2027-2030 AREA PLAN

prepared by Northwest Regional Council for Island, San Juan, Skagit, and Whatcom Counties

Human Services with **YOU** at the Center

NWRC

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Mount Vernon, WA 98273

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1. Executive Summary: Northwest Regional Council (NWRC) Area Plan

The Northwest Regional Council (NWRC) is an association of county governments serving older adults, individuals with disabilities, and people with complex medical conditions across Island, San Juan, Skagit, and Whatcom counties. This strategic plan establishes the agency's mission, and operational direction over the next four years.

NWRC is governed by an eight-member governing board consisting of two elected officials from each participating county. The governing board members review and approve changes to NWRC operations, budget, and infrastructure.

NWRC operates out of two main locations in Whatcom and Skagit Counties. Additionally, they provide some direct services in Island and San Juan Counties, while others are provided through key partners. Please see the list below for additional focal point information.

1.1 Core Services Provided

NWRC provides comprehensive care management services by helping individuals navigate complex healthcare systems and connect with critical resources. Additionally, the team delivers specialized in-home care options and supports unpaid family caregivers, while offering clinical behavioral health therapy and targeted dementia programs. They also enhance community mobility and outreach through non-emergency medical transportation and dedicated outreach to local Tribal Elders. Finally, NWRC ensures long-term care readiness by managing local provider enrollment and facilitating public application access for the WA Cares Program.

1.2 Key Commitments Moving Forward

Bridging Systems - Connect regional healthcare with local social services to reduce barriers for clients ensuring they receive the highest quality care possible.

Targeting Vulnerabilities - Identify and support specific groups of people whose needs are currently overlooked or undocumented, while actively working to dismantle the specific local rules, prejudices, or economic barriers that hold them back.

Cultivating and maintaining community trust – The NWRC team designs personalized care plans that focus entirely on the unique needs of each client, ensuring other providers listen closely to patient feedback and quickly adjust treatment and care strategies as those needs change.

Current Governing Board Assignments:

Whatcom County
County Executive Satpal Sidhu
Council Member Mark Stremler

Skagit County
Commissioner Joe Burns
Commissioner Peter Browning

Island County
Commissioner Jill Johnson
Commissioner Janet St. Clair

San Juan County
Council Member Kari McVeigh
Council Member Jane Fuller

Focal Points:

Island County (Senior Information & Assistance Program)

Oak Harbor Office
51 SE Jerome
Oak Harbor, WA 98277
(360) 675-0311

South Whidbey Office
14594 SR 525
Langley, WA 98260
(360) 321-1600

Camano Island Office
606 Arrowhead Road
Camano Island WA 98282
(360) 387-6201

San Juan County (Senior Information & Assistance Program)

Lopez Island
Located in Woodmen Hall
4102 Fisherman Bay Road
PO Box 154, Lopez, WA 98261
(360) 370-7521

Orcas Island
Senior Center/County Services Bldg
62 Henry Road
PO Box 1146, Eastsound, WA 98245
(360) 376-2677 V/TDD

San Juan Island
Mullis Senior Community Center
589 Nash Street
PO Box 951, Friday Harbor, WA 98250
(360) 378-2677

Skagit County (Aging & Disability Resources Program)

Northwest Regional Council
301 Valley Mall Way, Suite 100
Mount Vernon WA 98273
(360) 428-1301

Whatcom County (Aging & Disability Resources Program)

Northwest Regional Council
600 Lakeway Drive
Bellingham, WA 98225
(360) 738-2500

2. Stewardship and Oversight

For over fifty years, the Northwest Regional Council (NWRC) has served as a vital cornerstone for older adults, adults with disabilities, and family caregivers across our communities. Our mission is rooted in a profound commitment to dignity, independence, and quality of life. At the heart of this mission lies our committed stewardship and oversight of Older Americans Act (OAA) program. This is a responsibility we approach not just as a regulatory requirement, but as a promise to the people we serve.

Coordinating Comprehensive Patient Care

Effective support requires a unified approach. To really bring the vision of the Older Americans Act to life, NWRC focuses on the whole picture. A successful aging network operates as a cohesive community rather than a collection of separate programs. Whether providing nutritional support, assisting caregivers, or conducting wellness visits, the NWRC team works to unify providers to ensure every service is delivered with collective dedication.

To best serve our community, we make sure our entire team works as one:

Policy and Procedure Alignment: By aligning our operations, financial planning, and data infrastructure, we ensure complete fiscal accountability and maximize the impact of our services.

Data-Driven Evaluation: We closely evaluate numbers and program results to see how we're making a real difference. This keeps us accountable and helps us improve our services.

Empowered Staff and Public Awareness: Our team highly is trained to give our clients the best services possible, while open communication keeps our communities close and informed.

Safeguarding Trust and Advocacy: As trusted advocates for older adults, maintaining the absolute integrity of our voice is essential. Our stewardship ensures that advocacy activities remain unbiased, ethical, and entirely focused on the well-being of our community members. Our job is to connect people in need with the right resources. We handle that responsibility with total transparency, making sure our work is always ethical, compliant, and trustworthy.

Adapting for a Resilient Future: Community needs are always evolving, and our programs must keep pace. Through ongoing assessment, NWRC closely tracks the changing realities of aging and caregiving. We actively adjust our strategies to keep our services efficient, relevant, and highly effective for those who depend on them. At the NWRC, we do a lot more than just manage programs. By balancing careful budgeting with reliable services and passionate advocacy, we build a strong network of care. Our goal is to honor our older adults and people with disabilities and support our community for generations to come**.**

2.1 Mission, Vision, Values

Northwest Regional Council Belief Statement:

Innovation in human services starts with believing that everyone matters. At our core, we care. So, we listen.

Northwest Regional Council Anthem:

- We connect and create new solutions to navigate the challenges of aging and disability.
- Proactive paths to behavioral health and recovery.
- And new partnerships between healthcare and social services.
- We build better support systems, to better serve people, because we exist for people.

Northwest Regional Council Mission:

To build a comprehensive and coordinated support system for older individuals, people with disabilities, and people affected by complex medical conditions in Island, San Juan, Skagit, and Whatcom Counties.

The support system will:

(1) Promote personal independence and dignity, and
(2) Improve the quality of life by removing barriers that can create physical and social isolation.

NWRC Values and Envisions:

Community Access for All

Individuals who need long-term services and supports can make informed choices about their care.

Services are easy to access, understandable, and physically, culturally, linguistically, and financially accessible.

Consumer Protection and Safety

Services and assistance help clients avoid abuse, access safe products, and make choices about health behaviors that allow their best quality of life.

Evidence-Based Programming

Services and programs incorporate evidence-based best practices, evolve based on consumer input and needs.

Consumer Empowerment and Advocacy

Consumers are their own advocates to shape services that are comprehensive, cost-effective, flexible, well-coordinated, and prudently managed.

Caregiver Support

Caregivers have access to appropriate training and other support for their caregiving responsibilities.

Communities that are aware of the care needs of NWRC's target populations and have knowledge of the network of services and programs that support them.

Communities that participate in the development of essential services use their strengths and assets to identify, prioritize, and guide opportunities for the future.

2.2 AAA Services and Partnerships

The following table demonstrates the range of services provided by the Northwest Regional Council including direct and contracted services. A narrative description of each program follows.

AAA Services Provided	Service County			
	Island	San Juan	Skagit	Whatcom
Care Management				
In-home Case Management	X	X	X	X
Care Coordination	X	X	X	X
Behavioral Health (in-home)	X	X	X	X
Community Programs				
Aging & Disability Resources	X	X	X	X
Health & Wellness Programs	X	X	X	X
American Indian/Tribal Outreach	X	X	X	X
WA Cares Fund	X	X	X	X
Nutrition				
Congregate Nutrition	X	X	X	X
Home Delivered Meals	X	X	X	X
Senior Farmers Market Program	X	X	X	X
In-Home Support				
In-home care	X	X	X	X
Family Caregiver Support				
Family Caregiver Support Programs	X	X	X	X
Dementia Support Program	X	X	X	X
MAC/TSOA	X	X	X	X
Other				
Medicaid Transportation	X	X	X	X
Volunteer Services			X	X
Senior Legal Assistance	X	X	X	X
Long-Term Care Ombudsman	X	X	X	X
Supportive Housing			X	X
Supportive Employment			X	

Care Management (CM)

1. In-Home Case Management: assists functionally impaired adults at risk of institutionalization in accessing, obtaining, and effectively utilizing the necessary services which will enable them to maintain the highest level of independence in the least restrictive setting. Activities include a comprehensive assessment of individual needs, development of a detailed plan of services, authorization of services, and ongoing monitoring of services.
2. Care Coordination: Helps people with complex chronic conditions maintain their health and more effectively use the medical system. NWRC offers Health Homes Care Coordination, Hospital Care Transitions Care Coordination, and Recovery Care Coordination.
3. Behavioral Health (in-home): Offers individual counseling to those who cannot attend in-office services due to physical or behavioral challenges.

Aging and Disability Resources

1. Aging and Disability Resources: is the focal point for information about services for older adults and people with disabilities and their families. Functions of the I&A component include information giving, service referral, assistance, advocacy, and screening to determine whether an older person should be referred to another agency/organization for support. The I&A component is responsible for Information and Assistance program publicity, outreach, and developing and maintaining a file of community resources which serve older adults and persons with disabilities.
2. Health & Wellness Activities: including medication management, nutrition education, hospital transitions, falls prevention, oral health support, and Chronic Disease Self-Management classes.

3. American Indian/Tribal Outreach: Works with the six federally recognized tribes in the region to provide culturally appropriate supports and services to older adults and people living with disabilities.

Nutrition

1. Congregate Meals: helps meet the complex nutritional needs of older persons who are at risk by providing sound, satisfying meals, and other dietary services, including outreach and education, in a group setting.
2. Home Delivered Meals: provides nutritious meals and related services to older adults, and those eligible under Title XIX, who are homebound due to illness, disability, or who are otherwise isolated.

3. Senior Farmers Market Program: provides fresh, locally grown produce to home delivered meal clients, through congregate meal programs, or through vouchers to be used at approved Farmers Markets throughout the region.

In-Home Care

1. In-home care: provides in-home assistance for eligible adults who would otherwise require services in a nursing home. Case Management is provided to organize and facilitate services that may include personal care, transportation, housework, home delivered meals, adult day care, nursing services, environmental modifications, client training, and/or personal emergency response systems.

Family Caregiver Support

1. Family Caregiver Support Program: Provides services and supports to family caregivers. The cornerstone of this program is the Family Caregiver Support Specialists, who provide coordination of services and a wealth of information and resources. There are caregiver resource libraries; caregiver kits with general information about caregiving available in English, Spanish, and Russian; in-home

training; *Powerful Tools for Caregivers* classes; caregiving respite services; and supplemental services.

2. Dementia Support Program: Provides assistance to families and individuals who are navigating dementia or cognitive change. Program staff provide community education, consultation, and proven interventions to help individuals and their families maintain personal choice and quality of life.
3. MAC/TSOA: The Medicaid Alternative Program (MAC) creates a new choice for people who are eligible for Categorically Needy (CN) or Alternative Benefit Plan (ABP) Medicaid but are not currently accessing Medicaid-funded LTSS. The Tailored Supports for Older Adults (TSOA) program is funded under the Medicaid Transformation Project Demonstration. It provides a small personal care benefit to people who don't have an unpaid family caregiver to help them. Both MAC and TSOA provide services to unpaid caregivers designated to assist them in providing quality care to eligible family members while also improving their own well-being.

Other NWRC Programs

1. Medicaid Transportation: provides brokerage and arrangement for transportation to covered medical services. This is a state funded service for persons eligible for Medicaid and who have no other means of transportation available, or whose available transportation services are inadequate or inappropriate to meet their needs.
2. Volunteer Services: provides assistance to persons age 18 and over who cannot afford to pay for the needed services and lack assistance by willing family members or other community programs. Tasks performed by volunteers may include tasks such as heavy chores, household cleaning and light maintenance, transportation, home repair, as well as personal care tasks that do not require the expertise of a specialist or licensed health practitioner.

3. Regional Long-Term Care Ombudsman: provides information, outreach, and advocacy for individuals in long-term care residential settings, including nursing homes, adult family homes, and assisted living facilities.
4. Senior Legal Assistance: Assists older persons in advocating for their rights, benefits, and entitlements. Services focus on non-criminal matters and are provided by an attorney. The attorney's services range from helping clients secure food and shelter to drafting simple legal documents and providing representation in complex litigation. Services include disseminating information about legal issues to older adults, services providers, groups discussions, and the media.
5. Supportive Housing: provides assistance in finding or sustaining housing to individuals receiving case management or care coordination services.
6. Supportive Employment: provides assistance to individuals in need of assistance with finding and/or retaining employment.

3. Context

3.1 Planning and Review process

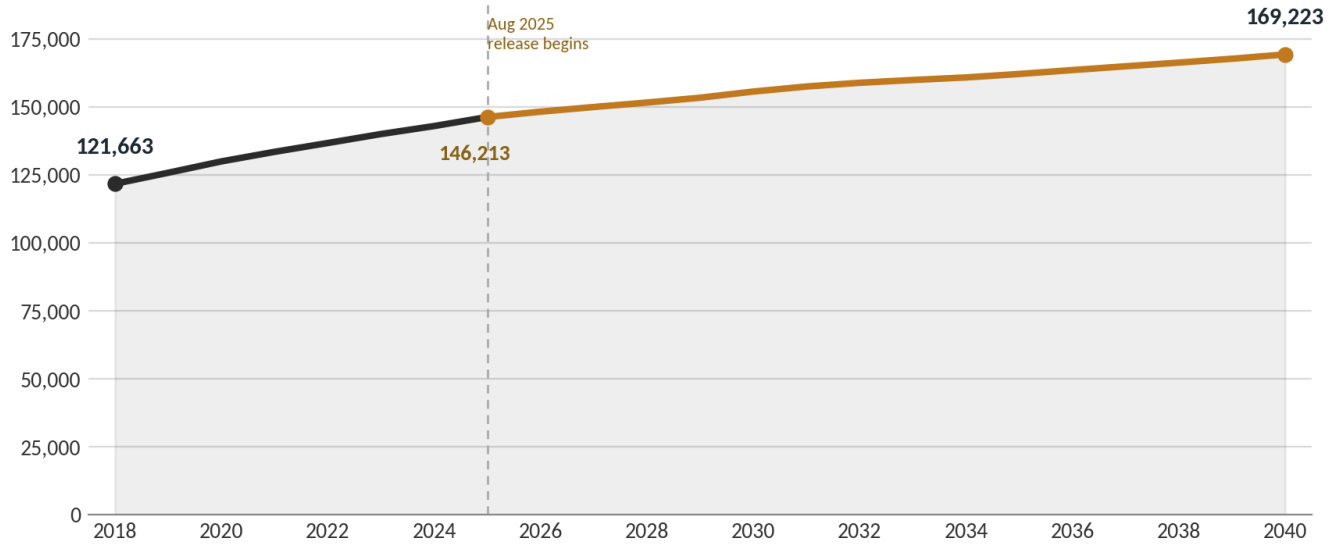
Initial research conducted early in the process and guidance from DSHS's Area Plan Instructions were used to create a survey that asked a variety of questions about the needs of our community. The Survey tool was made available via internet, in addition to paper copies for those preferring a hard copy.

Using survey responses and focus group sessions to gather data, feedback on the key issue areas was gathered, evaluated, and used to determine goals moving forward.

3.2 Demographics

Across Island, San Juan, Skagit, and Whatcom counties, the population aged 60 and older is projected to grow from 121,663 in 2018 to 156,699 by 2030, which is an increase of nearly 29% in just twelve years. This growth is not evenly distributed. Increasing demands for dementia care, disability supports, and culturally responsive services are rising faster than the older adult population overall, and some communities are aging faster than others.

Persons Aged 60+ across Island, San Juan, Skagit, and Whatcom Counties



+39.1%

Growth in the 60+ population, region-wide, 2018–2040

+54.25%

Growth in persons aged 65+ living with dementia, 2018-2040

+5.5%

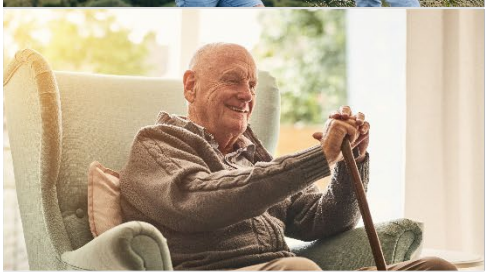
Growth in persons aged 60+ living with a disability, 2018-2040

Key Takeaways (2018-2030 Age Wave Data)

- Demographic shifts among older adults vary significantly across local counties. Whatcom is currently pacing toward the fastest growth at 34.5%, closely followed by Skagit at 31.8%. Island County follows at 17.8%, while San Juan anticipates a milder 13.1% increase.
- Dementia rates are rapidly outpacing this general growth. Projections show a 65% increase by 2040, a figure that highlights a pressing need to expand memory care programs and family caregiving resources immediately.
- Diversity within this age group is also shifting. The minority senior population is projected to rise by 59.7%, doubling the growth rate of the broader 60+ demographic. This reality requires service providers to shift toward culturally responsive care models.
- These concurrent trends will place intense pressure on long-term care systems. While demand will rise across the board, skilled nursing facilities face the steepest curve, with utilization expected to climb by 54.8%. This amplifies the need for expanded options in aging care.





About This Forecast

The following charts visualize the NWRC Age Wave population and aging-service utilization forecast for NWRC's four-county planning and service area: Island, San Juan, Skagit, and Whatcom counties. It draws on two datasets. The most current is Washington State's August 2025 Age Wave release, which projects population and service-need trends for the region through 2040. The second is NWRC's forecast from Department of Social and Health Services (DSHS) Research and Data Analysis Division (RDA), last updated July 16, 2019, which projects trends annually from 2018 through 2030 using ACS demographic data and Washington State service utilization data. This is the only version broken out by county, and it remains the source for the county-by-county charts later in the report.

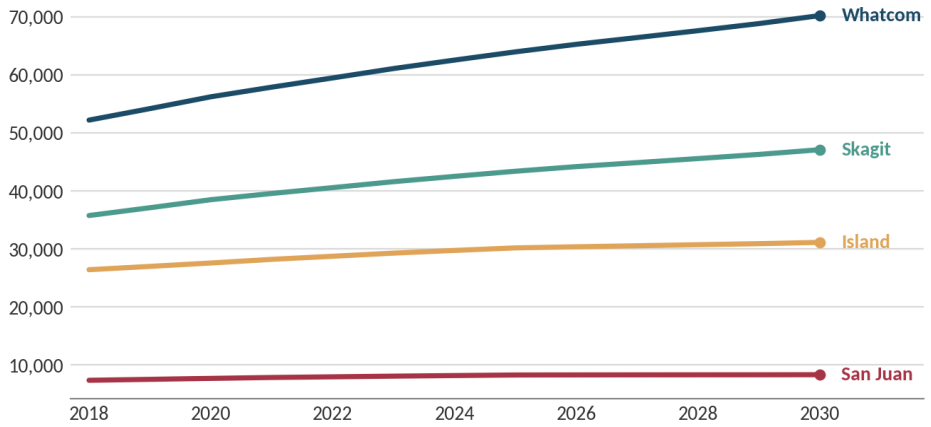
Metric	2025	2030	2040	% Change (2025–2040)
Population Aged 60 or Older	146,213	155,575	169,223	+15.7%
Aged 60+ at or Below 100% of the Federal Poverty Level	13,918	14,929	16,958	+21.8%
Aged 60+ at or Below the EESSI Income Threshold	25,142	26,847	29,361	+16.8%
Aged 60+ Identifying as a Person of Color	14,961	18,150	26,178	**+75.0%**
Aged 60+ at or Below 100% FPL and a Person of Color	1,883	2,226	2,929	**+55.6%**
Aged 60+ with Limited English Proficiency	2,031	2,237	2,585	+27.3%
Aged 60+, American Indian or Alaska Native	2,971	3,419	4,347	**+46.3%**
Aged 60+, American Indian or Alaska Native, and Living with a Disability	742	851	1,074	**+44.7%**
Aged 60+ Living with a Disability	22,305	23,822	26,130	+17.2%
Aged 18+ Living with a Disability	30,746	32,869	36,193	+17.7%
Aged 60+ with a Cognitive Impairment	10,213	10,945	12,097	+18.4%
Aged 18+ with a Cognitive Impairment	25,126	26,459	29,161	+16.1%
Aged 60+ with an IADL Limitation	13,994	14,969	16,442	+17.5%
Aged 18+ with an IADL Limitation	22,903	24,268	26,633	+16.3%
Aged 65+ Living with Dementia	7,922	9,859	13,370	**+68.8%**
Skilled Nursing Facility (SNF) Service Users	502	584	747	**+48.7%**
In-Home Service Users	2,767	2,965	3,344	+20.9%
Community Residential Service Users	898	1,001	1,206	+34.3%

Appendix A: DSHS Regional Outlook Detail *August 2025 Release, 2025–2040*

Population, Poverty & Diversity

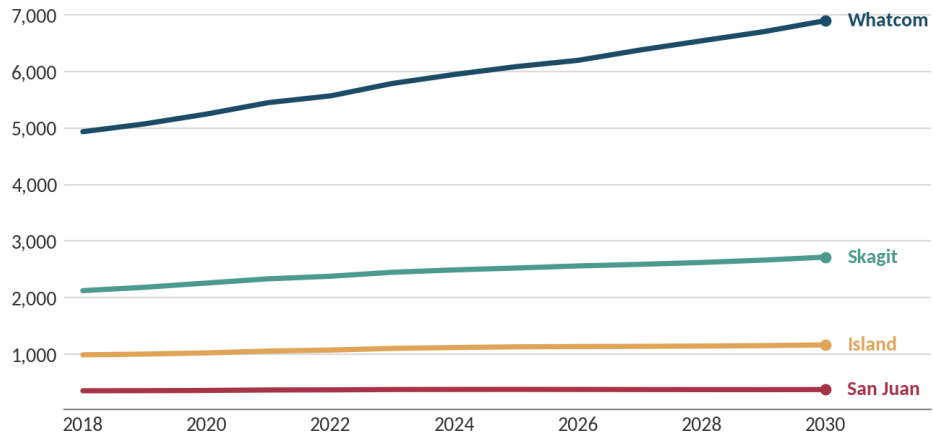
Older adult population growth, economic need, and demographic diversity are foundational to service planning. The charts below compare each county's trajectory for population size, poverty status, and diversity of the 60+ population. The charts below draw on our 2019 county-level forecast (2018–2030) and track each county's trajectory for population size, poverty status, and diversity.

Population Aged 60 or Older



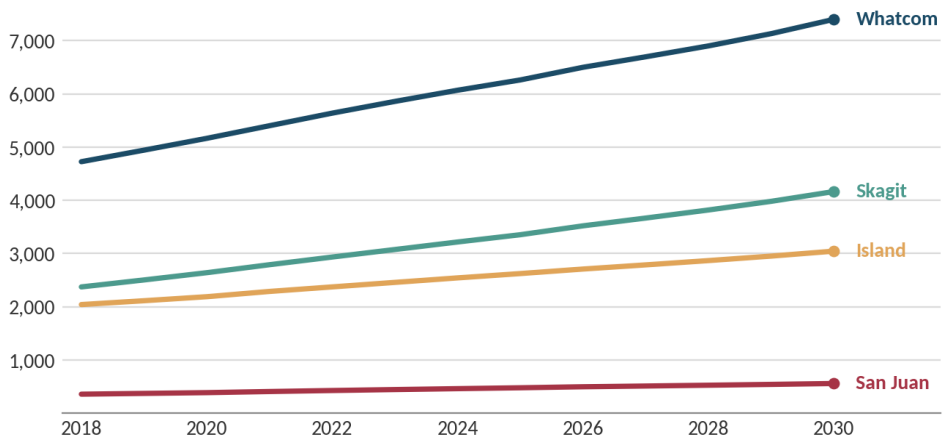
By 2030, the number of adults aged 60 and older in our region is projected to grow from about 122,000 to nearly 157,000, an increase of almost 29% in just over a decade.

Aged 60+ at or Below 100% of the Federal Poverty Level



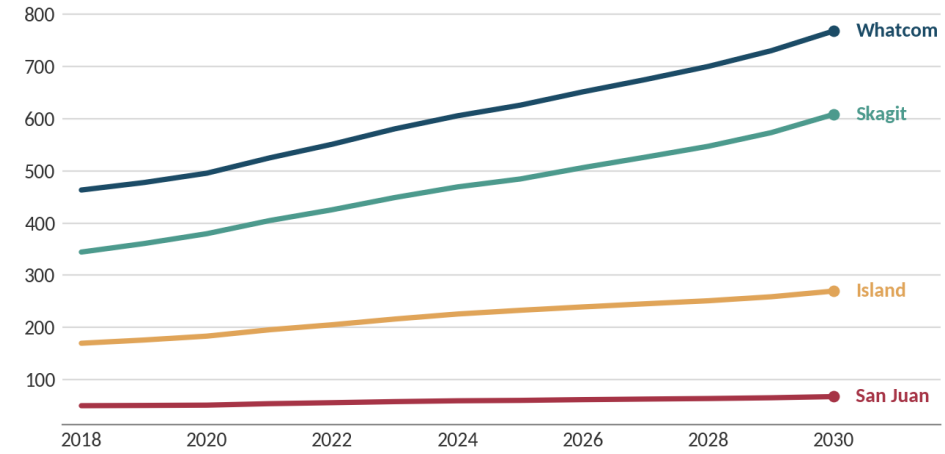
By 2030, the number of older adults in our region living at or below the federal poverty level is projected to grow from about 8,400 to more than 11,000, an increase of nearly 33% in just over a decade.

Aged 60+ Identifying as a Racial or Ethnic Minority



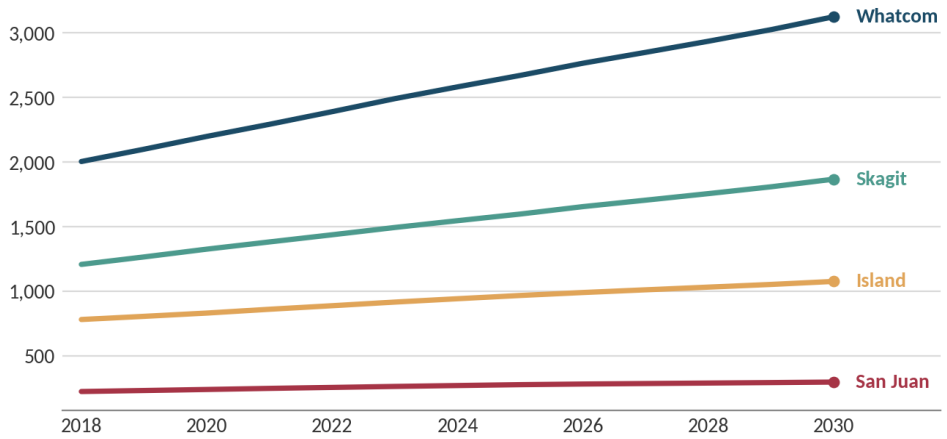
By 2030, the number of older adults in our region identifying as a racial or ethnic minority is projected to grow from about 9,500 to more than 15,000, an increase of nearly 60% in just over a decade.

Aged 60+ at or Below 100% FPL and a Racial or Ethnic Minority



By 2030, the number of older adults in our region who are both at or below the federal poverty level and identify as a racial or ethnic minority is projected to grow from about 1,000 to more than 1,700, an increase of nearly 67% in just over a decade.

Aged 60+ with Limited English Proficiency

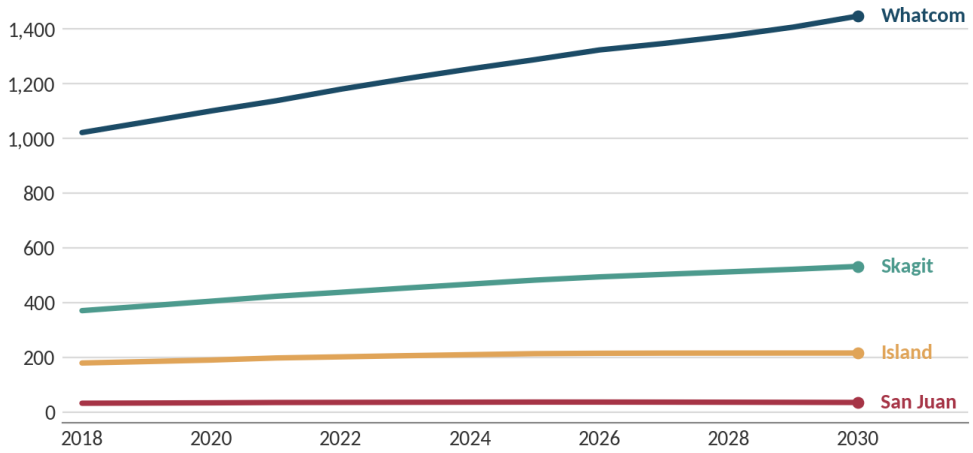


By 2030, the number of older adults in our region with limited English proficiency is projected to grow from about 4,200 to more than 6,300, an increase of about 51% in just over a decade.

American Indian & Alaska Native Population

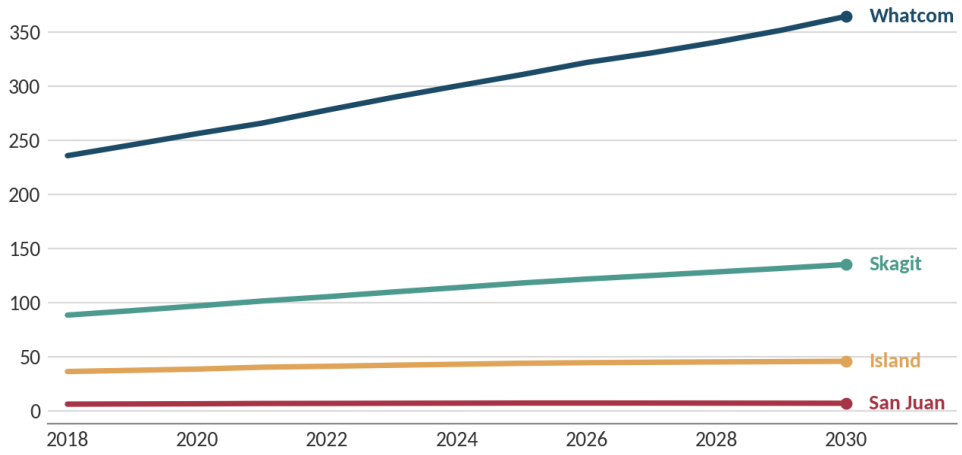
NWRC serves several Tribal communities across the region. The charts below track the American Indian/Alaska Native population aged 60 and older, and the subset living with a disability.

Aged 60+, American Indian or Alaska Native



By 2030, the number of older adults in our region who are American Indian or Alaska Native is projected to grow from about 1,600 to more than 2,200, an increase of about 39% in just over a decade.

Aged 60+, American Indian or Alaska Native, and Living with a Disability

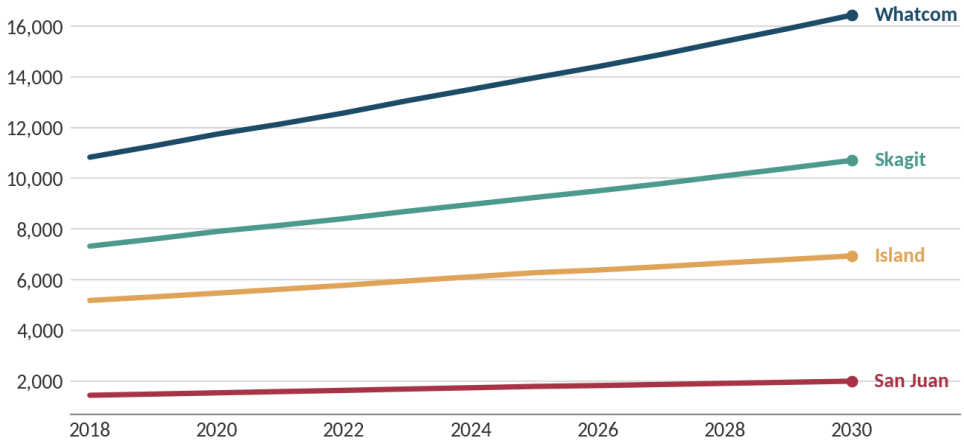


By 2030, the number of older adults in our region who are American Indian or Alaska Native and living with a disability is projected to grow from about 370 to more than 550, an increase of about 51% in just over a decade.

Disability & Functional Need

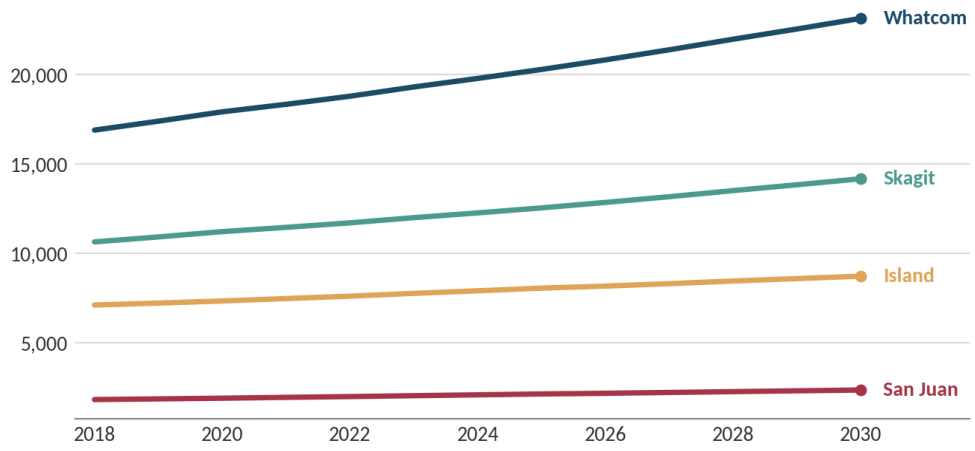
Disability, cognitive impairment, and limitations in instrumental activities of daily living (IADL) drive demand for case management, in-home support, and caregiver services. Each measure is shown for both the 60+ and 18+ populations where available.

Aged 60+ Living with a Disability



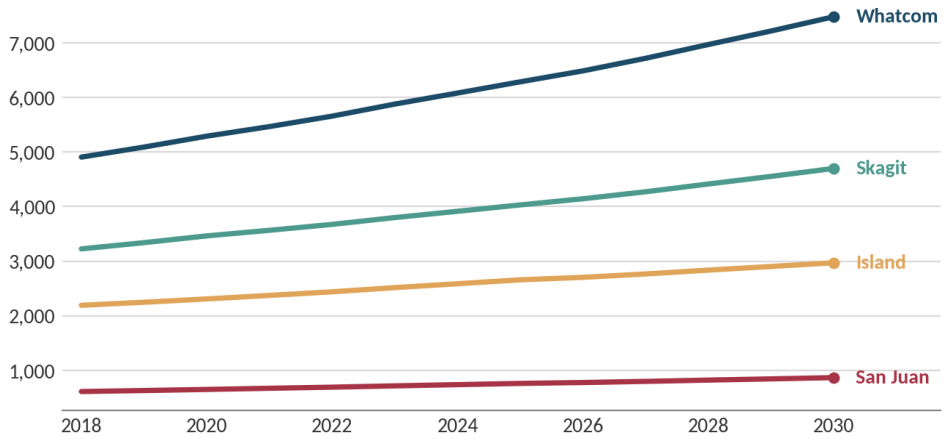
By 2030, the number of older adults in our region living with a disability is projected to grow from about 24,800 to more than 36,000, an increase of nearly 46% in just over a decade.

Aged 18+ Living with a Disability



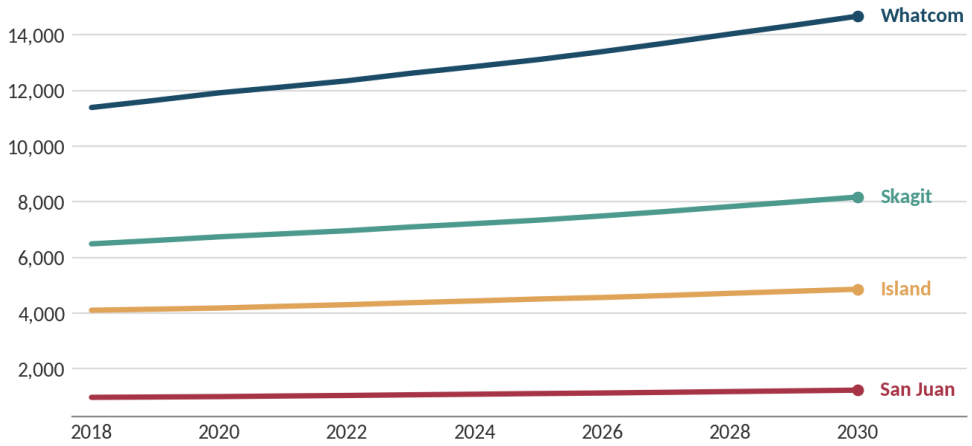
By 2030, the number of adults in our region living with a disability is projected to grow from about 36,500 to more than 48,000, an increase of nearly 33% in just over a decade.

Aged 60+ with Cognitive Impairment



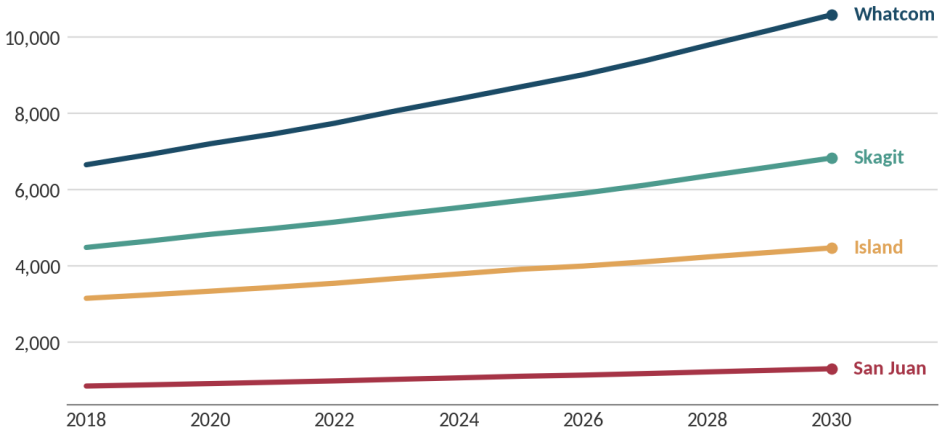
By 2030, the number of older adults in our region with cognitive impairment is projected to grow from about 10,900 to more than 16,000, an increase of nearly 47% in just over a decade.

Aged 18+ with Cognitive Impairment



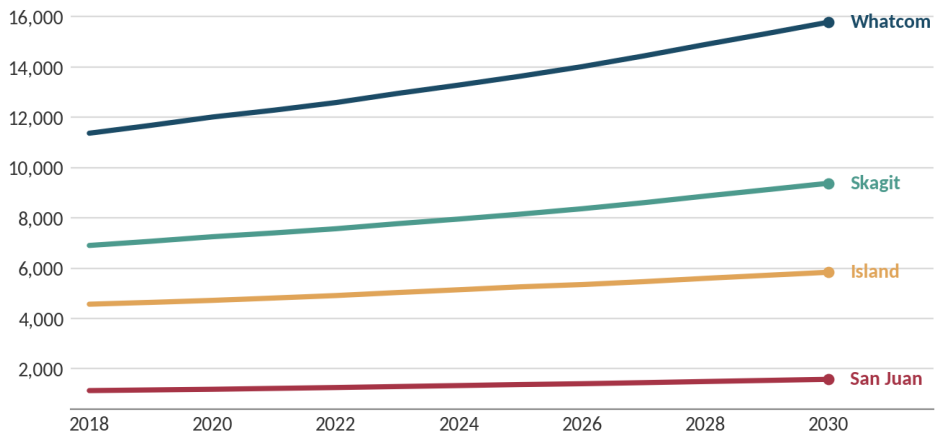
By 2030, the number of adults in our region with cognitive impairment is projected to grow from about 22,900 to nearly 29,000, an increase of about 26% in just over a decade.

Aged 60+ with an IADL Limitation



By 2030, the number of older adults in our region with an IADL limitation is projected to grow from about 15,200 to more than 23,000, an increase of about 53% in just over a decade.

Aged 18+ with an IADL Limitation

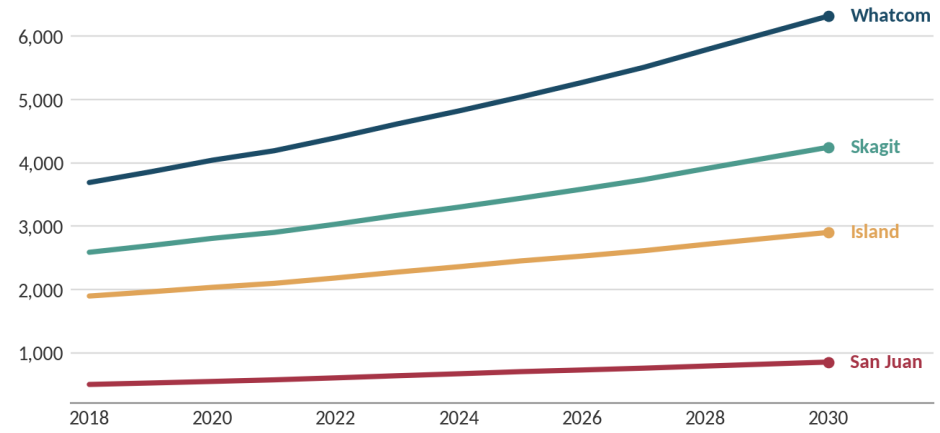


By 2030, the number of adults in our region with an IADL limitation is projected to grow from about 24,000 to nearly 32,600, an increase of about 36% in just over a decade.

Dementia

Dementia prevalence among adults 65 and older is the fastest-growing need identified in this forecast, with direct implications for memory care, respite, and family caregiver support programs.

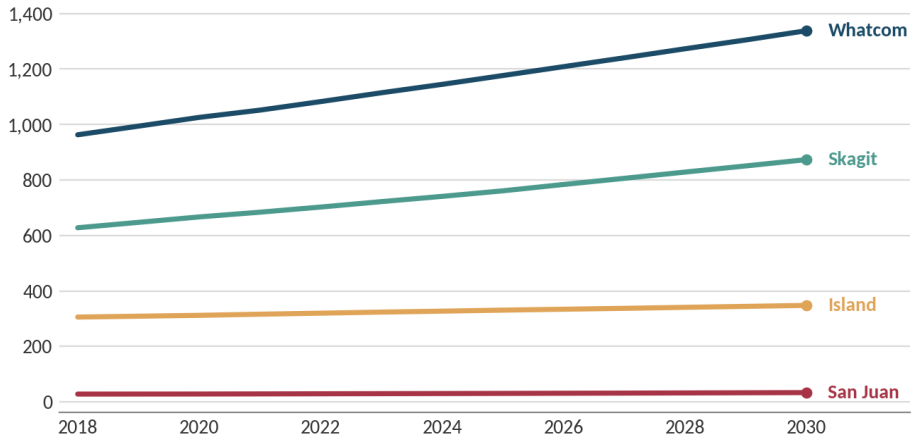
Aged 65+ Living with Dementia



By 2030, the number of older adults in our region living with dementia is projected to grow from about 8,700 to more than 14,300, an increase of about 65% in just over a decade.

Service Utilization

In-Home Service Users



By 2030, the number of people in our region using in-home services, support such as personal care, homemaking, and respite that allows older adults to remain in their own homes, is projected to grow from about 1,900 to nearly 2,600, an increase of about 35% in just over a decade.

Data Appendix

Full 2018 and 2030 values and percent change for every measure in this forecast, by area, are listed below. "Region Total" is the sum of Island, San Juan, Skagit, and Whatcom counties. The following table offers population specific information on various populations in need. The percentage-of-change column in each appendix highlights, in red, any population that changed by more than 40% over the span covered by the dataset, 2018 to 2030 for the county-level data, and 2025 to 2040 for the newest regional release.

Metric	Area	2018	2030	% Change
Population Aged 60 or Older	**Region**	121,663	156,699	+28.8%
Population Aged 60 or Older	Whatcom	52,176	70,192	+34.5%
Population Aged 60 or Older	Skagit	35,734	47,081	+31.8%
Population Aged 60 or Older	Island	26,402	31,113	+17.8%
Population Aged 60 or Older	San Juan	7,350	8,313	+13.1%
Aged 60+ at or Below 100% of the Federal Poverty Level	**Region**	8,407	11,160	+32.7%
Aged 60+ at or Below 100% of the Federal Poverty Level	Whatcom	4,935	6,898	+39.8%

Metric	Area	2018	2030	% Change
Aged 60+ at or Below 100% of the Federal Poverty Level	Skagit	2,126	2,719	+27.9%
Aged 60+ at or Below 100% of the Federal Poverty Level	Island	991	1,166	+17.7%
Aged 60+ at or Below 100% of the Federal Poverty Level	San Juan	356	377	+5.9%
Aged 60+ at or Below the EESSI Income Threshold	**Region**	21,752	29,527	+35.7%
Aged 60+ at or Below the EESSI Income Threshold	Whatcom	11,079	16,007	**+44.5%**
Aged 60+ at or Below the EESSI Income Threshold	Skagit	6,536	8,630	+32.0%
Aged 60+ at or Below the EESSI Income Threshold	Island	3,034	3,659	+20.6%
Aged 60+ at or Below the EESSI Income Threshold	San Juan	1,103	1,232	+11.6%
Aged 60+ Identifying as a Racial or Ethnic Minority	**Region**	9,495	15,166	**+59.7%**
Aged 60+ Identifying as a Racial or Ethnic Minority	Whatcom	4,725	7,400	**+56.6%**
Aged 60+ Identifying as a Racial or Ethnic Minority	Skagit	2,372	4,164	**+75.5%**
Aged 60+ Identifying as a Racial or Ethnic Minority	Island	2,041	3,045	**+49.2%**
Aged 60+ Identifying as a Racial or Ethnic Minority	San Juan	357	557	**+56.1%**
Aged 60+ at or Below 100% FPL and a Racial or Ethnic Minority	**Region**	1,028	1,714	**+66.7%**
Aged 60+ at or Below 100% FPL and a Racial or Ethnic Minority	Whatcom	463	768	**+65.8%**
Aged 60+ at or Below 100% FPL and a Racial or Ethnic Minority	Skagit	345	608	**+76.5%**
Aged 60+ at or Below 100% FPL and a Racial or Ethnic Minority	Island	170	270	**+58.8%**
Aged 60+ at or Below 100% FPL and a Racial or Ethnic Minority	San Juan	50	68	+34.6%
Aged 60+ with Limited English Proficiency	**Region**	4,213	6,363	**+51.0%**
Aged 60+ with Limited English Proficiency	Whatcom	2,004	3,125	**+56.0%**
Aged 60+ with Limited English Proficiency	Skagit	1,207	1,867	**+54.7%**
Aged 60+ with Limited English Proficiency	Island	780	1,075	+37.8%
Aged 60+ with Limited English Proficiency	San Juan	222	296	+33.0%
Aged 55+, American Indian or Alaska Native	**Region**	2,418	2,965	+22.6%
Aged 55+, American Indian or Alaska Native	Whatcom	1,331	1,757	+32.0%
Aged 55+, American Indian or Alaska Native	Skagit	707	825	+16.6%
Aged 55+, American Indian or Alaska Native	Island	314	324	+3.4%
Aged 55+, American Indian or Alaska Native	San Juan	66	59	-10.7%
Aged 60+, American Indian or Alaska Native	**Region**	1,602	2,229	+39.1%
Aged 60+, American Indian or Alaska Native	Whatcom	1,021	1,447	**+41.7%**
Aged 60+, American Indian or Alaska Native	Skagit	370	532	**+43.7%**

Metric	Area	2018	2030	% Change
Aged 60+, American Indian or Alaska Native	Island	179	215	+20.4%
Aged 60+, American Indian or Alaska Native	San Juan	32	35	+8.9%
Aged 60+, American Indian or Alaska Native, and Living with a Disability	**Region**	368	553	**+50.5%**
Aged 60+, American Indian or Alaska Native, and Living with a Disability	Whatcom	236	365	**+54.6%**
Aged 60+, American Indian or Alaska Native, and Living with a Disability	Skagit	89	135	**+52.7%**
Aged 60+, American Indian or Alaska Native, and Living with a Disability	Island	37	46	+25.8%
Aged 60+, American Indian or Alaska Native, and Living with a Disability	San Juan	6	7	+12.3%
Aged 60+ Living with a Disability	**Region**	24,756	36,066	**+45.7%**
Aged 60+ Living with a Disability	Whatcom	10,828	16,436	**+51.8%**
Aged 60+ Living with a Disability	Skagit	7,317	10,705	**+46.3%**
Aged 60+ Living with a Disability	Island	5,177	6,934	+33.9%
Aged 60+ Living with a Disability	San Juan	1,434	1,992	+38.8%
Aged 18+ Living with a Disability	**Region**	36,467	48,394	+32.7%
Aged 18+ Living with a Disability	Whatcom	16,888	23,135	+37.0%
Aged 18+ Living with a Disability	Skagit	10,640	14,170	+33.2%
Aged 18+ Living with a Disability	Island	7,112	8,727	+22.7%
Aged 18+ Living with a Disability	San Juan	1,828	2,362	+29.2%
Aged 60+ with a Cognitive Impairment	**Region**	10,936	16,018	**+46.5%**
Aged 60+ with a Cognitive Impairment	Whatcom	4,907	7,480	**+52.4%**
Aged 60+ with a Cognitive Impairment	Skagit	3,225	4,700	**+45.7%**
Aged 60+ with a Cognitive Impairment	Island	2,192	2,972	+35.6%
Aged 60+ with a Cognitive Impairment	San Juan	612	866	**+41.7%**
Aged 18+ with a Cognitive Impairment	**Region**	22,941	28,923	+26.1%
Aged 18+ with a Cognitive Impairment	Whatcom	11,387	14,672	+28.8%
Aged 18+ with a Cognitive Impairment	Skagit	6,486	8,169	+26.0%
Aged 18+ with a Cognitive Impairment	Island	4,100	4,855	+18.4%
Aged 18+ with a Cognitive Impairment	San Juan	968	1,227	+26.7%
Aged 60+ with an IADL Limitation	**Region**	15,155	23,203	**+53.1%**
Aged 60+ with an IADL Limitation	Whatcom	6,653	10,583	**+59.1%**
Aged 60+ with an IADL Limitation	Skagit	4,488	6,832	**+52.2%**
Aged 60+ with an IADL Limitation	Island	3,156	4,476	**+41.8%**

Metric	Area	2018	2030	% Change
Aged 60+ with an IADL Limitation	San Juan	858	1,311	+52.8%
Aged 18+ with an IADL Limitation	**Region**	23,969	32,581	+35.9%
Aged 18+ with an IADL Limitation	Whatcom	11,368	15,786	+38.9%
Aged 18+ with an IADL Limitation	Skagit	6,903	9,379	+35.9%
Aged 18+ with an IADL Limitation	Island	4,567	5,838	+27.8%
Aged 18+ with an IADL Limitation	San Juan	1,131	1,579	+39.7%
Aged 65+ Living with Dementia	**Region**	8,668	14,318	+65.2%
Aged 65+ Living with Dementia	Whatcom	3,688	6,319	+71.3%
Aged 65+ Living with Dementia	Skagit	2,586	4,246	+64.2%
Aged 65+ Living with Dementia	Island	1,895	2,901	+53.1%
Aged 65+ Living with Dementia	San Juan	498	852	+71.1%
Skilled Nursing Facility (SNF) Service Users	**Region**	642	993	+54.8%
Skilled Nursing Facility (SNF) Service Users	Whatcom	426	665	+56.2%
Skilled Nursing Facility (SNF) Service Users	Skagit	175	263	+50.6%
Skilled Nursing Facility (SNF) Service Users	Island	41	63	+55.3%
Skilled Nursing Facility (SNF) Service Users	San Juan	1	3	+162.2%
In-Home Service Users	**Region**	1,924	2,592	+34.7%
In-Home Service Users	Whatcom	963	1,338	+39.0%
In-Home Service Users	Skagit	628	873	+39.1%
In-Home Service Users	Island	306	348	+13.8%
In-Home Service Users	San Juan	28	34	+18.8%
Community Residential Service Users	**Region**	523	756	+44.6%
Community Residential Service Users	Whatcom	262	395	+50.7%
Community Residential Service Users	Skagit	178	251	+40.9%
Community Residential Service Users	Island	81	106	+31.7%
Community Residential Service Users	San Juan	2	4	+84.9%

3.3 Target Population: serving older adults in greatest social and economic need

Delivering vital services to older adults and people with disabilities across Whatcom, Skagit, Island, and San Juan Counties involves navigating severe environmental, financial, and digital barriers. These four counties face a rapidly aging population. The unique geography in this corner of the state creates many barriers providing continuous care.

Whatcom County

Whatcom County faces significant obstacles caring for its high-needs residents because its rugged, rural landscape makes travel long and expensive. Home-care aides and Meals on Wheels drivers struggle to reach isolated clients in the Cascade foothills, a problem made worse when winter storms, mountain snow, and lowland floods block roads and cut off power. Even when help arrives, older homes and public spaces rarely feature modern accessibility updates like ramps or roll-in showers. To make matters worse, high housing prices prevent specialized caregivers from living near the communities they serve.

Compounding these physical challenges is a massive gap in technology and medical infrastructure. Reliable internet drops off sharply outside urban centers, causing deep digital isolation for rural residents who need virtual services. Even when connection is available, video telehealth sessions cost too much for seniors living on fixed incomes. Ultimately, these issues create severe financial and logistical pressure, leading to provider shortages and a lack of long-term local care facilities that accept Medicaid. Without these local options, adults with high support needs are often forced to move away from their families to get the care they need.

Skagit County

Skagit County faces severe geographical and infrastructural hurdles, especially in its eastern regions where the landscape transitions into the rugged Cascade foothills. These vast, isolated distances make it incredibly difficult for residents to stay connected with their communities and maintain independent lives. Compounding this isolation is a critical shortage of accessible housing and public facilities, as many older buildings lack basic modifications like wheelchair ramps and roll-in showers. Furthermore, digital equity remains a major issue. High-speed broadband service drops off sharply outside urban centers, cutting off rural populations from modern telehealth and remote care coordination. Even where technology is available, many residents on fixed incomes face

financial and digital literacy hurdles that prevent them from participating in video-based medical visits.

Financially, the county has encountered steep structural deficits over the years. These constraints led to local government transitioning the Senior Nutrition program to a nonprofit operator. At the same time, care for older adults and individuals with disabilities is stretched to its limits. Skyrocketing real estate costs have priced out professional caregivers, exacerbating a broader shortage of medical staff. Because very few local long-term care facilities accept Medicaid, vulnerable adults are frequently forced to relocate to entirely different regions away from their families. All these systemic issues peak during seasonal emergencies, when winter storms and lowland floods routinely wash out rural roads. These events leave homebound individuals trapped without electricity or access to physical emergency aid.

Island County

Island County operates under distinct geographic and environmental constraints, where unique island topology creates structural barriers to delivering continuous healthcare services. The local built environment features an aging housing infrastructure that lacks modern accessibility modifications, preventing older adults and individuals with disabilities from living independently without undergoing prohibitive renovation costs. Furthermore, high-speed internet infrastructure remains unevenly distributed across the region, creating a digital divide that limits access to critical telehealth services for isolated rural residents who cannot afford high-bandwidth data plans on fixed incomes. Service delivery is under critical strain due to a contracting regional healthcare framework and a severe shortage of credentialed medical professionals. In affluent submarkets like Whidbey Island, high local housing costs worsen this staffing deficit by preventing specialized caregivers from residing near the clients they serve. Compounding these challenges, the absence of local long-term care facilities accepting Medicaid forces high-needs adults to relocate outside the county, effectively cutting them off from established family and community support networks. Finally, regular emergency conditions, such as severe winter storms and lowland flooding, frequently compromise local transportation lines, shutting down rural roadways and leaving vulnerable individuals entirely isolated without power or access to direct medical assistance.

San Juan County

San Juan County faces tough logistical challenges because living on islands means everything depends on ferry schedules. A missed boat or a weather cancellation can directly delay life-saving medical care. The area also lacks senior-friendly and accessible housing or public spaces, which limits mobility for a rapidly aging population. High-speed internet is hard to come by, leaving only about 41% of residents with fixed broadband. This digital gap isolates people who rely on virtual services to connect with the outside world. Without enough bandwidth, and living on fixed incomes, many residents cannot use video-based telehealth or remote mental health services. On top of that, a high cost of living and expensive housing price out paid caregivers, making the local worker shortage even worse. Because the county has no local long-term care facilities that accept Medicaid, adults who need intense daily help are often forced to move to other regions completely away from their families. Finally, during severe winter storms and extreme weather, the county becomes completely cut off when canceled ferries stop mainland travel and local flooding blocks roads, trapping homebound residents without power or any way to get help.

Access to healthcare for older adults and people with disabilities in Whatcom, Skagit, Island, and San Juan Counties is in a state of critical strain. Regional healthcare infrastructure is contracting, leaving vulnerable populations to navigate severe provider shortages, soaring costs, and vanishing local choices. Every county in Washington state is now designated at least partially as a health professional shortage area.

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4. Goals, Objectives, Strategies, and Outcomes

Key Issue Areas

4.1 Greatest Social Need and Greatest Economic Need

The Northwest Regional Council (NWRC) provides essential services to older adults and people with disabilities facing severe financial hardship or social isolation. To comply with federal guidelines (45 CFR 1321.3), we prioritize individuals dealing with low income, minimal savings, or life challenges that threaten their safety and independence. By focusing on these critical needs, we ensure our resources go directly to the community members who need them most to stay safe, self-reliant, and connected.

NWRC serves the community's most vulnerable populations. Priority is given to low-income older adults, individuals with disabilities, and vulnerable underserved populations. Focused support also goes to people living with dementia, their caregivers, and adults at risk of institutionalization. Additionally, the programming reaches rural seniors and older individuals who are navigating complicated health systems that inherently present barriers to connecting with the best quality care that is available. More broadly, these comprehensive services are open to any adult aged 60 and older, as well as anyone with or caring for a person with a disability.

Goal: To ensure everyone gets the help they need, we focus our outreach and services on individuals facing the greatest social and economic hardships. We work closely with community partners to coordinate care and deliver support directly to those who need it most. By actively removing confusing obstacles and making our programs easier to understand, we help people navigate our system with confidence and dignity.

- **Objective***: NWRC staff will continue to identify the most effective strategies for informing and connecting with those in the community who need these services. NWRC staff will*

continue to prioritize successful events and continue to broaden offerings as they become available.

- **Strategy:** NWRC will use community feedback to find out exactly where help is needed most, continue attendance at our most popular events, and carefully roll out new services as they become available.

Outcome: Clients in need will get the exact care they need through our growing network of community support and direct outreach.

Social Isolation continues to be a national, and local public health threat. The region is facing a rapidly aging demographic, with some areas home to the oldest populations in the state. In San Juan County, for instance, over 34% of residents are 65 or older, which is more than double the statewide average of roughly 16%. This demographic shift significantly increases the number of people at risk for age-related isolation. Compounding this issue is the high number of seniors living alone, which accounts for roughly 28% to 32% of the older population across the NWRC service region. The Washington Department of Social and Health Services recognizes living alone as a primary indicator for severe social isolation. Furthermore, disability rates add another layer of vulnerability to the community. While about 11% to 13% of residents under 65 live with a disability, that figure spikes to over 30% for those over 65. Physical and cognitive challenges restrict community mobility, which intensifies feelings of isolation among neighbors.

Goal: *Address social isolation as a societal issue that affects many community members in our four-county region, especially vulnerable older adults, and persons with disabilities.*

- **Objective:** To continue addressing social isolation as it impacts our clients and community at large.
  - **Strategy:**
    - Educate staff on warning signs for social isolation and learn about the programs available to help people reconnect.
    - Work with community members and partners to develop programs that address social isolation in individual communities, and the region.

Outcomes: NWRC will track and assist with the development of 1 social isolation program per year.

References:

Poverty Facts: The population of Poverty USA. https://www.povertyusa.org/facts

Social Isolation in Washington State. Department of Health. https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/socialisolation/HCS_IsolationPaper_UPDATED_5.7.2021.pdf

4.2 Healthy Aging Older Americans Act (OAA) Core Programs

Many indicators in Washington State point to a Home and Community Based Service infrastructure that ranks higher in the nation for supporting aging in place. While that notion is supported in national data sets, there is still disparity in population. In the state of Washington approximately 85% of adults aged 65 and older live with at least one chronic illness, with conditions like arthritis, heart disease, cancer, and diabetes heavily impacting the rapidly growing older demographic. This high prevalence places a major strain on caregivers and state long-term services as the aging population continues to expand.

In Washington state, managing multiple chronic health conditions simultaneously is a widespread challenge that escalates significantly with age. While roughly 15% of all adults across the state live with three or more concurrent diagnoses (such as arthritis, diabetes, and heart disease) the burden is unevenly distributed across different stages of life.

The prevalence breaks down distinctly across age groups:

- **Ages 18 to 44:** Multiple chronic conditions are relatively rare in young adulthood, affecting about 6% of this population. In these cases, the data typically reflects a combination of mental health conditions alongside a physical ailments.
- **Ages 45 to 64:** The rate increases sharply to approximately 20% in midlife. This is the period when cardiovascular, metabolic, and joint issues frequently begin to intersect.
- **Ages 65 and Older:** Older adults experience the highest concentration of illness, with between 62% and 78% of older Washingtonians navigating multiple chronic diagnoses at the same time.

The aging process becomes especially difficult when failing health collides with an insufficient support system, often making it impossible to live independently at home. What starts as gradual physical decline can quickly turn into a medical crisis. Combined with rising housing costs and a lack of local resources, many older adults are left incredibly vulnerable.

Goal: *Continue providing information and referral assistance through our Aging and Disability Resources (ADR) Program, expanding where funding allows.*

- **Objective:** To maximize opportunities to educate, connect and provide services to those in need of services to remain independent in the community.
    - **Strategy:** Continue offering assistance at successful community events and to evaluate new options for connecting with those in need.

Outcome: NWRC will continue to spread awareness the helpful information and services available through the ADR Program.

Goal: *Continue efforts to fully participate in advocacy efforts in partnership with W4A to ensure we are doing all we can to secure as much funding as possible for our community.*

- **Objective:** To prioritize advocacy for OAA programs.
    - **Strategy:**
        - Continue building a community of aging and disability advocates who will contribute to Advocacy efforts in their homes and communities.
        - Visit Senior Advocacy Day in Olympia with representation from the Northwest Senior Services Advisory Board (NWSSB).

Outcomes: NWRC will commit fully to the continued funding of valuable services funded by the Older Americans Act, allowing more older adults and persons with disabilities to remain independent in their homes and communities.

Goal: *Strengthen and maintain existing nutritional infrastructure by continuing with current meal offerings and pursuing additional offerings as funding allows.*

- **Objective:** Assist in building new partnerships and connecting existing service providers to address gaps in the current nutritional infrastructure system.
    - **Strategy:** Remain aware and available to partners when funding challenges arise, assisting when possible.

Outcome: Contracted nutritional providers across the region will continue offering nutritional services and find new avenues for supplemental funding challenges occurring in their respective communities.

Health Promotion and Falls Prevention Debilitating falls for persons over the age of 65 are a serious threat to remaining independent and aging in place through elderhood. Falls

account for 57% of all injury-related deaths for adults 65+ across the state. In the North Sound Region of the state, which includes PSA 2 and Snohomish County, Hospital and emergency data indicate a consistent baseline where roughly 31% of older adults report experiencing a fall each year.

Goal: *Stay committed to the growth of falls prevention programming in the region.*

- **Objective:** Increase offerings by contributing to efforts with community partners to build up infrastructure for future growth.
    - **Strategy:** Continue contributing to existing Falls Prevention Coalition and encourage smaller counties to take measures to address this growing public health concern.

Outcome: Falls prevention programming will grow and become more available to the community.

Goal: *Provide programs that encourage healthy lifestyle changes that can delay or potentially prevent the onset of dementia and/or the progression of the disease process.*

- **Objective:** Continue expanding offerings in multiple settings and modalities, with the intent of providing general education for residents of all ages.
    - **Strategy:** Continue expanding upon existing educational programming and remain focused on exploring new opportunities to provide new services, or partnerships for program delivery.

Outcome: Over the next 4 years, new brain health and healthy lifestyle programs will be created and gain momentum in the community.

References:

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https://www.ncoa.org/article/the-top-10-most-common-chronic-conditions-in-older-adults/

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Falls in Washington State 2020, Washington Department of Health. https://doh.wa.gov/you-and-your-family/injury-and-violence-prevention/older-adult-falls/falls-washington

4.3 Expanding Access to Home and Community-Based Services (HCBS): Addressing Services that Support Aging in Place

Most Americans want to stay in their own homes as they age. A recent 2025 survey showed that 84% of people over 50 perceive 'aging in place' as a top priority, with well over half calling it deeply important to them.

Washington residents face challenges as its aging population accelerates rapidly and most of the older adult population strives to age at home with community support. Currently, about one in ten Washingtonians is over the age of 65. By the year 2050, the number of those over the age of 85 is projected to be one in four. This rapid demographic shift is putting immense pressure on available resources, especially as the caregiver ratio shrinks. State metrics show a critical tightening of human resources, with Washington now having only about thirty-six working-age adults available for every senior aged 85 or older. Compounding this labor shortage is a major financial gap for older adults living on fixed incomes amidst rising costs. The average Social Security benefit in the state is roughly $1800 per month, making it increasingly difficult for seniors to secure age-appropriate housing. As a direct result of these financial strains, older adults have become the fastest-growing segment of the homeless population.

Goal: *Provide person-centered in-home Long-Term Services and Supports (LTSS) that are well integrated with the healthcare services for older adults and people with disabilities to allow them to remain as independent, healthy, and safe as possible.*

- **Objective:** Optimize independent living, safety, and health outcomes for older adults and individuals with disabilities by delivering person-centered in-home that seamlessly integrate with their clinical healthcare services.
  - **Strategy:** Work to continue bridging the gap between healthcare providers and community social services through shared communication tools and joint care managers, ensuring clients get coordinated support that keeps them safe at home.

Outcome: NWRC will continue to provide LTSS to all those in need, increasing quality of life for individuals and their support networks.

Goal: *Provide person centered coordination of health and community support for people who face significant health challenges, including behavioral health and substance use, in a manner that improves their health and reduces avoidable healthcare costs.*

- **Objective:** Help high needs clients better healthcare and connect with community services that break down barriers to receiving quality care.
  - **Strategy**: Empower high-need clients to access quality healthcare and community resources by removing systemic barriers, building trust, and delivering personalized, wraparound support that drives long-term health equity and stability.

Outcome: Clients will acheive better health and stability through a smooth, open network of care.

Goal: *Represent the interests of families, consumers, and providers in shaping access to, the scope, quality, and availability of services, and the consumer protections that will be essential to delivery of services, including those delivered through the WA Cares Fund Program.*

- **Objective:** NWRC is committed to protecting the interests of families, consumers, and providers under the WA Cares Fund, ensuring the program delivers safe, reliable, and high-quality care across the region.

- **Strategy:** NWRC will stay connected with beneficiaries and providers to advocate for stronger consumer protections, while streamlining provider onboarding and delivering clear public outreach to ensure everyone can easily access their WA Cares benefits.

Outcome: The WA Cares Program beneficiaries will have easy access to high-quality care, a robust network of well-supported providers that will meet regional demand, and strong consumer protections safeguard every participant.

Goal: *Continue offering Non-Emergency Medicaid Transportation to our region and expand to other payer sources as funding allows.*

- **Objective:** To maintain consistent service excellence and operational stability through sustained collaboration with the HCA.
- **Objective:** Continue to search for innovative opportunities or partnerships that could lead to additional funding sources for regional transportation options.
  - **Strategy:** Maintain structured partnerships and balance operational compliance with proactive risk management.

Outcome: NEMT Services will remain stable and grow to meet the transportation demands of the region.

References:

Older adults want to 'age in place,' but their options are limited in most states. Washington State Standard. https://washingtonstatestandard.com/2023/11/02/older-adults-want-to-age-in-place-but-their-options-are-limited-in-most-states/

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Pew Research Organization: https://www.pewresearch.org/short-reads/2026/02/26/most-older-adults-who-live-at-home-want-to-age-in-place-but-they-arent-entirely-confident-theyll-get-to/

4.4 Caregiving: Enhancing Services and Supports for Caregivers

Washington has 1.25 million family caregivers who bring an estimated **$25 billion** in estimated economic value to the state. It is well-documented that family caregivers face

challenges including finding work/life balance, financial strain, caregiver stress, and compromised health leading to increased likelihood of chronic illness and mortality.

Caregivers are **family members or friends** who typically provide **unpaid, long-term**, community-based care and assistance to older adults and people with chronic health conditions or disabilities**.** Caregivers help with a variety of routine tasks such as shopping, paying bills, bathing, dressing, and managing medicines. They are often a source of emotional support and companionship for care recipients.

Family Caregiver profile:

- 61% of caregivers are women.
- 42% of adult family caregivers are 65 years or older.
- Caregivers on average provide 27 hours of care per week.
- 57% of caregivers provide high-intensity care.
- They routinely assist with meal preparation, chores, medical appointment management, daily dressing, and bathing.
- Nearly half of caregivers experience financial strain, affecting personal savings, food budgets, and ability to manage household finances.
- Family caregivers spend an average of $7,000 annually out of pocket, which equates to 26% of their total income.
- Over 70% of working-age caregivers continue to work outside of the home and often disrupt their own schedules and opportunities for advancement and lose retirement savings.

NWRC Family Caregiver Support Offerings:

Family Caregiver Support Program (FCSP) This program provides access to a range of supports tailored to the individual caregiver's strengths and needs. This includes information and assistance referrals, caregiver education, respite services as available, support group referrals, assistive device provision, and other services as needed. FCSP provides a spectrum of support for all stages of caregiving and services are distributed throughout the four-county region.

Goal: *Continue offering services through the Family Caregiver Program and expand when additional funds become available.*

- **Objective 1:** Continue providing essential services needed by growing family caregiver population, with expansion of the program as funds allow.

- **Objective 2:** Assist family caregivers to provide as much care as possible, for as long as possible.
    - **Strategy:** NWRC will continue to maintain and expand family caregiver support throughout the region using state and federal resources.

Outcome: Family Caregivers will find support at NWRC that reduces caregiver stress, improves quality of care, and enhances their relationship with their care recipient.

MAC/TSOA Dyad program NWRC offers this unique support system for aging residents and their loved ones through its **Medicaid Alternative Care (MAC)** and **Tailored Supports for Older Adults (TSOA)** programs. These programs help adults who are at least fifty-five years old continue living independently in their own homes instead of moving into a nursing facility. While they share the same goal of offering helpful resources like respite care, housekeeping, and specialized medical equipment, they target different financial situations. The MAC program serves individuals who already qualify for Medicaid but chose not to enroll in traditional long-term services, while the TSOA program helps those who are not financially eligible for Medicaid but still need an extra layer of assistance to stay stable at home. By offering training, support groups, and a much-needed break for unpaid family caregivers, NWRC is working to reduce caregiver burnout and delay the need for more costly institutional care.

Goal: *NWRC will continue offering MAC/TSOA Dyad Program and expand as funding allows.*

- **Objective:** Remain strategic in planning and program operation by exploring all alternatives to keep program available to the community.
    - **Strategy:** Program leadership will continue to work with State to explore opportunities to keep this program available.

Outcome: The MAC/TSOA Dyad Program will continue to operate in coming years.

Dementia Support Program NWRC is one of three specially funded Dementia Support Programs in the State of Washington. The catalyst funding started in 2021 and the program continues to receive maintenance funding. This program makes an impact on the community by working with new and emerging partners in all four counties. These partnerships have led to the regional growth of the Dementia Friends Program, the opening of a dementia community center in Whatcom County's shopping mall, expansion of early-stage programming, and individual counseling and support to a growing number of persons and their families impacted by brain change.

Goal: *To provide dementia specific community education that reduces stigma and fosters growth of new dementia friendly services in the region, while also providing assistance in the development of those programs.*

- **Objective:** Provide dementia friendly education, services, and training to existing and regional partners, planting seeds for future growth of programs and services.
    - **Strategy:** Continue with current Building Dementia Capable Communities (BDCC) activities in the community and expand to new areas as able with additional funding.

Outcome: Dementia Friendly programs will consistently grow over the next four years, and our area will be recognized as a dementia friendly region.

Goal: *Provide specialized support for people and families with planning, care consultation, connection to resources and long-term planning.*

- **Objective:** To provide needed supports and services that will allow the person and their family to age in the community for as long as possible.
    - **Strategy:** Have dedicated staff time devoted to responding to calls and requests for individual care consultation and follow-up.

Outcome: Continue providing the same number of consultations and client interactions, while working to add staff and capacity for additional care consultations.

Goal: *Provide Evidenced-Based interventions, including the STAR-C program, to help persons with dementia and their families remain in their setting of choice for as long as possible.*

- **Objective:** Continue offering STAR-C Caregiver education program, and Montreal Cognitive Assessment Screenings (MoCA).
    - **Strategy**: Contribute to the momentum of the STAR-C program maintenance and growth with existing staff who can contribute to training and dissemination of program materials.

Outcome: Evidenced-Based Program offerings will continue to increase as the growth of these programs is prioritized in the next four years.

Goal: *To continue fostering growth of new dementia friendly services in the region and provide assistance in the growth and development of those programs.*

- **Objective:** Use lessons learned from previously successful dementia program growth (Amy's Place with Dementia Support NW) and assist with the development of new supportive programs for caregivers and their families.
    - **Strategy:**
        - Continue existing work at Amy's Place and work on growing that model nationally in collaboration with Dementia Support NW.
        - Create tool kits for existing programs that become shelf-ready for existing and future community partners.

Outcomes: Dementia Friendly support programs will continue to flourish in our region and those receiving support will grow with the expected population increase in the future.

References:

AARP Caregiving in the US 2025: October 2025. https://www.caregivingintheus.org/wp-content/uploads/2026/01/caregiving-in-the-us-2025-washington.doi_.10.26419-2fppi.00383.032.pdf

AARP Public Policy Institute: Valuing the Invaluable 2026. https://www.aarp.org/pri/topics/ltss/family-caregiving/valuing-the-invaluable-2026-update/

John A Hartford Foundation National Alliance for Caregiving 2025 Report and Data Hub: https://www.johnahartford.org/resources/view/national-alliance-for-caregiving-caregiving-in-the-us-2025-report

The Caregiving Landscape: Data and insights on the caregiver Experience in the U.S. https://www.caregiveraction.org/caregiver-statistics/

Alzheimer's and Public Health Action in Washington: https://www.alz.org/professionals/public-health/state-overview/washington

4.5 Planning with Native American Tribes and Tribal Organizations (7.01 Plan)

Policy 7.01 Plan and Progress Report for Area Agencies on Aging (AAAs)

Timeframe: July 1, 2026 to June 30, 2027

Administration/Division: ALTSA/HCS **Region/Office: Region 2 North/Northwest Regional Council** **Tribe(s)/RAIO(s): Lummi, Nooksack, Upper Skagit, Sauk-Suiattle, Samish, Swinomish**

Annual Due Date: April 2 (Submit Regional Plan to the Assistant Secretary) and April 30 (submit Assistant Secretary Plan to OIP).

Implementation Plan				Progress Report
(1) Goals/ Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff**	**(5) Status Update for the Fiscal Year Starting last July 1.**
1. Continue to provide Tribal Outreach Assistance services.	a. Continue to visit each tribe at least three times per year, in person. Update as of 7/27/26- meetings are being set up regularly with our tribal program specialist b. Hold meetings with tribal groups to discuss elder issues at least once annually and as requested. Update as of 7/27/26- Stacy and Joanna have met with service providers and other groups, Joanna is going to luncheons c. Expand activities in this area through grants available.	a. Enhanced access to needed service for tribal elders. b. Increased collaboration with local tribes and community partners to assure appropriate services.	Stacy Malone-Miller Tribal Program Specialist (Joanna Hanson)	**Services are prioritized to be offered in person, by phone, or video conference.**
2. NWRC solicits and organizes annual listening sessions with Tribal Leadership	a. Visit each tribe at least once annually for a listening session.	a. Enhance communication and collaboration with all 6 tribes.	Amanda McDade Stacy Malone-Miller Katie Durbec	**Amanda McDade visited with Lummi, Swinomish, Samish and the NWSSB Tribal Representative in early 2026 to conduct listening sessions. Efforts to meet with Sauk-Suiattle, Upper Skagit and Nooksack are continuing.** Update as of 7/27/26- Amanda was able to meet with Sauk-Suiattle Tribal specialist will continue to meet with tribes but will pull NWRC leadership into these meetings when appropriate

Policy 7.01 Plan and Progress Report for Area Agencies on Aging (AAAs) **Timeframe: July 1, 2026 to June 30, 2027**				
3. Continue to provide technical assistance to local tribes for planning and coordination	a. Work with local tribes to develop plans for to identify sources of funds for addressing the needs for long term services and supports. b. Continue to work with tribal staff to collaborate and coordinate services and resources to best serve the elderly community.	a. Development of tribally-owned and operated services on those reservations that choose to participate.	Amanda McDade Stacy Malone-Miller Ryan Blackwell	**Staff continue to provide information to tribes. We will continue to support tribes in their efforts to develop LTSS and operate them in their own community.** **Lummi Nation and Nooksack have become Medicaid Health Homes Care Coordination Organizations and NWRC continues to provide technical assistance as we continue to grow these programs.**
4. Establish contracts with local tribes for Medicaid LTSS services so that they can provide client training, skilled nursing, and environmental modifications for their tribal members who need them.	a. Develop agreements. b. Provide technical assistance for using them. c. Work with tribes and case managers to assure that all understand the use of the services and how to access them.	a. Increased use of Medicaid LTSS services by Tribal members. b. Provide resources to Tribes to pay for services to their own members.	Ryan Blackwell	**Contracts have not been widely utilized and staff continues to work with tribes and case management staff to facilitate the use of the services.**
5. Maintain billing agreements with local tribes for Medicaid Transportation services.	a. Develop agreements b. Provide technical assistance for using them. c. Work with tribes to assure that all eligible trips are billed d. Bill Non-Emergency Medical Transportation (NEMT) for Tribal Trips.	a. Increased use of Medicaid Transportation by Tribal members. c. Provide resources to Tribes to pay for Medicaid transportation to their own members	Aly Horry Shu-Ling Sun	**Contracts are in place with Lummi, Nooksack, Sauk-Suiattle, Stillaguamish, Swinomish, and Upper Skagit Tribes. Programs have been successfully implemented in each area and tribes are receiving reimbursement. Continued technical assistance is provided to keep tribes informed about changes in the program due to budget cuts as well as training new staff and administrators about the service.**

Policy 7.01 Plan and Progress Report for Area Agencies on Aging (AAAs) **Timeframe: July 1, 2026 to June 30, 2027**				
5. Continue to provide tribal support to assist Case Management and Care Coordination staff in region.	a. Participation in Tribal clients' assessments, annual review, and financial eligibility reviews. b. Consultation and training with case managers related to issues for tribal elders. c. Provide an identified In-Home Case Manager and Care Coordinator for tribal members in Whatcom & Skagit County.	a. Enhanced assessment for elders and appropriate services.	Amanda McDade Stacy Malone-Miller Amy Atticus Tribal Program Specialist	**NWRC has In-Home Case Managers, and a Health Home Care Coordinator who are the primary staff for Tribal members in our region.** (Brenda Perkins, April Hynlynski, and Maria Orloff take on many tribal programs) **Tribal Programs Specialist is making connections with tribal elders and staff to build trust and rapport to effectively conduct home visits and provide services and resources that enhance the quality of life for the elderly.** Joanna to shadow a case management home visit
6. Provide Medicare program training and technical assistance for local tribes.	a. Presentations at each Elders' Center. b. Assist with enrollment along with Shiba volunteers	a. Elders will enroll in Medicare Part D programs.	Aging and Disability Resources Staff Tribal Program Specialist Stacy Malone-Miller	**NWRC continues to provide assistance with applications for Medicare parts B and D as requested. Presentations have been made to clinic and elder staff as requested to ensure that the clinics understand the programs and the application process.** Joanna to take the Medicare 101 training in august and working with Tim to plan for open enrolment in October
7. Provide cultural awareness training for NWRC and contractor staff.	a. Continue to address cultural awareness in staff orientation. b. Annual training for NWRC. c. Training for contractors when suggested by tribes or requested by contractors.	a. Increased cultural competency when working with Tribal Elders and their families.	Stacy Malone-Miller Tribal Program Specialist	**NWRC staff have participated in both in person and virtual/webinar trainings to increase cultural competencies and overall understanding of working with indigenous communities.**
8. Include Tribal representation on the Northwest Senior Services Board (NWSSB)	a. Continue to have tribal members on the NWSSB to provide input to local aging programs, policy development, and decision-making.	a. Enhanced communication and collaboration through NWSSB members and local tribes.	Amanda McDade Bethany Chamberlin	**We currently have a tribal representative on the NWSSB.**

Policy 7.01 Plan and Progress Report for Area Agencies on Aging (AAAs) **Timeframe: July 1, 2026 to June 30, 2027**				
9. Participate with DSHS Regional Administrators, Tribal Representatives, OIP staff, and Snohomish County AAA in Region 3 in quarterly Regional Tribal Coordinating Council (RTCC) meetings.	a. Meetings are held quarterly and NWRC staff attends regularly. b. Develop agenda items for trainings, which may occur outside of the RTCC meetings (adult family home, tribal orientation meetings for DSHS divisions, cultural competency). c. Bring meeting information to tribes that did not attend.	a. Better communication with Tribal Elders. b. Enhanced access to services in the region. c. Fewer missteps for non-tribal staff working with Tribal Elders.	Tribal Program Specialist Stacy Malone-Miller	**Meetings continue to be an excellent environment to share ideas, resources, and solve problems for all attendees. This is a model program and has now been used as a best practice and model for programs implemented in other areas of the state.**
10. Work with local tribes to create a plan to transition Wisdom Warriors Program to tribal leadership.	a. Continue discussions with the tribes around their desire for Wisdom Warriors and locate local facilitators. b. Work with clinic personnel and elders programs to offer classes about medication management, nutrition, caregiver support, and CDSME (Pain and Chronic Illness) c. Train lay leaders to provide services under the NWRC licensure.	a. Enhanced well-being for Tribal elders.	Amanda McDade Bethany Chamberlin	**Staff are working the Wisdom Warriors project to promote healthy living and management of chronic illnesses with tribal elders.** **These classes are also available in other communities upon request.** ***CDSME = Chronic Disease Self-Management Education**
11. Offer culturally tailored dementia caregiving education to tribes in region.	a. Conduct Savvy Caregiver in Indian Country training and/or workshops b. New tribal program specialist will become MoCA certified and conduct cognitive assessments for tribal elders. a. c. Tribal Program Specialist will complete the Dementia Friends sessions to help promote dementia friendly communities and awareness in tribal communities.	a. Enhanced access to dementia specific services in the region.	Stacy Malone-Miller Tribal Program Specialist	Update as of 7/27/26- Joanna is now MOCA certified and currently working on Dementia Friends- will take the training with Kate and Kelsey Will look into savvy caregiver training

5. Appendix A: Emergency Response Plan

In Progress

6. Appendix B: Advisory Council

MEMBER	COUNTY	OFFICE
Georgiann Dustin	Whatcom County	Chair
Laura Castro-Benzing	Whatcom County	
George Edward	Whatcom County	
Jana Finkbonner	Whatcom County	
Vacant	Whatcom County	
Vacant	Whatcom County	
Vacant	Whatcom County	
Vacant	Whatcom County	
Vacant	Whatcom County	
Mike Shaw	Skagit County	
Morgan Hendricks	Skagit County	
Carl Bender	Skagit County	Vice-Chair
Vacant	Skagit County	
Vacant	Skagit County	
Vacant	Skagit County	
Mary Kanter	Island County	
Grethe Cammermeyer	Island County	
Shirley Bennett	Island County	
Kathryn Beaumont	Island County	
Lucretia Devine	San Juan County	
Gail Leschine-Seitz	San Juan County	
Stephen Schubert	San Juan County	

At-Large Members: Elected Official appointed by Northwest Regional Council

- Jennifer Lautenbach (Everson City Council)

Total Active Membership	**15**
Members age 60 or over	11
Minority members	1
Self-indicating a Disability	3
Self-indicated a Disability under age 60	0

7. Appendix C: Planning and Public Review Process

The planning process used during the creation of this document included the following:

Research on Specific Issue Areas: March – May - June

NWRC staff researched key issue areas for development of the plan, including issue profiles and objectives, incorporating recent state legislative topics, the efforts of local community partners, Washington State's Plan on Aging, the work of the Bree Collaborative, and the Health Care Authority's Plan for a Healthier Washington.

NWSSB and Northwest Regional Council: July – September

NWRC staff drafted this plan based on guidance and information compiled throughout the process from the public, community partners, the NWSSB, and the NWRC Governing Board. The local Tribes in our region also provided input and assisted in developing our local Policy 7.01 Plan.

- NWRC Governing Board Meetings: December
- NWSSB Advisory Meetings: July, September & November
- NWRC Management/Department Head Team Meetings: April - September
- Survey dissemination: June-July
- NWRC Staff Planning Sessions: June – July
    a. In-person/virtual Skagit located teams – June
    b. In-person/virtual Whatcom located teams – July
    c. Online open hours – June - August
- NWRC Equity Committee: July
- Key Informant Discussions:
    a. Aging Well Whatcom Initiative May - September
    b. Island County Commissioners Work Session – July
    c. Skagit County – May, June
    d. San Juan County - June
- Public Sharing: August - September
- Draft Plan Circulated for Public Comment – August - September

Public Comment Sessions:

- August 20th
- September 10th

Final Plan Completed: September – November 2026

The NWSSB reviewed the draft version and offered input at the September 10, 2026 meeting. The NWSSB voted to approve the draft version and will review and take action on the updated version of the plan at the scheduled November 2026 meeting.

Final Action December 2026

Based on NWSSB recommendation, the 2027–2030 Plan will go before the Northwest Regional Council Governing Board at their December 5, 2026 meeting for final action.

8. Appendix D: Report on Accomplishments from the 2024-2027 Area Plan

In progress

9. Appendix E: Statement of Assurances and Verification of Intent

In progress