Area Plan on Aging

Seattle-King County, Washington

2016–2019

Draft for Public Review

ads

Aging and Disability Services

AREA AGENCY ON AGING FOR SEATTLE-KING COUNTY

Aging and Disability Services (ADS)

Maureen Linehan, Director

Sponsors

Catherine Lester	Adrienne Quinn	Sara Levin
Director, Seattle Human Services Department	Director, Department of Community & Human Services	Vice President, Community Services
City of Seattle	King County	United Way of King County

Seattle-King County Advisory Council on Aging and Disability Services

Mary Anderson	Ava Frisinger	Hon. John Okamoto
Marsha Andrews	Beverly Heyden	Elizabeth A. Phelan, MD
Hon. David Baker	Molly Holmes	Tony Provine
Claire Brannan	Kathe Matrone	Dave Rogers
Katty Chow	Mac McIntosh	Berta Seltzer
George Dicks	Kate Miller	Sue Shaw
Kris Fredrickson	Tom Minty	Lorna Stone

Special Acknowledgements

Area Plan Coordination & Production

Karen M. Winston, ADS Planning & Development Specialist

Irene Stewart, ADS Planning & Development Specialist

Area Plan Contributors

Allison Boll, ADS Human Services Program Coordinator

Susan Kinne, PhD, Seattle Human Services Department & Public Health—Seattle & King County

Maria Langlais, ADS Planning & Development Specialist

Gigi Meinig, ADS Planning & Development Specialist

Angela Miyamoto, ADS Planning & Development Specialist

Mary Pat O'Leary, RN, BSN, ADS Planning & Development Specialist

Lorraine Sanford, ADS Administrative Specialist II

Andrea Yip, ADS Planning Manager

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September 2015

Dear Friend:

During the past few years our communities have experienced one of the most challenging periods in history. The recession has had an impact on all Americans, including older adults. In addition, the number of older adults in our region has increased and is expected to increase dramatically as the baby boomer generation continues to cross the threshold into retirement age.

Although this significant demographic shift poses many challenges, it also brings many new opportunities for advocacy, creativity, leadership, education, healthy aging, and community engagement.

The Aging and Disability Services 2016–2019 Area Plan is a guide to help us meet the challenges and opportunities that are before us, by focusing on five service areas:

- Long Term Services and Supports
- Delay of Medicaid-funded Long Term Services and Supports, Health Promotion and Disease Prevention
- Service Integration and Systems Coordination
- Older Native Americans
- Age-Friendly Communities

As we strive to achieve these goals, we will do our best to maintain the range of services we provide and ensure that our services are culturally diverse and culturally competent, to meet the needs of our region's increasingly diverse population, especially those who are the most vulnerable. We will rely on evidence-based models that have been shown to produce successful results. And we will track our progress using nationally-recognized data indicators that will measure trends and help us assess our work.

Each of us takes pride in being a part of the three-sponsor organizational model of Aging and Disability Services, which is the designated Area Agency on Aging for King County. Together, the City of Seattle Human Services Department, King County Department of Community and Human Services, and United Way of King County coordinate our planning and investments to create choices for elders and people with disabilities in the Seattle-King County region. We are confident that our seamless system will continue to make the Seattle-King County region a great place to live for people of all ages.

We look forward to hearing from you with your thoughts and suggestions as we strive to provide and promote high-quality services to elders and people with disabilities around the region.

Sincerely,

Catherine Lester
Director, Seattle Human Services Department
City of Seattle

Adrienne Quinn
Director, Department of Community & Human Services
King County

Sara Levin
Vice President, Community Services
United Way of King County

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Section A:
Area Agency Planning & Priorities

A-1: Introduction

Aging and Disability Services (ADS)—the Area Agency on Aging for King County—is delighted to present the 2016–2019 Area Plan on Aging for the King County (Planning and Service Area #4). This plan guides the work of our agency over the course of four years. It reflects the needs of our community and highlights goals for developing age-friendly communities.

Our agency was created in May 1971 when Seattle Mayor Wes Uhlman created a Division on Aging within the City of Seattle's Office of Human Resources. In 1973, in accordance with the federal Older Americans Act, the State of Washington designated 13 Area Agencies.

The same year, an interlocal agreement was signed by the City of Seattle, King County, and United Way, establishing the Area Agency on Aging structure we know today, with three sponsors and a planning council (now known as the Seattle-King County Advisory Council on Aging & Disability Services). The Division on Aging eventually came to be called Aging and Disability Services, and it is hosted by the City of Seattle Human Services Department. Subsequent interlocal agreements have refined the relationship between the three sponsoring organizations.

The Area Agency on Aging works with a volunteer Advisory Council that assists in identifying unmet needs, advises on needed services, and advocates for policies and programs that promote quality of life. As required by the OAA, this Area Plan incorporates suggestions from the Advisory Council as well as numerous community partners. To better understand local needs, ADS engaged community members through focus groups, forums, workshops, and surveys (see Section A-3: Planning and Review Process) and collecting survey results.

Aging and Disability Services provides services in these areas:

- Adult day health
- Caregiver support
- Disabilities
- Elder abuse
- Health promotion
- Information and assistance
- In-home care
- Kinship care
- Long-term care case management
- Mental health
- Nutrition (congregate, emergency, and home-delivered meals)
- Respite
- Senior centers
- Transportation
- Veterans counseling

ADS serves over 38,000 clients each year (unduplicated count, through all fund sources). Our most recent Demographic Profile provides the demographic attributes of clients served by ADS programs in 2014, including age, ethnicity/race, income, and region.

For more information, contact Aging and Disability Services (Maureen Linehan, director) at 206-684-0660 or aginginfo@seattle.gov, or visit www.agingkingcounty.org.

ADS Vision

Healthy Aging

No Disease

Financial Security

Independence

Livable Communities

Quality Health Care

A-2: Mission, Vision and Values

The mission of Aging and Disability Services (ADS) is to develop a community that promotes quality of life, independence, and choice for older people and adults with disabilities in King County.

To accomplish our mission, we will:

- Work with others to create a complete and responsive system of services.
- Focus attention on meeting the needs of older people and adults with disabilities.
- Plan, develop new programs, educate the public, advocate with legislators, and provide direct services that include the involvement of older adults and others representing the diversity of our community.
- Promote a comprehensive long-term care system.
- Support intergenerational partnering, planning, and policy development.

In fulfilling our mission, we follow these values:

- Older people, adults with disabilities, and their families have a right to be treated with respect and dignity and to make decisions affecting their lives.
- Diversity brings richness to our community and within our agency and supports a wealth of ways to capitalize on this strength.
- The support and nurturing provided by family, domestic partners, and friends are important, and we seek to strengthen this capacity.
- Community partnerships are central in bringing together funders, providers, consumers, and community members to develop solutions that address changes in housing, education, health, long-term care, and advocacy needs.
- The concerns of low-income older people, adults with disabilities, and traditionally underserved groups are recognized, as well as the needs and potential of every member of the community.
- Efforts that encourage independence and enable individuals to remain in their community for as long as possible provide our focus.
- It is important that older people, adults with disabilities, and those having cultural and language differences within our community have knowledge of and access to the services for which they are eligible.
- Accountability to the public trust means the programs we oversee are consumer guided, responsive, and useful.
- Leadership is shared with our regional, state, and federal partners and other city institutions as they develop ways to serve older people and adults with disabilities.

A-3: Planning and Review Process

ADS gathered input on the Area Plan on Aging for King County, 2016–2019 in 2014 and early 2015.

Participants discuss priorities at a Community Living Connections/Aging and Disability Networking event in Bellevue. Photo by Lorraine Sanford.

2014 Community Outreach & Engagement
In an effort to inform two 2015 Request for Investment processes, ADS staff conducted community engagement activities, during the summer of 2014 with over 110 aging network and community providers throughout King County, including immigrant/refugee communities and advocates for people with disabilities. These sessions helped to identify challenges and opportunities facing local communities. A report is available online at www.agingkingcounty.org/docs/2014-community-engagement-summary.pdf.

Area Plan Survey
The ADS Advisory Council hosted an online questionnaire from January to March 2015, promoted through their AgeWise King County e-newsletter and social media. Print and (by request) Braille copies were also available. The questionnaire link was sent out to 138 community organizations, 232 churches, and 46 service organizations, and circulated among the general public via local blogs. Survey distribution also focused on specific populations including the Filipino-Speaking, Chinese-Speaking, East African, and rural communities.

Survey categories included top needs, caregiving, transportation, housing, food security, healthy aging, livable communities, and information and assistance. In all, 580 individuals completed the questionnaire. Among the completers, about 60 percent were between the age 60 to 74.

Top Three Needs of Older Adults	Top Three Needs of Adults with Disabilities
Housing	Transportation
Health and Wellness	In-home Assistance
Transportation	Housing

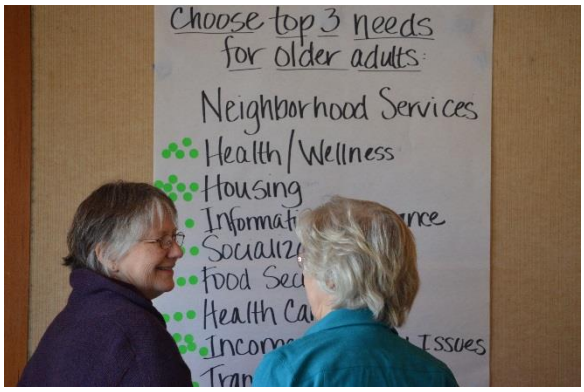
Results from 2015 Area Plan Survey

Focus on the Future Community Forums on Aging

Three public forums informed development of specific sections of the 2016–2019 Area Plan on Aging for Seattle-King County. ADS facilitated cross-county coordination with the Snohomish County Division of Long Term Care & Aging, Pierce County Community Connections, and the City of Bellevue Human Services Department

Participants discussed behavioral health and memory care at the 2015 Focus on the Future Forum in Bellevue. Photo by Lorraine Sanford.

Each forum involved expert speakers on needs, trends, evidence-based practices, and future forecasts regarding older people and adults with disabilities. Over 100 community members and providers participated.



At each forum, participants identified the top needs of older adults and individuals with disabilities. Photo by Lorraine Sanford.

Two of the three forums were held in neighboring Snohomish and Pierce counties.

- Health and Well-Being (March 6, 2015), Mountlake Terrace Senior Center. Top needs identified: Income and Financial assistance, Housing, and Health and Transportation (tied)
- Community Design & Healthy Aging (March 30, 2015), Mountain View Community Center, Edgewood. Top needs identified: Transportation, Health, and Socialization
- Behavioral Health & Memory Care (April 3, 2015), Bellevue City Hall. Top needs identified: Housing, Income and Financial Assistance, Transportation, In-Home Assistance, and Socialization

Feet First Board of Directors: On February 18, 2015, Aging and Disability Services staff provided a brief presentation on the five goals on the 2012–2015 Area Plan on Aging—improve health care quality, address basic needs, improve health and well-being, increase independence for frail older adults and people with disabilities, and promote aging readiness—to the Feet First Board of Directors. The presentation focused on common interests—transportation and community mobility, universal design, accessibility, and healthy aging (including fitness).

Seattle Commission for People with disAbilities: On February 19, 2015, ADS staff facilitated a discussion about access to information and services among approximately 20 individuals who attended the monthly Seattle Commission for People with disAbilities. Staff discussed the purpose of the Area Plan survey and the importance of public comment in preparing the plan.

Our Elders, Our Selves: Visiting the Past, Planning for Our Future

In 2014 and 2015, ADS produced a 40-minute documentary about the evolution of aging programs and services in King County. The premier screening of Our Elders, Our Selves: Visiting the Past, Planning for Our Future on February 19, 2015 involved approximately 80 older adults, caregivers, consumers and providers who gave input on the needs of older adults. Participants were also asked to complete Area Plan surveys. Top needs identified: Transportation, Affordable Housing, and Safety

Alzheimer's Disease Working Group Community Listening Session
On April 1, 2015, ADS staff attended the Alzheimer's Disease Working Group Community Listening Session at North Seattle College. About 40 community members and providers provided input regarding needs and what could be improved to better help people with Alzheimer's and dementia, and their family caregivers.

White House Conference on Aging
On April 2, 2015, ADS staff and Advisory Council members participated in the White House Conference on Aging regional forum in Seattle with over 200 older adults, caregivers, advocates, and community leaders. The conference highlighted contributions of older adults and provided an opportunity to hear directly on key issues such as ensuring retirement security, promoting healthy aging, providing long-term services and supports, and protecting older adults from financial exploitation, abuse and neglect.

Aging the LGBTQ Way Town Hall Meeting
About 75 individuals attended an Aging the LGBTQ Way Town Hall meeting on May 13, 2015, co-sponsored by the University of Washington School of Social Work and ADS. The event was facilitated by Dr. Karen Fredriksen-Goldsen, principal investigator of Caring and Aging with Pride over Time, the first national federally-funded longitudinal project on lesbian, gay, bisexual, and transgender older adults and their caregivers. Additional co-sponsors included the UW Healthy Generations Hartford Center of Excellence; UW School of Social Work Safe Zone; LGBTQ Allyship; Mature Friends Seattle; Northwest LGBT Senior Care; Older Lesbians Organizing for Change; Sage Olympia; Senior Services; SEIU 775; and the Tacoma Older LGBT.

Dr. Karen Fredriksen-Goldsen, Caring and Aging with Pride over Time (left), and ADS director Maureen Linehan. Photo by Lorraine Sanford.

Participants voiced their concerns about the future of LGBTQ aging in Seattle and the Pacific Northwest region. Suggestions included:

- Provide sensitivity training for medical and social service providers.
- A community center for LGBTQ seniors for socialization and to access services.
- Increase support for the transgender community, and housing that is LGBTQ friendly.

For more information, visit The National Health, Aging, and Sexuality Study: Caring and Aging with Pride over Time at www.caringandaging.org.

Area Plan Public Hearings
The ADS Advisory Council hosted three public hearings on draft Area Plan on Aging:

- East King County: July 28, 2015 (Bellevue, WA)
- South King County: July 29, 2015 (Kent, WA)
- Seattle and North King County: August 3, 2015 (Seattle, WA)

The information gleaned from these activities and events has been incorporated into this Area Plan on Aging. In Section C-5 (Create Age-Friendly Communities) addresses key issues for older King County residents and adults with disabilities.

For more information about Area Plan development, contact ADS planner Karen Winston at karen.winston@seattle.gov or visit www.agingkingcounty.org/update_process.htm.

A-4: Prioritization of Discretionary Funds

ADS Advisory Council members Berta Seltzer, Katty Chow, and Marsha Andrews. Photo by Lorraine Sanford.

ADS sub-contracts with over 60 agencies to provide a network of in-home and community services, support programs and assistance to older adults and qualified disabled adults. In 2014, over 38,664 older adults, family caregivers and adults with disabilities in King County received services from the local Aging Network.

The 2015 budget totals $38 million. Of this funding $24 million is "non-discretionary and earmarked for specific services, such as Medicaid Title XIX case management, U.S. Department of Agriculture meals, and state-funded caregiver support and respite care."

The budget also includes $6.2 million of "discretionary" funds from the federal Older Americans Act, the state Senior Citizens Services Act, and the City of Seattle General Fund. Discretionary funding has some flexibility and can be directed to meet priority needs in King County.

The ADS Advisory Council's Planning and Allocations (P&A) Committee recommends strategies to increase or decrease discretionary funding to service areas. The committee consists of the Advisory Council chair and six members from the three ADS sponsor organizations (City of Seattle, King County, and United Way of King County).

For the 2016 discretionary allocations process, the P&A Committee considered the following in their deliberations:

- ADS Sponsors allocation guidelines.
- 2015 discretionary allocations approved by Sponsors.
- Service area trends and issues.
- Prioritization of services that enable elders to access services, especially in the midst of difficult economic times.

Should a net increase in discretionary funding occur in 2016, the P&A committee recommends that additional allocations be made to priority core services:

- Case Management
- Elder Abuse
- Nutrition
- Transportation
- Community Living Connections (formerly Information & Assistance)

If funding increases or decreases in the future, the P&A Committee will re-convene and examine the most updated global revenue picture for services for older residents in King County, as well as existing funding principles, and make recommendations which will be subject to public review and Sponsors' approval.

Section B:
Planning & Service Area Profile

B-1: Population Profile and Trends

A snapshot of King County, below, shows that 17 percent of the population is age 60 and older. This population is expected to grow to nearly 25 percent by 2040, as the "age wave" settles on King County.

Age	Population	% Total	Male	% Total	Female	% Total
Total King	2,007,779	100%	1,001,982	100%	1,005,797	100%
60-69	190,739	10%	92,182	9%	99,574	10%
70-79	86,334	4%	40,079	4%	47,272	5%
80+	64,249	3%	24,048	2%	41,238	4%
Total 60+	**341,322**	**17 %**	**156,309**	**15%**	**188,084**	**19%**

Table 1. King County population age 60+ snapshot.[1]

Figure 1, below, illustrates the "age wave" in King County, as the baby boomer generation (born 1946–1964) has aged. Since the year 2000, the 55–69 year old cohorts have expanded in size. By 2035, all of the baby boomers will have moved into the rank of the older (60+) population.

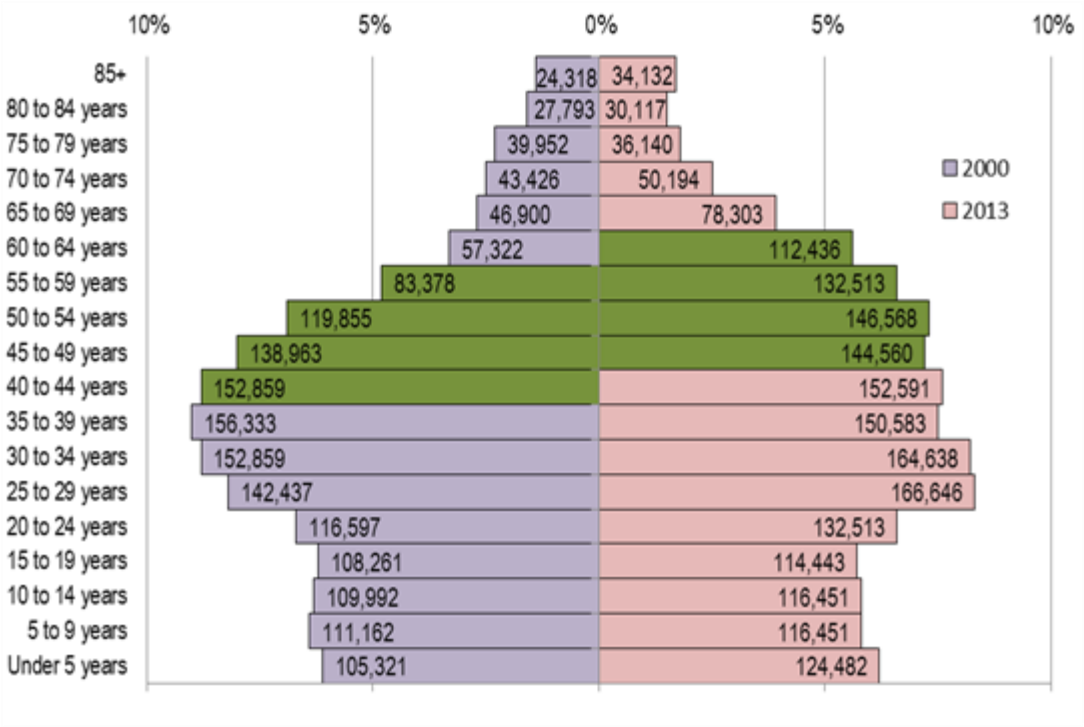


Figure 1. King County Baby Boomers compared to other age cohorts, 2000–2013[2]

Over the past decade, average life expectancy in King County has climbed to 81.6 years of age. Increased life expectancy will strengthen the wave of aging boomers and steadily increase their total number contained within the elderly sub-population.

[1] American Community Survey (2011–2013 three-year estimates), King County
[2] Ibid.

Figure 2, below, shows the average life expectancy at birth by gender and race. In the figure, the brackets on the bars represent the confidence interval for the estimated percentage of older adults in fair or poor health. If the confidence intervals of two estimates don't overlap, the estimates are significantly different and are not due to sampling error. As shown, there are statistically significant differences in life expectancy across race. This is further understood by considering the relationship between socioeconomic status, race, and health over the life course (see B-3: Targeting Services). In King County, who you are and where you live are factors in how you age.

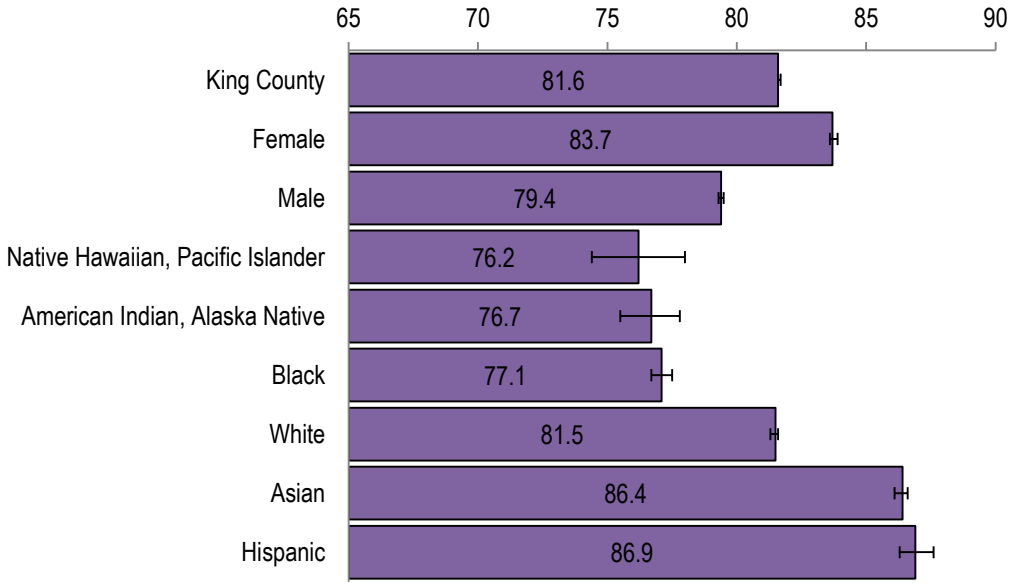


Figure 2. Life Expectancy at Birth, 2008–2012 Average[3]

The average person aged 65 in Washington state can expect to live 19 more years if the current age-specific death rates stay the same for his or her life; however, only 15 of these years are expected to be years of healthy life.[4]

[3] Center for Health Statistics, Washington State Department of Health, 08/2014.
[4] Centers for Disease Control and Prevention, State-Specific Healthy Life Expectancy at Age 65 Years

Sound Steps participants Roberta and Janet enjoy a walk around Seattle's Green Lake.
www.seattle.gov/parks/seniors/soundsteps.htm

Current population projections are illustrated in Figure 3, showing that King County's elder population (age 60+) will near 25 percent of the total population by 2040. The fastest-growing segment of the total population is the oldest old—those 85 and over. The number of the United States population in the oldest old age group is projected to grow from 5.8 million in 2010 to 8.7 million in 2030.[5]

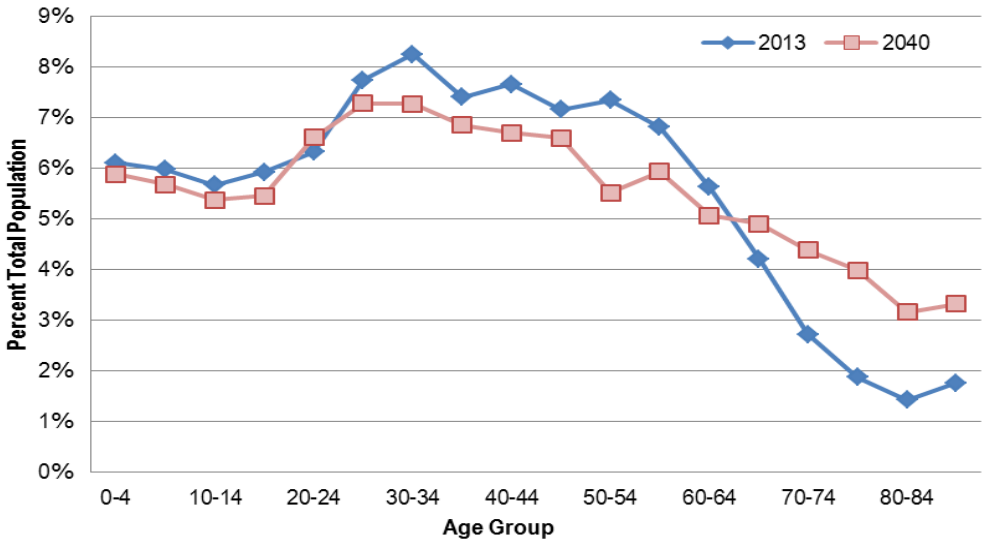


Figure 3. King County Projected Population Growth by Age Cohort, 2013–2040[6]

[5] United States Census Bureau. The Next Four Decades. The Older Population in the United States: 2010 to 2050. Population Estimates and Projections
[5] Washington State Office of Financial Management 'medium' 2012 population projections, plus American Community Survey (1995 & 2005) estimates and decennial Census (2000 & 2010) counts.

Overall, from 2000–2013 King County's older adult population grew by more than 42 percent. Table 2 indicates that about 80 percent of the total numerical growth in the 60+ population happened in Seattle, South Urban and East Urban sub-regions.

Sub-Region	2000	2013	Number Growth	Sub-region Growth as Percent of Total Growth
East Rural	3,292	6,161	2,869	3%
East Urban	52,985	82,332	29,347	28%
North	21,406	28,575	7,169	7%
South Rural	5,799	10,643	4,844	5%
South Urban	70,152	103,492	33,340	32%
Seattle	87,063	111,362	24,299	24%
Vashon	1,800	3,310	1,510	1%
Total King	242,497	345,875	103,378	43%

Table 2. Growth in Age 60+ Population by Sub-Region.[7]

Figure 4, below, shows the current sub-regional distribution of the 60+ population in King County. Although small in number, the Vashon Island population currently has the largest percentage of older adults of any sub-region in King County, followed by the North and Seattle sub-regions. The Seattle and South Urban sub-regions have the greatest number of older adults.

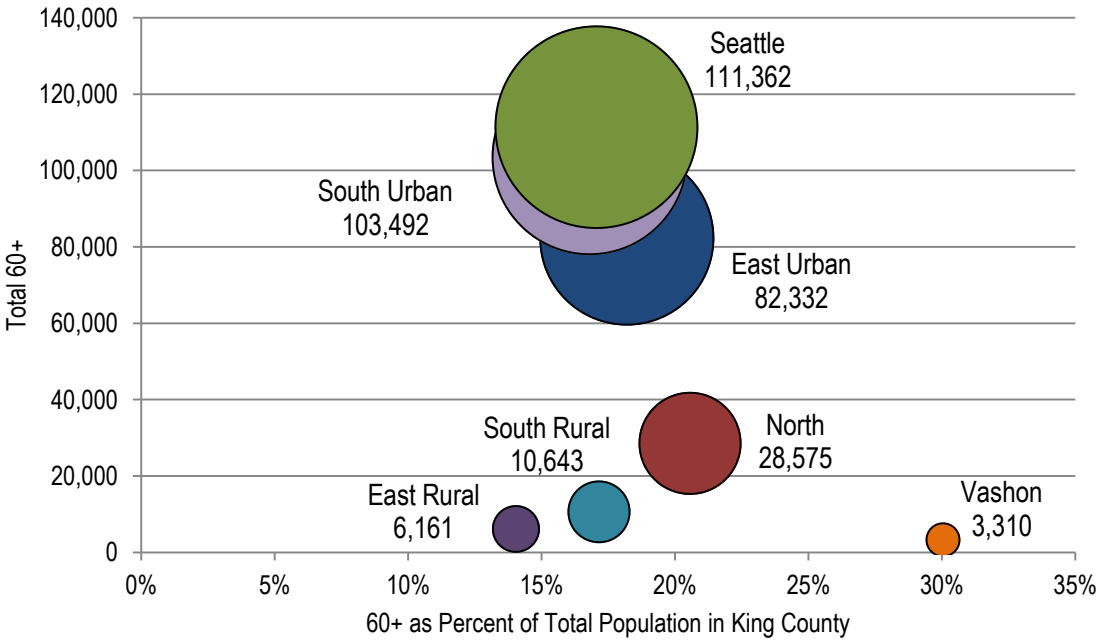


Figure 4. Age 60+ by Sub-Region.[8]

[7] Washington State Office of Financial Management. 2013 Population Count and Estimates
[8] Ibid.

An estimated 20 percent of rural residents are 60 years and over. The median age of rural residents in King County is 45.5 years compared to 42.7 nationally.[9] Table 3, below, shows the number of King County residents 60+ residing in rural areas. Older adults in rural areas are geographically isolated and they are also more likely to live alone. Of the total King County population 65 and older, 69,655 (21 percent) individuals live alone in. About 70 percent of the older adults living alone are women.[10]

Rural King County	
Total Rural Population	61,938
60 and 61 years	2,017
62 to 64 years	2,640
65 and 66 years	1,328
67 to 69 years	1,691
70 to 74 years	1,943
75 to 79 years	1,227
80 to 84 years	798
85 years and over	694
Total 60+	**12,338**

Table 3. Rural Residents by Age, 2010, King County[11]

As the aging demographic in King County is changing, so is the racial and ethnic diversity. Much of the King County's diverse growth can be accounted for by immigrant and refugee arrivals. Overall, about 22 percent of the King County population is foreign born. Individuals are considered foreign born if they are born outside the US, or its possessions, to non-US parents. Foreign born people may be classified by their naturalization status (citizen or non-citizen).

Foreign Born Population	
Total King County Population	2,007,779
Total Foreign Born Population	407,841
55 to 64 years	11%
65 to 74 years	6%
75 to 84 years	3%
85 years and over	2%
Speak English only	16%
Speak a Language other than English	84%
Speak English less than "very well"	43%
Below Federal Poverty Level	16%

Table 4. Foreign Born Population by Age, Language and Poverty, King County, 2009–2013[12]

From October 2013–July 2014, Washington had 2,430 reported refugee arrivals. This represents an increase from 2012 arrivals by 265 individuals or 12 percent.[13] Over half of the

[9] 2010 United States Census, King County
[10] American Community Survey (2011–2013 three-year estimates), King County
[11] 2010 United States Census, King County.
[12] American Community Survey (2009–2013 five-year estimates).
[13] Washington Office of Refugee and Immigrant Assistance. Refugee Health Screenings, 2012–2014.

new refugee arrivals in Washington resettle throughout King County, predominately in South King County.[14] Table 5, below, shows a breakout of foreign born population by sub-region.

Foreign Born Population by Sub-Region						
East Rural	East Urban	North	Seattle	South Rural	South Urban	Vashon
8%	25%	17%	18%	6%	24%	6%

Table 5. Foreign Born Population by Sub-Region[15]

Bhutanese elders participated in an Aging and Disability Services forum. Photo by Karen Winston.

King County's diversity is also reflected in the older adult population. About 23 percent of King County residents age 60 and older are people of color, a four percent increase from 2011. Figure 5, below, illustrates the overall racial composition of King County's elders. It is estimated that 1.4 percent (or 5,174) of the King County population age 60 and older is all or part American Indian/Alaska Native, though this population has been shown to be undercounted.[16] There are two federally recognized tribes in King County—the Muckleshoot Indian Tribe and the Snoqualmie Indian Tribe. See Section C-4: Native Americans.

[14] Ethnomed. (2011). *Toolkit for primary care providers treating refugees.* "Background and Need". Retrieved from https://ethnomed.org/clinical/refugee-health/toolkit.
[15] American Community Survey (2009–2013 five-year estimates), King County.
[16] American Community Survey, Public Use Micro Sample (PUMS), King County (2009–2013)

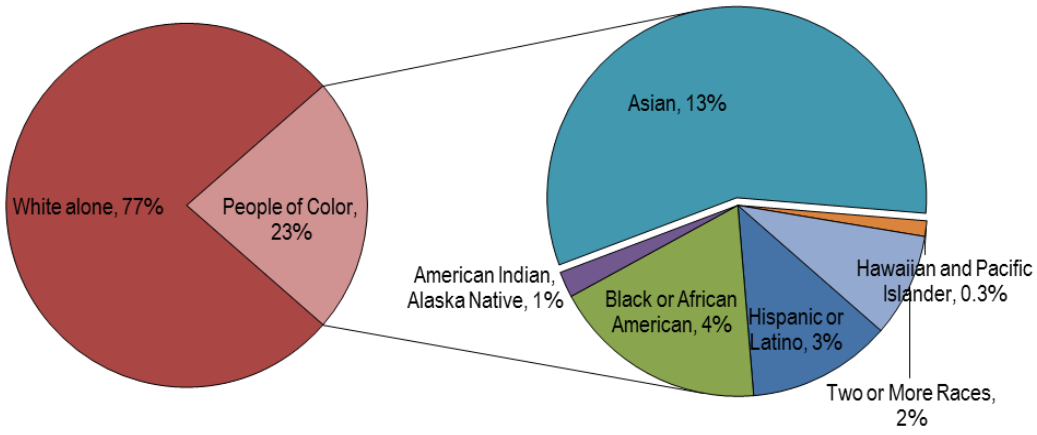


Figure 5. King County Population Age 60+ by Race.[17]

King County's aging population is also linguistically diverse. Among King County residents age 65 or older, 41,899 (19 percent) speak a language other than English at home, and 7,431 (3 percent) of these residents do not speak any English. As shown by Figure 6, among older King County residents who do not speak English "very well," the largest group speaks an Asian or Pacific Island language.[18]

Ukrainian elders participated in an ADS focus group. Photo by Karen Winston.

[17] American Community Survey (2011–2013 three-year estimates), King County
[18] Language categories are presented as defined by the American Community Survey, see www.census.gov/programs-surveys/acs/technical-documentation/code-lists.html for subject definitions.

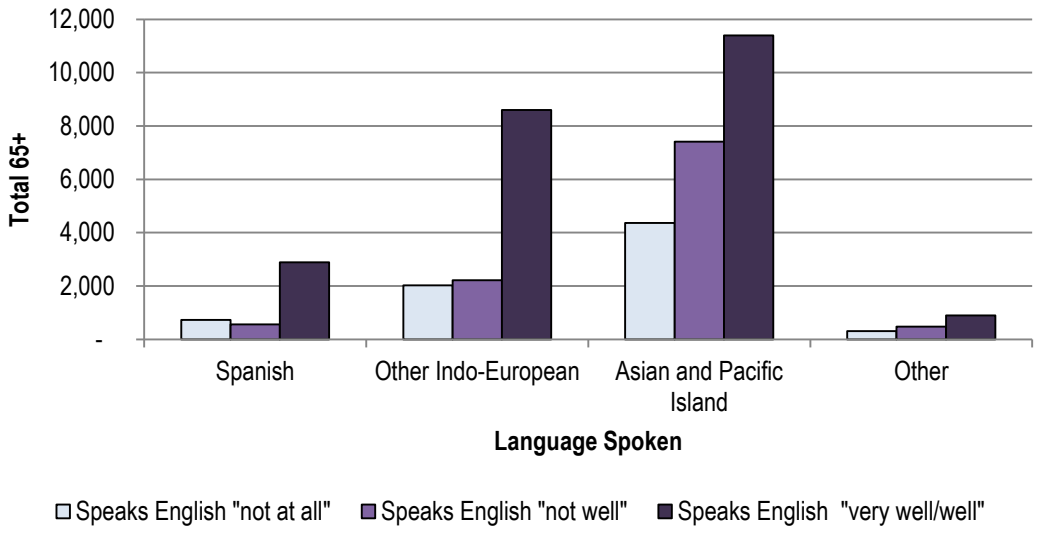


Figure 6. 65+ English Proficiency by Language Spoken, King County[19]

Table 6, below left, shows the major languages, other than English, spoken in King County by residents over age five and over age 60. It is estimated that 27 percent of King County residents over age 5 speak a language other than English. Figure 7, below right, shows the major languages spoken by the 60+ population.

Language	Total Population 5+
English	1,371,265
Spanish	121,960
French	12,464
German	10,685
Slavic	35,189
Other Indo-European	51,490
Chinese	60,327
Vietnamese	32,718
Tagalog	27,359
Korean	21,178
Japanese	14,190
Other Asian	34,155
Other Pacific Islander	13,522
Native North American	669
Other	44,589
Total Other Language:	**480,495**

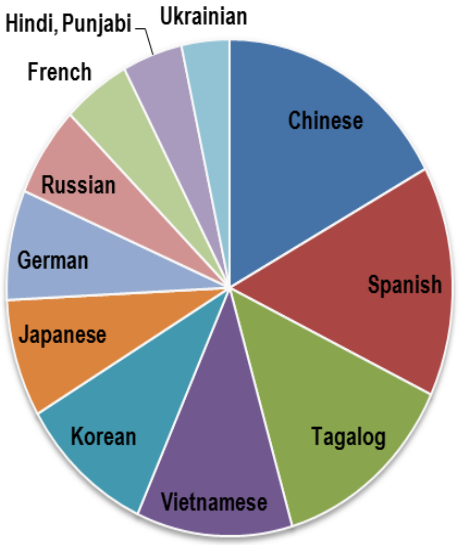


Table 6 (above left). Languages Spoken by King County Residents over Age 5[20]

[19] American Community Survey (2011–2013 three-year estimates), King County
[20] American Community Survey (2009–2013 five-year estimates), King County

Figure 7 (above right). Major Languages Spoken by King County Residents 60+[21]

As the older adult population becomes more diverse, the number of lesbian, gay, bisexual, and transgender (LGBT) older adults is also expected to grow. Based on national estimates, 2.4 percent (or 2.4 million) adults age 50 and older identify as lesbian, gay, bisexual, or transgender. This number is expected to double in the coming decades, alongside the growth the wider older population. Table 7, below, presents the sexual orientation of elders 60+ in King County. Approximately 2.5 percent of elders in King County report being non-heterosexual. Recent estimates suggest that 0.3–0.5 percent of the adult population identify as transgender.[22]

ADS co-sponsored an LGBTQ Town Hall meeting in May 2015. Photo by Lorraine Sanford.

Sexual Orientation	King County 60+
Heterosexual	97%
Lesbian, Gay, Bisexual	2%
Other	0.5%

Table 7, Sexual Orientation 60+, King County, 2010–2014[23]*

Minority elders in King County are disproportionately impacted by poverty. As shown in Table 8 below, a greater percentage of American Indian and Alaska Native older adults are living below the federal poverty line compared with all King County adults over 60, as are Hispanics/Latinos, African Americans, Asians, and Pacific Islanders.

Race/Ethnicity	Percent of 60+ Living in Poverty
American Indian, Alaskan native	23%
Black or African American	18%
Native Hawaiian and Pacific Islander	18%
Asian	17%
Hispanic or Latino	17%
Other	13%
White	7%
All 60+	**9%**

Table 8. Poverty Rate by Race, King County residents age 60+.[24]

Table 9 shows that the poverty rate among the 65+ population is highest in Seattle and South Urban sub-regions and lowest on Vashon Island, further illuminating disparities in poverty. One of every three older adults in poverty in Seattle lives in North Seattle.[25]

[21] American Community Survey (2011–2013 three-year estimates), King County
[22] Gates, G.J. (2011). *How many people are lesbian, gay, bisexual and transgender?.* Los Angeles: The Williams Institute
[23] Behavioral Risk Factor Surveillance Survey, King County, 2010–2014
[24] American Community Survey, Public Use Micro Sample (PUMS), King County (2009–2013).
[25] American Community Survey (2009–2013 five-year estimates).

East Rural	East Urban	North	Seattle	South Rural	South Urban	Vashon
5%	6%	8%	15%	6%	10%	2 %

Table 9. Residents age 65+ living in poverty, by sub-region.[26]

In 2013, an estimated 28 percent of individuals accessing King County emergency shelters were age 50 and older.[27] By 2025, an estimated 53,793 older adults will be in poverty, requiring 15,913 more housing units or vouchers than are available today.[28]

As the older adult population lives longer with chronic illnesses, they face an increased likelihood of acquiring a disability. The Behavioral Risk Factor Surveillance Survey defines disability as a physical or mental condition that limits an individual in any activity or using special equipment such as a wheelchair, special bed, etc. Table 10, below, shows the self-reported number of adults with disabilities in King County by age. About half of adults 60 years and older living below the federal poverty level have a disability. While older adults have higher rates of disability, there are a greater number of persons under 60 with a disability; currently, 23 percent of adults 18 and older are living with a disability.

Adults with Disabilities		
Age 18+	Age 60+	60+ in poverty
23%	38%	51%

Table 10, Rate of Disabilities by Age and Poverty, King County, 2011–2014[29]

While disabilities affect people of all races, ethnicities, languages, gender identities, and sexual orientations, they do not occur equally across racial and ethnic groups. Minorities with disabilities experience additional health disparities, economic barriers, and difficulties accessing care as a result of their disability[30]. Figure 8, below, shows the percent of individuals in King County with disabilities by age and race. It is important to note that this data reflects rates of disability; not numbers of persons with disabilities.

[26] American Community Survey, Public Use Micro Sample (PUMS), King County (2009–2013).
[27] Safe Harbors, 2013. Annual Homeless Assessment Report. Seattle/King County.
[28] Cedar River Group. (2009). Quiet Crisis: Age Wave Maxes out Affordable Housing. King County 2008–2025.
[29] Behavioral Risk Factor Surveillance Survey, King County and United States, 2011–2013.
[30] Yee, S. (2011). *Health and health care disparities among people with disabilities*. Disability Rights Education & Defense Fund.

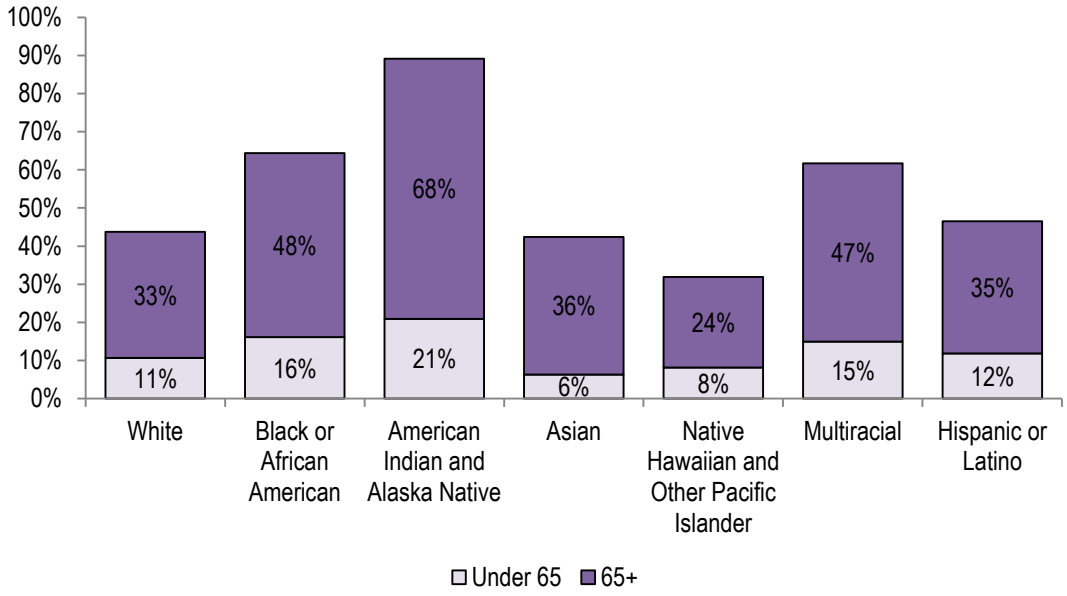


Figure 8. Rate of Disability by Age and Race, King County, 2009–2013[31]

Figure 9, below, presents self-reported limitations by age. The most common sources of limitation among the 65 and older population are ambulatory difficulties, independent living' limitations and hearing problems. Among the population under 65, the most frequently self-reported limitations are cognitive difficulties, ambulatory difficulties, and independent living difficulties.[32]

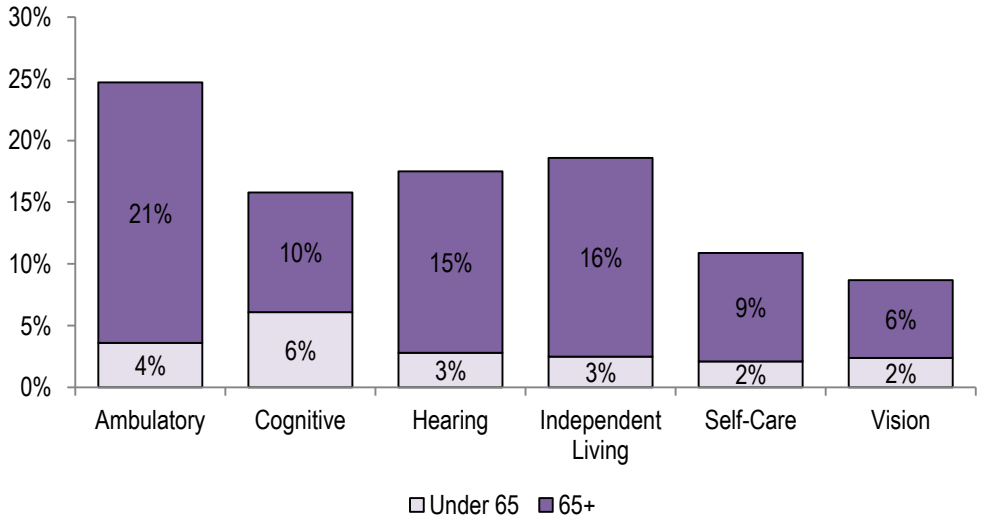


Figure 9. Rates of Functional Limitation by Type and Age, King County, 2009–2013.[33]

[31] American Community Survey (2009–2013 five-year estimates).
[32] Cognitive difficulty was derived from a question which asked respondents if due to a physical, mental, or emotional condition, they had serious difficulty concentrating, remembering, or making decisions. Ambulatory difficulty was derived from a question which asked respondents if they had serious difficulty walking or climbing stairs. Independent living difficulty was derived from a question which asked respondents if due to a physical, mental, or emotional condition, they had difficulty doing errands alone such as visiting a doctor's office or shopping.
[33] American Community Survey (2009–2013 five-year estimates).

Even as boomers reach retirement age, a significant proportion of the cohort will continue to work full time. Figure 10, below, shows the number and percent of U.S. adults 55+ who reported working full time from 2005–2015. Currently, over one third of men age 55+ and nearly one quarter of women age 55+ report working full time. In King County, 48 percent of men and 37 percent of women age 55+ were employed (full and part time) in 2009–2013.[34]

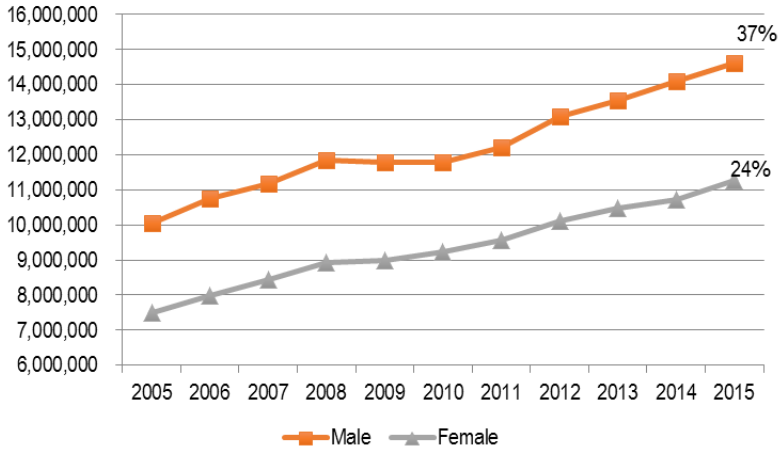


Figure 10. 55+ Employed Full Time, By Gender, 2005–2015, U.S.[35]

Given the rise in technology, older adults are also increasingly connected to their communities through social networks, employment and civic engagement opportunities. As of 2012, more than half of U.S. adults 65 years and older are using the internet. Figure 11, below, shows the trend growth in the proportion of older adults who go online.

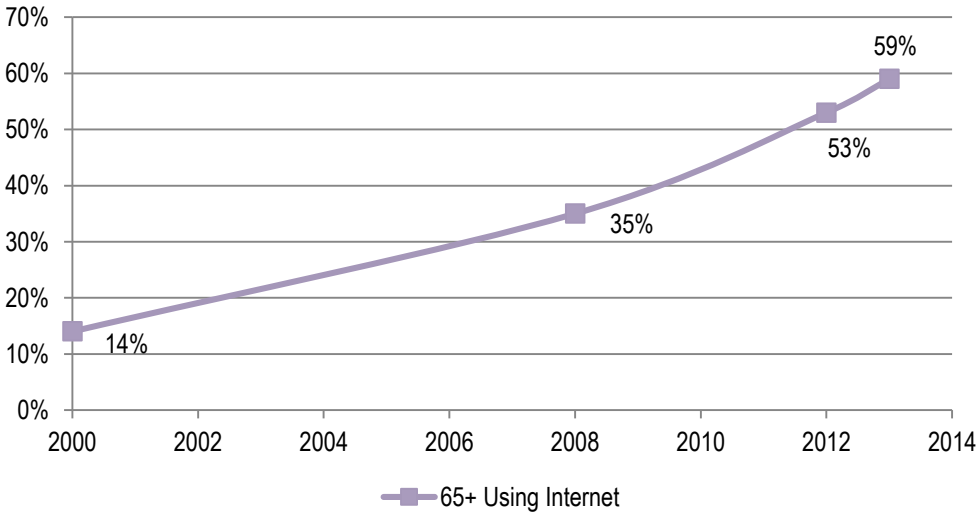


Figure 11, U.S. Adults 65+ Who Use Internet, 2000–2013[36]

[34] American Community Survey (2009–2013 five-year estimates).
[35] Bureau of Labor Statistics. Labor Force Statistics from the Current Population Survey. 2006–2015
[36] Smith,A.(2014). Older Adults and Technology Use. Pew Research Center. Retrieved from www.pewinternet.org/2014/04/03/older-adults-and-technology-use/

Seniors Training Seniors participants learn computer skills in small classes lead by computer-savvy volunteers.
www.seattle.gov/humanservices/seniorsdisabled/mosc/classes.htm

B-2: Indicators

		Better than National Baseline
I.	**Percent 65+ Paying >30 Percent of Income towards Housing**	**N**

Paying more than 30 percent of income for housing is an indicator of housing cost burden. Households with this burden are more vulnerable to food insecurity, lack of adequate healthcare, loss of housing and other difficulties as a result of cost pressures.[37] Figure 12, below, presents a comparison of King County and United States elders who pay more than 30 percent of their total income on housing, by year. The proportion of King County renters who pay more than 30 percent of their income on housing has grown 5.5 percent from 2008 to 2013.

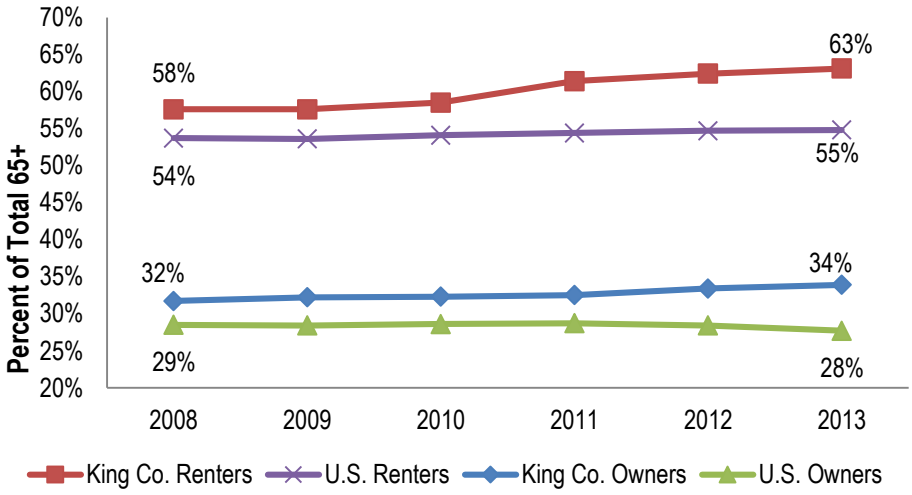


Figure 12. Percent of 65+ Paying >30% of Income Towards Housing, by year[38]

II.	**Percent 65+ Using Public Transportation**	**Y**

Transportation is an important element of connection between communities, individuals and services. Twenty-six percent of King County residents age 65+ report using public transportation to get to and from their neighborhoods. Table 11, below, presents a proportional comparison of King County elders with United States elders who use public transportation.

65+ Using Public Transportation	National	King County
Around Neighborhood	23% (2009)	26% (2011)

[37] Viveiros, J., Sturtevant, L. (2014*). The Housing affordability challenges of America's working households.* Housing Landscape 2014. Center for Housing Policy.
[38] American Community Survey (2011–2013 three-year estimates)

Commuting to Work	4% (2013)	8% (2013)

Table 11. 65+ Using Transportation to Work and Neighborhood, U.S. and King County[39]

III.	Percent 65+ reporting "Good to Excellent" Health	Y

Age is a consistent correlate of fair or poor health. Figure 13, below, shows that 82 percent of King County adults 65+ report being in "good" to "excellent" health, higher than the U.S. proportion (74 percent).

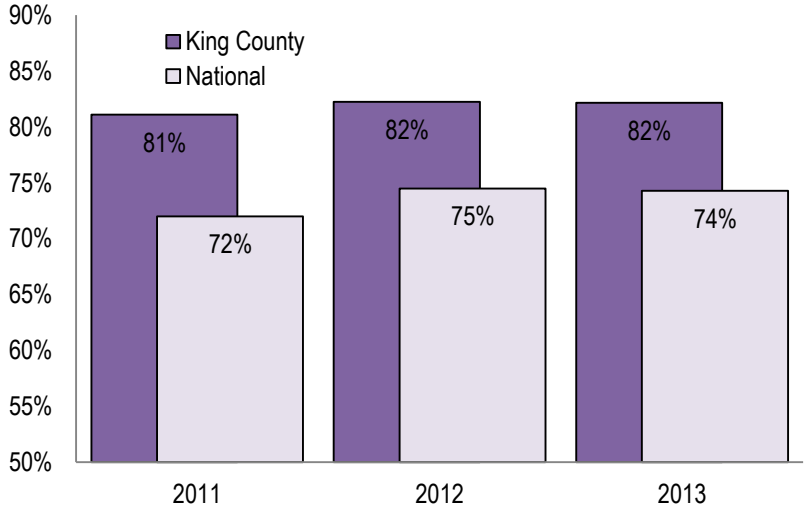


Figure 13. Proportion 65+ In Good To Excellent Health, By Area, 2011–2013[40]

Socioeconomic conditions, such as concentrated poverty and the accompanying stressful conditions are major social determinents of health. Figure 14, below, presents the average life expectancy in King County by neighborhood poverty and sub-region.

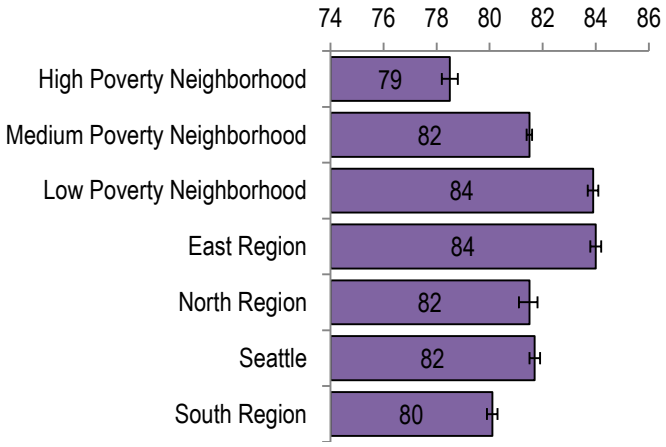


Figure 14. Average Life Expectancy by Poverty and Sub-Region, King County, 2008–2012*[41]

[39] Ibid.; King County Communities Count Survey, 2011; 2009 National Household Travel Survey
[40] Behavioral Risk Factor Surveillance Survey, King County and United States, 2011–2013
[41] Center for Health Statistics, Washington State Department of Health, 08/2014.

Data indicates that communities of color report being in poorer health than whites. Figure 15, below, presents the estimated percentage of King County adults 60+ who report being in good to excellent health by race. The wide confidence intervals for the AIAN and NHPI populations reflect the small sample of these adults in the population.

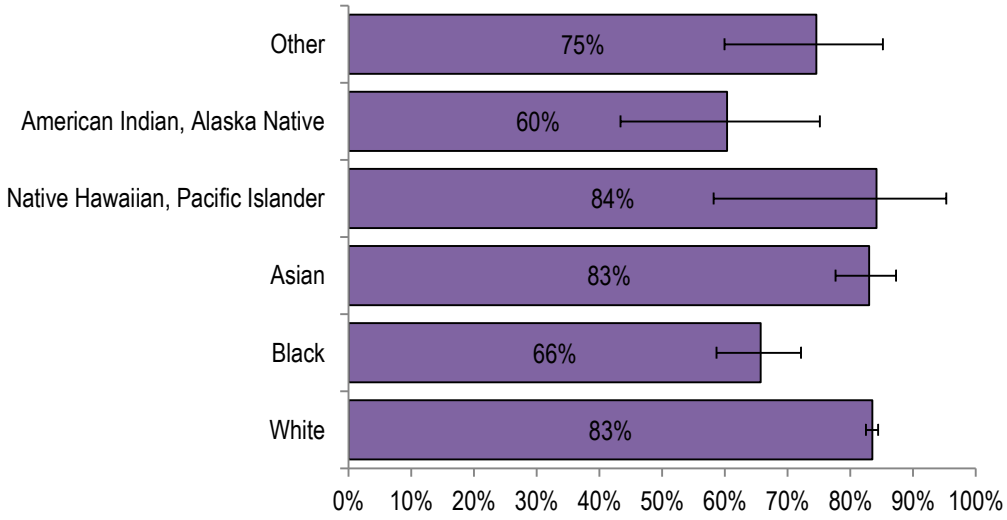


Figure 15. Adults 60+ Reporting Good to Excellent Health by Race, King County, 2011–2013[42]

There are further disparities present within ethnic subgroups. Figure 16, below, presents the estimated percentage of Asian and Pacific Island adults 60+ reporting good to excellent health in King County. The wide confidence intervals reflect the small sample sizes within the data source and the margin for sampling error.

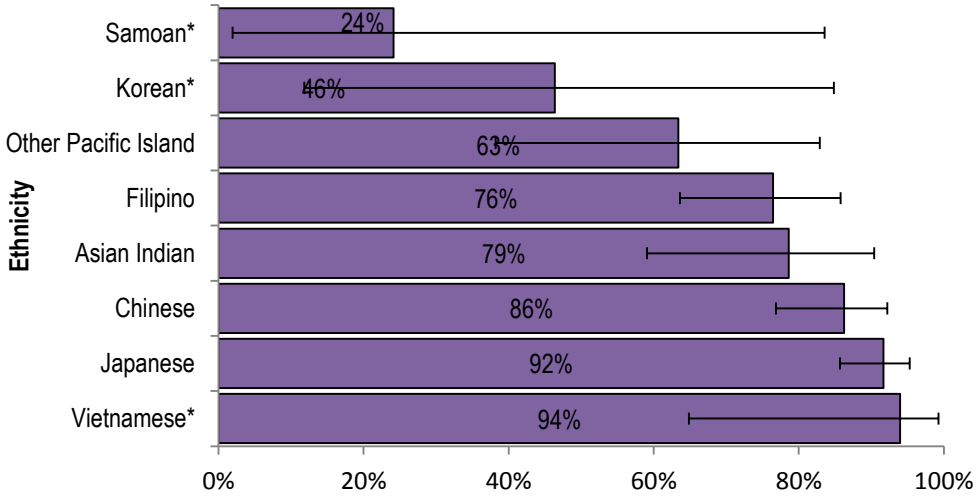


Figure 16. Percent of Asian Pacific Islander 60+ Reporting Good to Excellent Health by Ethnicity[43]

[42] Behavioral Risk Factor Surveillance Survey, King County, 2011–2013
[43] Behavioral Risk Factor Surveillance Survey, King County, 2004–2014

IV.	Percent 65+ Cutting or Skipping Meals Due to Lack of Money	N

Food adequacy/inadequacy is determined by survey responses to questions about running out of food, being able to eat balanced meals, skipping or cutting the size of meals, eating less than people feel they should, or going hungry. Table 12, below, presents the percentage of adults in King County age 65+ who report cutting or skipping meals in the last 12 months because there wasn't enough money for food.[44]

Percentage 65+ Skipping Meals	
King County	National
5% (2014)	4% (2003)

Table 12. Adults 65+ cutting or skipping meals, U.S and King County

V.	Percent 65+ Consuming At least One Serving of Fruits and Vegetables	Y

84 percent of King County adults age 65+ consume more than one serving of fruits per day and 75 percent consume more than one serving of vegetables each day. Table 13, below, presents the fruit and vegetable servings consumed by King County adults age 65+ compared to U.S. adults 65+.

Fruit and Vegetable Consumption	King County	National
At least 1 serving of fruits/day	85%	70%
At least 1 serving of vegetables/day	75%	80%

Table 13. Fruit and Vegetable Consumption, King County and U.S, 2011–2013[45]

VI.	Percent 65+ Meeting Physical Activity Recommendations	Y

The loss of strength and endurance attributed to aging is partially caused by reduced physical activity. The Office of Disease Prevention and Health Promotion developed physical activity guidelines by age. Figure 17, on the following page, presents the percentage of adults 65+ in King County and the U.S. who meet physical activity guidelines.

[44] Behavioral Risk Factor Surveillance Survey, King County, 2007–2014 plus AdvantAge Survey, 2003.
[45] Behavioral Risk Factor Surveillance Survey, 2011–2013.

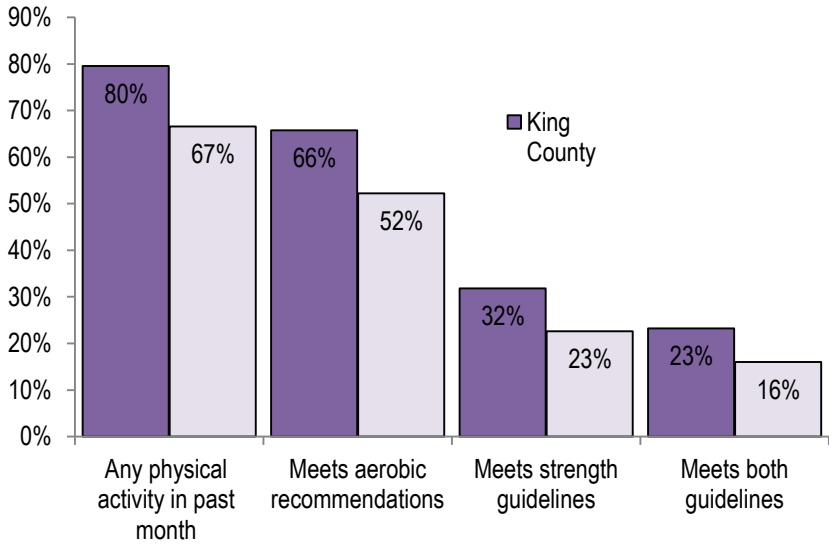


Figure 17. Physical Activity 65+, King County and U.S., 2011–2013[46]

VII.	Percent 65+ with Flu Shot or Vaccine	Y

Figure 18, below, presents the trend percentage of elders 60+ who report receiving a flu shot or vaccine in the past 12 months. From 2001 (69 percent) to 2014 (59 percent) the percentage of elders 60+ who report receiving flu shots and vaccines has declined.

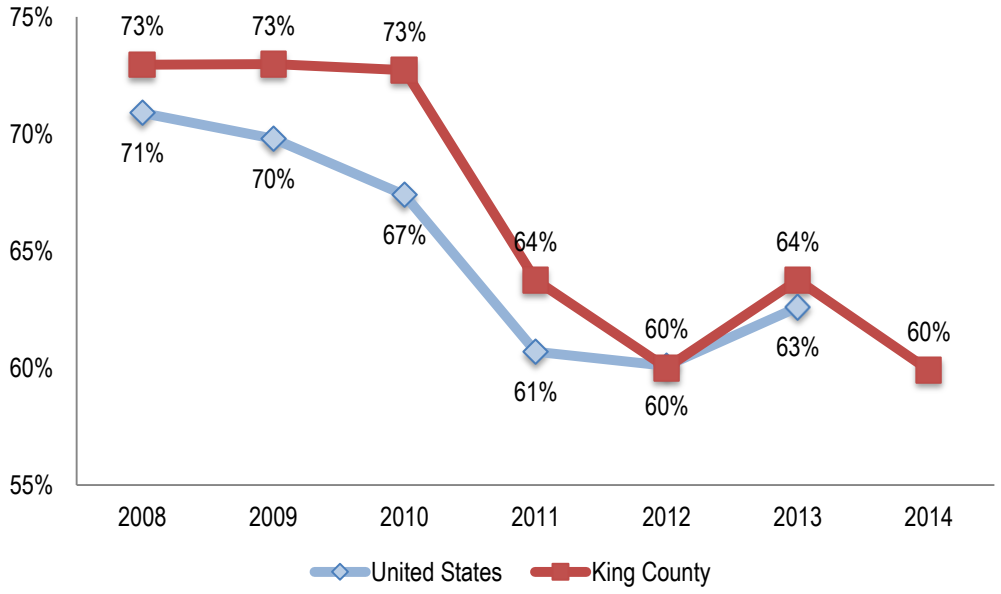


Figure 18. 65+ with Flu Shot or Vaccine, King County and U.S., 2008–2011

[46] Ibid.

VIII. Percent 65+ Who Have Someone Available to Help	N

Family and social support are important factors in supporting well-being in older adulthood. Lack of family and social support is adversely related to both mental and physical well-being.[47] Table 14 presents the percentage of King County and U.S. adults who did not have someone available to help them in the past 12 months with specific activities.

Help Available	King County	National
if confined to bed	72%	74%
with chores if sick	77%	-

Table 14. Help Available, by Type of Assistance, U.S and King County, 2011[48]

VIV. Percent 65+ Participating in Social and Civic Engagement Activities	Y

Table 15, below, presents proportion of adults 65 years and older who participate in social and civic engagement activities in the United States and King County.

Activity	National[49]	King County[50]
Social Enrichment	89%	71%
Volunteering	24%	47.5%

Table 15. 65 + Social and Civic Engagement, King County and United States, 2011–2013 [51]

[47] White AM et al. "Social Support and Self-Reported Health Status of Older Adults in the United States." American Journal of Public Health 99(10):1872–1878, 2009
[48] King County Communities Count Survey, 2011 plus National Elder Mistreatment Survey 2008
[49] Engages in at least one social enrichment activity
[50] Engages in three or more social enrichment activity
[51] King County Communities Count Survey, 2011; Behavioral Risk Factor Surveillance Survey, United States, 2013

B-3: Targeting Services

ADS remains committed to serving limited English-speaking elders; residents under 60 with disabilities; elders in low-income communities of color; rural elders; lesbian, gay, bisexual, and transgender elders; and others with great economic and social need.

Limited English-speaking elders

Over 400,000 immigrants and refugees reside in King County, about six percent of whom are 65 years or older. English proficiency is considered to be a gateway to economic opportunity for immigrants. Limited English-speaking immigrants tend be concentrated in low-paying jobs, earning up to 40 percent less than their English proficient counterparts. About 43 percent of foreign born residents in King County speak English less than “very well”. Among older King County residents who do not speak English “very well”, the largest number speaks an Asian or Pacific Island language.

Language proficiency adds an additional barrier to accessing information, services and transportation. Specifically, these difficulties impact an individual’s ability to find a doctor, as well as understand health related information and treatment options. Language barriers also make it difficult for a client to explain their situation to a service provider who does not have the language capacity to communicate with the individual. The lack of adequate interpretation and language access results in decreased quality of care and increased errors. These challenges are exacerbated by lack of health insurance. Racial and ethnic minorities are less likely than the rest of the population to heave health insurance. Currently, 15 percent of Asian adults ages 18–64 in King County did not have health insurance between 2009–2011.

Community partners that work with linguistically diverse populations in King County have highlighted the importance of building the linguistic capacity of staff providing aging and health related services. Community members would like staff to have language capacity and a cultural understanding of the group they are working with. Additionally, information and materials should be offered in the language of the community being served. This is particularly important when attempting to determine eligibility for government programs.

The value of trust and relationships was also highlighted in engagement activities. Individuals prefer to meet with staff with whom they feel they have a connection, even though other staff may be available. Ensuring quality care and provision of services begins with asking how other individuals want to be treated. This is an essential step towards developing relationships built on respect, inclusivity and sensitivity—relationships that are critical to serving culturally, ethnically and linguistically diverse populations.

People Under 60 with Disabilities

One of the myths of aging and disability is the assumption that disability is a fact of old age. In fact, disabilities affect people of all ages. Some individuals are born with one or more disabilities and others acquire them over the course of their lifetime, whether through illness, injury or other causes. While adults age 60 and older have higher rates of disabilities, there are a greater number of persons with disabilities who are under the age of 60. The BRFSS defines disability as a physical or mental condition that limits an individual in any activity or using special equipment such as a wheelchair, special bed, etc. In King County 23 percent of the population

18 and older has a self-reported disability. The most frequently self-reported activity limitations among the population under 60 years are cognitive and ambulatory, plus problems performing a variety of activities of daily living (i.e., basic tasks of everyday life, such as eating, bathing, dressing, and toileting).

No single disability affects a person in exactly the same way as another, yet persons with disabilities face many similar challenges when it comes to accessing healthcare and community-based services. Some of these challenges are due to a lack of education and awareness; others may be due to attitudes and actions that are widely upheld by people in the community. As a result, individuals with disabilities often encounter professionals who are unprepared to identify and meet their needs. Not only are information materials and services rarely adapted for use by persons with disabilities, but many service providers do not acknowledge persons with disabilities as knowledgeable partners in their care. As a result, persons with disabilities report being excluded from conversations or provided very limited information in healthcare settings. Due to the interrelated roles of awareness, physical access, communication and inaccessible information formats, barriers to receiving support seem to be intensified for individuals with sensory disabilities.

Persons with disabilities are in need of accessible, appropriate and comprehensive care and services that enable them to live full lives in the community. In community engagement events attended by ADS, service providers in King County stressed that services for the disability community need to be appropriate for the person, delivered in the appropriate format and at the right time. For example, staff may need to provide the service at the person's home or other convenient location for the individual due to transportation or other mobility issues. Persons with disabilities may also need additional support accessing and navigating services, including getting to a service, getting around the service setting, and communicating with staff about their needs. Additionally, service providers should use adaptive and assistive technologies when developing information materials, and should offer community events in accessible formats.

As people with disabilities live longer, they will contribute to the growing rates of disabilities in the older population. Through strengthened partnerships and collaboration across service and healthcare systems, persons with disabilities will have increased opportunities to engage in their communities and stay well as they age.

Low-Income Communities of Color

As shown in Table 8, communities of color in King County are disproportionately affected by poverty. Sub regional differences in poverty also illuminate these disparities, as the poverty rate among the older population is highest in the Seattle and South Urban sub-regions and lowest on Vashon Island. Specifically, 40 percent of the low-income population residing in Seattle resides in North Seattle.

In King County, as elsewhere, those with lower income are more likely to be in fair to poor health. Socioeconomic factors such as concentrated poverty and neighborhood are correlated with dispirit outcomes across health, life expectancy and disability measures. On average, communities of color fare considerably worse across these areas than White adults 60 years and older. Further contributing to this issue, the cost of housing has increased significantly in King County. As a result, individuals are moving to suburban regions, where housing is more affordable. This geographic segregation by income exacerbates health, employment, educational and racial disparities.

As identified through community engagement and outreach activities in suburban King County communities, public transit is limited or difficult to access outside of urban areas. Yet many health and social services are centralized in urban areas like Seattle. Therefore individuals may face personal travel expenses in order to access needed services, especially if organizations do not have the capacity to travel to a particular region. This places an economic burden on low income communities of color, compromising access to social services and healthcare. Not only are many of these communities geographically isolated, but isolation as a result of culture, race and ethnic status may further restrict ability to access needed services.

As the aging service network continues to meet the needs and expectations of diverse populations, access and equity are critical components of service delivery. Offering services and programs in the communities where people are residing is one strategy to increase access and decrease the social and economic burden placed on low-income communities of color.

Rural Elders

The Administration on Aging defines rural areas as any non-urban area (a central place and its adjacent densely settled territories with a combined minimum population of 50,000), and incorporated areas with less than 20,000 inhabitants. An estimated 20 percent of rural residents are 60 years and over. This number has steadily increased in the past decade. Yet, total population growth continues to be limited, indicating that the growth in older adults is due to the aging within the community rather than migration.

Older adults in rural areas of King County experience difficulties accessing services, food, transportation, and healthcare due to geographic isolation. Additionally, housing in these areas is often small or unsafe due to lack of available housing repair programs and interest from housing developers. The most isolated elders in rural areas are those who live alone, most of whom are women.

As reported in community engagement and outreach activities, many of the older adults in rural areas live without cars and do not have caregivers nearby to help transport them to medical appointments. Community members also voiced concerns about a lack of sidewalks in their communities, increasing their isolation as they feel unable to safely leave their homes.

During ADS outreach events and community meetings, rural community members expressed several creative strategies to address the needs of elders in their communities. One such idea was building the capacity of the Volunteer Transportation (add link) programs in those regions. This successful program recruits volunteers, who use their own cars to provide rides to essential appointments. Historically, it has been difficult to find volunteer drivers for rural areas.

As developmental pressures grow alongside the population, increased demand will be placed on our forestland, farmland, and biodiversity. It is critical to ensure that all of King County, including its rural communities, remains a healthy and vibrant place to age.

Lesbian, Gay, Bisexual and Transgender Elders

Lesbian, gay, bisexual, and transgender (LGBT) elders have historically been undercounted, understudied and underserved. While there have always been LGBT elders, few have been open about their sexual orientation and/or gender identity until recent years. National estimates

of this population vary greatly and existing surveys often use categories and language that may not be welcoming to respondents. Reliable sources currently estimate that 2.4 million (2.4 percent) of adults age 50 and older identifies as lesbian, gay, bisexual or transgender. Local government sources estimate that two percent of older adults in King County identify as LGB. This number is expected to double in the coming decades, alongside the wider older adult population.
Aging service providers will have to develop programs and inclusive strategies to meet the needs of this population, which vary from heterosexual and non-gender variant people for social, cultural and legal reasons. Firstly, the social stigma associated with being LGBT continues to be a barrier to full participation and equal access to services for many LGBT elders. Lesbians, gay men, and bisexual women and men are more likely than heterosexuals to report discrimination. Transgender older adults report higher rates of victimization and discrimination that non-transgender LGB older adults. More than a quarter of transgender adults have experienced discrimination by a physician or have been denied enrollment in health insurance due to their gender identity. Lifetime victimization accounts for poor general health, disability and depression among LGBT older adults.

Social support is an important factor of wellbeing in older age. LGBT elders rely far more heavily on non-traditional caregivers than on family members. Many LGB older adults do not have children or legally-recognized family members to help them, instead relying on unmarried partners and friends of similar age for assistance. Studies of social support available to transgender adults indicate that social support is limited, even among the LGB community.

Economically, LGBT elders are less financially secure that the wider older adult population. Transgender adults in particular earn less household income and are more likely to be unemployed than non-transgender adults. A lifetime of employment discrimination translates into earning disparities, reduced life-long earnings, smaller Social Security payments, fewer opportunities to build pensions, and more limited access to health care.

In a Seattle town hall meeting, community members spoke to the need for expanded local resources and options available for LGBT older adults. Additionally, participants identified the need for aging service providers to receive training on working with LGBT elders. The more that aging service providers work together to create a community that is informed, sensitive to and supportive of LGBT elders, the more likely it will be that LGBT elders will feel safe to access services and support.

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Section C:
Issue Areas, Goals and Objectives

C-1: Long Term Services & Supports, Medicaid Case Management

Aging and Disability Services (ADS) has a goal of maximizing current program, funding and staff capacity to meet the needs of complex long-term services and supports (LTSS) clients.

Background

Washington is a national leader in offering home and community-based LTSS for people with significant disabilities under the Medicaid program. Washington residents can choose to receive support in adult family homes, in assisted living, in their own homes, or in a nursing home. As would be expected, about 75 percent choose to receive care in their homes, either from an agency or an individual provider of their choosing.

Not only is in-home care the preferred LTSS option, it is the most cost-effective. It costs less than $2,000 per month, on average, for in-home care compared to over $5,000 per month for care in a nursing home. In-home care makes efficient use of funding. Rather than assuming the cost of full, 24/7 complete care, it supplements what individuals and families can do for themselves with intermittent, paid, gap filling services supports. To ensure success and safety, plans of care must be tailored to each situation because each individual and family differs widely in what they can do for themselves.

The number of people 65 and older is growing, and people with disabilities of all ages are living longer with multiple chronic conditions. In response to this demand, Washington's in-home program has developed capacity and expertise to support people with moderate to severe physical limitations as well as those who are medically complex, including clients with significant behavioral and cognitive challenges.

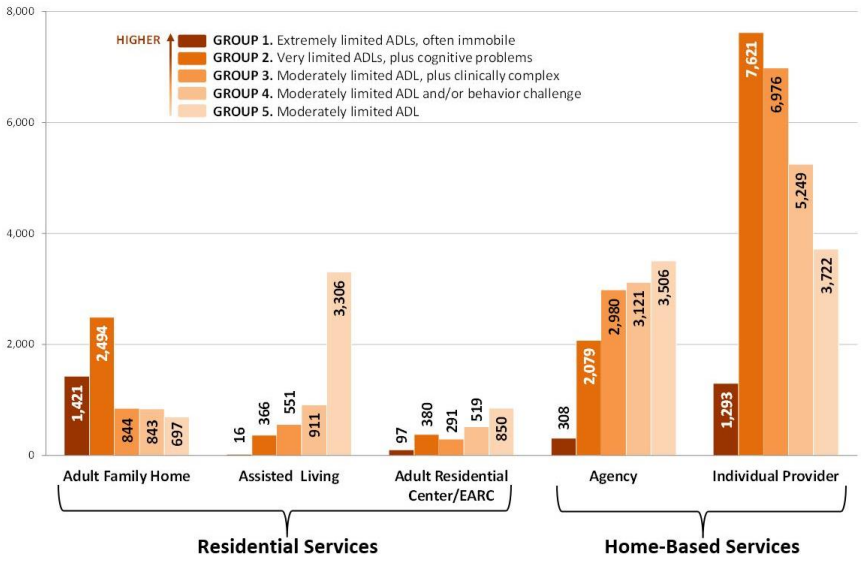


Figure xx. Long-Term Care Assessment by Setting and Acuity

As the chart above demonstrates, statewide there are approximately 38,000 people in the home and community-based portion of Washington's LTSS system who face a broad range of

challenges to their health and independence. All need assistance to accomplish daily activities such as bathing, dressing, preparing meals, personal hygiene and moving about.

About 30 percent (11,300 people) of those have very little ability to accomplish daily activities (e.g., eating, dressing, bathing) due to physical mobility and cognitive limitations. That is roughly equal to the number of Washington's nursing home residents with similar conditions who are covered by Medicaid. Another 30 percent are slightly more able to accomplish daily activities but are challenged by a complex combination of difficult to manage diagnoses and health conditions.

The levels of acuity among LTSSS clients have continually increased over the past decades and require increasingly sophisticated service planning, coordination, and monitoring to maintain independence, health, and safety.

Case Management of In-home LTSS

In any given month, ADS manages around 10,000 in-home LTSS cases, and 12,000 individuals over the course of a year. Clients receive a comprehensive assessment of their functional and health support needs. After assessment, they receive an individual service plan that authorizes personal care help with activities of daily living such as bathing, personal hygiene, ambulation and meal preparation. In addition, the case manager can authorize other supportive services such as personal emergency response systems and medication management. On average, Case Managers authorize about $2,000 per month in supportive services.

Beyond what is directly authorized for payment, the case management team (which includes nursing and social services professionals) helps people access healthcare and other services in the community. To monitor care and maintain safety of this very vulnerable population the case manager does home visits and maintains contact with family and providers to monitor the effectiveness of the plan of care.

As clients increase in complexity, the responsibility of helping them meet health outcomes will also shift in the next four years. Legislation passed in 2013 (HB 1519) directs DSHS and Health Care Authority (HCA) to establish accountability measures for service coordination agencies such as Regional Support Networks (RSN) and Area Agencies on Aging (AAA). Within the next four years, outcome measures will be added to AAA contracts.

For the first time in many years, the 2015–2017 state budget included an increase in maintenance level funding for the Medicaid Case Management program. The additional $10.5 million statewide translates to a nine percent increase in reimbursement rates and will enable AAAs to better balance revenue and expenditures through the next biennium. Unfortunately, following years of flat funding and increases in both client complexity and operational costs, the nine percent increase is still significantly short of what is needed to restore the program to pre-recession capacity and quality levels.

To address this shortfall, a state convened workgroup that included AAA staff and directors identified opportunities for programmatic changes and cost saving strategies. Some of the workgroup's recommendations will be effective with the 2016 contract year and are aimed at reducing administrative burden and case manager staff time. At the same time, ADS has been pilot testing internal operational changes that improve both efficiency and quality of service for clients while managing higher caseloads.

While these efforts will keep the program operational, more funding is needed to maintain these critical services and to ensure quality of care, minimize risk for staff and clients, and support positive health outcomes. In-home monitoring of care, inclusion of nurse expertise on the care team, supervisory quality control and quality of care planning will continue to challenge the AAA at current levels of funding. If not rectified by FY2017, it will be necessary to reduce or eliminate related quality assurance benchmarks.

Long-term Services and Supports: Goal

Maximize current program, funding and staff capacity to meet the needs of complex Long Term Services and Supports clients.

Long-term Services and Supports: 2016–2019 Objectives

Explore opportunities to address the increase in medical complexity such as revamping the use of medication management funds; training on disease or health related topics.

- Advocate for full funding to maintain quality in-home case management so that individuals receive stabilized care that allows them to stay in home as long as that is their choice.
- Implement operational changes, such as team based staffing approaches, to improve efficiencies and reduce costs.

C-2: Pre-Medicaid Services

Aging and Disability Services (ADS) has a goal of delaying Medicaid-funded long-term services and supports by encouraging health promotion and disease prevention.

C-2-1: Community Living Connections & Family Caregiver Support Program

ADS has developed strategies for development of Community Living Connections and expansion of the Family Caregiver Support Program, using current funding and potential expansion funding.

Community Living Connections

Community Living Connections (CLC) is an expansion of the current Information and Assistance/Referral (I&A/R) program. It is not a physical center or location, but a service delivery framework, serving older adults and people with disabilities through a "No Wrong Door" approach. This model builds on existing infrastructure and resources to create a coordinated network of service providers who will provide seamless and efficient access to services throughout King County. The CLC integrates several established service areas (Information & Assistance, Disability Access Services, and Discretionary Case Management) into one integrated model, with multiple components and access points.

A new service area—Person-Centered Options Counseling—was pilot-tested with three agencies in 2014 and will be implemented throughout King County. This interactive process provides guidance to individuals needing supports and services. Through a personal interview, staff helps people identify what is important to them and for them, so they are able to create an action plan to help them live independently in the community.

Recognizing the need for services to be accessible in the community where people reside, ADS created a hub-based model. Staff from over 100 agencies participated in more than 30 community engagement activities. Place-based services was the salient theme that emerged. The model is a coordinated effort with several components, including a central access point, regional leads, and network agencies.

While services may be accessed through any agency, there is one main point of entry that provides I&A/R over the phone or through an electronic medium. If participants need further assistance and service planning, they are referred to regional leads or other network agencies.

The continuum of CLC services, as described in the AAA services section of this Area Plan, will be coordinated by regional leads in north King County/Seattle, east King County, and south King County. Lead agencies—the primary CLC contact for the geographic hub—provide I&A/R services. They also convene key partners at regularly scheduled meetings and market CLC to agencies and organizations in the area.

Lead agencies are the heart of the CLC network and sense the pulse of the region. They understand the dynamics of the community and bring organizations together to form the network. Agencies in the CLC network will refer to each other in a coordinated, seamless,

person-centered manner so that older adults, people with disabilities, and caregivers receive information necessary to remain independent in the community.

To help facilitate seamless service delivery, the State of Washington developed a client management and resource directory information system called GetCare. The system is a platform to create seamless linkages between clients needing information and the services needed. People are able to search for resource information, complete an assessment, and self-refer to programs and services. Agencies utilizing GetCare are able to transfer clients seamlessly to each other.

While the public can search the web-based system for resource information, ADS recognizes that many community members need assistance in navigating the maze of information available. I&A/R is available but many people do not know of its existence. ADS plans to develop a marketing and outreach plan and work with the CLC network to implement communication strategies so that residents know where to go or who to call to find information.

Family Caregiver Support Program

CLC (specifically I&A/R) is often the "front door" for people to access the suite of long-term supportive services. As such, CLC staff will identify and refer family caregivers to the Family Caregiver Support Program (FCSP), marketed in King County as the King County Caregiver Support Network, to receive services tailored to their caregiving needs. Coordination between agencies is crucial so that caregivers receive the right services, at the right time, in the right format.

The No Wrong Door philosophy of the CLC system is also applied to the FCSP agencies as all subcontracted agencies will have staff who are trained to use the Tailored Caregiver Assessment and Referral (TCARE®) protocol. This evidence-based tool tailors supports and services to individual caregivers unique needs. TCARE® has been shown to improve caregivers' well-being and mental health outcomes. By having trained TCARE® users at every FCSP agency, caregivers will be able to receive the benefits of TCARE® so they are able to care for their loved one in the community.

Two Request for Proposal (RFP) processes concluded in mid-2015 increased the number of service providers for the CLC and FCSP service areas. Specifically, agencies will serve the African American, homeless, deaf and hard of hearing, and deafblind populations. Participants with limited English proficiency including Asian, Pacific Islander, East European, Latino, and East Africans will also be served in the CLC network.

The expanded CLC network also has expertise in serving people with a disability, including youth with a disability who are now aging into adulthood and need supports and services to live independently in the community. The agency that serves this population also provides culturally and linguistically relevant services to Asian, Latino, East African and African American families. The RFPs expanded the breadth of focus populations that will be served through CLC and FCSP services.

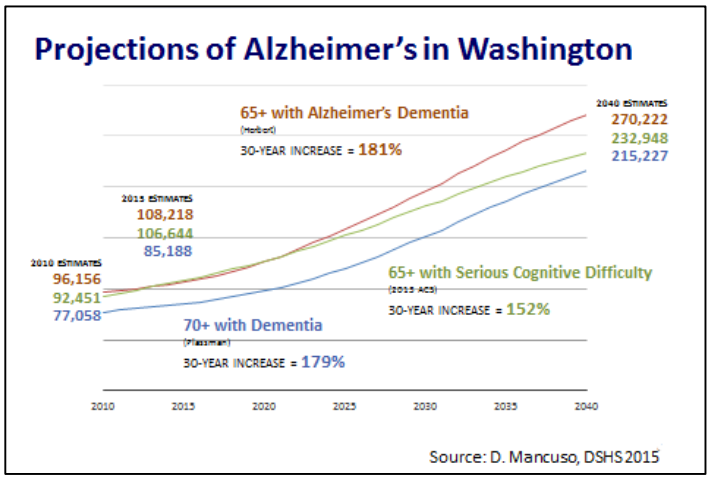
If additional funding becomes available, ADS would invest it in direct services, allocating the monies to the subcontracted agencies to add staff capacity. Increased funding would allow more populations to be served through the extensive CLC and FCSP network.

C-2-2: Alzheimer's, dementia, and memory care

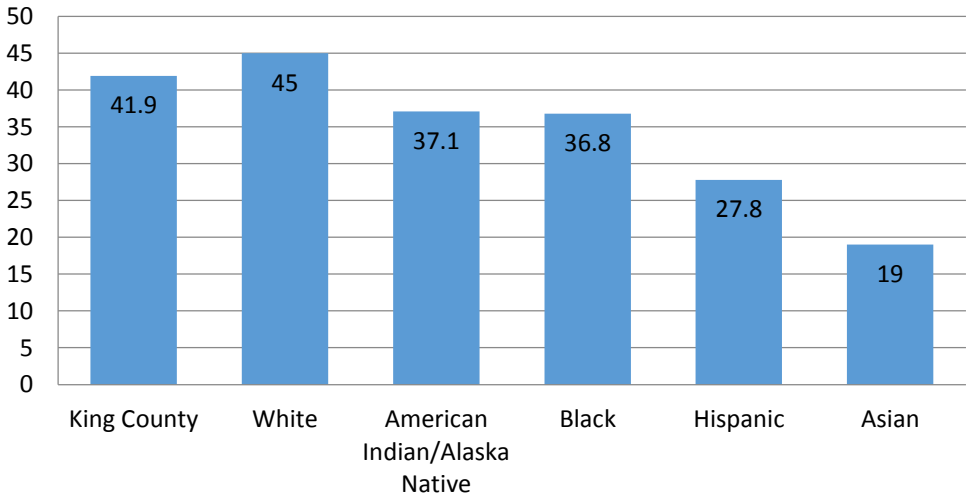
Today, Alzheimer's disease is the largest unrecognized public health crisis of the 21st Century. In Washington state, an estimated 110,000 individuals have Alzheimer's disease or a related dementia. With the aging of the baby boom generation, the number of older adults with dementia is increasing. Yet, services and supports are not keeping up. Alzheimer's disease is the sixth leading cause of death in the United States, and the third leading cause of death for Washington state and King County, respectively. For women in King County, Alzheimer's disease is the third leading cause of death, while it is the sixth for men.

Over the next 30 years, it is projected that in Washington state, the number of people age 65 and older with Alzheimer's and dementia will increase by 181 percent. For those ages 65 and older with serious cognition, the number is likely to increase by 152 percent. While the number of people with dementia, who are age 70 years and older, is expected to increase by 179 percent.

American Indians/Alaska Natives make up only 1.1 percent of the King County population, yet they experience higher death rates attributed to Alzheimer's disease and related dementias, due to racial disparities in the prevalence of the disease. This is also the case for African Americans (6.6 percent of the population) and Hispanic Americans (9.3 percent of the population). Hispanics are 1.5 times more likely, while African Americans are about two times more likely than older whites to have Alzheimer's disease.



As the U.S. population ages and minorities become a higher proportion of the older population, a higher percentage of people with Alzheimer's Disease will be minorities.



King County Alzheimer's Death Rates, by Race/Ethnicity, 2008-2012
Rate = Death per 100,000, All Ages

State Alzheimer's Disease Plans
In 2011, President Barack Obama signed the National Alzheimer's Project Act into law. This was followed by the first National Plan to Address Alzheimer's Disease, released in 2012. States must also be prepared to address this crisis and are working to develop and implement plans to guide state governments on critical dementia issues and possible solutions, while improving services and supports for families affected by the disease.

Washington State has convened an Alzheimer's Disease Working Group to develop a state plan. The work group comprises people with dementia, caregivers of people with dementia, state agency leadership, legislators, health care providers, home and residential care providers, health policy advocates, and researchers. In 2014, the Working Group engaged essential stakeholders statewide to gather input to shape the plan. The plan will define the scope of the economic and social impact of Alzheimer's disease and set the direction for the state to become dementia capable. The completed plan is due to the governor on January 1, 2016.

Memory Care Wellness—Dementia Capable Pilot
Aging and Disability Services collaborated with the Washington State Department of Social and Health Services, Alzheimer's Association, University of Washington, Washington Department of Health, and four other Area Agencies on Aging on a three-year grant to increase the dementia-capability of the Community Living Connections (CLC) Aging and Disability Resource Network. The goal is to train staff to identify people with possible dementia and provide dementia-capable services. People with dementia and their family caregivers will have increased access to evidence-informed early stage memory loss programs and behavioral support. Individuals with dementia will be identified in a statewide data system that allows staff to track and follow up on referrals and services used. The number of people with possible or early stage dementia who are referred to physicians for evaluation and to support services.

C-2-3: Health Promotion

Aging and Disability Services promotes evidence-based health promotion programs

A Matter of Balance

Chronic Disease Self-Management Program

Diabetes Self-Management Program

EnhanceFitness

EnhanceWellness

PEARLS (Program to Encourage Active and Rewarding Lives)

The initial funding used to support CDSMP and DSMP programs expired in August 2015; however, beginning in 2016, Aging and Disability Services will implement an investment process for the Health Promotion service area (TIII-D). One of the goals for this process is to expand opportunities for high-need populations to participate in evidenced-based Chronic Disease Self-Management Programs, Chronic Pain Self-Management workshops, and Tai Ji Quan: Moving for Better Balance®. The overall goal is to facilitate a menu of evidence-based health promotion programs available for community-dwelling older adults and adults with disabilities.

In addition, ADS informs staff from public health, community clinics, and other healthcare professionals about CDSME programs and facilitates strategies for supporting workshops. ADS will also continue facilitating discussions with managed care organizations, Medicare, and other healthcare organizations, with the goal of embedding CDSME programs into healthcare systems. ADS also supports quarterly meeting of the King County CDSMP Network of organizations involved in CDSME programs.

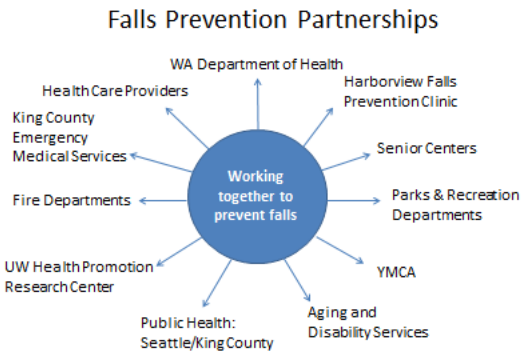
C-2-4: Falls Prevention

Falls are a preventable public health concern impacting quality of life, health care costs, and premature institutionalization. The prevalence of falls among older adults is increasing in tandem with the increase of the age 60 and older population. In Washington state, one in every three people age 65 and older living in the community falls each year, and fall rates increase sharply with advancing age. In King County, 21 percent of adults 60 and older report having fallen in the previous three months. About 20 percent of those falls result in injuries that limit activities or require a doctor.

In 2012, falls were the leading cause of all injury-related hospitalizations in Washington state, leading to over 14,000 hospitalizations. Fall hospitalization rates among older adults are significantly higher in urban and large town rural areas, like King County, compared to other areas of Washington. In King County, 18 percent of Emergency Medical Services 911 calls from older adults are fall-related incidents. For adults 60 and older in King County, falls accounted for 72 percent of all injury hospitalizations in this population. Although the rate of hospitalizations due to falls has declined in King County for adults age 60 and older since 2000, the number of hospitalizations for this age group increased 17 percent between 2000 and 2012, reflecting a larger number of adults age 60 and older**.**

Falling can also lead to premature institutionalization. Among older Washington state residents who were hospitalized for a fall in 2008, 53 percent were discharged to skilled nursing facilities for additional care. In 2000, the total cost for falls in the U.S. was $19 billion. In Washington state, the estimated costs for fall hospitalizations for adults 65 years and older was $473 million.

Falls prevention is an integral part of the framework for promoting independence and aging in place. Creating linkages and partnerships to strengthen community infrastructure is critical. Older adults need to be aware of their fall risk before a fall occurs, while healthcare providers need to be informed about available community programs and resources for patient referrals. At the same time, community systems and organizations should work together to increase awareness, coordination and support for vulnerable adults.



Pre-Medicaid Services: Goal

Delay Medicaid-funded long-term services and supports by encouraging health promotion and disease prevention; increasing awareness about Alzheimer's disease, memory care and wellness; improving health care quality for older adults and adults with disabilities; and reducing the incidence of falls.

Pre-Medicaid Services: 2016–2019 Objectives

C-2-1: Community Living Connections (CLC)

a. Develop Seattle-King County Community Living Connections marketing and communications strategy and plan.

b. Develop geographic hubs delivering Information Assistance/Referral, Options Counseling and Care Coordination in Seattle/North King County, South King County, and East King County.
c. Provide Person-Centered Options Counseling to individuals needing assistance with long term support service planning

Family Caregiver Support Program (FCSP)

d. Increase provision of TCARE® assessments to caregivers of African or African descent.
e. Increase provision of TCARE® assessment and care plans for family caregivers who show moderate to significant caregiver burden.

CLC-FCSP (cross-system objective)

g. Provide cross-system training and meeting opportunities for CLC and FCSP providers to improve referral network, including resources for and working with priority populations:
    - LGBTQ elders
    - Rural elders
    - Residents with disabilities under age 60

C-2-2: Alzheimer's, dementia, and memory care

a. Provide Early Stage Memory Loss (ESML) workshops to caregivers caring for someone with Alzheimer's disease or dementia.
b. Provide STAR-C training to caregivers to help caregivers manage behavioral symptoms of their care recipient with Alzheimer's disease or dementia.
c. Maintain Memory Care and Wellness Adult Day Services in King County.
d. Provide TCARE® to underserved communities of color in King County.
e. Promote brain health and the importance of early detection, with special emphasis on communities of color.
f. Support the dissemination of Staying Connected and Staying in Motion.
g. Coordinate with public health on implementing the Alzheimer's state plan with a focus on communities of color.

C-2-3: Health promotion

a. Expand evidence-based health promotion programs, available for community-dwelling older adults and adults with disabilities through the 2016 investment process.
b. Collaborate with healthcare professionals to expand and sustain CDSME programs throughout King County.
c. Provide Chronic Disease Self-Management trainings (CDSME, DSME, and CPSME) to eligible participants receiving medical care at the University of Washington Harborview Medical Center
d. Seek funding from non-traditional sources such as insurance providers, county-wide levies in support of evidenced-based health promotion workshops.

C-2-4: Falls prevention

a. Increase awareness about fall risk, prevention and community resources among community-dwelling older adults and relevant healthcare professional groups.
b. Increase access to evidence-based falls prevention programs, information and resources.

c. Promote the dissemination of evidence-based falls prevention programs in community-based organizations.
d. Collaborate with Fire Department, Emergency Medical Services, healthcare, and housing providers.
e. Provide falls prevention training for case managers and health care professionals on the recognition/identification of older adults at fall risk and appropriate referrals to programs and services.

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C-3: Service Integration & Systems Coordination

Health care reform in Washington

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 created opportunity for innovation in achieving the triple aim: Better Health, Better Care, Lower Cost.

In 2012, the State of Washington received Centers for Medicare and Medicaid Services (CMS) funding to develop an innovative integrated service delivery plan for beneficiaries who are eligible for Medicare and Medicaid ("dual-eligible"). The Washington State Health Care Authority and DSHS collaborated on two strategies for dual integration: Health Homes and Health Path Washington, a fully-integrated capitation model delivered through managed care organizations. While Health Homes was launched throughout the state, King County chose to participate in Health Path Washington. From 2013–2015, Aging and Disability Services (ADS) participated in planning sessions with the managed care plans and King County Regional Support Network and Public Health—Seattle & King County.

In 2015, the State decided to discontinue implementation of Health Path Washington when one of the two managed care plans withdrew their participation. Although Health Path Washington was cancelled, the collaboration and partnership building provides a base for future integration efforts.

AAA experience with managed care

In 2006, ADS partnered with Harborview Medical Center and four community health systems to form King County Care Partners, a pilot managed care program which provided specialized intensive chronic care management for Medicaid fee-for-service clients. The goals of the program were to improve health outcomes, support health home development, and prevent avoidable medical costs by improving self-management skills.

In 2012, the Health Care Authority moved all Medicaid-only SSI blind and disabled clients to five managed care organizations (MCO) under the Healthy Options program. ADS was able to continue King County Care Partners by contracting with one Healthy Options MCO—Community Health Plan of Washington. ADS staff visit clients in the hospital and then in the community to prevent re-hospitalization. Transitional care services include post-discharge service coordination, medication reconciliation, problem-solving, care plan development, and follow-up to support self-management. Care coordination services include a comprehensive assessment, ongoing consultation, cross-system coordination, individual and family support, referral to community and social support services, and help connectiing to primary care.

ADS plans to continue working with MCOs through Healthy Options and possibly Health Homes, if expanded to King County.

Local health reform efforts

The state revealed the Washington State Health Care Innovation Plan in December 2013. The plan is guided by three core strategies: improve how we pay for services, ensure health care

focuses on the whole person, and build healthier communities through a broad collaborative regional approach. In 2015, the Center for Medicare and Medicaid Innovation awarded the State $65 million to implement their innovation plan, now called Healthier Washington.

As the State devised the Healthier Washington plan, King County also charted its course for health and human services transformation by 2020. The King County Transformation Plan looks at affecting both the individual/family and the community through strategies designed to improve access to person-centered, integrated, culturally competent services and improve community conditions where people live, work, learn, and play.

A strategy of both Healthier Washington and King County Transformation Plan is creating an Accountable Community of Health (ACH). The State recognized that innovation and collaboration are already occurring in local communities with public and private entities working together on shared health goals. During the span of this Area Plan, ADS will collaborate and align with Accountable Community of Health goals, ensuring that AAA initiatives such as Community Living Connections and Chronic Disease Self-Management are integrated into the structure. ADS participates in the Interim Leadership Council created to guide the Accountable Community of Health design.

Care transitions and beyond—complex client coordination

Coordination of care and services is vital to Seattle-King county older adults and those with disabilities who are discharged from the hospital or skilled nursing facility to the community. Medical facilities are penalized for unnecessary readmissions while most of a person's care is in the community. ADS works with community partners to provide an overview of services and supports, and to help integrate the services and supports into the transitions across settings. ADS supports person-centered planning so patients are empowered to be active members of their health care team.

ADS' experience with chronic care management, managed care, caring for over 10,000 complex clients in-home, and coordinating an aging and disability network positions the AAA to coordinate activities between the health care system and community. ADS is active in a variety of groups convened to address coordination, including:

- **South King County Care Links**: This group's purpose is to create an encompassing network of providers who are dedicated to creating consistent, thoughtful, and safe care transitions for patients and families across the care continuum.
- **Auburn Care Coordination**: This group coordinates services for residents living in the three Auburn Court Apartments operated by the Senior Housing Assistance Group (SHAG). The service coordination helps to provide education, decrease avoidable 911 calls, and improve the life/safety of residents.
- **Mobile Integrated Health-Community Paramedics**: This statewide group includes more than 25 healthcare industry organizations and community partners—fire chiefs, health plans, Home Care Association of Washington, King County Medic One, University of Washington School of Medicine, Washington Ambulance Association, Washington State Council of Firefighters, Washington State Department of Health, Washington State Health Care Authority, Washington State Hospital Association, and Washington State Nurses Association.
- **King County Vulnerable Population Strategic Initiative**: Work is underway to ensure that King County residents receive the best possible emergency services regardless of age, race, ethnicity, socioeconomic status, gender, culture, or language spoken. The

initiative focusses on three EMS components: dispatch service, on-scene service, and after-care community service. Under this initiative, ADS has pilot-tested a collaboration with Seattle Fire Department (SFD) to work with older adults experiencing abuse and neglect. During a nine-month period ending in June 2015, the AAA responded to 223 referrals and followed up with feedback to the SFD referents.

These groups work to improve EMS services and transitions of care among hospital, skilled nursing facility, and community providers and caregivers. Recent data indicates that the South King County community is improving their hospital admissions and re-hospitalizations. Since 2012, the data show a 10 percent improvement in all-cause re-hospitalizations for Medicare recipients. Although the trend lines look positive, continued effort and coordination is needed to continue reduction of avoidable hospitalizations.

In addition to participating in workgroups and pilots, ADS plays a convening role in the community. For example, since 2011, ADS has coordinated four community-based care transitions conferences and expects to facilitate annual conferences in the future. The conferences relate to health care quality as well as issues related to care transitions. Community partners, family caregivers, patients, professionals providing direct care services, leaders of community-based agencies, including hospitals, skilled nursing facilities, home health care agencies, and home care provider agencies attend the conferences. In 2014, the conference drew 160 attendees from 70 community organizations. In 2015, more than 200 people participated in the conference.

ADS case manager Keith Rapacz was among more than 200 participants in The Waves of Change in Health Care conference on June 4, 2015. Photo by Lorraine Sanford.

In King County, the biggest challenge the AAA has in implementing strategies for change is working with vast health and community systems and a multitude of initiatives. King County has 12 hospitals and health systems, several with multiple campuses; more than 60 skilled nursing facilities; and hundreds of community-based health and human services provider organizations. Challenges in this environment include accountability, alignment of ongoing initiatives, staff continuity in planning meetings, and constant education of services and supports.

Strategies to address the challenges include active participation in bigger health care reform efforts such as the Accountable Communities of Health. The AAA can continue to be a convener of health and community organizations. The AAA can use its aging and disability network to educate the health system on community-based services and create competency within the network on health outcomes.

Elder justice coordination

Preventing elder abuse is an important issue to consider in systems coordination and health reform. A startling number of elders continue to face abusive conditions. Every year an estimated five million older adults (one in ten individuals age 60-plus) experience abuse, neglect, or exploitation, and many experienced it in multiple forms.

The incidence of elder abuse in America is so pervasive that the Centers for Disease Control and Prevention now consider it a major public health problem. Elders who experience abuse have a 300 percent higher risk of death when compared to those not abused. In addition, abused elders have more health care issues, including increased bone or joint problems, digestive problems, depression or anxiety, chronic pain, high blood pressure, and heart problems. Elder abuse is also associated with increased rates of hospitalization. Those who had experienced abuse are twice as likely to be hospitalized as other elders.

The AAA has played a significant role in supporting elder abuse prevention and awareness for the community. In 2011, the AAA partnered with the King County Prosecuting Attorney's Office to pilot a much-needed program that filled a gap of advocacy and service coordination for survivors of elder abuse, neglect and exploitation. A designated case manager provided safety planning, information and assistance, service referrals, court accompaniment, coordination of services, and personal advocacy. The pilot ended in 2013, but the ADS Advisory Council has continued to support the work by allocating 1.0 FTE in the base budget. In 2014, the elder abuse program served 81 older adults experience abuse.

Although King County has one of the finest elder abuse prosecuting teams and many trained law enforcement partners, there is still a need for awareness and training. Lack of training affects community-wide response to elder abuse. Law enforcement, first responders, city prosecutors, judges, social service providers, and medical professionals need training and re-training to understand the nature and scope of elder abuse in order to recognize signs, report appropriately, and coordinate effectively with victim services.

Service Integration & Systems Coordination: Goal

Integrate Aging Network services with other health and human services systems for better health and better care at a lower cost.

Service Integration & Systems Coordination: 2016–2019 Objectives

C-3-1: Participate in the development of the King County Accountable Communities of Health goals.

C-3-2: Coordinate with health care providers, hospitals, and community partners on an annual care transitions conference.

C-3-3: Participate in multi-stakeholder collaborations that strive to improve health outcomes and reduce unnecessary EMS and Emergency Department use.

C-3-4: Increase county-wide access and awareness of elder abuse, neglect, and financial exploitation.

C-3-5: Strengthen connections with prosecutors, law enforcement, and first responders to better coordinate a response for older adult victims of abuse and neglect.

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C-4: Native Americans

Muckleshoot elder
Doris Allen.
Photo by John Loftus.

Aging and Disability Services is working to address the health and social needs of Native Americans age 60 and older—including Indians, Eskimos and Aleuts—who live in King County.

Of the 1.9 million people living in King County, 39,117 (two percent) identify as American Indian/Alaskan Native (AI/AN) alone or in combination with another race. It is estimated that 1.4 percent (5,174) of the King County population age 60 and older is all or part American Indian/Alaska Native, though this population has been shown to be undercounted. See B-1: Population Profile and Trends.

The American Community Survey (2009–2013) estimates that 669 individuals speak a Native North American language in King County, including American Indian and Alaska Native languages. Of those individuals, seven percent speak English less than "very well." Among the AI/AN population, persons 65 years of age and older account for 5.8 percent of AI/AN in King County, compared to 10.9 percent of the general population.

Urban Native Americans

Beginning with the federal relocation program and continuing through the decades following, AI/ANs from more than 100 tribes and Alaska villages migrated to King County, primarily Seattle. In addition, there are a large number of Canadian Indian or First Nations people who are part of the urban Indian community.

In 1970, two organizations were formed to provide social and health services—United Indians of All Tribes and the Seattle Indian Health Board. During the 1990s, the Seattle Indian Health Board served individuals from more than 200 tribes.

AI/AN people in King County are more likely to be poor, with 24 percent living in poverty, as compared to just 10.2 percent of the general population. American Indians and Alaska Natives living in cities face poverty, unemployment, disability and inadequate education at rates far above other populations. These and other risk factors have contributed to a health crisis in this population despite an ongoing effort to eliminate health care disparities across all races and ethnicities.

Duwamish Tribe
The people known as the Duwamish Tribe are descendants of Chief Seattle. Their ancestral homeland includes the cities of Seattle, Mercer Island, Renton, Bellevue, Tukwila, and much of King County. The Duwamish have about 600 enrolled members.

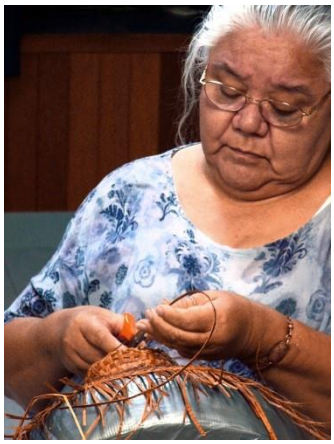
For decades, Duwamish tribal members have fought for federal recognition but courts have denied their petitions. In the absence of federal recognition, funding, and human services, Duwamish tribal services have struggled to provide social, educational, health and cultural programs. Recognized status would provide access to many federal benefits, including fishing rights and healthcare.

Statue of Chief Seattle located at Tilikum Place, a small park at 5th & Denny in downtown Seattle. City of Seattle Archives photo.

7.01 Implementation Plans

In addition to a large urban Indian population in the greater Seattle area, there are also two federally recognized tribes within King County: the Muckleshoot Indian Tribe and the Snoqualmie Indian Tribe.

In compliance with the Washington State 1989 Centennial Accord and current federal Indian policy, 7.01 plans are created in collaboration with Recognized American Indian Organizations in the planning of the Washington Department of Social and Health Services and Area Agencies on Aging (AAA) service programs, to ensure quality and comprehensive service delivery to all American Indians and Alaska Natives in Washington state. The plans address concerns identified by tribal members, identify tribal leads and AAA staff, action steps to address each concern, and provide a yearly summary of the progress.



Muckleshoot elder Leah Moses. Photo by John Loftus.

Muckleshoot
The Muckleshoot Indian Tribe comprises descendants of the Duwamish and Upper Puyallup. The 2000 Census reported a resident population of 3,606 on reservation land, of which 29 percent reported solely Native America heritage. Of these, approximately 600 are age 60 and older. Aging and Disability Services has collaborated with Muckleshoot tribal members on a 7.01 Implementation Plans since 2005.

To review the Muckleshoot 7.01 Implementation Plan in the Appendix, click here.

Snoqualmie
The Snoqualmie Indian Tribe comprises approximately 500 members. Of these, approximately XXX are age 60 and older. The tribe lost federal recognition in 1953, but regained Bureau of Indian Affairs recognition in 1999. This allowed the tribe to develop the Snoqualmie Casino, which financially supports services and resources for tribal members and the local community. Today, many live in Snoqualmie, North Bend, Fall City, Carnation, Issaquah, Mercer Island and Monroe.

To review the Snoqualmie 7.01 Implementation Plan in the Appendix, click here.

Native Americans: Goal

Ensure greater success for Native American elders in King County.

Native Americans: 2016–2019 Objectives

C-4-1: Strengthen ADS ability to serve community groups that have not been served previously, i.e. urban Native Americans

C-4-2: Continue 7.01 Implementation Plan collaboration with federally recognized tribes in King County.

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C-5: Livable Communities

Introduction

In devising this Area Plan, ADS conducted a wide variety of community outreach and engagement events and activities in 2014 and early 2015 (see A-3: Planning and Review Process). The most frequent themes heard were related to health and wellness, housing, in-home assistance, income/financial assistance, safety, socialization, and transportation. Much of this can be summed up as the desire for "livable communities."

The greater Seattle region has many strengths. It is acknowledged by the general population as a great place to grow up and live. By reducing physical and social barriers to aging in place; promoting creative ways for older adults to maintain, share, and grow their talents, skills, and experiences; and ensuring livable communities for all ages, Seattle-King County can also be a great place to grow old.

Characteristics of a livable community

AARP defines a livable community as "one that has affordable and appropriate housing, supportive community features and services, and adequate mobility options, which together facilitate personal independence and the engagement of residents in civic and social life."

When residents can live comfortably—regardless of ability—and age in place, everybody benefits. According to the World Health Organization, cities that encourage active aging and enhanced quality of life share eight characteristics:

1. Outdoor spaces and buildings
2. Transportation
3. Housing
4. Social participation
5. Respect and social inclusion
6. Civic participation and employment
7. Communication and information
8. Community support and health services

Related AAA Programs, Services & Partnerships

Coordinated Response to Abuse, Neglect & Exploitation

Housing Development Consortium

King County Mobility Coalition

Northwest Universal Design Council

Older Americans Month

Puget Sound Regional Council Special Needs Transportation Committee

Senior Centers

Senior Coffee Hours

Senior Community Service Employment Program

Seniors Training Seniors (computer classes)

Social media

For more information, visit:

Create Livable Communities

www.agingkingcounty.org/livable-communities.htm

Encourage Financial Security

www.agingkingcounty.org/financial-security.htm

Promote Healthy Aging/ Stay Connected

www.agingkingcounty.org/healthy_aging.htm#connected

National, state and local trends and challenges

- The need for affordable housing in King County greatly surpasses the supply. An additional 936 subsidized housing units need to be created each year until 2025 just to maintain the current ratio of affordable housing to less-affluent older adults.
- A higher percentage of King County residents age 65 and older pay more than 30 percent of their income for housing, as compared to U.S. residents of the same age.
- A higher percentage of King County residents age 65 and older use public transportation than U.S. residents of the same age.

- Older adults outlive their ability to drive safely by an average of 7–10 years.
- Older adults will choose to age in place rather than relocate to retirement facilities or communities where access to services is more convenient.
- Individuals with limited mobility have difficulty accessing basic needs, including food, employment and health care, and face inactivity, social isolation, and exclusion.
- The monthly housing costs for elder homeowners without a mortgage in King County typically exceeds $600/month. On average, elders with a mortgage pay $1,617/month.
- Social Security is the only source of income for about three in ten Washingtonians age 65+.
- The Elder Economic Security Standard Index for Seattle-King County shows that monthly household expenses greatly exceed the average Social Security benefit. Elders in poor health have even more difficulty meeting the cost of living in the greater Seattle area.
- Many Seattle-King County residents will not have the resources they need to cover basic needs and healthcare expenses in their retirement.
- Loneliness and social isolation are a threat to longevity. Lack of social relationships influences the risk of death comparable to well-established mortality risk factors such as smoking and alcohol consumption, and exceeds the influence of other risk factors such as physical inactivity and obesity.

The Green Way to Travel in Your Neighborhood (AgeWise King County, May 2015). Seattle Department of Transportation photo.

Age-friendly Communities: Goal

Promote/develop a regional framework to increase awareness about the aging population; and influence municipalities, stakeholders, policy and decision makers, and consumers to prepare their communities for the aging population; and encourage people of all ages to keep moving and stay connected.

Age-friendly Communities: 2016–2019 Objectives

C-5-1: Housing

a. Advocate for increased funding for low-income housing, and to reduce barriers to providing services to older adults in subsidized housing, and encourage development of alternative housing for aging in place.

b. Provide education about the benefits of Universal Design (UD) and promote the inclusion of UD principles in all capital construction programs.

c. Promote community-based options for home repair, weatherization, and conservation that can help older adults live more comfortably and save money.

d. Advocate for a 24/7 shelter for older adults experiencing homelessness, and coordinate with stakeholders and community partners on implementation.

C-5-2: Community mobility

a. Advocate to increase the availability of transportation options.

b. Advocate/work to increase funding for older adult transportation programs such as the Hyde Shuttle.

c. Promote community design that supports mobility, such as public transportation, walking, and bicycling.

C-5-3: Economic security

a. Participate in public education and marketing campaigns to promote individual savings for later life.

b. Encourage hiring and retention of older workers, allowing them to work and save longer.

C-5-4: Social and civic engagement

a. Advocate for increased funding for senior centers and related services to reduce social isolation.
b. Utilize current technology to enhance access to aging information, programs and services as well as social and civic engagement for older adults.

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