Welcome to the Area Plan Draft 2024-2027

Kitsap County Aging and Long-Term Care

THE PUBLIC IS INVITED TO REVIEW THIS DRAFT. PLEASE DIRECT QUESTIONS OR COMMENTS TO:

Tawnya Weintraub, Human Services Planner
Email: tweintra@kitsap.gov
Mail: 614 Division Street, MS-5
Port Orchard, WA 98366
Phone: 360-337-5690 or 1-800-562-6418
Fax: 360-337-5747

Kitsap County Area Agency on Aging: Division of Aging and Long-Term Care (ALTC)

Stacey Smith, ALTC Administrator

Sponsored by

Kitsap County

Charlotte Garrido, Chair
Board of County Commissioners
District #2

Christine Rolfes, Commissioner
Board of County Commissioners
District #1

Katie Walters, Commissioner
Board of County Commissioners
District #3

Doug Washburn, Director
Human Services Department

Aging and Long-Term Care Advisory Council

Steven McMurdo, Chair
Barbara Paul, Vice Chair
Linette Zimmerman
Cynthia Blinkinsop
Ranae Beeker
Ann Paoletti
Karol Stevens
Elizabeth Safsten
Sandra Miles
Charmaine Scott, 1/10th
Community Advisory Committee
Susan Kerr, State Council on Aging

Area Plan Prepared By:

Stacey Smith, Administrator
Tawnya Weintraub, Human Services Planner

Special Acknowledgements:

Jason Doty, Supervisor, Senior Information & Assistance, Care Transitions
Hannah Ander, Supervisor, Family Caregiver Support, Medicaid Alternative Care, Tailored Support for Older Adults
Adeanna Hume and Rochal Roach-George, Supervisors, Medicaid Unit
Cristiana Fillion, Office Support Specialist
Sarah Barnett, Fiscal Technician
Aging and Long-Term Care Advisory Council
Washington Association of Area Agencies on Aging

Table of Contents

SECTION A
Area Agency on Aging Planning and Priorities

Introduction

Welcome to the Kitsap County Area Agency on Aging 2024-2027 Area Plan.

Kitsap County Aging and Long-Term Care (ALTC) is a Division of Kitsap County Department of Human Services and the designated Area Agency on Aging (AAA) for Kitsap County.

In 1965, the United States Congress enacted the Older Americans Act, and in 1973 the Older Americans Act Comprehensive Services Amendments established the Area Agencies on Aging (AAA). AAAs are responsible to plan, coordinate, and advocate for the development of a comprehensive service delivery system at local levels to meet both the short- and long-term needs of older persons in their planning and service area. The AAA focuses on services that promote healthy aging and options that support aging and older adults with disabilities to live as independently, and with as much dignity as possible. There are 618 Area Agencies on Aging across the country, and 13 Area Agencies on Aging in Washington State.

For further information on the history of programs for older Americans, please visit the Administration for Community Living website at: www.acl.gov

Additional information is also available through the Kitsap County Aging and Long-Term Care website www.agingkitsap.com

The Older Americans Act (OAA) requires the development of the four-year Area Plan, which serves as the strategic overview of the direction, activities, and accomplishments of ALTC. The Area Plan describes the Planning and Service Area (PSA) in terms of demographics, geography, economy, profile of services and service infrastructure. The needs and service preferences of older adults and adults with disabilities are discussed and planning objectives and accompanying budgets are outlined. The plan development process is mandated by the federal Older Americans Act and must be written in a format prescribed by the Department of Social and Health Services (DSHS) Aging and Long-Term Support Administration (ALTSA).

The Older Americans Act (OAA) also requires the Area Agency on Aging to establish a volunteer Advisory Council to assist in identifying unmet needs, provide advice on needed services, and advocate for policies and programs that promote quality of life. Our plan incorporates suggestions from the Advisory Council as well as other partners in the community.

The Area Plan reflects community needs and highlights goals for developing age-friendly, dementia-friendly communities while preparing for an increase in the aging population. The plan sets the stage for ALTC over the next four-year period and is the foundation for workplans, funding priorities, and planning efforts to provide services for people who are 60 or older or who need long term care. Our major goals are to:

- Address basic needs of older adults and individuals with disabilities
- Improve health and well-being of older adults and caregivers
- Promote civic and social engagement
- Increase independence and choice for older adults and people with disabilities
- Promote aging readiness and healthy aging
- Support individuals and caregivers impacted by dementia
- Identify and meet local gaps impacting older adults as a result of COVID-19

As we work to meet these goals, services and advocacy activities are also provided for adults age 18 and older with functional disabilities receiving Medicaid-funded in-home care and adults age 60 and older (services to Tribal Elders begin at age 55). Services are provided directly by ALTC staff, with participation by volunteers or through subcontracts.

Revenue for both administration and services received through grants and contracts is administered by ALTC. Federal funding sources are the Older Americans Act, Title XIX of the Social Security Act, and American Rescue Act funds.

State funding includes the Long-Term Care Ombudsman Program, Senior Citizens Services Act, Family Caregiver and Kinship Caregiver Support programs, Senior Drug Education, Care Transitions, Senior Nutrition, and Home Delivered Meal expansion funds.

Kitsap County general fund provides partial support of the Long-Term Care Ombudsman program. Time-limited special project grants are another revenue source, when awarded.

The total 2024 budget is approximately $6.9 million.

This Area Plan was developed by ALTC staff with valuable input from target populations, providers, clients, and the public. The plan has been recommended by both the Area Agency on Aging Advisory Council and the Kitsap County Board of Commissioners.

Questions or comments may be directed to:

Tawnya Weintraub, Human Services Planner
Email: tweintra@kitsap.gov
Mail: 614 Division Street, MS-5
Office: 1026 Sidney Avenue, Suite 105
Port Orchard, WA 98366
Phone: 360-337-5690 or 1-800-562-6418
Fax: 360-337-5747

Mission, Values, Vision

Kitsap County

Our Mission: Kitsap County government exists to promote the health, safety, and welfare of our citizens in an efficient, accessible, and effective manner.

Department of Human Services

Our Mission: Serve the community by providing superior and responsive services to develop, fund, coordinate, and/or deliver essential and effective human services that address individual and community needs, preserve the rights and dignity of those they serve, and promote the health and well-being of all Kitsap area residents.

Aging and Long-Term Care

Our Mission is to work independently and through community partnerships to promote the well-being and independence of older adults, adults with disabilities, and caregivers.

Our Objectives are to:

- Assist citizens in securing and maintaining maximum independence and dignity in their living environment of choice with appropriate support services;
- Remove individual and social barriers to economic and personal independence;
- Prevent unnecessary or premature institutionalization;
- Help older and disabled adults become involved with other people, reducing isolation and loneliness;
- Help older persons enjoy better health through improved nutrition, and health promotion and disease prevention education and activities;
- Connecting caregivers to individualized support and guidance to help empower them in their caregiving role;
- Partner with other county departments, community agencies and non-profit organizations to further develop positive, healthy aging opportunities in Kitsap County;
- Provide excellent customer service to the community by acknowledging, listening, and valuing each member.

The Planning and Review Process

The Kitsap County Aging and Long-Term Care (ALTC) 2024-2027 Area Plan was developed as the combined product of earlier Area Plans, years of delivery and coordination of local services, needs-analysis based on community survey responses, current trends and identified needs in the aging network and Kitsap County.

Central themes, goals and objectives of previous Area Plans were the starting point for the community planning process. Identified themes in this plan apply not only to Kitsap County, but all 13 Area Agencies on Aging in Washington State.

Focus themes include:

- Healthy Aging
- Strengthening and expanding services that delay or prevent entry into Medicaid-funded Long-Term Services and Supports
- Person-centered home and community-based services
- Tribal Partnerships and 7.01 plans
- COVID-19 Response Services and Supports and plans for recovery

Developing Age-Friendly communities is an ongoing goal. An Age-Friendly community is supportive of the needs of older adults and can provide a safe, healthy, and productive environment. This kind of environment meets basic needs, promotes physical and mental health and well-being, supports the independence of older adults and adults with disabilities, and fosters social and civic engagement.

For this Area Plan, ALTC developed a multi-phased planning process to gather valuable input from the community, aging network service providers and other interested parties. Surveys were distributed to the public in a variety of ways: social media campaign, online posting to Aging website, automated County email distribution list, mail, newsletters, and community outreach events. Service providers assisted with distribution to their clients, including community dining sites and home-delivered meal participants.

Responses, comments, and suggestions received directly, via surveys or through public events were taken under advisement by ALTC staff. Several of the issues were of strategic importance in our area and were included in the plan objectives.

ALTC also uses a client tracking system that provides detailed demographic and service statistics regarding persons who already use services in Kitsap County. This data, combined with service information from Department of Social and Health Services (DSHS) such as 1519 measures and Research and Data Analysis supplemental information, population data from the Washington State Office of Financial Management

and the United States Census of Population, and additional local information, provide the basis for planning assumptions and statistics in the plan.

ALTC staff analyzed the combined body of knowledge and developed recommendations for planning issues and objectives. These results were presented for review and comment to the Advisory Council. Incorporating the Council's recommendations, ALTC staff drafted the final text for the planning objectives in the 2024-2027 Area Plan, Section C.

The 2024-2027 Area Plan includes accomplishments for 2022-2023 and 7.01 plans for the Port Gamble S'Klallam Tribe and the Suquamish Tribe. It also includes the 2024 Area Plan budget and cost allocation plan.

Community survey results and the draft plan were presented at a public Kitsap County Board of County Commissioner work study session on August 14, 2023; and at the Aging Advisory Council for public review and comment on June 21, 2023. Opportunity for questions and comment is offered to all in attendance. Anyone not able to attend the public meetings or hearing could request a copy and offer comments by phone, mail, or email. The draft plan was also posted on the ALTC website from August 15-September 15, 2023 and was available in hardcopy at the ALTC office and Kitsap County Fair designated Senior Lounge area.

Recommendations for modifications to the Area Plan were evaluated and modifications accepted by the Advisory Council were made prior to submission to DSHS/ALTSA for final approval.

The public process for the 2024-2027 Area Plan is described in Appendix E.

Prioritization of Discretionary Funding

As the Area Agency on Aging for Kitsap County, Aging and Long-Term Care administers federal, state, and local funds for services for older adults and adults with disabilities.

Aging and Long-Term Care receives funding in two broad categories:

- Non-discretionary or targeted funding: These dollars, sometimes referred to as pass-through dollars, must be used for a specific, named program and may not be applied to any other project. The Area Agency's decision-making authority for funds is confined to the specific program for which the funds are received.

- Discretionary funding: Defined as those resources the Area Agency on Aging has the authority to decide locally the purpose for which the funds should be used.

Of the 2024 annual ALTC budget, approximately 74% is considered "non-discretionary" and is designated for specific services such as Medicaid Title XIX Case Management for individuals receiving in-home care, the Nutrition Services Incentive Program (Senior Nutrition) and the state-funded Respite Care program.

The 2024 annual budget includes about 16% in "discretionary funding" from the Federal Older Americans Act (OAA) and Washington State Senior Citizens Act (SCSA). "Discretionary" funding is more flexible and can be used to meet local priority needs within a range of allowable services in Kitsap County. Historically Kitsap County's discretionary resources have been used to address services identified through the planning process to preserve the safety and well-being of older adults and persons with disabilities.

Beginning March 2020 COVID-19 stimulus funding was allocated to Area Agencies on Aging to support local needs of older adults as a result of COVID-19 public health directions. The stimulus funding included the Family First Coronavirus Response Act (FFRCA), Coronavirus Aid, Relief, and Economic Security (CARES), Coronavirus Preparedness and Response Supplemental Appropriations Act (CPRSA), Consolidated Appropriations Act (CAA)—Nutrition and AAA Vaccination Assistance funding, Coronavirus Response and Relief Supplemental Act (CRRSA) No Wrong Door Vaccine Access, SEIU Vaccine Navigation Assistance, and the American Recue Plan (ARP). In 2024, the only remaining stimulus funding is the American Rescue Plan that expires September 30, 2024.

This plan identifies all currently funded discretionary services and rates them according to a formula. Resources are allocated to those services deemed most critical before those that score lower in priority.

There are three components in the service prioritization formula:

1. *Community Recovery and Life Support.* This addresses how critical a service may be in helping to maintain an older person with care or support needs to live independently in the community. This category may be thought of as a "basic-survival" category, where food, medical care and income maintenance would score higher than socialization, recreation, or minor support services. The primary question addressed is "how well could they get along without this service?" This includes COVID-19 impacts and recovery services.
2. *Service to the Target Population.* This classifies how well a service reaches those persons in the greatest social and economic need. Services that screen individuals on indicators identifying these needs rank highest in this category.
3. *Scarcity of Alternative Resources.* This asks the question "if we do not fund this service, are there reasonable, accessible alternatives that may substitute?"

In identifying potential gaps in local services, and with additional funding, Aging and Long-Term Care staff, recommendations from Advisory Council, and the Area Plan will guide service funding priority levels and program development.

Throughout this plan it was necessary to balance needs, goals, and objectives with the reality of a growing target population, increased costs, and available funding.

SECTION B
Planning and Services
Area Profiles

B-1 Kitsap County Population Profile

Kitsap County occupies a unique portion of Washington State, directly between the urban areas of Seattle and Tacoma and the wilderness of the Olympic Mountains. It is bounded by the Hood Canal on the west, Puget Sound on the east, and Mason and Pierce Counties to the south. The Kitsap Peninsula is surrounded by water on three sides and includes two islands. Two main bridges, the Tacoma Narrows and Hood Canal floating bridge, link Kitsap to the surrounding land masses. Five ferry terminals connect Kitsap by water directly to King and Snohomish counties. In the past 5 years, three additional fast passenger ferries were added to routes. Kitsap County is situated along the western shore of the central Puget Sound region. It comprises a total land mass of 395 square miles (or 0.6 percent of the state's total land mass). Kitsap County ranks 36th in geographic size among Washington counties, 7th in total general population and is the 4th most densely populated county in the state. Kitsap County is also noted for offering the "most waterfront" among all the counties. According to the Census data, the population has been increasing steadily and the estimated population of Kitsap County is 275,611.

In Kitsap County, there are four incorporated cities, which make up 35% of the total population in 2020. While Bremerton makes up the largest percentage of the population, Port Orchard is the fastest growing. From 2000 to 2020, there was a 103% increase in the population of Port Orchard. The County seat is in Port Orchard. Unincorporated areas made up the largest percentage of the population in 2020 but have only grown 12% since 2000 and 6% since 2010 compared to the growth of incorporated areas by 33% and 18% since 2000 and 2010 respectively (Table 1).[1]

Table 1. Population Growth by Location, Kitsap County[1]

	Census 2000	Census 2010	Census 2020	% Of Total 2020
Total	**231,969**	**251,133**	**275,611**	**100%**
Unincorporated	159,896	170,022	179,719	65%
Incorporated	72,073	81,111	95,892	35%
Bainbridge Island	20,308	23,025	24,825	9%
Bremerton	37,259	37,729	43,505	16%
Port Orchard	7,693	11,157	15,587	6%
Poulsbo	6,813	9,200	11,975	4%

MILITARY AND VETERANS

There is a distinctive military presence, active and retired, throughout the County. Naval Base Kitsap is the 3rd largest installation in the US Navy, and the largest on the west coast. According to the Kitsap Economic Development Alliance, "It's Kitsap's largest

[1] Source: Washington State Office of Financial Management, http://www.ofm.wa.gov/.

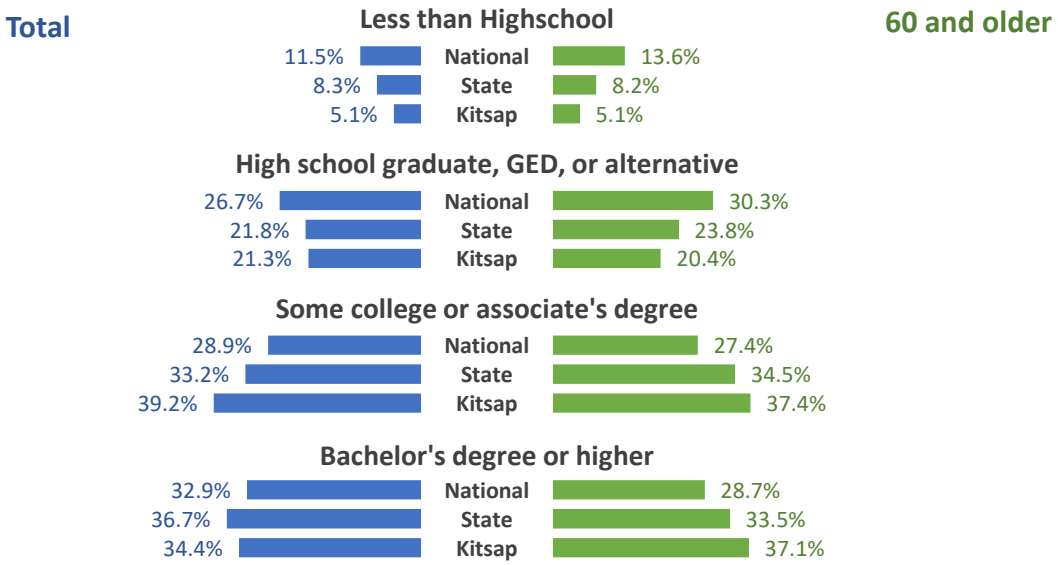
employer, with 20,000 civilian personnel, 11,000 military personnel, and thousands of associated contractors and indirect employees."[2]

Kitsap veterans comprise 13.9% of the total population. This is more than 1.5 times the rate in Washington: 8.2% and more than double the rate in United States: 6.4%.[3]

Education Level

In general, older adults in Kitsap County are more educated when compared to older adults in Washington and the United States. Older adults in Kitsap are also more likely to report having a bachelor's degree or more compared to all adults ages 25 and older.[4]

Figure 1. Percentage of Population by Education Level, 2016-2020[4]



Income and Poverty

In Kitsap County 8.6% of the total population lives in poverty. It is important to note that while net County growth has historically been accompanied by increased economic activity, the aging of our adult population will be characterized by fixed and falling incomes. From 2016-2020, older adults reported their most common source of income was from social security and retirement income. The average 12-month income from social security in Kitsap County was $21,584. The average income of those who

[2] Source: Kitsap Economic Development Alliance http://kitsapeda.org/key-industries/defense/. Accessed July 23, 2023

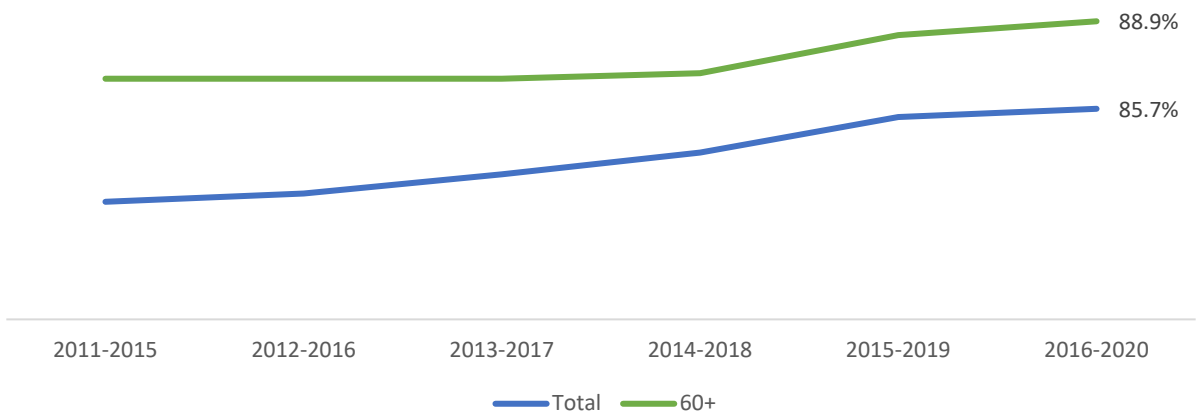
[3] Source: Census Reporter.org https://censusreporter.org/profiles/05000US53035-kitsap-county-wa/. Accessed July 23, 2023.

[4] Source: U.S. Census Bureau, American Community Survey (ACS), https://www.data.census.gov/

reported receiving income through earnings (wage income, salary income, or income from self-employment) was lower among older adults compared to all adults.

Older adults more commonly reported being at or above 150 percent of the poverty level compared to all adults. Bremerton was the region with the lowest percentage of residents who reported being at or above 150 percent of the poverty level. The percentage of the population who reported being at or above 150 percent of the poverty level has been slowly increasing over time.[4]

Figure 2. Percentage of population at or above 150 percent of the poverty level, Kitsap County, 2011-2020



Additionally, sustainable government resources for social and health programs serving older persons have remained stagnant, while being stretched across a rapidly expanding older population.

HOUSING

From 2016-2020, 82.5% of older adults in Kitsap County reported being the owner of their housing unit (as opposed to renting). This percentage was higher among older adults than all adults. Kitsap also reported a higher percentage of ownership when compared to the national and state percentages. Within Kitsap County, Bainbridge Island had the largest percentage of residents who reported owning their housing unit while Bremerton had the lowest percentage of residents who owned their housing unit.

In general, the average household size for older adults is lower when compared to all adults. Additionally, the average household size is greater among those who own their housing unit compared to those who rent.

Safe and affordable housing, including affordable rental options has become increasingly more difficult to find due to rapid general population growth as a result of fast ferries. According to Redfin, in June 2023, Kitsap County home prices were down 6.5% compared to 2022, selling for a median price of $553K. This is following the

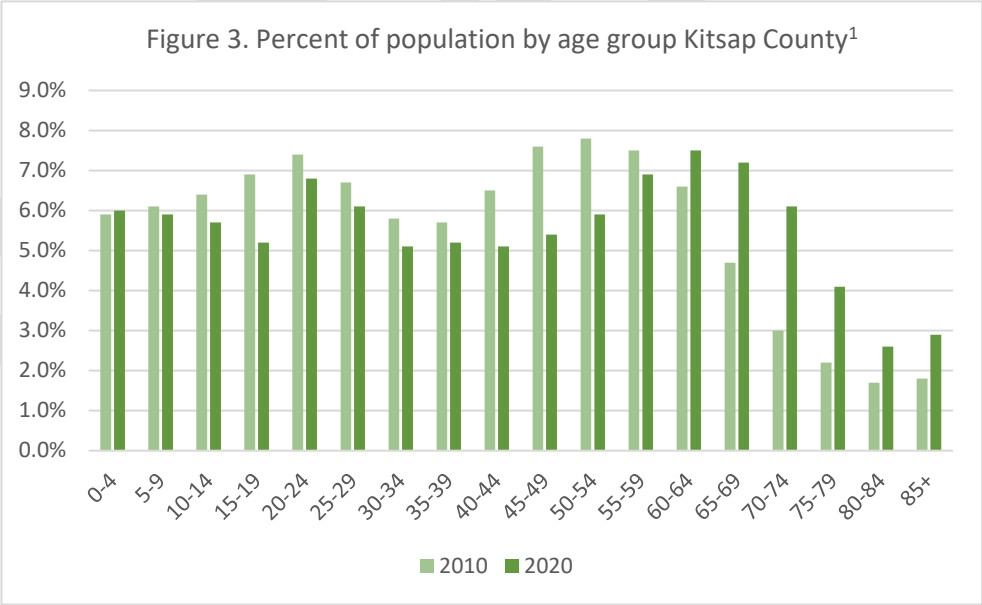
previous 2021 plan update where home prices were up by 24.9%, but the median price of $500K was less.

In 2023 Kitsap County ($1,872) has a 48% higher Fair Market Rent (FMR) for 2-Bedroom housing than the average of Washington ($1,265) and therefore a higher gross rent. Kitsap County is ranked 5th out of 39 counties. This means the FMR, or in other words, the gross rent is higher than 34 other counties. Kitsap County is the 5th most expensive county in terms of Fair Market Rents.[5]

Aging Population

The population of Kitsap has been increasing steadily. In 2020, the population saw an 8.4% increase from the population in 2010. The older adult population has also been rapidly increasing. There were 49,764 older adults (ages 60 and older) in Kitsap County in 2010 which made up 20% of the population. This increased to an estimated 83,167 in 2020 making **older adults 31% of the population**. Additionally, there were 4,510 people who were 85 and older (1.8% of the population) in 2010 which increased to 8,038 (3% of the population) in 2020. **This represents a 67% increase in adults 60 and older and a 78% increase in adults 85 and older**.[1]

Kitsap County continues to experience significant growth in the aging population.



In 2010, 7.8% of Kitsap residents were ages 50-54 which represented the largest age group in the county. In 2020, the largest age group is 60-64 making up 7.5% of the population.

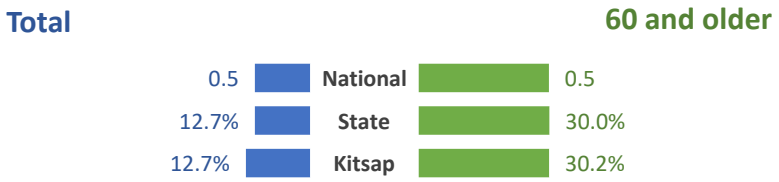
[5] Source: Kitsap County, WA 2023 Fair Market Rents. USHousingDate.com. https://www.ushousingdata.com/fair-market-rents/kitsap-county-wa. Accessed July 23, 2023.

Overall, from 2016-2020 the median age of Kitsap County residents was 39.2 years which was older than the state median of 37.8 years. The median age of males in Kitsap County was 37 years while the median age of females was 41.5 years.[1]

Previous population growth estimates indicated that by 2020 one in every four County residents will be over the age of 60. The estimate for 2020 is one in three . The older adult population growth will continue to have severe implications for the County as a community, as well as for the shrinking service dollar.

Among the civilian noninstitutionalized population, older adults were more than twice as likely to report having a physical, emotional, or mental disability when compared to adults 18 and older.[4]

Figure 4. Percentage of Population with a Physical, Emotional, or Mental Disability, 2016-2020[4]



The shifting demographics and special considerations of an aging population are not unique to Kitsap County. As a result of the remarkable improvements in health education, medicine, nutrition, and general living standards over the last century, people who reach age 60 can now expect to live almost 25 more years. Further, as life expectancy rises, the number of “oldest old” (age 85+) also increases. For this reason, programs and policies directed to the 60+ population must consider the needs of at least two generations of older adults.

Diversity and Minority Population Considerations

In 2010, 10% of the 60+ population reported their race or ethnicity as something other than White. This increased to 13% of the 60+ population in 2020. This growth primarily occurred in the Hispanic population (138% growth) and the multi-race population (134% growth). Other groups that more than doubled in size since 2010 include the Black population (117% growth), the Native Hawaiian or Other Pacific Islander (NHOPI) population (117% growth), and the Asian population (115% growth). The American Indian/Alaska Native (AIAN) and White populations grew by 77% and 61% respectively. The largest race and ethnicity minority groups of the 60+ population are Asian followed by Hispanic, multi-race, Black, AIAN, and NHOPI (Figure 5).**Error! Bookmark not d efined.**

Figure 5. Population by Race/Ethnicity (Ages 60+), Kitsap County, 2010-2020[1]

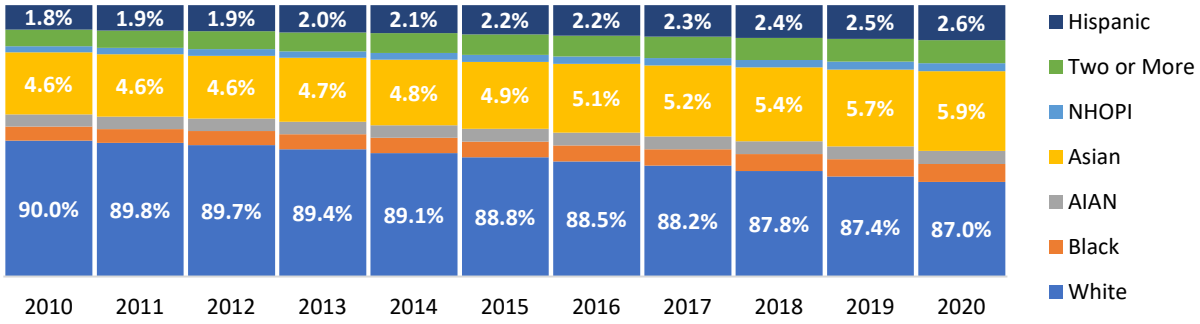
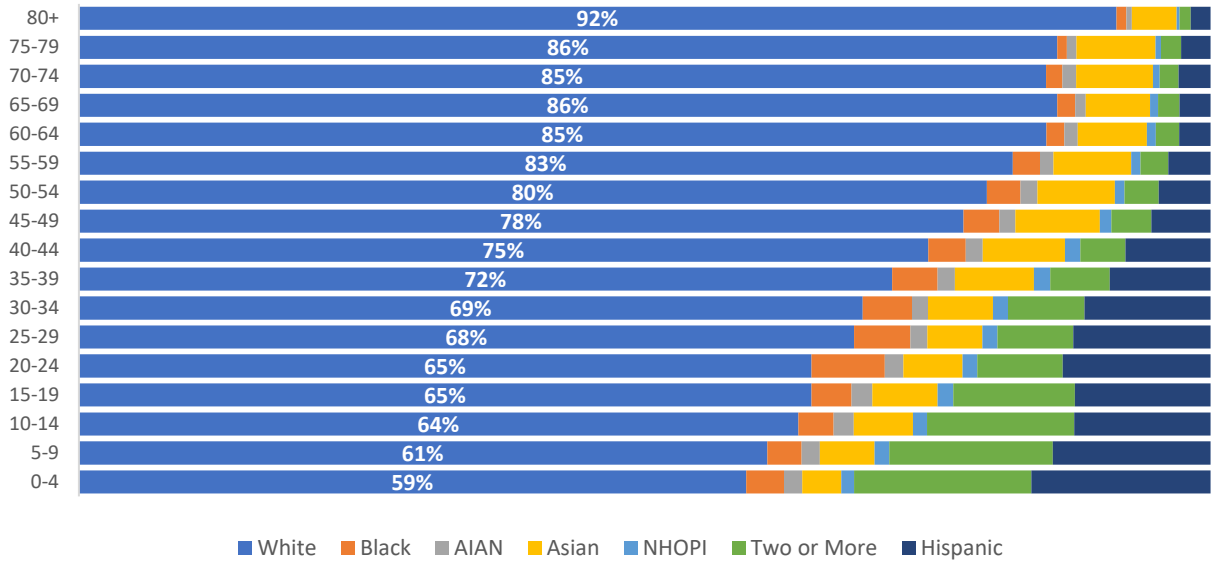


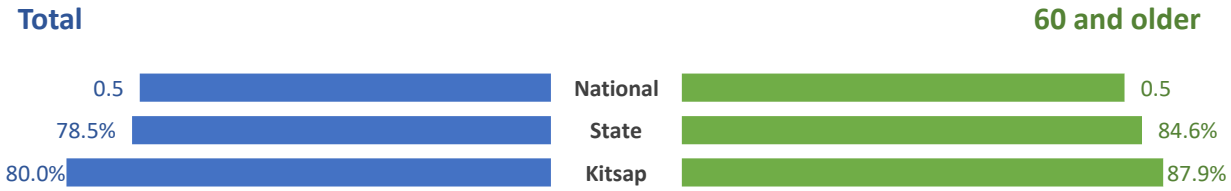
Figure 6. Population by Race/Ethnicity and Age Group, Kitsap County, 2020[1]



In 2020, 5-year estimates show that the most common languages spoken at home in Kitsap among those 5 and older are Spanish (6,418), followed by Tagalog of Filipino (4,451), Other Asian/Pacific Island languages (2,334), Other Indo-European Languages (1,577), German or West Germanic (868), Chinese including Mandarin and Cantonese (749), and Korean (469).

From 2016-2020, 92.0% of older adults in Kitsap County reported speaking English at home. Approximately 2.8% of older adults in Kitsap County reported speaking English less than “very well.”[4]

Figure 7. Percentage of Population that Speaks English at Home, 2016-2020[4]



Aging and Long-Term Care (ALTC) targets traditionally underserved populations and focuses efforts to assure equal access to services. Local emphasis is to reach persons who are in the greatest social and economic need or who are low-income minorities. These individuals and families may face barriers for a variety of reasons. This matches Older Americans Act requirements for programs to target individuals with the greatest need. Target populations include individuals with the greatest economic and social needs, who live in a rural location, are members of an ethnic minority group, and those who are at risk of institutional placement.

Although not eligible for Older Americans Act program funding, part of ALTC's work is to provide services to people under 60 with disabilities and their family caregivers.

ALTC recognizes the need for engagement strategies for older (60+) individuals and their families who identify as something other than heterosexual. According to U.S. research, 7.2% individuals identified as Lesbian, Gay Bisexual and Transgender(LGBT) in a 2022 poll. Participants from different generations in the Gallup poll showed that "Adult members of Generation Z, those born between 1997 and 2004 who were aged 18-25 in 2022, are the most likely subgroup to identify as LGBT, with 19.7% doing so. The rate is 11.2% among Millennials,(born between 1981-1996), and 3.3% or less among older generations."[6]

Approximately 4.5% of American adults identified as lesbian, gay, or bisexual, or transgender in 2018. Washington State is one of ten U.S. States with the highest number of adults identifying as lesbian, gay, or bisexual, at 5.2% of the total state population.

Among older adults, from 2011 to 2020, 2.3% of adults 60 and older in Kitsap County, and 2.9% in Washington, identified their sexuality as something other than heterosexual. Additionally, 0.6% of older adults in Washington identified as transgender or gender nonconforming from 2016-2023.[7]

[6] Source: U.S. LGBT Identification Steady at 7.2%, Jeffrey M. Jones, February 22, 2023. http://news.gallup.com. Accessed August 3, 2023.

[7] Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS) Data

KITSAP COUNTY DEMOGRAPHIC CHARACTERISTICS[8]

Demographic	2010 ALTSA Forecast	2020 ALTSA Forecast	2025 ALTSA Forecast
Age 60+	49,885	74,292	85,008
Age 60+ Minority	5,577	8,933	10,820
Age 60+ Low Income (at or below federal poverty level)	1,990	3,077	3,431
Age 60+ Low Income Minority	535	620	745
Age 60+ with Disabilities	10,639	14,300	17,262
Adults age 18+ with Disabilities	17,401	21,292	24,125
Age 65+ with Dementia	2,962[9]	5,038	6,467
Age 60+ with Alzheimer's disease, Dementia, or other Cognitive Impairment	4,571	6,052	7,303
Age 18+ with Cognitive Impairment	11,087	13,274	14,549
Age 60+ At risk for institutional placement	998	1,079	1,200
Age 60+ Limited English Proficiency	1,682	2,723	3,330
Age 55+ American Indian/Alaska Native	518	780	862
Native American Tribes	2	2	2
Tribes with Title VI Funding	2	2	2
Age 60+ in Rural Areas[10]	8,929	N/A	N/A

Kitsap County is a mix of rural and urban areas. Targeting efforts to these rural areas is incorporated in outreach plans.

[8] Source: 2020 and 2025 data derived from Selected Population and Aging Service Utilization Forecast, Kitsap County Division of Aging & Long-Term Care. "Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2030 in Washington State" Technical Report. David Mancuso, PhD and Jingping Xing, PhD June 2019 DSHS Research and Data Analysis Division Olympia, Washington.

[9] Data in 2010 forecast is based on individuals who are age 70+

[10] Data is not part of ALTSA forecast. "Rural," as the Census defines it refers to concentration of development and might capture some residents of incorporated cities. For instance, a city may be entirely incorporated, but the figure provided includes residents aged 60+ who live in areas with Census-defined rural character. That definition is here: https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html.

ALTC utilizes a variety of methods to reach populations at risk, and interact sensitively, effectively, and professionally with people from diverse cultural, socioeconomic, educational, racial, ethnic, age, gender, sexual orientation, faith community and professional backgrounds, and individuals with special needs and different abilities.

Changing demographics and populations represented in Kitsap County are considered throughout the Area Plan.[11]

[11] Data for the above section was considered from a variety of sources. Some of the data was based upon projections and there may be variation between the estimates. Data sources are referenced.

B-2 AAA Services and Partnerships

Aging and Long-Term Care provides services countywide, either through direct services performed by personnel or contracts with agencies. The following is a brief description of services and the target population.

Adult Day Services

Adult Day Care

Social day care services offer families of older persons relief from constant care and provide isolated persons with opportunities for socialization. Services are designed to address the social needs of participants and the need of families for a safe, comfortable place that will support the person they provide care for.

Adult Day Health

Adult Day Health provides services to eligible individuals in a group setting. Services are designed to provide professional evaluation and address the physical, emotional, and cognitive needs of participants and include rehabilitative nursing, health monitoring, occupational therapy, personal care, social services, activity therapy, and a mid-day meal.

Behavioral Health Services

Older Adult and Family Caregiver Support Mental Health Counseling

Services include outpatient counseling, consultation and education services designed to evaluate the need for mental health intervention, determine the type of intervention needed, provide appropriate evidence-based treatment, and disseminate information to help persons gain access to needed mental health and other community services. Specialized training, consultation and education are also available to community organizations to improve services and increase public awareness of mental health issues.

Substance Abuse Counseling

Specialized consultation for ALTC staff and assessments for persons age 60 and older which include individualized treatment recommendations. Provides for assistance in obtaining treatment at whatever level available that the client is willing to accept.

Also includes community planning efforts to provide enhanced services for persons in need of substance abuse services, both in and out-patient.

These specific services are currently on hold, with referrals made to other behavioral health services as appropriate and available, until a provider is contracted. There were no responses to the 2022 and 2023 Requests for Proposals for these services.

CARE TRANSITIONS

The Care Transitions service offers support to adults with acute needs to transition home from the hospital. The goal is to reduce future hospital visits. This is accomplished through receiving referrals from local hospitals, meeting with individuals to complete an assessment, and development and implementation of an individual plan of care. Examples of support may include assistance with referral to caregiving programs, coordinating transportation to doctor appointments, support with applying for programs offering nutrition, and establishing and working with natural supports.

DEMENTIA CONSULTATION

Services include specialized consultations, education and resources for caregivers, and behavioral strategies for managing care. Services are provided at no charge to individuals experiencing dementia and informal caregivers supporting a person with dementia.

Dementia and memory loss workshops associated with mild to major neurocognitive disorders referred to as the “dementia spectrum” are additional services provided.

FAMILY CAREGIVER SUPPORT PROGRAM

Trained Case Managers and Assistance Specialists provide multifaceted systems of support services for unpaid Family caregivers. Services include information about available programs; assistance in gaining access to services; individual counseling, and caregiver training to assist caregivers with decision-making and problem-solving related to caregiving roles; respite care for caregivers to get temporary relief from their caregiving responsibilities; and assistance with developing and maintaining family caregiver services.

INFORMATION & ASSISTANCE/COMMUNITY LIVING CONNECTIONS

Information & Assistance (I&A) is an integrated system of functions designed to identify older persons and their caregivers who need service(s) and link them with the most appropriate resource(s). Program functions may range from simple provision of information to individualized assistance and follow-up. The I&A program is a key element in implementation of the Department of Social and Health Services Long-Term Care policy, which promotes the utilization of in-home and nonmedical residential care as consumer-preferred alternatives to nursing home placement for vulnerable adults.

The I&A program is an access point for receiving referrals, services, and consultation. Functions of the I&A program include information-giving, service referral, assistance, and person-centered counseling, client advocacy and screening to determine whether an older person, or their caregiver, should be referred to other services and supports.

I&A assists older adults to access necessary support services. Services are designed to achieve and maintain the maximum level of health and independence as possible.

The I&A program is responsible for I&A program outreach and publicity and developing and maintaining information about community resources that serve older people and caregivers.

KINSHIP CAREGIVER SUPPORT PROGRAM

The Kinship Caregiver Support Services Program provides referrals for services and limited financial assistance to eligible kinship caregivers (grandparents and relatives raising children) by assisting them to obtain resources necessary to help stabilize the family. These services are frequently utilized by grandparents raising grandchildren.

LEGAL ASSISTANCE SERVICES

The Legal Assistance program assists older adults in advocating for their rights, benefits, and entitlements. Legal services in noncriminal matters range from advice and drafting of simple legal documents to representation in complex litigation. Services also include disseminating information about legal issues to older persons, family caregivers, service groups, and others through lectures, group discussions, and the media.

LONG TERM CARE OMBUDSMAN

The Long-Term Care Ombudsman Program is a coordinated system of services designed to improve the quality of life for residents of nursing homes, assisted living facilities, congregate care facilities and adult family homes. Services provided by state and local ombudsmen include investigating and resolving complaints made on behalf of residents or by residents; identifying problems which affect a substantial number of residents; recommending changes in federal, state and local legislation, regulations, and policies to correct identified problems; identifying and seeking resolution for safety and quality of facility-based care issues and assisting in the development of resident councils, family councils, and citizen organizations concerned about the quality of life in long-term care facilities.

The local Kitsap Ombudsman program provided 8.8% of the total hours in Washington State in 2022 while receiving only about 4% of the total revenue.

Medicaid Case Management

Professionally trained case managers assist functionally impaired adults, over the age of 18 years, at risk of institutionalization in accessing, obtaining, and effectively utilizing the necessary services to maintain the highest level of independence in the least restrictive setting. Services are provided to recipients of Department of Social and Health Services Community First Choice (CFC), Community Options Program Entry System (COPES) and Medicaid Personal Care (MPC) programs.

Case managers assess need, plan for, coordinate, and monitor services provided to clients. The objectives of case management are to support client independence; match services to client's needs as they change over time and within the limitations of the program to meet those needs; be a custodian of the state's resources; provide continuity of care through coordination with others; assist clients to access needed services; develop a plan to overcome barriers to accessing services; authorize appropriate services; advocate for clients and support client self-advocacy.

Medicaid Transformation Demonstration

Washington State and the Centers for Medicare and Medicaid Services (CMS) have a Medicaid Transformation Demonstration (MTD) agreement with goals to improve healthcare for families and control costs.

Under this 1115 Medicaid Demonstration Waiver, currently referred to as the Medicaid Transformation Project (MTP), the Medicaid Alternative Care and Tailored Supports for Older Adults (MAC/TSOA) programs were created to address the needs of a growing aging population through new program benefits to preserve and promote choice in receiving services, support families to care for loved ones and increase caregiver well-being, and to delay or avoid the need for more intensive and costly Medicaid-funded long-term services and supports when possible. Washington State Health Care Authority, on behalf of Department of Social and Health Services, received an additional extension year for 2022, and then through June of 2023. ALTC staff participated in the statewide efforts to submit a renewal Waiver for year 7 of the program, beginning in 2023. The latest extension is through June 30, 2028.

Medicare Improvements For Patients And Providers Act

Medicare Improvements for Patients and Providers Act (MIPPA) provides Medicare and Medicare Part D outreach and assistance to Medicare beneficiaries to enroll in Medicare Part D or to apply for Medicare Low-income Subsidy (LIS) and Medicare Savings Plans (MSP's). Staff also encourages beneficiaries to participate in disease prevention and wellness activities; and coordinates these activities with the local sponsor of the Statewide Health Insurance Benefits Advisors program.

NURSING SERVICES

Medicaid-funded in-home care programs include Registered Nurse Consultant (RNC) services. The RNC role is to provide nursing expertise to case managers and support client safety. The RNC collaborates with case managers and community partners on client-related medical issues that might impact their plan of care. The RNC visits clients referred by case managers; evaluates the effectiveness of the plan of care in relation to any changes in the client's condition or environment; observes the performance of authorized tasks by the personal care service provider, provides task-specific training and directs further formal provider training when necessary; and recommends changes to the existing service plan. The RNC may also provide short term case management for the most medically complex cases.

NUTRITION SERVICES

Home Delivered Meals

The Home Delivered Meals program provides nutritious meals and other nutrition services to older persons who are homebound due to illness, disability, or isolation. Services are intended to maintain or improve the health status of these individuals, support their independence, prevent premature institutionalization, and allow earlier discharge from hospitals, nursing homes, or other residential care facilities.

Community Dining Sites

Congregate Nutrition services help meet the complex nutritional needs of older persons by providing nutritionally balanced meals and other nutrition services, including nutrition outreach and nutrition education in a group setting at local community dining sites. There are seven meal sites at various Kitsap County locations. One site is available through Port Gamble S'Klallam Tribe, others are provided through Meals on Wheels Kitsap. These sites provide a healthy meal and socialization for local older adults.

In 2023 five community dining sites are reopened for community dining after being closed as a result of COVID-19. Another two sites remain as "grab and go" locations.

Senior Farmers Market Nutrition Program

Low-income seniors, 60 years or older, or tribal elders 55 or older, can qualify for farmers market benefits that can be used to buy locally grown fresh fruits and vegetables at many farmer's markets and some roadside farm stands across the state from June through October. This program promotes community connections and decreased isolation, nutrition with fresh fruits and vegetables, as well as support for local farmers. In 2023 the benefit amount is $80 per eligible program participant.

Additionally, with support from other funding sources, homebound seniors in Kitsap County may receive home delivered produce through the Home Delivered Meals program.

Nutrition Education

Services provide education to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health information (as it relates to nutrition) and instruction to participants or participants and caregivers in a group or individual setting overseen by a dietitian.

Nutrition Support

Contracted service with a community agency for enhanced produce, storage, refrigeration, physical space and staffed hours for their Senior Nutrition onsite “Senior Counter” program. The intent is to support the program with funding to provide seniors with increased fresh produce, meats and dairy as well as program staffing to address senior food insecurity due to COVID. Enhanced senior nutrition is provided to individuals 60 years and older to ensure older adults can remain safe, limit travel to community stores, and ensure a safety check during COVID-19 pandemic and recovery.

Respite Care Services

In-Home and Out-of-Home Respite Services

Respite care provides relief for family or other informal caregivers of adults with functional care or supervision needs. Both in-home and out-of-home respite care is provided on an hourly and daily basis, including 24-hour care for consecutive days. Respite care workers provide supervision, companionship and personal care services usually provided by the primary caregiver. Services appropriate to needs of individuals with dementia are also provided. Medically related services, such as administration of medication or injections, may only be provided by a licensed health practitioner.

Tailored Caregiver Assessment and Referral TCARE® protocol is used to determine eligibility for respite services, which are authorized by ALTC case managers. Case Management includes the following tasks: caregiver screening and assessment for eligibility, developing a TCARE® service plan, authorizing the level and amount of respite to be provided, arranging for care with the respite service provider and caregiver, and maintaining contact with caregiver for reassessment and referral to other programs and services.

Senior Drug Education Program

Senior Drug Education provides adults, age 60 and older, education and information on safe and effective use of medication (prescription drugs, vitamins, and herbs) through

seminars, presentations, health fairs, education materials, online or recorded video presentations posted on the Aging and Long-Term Care website, and one-to-one education and consultation.

- Please note that although services may be available to individuals countywide, accessing those services may still be difficult based on office or service location and transportation needs, wait lists, or the ability to meet eligibility criteria or to privately-pay.

For further information regarding a specific service, please call Senior Information & Assistance at 360-337-5700 or 1-800-562-6418 or visit our ALTC website at **www.agingkitsap.com**

SOCIALIZATION, HEALTH, AND WELLNESS

Enhance®Fitness

Enhance®Fitness is a sequence of specially designed and tested exercises developed for older adults. These exercises focus on four key areas critical to the health and fitness of older adults: stretching and flexibility; low impact aerobics; strength training; and balance. The program consists of one-hour classes that meet two to three times a week and are designed to be supportive, socially stimulating, and tailored to meet the needs of older adults. Kitsap ALTC currently contracts with one community-based agency to serve older adults.

Community Café

A pilot program for individuals over the age of 60 years and their caregivers to engage in meaningful learning and sharing about relevant topics with the goal to build spirit, mind, and body health toward thriving with greater purpose, connection, and well-being. A local agency is contracted to develop, promote, and administer a Community Café service in-person for older adults and their caregivers to promote healthy aging and decrease negative impacts of social isolation due to COVID.

Social Check-in Calls

Check-in calls are available for Kitsap residents age 60+ who would like a friendly phone call. Calls are social in nature. A customized schedule Monday-Friday 8-4:30 is offered that is flexible for seniors to change at any time. Staff can also help seniors explore resources in the community and there is no income eligibility to participate. Referrals are initiated through a call to Kitsap County Aging and Long-Term Care.

Memory Screening

This service is offered through a partnership with the Alzheimer's Foundation. Memory screenings are free and scheduled by calling Senior Information and Assistance. Staff use the Brief Alzheimer's Screening (BAS) to accomplish screenings, offered in-person or via phone. Results are discussed immediately following the screening and additional information (date of the screening, name of the screening, scoring, and ideas for promoting better brain health) is mailed to participants. Screenings are not intended to diagnose but can lead to discussions between participants and their care team.

Veterans-Directed Home Services

This is a participant directed program for VA Puget Sound Health Care System enrollees who are eligible for home and community-based services. Participants manage their own budget to purchase goods and services to remain independent in the community.

ALTC Partnerships

Aging and Long-Term Care is involved in multi-tiered efforts to integrate local systems and services and participates in statewide and national efforts This includes integrating community-based care with traditional partners, as well as creative outreach to non-traditional ancillary service providers. ALTC staff are involved in robust community-based workgroups to address local needs through coordination of care approaches to reduce duplication of efforts, provide for smoother transitions and more individualized care. A list of the local workgroups is in the table below.

ALTC System Integration and Service Coordination Efforts

Local Efforts
The following local committees and groups are formally meeting in Kitsap County:

Committee Name	Purpose of Committee	Frequency of meetings
HealthCare Coalition	Facilitated by the Northwest HealthCare Response Network to plan for emergency response surge capacity and capability by developing a county-wide management system for integrating medical and health resources during large-scale emergencies.	Monthly
Vulnerable Populations Taskforce	Co-led by Kitsap County Department of Emergency Management and Aging and Long-Term Care to strategize about local disaster preparedness for vulnerable individuals throughout the County.	Paused due to COVID-19. Plans to be re-established in 2024.

Committee Name	Purpose of Committee	Frequency of meetings
"ESF-8" Meeting	Led by Kitsap Public Health for medical and social services community agencies to respond to local disasters, prepare for known events (like heat, snow and smoke) and share information.	New- Started Spring 2023 Quarterly
Functional Assessment and Services Team (FAST)	Subcommittee that works in collaboration with local Kitsap County Department of Emergency Management and Red Cross to provide shelter and specialized services in disasters.	Meets at least annually
Long Term Care Alliance	Forum to share local services updates and problem-solve common community concerns.	Monthly
Regional Resource Team (RRT); A-Team	Facilitated by DSHS Adult Protective Services to share system and service information for high profile "client of concern" cases.	Meets upon request
Kitsap Long Term Care Ombudsman Volunteer meetings	Facilitated by Kitsap ALTC Regional Ombudsman to communicate information to the volunteer Ombudsman about access, program revisions, and problem solve common trends.	Twice a month
Kitsap Information & Referral Network (KIRN)	A network of Information and Referral professionals from human services organizations facilitated through Peninsula's 211 to share program information, network, and facilitate referrals.	Monthly
Voter Access Advisory Committee	Hosted by the Kitsap County Auditor's office, this is a diverse group of county residents representing advocacy groups and Kitsap County employees providing expertise and guidance regarding Kitsap's Voter Access Plan.	Annual; upon request
Kitsap Network Provider & Partner Meeting	Facilitated by ALTC staff to review system, policy changes and enhance cross-agency communications. Incudes local HCS, DDA, APS and ALTC staff and subcontractors.	Twice per year Spring & Fall

Committee Name	Purpose of Committee	Frequency of meetings
Ethics Board with local hospital (St. Michaels Medical Center)	Hospital staff facilitate meeting that includes AAA Ombudsman to review current practices, protocols, and case reviews of hospital admitted patients with end-of-life issues.	Quarterly
Kitsap County Human Services Department-Program Managers	County Human Services Program Managers meeting to share information, discuss Kitsap County internal processes, meet with local leaders, and plan for social service integration efforts.	Monthly
Kitsap Suicide Prevention	Facilitated by Kitsap Human Services Deputy Director to address suicide rates and prevention strategies. Attendance from schools, social services, health providers, veteran groups, League of Women voters, and Aging.	Quarterly

Regional multi-county efforts

Kitsap County Aging and Long-Term Care (ALTC) participates in the following regional workgroups:

Committee Name	Purpose of Committee	Frequency of meetings
DSHS Region 3 Home and Community Services: Bremerton Office	Coordination between Home & Community Services assessment and financial teams for LTSS and MDT cases.	Quarterly
DSHS Region 3 Residential Care Services	Coordinate between Residential Services staff (licensures and investigators) and regional Ombudsman.	Quarterly
DSHS Region 3 Housing & Supportive Employment Collaborative	Coordination between state program and local providers of Housing and Supportive Employment Programs	Quarterly
Statewide Long Term Ombudsman Meetings	Statewide Ombudsman meets with all the Regional Ombudsman to share information, discuss trends, and advocate.	Monthly

Statewide efforts
ALTC also participates in the following statewide committees and workgroups:

Committee Name	Purpose of Committee	Frequency of meetings
W4A (Washington Area Agency on Aging Association)	Association of local AAA's to share information, discuss proactive solutions to common issues, and advocate for flexible system reform.	Monthly
Community Living Connections- Policy Maintenance & Recommendation Committee (PMRC)	Statewide committee involving Aging and Long-Term Support Administration (ALTSA) and Area Agencies on Aging staff to review and suggest policy standards for Community Living Connections.	Monthly
Community Living Connections- Resource Subcommittee	The CLC-GetCare Resource Directory assists staff and provider agencies across the state to assist individuals to understand and access options. It will also be available online for anyone to view and search. This meeting provides an accurate, consistent, clear operational structure for coordinated statewide input and updates.	Monthly
Long-Term Care Ombudsman Programs	Statewide meetings provide continuing education, discussion of trends and sharing of information.	Twice a month
Area Agency on Aging and Aging & Long-Term Support Administration Contract Manager Meetings	Statewide meetings to discuss monitoring, contracting and policy including changes, processes, and best practices.	Monthly
Area Agency on Aging and Aging & Long-Term Support Administration Fiscal Manager Meetings	Statewide meetings to discuss items related to fiscal operations and share best practices.	Every other month
Area Agency on Aging and Aging & Long-Term Support Administration Medicaid Clinical Directors Meetings	Statewide meetings to discuss items related to Medicaid Title 19 program and share best practices.	Monthly

Committee Name	Purpose of Committee	Frequency of meetings
Area Agency on Aging (AAA) and Aging and Long-Term Support Administration (ALTSA)- Unpaid Caregiver Collaboration (UPCC)	Statewide meetings to discuss items related to unpaid Family Caregivers and Medicaid Transformation Demonstration programs and share best practices.	Monthly
Washington State Council on Aging (SCOA) Kitsap AAA Advisory Council member is a representative.	SCOA is an advocacy group for senior issues and a unified voice across Washington. Members are appointed by the Governor. AA Advisory Councils are charged with advising the Governor, DSHS Secretary and Assistant Secretary of ALTSA. (RCW 43.20A.695). Members are representatives of local communities, Area Agencies on Aging Advisory Councils, cities & counties, the legislature, and the long-term services and supports field. The membership provides SCOA with a built-in communications and outreach platform with statewide reach.	Monthly 8 months out of the year
Washington Connection Advisory Committee	The Advisory Committee provides recommendations to the Executive Sponsor on direction for the Washington Connection benefit portal functionality, access to services, online application, and funding.	Quarterly

B-3 Designated Focal Points- Kitsap County

Organization or Site Name	Focal Point Address	Public Contact Information	Services Coordinated at the Site
Kitsap County Aging & Long-Term Care Givens Community Center	1026 Sidney Ave, Suite 105 Port Orchard, WA 98366	Phone: 360-337-5700 or 1-800-562-6418 Email: seniorinfo@kitsap.gov Website: www.agingkitsap.com	AAA direct services: Senior Information and Assistance Care Transitions Memory Screening Medicare Improvement Patient and Providers Act (MIPPA) Social Check-in Calls Senior Drug Education Family Caregiver Support Program Medicaid Long Term Care and Medicaid Transformation Demonstration, and Veterans Directed Home Services Case Management Long Term Care Ombudsman Program Additional services at this location: Senior Center-Friends of Givens Kitsap Recovery Center

Organization or Site Name	Focal Point Address	Public Contact Information	Services Coordinated at the Site
Fishline (North Kitsap)	19705 Viking Ave NW Poulsbo, WA 98370 PO Box 1517 Poulsbo, WA 98370	Admin/Operations 360-779-4191 Client Services-Comprehensive Services Center 360-779-5190 Email: info@fishlinehelps.org Website: www.Fishlinehelps.org	AAA Family Caregiver Support Program, Senior Information and Assistance, MAC/TSOA. Services at Fishline: Food Bank, Utility & Rental Assistance, Mobile Shower, Case Management/Social Work, Transportation, Employment/Education, Children Services Additional Comprehensive Services Providers: Peninsula Community Health Services-Dental Kitsap Mental Health Services Department of Social & Health Services Kitsap Community Resources: Housing Solutions Center, Family Development, Energy Assistance American Legion (Veteran Services Officer) Dispute Resolution Center: Mediation, Education & Behavioral Health Ombudsman Kitsap Sexual Assault Center (KSAC)

Organization or Site Name	Focal Point Address	Public Contact Information	Services Coordinated at the Site
			Crime Victim Assistance Center (CVAC) Sound Works Job Center YWCA (Domestic Violence)

SECTION C
Issue Area Themes

C-1 Health and Wellness in an Age-Friendly, Dementia-Friendly Community

C-1.1 Healthy Aging

PROFILE OF THE ISSUE

As individuals live longer, a commonly expressed goal remains to age well and maintain health and independence. In the United States the “baby boom” generation, the largest ever born (78 million Americans), is in the process of transforming American society as it moves into its older years. Baby boomers are changing the expectations of aging, and by necessity, highlighting the importance of communities that provide affordable and accessible opportunities for people to age well, and age in place.

These population changes present opportunities, as well as challenges, in meeting the needs of Kitsap County residents. Preparation is needed in multiple areas. It will take time to advocate for and develop the kind of community services, programs, housing options and environment needed to respond to these changes.

A comprehensive approach to planning is necessary. We need to bring issues relevant to an age, dementia, and disability friendly community to government leaders, business leaders, civic leaders, and the larger community and advocate for positive change. By looking at this issue in a holistic manner, we can greater impact changes affecting the community.

There is still a need to focus on the vision of an Age-Friendly Community that:

1. Encourages people of all ages to prepare for retirement and life beyond 60 years.
2. Develops “age sensitive” service infrastructures that support people as they age.
3. Establishes and adapts existing services to recognize and accommodate the needs of older adults and adults with disabilities.
4. Builds and adapts physical infrastructures that support people as they age.
5. Promotes creative ways for the County’s aging population to utilize their talents, skills, and experiences in both paid and unpaid roles for the benefit of both the individual and the community at large.
6. Promotes flexibility in the workplace to accommodate and support family caregivers.
7. Promotes flexibility in the workplace to accommodate and support the vital role of an increasingly aging pool of workers.

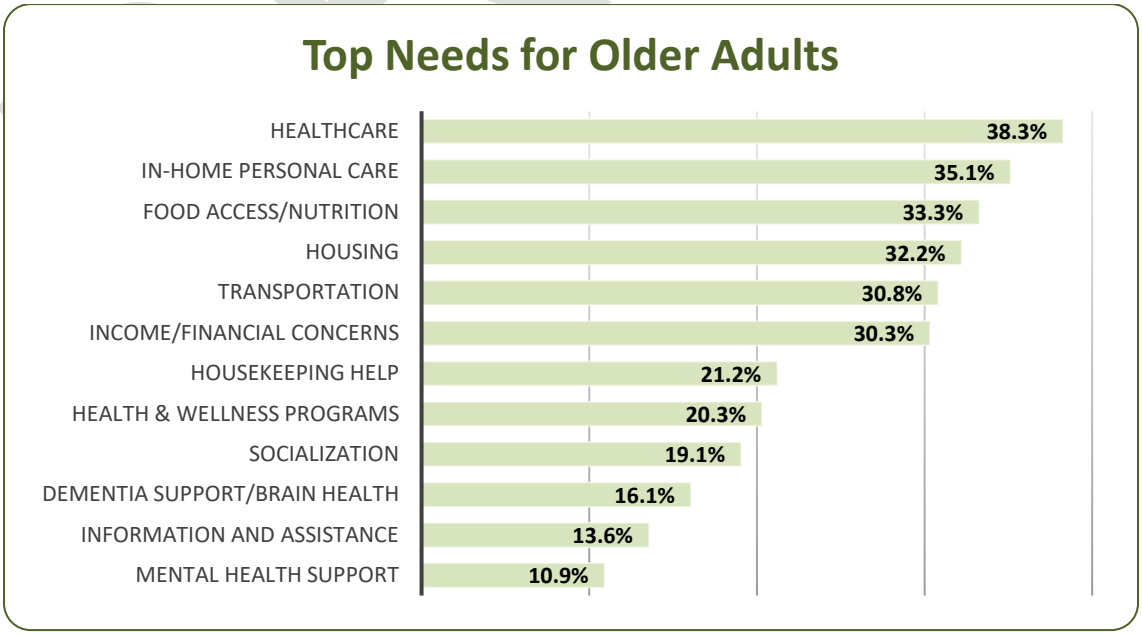
Change that enhances older adults’ quality of life will improve conditions for everyone because Age-friendly communities are good places for people of all ages and abilities to live. Age-friendly communities become communities of choice for everyone.

As a part of the Area Plan process, Kitsap County Aging and Long-Term Care (ALTC) surveys local public, seniors, caregivers, nutrition program participants, and providers with the goal of preparing the county to respond to growing demands. In 2023, ALTC received over 1400 survey responses. The objective continues to be to identify the most critical issues necessary to creating and maintaining a community that would respond to these needs and be socially enriching in the process. In the 2023 survey, and surveys completed for prior area plans, several commonly identified issues consistently surface. It is interesting to note that although issues identified by respondents may shift in priority, fundamentally the overarching issues remain constant. (Prioritization may change as the population ages in place, the economy fluctuates, transportation costs rise, social and cultural perspective shifts occur, and in recent years, impacts of the pandemic). Therefore, they continue to be a focus. Priority issues are outlined below, and in the goals and objectives to be addressed over the next four-years.

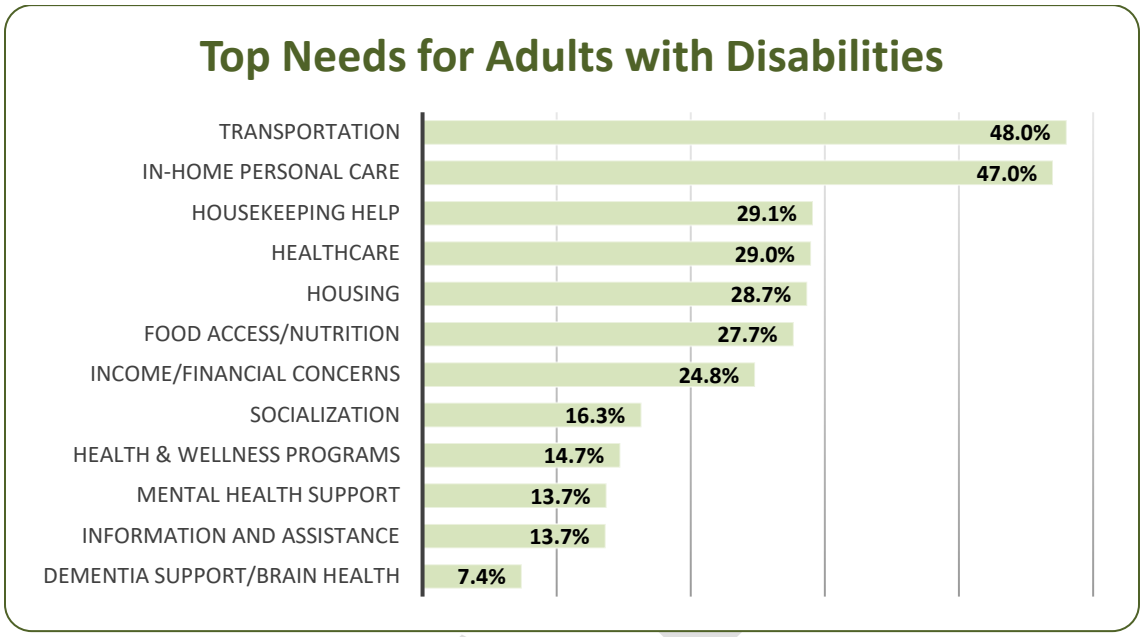
2023 Community Needs Survey: Data and Trends

Priority Needs Of Target Populations

Ensuring that basic needs are met is critical for all community members. In the 2023 Area Plan Community Needs Survey, respondents were asked to identify the top three needs for older adults and adults with disabilities. Basic needs are interrelated and strongly connected to additional factors that affect all areas of a person's life. For example, the rising cost of healthcare has the potential to directly impact the ability to afford housing or food in our area. Below is a graph depicting results that the top concerns of older adults identified through the survey are healthcare, in-home personal care and food access & nutrition, followed closely by housing, transportation, and financial concerns .

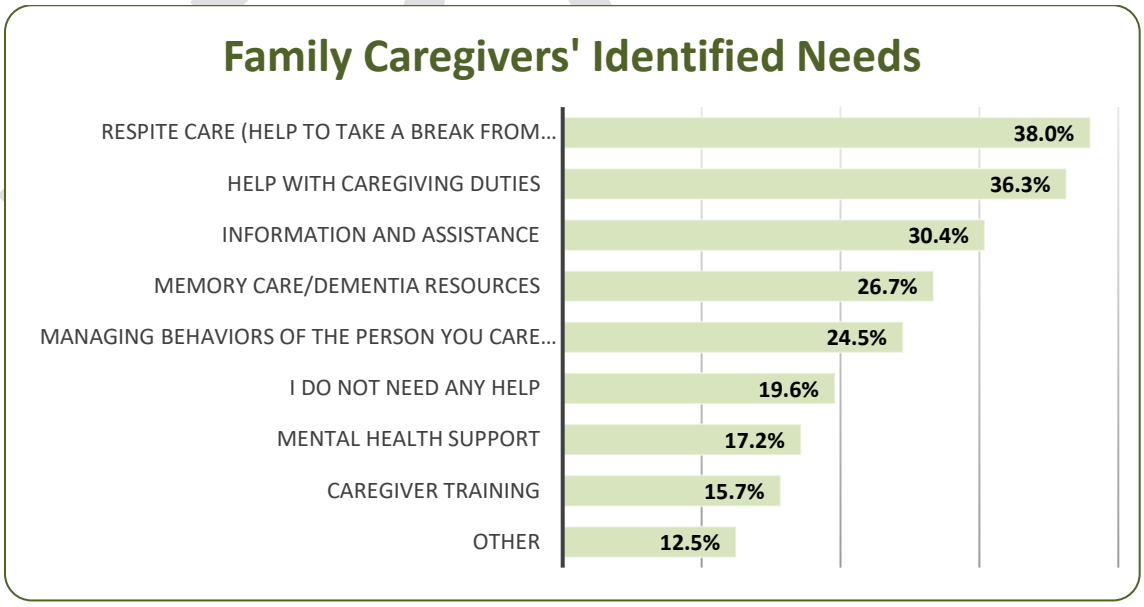


Top identified needs for adults with disabilities rated differently, as demonstrated below:



CAREGIVING

About 29% of survey respondents provide care for an adult family member, friend, or neighbor. Caregivers' priority needs are respite care and help with caregiving duties, followed closely by information and assistance and memory care/dementia resources.



Services to support the identified needs for older adults and caregivers is detailed later in this Area plan.

WELLNESS AND COMMUNITY ENGAGEMENT

Access to opportunities for social and civic engagement, meeting with friends, neighbors, or other community members in a variety of recreational, cultural and employment settings, is a key element in the healthy life of any community. It is an essential feature of a community that is Age-friendly. Social engagement is a key to maintaining mental, emotional, physical health and independence. The strongest predictor of premature death among older people is social isolation; cognitive decline is approximately twice as great among those reporting no social ties than in those who had frequent contact with relatives, friends or participated in regular social activities. Fostering healthy social contact and engagement does more than enhance quality of life, it is a basic component to any service strategy whose goal is to foster health and well-being for older adults.

Positive Trend

More than half of survey respondents participate in exercise or wellness programs (52%).

One third (33%) are volunteering. This survey demonstrated a drop in individuals who participated in social, cultural or religious activities in the community, however, from 63% to 35%. Given the pandemic, this is probably not surprising. Of those that marked "other activities" they were involved in, hobby groups were at the top.

- **Cost, transportation, and needing information about where to attend ranked as the top 3 identified reasons involvement was difficult.**

When respondents marked "other" (22%) to reasons participation may be difficult, the top reasons were caregiving, physical health, COVID concerns, unavailable programs, followed closely by mental health or mental strain.

Fall Prevention

Although it is promising to see involvement in exercise, wellness programs and other self-care activities, we know that for many older adults, falls are still a huge risk.

According to the Centers for Disease Control and Prevention, more than 1 in 4 people 65 and older falls each year. Falls can lead to a loss of independence, but they can be preventable.

In Kitsap County for people ages 65 and older:

- There were 665 hospitalizations[12] and 35 deaths[13] from falls in Kitsap residents aged 65 and older in 2019. While there has not been much change in hospitalization rates for falls in older adults, there has been a statistically significant decreasing trend in fall deaths in Kitsap from 2014 to 2020, with only 31 deaths in 2020. Although the decreased trend is good, attention to prevention is important.
- The risk of hospitalization or death due to fall-related injuries significantly increases as you age. Compared to the 65-74 age group, those ages 75-84 were almost 5 times more likely to die due to a fall-related death and more than twice as likely to be hospitalized due to a fall related injury. Those ages 85 and older were nearly 19 times more likely to die due to a fall-related death and nearly 5 times more likely to be hospitalized due to a fall-related injury.[12] [13]

NUTRITION AND FOOD ACCESS

This topic rated in the top three identified needs for older adults in the 2023 ALTC survey.

In answer to the question “How do you usually get the food you eat?”, respondents replied with the following:

- 96% shop at a grocery store for their food
- 42% eat at restaurants
- 24% get food from personal or community gardens
- 21% purchase food at a farmer’s market
- 10% get their food from other sources (friends/family, housing program)
- 7% go to a food bank
- 7% get meal delivery from the grocery store or pre-packaged
- 6% receive senior program home delivered meals
- 3% eat at a congregate or community meal

[12] Source: WA Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS). Washington State Department of Health, Community Health Assessment Tool (CHAT).

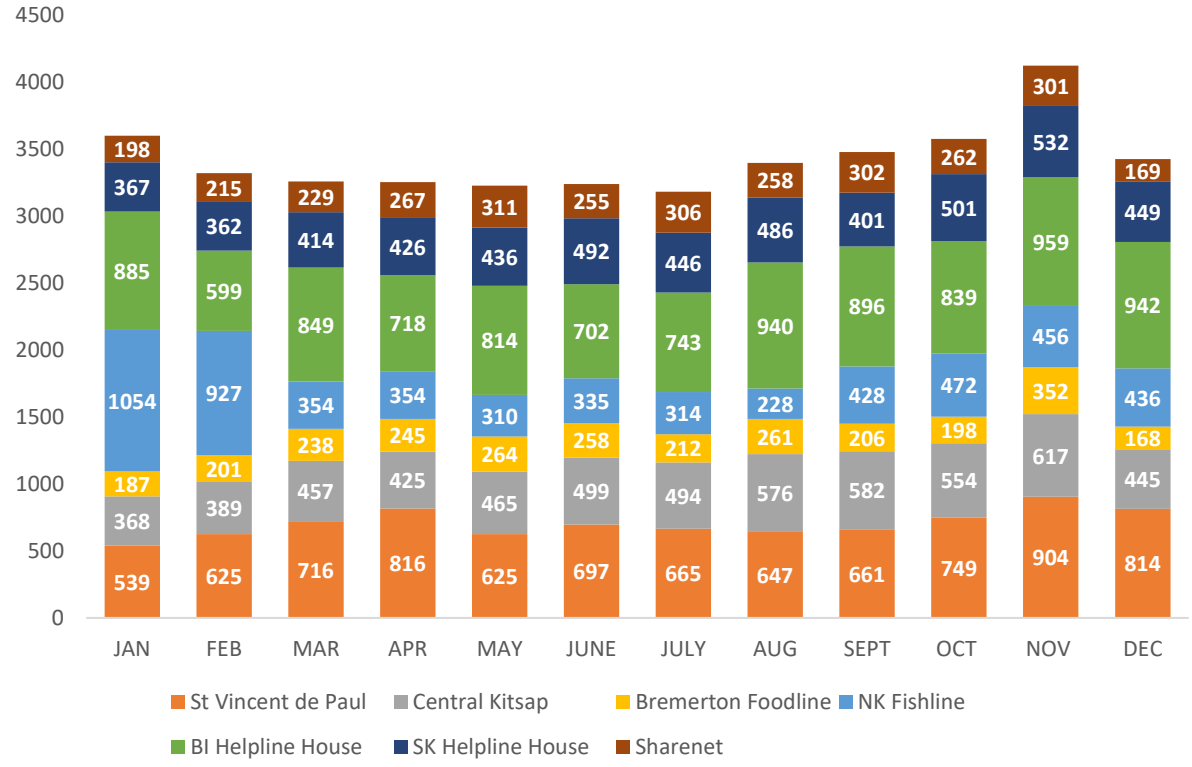
[13] Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data, Community Health Assessment Tool (CHAT)

Individuals who ate smaller portions or skipped meals listed, in order, these reasons: health issues, poor appetite, dental problems, not enough money to purchase food, inability to prepare food, inability to get to a grocery store, and inability to get to a meal site.

Food Insecurity

In 2022, there were a total of 41,058 (duplicated and unduplicated) visits to the food banks of Kitsap County by older adults (ages 55 and older). The food banks experienced the most visits among older adults in November 2022 with a total of 4,121 across all organizations. Additionally, the most visited food bank among older adults in Kitsap County in 2022 was the Bainbridge Island Helpline House with a total of 9,886 visits[14].

Figure 8. Food Bank Participation by Organization, Kitsap County, 2022



[14] Source: Felicia Kolhage, St. Vincent de Paul, Email Communication, 2023

From 2016-2020, a total of 7.9% of older adults in Kitsap County reported receiving Supplemental Nutrition Assistance Program (SNAP) funding. The highest rate of SNAP funding was among residents of Bremerton[15].

A systematic review of evidence showed home-delivered meal services increased the percentage of older adults who met their Recommended Daily Allowances for energy and protein and decreased malnutrition by 15.5 percentage points. Congregate meal services decreased malnutrition by nine percentage points[16].

In response to the pandemic, congregate community dining sites offered carry-out meals as an alternative to onsite dining, and in 2023 this is still an option. Program participants still seek this option even as sites are reopened. Home Delivered Meals remained an important nutrition service, and check-in with seniors, countywide.

Education and outreach efforts to inform older adults about availability of food benefits, and nutrition programs, as well as advocating for funding for programs, are important strategies to help reduce food insecurity.

The numbers of older adults will continue to dramatically increase, due to the Baby Boomers and increased life span. This population will be more diverse, and since health disparities exist within minority populations, chronic health problems will increase as well. The cost of medical care, as well as the potential loss of the contributions of older adults due to disability, makes an emphasis on healthy aging imperative.

SERVICES USED AND BARRIERS TO ACCESS

Services identified as “currently used” were housekeeping, transportation, and in-home personal care. These were closely followed by exercise, senior and community centers and caregiver support.

[15] Source: U.S. Census Bureau, American Community Survey (ACS), https://www.data.census.gov/

[16] Source: Guide to Community Preventive Services. Nutrition: Home-delivered and Congregate Meal Services for Older Adults. June 22, 2022. https://www.thecommunityguide.org/findings/nutrition-home-delivered-and-congregate-meal-services-older-adults.html

"Poor or no sidewalks"
is the largest barrier to community access, followed by few amenities near my home, lack of physical ability, and no public transportation.

TRANSPORTATION

Most survey respondents reported they drive. However, when given the opportunity to write in what they felt was an unmet need, respondents overwhelmingly considered the need for bus or other transportation as an unmet need or barrier to independence for older adults in Kitsap County.

- 85% drive where they need to go
- 26% ride with friends, neighbors or family
- 6% ride the bus
- 4% use ACCESS
- 3% use a taxi
- 2% use a volunteer transportation program
- 1% use a Transit shuttle or other accessible service
- 1% use Paratransit

HOUSING

When asked about problems with housing, 34% of survey respondents indicated they had no problems with housing. However, of those who did, the top 5 responses in order included:

- Need minor home repairs
- Property taxes
- Housekeeping
- Affordability
- Need major home repairs

"Other" followed closely, and that top response was yardwork.

Independence And Access For All

Maximizing independence is vital to the health of our communities. A community that can provide accessible and affordable transportation, adequate in-home services and choices in community supports offers its residents opportunities to be active and involved. These issues are especially important to older people and people with disabilities dependent upon services for control over their lives, independence, and avoiding institutional care.

Photo courtesy of Kitsap Transit

Inherent in any discussion about needs is the related question about how do we develop strategies to address these concerns? All needs and possible opportunities need to be considered as we plan and involve consumers and stakeholders in these important conversations.

Problem Statement

The County's population is rapidly aging. Government, business, civic, education and community leaders need to proactively plan for the changes this will make in how they provide services, build infrastructure, capture the valuable contribution of older adults, and integrate aging citizens into all aspects of our community.

Goals

Encourage further development of an Age-Friendly Community through increased awareness of changing demographics and the dramatic increase in the aging population. Work with individuals, community members, providers, business, and government in efforts to meet the basic needs of older adults and caregivers.

Promote positive aging and community engagement opportunities.

Advocate for funding and creative resource development for services targeted to older adults and caregivers.

OBJECTIVES

1. Support food access efforts and nutrition resources.

Measured by:

- Advocate for sustainable nutrition funding and policies that provide opportunities to expand and/or continue services with flexible options like continued carry-out meal alternatives for congregate nutrition in addition to meal sites, expanded home delivered meals, and other creative nutrition programs.
- Promote food access and nutrition resources through community outreach and individualized consultation for seniors and caregivers.

Completion Date: 12/2027

2. Promote positive aging, socialization opportunities, and wellness, exercise, and prevention activities.

Measured by:

- Outreach and special campaign materials utilized in community education.
- Explore partnership and funding opportunities focused on fall prevention and wellness and exercise programs.
- Promote events, socialization, and exercise and wellness activities at various senior and community centers and other sites across the county.

Completion Date: 12/2027

3. Continue and further develop the advocacy campaign regarding issues that impact older adults and caregivers.

Measured by:

- Advisory Council meeting and W4A Legislative committee meeting minutes.
- Support of issues at legislative forums, town halls and other activities.
- Develop and promote training for the community to be senior advocates.
- Facilitate meetings with elected officials.
- Partnering with existing organizations with common issues.

Completion Date: 12/2027

4. Continue to participate in local housing and transportation planning.

Measured by:

- Meetings with local housing providers and advocates through Kitsap Continuum of Care; coordination with Kitsap County Human Services Department Homelessness/Housing Program Planner.
- Meetings with local transportation providers and representing Kitsap County needs on regional transportation planning committees.
- Representation at public meetings and councils as appropriate.

Completion Date: 12/2027

Multiple sections in this Area Plan address health and wellness goals for older adults, individuals with special needs, and caregivers across family and community systems.

C-1.2 Alzheimer's, Dementia and Brain Health

PROFILE OF THE ISSUE

In Washington State, an estimated 125,000 individuals have Alzheimer's disease or a related dementia.[17]

In Kitsap County, the projected prevalence rate of persons age 65 and above with Alzheimer's disease is 9.8%, by 2030 it is projected to be 12.1%. Kitsap County's annual growth rate is among the highest in the state when compared to other counties.[18] With the aging of the population, the number of older adults with dementia is increasing.

Dementia Support/Brain Health was identified as a need for help for 27% of caregivers and a priority for 16% of older adults in the 2023 Kitsap County Aging and Long-Term Care Community Needs Survey.

Dementia is not always diagnosed, even as individuals experience memory loss or other changes. Based on the 2020 Behavioral Risk Factor Surveillance System (BRFSS) for People Aged 45 Years and Older, "Subjective Cognitive Decline is self-reported memory problems that have been getting worse over the past year."

Results from the BRFSS survey for Washington indicate that:

- 1 in 11 people aged 45 years and older are experiencing Subjective Cognitive Decline
- 79% of people with SCD have at least one chronic condition
- 38% of people with SCD had to give up day-to-day activities
- Less than half of people with SCD have discussed their symptoms with a healthcare provider
- Over a third of people with SCD say it interfered with social activities, work, or volunteering
- 30% of people with SCD need help with household tasks[19]

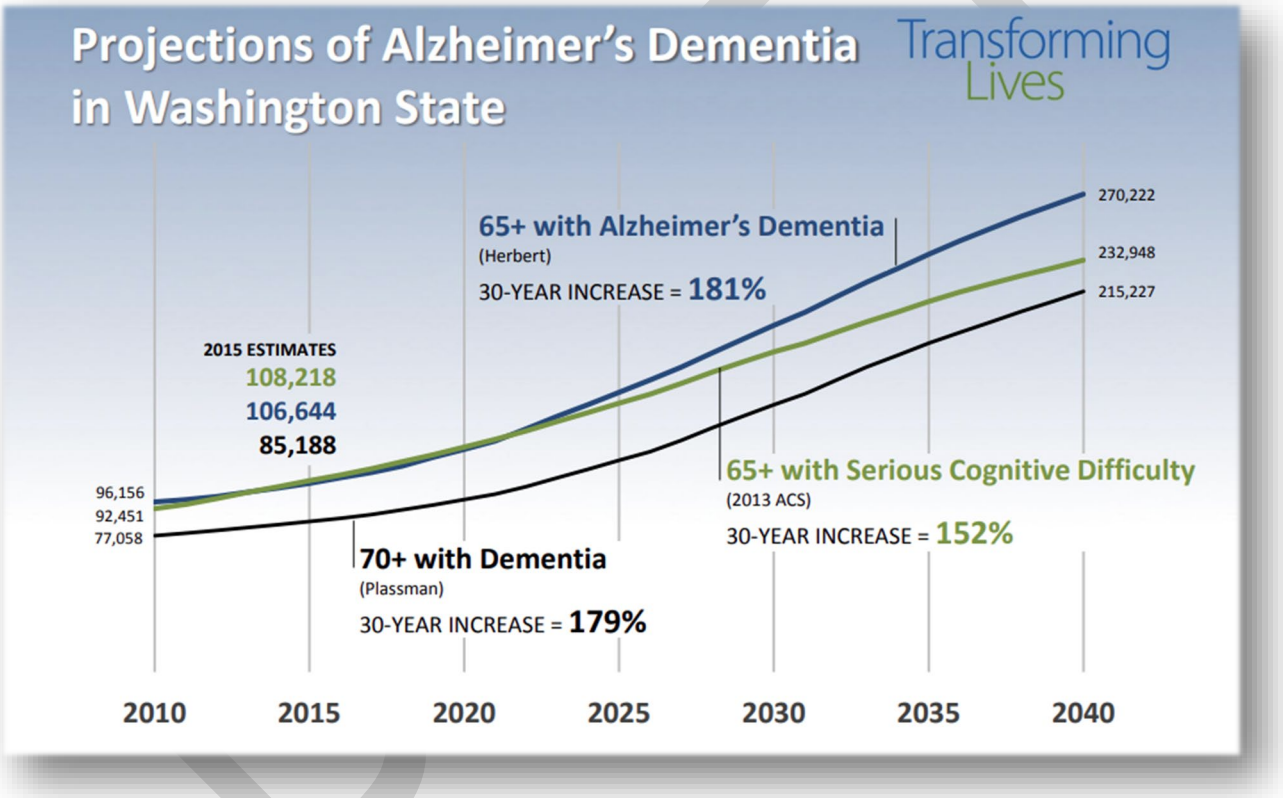
[17] Source: Washington State Department of Social and Health Services, Washington State Plan to Address Alzheimer's Disease and Other Dementias 2023-2028 Draft for Public Comment, Accessed June 23, 2023.

[18] Source: Washington State Department of Social and Health Services, Washington State Plan to Address Alzheimer's Disease and Other Dementias, January 1, 2016. https://www.dshs.wa.gov/altsa/stakeholders/alzheimers-state-plan. Accessed August 10, 2023.

[19] Source: Centers for Disease Control and Prevention, Subjective Cognitive Decline, https://www.cdc.gov/aging/data/infographic/2020/pdfs/wa-scd-h.pdf. Accessed August 9, 2023.

Alzheimer's disease is the 5th leading cause of death in the United States, and currently the 3rd leading cause of death in Washington State, and 4th in Kitsap[20] County. In Kitsap County, Alzheimer's disease is a major concern. When looking at the 20-year trend between 2000-2020, it is the 2nd leading cause of death.[21]

As seen in the chart below, over the next 30 years, it is projected that in Washington State, the total number of people age 65 and older with Alzheimer's and dementia will increase by 181 percent. For persons age 65 and older with serious cognition difficulty, the number is likely to increase by 152 percent. The number of people with dementia who are age 70 years and older is expected to increase by 179 percent.[18]



Planning to address the needs of individuals and caregivers impacted by dementia is vital to the vision of a healthy community.

Dementia is being diagnosed earlier than in previous years and people may be aware of their dementia diagnosis in the early stages of the disease. Early diagnosis is critical.

---

[20] Source: Washington State Department of Health, All Deaths – County and State Dashboards, https://doh.wa.gov/data-statistical-reports/washington-tracking-network-wtn/death/county-all-deaths-dashboard. Accessed August 10, 2023

[21] Washington State Department of Health, Center for Health Statistics, Death Certificate Data 2020, Community Health Assessment Tool (CHAT), December 2021. https://doh.wa.gov/data-statistical-reports/washington-tracking-network-wtn/death/county-all-deaths-dashboard. Accessed August 10, 2023

"Early diagnosis promotes early planning, risk reduction and opportunities for savings and impact.

The Problem:

- More than half of Washingtonians who reported that they have "memory loss that is getting worse", have not talked to a health care professional about it.
- Fewer than half of the people who meet the clinical criteria for dementia receive a diagnosis.
- Less than 10% of Washingtonians, at time of diagnosis, were referred to an Alzheimer's organization, just 14% were referred to information about community resources.
- Without diagnosis or post-diagnostic support, people with dementia and their families can't get the help they need – and care ultimately becomes more costly.
- The average annual Medicaid payments per Medicare beneficiaries with dementia were twenty-three times as great as those without dementia."[22]

The needs of someone with an early diagnosis of dementia are different from someone diagnosed later in the disease progression. Programs that focus on abilities, strengths, and bringing together individuals with early-stage diagnosis are vital. Additional supports for dementia-specific services addressing brain health, prevention, social engagement and needs at all stages of diagnosis are critical as well.

Currently it's estimated there are more than 213,000 unpaid family care partners of people living with dementia in Washington.[17]

For those friend and family caregivers taking care of a person with dementia, although it can be rewarding, impacts can be significant too. *Based on the 2023 Kitsap County Aging and Long-Term Care (ALTC) Area Plan Community Needs Survey, caregivers indicated priority needs are respite care, help with caregiving duties, and Information and Assistance, followed closely by memory care/dementia resources and managing behaviors of the person they care for.* It is important to realize that for some caregivers, especially caregivers who deal with dementia, providing care is often more than helping with daily living activities. It can mean all of that plus learning about different behaviors and communication changes of the person they care for, struggling with role changes in relationships and at times, living with the isolation that can result. Caregiving may include trying to deal with feelings of anxiety and depression of both the person they care for and themselves. Caregivers dealing with these issues may benefit from counseling and consultation with trained professionals, local or online support groups and workshops, and information to help with their specific needs.

[22] "Meeting Dementia Head On", Dementia Action Collaborative Washington State January 18, 2019. https://www.dshs.wa.gov/altsa/dementia-action-collaborative. Accessed July 24, 2019.

Dementia support education, consultation and referral are available through the Senior Information & Assistance/Community Living Connections and Family Caregiver Support programs at Kitsap County ALTC. Counseling referrals to assist individuals and caregivers and help to provide options in the community or through their healthcare providers is also available.

Kitsap County ALTC prioritized work investments to address the need for expanded dementia supports in the last Area Plan timeframe and this work continues.

In 2020 and 2021 the Partners in Memory Care project provided services to Kitsap residents, and their caregivers, to address challenging behaviors and stress associated with aging and mild to major neurocognitive dementia disorders and memory impairment. During 2023 the Dementia Consultant service continued, although changed to a new provider and utilizing different funding. This service for Kitsap residents, and their caregivers, supports addressing challenging behaviors and stress associated with aging and mild to major neurocognitive dementia disorders and memory impairment. It is also dedicated to providing community-based personalized education and strategies to address challenging behaviors that may affect the ability to stay where they live, regardless of an individual's ability to pay or funding source.

Current Dementia Consultant services are funded through Older American's Act dollars instead of the Mental Health 1/10th of 1% sales tax funding. Referrals for the Dementia Consultant are made through the Senior Information and Assistance phone number or email address.

In March of 2022 Kitsap Aging and Long -Term Care began offering memory screenings to seniors aged 60 and older. Memory screenings are free and can be scheduled by calling Information and Assistance. This is through a partnership with the Alzheimer's Foundation.[23] Kitsap Aging and Long-Term Care staff use the Brief Alzheimer's Screening (BAS) to accomplish this. Screenings typically take close to 10 minutes and can be completed in-person or via phone. Results are discussed immediately following the screening and additional information (date of the screening, name of the screening, scoring, ideas for promoting better brain health) are mailed to participants via USPS. These screenings are not intended to diagnose but do sometimes lead to discussions between patients and their care team.

Washington State Plan to Address Alzheimer's Disease and Other Dementias

Prompted by national legislative change, states worked to develop and implement plans to guide state governments on critical dementia issues and possible solutions, while improving services and supports for families affected by the disease. Washington State convened an Alzheimer's Disease Working Group (ADWG) to examine the needs of individuals with Alzheimer's disease. This group in concert with the Dementia Action

[23] Source: "What is a Memory Screening?" Alzheimer's Foundation of America, alzfdn.org. https://alzfdn.org/memory-screening/what-is-memory-screening/. Accessed May 2, 2023.

Collaborative (DAC) created recommendations and developed the state plan. The plan defines the scope of the economic and social impact of Alzheimer's disease; setting the direction for the state to become dementia capable.

In 2022, House Bill 1646 codified the Dementia Action Collaborative (DAC), identified members to be appointed by the Governor, and required an update of the plan by October 1, 2023 and annual recommendations each year thereafter through 2028.

Goals for the 2023 updated plan include:

- Increase Public Awareness, Engagement and Education about Dementia
- Prepare Communities for Significant Growth in population living with Dementia
- Promote well-being and safety of people living with dementia and their family caregivers and care partners
- Promote equitable access to comprehensive, culturally relevant support for family caregivers and care partners
- Promote risk reduction and evidence-based health care for people at risk of or living with cognitive impairment and dementia
- Increase equitable access to culturally relevant, dementia-capable Long-Term Services and Supports
- Facilitate innovation and research related to risk reduction, causes of and effective interventions for cognitive decline and dementia.[17]

At the local level, Kitsap County Aging and Long-Term Care plans to incorporate findings, align local goals and explore implementation of successful or new strategies and programs in future work.[18] Work that has occurred in the last few years include implementation of staff training to complete free memory screening, and work to continue access to a dementia consultant for individuals experiencing memory loss and their caregivers.

GOALS

Increase awareness about Alzheimer's disease, memory care and wellness; promote brain health and increase access to detection and services earlier in the disease process; and enhance service options to offer dementia-specific education, consultation, counseling, training, and respite options for individuals with memory loss and their caregivers.

OBJECTIVES

1. Sustain Dementia Consultant services dedicated to providing community-based personalized education and strategies to address challenging behaviors threatening placement, regardless of an individual's ability to pay or funding source.

Measured by:

- Local advocacy for additional state and national funding to support individuals and caregivers impacted by dementia.
- Contract with provider to provide Dementia Consultant services in Kitsap County.

Completion date: 12/2027

2. Partner with organizations and local professionals to coordinate workshops, conferences, and other education opportunities to individuals with memory loss and caregivers caring for someone with Alzheimer's disease or dementia.

Measured by:

- Provide evidenced-based or other training or support opportunities to caregivers to help caregivers manage behaviors.
- Ongoing promotion of safety resources and educational materials for this population.

Completion date: 12/2027

3. Explore and support local development of dementia-specific community engagement opportunities and creative approaches to local partnership development to enhance options to meet the needs of this population.

Measured by:

- Memory screening support activities delivered by ALTC staff.
- Coordination activities with Alzheimer's Association and other community potential partners.
- Promotion of inclusive, independent, active engagement opportunities for persons with dementia.
- Support of statewide efforts addressing workforce shortages impacting access to care and respite.

Completion date: 12/2027

C-2 Service Options that Support Older Adults and Family Caregivers

This section is about responding to the identified needs of community members, providing options to meeting individual goals, and working on alternatives to Medicaid funded long-term services and supports. This is accomplished by connecting services and support options to meet local needs.

C-2.1 Community Living Connections

PROFILE OF THE ISSUE

Community Living Connections (CLC) is an expansion of the Senior Information and Assistance (I&A) program.

Kitsap County Aging and Long-Term Care (ALTC) made a major commitment to increase visibility and expand services through the Information & Assistance Program (I&A) over the last 20+ years. A separate service unit was created to ensure the necessary resources and program structure to attain these objectives. With the Family Caregiver Support program integrated into I&A operations, services were further developed to respond to the trend that more people opt for care in the home over institutional services, and that for many, Medicaid is not a viable option.

Community Living Connections (CLC) is a statewide vision. It is not just a physical location, but a service delivery framework serving older adults and individuals with disabilities and their caregivers. CLC builds on existing infrastructure and resources to provide seamless and efficient access to services. CLC integrates established service programs into one integrated model with multiple components.

ALTC staff providing direct service receive training in Person-Centered Options Counseling, a service intervention available through CLC. This interactive process provides guidance to individuals needing supports and services. Through a personal interview, staff helps individuals identify what is important to them and for them, so they can create an action plan to help them live independently in the community.

To help facilitate seamless service delivery, Aging and Long-Term Support Administration (ALTSA) of Department of Social and Health Services (DSHS), worked with Area Agencies on Aging (AAA) to develop a client management and resource directory information and referral system called GetCare. The system is a platform to create seamless linkages between clients needing information and the services needed.

To assist with consumer choice and independence, consumers can search for resource information, complete an assessment, and self-refer to programs and services. Local data is updated by ALTC staff for statewide access and consumer self-service. Services not appropriate for self-service or requiring specific interventions or referral processes remain at the local level. Although the public can search the web-based system for resource information, community members may need assistance in navigating the information available. I&A is available to provide that assistance, but people may not know about the services.

It remains a challenge to increase community awareness and to get useful information to older people and caregivers so they can make informed choices. As we think about targeting outreach, 43% of the Area Plan 2023 survey respondents indicated they get information about services for seniors and caregivers online, (followed by friends and

neighbors, email, health care provider, AARP, public health, family, TV, social media, and ALTC).

Community members may continue to be unaware of the Information & Assistance service. Lack of information results in delayed or less effective interventions than if consumers have access to information and support prior to a crisis or when they are preparing to make decisions. Ongoing access to information and support is important.

Additionally, the availability of on-line information is changing the way many consumers seek information. Given that older adults are online more, and those who are not may rely upon family and friends to assist with critical choices for care, the use of websites, on-line resource databases and self-help materials will continue to be needed to provide improved access to information about choices and resources for seniors and their family members. These efforts should complement the traditional approaches to information distribution (telephone directories, newspapers, brochures, and resource directories).

Finally, with the trend to grow and streamline Information and Assistance (I&A) services with Community Living Connections (CLC), funding this program is an ongoing challenge. As we work to improve service delivery options – plus expand upon the existing program by serving a wider population – it is critical that adequate funds are provided for these services.

Currently, Information & Assistance services available in Kitsap County include:

- **Senior Information & Assistance (Senior I&A)** is a program that is an integrated system designed to locate and identify persons who need services and link them with the most appropriate resources. The I&A program provides information, screening for program eligibility, service referral, assistance, and advocacy. The program also includes information about and referral to Family Caregiver Support. The I&A program also takes a lead role in coordinating public education efforts and maintaining a directory of community resources. These programs and services are key components in a long-term care system that promotes aging in place.

- **BenefitsCheckUp** is available online through the National Council on Aging. It provides links to apply for a variety of cost-savings programs a person may qualify for in their local area. Information and support to access it is available through Senior I&A. There is also a link on the agency website. Individuals who do not have internet access or would have difficulty getting to the office can ask for a printed questionnaire to complete and mail back. Their information is entered on the website and their report and local services materials are provided at no cost.

- **Medicare Improvements for Patients and Providers Act (MIPPA)** offers beneficiaries Medicare and Medicare Part D outreach and assistance services provided by Senior I&A staff, including assistance to Medicare beneficiaries to

enroll in Medicare Part D or to apply for Medicare Low-income Subsidy (LIS) and Medicare Savings Plans (MSPs). MIPPA outreach includes coordination activities and education efforts to encourage beneficiaries to participate in disease prevention and wellness activities.

- **Hospital Care Transitions** is a newer service that offers support to adults with acute needs to transition home from the hospital. The goal is to reduce future hospital visits. This is accomplished through receiving referrals from local hospitals, meeting with individuals to complete an assessment, and development and implementation of an individual plan of care. Examples of support may include assistance with referral to caregiving programs, coordinating transportation to doctor appointments, support with applying for programs offering nutrition, and establishing and working with natural supports.

- **Senior Drug Education** provides adults, age 60 and older, education and information on safe and effective use of medication (prescription drugs, vitamins, and herbs) through seminars, presentations, health fairs, education materials, online or recorded video presentations posted on the Aging and Long-Term Care website, and one-to-one education and consultation.

- **Social Check-in Calls** are available for Kitsap residents age 60+ who would like a friendly phone call. Calls are social in nature. A customized schedule Monday-Friday 8-4:30 is offered that is flexible for seniors to change at any time. Staff can also help seniors explore resources in the community and there is no income eligibility to participate. Referrals are initiated through a call to Senior I&A.

I&A/CLC Core Components

(As defined by the Administration for Community Living)

Information, Referral, and Awareness

Strategies are in place to include surveys, inquiries when individuals' complete registration/reservations to attend events, direct inquiry as to how individuals hear about services, and post-event evaluations.

Options Counseling and Assistance

This service is provided through I&A direct service staff. I&A/Family Caregiver staff complete Person-centered Options Counseling training.

Streamlined (Access to) Eligibility for Public Programs

I&A Staff are utilizing BenefitsCheckUp and Washington Connections online tools. Training related to CLC is ongoing.

Person-Centered Transition Support

I&A/Family Caregiver staff are familiar with this model of support and service. If increased staff resources and funding are available, other models and provider agreements to serve expanded consumer populations may be considered.

Consumer Populations, Partnerships and Stakeholder Involvement

Direct services include Family Caregiver Support, Medicare Improvements for Patients and Providers (MIPPA), Senior Drug Education, Hospital Care Transitions, information about WA CARES, and case management for Medicaid-funded programs. Service expansion would necessitate additional staff resources and funding to put in place partnership agreements and provide expanded services to a broader population. Informal partnerships continue, and work to strengthen and expand partnerships is ongoing. Agreements or contracts to expand services would also require additional funding.

Quality Assurance and Continuous Improvement

ALTC relies on the Aging and Long-Term Support Administration of DSHS to provide support with sustainability and identifying standard CLC metrics.

Training

Some services accessed already exist through ALTC are provided by new or established partners. However, there are gaps in services and access to resources at all levels and for many target population consumers. Staff need ongoing training opportunities with providers serving populations under 60 years of age and special needs populations. And those providers may need additional information about the local services available. Accessing training opportunities for program staff while still being able to respond to service needs is difficult due to limited staff resources.

Partnerships

Kitsap County ALTC has strong partnerships and local community connections. Partnerships include local networking groups, cross-system referral sources, subcontractors, and local providers. Some examples are Kitsap Information Referral Network, Long Term Care Alliance, Kitsap Housing and Homeless Coalition (KHHC), Vulnerable Adult Task Force and other networking and community collaborations.

Kitsap County Aging and Long-Term Care collaborates with partner organizations who develop easy-to-read program materials. Through distribution to the public, materials and partner agencies offer other ways to access services. Additionally, public information is disseminated through partner meetings and outreach. Outreach includes annual Older Americans month activities, program overviews to senior centers,

resources for seniors and family caregivers at the “Senior Lounge” at the annual Kitsap Fair and Stampede, and other public information activities that occur through the year.

ALTC plans to strengthen existing, and establish new, connections with Veterans Assistance (VA) Medical centers, the local VA clinic, and local Veteran’s Home (Retsil) and military support services referral sources. We plan to reach out to a variety of community partners, providing cross training opportunities, and involving stakeholders in building a strong network.

Potential new partnerships could be with faith communities, providers of services to disability and advocacy groups, and other programs that serve a variety of target populations. Strategies to engage would include:

- Coordinating cross-training opportunities for direct services staff
- Coordinate on special events offering topics pertinent to broader populations
- Initiate meetings to build rapport and develop new partnerships
- Invite potential stakeholders to community and planning events

The traditional Senior Information & Assistance service model has evolved with the addition of the Family Caregiver Support Program and TCARE®, Medicare Improvements for Patients and Providers (MIPPA), and more recent additions of Care Transitions and a social check-in call service. Additionally, national Information & Referral (I&R) standards provide criteria for the development of comprehensive systems to meet the needs of diverse communities and consumers.

The Older Americans Act (reauthorized) and Lifespan Respite Bill emphasize the importance of establishing Community Living Connections resources and may be a condition for many future funding opportunities. This presents opportunities for Area Agencies on Aging to expand their role as a trusted source of information and guidance. Along with expanded roles comes the challenge to review existing business models and the need for potential organization and system redesign.

PROBLEM STATEMENT

1. Community members may not access services that are available because of the perception that no cost or low-cost services are limited by eligibility criteria or are cumbersome to access. Despite community awareness efforts, consumers may not seek information about services until they, or a family member, have a need for these services. Often it is then at a crisis.
2. Consumers report difficulty navigating through the many different organizations providing various pieces of information or services.
3. The “network” of options is more limited for some individuals who come to the program with the greatest social and economic need. At the same time, referrals

demonstrate increased complexity in individual and family situations, and are present regardless of social and economic need.

4. Inquiries and requests for assistance from the public have increased significantly over the last decade, with a 48% increase seen even over the last three years. While the program continues to be a priority need identified by local community members, funding will need to increase to adequately meet demands. There is not a sustainable revenue source to fund expansion of services to meet the increased demand driven by the increasing numbers of people who face aging and disability challenges. The next four years presents opportunities to continue to explore options for doing business differently and seek alternatives to help address this challenge.

GOAL

To provide older adults, persons with long term care needs and families with access to the Information & Assistance they need to meet their goals and address needs. Providing this service with an emphasis on consumer choice and multiple access options like in-person, phone, mail and online continues to be a priority.

OBJECTIVES

1. Improve consumers access to long term care and healthy aging information.

Measured by:

- Assessment and posting of relevant links/content to ALTC website.
- A minimum of 8 targeted outreach events per year.
- Information and Assistance call outcome summaries.

Completion Date: 12/31/2027

2. Conduct Medicare outreach and education including disease prevention, wellness topics, and assisting beneficiaries with Part D enrollment and/or application for a Low-income Subsidy (LIS) and Medicare Savings Programs (MSPs).

Measured by:

- Quarterly reports of number of Medicare beneficiaries served.
- Quarterly reports of health and wellness outreach and partnership activities.

Completion Date: 12/31/2025

3. Advocate for sustained or increased Senior Citizen Services Act (SCSA) funding and new funding opportunities to support Senior I&A/CLC services.

Measured by:

- Advisory Council Minutes.
- Meetings with elected officials.
- Public Forum(s) and other community input opportunities.

Completion Date: 12/2027

C-2.2 Family Caregiver Support Program

PROFILE OF THE ISSUE

Estimates suggest that nearly one-quarter of all people aged 65 and older in the United States have a disability that results in a need for some type of long-term care. This means they need assistance with activities of daily living (bathing, eating, toileting, mobility), or instrumental activities of daily living (transportation, laundry, cleaning). Some will need care twenty-four hours per day, others less often.

Although caregiving has an affect at all ages, the aging of the population is impacting caregiving trends as well, the national average age of caregivers is 50 with 20% of the care to adults 50 or older being provided by caregivers 65 and older[24].

Caregivers across all ages spend an average of 24 hours per week on caregiving. Most caregivers of adults care for a relative (89 percent), typically a parent or parent-in-law (50 percent), spouse or partner (12 percent), grandparent or grandparent-in-law (8 percent), or adult child (6 percent), though 10 percent provide care to a friend or neighbor[25].

About one in four caregivers reported caring for more than one person in the past 12 months. On average, caregivers reported providing care for 3.9 years[26]

Caregivers may need ongoing support to provide care and support safely and effectively. This need is recognized at both national and state levels. The Family Caregiver Support Program (FCSP) receives state and federal funding to focus on the needs of unpaid caregivers. FCSP staff is trained to use the evidenced-based Tailored Caregiver Assessment and Referral (TCARE®) protocol.

Top priorities of surveyed KITSAP COUNTY CAREGIVERS

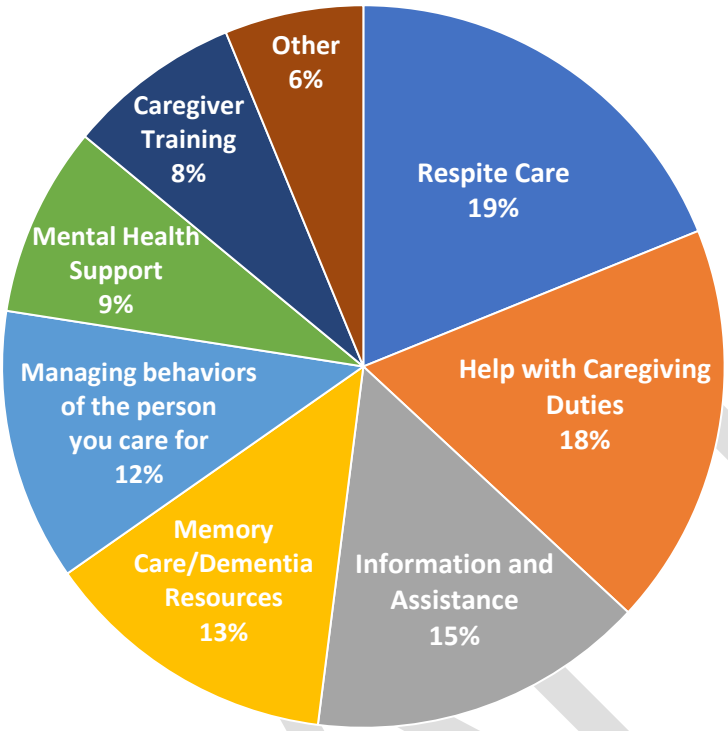
- Respite for caregiving
- Help with caregiving duties
- Information and Assistance

[24] Source: AARP and National Alliance for Caregiving. "Caregiving in the U.S. 2020: A Focused Look at Family Caregivers of Adults Age 50+." Caregiving.Org, November 2020. https://www.caregiving.org/wp-content/uploads/2021/05/AARP1340_RR_Caregiving50Plus_508.pdf. Accessed August 4, 2023.

[25] Source: AARP and National Alliance for Caregiving. "Caregiving in the U.S." Caregiving.Org, May 2020. https://www.caregiving.org/wp-content/uploads/2020/08/AARP1316_ExecSum_CaregivingintheUS_508.pdf. Accessed August 4, 2023.

[26] Source: Caregiving.org. "National Alliance for Caregiving," n.d. Accessed August 4, 2023.

Identified Needs



One of the goals in working with families is to offer a diverse and responsive set of supports that mirrors the diversity and complexity of their unique caregiver situation.

Informal partners in care may need support setting up formal authority for decision-making or navigating access to benefits systems. The evidenced-based Tailored Caregiver Assessment and Referral (TCARE®) protocol that includes the personal caregiver survey, screening, assessment and tailored one-to-one consultation combined with support services are available to help meet that goal with family caregivers.

Since many persons helping and supporting care have assumed responsibilities but do not necessarily call themselves “caregivers”, they may not look for services or supports targeted in that way. Understanding that, it can present a barrier because identifying as a caregiver opens doors to services and supports.

Another aspect of caregiving is the economic impact of providing care. Caregivers often make financial sacrifices to support the care of others. They may contribute their personal income or savings, or may sacrifice their employment, or employment position.

- *One in 5 caregivers report high financial strain as a result of caregiving (18 percent).*
- *Four in 10 have experienced at least one financial impact as a result of their caregiving (45 percent).*

- *Most commonly, 3 in 10 have stopped saving (28 percent) and 1 in 4 have taken on more debt (23 percent), both of which could have longer-term repercussions on caregivers' financial security into the future, especially if the caregiving situation lasts a long time.*

"Six in 10 caregivers report working while caregiving (61 percent) and the majority have experienced at least one work-related impact (61 percent). Most working caregivers report going in late, leaving early, or taking time off to accommodate care (53 percent). One in 10 working caregivers have had to give up work entirely or retire early (10 percent). When this happens, caregivers more often face financial impacts (2.9 on average) and are twice as likely to report high financial strain (35 percent)."[27]

Caregiving also takes a financial toll on employers. It is estimated that Alzheimer's disease (AD) costs business in the United States billions of dollars a year due to time employees take off to care for a relative with the disease. When all types of caregiving are taken into consideration, the cost to business is even higher.

To help offset these issues, more employers are offering flexible schedules, reduced hours, unpaid time off, and other creative approaches to their workers with caregiving responsibilities[28]. With such supports, more caregivers can provide care while remaining productive employees.

Locally, the number of families coming to the family caregiver respite program with higher level needs and higher complexity of caregiving and life situations is rising. Caregivers often have their own health problems. There is sometimes reluctance to accept referrals for Medicaid in-home or facility options, due to financial considerations or perceptions about family caregiver responsibilities and avoidance of formal, government interventions. As people are living longer, there is a higher burden on adult children caregivers who can be either seniors themselves or sandwich generation caregivers with younger families at home. There is also a need for specialty-trained caregivers as the complexity of care for in-home care needs rises.

[27] Source: AARP and National Alliance for Caregiving. "Caregiving in the U.S." Caregiving.Org, May 2020. https://www.caregiving.org/wp-content/uploads/2020/08/AARP1316_ExecSum_CaregivingintheUS_508.pdf. Accessed August 4, 2023.

[28] Source: Valuing the Invaluable: Putting a Dollar Value to Family Caregiving, AARP Public Policy Institute-Source: Reinhard, Susan C., Feinberg, Lynn Friss, Choula, Rita, and Houser, Ari. Valuing the Invaluable: 2015 Update – Undeniable Progress, but Big Gaps Remain (2015): 1-25. AARP Public Policy Institute. July 16, 2015.

FAMILY CAREGIVER SUPPORT SERVICES

The Family Caregiver Support Program (FCSP), associated with Senior Information & Assistance, provides family caregivers with information, consultation, service coordination and other support services including:

I. Caregiver Resource Center & Library located at the Givens Community Center in Port Orchard offers materials for on-site reading and check out. These include a comprehensive selection of books, videos, periodicals, and pamphlets, as well as an Internet connection and directory of caregiver-oriented sites.

II. Caregiver Case Manager and Assistance Specialists are available to help caregivers decide what assistance they need, help coordinate these services,

TCARE® personal caregiver survey, assessment and consultation are provided to interested caregivers to help determine caregiver needs and options.

Kitsap County caregivers may receive support with the following FCSP Services:

- Information Services-group activities and outreach activities are delivered by ALTC direct services staff. The ALTC website is also a source of information for caregivers.
- Specialized family caregiver information-ALTC Case Managers and Assistance Specialists provide consultation and one-to-one support.
- Specialized family caregiver assistance provided by ALTC staff, including TCARE® Screening and Assessment/Care Planning.
- Counseling-Depending on need, referrals are made or support in accessing available services are provided.
- Training- includes one-time classes, caregiver education series, and special events such as workshops or conferences.
- Support Groups-these groups allow caregivers an opportunity to talk about their roles, problems and concerns with a peer group that may better understand their situation. Groups usually target a specific population of caregivers or are for individuals with a specific diagnosis (Alzheimer's, cancer, diabetes, etc.).
- The type of support groups supported, and how support is provided by ALTC varies as the agency responds to requests for special assistance. Examples include Alzheimer's Association groups, Parkinson's Support Group, Caregiver Support Groups, Brain Injury Support, ARC "Parent to Parent" group and education and support series.

- Respite Care Services: Respite gives a break to the unpaid or family caregiver by providing substitute care. Service may be provided in or out-of-home (including Adult Day Care, Adult Day Health, and short-term care in a licensed nursing facility) and is offered on a sliding-fee scale.
- Supplemental Services. Services include nutrition consultation, home delivered meals, legal, counseling, and durable medical equipment, or supplies. Service distribution method is based on a provider authorization to deliver the service to the caregiver or care receiver. No funds are provided to individuals directly.

There are currently no AAA service limits in effect that exceed the eligibility criteria associated with TCARE® statewide policy for services and steps. However, COVID-19 created new challenges for caregivers' access to services and availability of formal paid caregivers.

KINSHIP CAREGIVER SUPPORT PROGRAM:

Kinship Care is defined as full-time care provided by a child's relative or close family friend[29]. Although most often it is grandparents raising grandchildren, kinship care also includes care of children by other non-parent relatives. A 2019-2020 survey completed in collaboration with the Department of Social and Health Services, the Washington State Department of Children, Youth & Families, Partners for Our Children, and the University of Washington School of Social Work asked 898 kinship caregivers in Washington State questions about their experiences. Among these participants, the average age of respondents was 58 years of age and 90% of respondents identified as female.

- The median income of these caregivers was between $30,000 and $39,999. This was lower than the median income of Washington State, $73,294.
- Kinship Caregivers were most commonly identified as grandparents of the child in their care.
- Financial support was reported as the most common unmet need (35%) followed by recreation and social activities for the child (31%) and respite care (23%).

Compared to younger respondents, older respondents (55 and older) reported lower income. They were less likely to receive income from wages and salary and more likely to receive income from social security, disability, payments, pension, and TANF grants. Compared to younger respondents, the older caregivers were more likely to select their own physical health, delaying their retirement, and the child's education as challenges associated with kinship care. Additionally, older caregivers were more likely to report accessing special education services for children in their care as an unmet need[29].

[29] Kinship Care in Washington State, Partners for Our Children, https://www.dshs.wa.gov/altsa/home-and-community-services-kinship-care/kinship-care. Accessed August 4, 2023

In Washington State over 42,000 grandparents are responsible caregivers for a relative's children, an estimated 49% of those are age 60 years and over. In Kitsap County, 46% of grandparents responsible for grandchildren are 60 year of age and older [30]. An estimated 3.0% of householders 30 years and over, and 5.0% of those 60 years and over, live with and are responsible for care of grandchildren. In Kitsap County, an estimated 4.3% of persons 60 years and over live with grandchildren and are responsible for care[31].

Kinship care may become necessary for a variety of reasons including parental substance abuse, death, incarceration, abandonment, domestic violence, mental health issues, neglect or abuse, or a teenager not ready to be a parent. Kinship caregivers are often faced with unanticipated expenses when assuming responsibility for minor grandchildren or other relatives. Costs for legal guidance, including custodial authority, and other, basic needs such as clothing, child-appropriate furniture and housing changes can add to this burden.

Kinship Caregiver Support Program services are offered through contract and include information, referral, and support services to kinship caregivers. The program priority is to serve those who are at the greatest risk of being unable to maintain the caregiving role. Kinship funds are used to meet basic needs of an emergent, non-recurrent nature.

Examples of these needs:

- Emergency financial assistance for basic needs (housing, food, clothing, supplies, and other items for their relative's children);
- Supplemental school supplies when other resources are unavailable;
- Transportation; and
- Other supportive services for target population as may be identified during the screening process and subject to availability of funds and approval by the AAA.

While the needs of kinship caregivers may differ, there is a clear need to support kinship caregivers providing care to these children.

[30] U.S. Census Bureau. 2021 American Community Survey 5-Year Estimates, B1005 Grandparents Living with Own Grandchildren Under 18 Years by Responsibility for Own Grandchildren by Presence of Parent of Grandchildren and Age Of Grandparent. https://data.census.gov/table?q=b10051&t=Grandparents+and+Grandchildren&g=040XX00US53_050XX00US53035&tid=ACSDT5Y2021.B10051. Accessed August 4, 2023.

[31] U.S. Census Bureau. 2021 American Community Survey 5-Year Estimates, S0102 Population 60 Years and Over in the United States. https://data.census.gov/table?q=S0102:+POPULATION+60+YEARS+AND+OVER+IN+THE+UNITED+STATES&g=040XX00US53_050XX00US53035&tid=ACSST5Y2021.S0102. Accessed August 5, 2023.

Port Gamble S'Klallam Tribe is delivering Kinship Navigator Services targeted to tribal kinship families through grant funding. Providing care to relatives is a cultural and integral part of Native American life. The Indian Child Welfare Act passed by Congress in 1978 and the role it plays in ensuring that Native American children are placed with Native American families is of significance to kinship care for Tribes when foster care placement may occur.

Kitsap County ALTC is planning for Kinship Navigator Services to be implemented to serve caregivers countywide in 2024.

Problem Statement

1. Caregivers need support and assistance at all stages of their caregiving journey. Different caregivers need different kinds of support. As more people opt for care in the home, the demand for more specialized services increases.
2. Many caregivers do not identify themselves as "caregivers," and may not recognize that they may be eligible for assistance. Caregivers may not know what services are available or how to access them, especially in times of severe stress or emergencies. Without additional support, increased stress and health impacts may result and potentially shorten or degrade the home care option.
3. Caregivers need economic and employer support to maintain their responsibilities. Employers need support in dealing with caregiving issues in their workforce. Employed caregivers need access to education about their options.
4. Individuals from ethnic minority communities, persons with disabilities, and LGBT and non-traditional caregivers who may not be recognized as family may need additional support and assistance to access caregiver support services.
5. Kinship caregivers need a range of assistance in their role raising children and navigating the legal, social, and economic support systems. Kinship caregivers report they need financial assistance for the children in their care. Based on program support requests, caregivers need help providing necessities and accessing medical care, affordable housing, and adequate transportation.
6. There continues to be a need across the Kitsap County service area to develop and maintain caregiver support options; including options such as community partnership development and research into volunteer opportunities that may not receive or require funding support.

Goals

To raise the level of awareness about caregiving, develop a continuum of support options for caregivers, provide resources and supports for family and kinship caregivers, and strengthen stabilization in the caregiver population of Kitsap County.

OBJECTIVES

1. Identify and develop an array of primary and supplemental caregiver support services to assist caregiver populations. Conduct up to three planning or community partnership meetings to explore additional support options:

Measured by:

- Meeting notes and recommended action(s) from coordination meeting(s) with relevant providers.
- Community outreach and education to military and Veteran Assistance providers, emergency responders, health care providers, and other potential new partners.
- Increasing available supplemental services provided to enrolled Family Caregiver participants.

Completion Date: 12/2025

2. Support caregivers through education, training, and other support opportunities. Identify a measurable or evidenced based program that meets the needs of the Kitsap County caregiver community.

Measured by:

- Schedule of caregiver education, training, or other supportive event(s).
- Dedicated efforts and outreach to notify caregivers about available training opportunities.

Completion Date: 12/2027

3. Continue outreach to the faith, business, and healthcare professional communities to provide information to members and employees regarding caregiver support services, including kinship care. Conduct a minimum of two presentations or participate in two events targeting faith communities, healthcare professionals, and employers biannually.

Measured by:

- Schedule of presentations and copies of reports.
- Community and partner education about programs to support individuals and families.

Completion Date: 12/2027

C-2.3 Medicaid Transformation Demonstration

PROFILE OF THE ISSUE

The Medicaid Transformation Project (MTP) is Washington's, Section 1115 Medicaid demonstration waiver, between the Health Care Authority (HCA) and the Centers for Medicare & Medicaid Services (CMS). MTP provides the ability to create and continue to develop projects, activities, and services that improve Washington's health care system. The 1115 Waiver, part of Healthier Washington, transforms the delivery system for the 25% of Washington's population served by Medicaid, engaging and supporting Apple Health clients, providers, and communities in achieving improved health, better care, and lower costs.

MTP was implemented in 2017 as a 5-year demonstration waiver and was scheduled to end on December 31, 2022. On July 15, 2022, HCA and Department of Social and Health Services (DSHS) submitted the MTP 2.0 waiver renewal application to CMS. CMS approved a short extension from January 1 – June 30, 2023 to allow sufficient time to review MTP 2.0 waiver renewal application. On June 30, 2023, HCA and DSHS received approval from CMS of the MTP 2.0 waiver renewal application. This will continue and expand long-term services and supports (LTSS) offered under MTP's MAC and TSOA programs[32] .

The demonstration project has two main components:

1. **Medicaid Alternative Care (MAC)** - Creation of a benefit package for individuals who are eligible for Medicaid but not currently accessing Medicaid-funded LTSS. This benefit package provides services to unpaid caregivers designed to assist them in getting supports necessary to continue to provide high-quality care and to focus on their own health and well-being.
2. **Tailored Supports for Older Adults (TSOA)** - Establishment of a new eligibility category and benefit package for individuals "at risk" of future Medicaid LTSS use who currently do not meet Medicaid financial eligibility criteria. This is designed to help individuals avoid or delay impoverishment and the need for Medicaid-funded services. For eligible individuals with an unpaid caregiver, this benefit package can provide services to unpaid caregivers designed to assist them in getting supports necessary to continue to provide high-quality care and to focus on their own health and well-being.

[32] State of Washington Department of Social and Health Services ,Aging and Long-Term Support Administration, Home and Community Services Division MB H23-057 – Policy & Procedure, July 18, 2023

MAC and TSOA include the following benefits:

- **Caregiver Assistance Services:** Services that take the place of those typically performed by unpaid caregiver.
- **Training and Education:** Assist caregivers with gaining skills and knowledge to care for recipient.
- **Specialized Medical Equipment & Supplies:** Goods and supplies needed by the care receiver.
- **Health maintenance & therapies:** Clinical or therapeutic services for caregivers to remain in role or care receiver to remain at home.
- **Personal Assistance Services**: Supports involving the labor of another person to help individuals without a caregiver (only for TSOA).
- **House Housework and Errands** services authorized for the purpose of providing housework for household areas normally cleaned by the caregiver; completing errands for those trips that the caregiver is unable to perform due to caregiving; or providing these services to benefit an individual on TSOA.

Additional benefits were approved in 2023 that will require new providers through new contracts.

The Medicaid Transformation Project also includes Initiative 1 projects related to regional Accountable Communities of Health and Initiative 3 programs-supportive housing and employment benefits targeted to a group of individuals served by Medicaid:

- **Supportive Housing:** This will provide supports to assist individuals to remain in their setting of choice. The goal is to increase independence and stability for the individual and aims to avoid costly and disruptive institutional stays and homelessness.
- **Supported Employment:** This will provide supports to assist individuals with functional disabilities to become job-ready and maintain employment.

The Medicaid Transformation included two more Initiatives to the Waiver after initial approval:

- **Initiative 4: Substance Use Disorder:** This allows people receiving substance use disorder treatment (SUD) in more than 16 beds inpatient setting to use Federal funds to support services.
- **Initiative 5: Inpatient Mental Health Services:** This allows mental health treatment in more than 16 beds inpatient setting to use Federal funds to support services.

Kitsap County ALTC staff assist in education and referral related to these services. Depending on program, services may be provided through referrals to community partners.

Washington State had already created a rebalanced system where individuals have community care options for Long-Term Services and Supports (LTSS). In 2020 the LTSS system was ranked 2nd in the nation by AARP for high performance, and also 2nd for supporting family caregivers[33]. Washington built on the successes of the system and created an expanded system of care focused on outcomes, supporting families in caring for loved ones, delaying, or avoiding the need for more intensive Medicaid-funded LTSS where possible, creating better linkages to a reformed healthcare system and continuing the commitment to a robust Medicaid LTSS system.

These programs offer additional choices for support for older adults and caregivers.

Problem Statement

The ability to "age in place" has been a challenge for individuals and family caregivers who have not qualified for assistance, or because of concerns about Medicaid Estate Recovery or co-pay requirements. However, these caregivers encounter the same limitations of lack of knowledge, resources, time, and increased stress.

It is challenging for the public to know about what options and programs are available that support choices for care and offer relief for family caregivers. It can also be difficult to recruit and retain an adequate number of providers. That, combined with caregiver shortages have made it difficult to continue to meet needs.

The vision of the MAC and TSOA programs is to support individuals, caregivers, and families to provide services for their loved ones and maintain their health and wellbeing.

Goals

MAC and TSOA benefits will support older adults in Kitsap County to age in the setting of their choice and provide support for caregivers.

Objectives

1. Increase the individuals and caregivers served through collaboration with ALTC staff, Department of Social and Health Services Aging and Long Term Supports Administration, and local provider networks to engage potentially eligible individual.

[33] Source: Long-Term Services & Supports State Scorecard, http://www.longtermscorecard.org . Accessed July 20,2023.

Measured by:

- Provide staff and local provider network training and program information.
- Staff and Advisory Council program promotion to community agencies, via presentations & contacts to schools, medical service providers, discharge planners, churches, etc.
- Identify opportunities to include new program information in ALTC resource lists.
- Analyze annual Outreach efforts as needed; update Outreach Milestone, as required.

Completion Date: 12/2027

2. Target program outreach to caregivers to increase caregiver dyads served.

Measured by:

- Offer pre-screening for TSOA Dyad services for all newly completed TCARE screenings received at AAA level.
- Provide T-CARE screenings & access to customized care plans for caregivers.
- Provide person centered counseling and customized services and supports to newly identified caregivers (e.g., respite, counseling, support groups).

Completion Date: 12/2027

3. Recruit and maintain provider network adequacy.

Measured by:

- Develop additional contracts to meet caregiver needs.
- Identify and recruit local providers for new contracted services, with efficient and timely service delivery.
- Provide training for case managers regarding planned implementation of Consumer Directed Care Network of Washington and access to caregivers that can be authorized to provide services through the MAC & TSOA program.
- Provide technical assistance to current MAC & TSOA local contract providers or interested providers, such as the local Tribes, about Medicaid contracting requirements.

Completion Date: 12/2025

C-3 Home and Community-Based Services: Case Management and Systems Coordination

PROFILE OF THE ISSUE

Kitsap County Aging and Long-Term Care offers the following Medicaid-funded care management program:

- Traditional Medicaid Long Term Services Case Management.

Aging and Long-Term Care's care coordination programs have two goals:

1. To provide person-centered in-home services and supports that are well integrated with the health care services, for seniors and adults with disabilities, in a manner that allows them to stay independent and safe.
2. To provide person-centered coordination of health and community supports for people who face significant health challenges to improve their health and reduce avoidable health care costs.

HOWEVER,

a) The number of people 65 and older (who use 75% of Long-Term Services and Supports) is growing.
b) People of all ages are living longer with disabilities, chronic conditions, and treatment option.
c) The healthcare system provides fragmented care, struggles with adequate workforce and is confusing, particularly for those with complex conditions.
d) Individuals in Kitsap County who need in-home care are accessing community-based in-home and residential options at a lower rate than the comparable Washington State average.

Medicaid Case Management Program Background

Washington State was identified by AARP as a national leader in offering home and community based Long Term Supports and Services, ranked as 2nd in the nation in the 2020 Scorecard.[34] Washington residents can choose to receive support in a wide array of settings- their own home, a relative's home, adult family home, assisted living, continuum of care facility, or in a skilled nursing facility.

[34] Source: "Advancing Action, 2020 Scorecard Report: State Rankings." Long-Term Services & Supports State Scorecard, 24 Sept. 2020, http://www.longtermscorecard.org/2020-scorecard/state-rankings. Accessed May 25, 2023.

Not surprisingly, about 75% of individuals choose to reside in their home, with an agency or individual care provider. To make that choice viable it has been essential for Washington's in-home program to grow in its capacity to support people with moderate to severe physical and psychological limitations as well as those who are medically complex, often accompanied by significant behavioral and cognitive challenges.

Supporting people of all acuity levels in community-based settings is key to accommodating the growing population.

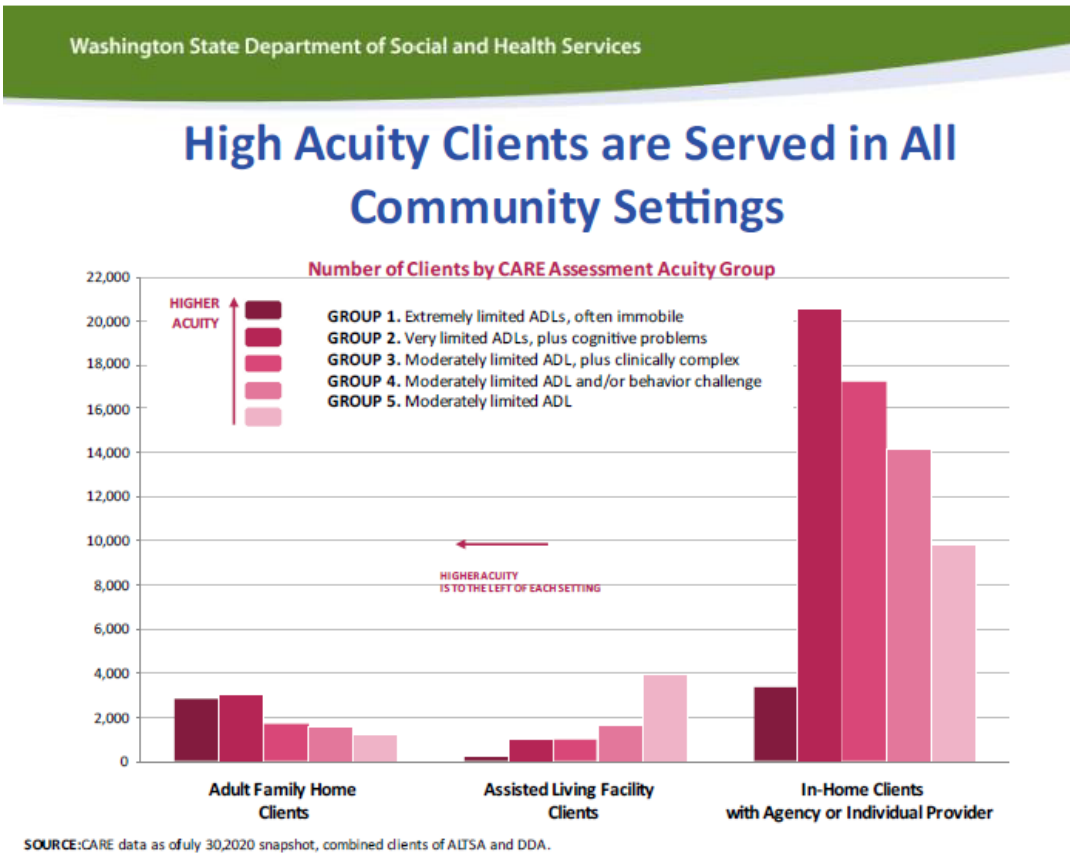
Statewide as of March 2023, there are about 77,010 people served in the long term services and supports Washington State Home and Community Based programs. Of those, 7,091 are in skilled nursing facilities.[35] These individuals face a broad range of challenges to their health and independence. All need assistance to accomplish daily activities such as bathing, dressing, preparing meals, personal hygiene and moving about. With a combination of cognitive limitations and extremely limited mobility, about 30% of those individuals have very little ability to accomplish their daily activities. Another 30% are slightly more able to accomplish daily activities but are challenged by a complex combination of difficult to manage diagnoses and health conditions. Those levels of acuity have continually increased over the past decades and require increasingly sophisticated service planning, coordination, and monitoring to maintain independence, health, and safety.

- The acuity of individuals served through the Medicaid Case Management has vastly increased. The average client served has five chronic conditions, seven medications, and participates in the program for 60 months.
- Prior to the COVID-19 pandemic, one in four individuals discharged to long term care from a state mental hospital reside at home.
- Prior to the COVID-19 pandemic, one in three individuals with a psychotic disorder are receiving long term care resided at home.[36]

[35] Source: Aging and Long-Term Support Administration Strategic Plan Metrics 2021-2023. Department of Social and Health Services, May 2023. p. 4. https://www.dshs.wa.gov/data/metrics/ALTSA.pdf. Accessed August 3, 2023.

[36] Source: Washington State Department of Social and Health Services, Research and Data Analysis Division: 5732/1519 Measures, June 2019

The table below highlights the prevalence of severe mental illness in the long-term care service population.



Before and during COVID-19, in-home care has been the preferred community-based in-home option and is the safest and most cost-effective.

Washington state was able to re-balance overall statewide costs by investing in the community-based system. It costs less per person per month for in-home care compared to a nursing home stay. In-home care makes efficient use of funding; rather than assuming the cost of 24/7 complete care, it supplements what individuals and families can do for themselves with intermittent, paid, gap-filling services and supports. To ensure success and safety, plans of care must be tailored to each situation because each individual and family strengths are unique.

The average per capita cost for medical care is significantly higher for individuals with one or more chronic conditions. Care for people with chronic conditions accounts for 77% of Medicaid spending for beneficiaries living in the community. Among the Medicaid population the costs per capita are more than double the average and for people age 65 and older the costs are more than five times higher.

Fragmented care escalates medical cost for adults with complex, chronic medical conditions who must rely on a cross sector mix of medical, long-term care, behavioral health and social service supports. Multiple primary and specialty care physicians, pharmacies, and other healthcare professionals can result in a lack of coordination across systems and a loss of continuity in communication and care. This can result in duplication of services. At other times, this results in gaps in service-delivery that negatively impact health outcomes. These issues can all impact successful transitions from home to care, facility to hospital, or hospital to home and result in re-hospitalizations or poor health outcomes.[37]

EXISTING EFFORTS:

- **Case Management of In-home LTSS:** Kitsap County's Medicaid Case Management program has increased full-time positions with increased funding. However, some positions have remained unfilled due to poor recruitments pools. The agency is competing with Department of Social and Health Services, Home and Community Services, Adult Protective Services, and Child Protective Services case management vacancies in our area. When vacancies are filled, the caseload ratio will be 68:1, with current vacancies, caseloads are 95:1.

Case Management services are provided for cases authorized through Community First Choice (CFC), Medicaid Personal Care (MPC), and Community Options Program Entry System (COPES) programs. Through a combination of case turnover and changes in needs, Kitsap County Aging and Long-Term Care staff provided over 1,294 assessments in 2022. Of those, there were 825 annual assessments, 96 significant changes, 265 interim assessments, 9 brief, and 1 initial.

The 2023 combined 1st and 2nd quarter assessments totaled 694, (464 annual, 48 significant change, 179 interim and 3 brief assessments). At that pace, the numbers will be higher than the prior year. In the 2nd quarter of 2023, there were 967 individuals on the caseload.

These services are designed to prevent individuals from needing a higher level of care in an institutional setting, such as a nursing home. Financially eligible clients receive a comprehensive assessment of their functional and health support needs.

After assessment they receive an individual service plan that authorizes assistance with personal care tasks such as bathing, personal hygiene, ambulation, and meal preparation. In addition, the case manager can authorize other supportive services such as home delivered meals, adult day health, personal emergency response systems,

[37] Source: Health Homes Program National Governors Association presentation slide deck by Bea Rector, May 2019. Washington State Health Care Authority: Health Homes web page. https://www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes. Accessed on August 31, 2019.

medication management devices, environmental modifications such as wheelchair ramps or stair-lifts, durable medical equipment and supplies not otherwise covered.

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

Case managers provide robust care coordination and support clients' independence by helping access needed services. Case managers need time to assist clients with fully developing a plan of care that is person-centered and proactively assist them to live independently in the community-based setting of their choice for as long as possible.

VETERAN DIRECTED CARE

The Veteran Directed Care (VDC) Program design was based on the Cash & Counseling Demonstration and Evaluation, an evidenced-based model funded by The Department of Health and Human Services Assistant Secretary for Policy and Evaluation, and The Robert Wood Johnson Foundation.

Veteran Directed Care provides Veterans with choice and control over the services they receive in comparison to other traditional Veterans Administration Long Term Services and Supports Programs. Veterans Administration Medical Clinics purchase VDC as a package from a local Aging & Disability Network Provider, in Kitsap County the Area Agency on Aging.

Eligible referred Veterans receive an annual participant plan with the following categories of supports and services tracked monthly by case managers:

- Personal Assistance Services
- Treatment and Health Maintenance Supports
- Participant-Directed Goods, Services and Supports
- Environmental and Vehicle Modifications
- Training and Educational Supports
- Family Caregiver Support Services

The Veterans Directed Care program launched in 2022. It served 5 Veterans in 2022 and 6 so far in 2023.

GOAL

Support an increasingly growing number of people, with increased acuity, who need long-term services and support (LTSS) to remain stable in their home or a community-based setting.

OBJECTIVES

1. Increase awareness, education and understanding of the traditional community-based long-term services and supports (LTSS) options available to individuals that reside at home.
2. Increase the number of eligible individuals who apply for community based LTSS through provider education, community outreach activities and coordination with DSHS Home and Community Services.

Measured by:

- Increased average number of total persons served each month from 965 to 1001, per the state forecast. This equates to at least 36 additional cases each month, with no attrition, by the end of 12/2024.

Completion Date: 12/2024

3. Increase caregiver workforce by supporting work of the DSHS Workforce Development team, local home care agencies, and Consumer Directed Employer to increase caregiver availability.

Measured by:

- Increased understanding of system to address workforce shortages, barriers to recruitment, and offering supportive activities to statewide workforce development and local efforts.

Completion Date: 12/2027

C-4 Tribal Partnerships

Kitsap Aging and Long-Term Care (ALTC) is working to address the health and social needs of Native Americans, both tribal elders age 55 years and older, and those with disabilities requiring in-home care and support that reside in Kitsap County. Each Tribe has their own values and traditions within the distinguishing different government and social service structures.

Kitsap ALTC has a strong history of working collaboratively with both Tribes to meet the distinctly different needs of Tribal people. Both Tribal 7.01 Plans include an over-arching goal that ensures coordination, eliminates barriers, and increases access to services for Tribal members. To build trust and service continuity, ALTC assigns a culturally sensitive case manager to tribal members with long term care needs receiving Medicaid-funded in-home care.

Relationship-building and sharing of resources among ALTC staff of all programs and the Tribes is ongoing, with special attention to shared needs and focus areas of elder safety, nutrition, support of traditional caregiving families, access to resources and promotion of health and prevention of disease.

Port Gamble S'Klallam Tribe

The mission of the Port Gamble S'Klallam Tribe is to exercise sovereignty and ensure self-determination and self-sufficiency through visionary leadership. The Tribe strives to ensure the health, welfare, and economic success of a vibrant community through education, economic development, preservation and protection of the rich culture, traditions, language, homelands, and natural resources of the Tribe.

In 1992 the Tribe became one of the first Self-Governance Tribes in the United States. Under Self-Governance, the Tribe has been able to dramatically improve and expand programs and services. Examples include the first tribal Temporary Assistance to Needy Families (TANF) program in Washington, the first TANF Tribe in the state to operate a federally funded child support program, an award-winning health clinic and an acclaimed dental clinic.

Prior to the COVID-19 pandemic, the Tribal Elders program prepared and provided five meals per week at the Elders Center. In Calendar Year 2020-2021, the community dining site converted to a home delivered option as needed. The Tribe blends the subcontracted funds from ALTC and Title 6 federal nutrition funds to provide this valued service. The Tribe welcomes eligible seniors from the community at this site. Other services include, providing firewood allotments to every elder home on reservation, home visits to arrange chore service, check on health status and refer to other services as well as hosting monthly activities at the Elders Center.

Suquamish Tribe

The vision of the Suquamish Tribe is “a strong, self-governing, sovereign Nation that provides for the health, education and welfare of our families, reflecting traditional Suquamish values”.

The Tribal Human Services department provides services in support of the Suquamish Vision Statement, which facilitates members and their families to be drug and alcohol free, mentally, physically, and economically healthy, engaged in cultural traditions with efforts to encourage elders, youth, and adult interactions promoting the goal of independence by educating members for ownership and control of their financially independent Nation.

Prior to the COVID-19 pandemic, the Elders' Program provided five meals per week at the Suquamish Village lunchroom, as well as meal delivery to homebound disabled persons who live on or near the Reservation. In Calendar Year 2020-2021, the community dining site converted to a model that safely connected Tribal elders to nutrition options. Other services include transportation for shopping and medical appointments, respite and chore services, and assistance with minor home repair and yard work, as well as garbage pick-up.

Goal And Objectives

In compliance with the Washington State 1989 Centennial Accord and current federal Indian policy, 7.01 plans are created in collaboration with Recognized American Indian Organizations in the planning of the Washington Department of Social and Health Services and Area Agencies on Aging (AAA) service programs, to ensure quality and comprehensive service delivery to all American Indians and Alaska Natives in Washington state.

The plans address concerns identified by tribal members, identify tribal leads and ALTC staff, action steps to address each concern, and provide a yearly summary of the progress.

Please see the following 7.01 Plans with the Suquamish and Port Gamble S’Klallam Tribes that outline mutually agreed upon focus areas, activities, and expected outcomes with dates. Both 7.01 Planning meetings included Tribal and ALTC representatives and the Regional Manager, Brenda Francis-Thomas, from the Office of Indian Policy.

The 7.01 Plans are reviewed at least annually. They are considered “living documents” that can be revised and updated as agreed upon by both parties at any time.

Resources

- Port Gamble S’Klallam Tribe, https://www.pgst.nsn.us/
- Suquamish Tribe, https://suquamish.nsn.us/

2023-2024 Biennium 7.01 Implementation Plan
for
Kitsap County Division of Aging & Long-Term Care (PSA 13) – Area Agency on Aging
Port Gamble S'Klallam Tribe

Biennium Timeframe: January 1, 2023 to December 31, 2024

Plan Due Dates:
October 1st of each odd numbered year a complete Implementation Plan is due for the coming biennium.
October 1st of even numbered years, a progress report is due.

Implementation Plan				Progress Report
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff and Target Date**	**(5) Status Update for the Previous Year (Due October 1 , 2024)**
1. Maintain and increase coordination, identify and eliminate barriers, and increase access to services to the Elders of the Port Gamble S'Klallam Tribe.	• Continue to share information and technical assistance. • Offer advocacy and outreach to the Port Gamble S'Klallam Tribe through presentations and services. • Kitsap Aging staff will regularly participate in established Tribal Vulnerable Adult Multi-disciplinary Team meetings.	Continued awareness and access to services that recognize and preserve the value of the rich culture and heritage of the Elders of the Port Gamble S'Klallam Tribe.	Cheryl Miller, Tribal Community Services Director Stacey Smith, Aging Administrator Tawnya Weintraub, Aging Planner Gail Archut and Mikko Azul, Aging Case Managers Jamie Aikman, Tribal Vulnerable Adult Case Manager Sue Hanna, PGST Elders Program Manager Sandy Walker, PGST RN Review Annually	

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Previous Year (Due October 1 , 2024)
2. (a) Provide specialized Information & Assistance about, and access to, caregiver support services to the Tribe. Assure recognition and respect for cultural diversity in caregiver support activities; and help in developing family caregiver support opportunities on the Port Gamble S'Klallam Tribe Reservation or geographically close locations. (b) Partner to connect Kinship Care families to training and support opportunities The Tribal Kinship Care Navigator Program continues through this plan period. Lifespan Respite funding awarded for the Tribe to offer respite to adults and children.	• Increase sharing of materials, resources, and coordination by conducting coordination meetings and, where appropriate, one-on-one visits to Tribal Elders and families. • Coordinate among staff of Aging and the Tribe to provide presentations or workshops to Tribal Elders and family members based on topics identified by Tribe. • Attend annual Strong Families Fair, when notified by the Tribe. • Coordinate cross-referral opportunities. • Share ongoing updates about Kinship Caregiver Support program. • Support and explore scholarship and other funding opportunities.	Increase and enhance caregiver and kinship support information and access to services.	Cheryl Miller, Tribal Community Services Director Tawnya Weintraub, Aging Planner Hannah Anders, Aging Caregiver Program Supervisor Sue Hanna, Elders Program Manager Star Hagen, Tribal Kinship Navigator Review Annually	

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Previous Year (Due October 1 , 2024)
3. Communicate and coordinate potential new community resources and local funding.	• Share a presentation of new AAA programs. • Share new resources/programs as a result of future funding.	Tribal and AAA staff are more informed about new social services resources and potential for growth and local partnerships.	Cheryl Miller, Tribal Community Services Director Sue Hanna, Elders Program Manager Jamie Aikman, Tribal Vulnerable Adult Case Manager Stacey Smith, Aging Administrator Tawnya Weintraub, Aging Planner Review Annually	

Completed/Tabled Items- past 3 years

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Previous Year
2023-None				
2022- None				
2021- None				
2020 Plan noted: <u>2018-2019 Goal</u> Continue to provide Senior Farmers' Market Nutrition Program Services to the S'Klallam Tribe.	Provide vouchers for redemption for produce at Kitsap County Farmers Markets, and home delivered produce through the Senior Nutrition Program Service Provider.	Increased availability of fresh fruits, vegetables and other produce to Tribal Elders.	Cheryl Miller, Community Services Division Director Tawnya Weintraub, Aging Planner Seasonal and ongoing	Goal Accomplished. The joint coordination efforts have been successfully integrated in routine operations.

2023-2024 7.01 Policy Implementation Plan
for
Kitsap County Division of Aging & Long-Term Care (PSA 13) – Area Agency on Aging
Suquamish Tribe

Biennium Timeframe: January 1, 2023 to December 31, 2024

Plan Due Dates:
October 1st of each odd numbered year a complete Implementation Plan is due for the coming biennium.
October 1st of even numbered years, a progress report is due.

Implementation Plan				Progress Report
(1) Goals/Objectives	**(2) Activities**	**(3) Expected Outcome**	**(4) Lead Staff and Target Date**	**(5) Status Update for the Previous Year (Due October 1 , 2024)**
1. Maintain and increase coordination, identify and eliminate barriers, and increase access to services to the adult members of the Suquamish Tribe. This goal remains as an overarching shared philosophy.	• Continue to share information and technical assistance. Special focus on non-Medicaid Senior Information & Assistance (I&A) services. • Offer increased advocacy and outreach to the Suquamish Tribe through presentations and services. • Schedule a Kitsap Aging presentation for Tribal Program staff. • Kitsap Aging and Suquamish Human Services will email updated staff organization charts, with external contact list that includes email addresses.	• Improved awareness and access to services that recognize and preserve the value of the rich culture and heritage of the members of the Suquamish Tribe. • Tribal program staff will become familiar with Kitsap Aging staff and services.	Nehreen Ayub, Suquamish Tribe Human Services Director Craig Nelson, Suquamish Human Services Program Manager Julie Mace, Suquamish Human Services Social Work Supervisor Barbara Hoffman & Amber Winemiller, Suquamish Community Health Nurses Stacey Smith, Kitsap Aging Administrator Tawnya Weintraub, Kitsap Aging Planner Jason Doty, Kitsap Aging Senior I&A Supervisor Gail Archut & Mikko Azul, Kitsap Aging Case Managers Brenda Francis-Thomas, OIP Regional Manager Review annually	

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Previous Year (Due October 1 , 2024)
2. Provide specialized Kitsap Aging Information & Assistance (I&A) about, and access to, caregiver support services. Continue to honor, respect, and recognize the ethnic and cultural diversity in caregiver support activities.	• Increase sharing of materials and resources. • Begin Quarterly meetings to discuss challenging/ complex cases, coordinate services and plan for community events. Tribe (Craig or Julie) will initiate these meetings by contacting Kitsap Aging (Stacey). • One-on-one visits to Tribal elders and families to explain range of services available accompanied by Tribal staff, when indicated. • Aging staff participate in Suquamish Tribal Health Fair, Caregiver Training, and other events.	• Increased and enhance caregiver support information and services. • Improve quality of care to Tribal members. • Increase awareness of Kitsap Aging services available to Tribal members.	Nehreen Ayub, Suquamish Tribe Human Services Director Craig Nelson, Suquamish Human Services Program Manager Julie Mace, Suquamish Human Services Social Work Supervisor Stacey Smith, Kitsap Aging Administrator Jason Doty, Kitsap Aging Senior I&A Supervisor Review quarterly and annually	

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Previous Year (Due October 1 , 2024)
3. Communicate as new programs (supported by stimulus or other discretionary funding) launch, evolve and end.	Kitsap Aging will share new programs and supports available through project funding. This could be accomplished through Quarterly meetings or other timely communication channels.	Tribal and AAA staff are more informed about new social services resources and potential for growth.	Stacey Smith, Kitsap Aging Administrator Tawnya Weintraub, Kitsap Aging Planner Jason Doty, Kitsap Aging Senior I&A Supervisor Gail Archut & Mikko Azul, Kitsap Aging Case Managers Nehreen Ayub, Suquamish Tribe Human Services Director Craig Nelson, Suquamish Human Services Program Manager Julie Mace, Suquamish Human Services Social Work Supervisor Barbara Hoffman & Amber Winemiller, Suquamish Community Health Nurses Review Annually	

Completed/Tabled Items

Goals/Objectives	Activities	Expected Outcome	Lead Staff and Target Date	Status Update for the Previous Year
Tabled: 2020 Goal Explore Tribal Community First Choice Plus (previously referred to as COPES) Medicaid waivered subcontracts to provide direct services. • For example, subcontracts include counseling, client training, choice guides, environmental modifications, and other services. *2023 update: Discussed at 2023 meeting, remains tabled for Kitsap Aging 7.01. DSHS Tribal Affairs will connect with tribe directly and provide technical assistance to Kitsap Aging contracts staff.*	Schedule a meeting to explore Community First Choice Medicaid waivered subcontracts (Interlocal Agreements) and requirements.	Schedule an initial meeting by December 2019.	Nehreen Ayub, Suquamish Tribe Human Services Director Suquamish Tribe Human Services Social Worker staff Tawnya Weintraub, Aging Planner Brenda Francis-Thomas, OIP Regional Manager Ann Dahl and Marietta Bobba, DSHS ALTSA Tribal Program Managers	2020: Goal moved to "on hold" at the February 16, 2021 7.01 meeting due to COVID-19 high priority items. 2023: Discussed at 7.01 meeting. DSHS Tribal Affairs staff, Tamara Gaston and Elizabeth (George), will follow-up with Tribal staff and Kitsap Aging contracting team.
Tabled: 2018 Goal Seek to establish joint planning and coordination around Kinship Care support for Suquamish Tribal members raising grandchildren. Mutually decided to table this goal for 2019.	• Conduct coordination and training meetings with Tribal Human Services, Tribal Child Welfare, Youth Center, School and Health Care staff. • Provide access to one-on-one services to Tribal members, as appropriate. Suquamish Tribe will invite AAA staff to a Tribal Historical (Multi-Generational) Trauma training.	Improved access to and information concerning Kinship Care services.	Kathy Kinsey, Suquamish Human Services Social Worker Supervisor Jennifer Calvin-Myers, Senior I&A Supervisor Subcontractor: Kitsap Community Resources	Due to staff changes and leadership vision- This goal is being tabled for 2019.

Goals/Objectives	Activities	Expected Outcome	Lead Staff and Target Date	Status Update for the Previous Year
Completed: 2018 Goal 2018 Goal: Completed/Tabled Continue to provide excellent Community First Choice Plus (previously referred to as COPES) Case Management services to Tribal members. Because this goal been achieved and is included in the 1st overarching goal, it is being discontinued as a standalone goal.	• On-going coordination meetings with Suquamish Tribe Human Services staff. • Identify 5 potential IPs from the Tribe (or North-end residents) interested in training.	• Minimization of difficulties with assessment and follow up process. • Remove distance and cultural barriers of IP certification	Kathy Kinsey, Suquamish Human Services Social Worker Supervisor Gail Archut, Aging Case Manager	Tribal staff shared excellent service from dedicated Kitsap AAA case manager, Gail Archut. There is a statewide Tribal subcommittee discussing IP disqualifying crimes exemptions for Tribal members.
Completed: 2018 Goal Continue to provide Senior Farmers' Market Nutrition Program Services to the Suquamish Tribe.	Provide vouchers for redemption for produce at Kitsap County Farmers Markets, and home delivered produce through the Senior Nutrition Program Service Provider.	Increased availability of fresh fruits, vegetables and other produce to Tribal Elders.	Tawnya Weintraub, Aging Planner Seasonal	Completed
Completed: 2017 Goal Explore recruiting representation from the Suquamish Tribe on the Advisory Council to the Division of Aging & Long-Term Care.	Nominate and facilitate appointment of a Suquamish member by the Kitsap County Board of County Commissioners to the Aging & Long-Term Care Advisory Council.	Increased Tribal expertise and cultural diversity in the activities of the Kitsap County Aging and Long-Term Care Advisory Council.	Exploration Completed	Currently, there is not representation from the Suquamish Tribe on Aging & Long-Term Care Advisory Council. 2015-2017 there were multiple attempts to recruit. Kitsap AAA will ensure Aging Council meeting notifications are sent to Tribal staff.

Goals/Objectives	Activities	Expected Outcome	Lead Staff and Target Date	Status Update for the Previous Year
***Discontinued 2012-2013, 2014-2015 Goal** Establish a Memorandum of Understanding (MOU) between Suquamish Tribe and Division of Aging and Long-Term Care.	Schedule additional meetings with Suquamish Tribe Human Services, to develop written understanding guiding interactions between the Tribal Elders and Information & Assistance and Case Management personnel.	Signed MOU between Tribe and Division of Aging and Long-Term Care resulting in increased and enhanced service delivery.		As per meeting on 7/16/2015 with Tribe, decided due to a good working relationship there is no need for MOU efforts at this time.
***Discontinued 2012-2013, 2014-2015 Goal** Work with Suquamish Tribe in an effort to contract with Division of Aging & Long-Term Care for OAA Title III funded Nutrition Program	Coordination and planning efforts with the Tribe and other relevant stakeholders.	A signed contract for Congregate Nutrition Services, agreeable to all parties.		As per meeting on 7/16/2015 with Tribe, decided to discontinue goal. Tribal nutrition program is funded through Title 6.
***Discontinued 2012-2013, 2014-2015 Goal:** Work with Kitsap Transit and the Suquamish Tribe to determine progress made regarding need for increased public transportation access in North Kitsap County including to and from the reservations.	Meetings with Kitsap Transit, the Suquamish Tribe and other relevant stakeholders to review the needs. Have an Advisory Council representative attend Kitsap Transit Transportation Issues for the Elderly & Disabled (T.I.E.D.) meetings.	Improved public transportation services to the Suquamish Tribal Elders.		As per meeting on 7/16/2015 with Tribe, decided to discontinue goal. Tribal Director is working directly with transportation vendor.
***Note:** At 7.01 meeting held 7/16/2015 agreed to prioritize shared goals and objectives by scaling down 7.01 Plan. This goal remains as an over-arching shared philosophy. Discussed special focus on materials and services for elders and caregivers.				

C-5 COVID-19 Response Services & Supports

PROFILE OF THE ISSUE

During the COVID pandemic, Kitsap ALTC staff worked remotely or on staggered in-office schedules, following direction outlined in Governor Inslee's Executive Order directing all residents immediately to heed current State public health directives to stay home, except as needed to maintain continuity of operations of essential critical infrastructure sectors to protect health and well-being of all Washingtonians. All ALTC employees were deemed essential workers by the Governor's Executive Order.

Effective May 11, 2023 the federal public health emergency (PHE) and Washington State Major Disaster Declaration (MDD) ended. The Governor's vaccine requirement for state employees was rescinded effective May 11, 2023.

During the COVID pandemic, remote telecommuting and reduced staff in the office required a short adjustment period, as well as flexible and responsive emergent planning to support network service delivery, case management services, and overall public health. As a result, greater emphasis has been placed on responding to emergent community needs, support of disease prevention and vaccine information, expanding and sustaining an effective service delivery network to support vulnerable individuals.

The following services were adapted to alternative delivery methods and are currently being re-established:

- Senior Congregate Meal sites
- Adult Day Health or Day Care services
- Case Management home visits and wellness checks
- Personal Care (adapted to some telephonic care and/or brief visits)
- Medicaid Waiver Client Training, Client Choice Guide and Professional Supports services (adapted to virtual or blended service delivery models)

Stimulus Funds & Identifying Local Gaps

On March 18, 2020, the Families First Coronavirus Response Act (FFCRA) was signed into law. It provided a temporary 6.2% increase to Federal Medical Assistance Percentage (FMAP) beginning January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency terminates, as declared by the Secretary of Health and Human Services. The enhanced FMAP is dependent on states continuing eligibility and maintaining benefit levels for Medicaid recipients from March 18, 2020 to the end of the quarter in which the public health emergency ends (June 30, 2023).

The additional revenue provided financial relief to network subcontractors to adapt their service delivery methods, retain staff, meet demands of increased costs and continue services. It also provided an opportunity for ALTC to outreach to local senior nutrition agencies, faith-based communities, and other community partners and provide financial assistance to support older adults and vulnerable populations isolated or disconnected due to the pandemic.

The stimulus funds were also used to create new ALTC direct services: a warm line telephone check-in service for isolated older adults, partnership with local health district for close coordination and dedicated projects, such as emergency response ESF #8 meetings, older adult chronic disease profile, community needs survey and fall prevention.

PROBLEM STATEMENT

As an essential social service for vulnerable populations, there is a need for ALTC to support the local community recovery efforts for older adults, younger adults with disabilities and their caregivers to remain stable in their home or a community-based setting.

As community recovery continues, new issues may arise. Stimulus funds need to remain flexible to meet unknown future needs. Federal, State and County leaders need to allow funding to address unique client and special population gaps.

GOAL

Continue to support community recovery through information sharing, delivery of services, and expansion of community-based network with organizations to address food, housing and economic insecurity as a result of COVID-19 impacts. Utilize stimulus funding to meet local needs and expand network services.

OBJECTIVES

1. Continue availability of nutrition services and other social services for older and homebound individuals.

Measured by:

- Continue funding for increased need for number of emergency take-out and home delivered meals.
- Continue to explore network service providers to include faith-based and other non-traditional senior nutrition providers to ensure alternative senior nutrition security.

- Continue to explore community partnerships and new contracts to deliver expanded services in response to COVID-19 needs.

Completion date: 2025

GOAL

Maintain ALTC staff to provide direct services, as well as administrative support, post COVID-19. Demands for caregiving of older and younger family members, personal health issues, relocations and early retirements have resulted in a 35% staff turnover since January 2021.

OBJECTIVES

1. Maintain adequate staffing and timely recruitment of vacancies to continue to provide direct services and expand the network.

Measured by:

- Timely recruitments of vacant positions
- Development of flexible remote worker policies to retain staff
- Creative use of office space with program expansion and limited cubicles

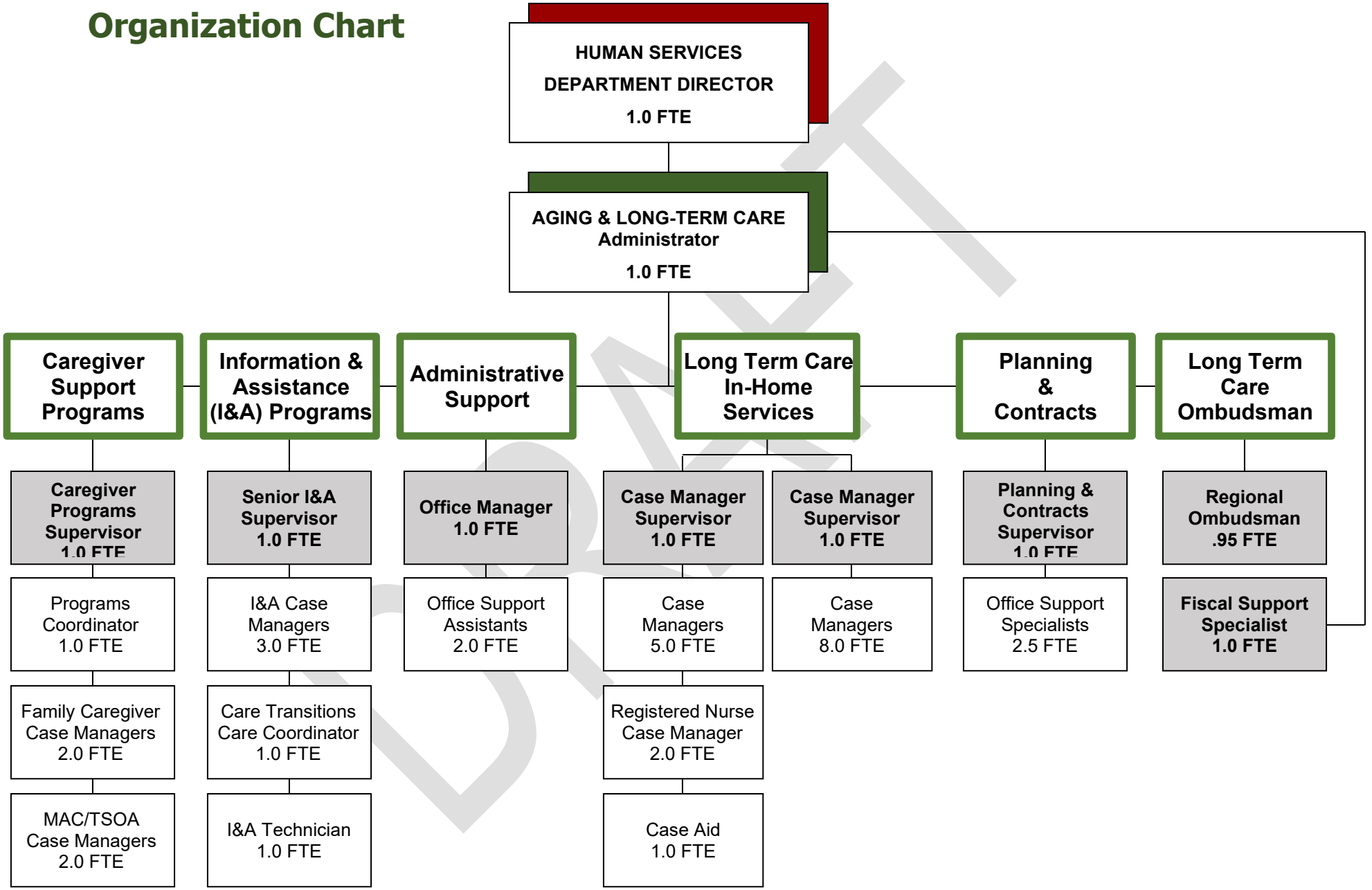
Completion date: 2024

SECTION D
Area Plan Budget

PLACEHOLDER

APPENDICES

Organization Chart



Area Agency on Aging Staff

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
Director, Dept. of Human Services	1 FTE	• Evaluates and supervises the Kitsap Division of Aging and Long-Term Care (ALTC) Administrator. • Executes subcontracts $10,000 or less.
Human Services Senior Manager ALTC Administrator	1 FTE	• Organizes, directs, coordinates, and executes administrative and functional activities of the Area Agency on Aging. • Develops policies, procedures, and oversight of budgets. • Serves as liaison with Department of Social and Health Services programs and County Commissioners, County Departments, outside agencies and the public. • Advocates with state and local officials on behalf of older persons. • Lead staff to Aging & Long-Term Care Advisory Council; Co-lead staff to Ombudsman Advisory Council. • Responsible for County contract negotiations, RFP, and oversight of County contracting process. • Disaster Response Coordinator for ALTC.
Human Services Supervisor ALTC Planner	1 FTE	• Manages the Planning, Contracts and Evaluation Unit; assigns and supervises work of staff. • Develops and updates the Area Plan.

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
		• Responsible for contract technical assistance, monitoring activities, contract compliance, and corrective action plan approval. • Oversight of Medicaid Waivered Services contract process, new contract applications, and technical assistance. • Coordinates with management staff to develop policies, procedures, and special projects. • Other management, planning and coordination activities as assigned.
Office Support Supervisor	1 FTE	• Supervises reception staff and Senior Employment Participant. • Designated WorkDay Human Resources Partner (for timekeeping) for Division and support to Management staff. • Liaison for Division in coordination of employee orientations, benefits, and county workplace policies. • Designated Provider 1 and IP Provider 1 Public Disclosure Requests Coordinator. • Purchases office supplies and equipment, as needed. • Inventories and assigns equipment- laptops, cell phones, hot spots, etc.
Fiscal Support Specialist	1 FTE	• Develops agency budgets (County YTD, line item and Area Plan) for Administrator review. • Performs fiscal desk monitoring and assists Planner with fiscal on-site monitoring of subcontractors.

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
		• Prepares and submits billings to funding sources and manages receivables. • Submits, processes and coordinates county and grant budget changes. • Oversees Administration, direct program time, subcontractor expenditures and cost allocation plan. • Analyzes utilization patterns and grant accounting, to maximize funding.
Office Support Specialist Contracts/Medicaid Waiver Services/ Administration	1 FTE	• Assists Planner with projects of the Planning, Contracts and Evaluation Unit. • Performs Medicaid Waiver and subcontract desk monitoring and program evaluation. • Maintains files and subcontract control documents for monitoring purposes. • Drafts and processes Medicaid Waiver Services application responses and contracts. • Maintains SharePoint Project Center. • Coordinates record retention activities.
Office Support Specialist Contracts/Medicaid Waiver Services/ Administration	.75 FTE	• Assists Planner with projects of the Planning, Contracts and Evaluation Unit. • Drafts and processes Medicaid Waiver Services application responses and contracts. • Performs Medicaid Waiver Services and subcontract desk monitoring and program evaluation. • Assists Fiscal and Administrative staff with database reporting and prepares fiscal monitoring and overpayment documents.

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
		• Processes Accounts Payable. • Support to Workday Human Resources Partner for timekeeping.
Office Support Assistant Reception	1 FTE	• Front reception- Receives and routes telephone calls and directs visitors. • Provides support to Medicaid Case Managers. • Backup for processing forms and ordering materials. • Provides support for special projects as needed. • Purchases routine office supplies. • Provides administrative support for monthly tasks across Aging Teams.
Office Support Specialist Administration/Contracts	.75 FTE	• Assists in maintaining files and subcontract control documents for monitoring purposes. • Completes monthly service recordings in the Community Living Connections (CLC) database for subcontracts. • Assists planner with Area Plan assignments and projects of the Planning, Contracts and Evaluation Unit. • Provides support to Administration, Senior Information & Assistance (I&A) and Caregiver Programs; prepares and sends mailings, supports Econtracts processes. • Web Content Editor. • Administrative support staff to Advisory Council, records minutes.

Supervisor Caregiver Programs (FCSP, MAC, TSOA)	1 FTE	• Manages Family Caregiver Support Program, Medicaid Alternative Care (MAC), Tailored Supports for Older Adults (TSOA) and other ancillary projects and assigns and supervises staff work. • Coordinates with management staff to develop policies, procedures, and special projects. • Reviews client records and is lead for state quality assurance review. • Serves as liaison between the County and public for Family Caregiver Support and MAC and TSOA programs. • Identifies and implements programs to meet staff training needs. • Coordinates outreach and media activities including Caregiver workshops.
Supervisor Senior Information & Assistance	1 FTE	• Manages Senior Information & Assistance (I&A) assignments and supervises work. • Reviews client records and provides staff consultation. • Coordinates outreach and media activities including County Fair events, Wellness Fairs, and other community outreach. • Lead staff on Community Living Connections (CLC) database and OAAPS reporting.
Programs Coordinator-MTD & FCSP	1 FTE	• Creates and monitors reports and completion of new and routine case management tasks. • Screening of client eligibility. • Tracks and establishes clients through Presumptive Eligibility.

		• Assesses client needs, develops care plans, and authorizes services. • Assigns new cases to case managers. • Monitors program deadlines.
Supervisor Medicaid Long Term Care Case Management	2 FTE	• Oversees Medicaid Title 19 Program and staff. • Joint Requirements Planner/Staff trainer duties. • Fair Hearing Coordinators. • Quality Assurance and clinical oversight. • Network home care agency liaisons.
Case Manager Programs: Title 19, MTD, FCSP	14 FTE *3 Vacant Positions*	• Provides information and referrals for service. • Conducts comprehensive assessments. • Develops Service Plan, implements, follows-up. • Completes supportive case management functions. • Plans service termination and implementation. • Provides local level of complaint resolution.
Case Manager Senior I&A	3 FTE	• Completes in-depth screening, both by telephone and in-person. • Provides information and referrals for service. • Participates in community outreach events and educational presentations. • Provides social check-in calls, memory screenings, vaccine information, and Personal Emergency Response referrals.

Care Coordinator Care Transitions	1 FTE	• Coordinates hospital to home care transitions. • Outreaches to hospital staff. • Provides information about local resources. • Provides assistance with program eligibility processes.
Registered Nurse	1 FTE *1 Vacant Position*	• Schedules and performs nursing consultation and visits. • Ensures best practices used by caregivers. • Maintains documentation and quality assurance for Nursing Services. • Manages casework for targeted medically complex or unstable clients. • Provides nurse consultation throughout programs to agency staff and participates in targeted contract monitoring of skilled nursing services.
Program Technician I&A Assistance Specialist	1 FTE	• Provides routine information and referrals for service. • Interviews clients to collect information for home delivered meals and Medicare Improvement Patient and Providers Act services. • Performs outreach activities and field visits. • Assists case managers with implementation of service plans. • Provides social check-in calls. • Designated Safety Officer.

Office Support Assistant Case Aide	1 FTE	• Provides clerical support to Medicaid Case Managers. • Contacts clients and caregivers on established schedule to check status of client and care plans. • Provides limited non-clinical field work.
LTC Regional Ombudsman	.95 FTE	• Identifies, investigates, and resolves facility-based complaints. • Mediates disputes. • Recruits, trains, support and supervise 25 volunteer ombudsmen. • Documents in computerized reporting system; submits monthly reports. • Co-lead to Ombudsman Advisory Council • Participates in statewide Ombudsman forums and legislative advocacy.

Total number of staff = 41
Total number of full-time, 40 hours per week staff = 38
Total number of part-time staff = 3
Total number of minority staff = 5
Total number of staff over age 60 = 10
Total number of staff self-indicating with a disability = N/A- information not available

Emergency Response Plan

From 2020-2023, due to 2020 COVID-19 response and staff (leadership) changes with the Kitsap County Department of Emergency Management, this document has not been finalized.

The existing emergency response Annex plan and vulnerable populations planning meetings were integral to the local success of early COVID-19 preparations, outbreak response, vaccine assistance, and community recovery efforts. Key community partners understood agency roles, methods of communication, command center operation protocols, and ESF #8 assignments. Ongoing disaster response exercises have provided learning platforms to practice protocols used in emergency/ disaster responses.

The Northwest Response Network provided another avenue for coordinated hospital and healthcare setting communication. Weekly hospital surge capacity reports and monthly meetings provided updated information on capacity of hospital Emergency Department and Intensive Care Unit beds, as well as trends related to workforce and prevalence of diseases (such as RSV, mpox and COVID-19).

This document is an overview of the Vulnerable Populations Emergency Response Plan currently under revision. The Vulnerable Populations Emergency Response Plan is referred to as the Annex, a conceptual framework and operations reference for local Emergency Response. The Annex is not meant to stand alone; it is intended to be used in support of and in conjunction with agencies, jurisdictions and special districts' emergency response plans, and their responding agencies' standard operation procedures. The Annex is consistent with the Kitsap County Comprehensive Emergency Management Plan (CEMP), the Kitsap County Emergency Operations Procedures and the Kitsap County All-Hazards Local Hazard Mitigation Plan. The Vulnerable Population Annex conforms to the requirements of the National Incident Management System (NIMS).

The Annex describes key policies, procedures and issues directly related to the preparedness, response, and recovery of populations identified as high risk and with access and functional needs. The document is co-authored by Kitsap County Department of Emergency Management, Kitsap Public Health District, and Kitsap County Division of Aging and Long-Term Care.

Kitsap ANNEX Plan for Vulnerable Populations

(Under Review)

The Annex is an extension of the Kitsap County Comprehensive Emergency Management Plan (CEMP). The objective of the CEMP is to incorporate and coordinate all County facilities and personnel, public health, and other jurisdictional resources of the cities and special districts within the County, into an efficient organization capable of responding to any emergency using, mutual aid, and other appropriate response procedures.

The original Annex, finalized in November 2014, is currently under revision to include the comprehensive response to a variety of disasters for vulnerable individuals. It is informed by guidance from the Federal Emergency Management Act (FEMA), US Department of Health and Human Services Toolkit for Aging & Disability Network in Emergency Planning, Northwest Healthcare Response Network System Emergency Response Plan, and Kitsap Public Health Emergency Planning Assessment of Access and Functional Community Needs in Kitsap County.

<u>Vulnerable Populations Taskforce and Local Partners</u>

These quarterly meetings were paused through the COVID pandemic. The plan is to reconvene these meeting in 2024.

Kitsap County's Department of Emergency Management (KCDEM) convenes and chairs the Vulnerable Population Task Force (VPTF) to coordinate the development response strategies. Developed in 2009, the mission of VPTF is to enhance preparedness and to coordinate response efforts in disasters by fostering connections between community –based organizations, local government, and private sectors. With representation of over 20 organizations, VPTF members provide services to various populations with access and functional needs throughout the County.
The mission is to increase communication and collaboration with agencies providing services to access and functional needs populations, specifically those populations who are homeless, disabled, with mental health/addiction disorders, young and seniors.

The VPTF consists of representatives from KCDEM, Kitsap Public Health District, treatment providers, variety of social service organizations, community-based organizations (profit and non-profit), faith-based organizations, community advocates, Red Cross, Kitsap Transit, and the Kitsap County Area Agency on Aging.

- Kitsap County Aging and Long-Term Care Administrator actively participates in the Vulnerable Populations Taskforce and is the contact person for disaster response and coordination. In the event of an actual emergency, the Administrator is called to the Kitsap County Emergency Commands Center for direction and oversight of activities related to older and disabled populations through the ESF #8 assignment.

- Kitsap County Aging and Long-Term Care Regional Ombudsman is a part of the Functional Assessment and Service Teams (FAST) that will reside in a community-based centrally located shelter to provide direct assistance and referral.

Criteria for Vulnerable Populations

History shows that disasters disproportionately impact populations with access and functional needs. Recognizing this, efforts are being made throughout Kitsap County to better prepare the community—individuals, local and county government agencies, key decision-makers, organizations, and emergency management responders—to take appropriate and informed actions as well as to empower individuals with access and functional needs in response and recovery efforts. The Annex describes key policies, procedures and issues directly related to the preparedness, response, and recovery of the high risk, and access and functional needs populations.

The elderly, children, and persons with disabilities or in isolated or homeless situations (at-risk, vulnerable populations) can experience communication and transportation barriers and as a result, often suffer disproportionately from disasters. Individuals who have high risk for harm from an emergency event due to significant limitations in their personal care or self-protection abilities, mobility, vision, hearing, communication, or health status. These limitations may be the result of physical, mental, or sensory impairments or medical conditions. Some of these individuals may be reliant on specialized supports such as mobility aides (wheelchairs, walkers, canes, or crutches), communication systems (hearing aids, TTY's, etc.), medical devices (ventilators, dialysis, pumps, or monitors), prescription medication, or personal attendants. For some individuals, loss of these supports due to emergency-related power and communication outages or transportation and supply disruptions may be the primary or only risk factor.

In fact, it is estimated that more than half of the people accessing disaster recovery centers have access and functional needs (FEMA, 2019). More intense post-disaster impacts can be experienced by access and functional needs persons due to disruptions in support systems; loss of medical equipment, assistive devices, and transportation; new health issues (hypothermia) or memory disorders; and inaccessible communication.

A Closer View of the Kitsap County Region
The region for this research project is Kitsap County. As shown in Attachment A, the Kitsap region is in the Pacific Northwest across the Puget Sound, west from the Seattle-Tacoma Metropolitan area in Washington State. The area includes the growing incorporated Cities of Bremerton (the largest population), Bainbridge Island, Port Orchard, and Poulsbo. Many parts of the region are **geographically isolated** by water most noticeably on Bainbridge and Blake Islands and much of the peninsula and isolated areas are reliant on transportation offered by four Washington State Ferry routes, three Kitsap Transit Ferry routes, and aging bridges (Agate Pass). An estimated 300,000 total persons reside in Kitsap County in any given day, including residents and visitors.

The Kitsap Department of Emergency Management (KDEM, 2019) focuses on persons requiring special consideration during an emergency including the elderly; young children; those with disabilities, sensory impairment, or economically disadvantages; those reliant on public transportation or in-care facilities; and persons isolated by culture/religion.

Plan for contacting high risk individuals

For people with access and functional needs, an emergency may take away their ability to perform certain functions that were previously possible, and/or their capacity to live independently, and/or navigate the available response and recovery systems effectively. Providing information before, during, and after an emergency can make a difference. Ensuring that preparedness and emergency information is accessible and available in multiple formats and contains content that addresses access and functional needs is critical. Further, plans for sheltering, evacuation, transportation, and recovery, among other areas, must carefully integrate access and functional needs to ensure that they are considered and addressed before a disaster occurs and can be responded to appropriately during and after the event.

The Division of Aging and Long-Term Care maintains updated hard copy and electronic list of individuals that receive case management services, such as through the Community First Choice/COPES/ Medicaid Personal Care, Family Caregiver, Medicaid Alternative Care and Tailored Supports for Older Adults, and Care Transitions programs. The paper copies of caseload lists would be transported to the Emergency Command Center (EOC) by Division staff during an emergency to facilitate contact and outreach efforts. Electronic client files are stored in a cloud-based data system and lists are located on a One-drive server that can be accessed through internet at any site.

Media and Social Media
In the event of an emergency, the County will alert the media and will make information available to the public. The KCDEM keeps a list of key contacts for radio, television, emergency text alerts, daily newspapers, and specialized publications. The designated

County Public Information Officer is tasked with connecting to the various media outlets to ensure that information is accessible and relevant to individuals with access and functional needs. They can also send community blasts through emergency alert text and highway reader boards.

Kitsap County Administration and Department of Emergency Management have accounts with Facebook, Twitter, Next Door, and other popular social networking websites to share preparedness, response, and recovery information.

Preparedness Activities

The Vulnerable Population Annex It is currently under revision to meet the changing requirements and community coordination efforts.

Ongoing drills for earthquakes and fires occur at least once a year. Desk drills and tabletop exercises occur at least annually in Kitsap County. KALTC participates in both these exercises. Planning and practice fosters collaboration between agencies and the non-governmental organizations and community before, during, and after disasters.

Community Education
The public's response to any emergency is based on their understanding of the nature of the emergency, the potential hazards, the likely emergency services response, and the knowledge of what individuals and groups should do to increase their chances of survival and recovery. Ensuring that members of the community with access and functional needs have personal preparedness plans in place for times of disaster warrants the implementation of a comprehensive public education program. Kitsap County is committed to running a public information program to prepare access and functional needs populations for the threat of disasters.

Training and Drills
One objective of KCDEM is to train and educate County employees on issues pertaining to Emergency Operations Centers, the CEMP, and Building Emergency Plans. The County, collectively, ensures that training is inclusive of populations with access and functional needs.

Both emergency response personnel and members of the community benefit from developing and implementing a comprehensive exercise program to test emergency plans, annually. Activities include workshops, tabletops, functional exercises, and de-brief which focus on the coordination of response and recovery efforts of agencies in assisting access and functional needs populations, development and participation to post-exercise evaluation, debriefing and after-action reports.

Functional Assessment Service Teams (FAST) Training
Kitsap County Department of Emergency Management is working in conjunction with the Kitsap County Aging and Long-Term Care (ALTC) and the American Red Cross to identify and train FAST members who can support populations with access and functional needs during emergencies. FAST training includes information regarding emergency management, activation, sheltering, and identifying and addressing emergency related issues regarding populations with access and functional needs.

System for Tracking Unanticipated Expenditures

The Division of Aging and Long-Term Care will track unanticipated expenditures through standard County business practices. If these automated systems are not available, a handwritten tally of expenses will be collected and entered as systems return on-line.

Business Continuity Plan

The Business Continuity Plan for Kitsap Aging and Long-Term Care is aligned with the Kitsap County Department of Emergency Management operations and protocols. The agency back-up systems are coordinated with the County Emergency Command Center and local emergency response efforts. Communication between local entities is key, as well as a single point for coordinated response through Kitsap 1. Kitsap 1 is used by 911 to create a local portal for communication needs and response. All community inquiries are funneled through Kitsap 1, transferred to the Emergency Command Center for triage and coordinated response.

The lines between response and recovery are fluid and diverse depending on the scope and nature of a disaster. In addition, actions taken during response impact directly on the way in which a jurisdiction undertakes recovery. The Division of Aging and Long-Term Care would resume back to normal business operations as directed by Kitsap County leadership and the County Administrator.

Advisory Council

NAME	REPRESENTING
Steven McMurdo, Chair	District 1 – Poulsbo
Barbara Paul, Vice Chair	District 1 – Poulsbo
Sandra Miles	District 1 – Bainbridge Island
Karol Stevens	District 1 – Keyport (member at large)
Charmaine Scott	District 2 – Port Orchard
Elizabeth Safsten	District 2 – Olalla
Linette Zimmerman	District 2 – Port Orchard
Ann Paoletti	District 2 – Port Orchard (member at large)
Ranae Beeker	District 3 – Bremerton
Cynthia Blinkinsop	District 3 – Silverdale
Susan Kerr	District 3 – Bremerton

Public Process

Activity	Date	Location	Group
Area Plan Survey press releases, announcements	March 1 Multiple March dates March 6	Media release, social media, website posting, email, partner distribution lists Caregiver newsletter feature	Public, staff, county employees
Area Plan Survey Review, posting, distribution.	Posted March 1 Closed April 1	Online, email distribution, mail, in-person deliveries	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers
7.01 Meeting	April 6	Human Services Building, Suquamish Tribe	Suquamish Tribe, Area Agency on Aging (AAA) Staff, Regional Manager with The Office of Indian Policy at Department of Social and Health Services (DSHS), and Aging and Long Term Support Administration Tribal Affairs Staff.
Board of County Commissioners (BOCC) Work study session	May 24	Kitsap County Administrative Building	BOCC, Human Services Director, ALTC Administrator, Public
7.01 Meeting	June 6	Virtual meeting with Port Gamble S'Klallam Tribe	Port Gamble S'Klallam Tribe and Area Agency on Aging (AAA) Staff and Regional Manager with The Office of Indian Policy at Department of Social and Health Services (DSHS)

Activity	Date	Location	Group
Public Notice of Advisory Council Meeting with Area Plan presentation	June 14	Kitsapgov email notification, Area Agency on Aging Advisory Council, ALTC website	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers
Advisory Council/Public Meeting Area Plan presentation	June 21	Virtual Meeting	Advisory Council and public, staff, providers
Public Forum Announcements	July 11 release (multiple dates)	NeoGov, ALTC website, email distribution	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers
Public Forum	July 25	Silverdale Library Announced: NeoGov, ALTC website, email distribution	Public, ALTC staff, community partners
Public Notice of Advisory Council Meeting	August 9	Kitsapgov email notification, Area Agency on Aging Advisory Council, ALTC website	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers
Area Plan presentation and work study session/ Board of County Commissioners (BOCC) Session-open to the public	August 16	Kitsap County Administrative Building	Kitsap County Aging and Long-Term Care staff, Director of Human Services, and Board of County Commissioners, public
Advisory Council/Public Meeting Area Plan presentation	August 16	Virtual Meeting-Announcement of Release of Draft Area Plan for input.	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers

Activity	Date	Location	Group
Press Release and Facebook posting of Area Plan Draft for public review	August 15	Press, media, social media and online	Public, providers and community partners, staff, council members
Area Plan Draft posted for public comment	August 15-September 15	Online: Aging and Long-Term Care website	Public, providers, community partners, staff, and council members
Legal Notice for Public Hearing	August 28	Online, press release	Public, providers, community partners, staff, and council members
Board of County Commissioners (BOCC) Presentation and Public Hearing	September 11	Kitsap County Commissioner's Chambers	Kitsap County Board of Commissioners, Aging and Long-Term Care staff, Advisory Council members, public.
Aging and Long-Term Care Advisory Council/Presentation and Public Meeting-Advisory Council Area Plan Approval	September 20	Givens Community Center, Port Orchard	Advisory Council, public, staff, providers
Board of County Commissioners (BOCC) Public Meeting BOCC approval/sign Final Area Plan	September 25	Kitsap County Commissioner's Chambers	Kitsap County Board of Commissioners, Aging and Long-Term Care staff, Advisory Council members, public. 2024-2027 Area Plan submitted to DSHS/ALTSA by 10/5/2023.

Report on Accomplishments of 2020-2023 Area Plan, 2022-2023

Issue Area C-1.1 **Healthy Aging in an Age-Friendly Community**		
Goal: Encourage further development of an Age-Friendly Community through increased awareness of changing demographics and the dramatic increase in the aging population. Work with individuals, community members, providers, business, and government in efforts to meet the basic needs of older adults and caregivers. **Promote positive aging and community engagement opportunities.** **Advocate for funding and creative resource development for services targeted to older adults and caregivers.**		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
1. Promote positive aging, socialization opportunities, and wellness, exercise, and prevention activities. Increase the number of eligible individuals who apply for community based LTSS through provider education, community outreach efforts and coordination with DSHS Home and Community Services. 2. Continue and further develop the advocacy campaign regarding issues that impact older adults and caregivers. 3. Continue to participate in local housing and transportation planning.	• Outreach and special campaign materials utilized in community education. • Explore partnership and funding opportunities focused on fall prevention and wellness and exercise programs. • Promote events, socialization, and exercise and wellness activities at various senior and community centers and other sites across the county. • Advisory Council meetings and W4A Legislative committee meeting minutes. • Support of issues at legislative forums, town halls and other activities. • Develop and promote training for the	<u>Ongoing:</u> • Aging and Long-Term Care (ALTC) Senior Social Check-In Phone Calls • Kitsap Housing and Homelessness Coalition monthly meetings. Distribution of minutes and agenda for staff to share with clients, public, and professionals. • Kitsap Information and Referral Network monthly meeting including information and sharing resources for housing, employment, and public benefits. • Long-Term Care Alliance (monthly) • Facilitation of the Kitsap Quarterly Provider & Partner quarterly meetings. <u>New ALTC website updates:</u> • April 2022: Added slide advertising free KN95 masks; Updated vaccine page. • December 2022: Promoted Enhanced®Fitness program. • March 2023: Added a Medication Tips and & Tools page to the ALTC website. <u>Presentations about Aging services to the following local groups:</u> Kitsap Aging Advisory Council, Tribal Community Services staff, Faith-based Caregiver programs, Silverdale & Poulsbo Library, Peninsula Community Health SHIBA program, Veterans Stand Down & Whole Health Day, Keyport Community club, Hansville Neighbors/Helping Hands, National Association of Retired Federal Employees, Village Greens, Veterans Advisory Council, Manchester Advisory Council, Retired Public Employees, Juneteenth Resource Fair, Silverdale Library/Senior Center, Clearbrook Inn Residents Council, Fairgrounds Senior Lounge, Poulsbo Friends of the Library, and Poulsbo Fire Cares.

	community to be senior advocates. • Facilitate meetings with elected officials. • Partnering with existing organizations with common issues. • Meetings with local housing providers and advocates through Kitsap Continuum of Care; coordination with Kitsap County Human Services Department Homelessness/Housing Program Planner. • Meetings with local transportation providers and representation of Kitsap County needs on regional transportation planning committees. • Representation at public meetings and councils as appropriate. Completion Date: 12/2023	<u>Caregiver newsletter promotion via GovDelivery Electronic notification system 2022:</u> • Virtual Community Café (YMCA) and • Trualta Online (live & recorded) Learning & Resources. • Falls Prevention Week • Suicide Prevention Month • Walk to End Alzheimer's event • September Alzheimer's Education Classes <u>Advocacy Campaigns included Aging Council Member involvement at:</u> • w4a Legislative Advocacy webinar • Spring & Fall Senior Lobby virtual event • Individual meetings with local and state elected officials throughout legislative sessions <u>Housing</u> Kitsap Aging Administrator appointed to Kitsap County Department of Community Development as a representative to the Planning Commission to represent the needs of individuals served through Aging, such as affordable housing and transportation needs. Attends 2 meetings per month. Kitsap Aging participates in monthly Kitsap County Human Services Program sharing. The Housing & Homelessness program and Aging share information. This was a key strategy to identifying community needs, including related to COVID-19. <u>COVID-19 response activities 2020-2023:</u> • 2022: Active participation with local Health District to assist vulnerable adults, Long Term Care workforce, and homebound individual vaccines. • Outreached to variety of senior nutrition providers and food banks to offer flexible CARES funding to address local needs. Developed CARES subcontracts for Meals on Wheels Kitsap, Port Gamble S'Klallam Tribe, and St. Vincent de Paul meal programs. • Outreached to current Older American subcontractors to offer flexible CARES funding to address increased demand. Developed CARES subcontracts for Kinship programs. • Outreached to faith-based community to support current efforts to develop and deliver monthly essential food and supplies to older adults.

		• Virtual Workshops for Older Americans Month 2022 included: • "Meet the Aging & Long-Term Care Office", "Age My Way", "Aging at Home: What should I know?" and AARP Cybersecurity Presentation. • Executed YMCA Enhanced®Fitness (fitness/fall prevention) and Community Café (social isolation) subcontracts for calendar year 2022-2023. • Partnership with Kitsap Public Health for Healthy Aging Initiative and local effort for promoting Healthy Aging. Transportation partnership meeting: Aging Advisory Council meeting with Kitsap Transit for input into their 20-year Long Range Plan.

Issue Area C-1.2 **Alzheimer's, Dementia, and Brain Health**		
Goal: Increase awareness about Alzheimer's disease, memory care and wellness; promote brain health and increase access to detection and services earlier in the disease process; and enhance service options to offer dementia-specific education, consultation, counseling, training, and respite options for individuals with memory loss and their caregivers.		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
1. Sustain Dementia Consultant services dedicated to providing community-based personalized education and strategies to address challenging behaviors threatening placement, regardless of an individual's ability to pay or funding source. 2. Partner with organizations and local professionals to coordinate workshops, conferences, and other education opportunities to individuals with memory loss and caregivers caring for	• Grant proposal submission seeking local mental health 1/10th of 1% sales tax funding for services. • Local advocacy for additional state and national funding to support individuals and caregivers impacted by dementia. • Ongoing promotion of safety resources and educational materials for this population (such as the Information Kit "Safety Concerns for people with Dementia", Silver Alert, and other resources).	<u>Dementia Consultation 2022-2023</u> Awarded local Kitsap County 1/10th BH sales tax funding for Dementia Consultant and community outreach services in 2022. Examples include: • The Dementia Consultant has provided collective impact and collaboration with law enforcement navigators, Poulsbo EMS CARES program, designated crisis response workers, and a bridge to other social services (such as the Alzheimer's Association) • Promotion of Dementia Roadmap and Legal brochures • Collecting referral information for primary care provider(s), legal, and counseling • Memory Screenings, started March 2022 • Robotic Pets pilot, started April 2022 • January 2023: Transferred program funding from 1/10th to ARP stimulus funding • January 2023 and June 2023: Transitioned to new Dementia Consultant <u>Partnerships, community engagement 2022</u> • Explored Falls Prevention subcontract, along with in-home safety assessment. • Continued Distribution of monthly caregiver newsletter; distributed through GovDelivery. • Exploring creating caregiver support groups.

someone with Alzheimer's disease or dementia. 3. Explore and support local development of dementia-specific community engagement opportunities and creative approaches to local partnership development to enhance options to meet the needs of this population	• Coordination activities with Alzheimer's Association and other community potential partners. • Promotion of inclusive, independent, active engagement opportunities for persons with dementia. Completion Date: 12/2023	• Explored a Program to Encourage Active, Rewarding Lives (PEARLS), evidence-based program for managing late-life depression subcontract; • potential provider declined. • Distributed educational material (Dementia Road Map, Alzheimer's Association rack cards with helpline info, 10 Warning Signs, among others) to consumers reaching out to I&A • Dementia Consultant provided 148 services in 2022. • I&A started providing memory screenings in March 2022, services continue. • I&A team met virtually with Alzheimer's Association Kitsap Chapter staff; reviewed classes and support groups available through Alzheimer's Association, common resources, ways of referring consumers. • Virtual Workshop for Older Americans Month- "Age My Way: Empowerment Through Better Brain Health." • Alzheimer's and Brain Awareness Month Spotlight on ALTC website. • June Caregiver Newsletter topic Alzheimer's and Brain Awareness Month with reference to UW Memory & Brain Wellness Center calendar of events. • Alzheimer's Education Classes promoted in September Caregiver newsletter. • Updated website in 2023 to include Dementia Legal Planning Toolkit and new Dementia Consultant Flyer.

Issue Area C-2.1 **Community Living Connections – Information and Assistance (I&A) Services**		
Goal: To provide older adults, persons with long term care needs, and families with access to the information & assistance they need to meet their goals and address needs. Providing this service with an emphasis on consumer choice and multiple access options like phone, mail, and online continues to be a priority.		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
1. Improve consumers' access to long term care and healthy aging information through Kitsap County ALTC website.	• Assessment and posting of relevant links/content to ALTC website. Completion Date: 09/2023	<u>Ongoing monthly:</u> • Updated menu for Meals on Wheels • Program data dashboard • ALTC Advisory Council meeting agenda **2022** • Added 2022 USAging badge • Posted information about virtual workshops for Older Americans Month 2022 • Posted Senior Farmers Market Program Flyer • Added Alzheimer's & Brain Awareness Month spotlight with links to multiple resources • Added Alternatives to Guardianship presentation (Northwest Justice Project/ALTC) to calendar of events • Updated older adult vaccination page • Added slide advertising free KN95 masks • Updated volunteering page • Added Family Caregiver Month information spotlight, scrolling banner & local AAA sponsored event flyer & registration • Promoted Enhanced®Fitness program **2023** • Created Medication Tips & Tools page • Added Caregiver Newsletter subscription link • Added Dementia Legal Planning Toolkit • Added new Dementia Consultant flyer • Added Kitsap transportation presentation • Added Medication tips and tools page • Added website tutorial video • Added 2023 Senior Farmers Market Nutrition Program application and webpage links • Added Older Americans Month banner and section

2. Conduct Medicare outreach and education* including disease prevention, wellness topics, and assisting beneficiaries with Part D enrollment and/or application for a Low-income Subsidy (LIS) and Medicare Savings Programs (MSPs). *Services through Medicare Improvement Patients and Providers Act (MIPPA)	• Report of number of Medicare beneficiaries served and outreach activities. Completion Date: 09/2023	**2022** • MIPPA - 35 beneficiaries provided individualized education, eligibility screening, and/or application assistance during the year • Senor Information and Assistance and MIPPA overview at Village Green in Kingston • Attended an Open Enrollment tabling event with system partner Peninsula Community Health Services (PCHS) Statewide Health Insurance Benefits Advisors (SHIBA) program. **2023** • Beneficiaries provided individualized education, eligibility screening, and/or application assistance (10 to date) <u>ALTC MIPPA Team provided community presentations for the following:</u> • Kitsap Housing Homelessness Coalition (KHHC) meeting • Kitsap Information Referral Network (KIRN) meeting • Keyport Improvement club • Senior Resource Fair at the Silverdale Library • The Hansville Neighbors Group • Residence Council at The Pearl at Oyster Bay; and • Collaborated on providing a Medicare overview to members of the community and attended an event with partners from PCHS SHIBA program
3. Advocate for sustained or increased Senior Citizen Services Act (SCSA) funding and new funding opportunities to support Senior I&A/CLC services.	• Advisory Council Minutes. • Meetings with elected officials. • Public Forum(s) and other community input opportunities. Completion Date: 12/2023	Kitsap ALTC Advisory Council workplan high priority goals include meeting with elected officials and advocate for increased funding. Advocacy Campaigns to request additional funding included ALTC Council Member involvement at: • w4a Legislative Advocacy webinar • Spring & Fall Senior Lobby virtual event • Fall State Council on Aging and w4a annual conference • Individual meetings with local and state elected officials throughout legislative sessions in 2022-2023 <u>Due to COVID-19:</u> In 2022 had increased federal Older Americans Act funding, and extended expiration dates for CARES, Consolidated Appropriations, and Vaccine Grant. • 2022-2024: American Rescue Plan funding, expires 9/2024

		2022-2023 January: Advisory Council legislative advocacy with state elected officials to increase funding. Due to adequate and diversified funding increases, increased SCSA is on hold and not a current priority request. June: Strategically itemized expenses to SCSA to utilize all funds. Ongoing: Grant management to ensure all funds are expended.

Issue Area C-2.2 **Family Caregiver Support Program**		
Goal: To raise the level of awareness about caregiving, develop a continuum of support options for caregivers, and provide resources and supports for family and kinship caregivers in Kitsap County.		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
1. Identify and develop an array of primary and supplemental caregiver support services to assist caregiver populations. Conduct up to three planning or community partnership meetings to explore additional support options.	• Meeting notes and recommended action(s) from coordination meeting(s) with relevant providers. • Community outreach and education to military and Veteran Assistance providers, emergency responders, health care providers, and other potential new partners. Completion Date: 12/2023	**2022-2023** • Expanded supportive services to caregivers that included robotic pets, virtual workshops, memory screenings, and a monthly educational newsletter. • Exploring subcontract for personal response units, in-home fall prevention assessments, and community partnership to caregivers. <u>2022 Community Presentations</u> Hansville Helping Hands, NARP, Village Greens, Veterans Advisory Council, Manchester Advisory Council, Retired Public Employees, Juneteenth Resource Fair, Silverdale Library/Senior Center, Fairgrounds Senior Lounge, Peninsula Community Health Services SHIBA, Veterans Stand Down, Poulsbo Library, Veterans Whole Health event <u>2023 Community Presentations and meetings</u> Keyport Community Club, Silverdale Library Resource Fair, Hansville Neighbors Group. Local VA outpatient clinic social worker attended team meeting to share about VA services & resources, ALTC supervisor provided information on caregiver support through ALTC and offered to provide a presentation to VA Outpatient Clinic team.
2. Maintain support for caregiver training through participation in and/or sponsorship of a caregiver	• Schedule of caregiver education and/or training event(s).	• Development of Caregiver Presentation and community presentation • Distribution of monthly Caregiver newsletter through GovDelivery • January Newsletter- “Asking for Help”

training conference and local training opportunities. Conduct a minimum of one community-wide education or training event annually.	• Dedicated efforts and outreach to notify caregivers about available training opportunities. Completion Date: 12/2023	• Education Series- Virtual Presentation: Topic- Personal Emergency Response Systems • February Newsletter- Virtual options for finding joy and local technology support • Education Series- Virtual Presentation: Topic- Support Groups • March Newsletter- Awareness month advocacy & resources: brain injury, breaking bias international women's day, worlds imagined theme for people with disabilities • Education Series- Virtual Presentation: Topic- Transportation • April Newsletter- Mental Health benefits of spring cleaning and how to help someone else. Info & resources about: National Healthcare Decision Day, Parkinson's Awareness, Kitsap County Development Resource Online Fair, and Earth Day and Free Parks day. • Long Term Care 101- presentation • May Newsletter- Older Adult Mental Health Awareness Symposium (National Council on Aging) • Alternatives to Guardianship- presentation • June Newsletter ad for Alternatives to Guardianship and Alzheimer's and Brain Awareness Month resources and activities. • Presentation-in-person- Bainbridge Island Senior Center. Caregiver Support- Topics: "Identifying as a Caregiver" and supports available, review of caregiver assessment, Tailored Caregiver Assessment and Referral (TCARE®), process and high-level overview of eligibility and benefits for Medicaid LTC, MAC, TSOA, and FCSP. • Presentation (live, virtual)- Bainbridge Island Senior Center, What's Up Wednesday's group. • Caregiver Support- Topics including: "Identifying as a caregiver" supports available, review of the TCARE® process and high-level overview of eligibility and benefits for Medicaid LTC, MAC, TSOA, and FCSP • July Newsletter "Safe Driving" and "Staying Safe in the Heat" • August Newsletter- "Help for Helpers", Senior Lounge at KC Fair & Stampede, Virtual Community Café (YMCA), Trualta Online Learning & Resources. • September Newsletter- Falls Prevention Week, Suicide Prevention Month, Walk to End Alzheimer's event, September Alzheimer's Education Classes (local chapter). • October Newsletter-"Surviving Natural Disasters" and related resources for caregivers

		• November Newsletter- Family Caregiver Month- "Caregiving Happens", with local AAA event information • Presentations, 2 sessions, (live, virtual)- "Caregiving Happens". ALTC created and hosted. • Distribution of flyer for Family Caregiver Month, Caregiving Happens presentation to local libraries, senior centers, case managers, tribal partners, network partners, social service agencies. • December Newsletter- "Dealing with Change from Loss", "Caregiver Stress During the Holidays", Dementia Action Collaborative Resource.
3. Continue outreach to the faith, business, and healthcare professional communities to provide information to members and employees regarding caregiver support services, including kinship care. Conduct a minimum of two presentations or participate in two events targeting faith communities, healthcare professionals, and employers annually.	• Schedule of presentations and copies of reports. • Community and partner education about programs to support individuals and families. Completion Date: 12/2023	<u>2022 Community Presentations</u> Hansville Helping Hands, NARP, Village Greens, Veterans Advisory Council Manchester Advisory Council, Retired Public Employees, Juneteenth Resource Fair, Silverdale Library/Senior Center, Fairgrounds Senior Lounge Peninsula Community Health Services Statewide Health Insurance Benefits Advisors program, Veterans Stand Down, Poulsbo Library, Veterans Whole Health event. July 2022: Coordinated & mailed FCSP & ALTC Rack cards to NW Family Practice Residency Program to share with medical clinic patients. <u>2023 Community Presentations</u> Keyport Community Club 2/18: Silverdale Library Resource Fair 3/15: Hansville Neighbors Group

Issue Area C-2.3 Medicaid Transformation Demonstration (MTD)		
Goal: Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) Benefits support the preference for older adults to age in the setting of choice and provide support for caregivers.		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
1. Increase the caregivers served through collaboration with ALTC staff, Department of Social and Health Services Aging and Long-Term Supports Administration, and local provider networks to engage potentially eligible individual.	• Analyze annual Outreach efforts; update Outreach Milestone, as needed. • Provide staff and local provider network training/ program information. • Staff and Advisory Council program promotion to community agencies, via presentations & contacts to schools, medical service providers, discharge planners, churches, etc. • Identify opportunities to include new program information in ALTC resource lists. Completion Date: 01/2023	2022-2023:Quarterly AAA, HCS, and DDA Provider & Partner meetings to share program updates and reminders. Annually reviewed and updated MTD-MAC and TSOA milestones; analyzed trends, barriers, and churn of clients. The 2023 Outreach plan submitted has a list of completed outreach for 2022 and plans for 2023. Ongoing open recruitment for an increased MTD case manager to assist with program growth. This position remained vacant through 2023 due to reduced caseloads and poor applicant's pool. Presentations about Aging services to the following local groups in 2022: • Kitsap Aging Advisory Council • Tribal Community Services staff • Faith-based communities • Community presentation to learn about Caregiver Services • Local libraries • Community groups (Hansville and Keyport) Updated ALTC Rack Card to simplify wording for MAC and TSOA and attract interest.
2. Target program outreach to caregivers to increase caregiver dyads served.	• Analyze annual Outreach efforts; update Outreach Milestone, as needed • Provide T-CARE screenings & access to customized care plans for caregivers.	2022-2023: Quarterly AAA, HCS, and DDA Provider & Partner meetings to share program updates and reminders for dyad growth <u>Program Staffing</u> 2022 Case manager program attrition, 100% staff turn-over and recruitment 2023 Ongoing assessment of recruitment and training <u>Services</u>

	• Provide person centered counseling and customized services and supports to newly identified caregivers (e.g., respite, counseling, support groups). Completion Date: 01/2023	Mailed out approximately 185 TCARE® Surveys to newly identified caregivers, from I&A contacts. (2022) Approximately 264 caregivers were provided specific caregiver support information through Senior I&A contacts (Jan.-June 2022) Approximately 197 caregivers were provided specific caregiver support information through Senior I&A contacts (July-Dec.)
3. Recruit and maintain provider network adequacy.	• Develop additional contracts to meet caregiver needs. • Identify and recruit local providers for new contracted services, with efficient and timely service delivery. • Provide technical assistance to current Family Caregiver Support Program local contract providers or interested providers, such as the local Tribes, who may be overwhelmed with the Medicaid contracting requirements. Completion Date: 12/2023	**2022-2023** Expanded provider network of supportive services to caregivers that included robotic pets, virtual workshops, memory screenings, monthly educational newsletter, YMCA Enhanced®Fitness, and Community Café, and partnership with Poulsbo EMS CARES programs for follow-up to caregivers with non-urgent issues. Exploring personal response units, fall prevention home assessments, and caregiver support groups. Outreach to potential home care agencies interested in Medicaid contract to expand network. One home care agency did not renew subcontract. One home care agency declined contract. Increased coordination with Tribal staff to assist Tribal members with MTD programs.

Issue Area C-3 Home and Community-Based Services: Case Management and Systems Coordination		
Goal: Support an increasingly growing number of people, with increased acuity, who need long-term services and support (LTSS) to remain stable in their home or a community-based setting.		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
1. Increase awareness, education and understanding of the traditional community-based long-term services and supports (LTSS) options available to individuals that reside at home. 2. Increase the number of eligible individuals who apply for community based LTSS through provider education, community outreach activities and coordination with DSHS Home and Community Services (HCS).	• Increase average number of total persons served each month from 950 to 997, per the state forecast. This equates to at least 47 additional cases each month, with no attrition, by end of 12/2023. Completion Date: 12/2023	2022-2023: Due to loss of caregiver workforce, approximately 50 case files are being held at Home & Community Services office for caregiver assignment. • March 2022: Consumer Directed WA (CDWA) transition impacted workforce availability. • Summer- Fall 2022: Met individually with each home care agency to better understand barriers and workforce challenges, as well as increase communication. • June 2022: Two presentations for family caregivers re: support and program options, at BI Senior Center. 1 live, the other virtual, on campus same day. Topics included introduction to Medicaid Long Term Care (LTC). • July 2022: Increase Personal Needs Allowance take effect. May increase eligible individuals and numbers served. • November 2022: Presentation “Caregiving Happens,” support and program options for caregivers and care receivers, including introduction to Medicaid LTC. The number of people being served through Medicaid initially was lower in 2022 at about 917. This may have been impacted by the challenges presented by getting new providers hired through the CDWA and caregiver workforce shortages. This slowed the transfer of files from the HCS office to Aging as caregivers must be working prior to transfer. In the 2nd quarter of 2023, there were 967 individuals on the caseload. <u>Outreach</u> Island Volunteer Caregivers Executive Board, Kitsap Aging Advisory Council, National Association of Retired Federal Employees, Kitsap Veterans Advisory Board, Older Americans Month attendees, Manchester Community Advisory Committee, Retired Public Employees Council (RPEC), Silverdale Library/ Senior Center, Clearbrook Inn Residents Council, Kitsap Veterans Advisory Board, and Poulsbo Friends of the Library.

		See outreach events listed above in C1.1. The ALTC overview presentations and events include information on LTSS programs. Reference quarterly coordination meetings with DSHS mentioned above.
3. Replenish the 27% shortfall in funding required to ensure high quality of clinical services provided. A crisis has developed due to chronic underfunding of in-home case management. With current funding, increased client acuity, increased inflation, and projected reduction of funding due to Consumer Directed Employer.	• Legislative advocacy and action need to occur to achieve and sustain full funding to maintain quality in-home case management. Adequate funding for a 75:1 ratio will be provided, with an index to keep pace with inflation over time. Completion Date: 12/2023	With additional funding, in 2022 new Medicaid case managers were hired to meet the increased demand. 2022 Advocacy campaign with state elected official results in increased funding (approximately $600,000 per year) to reduce caseloads to 75:1. July 2022: Posted for 2 new case managers and 1 additional nurse.
Goal: Provide person-centered coordination of health and community supports for increasing numbers of people who face significant health challenges to improve health outcomes and reduce avoidable health care costs associated with avoidable hospital visits, hospital admission, duplication of services, and emergency department visits for the Medicaid and Medicare populations. (Health Home program)		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
1. Increase engagement and enrolled clients served each month. 2. Increase awareness through outreach 3. Advocate for increased Health Home reimbursement through shared Medicare savings. Achieve full funding to maintain quality care coordination.	• Increase monthly average caseload to 55 served. Completion Date: 12/2023	Per 2021 update, due to COVID-19, face to face outreach and home visits were cancelled. The Health Home case manager requested a transfer to the Medicaid case management unit. The Health Home Program was closed. 2023: w4a legislative advocacy to request higher reimbursement rate. Program could be re-instated with higher reimbursement rate.

Issue Area C-4 Tribal Partnerships		
Goal: In compliance with the Washington State 1989 Centennial Accord and current federal Indian policy, 7.01 plans are created in collaboration with Recognized American Indian Organizations in the planning of the Washington Department of Social and Health Services and Area Agencies on Aging (AAA) service programs, to ensure quality and comprehensive service delivery to all American Indians and Alaska Natives in Washington state. The plans address concerns identified by tribal members, identify tribal leads and ALTC staff, action steps to address each concern, and provide a yearly summary of the progress.		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
1. Create and complete 7.01 plan with Port Gamble S'Klallam Tribe.	• Coordination, meetings, and plan finalization. Completion Date: 12/2023	2022: 7.01 Planning meeting occurred 08/16/2022. 2023: 7.01 planning meeting occurred 06/06/23.
2. Create and complete 7.01 plan with Suquamish Tribe.	• Coordination, meetings, and plan finalization. Completion Date: 12/2023	2022: Kitsap Aging confirmed interest in participation in update planning meeting. June and Fall 2022: Tribal Relations Regional Manager for the Office of Indian Policy, Office of the Secretary, Washington State Department of Social and Health Services sent inquiry to Tribe. An update planning meeting did not occur during the 2022 time period. 2023: 7.01 Planning meeting occurred 04/06/2023.

Issue Area C-5 COVID-19 Response Services & Supports		
Goal: Continue to support community recovery through information sharing, delivery of services, vaccine assistance, and expansion of community-based network with organizations to address food and economic insecurity as a result of COVID-19.		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
1. Advocacy and education activities for access to personal protective equipment (PPE) and other items to support staff and services providers to continue service provision.	• Attendance at Washington State Department of Health, Kitsap Public Health, Kitsap County Department of Emergency Management Emergency Operations Center and partner	2022: • Attended monthly Kitsap Public Health Board virtual meetings • Distributed local Kitsap Public Health information to community partners • Reviewed local Kitsap Public Health and state guidance, vaccination and COVID positive information at Aging and Long-Term Care Ombudsman Advisory Council public meetings. • Shared Kitsap County Emergency Operation Center (EOC) link for access to free PPE at Quarterly Provider and Partners meetings. • Maintained website information with current information and links to information – Kitsap County general website and Kitsap Aging website pages.

	meetings, and COVID-19 response coordination meetings. • Technical assistance with accessing and interpreting rapidly changing operational guidance, rates, implementation strategies, technology challenges, etc. Completion date: 2023	• Received large quantities of PPE from DSHS ALTSA and Kitsap County EOC for use by direct service staff for current and future outbreaks. • Provided free masks to community by mail – cloth (2020-2022) and KN95 (January- August 2022). • Created and distributed PPE Backpacks to all Case Managers in all Aging programs and educated staff on utilization of each item, in preparation to resume home visits. • Created replenishing PPE boxes for PPE Backpack items.
2. Increase access to vaccinations for older adults, homebound individuals, family caregivers, and home care providers.	• Offer assistance to local Kitsap Health District as a vaccine appointment partner. Direct access to vaccine appointments to assist individuals unable to access appointments due to technology challenges. • Provide accurate information about local vaccine and COVID-19 testing sites, as well as transportation options to the location sites. Completion date: 2023	• I&A staff made vaccine reservations for older adult community members needing assistance • I&A staff provided updated information about vaccine information and local providers to general public • Worked with Kitsap Public Health homebound vaccine team to disseminate postcards and identify homebound individuals for outreach in our community. • Executed new transportation contract with Gather Together Grow Together for free transportation assistance to vaccine sites.
Goal: Utilize stimulus funding to meet local needs and expand network services.		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
1. Increase availability of nutrition services for older and homebound individuals.	• Increase funding for increased need for number of emergency take-out and home delivered meals.	• 2022-2023: Additional CARES and ARP funding allowed the following nutrition subcontracts and services: • Meals on Wheels Kitsap to allow for more flexible alternative meals, increased costs associated with home delivered meals, increased Farmers Market

	• Support acquisition of necessary supplies and equipment for safe, expanded service needs. • Increase network service providers to include faith-based and other non-traditional senior nutrition providers to ensure alternative senior nutrition security. Completion date: 2023	vouchers, development of Diners Choice model, and updated computers and software systems. • Port Gamble Tribe Elders program to allow for more flexible alternative meals and increased costs associated with meals. • St. Vincent DePaul senior nutrition program to increase the number of individuals served, provide fresh produce and meats, as well as shelf stable non-perishable items and increased staff hours to operate the counter. • Sinclair Baptist Missionary faith-based church to provide home delivered monthly essential bundles that included non-perishable food items. • Kitsap Harvest to expand the senior nutrition program with more fresh vegetable bundles delivered to senior apartment sites. Technical assistance offered to new non-profit organization.
2. Support intergenerational Kinship Caregiver households to meet basic needs.	• Increase funding to create more flexible service delivery options and enhanced service availability. • Develop flexible policies to increase access to services. Completion date: 2023	2022: Offered an ARP subcontract to Kitsap Community Resources- declined. Plan to execute subcontract in 2022-2024 once it is requested
3. Explore community partnerships and new contracts to deliver expanded services in response to COVID-19.	• New and expanded contracts to provide additional funding to meet emergent needs. Completion date: 2023	2022: Started partnership with Gather Together Grow Together (G2G2) to offer assistance with getting to/from covid vaccine and booster appointments to older adults and caregivers 2022-2023: The following community partners were offered and/or executed a subcontract with Kitsap Aging to meet a local need: • Meals on Wheels Kitsap – food • Port Gamble Tribe Elders program- food • St. Vincent DePaul senior nutrition program- food • Sinclair Baptist Missionary faith-based church- food and essential incidentals • Kitsap Harvest- food (paused) • Gather Together Grow Together- vaccine transportation

		• Northwest Justice- legal assistance (declined)
		• MCS- counseling
		• Pathways Counseling, WA- counseling
		• YMCA Community Café' - social isolation
		• First Choice Home Care- home care
		• Serengeti Home Care- home care (paused)
		
		2022 New community services and partnerships included:
		• Kitsap Public Health Age Friendly Initiative (DOH grant)
		• NJP- Alternative to Guardianship webinar
		• AARP – Cybersecurity webinar
		• Honoring Choices booklet for advanced care planning
		• Kitsap Aging and Community Service office bi-monthly meetings to discuss local challenges, local workforce updates, and increase communication
		
		March 2022: Launched Care Transition new service to support hospital discharges.
		• Identified existing staff to provide .5 FTE capacity for new service; hired 1.0 FTE in July 2022.
		• Met with Virginia Mason hospital network staff for statewide regional collaboration, as well as outreach to local hospital discharge management staff. Meetings included:
		  ○ St. Michael's Care Management Supervisor
		  ○ St. Anthony's Hospital Care Management Supervisor
		  ○ St. Michael's Care Management Director and Supervisor
		  ○ Regional meeting with King & Pierce AAAs and network hospitals
		• December 2022- initial referrals generated
		• January 2023- program referrals

Goal: Maintain ALTC staff to provide direct services, as well as administrative support, through COVID-19. Demands for caregiving of older and younger family members, personal health issues, relocations and early retirements have resulted in a 35% staff turnover since January 2021.		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
1. Maintain adequate staffing and timely recruitment of vacancies to continue to provide direct	• Timely recruitments of vacant positions • Development of flexible remote worker policies to retain staff	Active staff recruitments for the following positions: • Medicaid Long-Term Care case manager to fill existing and new positions • MAC/TSOA case manager new position and attrition • Medicaid Long-Term Care registered nurse position • Care Transitions case manager new position

services and expand the network.	• Creative use of office space with program expansion and limited cubicles Completion date: 2023	• I&A case manager technician to fill existing position • I&A supervisor new position • Caregiver Programs supervisor Remote worker policies in place with the following expectations when there is not an active outbreak: • Direct Service staff at least 1 day a week in office; more if they prefer • Program Supervisors at least 2 days a week in the office; more if they prefer • Support Positions -a combination of remote and in office, such as front reception and program technicians • Employees on probation must be in the office every day until they pass probation; then they can work remotely. 2022: Explored various location to expand office space in Silverdale and Givens. Working with Kitsap County Information Services and facilities to assess potential space. No space identified in Silverdale. Fall 2022: Transformed small conference room at Givens to office cubicle space. Fishline office transitioned to shared office space between two staff.

Statement of Assurances and Verification of Intent

For the period of January 1, 2024, through December 31, 2027, the Kitsap County Aging and Long-Term Care accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (P.L. 116-131) and related state law and policy. Through the Area Plan, Kitsap County Aging and Long-Term Care shall promote the development of a comprehensive and coordinated system of services to meet the needs of older individuals and individuals with disabilities and serve as the advocacy and focal point for these groups in the Planning and Service Area. Kitsap County Aging and Long-Term Care assures that it will:

Comply with all applicable state and federal laws, regulations, policies, and contract requirements relating to activities carried out under the Area Plan.

Conduct outreach, provide services in a comprehensive and coordinated system, and establish goals objectives with emphasis on a) older individuals who have the greatest social and economic need, with particular attention to low-income minority individuals and older individuals residing in rural areas; b) older individuals with significant disabilities; c) older Native Americans Indians; and d) older individuals with limited English-speaking ability.

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

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

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

Information concerning whether there is a significant population of older Native Americans in the planning and service area, and if so, an assurance that the Area Agency on Aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under the Area Plan;

An assurance that the Area Agency on Aging will, to the maximum extent practicable, coordinate the services the agency provides with services provided under title VI of the Older Americans Act; and

An assurance that the Area Agency on Aging will make services under the Area Plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

Provide assurances that the Area Agency on Aging, in funding the State Long Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of Title III funds expended by the agency in fiscal year 2024 on the State Long Term Care Ombudsman Program.

Obtain input from the public and approval from the AAA Advisory Council on the development, implementation, and administration of the Area Plan through a public process, which should include, at a minimum, a public hearing prior to submission of the Area Plan to DSHS/ALTSA. Kitsap County Aging and Long-Term Care shall publicize the hearing(s) through legal notice, mailings, advertisements in newspapers, and other methods determined by the AAA to be most effective in informing the public, service providers, advocacy groups, etc.

Date	Stacey Smith, Administrator Kitsap County Aging and Long-Term Care
Date	Steven McMurdo, Advisory Council Chair Kitsap County Aging Advisory Council
Date	Charlotte Garrido, Chair Kitsap County Board of County Commissioners
Date	Katherine T. Walters, Commissioner Kitsap County Board of County Commissioners
Date	Christine Rolfes, Commissioner Kitsap County Board of County Commissioners