

REPORT ON ACCOMPLISHMENTS FROM THE 2008-2011 AREA PLAN

Family Caregivers & Kinship Caregivers

Goal:

To raise the level of awareness of caregiving in the Kitsap community at large and develop a continuum of support options for caregivers, and especially the underserved in ethnic minority groups, older individuals with greatest economic need, greatest social need, or disabilities, low-income minority older individuals, older individuals with limited English proficiency and older individuals residing in rural areas, and to assess the needs of and provide resources and supports for the growing populations of family and kinship caregivers in Kitsap County.

Objective:

Completed

Accomplishments:

By:

1. Respite authorizations around memory care; continue to seek to identify and develop an expanded array of primary and supplemental caregiver support services and information to assist both current and emerging caregiver populations, especially older individuals with greatest economic need, greatest social need, or disabilities, low-income minority older individuals, older individuals with limited English proficiency and older individuals residing in rural areas. Conduct a minimum of three planning meetings to study the

- Participated in planning meetings and activities with the Alzheimer's Association
 - Contact with Snohomish AAA regarding contract for Care Connections dementia consultant occurred in spring/summer of 2009 in coordination with grant outreach activities
 - Authorized Safe Return as a supplemental services through FCSP
 - Respite options were donated by local memory care facilities for caregivers to attend the December Caregiver Conference.
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a. Caregiving-related critical stress and the need, and viable options, for emergency relief as measured by:

- Minutes and recommended action(s) from coordination meeting(s) with mental health and other relevant providers
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- Changes in ability to authorize respite in emergencies is outlined in new TCARE management bulletins. These considerations were in no small part related to advocacy of Kitsap's FCSP staff and others involved in T-CARE's primary roll-out.
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b. The need for additional support group resources for topic-focused groups to address emerging caregiver challenges as identified through Caregiver Support Center and other gatekeeper entities as measured by:

- Minutes and recommended action(s) from coordination meeting(s) with health care, disease-specific and caregiver support groups
- Coordinated efforts at meetings – presentations to groups

■ Attempted to gain additional dollars and supports through pursuit of a Weinberg Foundation Grant. Specific areas included additional support group resources and funding for Powerful Tools. Although the grant was not awarded one major goal was attained: training of two staff in the Powerful Tools for Caregivers Class and implementation of the project. Kitsap County held the first 6-week seminar series April 21st through May 26th of 2009.

■ Presentations and/or materials were provided to the following support groups or organizations: Early Stage Memory Loss Seminar Series (2), ALS (1), Cancer Lifeline (1), Visual Impairment Support Group (3), CAPRI (12) across Bremerton, Poulsbo and Port Orchard groups.

■ Acquired TBI resources for the caregiver support library, to share with local support groups and to have available as a staff training resource.

c. Dementia/disease/age-specific out-of-home day services as respite care. Develop service options as feasible as measured by:

- Minutes and recommended action(s) from coordination meeting(s) with health care,
- Alzheimer's Association, Adult Day health, social day services and caregiver support groups

■ Held collaboration meeting with the Alzheimer's Association to express interest in bringing the care consultation model "Care Connections" to Kitsap as an in-home option since it had only been offered as a phone service. Although the grant was not funded, in 2008, the in-home service was provided to Kitsap members for a short period.

■ Out-of-home respite options were offered during the 2008 Caregiver Conference.

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2. Maintain support for caregiver training through participation in and/or sponsorship of a regional caregiver training conference and local training opportunities on as needed basis. Conduct a minimum of one community-wide education or training event annually as measured by:

- Schedule of caregiver education and/or training events)
- Special efforts and outreach to include caregivers in target populations

- Caregiver Conference in December 2008 held in South Kitsap as the last few years have been in North and Central Kitsap, in an effort to diversify audience participation and offer an option to reduce travel for South Kitsap caregivers.
- Caregiver Support information was featured also at the 2008 Annual Diabetes Health Fair sponsored by the Fil-Am Charities foundation. This event was held in November of 2008 in Silverdale.

3. Develop and implement a Caregiver Support-specific, local Internet page – links to documents/sites as measured by:

- Caregiver Support Web page

- The caregiver support brochures and program overview are completed on the website. We have not yet designed a page with specific links although the Where to Turn resource guide posted online has links to services.

4. Continue reach out to the business and professional communities to provide information to employees regarding caregiver support services. Conduct a minimum of two business and professional presentations or participation in events targeting that demographic annually as measured by:

- Schedule of presentations

- The 2008 Kitsap County Employee health fair featured information on caregiver support programs for county employee access.
- The 2009 Kitsap County Volunteer Appreciation event did so for other departments, staff, and volunteers.
- Events attempting to target the demographic included: Kitsap Computing Seniors, Military Saves Event at Bangor, Westound Women's Show, and the Health & Safety Fair in Bremerton.

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5. Increase outreach and coordination activities on behalf of elder ethnic minority populations, Native American Tribes and other target populations to provide adequate information about, and access to, caregiver support services, while assuring recognition and respect for ethnic and cultural diversity in caregiver support activities. Conduct a minimum of six coordination meetings. Increase caregiver support services to minority and/or tribal Elders as measured by:

- Records of meetings with Tribes, minority organizations, and other relevant stakeholders.
- Client tracking records, presentation/outreach tracking
- Develop project timeline

6. Maintain and expand outreach to the medical community to educate physicians and other health care providers of the need to more readily identify family caregivers in an effort to link them to Family Caregiver Support services. Increase physician and other healthcare referrals for patient-related caregiver support services as measured by:

- Client tracking records
- Meeting/outreach minutes; tracking

- Coordination meetings w/Fil-Am charities (3) in 2008. Co-sponsored the 2008 Fil-Am Charities Annual Diabetes Wellness Fair.
- Participated in (1) phone meeting and at least 1 in-person meeting with Gwendolyn Shepard (NACCP) around health disparities issues across all populations with a focus on program outreach and collaboration.
- Participated in the Cancer Lifeline Event held in Suquamish.
- Participated as a vendor at the Suquamish Tribe Health Fair and provided a vendor table at the June 2008 Medication Management Event at Kiana Lodge for the Suquamish Tribe.
- Collaborated with Port Gamble S'klallam to encourage attendance at the 2008 event as well.

- Ongoing coordination with PCHS marking and outreach liason re: collaborative outreach efforts and referrals across programs and services.
 - Leadership Kitsap at Harrison Hospital, staffed round-table discussion for all participants and had a booth.
 - AAA staff presented an inservice to the Gentiva Home Health team in 2009.
 - Participated in the 2008 and 2009 Westound Women's Show held by the Soroptomist of Greater Bremerton and attended by private-practitioners. Materials provided about programs on-site.
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7. Provide assistance with the development and maintenance of family and kinship caregiver support groups particularly to those most in need and unable to access current resources as measured by:

- Partner to develop one family caregiver support group annually
- Meeting minutes

■ Powerful Tools for Caregivers was launched as a new offering in Kitsap in 2009.

■ Two separate Alzheimer's Association Early Stage Memory Loss support groups were supported with staff facilitation in 2008 and 2009.

■ AAA staff provided outreach to the following support groups:

Alzheimer's Caregiver Support Group, Harrison Annex
ALS Support Group
Alzheimer's Association ongoing support group
VIP Support Group

8. Participate in the development of a statewide caregiver assessment tool as measured by:

- Records of relevant trainings/meetings

■ TCARE Policy Team representation by supervisor of the FCSP program. TCARE trainer in policy.

■ Participated in MB review

■ FCSP Respite CM completing training as "Train the Trainer" for Kitsap for application, screening and assessment.

9. Support community collaboration for Adult Day Services in North Kitsap and continued availability and easily accessible services as measured by:

- Meeting minutes, presentations

■ Advisory Council supported funding of ADS in Kitsap Co as per W4A Legislative Priorities

■ FCSP CM participated in the open house for the new BI site.

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10. Coordinate with interested parties to increase outreach to target populations for family and kinship caregiver services including API mealsites; Health Clinic EL Centro in Bremerton, Safe Return and coordination with Alzheimer's Association as measured by:

- Meeting minutes
- Schedule of outreach presentations

11. Advocate for kinship caregiver support and services by applying for kinship navigator funds/projects as measured by:

- Development and submission of proposal to request kinship navigator project funds

12. Continue funding and promotion of Adult Day Services, counseling and consultation for family and kinship caregivers as measured by:

- Continued funding of counseling/consultation services for family caregivers
- Continued provision of short-term counseling to kinship caregiver program participants

■ Outreach completed to API mealsite in Port Orchard, Fil-Am Charities foundation health fair in 2008. El Centro lost funding so is no longer a viable outreach.

■ Planned outreach in fall of 2009 to Foster Grandparents program, to be coordinated with Bill Tracy, program manager.

■ Information on ALTC programs provided to ESML and Powerful Tools participants.

■ Completed and submitted grant application with letters of support for The Kinship Navigator Program funded through Aging and Disability Services (ADSA). Only 1.5 programs were funded statewide, we were notified 08/08 that Kitsap was not awarded at this time.

■ Participation in Kinship Navigator surveys and conference calls.

■ Letter of Support for Children's Home Society Kinship Navigator Program submitted

■ Phone introduction w/LCSNW Program Coordinator regarding exploration of using the Foster Parent model with informal caregivers.

■ KMHS 2008 - clients = 11, hours served = 34.50

■ KMHS Jan-Jun, 2009 - clients = 12, hours served = 29

Information & Assistance Services and Aging & Disability Resource Centers (ADRCs)

Goal:

To assure that older adults, other persons with long term care needs, and families and community members have access to the information and assistance they need to enable elders to continue to live in the community as independently as they are able and to identify program strengths, challenges and needs for transitioning to ADRC.

Objective:

Completed By:

Accomplishments:

1. Improve consumers' access to long term care information:

- a. Maintain and expand the Kitsap County Senior I&A Internet Web Site as measured by:
- Operational Kitsap I&A web-site
 - Review and suggestions by users

- ALTC website coordination moved to Planning & Evaluation unit
- ALTC website operational, with program information, resources and links
- ALTC website promoted at Older Americans Month Conference and Kitsap County Fair & Stampede

b. Develop a computerized information-and-referral database as measured by:

- Operational database
- Utilize "Contact Us" in online referrals

- Information & Referral database is available on the network. This needs continuous updating.
 - Information on inaccuracies on 211 searchable website are provided to 211 staff.
 - An online contact referral form was developed and added to website. E-mail referral distribution designed to refer inquires to assigned intake specialists on a rotation schedule.
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2. Continue ongoing coordination with other Kitsap Information and Referral networks; maintain the BenefitsCheckup program with regular resource updates as issued; conduct/participate in annual community meetings to educate and inform local residents about WIN2-1-1 as measured by:

- Schedule of I&R Coordination meetings
- Current Kitsap BenefitsCheckup listings
- Schedule of WIN2-1-1 (Washington Information Network) Information meetings
- Schedule ADRC (Aging & Disability Resource Center) information and planning meetings upon program launch

- Participation in Kitsap Information & Referral Network Meetings (approx 6 per year)
- Participation in Provider Breakfast Meetings (11 per year)
- Participation in WIN211 meetings
- 211 Cards provided as part of outreach events and in mailings
- ADRC has not been funded for Kitsap County

3. Continue to strengthen and improve visibility of Senior and Information Assistance/Aging & Disability Resource Center as the primary entry point for the local Senior Services system. Conduct a minimum of 10 Outreach presentations annually as measured by:

- Visible, linked Internet presence
- Updated I&A outreach materials
- Records of outreach presentations

- Participation in Kitsap Information & Referral Network Meetings (approx 6 per year)
 - Participation in Provider Breakfast Meetings (11 per year)
 - Participation in WIN211 meetings
 - "Where to Turn" updated in October 2008.
 - Older Americans Tab updated in May 2008 and May 2009.
 - Reprinted ads in Senior Resource Guides for 2008 and 2009 in addition to updates/corrections to AAA listings.
 - The goal of 10 outreach activities per year was exceeded in 2008, with participate in more than 30 outreach activities. To date in 2009 we have participated in 25 various community outreach activities.
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4. Facilitate partnerships and increase coordination with community resources (i.e., ethnic cultural centers, faith communities, community centers, employers, non-profit organizations and associations), which may be appropriate alternative points of referral or serve as gatekeepers for consumers. Conduct a minimum of one coordination meeting with a different community partner annually as measured by:

- Schedule of coordination meetings and public events hosted or attended

- Faith Community outreach to Silverdale Baptist Seniors group, and volunteer outreach to Crista Shores, Evergreen Lutheran, Crossroads, Central Kitsap Presbyterian, and Central Valley Neighbors
- Training presentation provided to the BISCC/AIP volunteer/board that was also open to board members and staff of the Interfaith Volunteer Caregivers
- Coordinated with Kitsap Mall and LTC Ombudsman program to link local business donations of presents to needy seniors.
- 2008-2009-Partnered with Soroptimist of Port Orchard to launch a program to link low-income women seniors in South Kitsap to assistance offered through Soroptimist
- Presentation provided to the Friends of Givens-Senior Center
- Additional collaboration meetings and community outreach events including with the Continuum of Care Coalition were held between 2008-2009

5. Training of staff on under 60 population and disability specific topics as measured by:

- Schedule of Trainings

- Hearing Loss Association of Washington: Hearing Services & Adaptive Devices
- Homesharing program
- 211/Crisis Clinic
- Crime Victims Assistance Center
- Veteran's Assistance

6. Provide Senior Drug Education DVD as an educational tool within the community as measured by:

- Records of meetings/presentations
- Distribution of DVD

- Distribution at 2008 Caregiver Conference
 - Placement at Caregiver Support Center Library
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In-Home Services

Goal:

Maintain the quality of case management services to senior and disabled populations while working towards continuous improvement in the delivery of services to home care clients.

Objective:

Maintain the quality of case management services to senior and disabled populations while working towards continuous improvement in the delivery of services to home care clients.

Completed Accomplishments:

By:

1. Continue to advocate for a) increased funding for Medicaid case management programs, b) greater client responsibility, c) more resources for chronic care case management, and d) increased resources to fill service and support gaps for clients as measured by:

- Advisory Council meeting minutes
- AC Legislative Committee minutes
- Correspondence to legislators, ADSA

■Continued to promote increased funding for Medicaid case management program, greater client responsibility, more resources for chronic care case management, and increased resources to fill service and support gaps primarily through W4A legislative advocacy, participation in Senior Lobby activities, and facilitation of a local legislative forum.

■Advisory Council members also actively advocate for appropriate levels of public funding by contacting their state legislators and their congressional representatives.

2. Recruit qualified employees and provide on-going training to meet client demographics as measured by:

- Monitor changing demographics of population
- Provide staff training to improve service delivery to clients as demographics change

■Although turnover agency-wide continues to be very low, DALTC recently hired one new clinical employee in the I&A unit and two new clinical employees in the Medicaid Case Management unit.

■Providing formal, paid training outside of our agency has been challenging due to fiscal issues. However, whenever possible, we continue to provide training in-house on a variety of topics.

3. Review and implement applicable recommendations from the Client Satisfaction Survey as measured by:

- Client Satisfaction Surveys received
- Records of staff meetings

■ALTC continues to send Client Satisfaction Surveys to I&A and to Medicaid clients. Medicaid Case Management has implemented a new process to ensure timely review of Client Satisfaction Surveys and distribution of survey findings.

■Administrator to review survey distribution process with I&A Supervisor to determine if any modifications are required.

4. Continue to identify gaps in services or types of support needed in relation to clients with primary care issues related to mental health, chemical dependency, or traumatic brain injury as measured by:

- Advisory Council meeting minutes
- Correspondence with other agencies and providers
- Area Plan Updates, including survey results

■Service/support gap identification continues to occur on an ad hoc basis - typically service/support gaps are identified when a Medicaid or I&A client presents with treatment needs that can not be appropriately met in the community.

■A formal group was assembled to address the need for a local geropsych facility. Although this need remains a significant one in our community, a local provider is working on a large proposal that would address much of it.

5. Continue to review the Division for accessibility to clients, families and providers as measured by:

- Review of office floor plan for accessibility
- Review emergency exit plans and signage

■Accessibility of the Division was enhanced recently by designating the Medicaid Case Management copy room as an "as needed" counseling/meeting room for drop-in I&A clients.

■This has reduced the distance an elderly and/or disabled client may have to walk in order to meet with an I&A worker.

■Office floor plans have been reviewed for accessibility and have been deemed suitable. Emergency exit plans/signage have been reviewed and have been deemed sufficient.

6. Improve and standardize practices for RNs regarding particular client issues as measured by:

- Records of staff meetings

■RN practices have been improved and standardized most significantly by enhancing Administrative oversight of all Skin Observation Protocol referrals.

Healthy Aging

Goal:

Continue to promote equity and resources for older adults to access mental health and dental care.

Objective:

Completed By:

Accomplishments:

1. Advocate for implementation of depression screening and treatment services using a mental health delivery model focused on older adults and partnerships as measured by:

- Depression Screening Workgroup meeting minutes
- Records of meetings with partner agencies

- Informational article on depression, along with a screening tool, was submitted by the workgroup and published in the Kitsap Sun Older Americans Month pull-out section.
 - “Home Safety for Seniors” Poulsbo Walmart-materials promoting access to services
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2. Improve knowledge of importance and advocate for improved access to and prevention of dental disease in older adults in Kitsap County as measured by:

- Senior I&A outreach schedule
 - Support dental health workshop opportunities
 - Participate in regional forums, workgroups and/or training
 - Record of participation in oral health coalition meetings
 - Advisory Council meeting minutes
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- SmilePartners presented to Advisory Council
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Older Native Americans

Goal:

To maintain and increase coordination, identify and eliminate barriers, and i culture and heritage of the people of the two Tribes in Kitsap County.

Objective:

Completed By:

1. Continue to offer technical assistance, advocacy and increased outreach to both Tribes and American Indians, Native Alaskans and Canadian Indians residing off the reservations. Conduct a minimum of four (4) I&A and Caregiver Support presentations to each tribe and assist with the development and maintenance of a caregiver support group as measured by:

- Schedule of I&A/Caregiver Support Outreach

2. Seek to locate and participate in opportunities to enhance the health status of Indian communities. Provide specifically targeted outreach activities such as participation in the annual S'Klallam Tribal Health Fair as measured by:

- I&A Event Activity Records
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3. Seek to establish joint planning and coordination around Family Caregiver Support issues, especially to study the need for Kinship Care support for Elders raising grandchildren. Conduct a minimum of three (3) coordination meetings. Increase caregiver support services to minority and/or tribal Elders by 10% (also an Objective for Caregiver Support) as measured by:

- Records of meetings with Tribes, and other relevant stakeholders.
- Client tracking records

4. Continue efforts to negotiate a contract with the Port Gamble S'Klallam Tribe that preserves the government-to-government relationship of the Tribes with federal, state and county partners and that complies with the requirements of Kitsap County and the Department of Social and Health Services specifically in keeping with the standards for congregate nutrition and such other services as may be provided as measured by:

- Records of meetings with Tribes, and other relevant stakeholders.

5. Continue efforts to develop a Memorandum of Agreement between the Port Gamble S'Klallam Tribe and the Kitsap County Division of Aging and Long Term Care services as measured by:

- Records of meetings with Tribes, and other relevant stakeholders.
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6. Work with Kitsap Transit and other relevant stakeholders to review the needs for increased public transportation access in North Kitsap County including to and from the reservations as measured by:

- Records of meetings with Kitsap Transit, and other relevant stakeholders.

increase access to services that recognize the value of the rich

Accomplishments:

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- Participated in Suquamish Tribe Health Fair
 - Tribes invited to Medication Management Events in 2008 and 2009 as vendors and participants. The Suquamish Tribe had a table at the Kiana Lodge Medication Management event.
 - In our work as a SHIBA sponsor, we are partnering with the OIC around their work with the Suquamish Tribe Health Benefits Coordinator regarding SHIBA training for their staff.

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- Medication Management information and pill boxes have been provided to the nursing and clinical staff at the Port Gamble S'Klallam clinic for distribution to elders caregivers, and persons with disabilities.
 - Drop off of the resources has been coordinated between I & A and the LTCU Medicaid CM.
 - Medication Management Conference being hosted by the S'klallam Tribe October 19, 2009.
 - Newly revised Nutrition Risk Assessment Survey incorporating diabetes-specific statements available to S'klallam and Suquamish Tribes in October 2009.
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Congregate Meals:

- Port Gamble S'Klallam Tribe 2008: clients = 131, meals = 5,233
- Port Gamble S'Klallam Tribe Jan-Jun 2009: clients = 102, meals = 2,514
- 2008: 48% of clients between 60 and 74; 31% over 75; 21% under 60; 84% of clients are tribal minorities; 2.3% Asian and African American; 11.4% Caucasian

Kinship Caregiver:

- 2008 clients = 68

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- This contract was successfully executed by all parties in April 2009

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- Is an on-going need to be completed by 12/2011
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■ALTC staff person attends Kitsap Transit Transportation Issues for the Elderly & Disabled quarterly meetings (T.I.E.D); efforts to recruit an Advisory Council member to attend are on-going.

Elder Readiness

Goal:

Encourage the development of an Elder-Friendly Community by promoting the awareness of changing demographics and the dramatic increase in the aging population. Work with seniors, community members, providers, business and government in an effort to meet the basic needs of seniors. Continue to advocate for a fair share of resources and services targeted to seniors.

Objective:

Completed By: Accomplishments:

1. Conduct outreach and education in the community as measured by:

- Partner to plan and organize an Elder Readiness forum
- Conduct educational and training events
- Promote inclusion of aging curriculum into public schools at all levels
- Organize outreach to business and civic entities

- Aging Readiness forums have been convened in several larger AAA's. DALTC plans to learn from the lessons of these AAA's and determine if conducting an Aging Readiness forum (as they have been thus far presented) would be appropriate for our community.
 - Whenever possible and resources allow, will conduct outreach with business and civic groups.
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2. Support local service providers, businesses and agencies in their efforts to become a more 'Elder Ready' community as measured by:

- Providing checklists of issues to consider
- Sharing "Best Practices"
- Advisory Council meeting minutes
- Local Advocacy trainings/forums

- Attendance at Bainbridge Island Senior Community Center's Elder Friendly Communities Committee
 - ALTC has met with a local non-profit organization and provided them a letter of support for an Innovative Care Campus (ICC) grant application, which if received, would enhance their current services by providing a geropsychiatric unit, a site for healthcare occupations re-training, and expansion of their rehabilitation and childcare centers.
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3. Continue and further develop the advocacy campaign regarding senior issues as measured by:

- Advisory Council meeting minutes
- AC Legislative committee meeting minutes
- Candidate forums
- Develop and promote training for the community to be senior advocates
- Records of meetings with elected officials
- Partner with existing organizations with common issues

■Advisory Council hosted a legislative advocacy training

■Advisory Council hosted a legislative forum

■Advisory Council members attended trainings provided by Kitsap County, W4A, other AAAs and Washington State Senior Lobby

■Advisory Council members met with Kitsap County legislators on several occasions

■Advisory Council members advocated in person, and through correspondence, with their legislators on issues concerning seniors and disabled persons.

■Advisory Council is planning another legislative forum for fall 2009
