinDi Sanchez-Soler	1 FTE	Secretarial and administrative support to staff. Provides reception back-up and interacts with members of the public and community professionals.
Receptionist/Admin Asst	Janet Michaels	1 FTE	Reception, file set up and transfers, general admin, clerical assistance and staff support.

Health Home Care Coordinator	Andy Brown Paul Madison	2.0 FTE	Care coordination responsibilities will include assessment and care planning and monitoring of client status, and implementation and coordination of services.
Care Transitions Care Coordinator	Michelle Goodman	1 FTE	Develops care plans for patients being discharged from the hospital to help with their return to the community. The position works closely with patients, families, caregivers, and service providers to determine the resources available to meet the patient's needs
Training Specialist	Vacant	1 FTE	In progress
OAA Case Manager	Vacant	1 FTE	TBD
Health Home Case Aide	Shannon Smith	1 FTE	Assists with outreach to enroll new clients to the program and provide administrative support to the Health Home team.

*Total Number of Full Time Equivalents = 97.68 (FTE = 40 hours/week)
*Total number of staff = 98

Total number of minority staff = 11
Total number of staff aged 60 and older =7
Total number of staff self-indicating a disability = 1

*When fully staffed

APPENDIX C – EMERGENCY RESPONSE PLAN

Designated staff person who oversees planning tasks and determines how emergency management is carried out in the local jurisdiction.

The Deputy Executive Director has been designated to oversee the planning and operation of LMTAAA emergency management, with an order of succession that follows with the Chief of Programs and Services Officer, Chief Human Resources Officer, and Chief Fiscal Officer. An Essential Services and Functions Continuity Plan has been developed, which indicates the service or function, a priority score, assigned staff/team, and resources needed. The management team also maintains a current list of employee contact information for emergency purposes.

Letters of agreement between the AAA and local emergency operations leadership that identify responsibilities.

Memorandums of Understanding (available upon request)

- Lewis County Department of Emergency Management
- Mason County Division of Emergency Management
- Thurston County Emergency Management

Preparedness activities done by LMTAAA.

Our first priority will be protecting our own staff, facilities, and clientele. LMTAAA will, to the best of our capacity, attempt to honor our contractual obligations, with staff and client safety as our number one concern. Our resources would then be directed to support community and government responses, as appropriate with our available staffing and resources. LMTAAA has an active internal Safety Committee that focuses on policies and procedures related to staff office safety, field safety, and personal emergency preparedness planning, as well as organizing safety drills.

We have proactively encouraged preparedness with our staff, clients and providers and will continue to stress the importance of planning and preparing. We have emergency supplies in each office.

LMTAAA staff regularly participate in local emergency planning meetings in all three counties. LMTAAA staff are on the email distribution list to receive notification emails from all three Emergency Management agencies. Relevant email notifications are distributed amongst staff for personal information as well as distribution to clients as needed.
These email notifications are additionally distributed to the senior and disability provider network in our region, as well as our Tribal partners.

LMTAAA Case Managers discuss a personal emergency backup plan with every new client, including what they will do and who they will call in the event their caregiver cannot get to them during a natural disaster. Clients are additionally given a county specific emergency contact list for their use and reference.

Criteria for identifying high risk clients in the community.

In the event of an emergency, it may be necessary to contact our most vulnerable clients to determine if they are safe and receiving essential support. This may be in the event of a natural disaster such as earthquake, flooding, prolonged power outage, or pandemic related events. LMTAAA has determined that it is necessary to develop and keep updated prioritized client lists in the event that we or the local County Department of Emergency Management need to contact our clients to determine their safety.

The following are guidelines for each of the classifications:

High Priority Client for Contact

Solely:

- Is medically fragile and needs daily tasks to survive
- Has critical medical equipment that is dependent on electricity (i.e. oxygen, nebulizer)

-OR-

Two or more:

- Lives alone and is non-ambulatory
- Lives alone and is geographically isolated
- Lacks functioning or close informal support systems
- Has a non-family independent provider and/or agency provider

Low Priority Client for Contact

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

All other clients not listed as High or Low priority will be considered a medium priority.

The contact list includes the following:

Client Name
Physical Address
Phone Number(s)
Emergency Contact Name and Phone Number
Priority Designation

Case Managers are responsible for developing and maintaining the priority designation for all the clients on their caseloads. Each Case Manager reviews their client priorities at the end of each month: adding new clients, identifying terminated clients, and changing priorities if a client situation changes.

LMTAAA maintains a master alphabetical list of clients by zip code and by priority designation.

Through a Memorandum of Understanding, the list is additionally sent to each County Department of Emergency Management (DEM) in our service area. As part of the agreement, DEMs will:

- Store one digital and one hard copy of the client database. Protect confidentiality of the database by password protecting the digital copy and keeping the hard copy in a locked file cabinet.
- Destroy previous versions of the client database upon receipt of an updated version, using a destruction method that ensures confidentiality of information.
- Release the client database to LMTAAA when requested.

And as staffing and County priorities allow:

- Release information on geographically appropriate high priority clients to first responder agencies such as fire, police, and other governmental entities in the event of a County declared emergency for the purposes of performing health and welfare checks.

Plan for contacting high-risk clients and referring to first responders as necessary.

If emergency occurs after regular business hours, see attached Memorandums of Understanding with local Emergency Management. During business hours, the following is a list of health and welfare check questions to ask of high-risk clients, moving from general to specific:

1. Are you OK?
2. Do you have friends/family that have been there to help you? If no, can you call friends/family for assistance?
3. Has your caregiver been there to help you? If no, have you been in touch with your caregiver?
4. Do you have electricity? Heat? Water?
5. If the electricity is out, do you have medical equipment that isn't working that is essential for your health and care?
6. Do you have alternative options if your heat is out?
7. Do you have alternative options if your water supply is not working?
8. Do you have enough food to eat and liquids to drink?
9. Can you prepare the food?
10. How many more days' worth of accessible food/water do you have?
11. Do you have enough essential medication? How many more days' worth do you have?
12. Do you have any other concerns or needs at this time?

If a client is in immediate danger, 911 is called. If there is a need, but perhaps less imminent, the local County Department of Emergency Management is called.

Local partners

Lewis County

Through our partnership with Lewis County Department of Emergency Management:

American Red Cross
United Way of Lewis County
Salvation Army
Lewis County Health Department
LOVE, Inc.
Animal Services

Long Term Recovery Organization
Morton General Hospital
Providence Centralia Hospital
White Pass Community Services Coalition
American Medical Response
Centralia Seventh Day Adventist Church
Food Banks
Lewis County Gospel Mission
Community Action Council
WIN 211

Mason County

Through our partnership with Mason County Division of Emergency Management:

Mason County Sheriff's Office
North Mason Regional Fire Authority
Mason General Hospital
Squaxin Island Tribe
Skokomish Tribe
Central Mason Fire & EMS
Mason County Public Health
City of Shelton
MACECOM
American Red Cross
Mason Transit Authority
Shelton Chamber of Commerce
Mason County Public Works
Department of Ecology
Mason County Coroner
Washington Correction Center
Mason PUD 1, 3
Fire Districts 4, 11, 13, 18
Harrison Medical
United Way of Mason County
Economic Development Council
WSU Extension
Port of Shelton
School Districts
Adopt a Pet and Humane Society
American Red Cross
WIN 211
LOVE, Inc.
LDS church

Thurston County

Through our partnership with Thurston County Emergency Management:

Medical Reserve Corps
Faith Based Groups
Interfaith Works
Behavioral Health Resources
ARES/RACES
Intercity Transit
Animal Services/Rescue Organizations

Long Term Recovery Organizations
United Way of Thurston County
Food Banks
Senior Services for South Sound
St. Martins Alumni Association
St. Vincent DePaul
Goodwill
Salvation Army
American Red Cross
YMCA/YWCA
WIN 211
State Citizen Corps

Cooperation with the appropriate community agency preparedness entities when areas of unmet need are identified.

Natural disasters and emergencies are a constant concern for an organization responsible for the health and safety of consumers, whether directly served by LMTAAA or our community providers. Staying current with first responder needs and expectations is critical to the LMTAAA being of assistance in restoring services once first responders have gained control over any emergency situation. A strong emergency response department at each county level exists and coordinates with local providers on an ongoing basis. LMTAAA staff participate in local emergency preparedness meetings and receive planning updates from local emergency agencies.

LMTAAA staff participate on the Thurston County Disaster Assistance Council (DAC) and the Mason County Planning Team, which meet monthly and are led by the respective County Departments of Emergency Management. Both are active with County emergency services entities, the American Red Cross, and the Department of Health, as well as a variety of state and local governmental and private social services agencies.

LMTAAA staff also participate in the Coalition for Inclusive Emergency Planning (CIEP) advisory group, which works with state, local, and tribal stakeholders to build disability, accessibility, and inclusion into all aspects of emergency managements. CIEP provides technical advice on access and functional needs in the areas of effective communication, physical and programmatic access, and fosters working relationships among emergency managers.

Lewis County does not have these types of organized on-going groups, but LMTAAA staff are on the Department of Emergency Management email distribution list and receive relevant information when disseminated. LMTAAA staff reach out as needed and stay in communication with the County to receive relevant emergency information.

All contracted providers are required to develop emergency and continuity plans and are monitored to assure follow through. Contract language states, “The Contractor shall have a plan for serving currently authorized clients during periods when normal services may be disrupted. This may include earthquakes, floods, snowstorms, pandemic flu, etc. The plan needs to include the maintenance of lists, including the identification of those clients who are most at risk, as well as emergency provisions for service delivery.”

LMTAAA fully embraces our role as an active player in community-wide preparation and response. LMTAAA distributes information about emergency planning expos, and seasonal safety information, such as cooling station's locations and storm warnings, to staff and other network partners. We also work with clients, providers, and tribes as needed to support emergency preparedness activities.

A system for tracking unanticipated emergency response expenditures for possible reimbursement.

Unanticipated emergency response expenditures will be identified, to the extent possible, in a separate expense category in the financial records. Staff unable to access electronic timecards and expenditure worksheets will be given hard copy forms to be completed manually. The LMTAAA network is backed up to a server at our Olympia office. The email system is managed by ALTSA servers.

An internal Business Continuity Plan that emphasizes communications, back-up systems for data, emergency service delivery options, and transportation.

LMTAAA has a COVID Safety plan that is updated as necessary to stay in accordance with the COVID Safety recommendations from the Center for Disease Control and Prevention (CDC), Washington State Department of Health, and Labor and Industries (L&I)

APPENDIX D – ADVISORY COUNCIL

Lewis-Mason-Thurston Area Agency on Aging Advisory Council

Name	County Representing
Heidi Buswell	Lewis County
Debbie Aust	Lewis County
Tim Wood	Lewis County
Greg Rohr	Lewis County
Vacant	Lewis County
Vacant	Lewis County
Becky Conquist	Mason County
Tamra Ingwaldson	Mason County
Vacant	Mason County
Vacant	Mason County
Vacant	Mason County
Vacant	Mason County
Cat McGaffigan (Chair)	Thurston County
Michele Horaney	Thurston County
Eileen McKenzieSullivan	Thurston County
Angela Hock	Thurston County
Anna Schlecht	Thurston County
Ellen Wendt	Thurston County

Total members: 18 (7 vacant)
Total responses to demographic information request:

Of the12 responders:
Total number age 60 or over = 11
Total number minority = 1
Total number self-indicating a disability = 3
Total number of members of health care provider organizations = 3
Total number participating in other senior advocate groups: 6
Total number with leadership experience in the private or voluntary sectors: 12
Total number low income: 2

APPENDIX E – PUBLIC PROCESS

Process Summary

LMTAAA follows the policies and procedures associated with the Area Plan public process. The agency seeks feedback and input from the public along with the LMTAAA Advisory Council and the Council of Governments.

In an effort to collect input from our communities, the agency held events within the Lewis, Mason, and Thurston counties. Based on the information provided to the agency from those events and the public survey, the agency responded to those needs in the development of the plan. In addition, the agency's experienced staff, provided key input.

EVENT	DETAILS
Community Forum – Lewis County – Packwood	July 31st, 2023
Community Forum – Lewis County – Chehalis	January 3rd, 2024
Community Forum – Mason County – Belfair	July 25th, 2023
Community Forum – Mason County – Shelton Sr Center	August 16th, 2023
Community Forum – Thurston County – Lacey Sr Center	July 27th, 2023
Community Forum – Thurston County – Olympia Sr Center	August 8th, 2023
Virtual Focus Group	August 3rd, 2023
Public Hearing	January 16th, 2024
Survey	Distributed Paper Survey and Website Link June - September

Role of the Advisory Council and Council of Governments

The role of the Lewis Mason Thurston Area Agency on Aging Advisory Council is to support staff with coordinating and participating in the planned public events and to review and make recommendations on the plan.

The role of the Lewis Mason Thurston Council of Governments is to provide input and to approve the plan and the associated budget.

Role of the Office of Indian Policy

The Office of Indian Policy coordinates all tribal meetings between LMTAAA and the respective tribes within our service territory. The 7.01 planning process is a collaborative effort between LMTAAA and the tribes.

APPENDIX F – REPORT OF ACCOMPLISHMENTS

Issue Area 1: Healthy Aging	
Goal 1: Increase awareness and understanding of aging issues and programs that impact the health and well being of older adults, people with disabilities and caregivers.	
Measurable Objectives	**Accomplishments**
Develop and execute an awareness and advocacy plan.	A lot of this work was put on hold due to COVID, and this goal/objective/key tasks have been added to the new 2024-2027 Area Plan
Goal 2: Goal: Provide and explore evidence based programming that help prevent or manage chronic conditions.	
By year three of this area plan period, implement desired falls prevention activity(ies) in each county, in partnership with community organization	A lot of this work was delayed by the pandemic. A Matter of Balance (AMOB) classes have continued in Mason County in 2022 and 2023. Expansion of classes to other counties has been delayed and is not feasable at this time, due to a lack of identified volunteers and partners. Mason General Hospital resumed providing in-person classes led by volunteers at the Mason Senior Activities Center in Shelton in 2022 and 2023. The Falls Prevention Coalition hosted a presentation about the Otago meeting at a meeting in 2022.
Work in conjunction with identified partners to support the implementation of the CDSME State Grant from ACL.	This work was put on hold due to COVID
Goal 3: Increase the effectiveness and viability of key programming that promotes the health and well being of our clients and communities and that impact the social determinants of health.	
Bring awareness to malnutrition and increase nutritional value and offerings	Senior Centers remained closed until August 2021 due to the COVID-19 pandemic. Nutrition education info-sheets were delivered with Pick-Up and Home Delivered Meals throughout the pandemic. This occurred in Mason and Thurston Counties, Lewis County residents did not receive nutrition education. We are working with that provider, including a plan to provide Nutrition Education at a minimum of 4 times per year. 2022 & 2023 had an increase in Nutrition Education provided by a contracted nutrition provider in Mason and Thurston Counties. Along with increased education being provided this program also made more referrals to the Registered Dietician for guidance when a participant scored "high" on the Nutrition Risk questionairre that is conducted annually with each participant. Lewis County had organizational upheaval with new leadership taking place. Due to this, the program is focused on providing meals and getting their systems restructured to be able to meet the nutrition education goal moving forward. Mason county congregate has been underserved since September 2021 however drive thru meals have been offered as an alternative while a meal site is found. LMTAAA nutrition contract staff and two of our contracted nutrition providers are members of Defeat Malnutriton/NANASP. The Defeat Malnutrition coalition has been and will continue to be a resource for nutrition education as well as information on the Social Determinants of Health. We expect this information to increase participant knowledge about healthy food choices. Our contracted providers were providing many fresh options early in 2020, however during the pandemic meals were being delivered frozen which reduced fresh, unfrozen food options. Moving forward with the re-opening of congregate sites a focus on providing fresh options will resume. The registered dieticians are required to review menus and adapt them to the healthiest options while providing the minimum of 1/3 RDA. 2022 & 2023: All three of our counties are serviced by the same Registered Dietician. She has been meeting with Lewis County in particular to update their menus to include more fresh options and less sodium by utiliizing herbs and other flavor enhancing foods. She had done this same process in Mason & Thurston counties with great success. Mason county congregate has been underserved since September 2021 however drive thru meals have been offered as an alternative while a meal site is found.
Develop and execute an awareness plan for transportation options	Transportation Providers attended the Advisory Council Meeting on 4/7/2021. Options have been researched such as exploring voucher programs. Mason/Thurston provider increased trips from 2021 to 2022 by 72%. The number of people served from 2021 to 2022 increased by 43%. 2023 levels are continuing to increase as community need is growing.
Partner with local entities addressing affordable housing and homelessness concerns in each county.	Participated in local meetings, and expanded to each county
Assist in building the capacity of volunteerism within the communities the agency serves.	Postponed due to COVID
Goal 4: Foster the development and growth that strengthen the agency's comprehensive system of services and supports.	
Evaluate current system	I&A transformation to ADRC in 2023. Assessing client's journey from front dest to FCS. Capacity building work done in ADRC. Assessed needs for staffing needs and added an ADRC Supervisor
Implement changes that address the evolution of services and supports that align with future needs	Executive Leadership worked on Strategic Planning to identify staffing needs. Work to support workforce development with the implementation of a New Employee Handbook and structured onboarding process

Issue Area 2: Expanding and strengthening services and supports that prevent or delay entry into Medicaid

Goal: LMTAA delivers evidenced based and promising caregiver programs to targeted populations and communities at large.

Measurable Objectives	Accomplishments
Dementia Study Groups are maintained at current level and evidence base is developed so DSG can be tested and potentially replicable.	Dementia Study Groups moved to Zoom during the pandemic. In May 2023, the Lewis DSG returned to in-person meetings and we added an evening DSG for those who work during the day.
Either directly or through community partnerships, maintain and implement a menu of evidence based and promising trainings, workshops and presentations, providing at least 40 trainings annually.	Powerful Tools moved online. We have a new lead trainer and are scheduled 2 classes in 2023. Advance Care Planning workshop provided viaZoom in 2023 Partnered with a caregiver author to present Dementia training events at Centralia Timberland Library
Provide outreach and topical specific content as requested by area tribes.	ADRC Staff started attending Elder Lunches again in 2022 and are adding more in 2023.
Goal : Information and services provided through the Community Living Connections and Disability Resources Centers is accessible, accurate,	
Annually, collaborate with community based organizations which are reflective of existing and emergent discrete and diverse populations.	Collaboration with organizations added include Homes First and Habitat for Humanity. Some of this work is done through online Senior Action Network meetings. Information tables at local events such as; multiple visits to senior centerin all 3 counties, Tenino Oregon Trail Day, Toledo Senior Center, Resource Fair, Lake Fair Senior Day, Olympia Pride, Southwest WA Fair, Mason General, LMTAAA Open House, Squaxin Island Elder Lunch, Chehalis Elder Lunch, Nisqually Elder Lunch, Living Well Living Long, Bethel Church, Centralia College Back to School Event, Mason LPA Resource & Job Fair,Olympia Timberland Library, Yelm High School Resource & Career Fair, Valley View Health
Annually plan for and implement at least 40 outreach events and activities which reach diverse audiences throughout the calendar year, and are geographically representive of the populations in the LMTAAA service area.	This work was impacted by the pandemic. During Falls Prevention Awareness Week in 2022, presented to YMCA in Olympia and Twin Cities Senior Center in Lewis County as well as hosting Falls Risk Assessments at Living Well, Living Long event. Continued participation in the Senior Action Network led to outreach at LakeFair in 2022 and the development of the Dementia Conference in 2023. Staff moved monthly Provider Meetings online and combined the three counties. Dential Conference May 2023.
Maintain Information and Assistance capacity within each county office to assist consumers with information and access to services include Family Caregiver, MAC and TSOA programs.	All staff have received Medicare orientation and enrollment training. Staff providing increased support with MIPPA contract and addition of a MIPPA-focused ADRC Specialist in 2023 Staff are achieving the 5% call follow-up rate. All staff are trained in, and regularly encouraged to practice, a person-centered approach.
Develop and implement multi-dimensional outreach plan annually	The Family Caregiver newsletter is now being sent via email on a quarterly basis. Resources directory is available on website and web development company made sure it is ADA compliant. Twelve articles are submitted each year to the Senior News and Senior Dynamics (Chronicle insert) and sometimes the Mason County Journal.
Goal : Family Caregivers experience supported decision making through education, information and person centered guidance.	
Family Caregivers provide accurate and helpful assessments to ensure caregivers can access the services they desire, and/or are eligible for.	Staff are trained timely on job specific programs and assessment tools. Team meetings are run with a focus on person-centered training in order to maintain and develop skills.
Caregivers are supported by providing accurate, current education regarding choices and decision making.	All Dementia Study Group and workshop materials are evidence-based. Powerful Tools trainings continued to be presented online and are offered twice a year. Dementia Study Groups are offered 4 times a month. There are meetings for each county and one evening group for those who work during the day.
Caregiver Resource Managers and MAC/TSOA staff are trained and competent for their roles.	All new staff are provided with Person Centered training and Advanced Care Planning. Staff attended suicide prevention in 2022 Series of DEI training in 2022-2023.
MAC and TSOA program reach is increased	Networking and provided information to Providence and homecare agencies. Community Supports Director gives presentations to community groups and service clubs about services including MAC/TSOA.

Issue Area 3: Person-centered home and community based services	
Goal : To offer case management services according to State mandates and consumers' needs	
Measurable Objectives	**Accomplishments**
Secure adequate funding and sustainability of core case management services.	Funding Received to get us to 75-1 Completed 100% required QA reviews for 2022 and 2023 Case Management supervisors toate and attend monthly ACT meetings with APS. CM Lead attands monthly Vulnerable Task Force meetings
Goal :To provide Case Management services that embrace person-centered thinking, planning and practices	
Staff will receive training and resources necessary to be knowledgeable on person centered practices.	All Community Supports staff have received training in Person Centered Thinking/Options Counseling. Case Management staff participate in Coffee Talks from ALTSA Housing. I&A is familiar with public housing and housing vouchers. Optional training provided 4/2023 and 8/2023- "Client and their Benefits when working". Given by Supportive Employment-Laura DeVol. Victoria Nuesca - CFC PM attended CM meeting early 2020. Family Caregiver Specialists are trained with one specialist acting as subject matter expert. Case Management staff had training with local HCS on best practices on transfers
Goal : To create an environment of mutual respect, equity and acceptance of persons we serve and with whom we serve	
Employees will report receiving the training and resources necessary for performing their roles in the agencies Diversity, Equity, and Inclusion Plan.	2022 - 2023 Strategic Plan multiple trainings - All Staff Community Supports Director and Access Services Supervisor took the last Govt to Govt training offered. Director has attended Tribal Summits in 2022 and 2023. Staff DEI committee meets monthly Onboarding of new hires review recorded DEI training series LMT continues to look to hire people whi speak diverse languages
Goal : Provide advocacy assistance to in-home clients, and residents of residential facilities	
Staff will receive training and resources necessary to be knowledgeable on local advocacy resources; or ensure vulnerable populations have access and support systems to allow them to live in the settings of their choice.	Training by Bob Blancato 2023, N4A conference

Issue Area COVID 19 Response Services and Supports - Continue to serve our clients and	
Goal : Internal/Direct Services/Collaboration	
Measurable Objectives	**Accomplishments**
Minimize interruption to client services during pandemic	Staff wer set up so they could serve clients remotely (VPN, phones) Vaccination project was completed for clients and IPs Telephone Reassurance Project Completed Case Management Emergency Monitor calls
Goal : Internal/Direct Services/Collaboration	
Maintain relationships with community partners during a pandemic	Virtual Meetings (Providers meetings, Senior Action Network, Quarterly local HCS/AAA Case Management meetings) Participated in community events once held in-person again Continued to distribute printed materials
Services for the community	Transitioned Senior Farmer Market Program to I&A Emergency Meal Planning Adult Day Care

APPENDIX G – STATEMENT OF ASSURANCES AND VERIFICATION OF INTENT

For the period of January 1, 202 through December 31, 2027, the Lewis-Mason- Thurston Area Agency (LMTAAA) on Aging accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (P.L. 106-510) and related state law and policy. Through the Area Plan, LMTAAA 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 LMTAAA 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 goals objectives with emphasis on: a) older individuals who have the greatest social and economic need, with particular attention to low income minority individuals and older individuals residing in rural areas; b) older individuals with significant disabilities; c) older Native Americans Indians; and d) older individuals with limited English-speaking ability.

All agreements with providers of OAA services shall require the provider to specify how it intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas and meet specific objectives established by the LMTAAA for providing services to low-income minority individuals and older individuals residing in rural areas within the Planning and Service Area.

Provide assurances that the Area Agency on Aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with significant disabilities, with agencies that develop or provide services for individuals with disabilities.

Provide information and assurances concerning services to older individuals who are Native Americans, including:

A. Information concerning whether there is a significant population of older Native Americans 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 Native Americans to programs and benefits provided under the Area Plan.

B. 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

C. 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 Native Americans.

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 fiscal year 2000 on the State Long Term Care Ombudsman Program.

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/ADS. The LMTAAA 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.

_____	_____
Date	LMTAAA Executive Director
_____	_____
Date	LMTAAA Advisory Council Chair
_____	_____
Date	LMTAAA Council of Governments