Welcome to the Area Plan Draft 2027-2030

Kitsap County Aging and Long-Term Care

The Public is invited to review this draft.

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

Stacey Smith, ALTC Administrator

Sponsored by

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1. Executive Summary

Welcome to the Kitsap County Area Agency on Aging 2027-2030 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 the needs of older people in their planning and service area. The AAA focuses on services that promote healthy aging and options that support aging and adults with disabilities to live as independently, and with as much dignity as possible. There are more than 600 Area Agencies on Aging across the country, and 13 Area Agencies on Aging in Washington State.

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 within program parameters and available funding are outlined. The plan development process is mandated by the federal Older Americans Act and must be written in a format prescribed by the Washington State Department of Social and Health Services (DSHS) Home and Community Living Administration (HCLA).

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 and options that positively impact social determinants of health, while preparing for an increase in the aging population. The plan outlines our mission, describes our target populations, defines the areas of importance to improve support for those populations, and provides information about how resources are utilized.

The plan sets the stage for ALTC over the next four-years and is the foundation for workplans, funding priorities, and planning efforts to provide services. What's new this plan period is that we are also addressing service expansion to broader target populations,

beyond older adults and caregivers. Also, unprecedented program growth will necessitate organizational change and allow us to provide more service options to the community.

Our major goals are to:

- Address basic needs of individuals by connecting them to resources
- Improve the health and well-being of our community
- Promote connections with others, reduce social isolation and loneliness
- Increase independence and choice for older adults and adults with disabilities
- Promote aging readiness and healthy aging
- Support individuals and caregivers impacted by dementia
- Identify and meet local gaps impacting older adults, individuals with unique needs and abilities, and caregivers
- Address health disparities impacting health outcomes and offer healthy options for individuals and families
- Promote consumer empowerment and consumer advocacy
- Expand access to new and existing programs and services
- Maximize partnerships and provider relationships for local service delivery

In alignment with 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 or through subcontracts.

Aging and Long-Term Care funding has continued to diversify since our last plan period. 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, Medicaid Transformation Demonstration, Health Related Social Needs, and Rural Health Transformation.
- State funding includes the Senior Citizens Services Act, Family Caregiver and Kinship Caregiver Support and Navigator programs, Senior Drug Education, Care Transitions, Senior Nutrition, Senior Farmers Market Nutrition Program, Home Delivered Meal expansion funds, and WA Cares.
- Time-limited special project grants are another revenue source when awarded.
- Kitsap Aging and Long-Term Care does not receive Kitsap County general funds.
- The total 2026 budget is approximately $9.2 million.

ALTC COMMUNITY IMPACT

As of August 2026, the agency holds 75 contracts to provide community services:

- 26 for Medicaid Services
- 11 for Older Americans Act and State Services (some combined with Medicaid services)
- 7 for Home Care
- 31 for WA Cares Fund eligible services

2025 Service Highlights

- 1,811 Calls to Aging and Disability Resources Network team
- 1,255 monthly an average of Individuals served through case management
- 424,521 hours of in-home personal care for individuals on Medicaid long-term care services.
- 3,205 Respite Hours for family caregivers
- 27,476 Congregate and Home Delivered Meals delivered
- 1,044 older adults served through the Senior Farmers Market Nutrition Program
- 1,010 Legal Assistance Hours
- 37 Kinship Caregivers Supported

Sources: Home and Community Living Reporting, Older Adults Performance Reports , Community Living Connections, Aging and Long-Term Care databases.

This Area Plan was developed by Aging and Long-Term Care staff with valuable input from target populations, providers, clients, and the public. Available reports and data specific to plan elements are cited throughout the plan. The plan is recommended by both the Area Agency on Aging Advisory Council and the Kitsap County Board of Commissioners.

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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.

2.1 Mission, Vision, Values

Kitsap County

Our Mission: Kitsap County Government exists to protect and promote the safety, health, and well-being of all County residents in an accessible, efficient, effective, and responsive manner.

Department of Human Services

Our Mission: To provide essential 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 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.

With new programs and expanding services, our target population now includes individuals of all ages.

Our Objectives are to:

- Assist individuals in securing and maintaining maximum independence and dignity in their living environment of choice with appropriate support services, preventing unnecessary or premature facility-based care;
- Promote personal independence by reducing social and economic barriers
- Promote connections with others, reducing isolation and loneliness;
- Promote better physical/emotional health through improved nutrition, health promotion and disease prevention education and activities;
- Connect 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 and age friendly initiatives in Kitsap County;
- Provide excellent customer service to the community by acknowledging, listening to, and valuing each member.

2.2 AAA Services and Partnerships

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

Adult Day Services

Adult Day Programs are designed to support adults who are functionally or cognitively impaired, chronically ill, or recently discharged from hospitals or nursing homes. These programs combine social and medical care to create a safe, nurturing, and stimulating environment where participants can thrive while maintaining independence and engaging in meaningful activities. Local programs offer caregiver support and respite.

Adult Day Care

Social supervised day services offer families relief from care and provide program participants opportunities for socialization and enrichment activities. Services are designed to address the social needs of participants and provide respite for caregivers in a safe, comfortable place.

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 nursing routine health monitoring with consultation, assistance with some activities of daily living, social services, activity therapy, and a mid-day meal.

Aging and Disability Resource Network Information & Assistance/Community Living Connections

Aging and Disability Resource Network (ADRN), previously known as Senior Information & Assistance (I&A) is an integrated system of functions designed to identify individuals 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 ADRN program is an access point for referrals, services, and consultation. Functions of the program include information-giving, service referral, assistance, and person-centered counseling, client advocacy and screening to determine whether a person, or their caregiver, should be referred to other services and supports.

The program continues to assist older adults and individuals with different needs and abilities to access necessary support services. Services are designed to achieve and maintain the maximum level of health and independence possible.

The program is also responsible for ALTC program outreach and publicity and developing and maintaining information about community resources that serve older adults, individuals with different needs and abilities, and caregivers.

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 after referral receipt through meeting with individuals to complete an assessment, and development and implementation of an individual plan of care. Examples of support may include assistance with referrals to caregiving programs, coordinating transportation to medical appointments, support with applying for programs offering nutrition or other interventions, and working with natural supports.

Dementia Consultation

Services include specialized consultation, education, and resources for individuals with early stages or concerns with memory loss and caregivers. Services include answering questions about disease progression and medical interventions, advanced care planning, advanced legal planning, referrals to local support and educational groups, behavioral strategies and respite options for caregivers. Services are provided at no charge.

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

Health-Related Social Needs

The Health-Related Social Needs program operates under the Medicaid Demonstration waiver section 1115, also called the Medicaid Transformation Program 2.0. Services allow

qualifying Medicaid enrollees to receive evidence-based, non-medical services to address unmet, adverse social conditions that contribute to poor health. Nutrition services under this waiver started in 2026 and home adaptation devices services are being explored. HRSN services are effective through June 30, 2028.

Nutrition Services: This HRSN program requires additional criteria for eligibility, such as age, chronic conditions, and meeting USDA definition of food insecurity.

Current services include:

- Medically Tailored Meals: Meals tailored to support people with health-related conditions for which nutrition supports would improve health outcomes.
- Nutrition Counseling & Education
- Pantry Stocking with a variety of foods aimed at promoting improved nutrition.
- Fruit and Vegetable Box with fresh, frozen, or canned items

Home Adaptative Devices (exploratory): This HRSN program has established criteria for eligibility, chronic conditions associated with temperature or air quality, as well as power dependency for medical devices

Exploring adaptative home devices services, such as:

- Air Conditioners
- Heaters
- Air filtration devices and replacement filters
- Refrigeration units
- Portable power supplies

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.

KINSHIP NAVIGATOR PROGRAM

The Kinship Navigator program provides information and assistance functions and system navigation, along with supportive listening, to grandparents and other relatives who are raising relatives' children (under the age of 18 years) or planning to do so. They connect kinship caregivers over the age of 18 to community resources, such as health, financial, legal assistance, support groups, training, and urgently needed goods and services and

explain how to apply for federal and state benefits. Navigators walk alongside a family to guide the complex children and family serving systems.

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.

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 Management is also provided for the Veterans-Directed Home Services program.

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 Project

Under this 1115 Medicaid Demonstration Waiver, the Medicaid Transformation Project (MTP) Medicaid Alternative Care and Tailored Supports for Older Adults (MAC/TSOA) programs were created to address the needs of a growing aging population. Programs include options 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 when possible. The statewide efforts to submit a renewal Waiver for year 7 of the program beginning in 2023 were successful. The latest extension is through June 30, 2028. However, starting December 1, 2025, enrollments were paused for MAC & TSOA and there is a wait list.

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 encourage beneficiaries to participate in disease prevention and wellness activities and coordinate 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 case management for the most medically complex cases and is available for consultation to other program staff.

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 health status, support independence, prevent premature institutionalization, and allow earlier discharge from hospitals, nursing homes, or other residential care facilities.

Community Dining Sites

Congregate Nutrition services, also referred to as community dining sites, 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 six 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. Sites provide healthy meals and socialization for local older adults.

Another three sites are "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 farmers 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. The 2026 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.

Senior Nutrition

Contracted service with local food banks, Meals on Wheels Kitsap, and the Port Gamble S'Klallam Tribe for enhanced nutrition services. For example, produce, storage, refrigeration, physical space and staffed hours for an onsite "Senior Counter" program for older persons with unstable housing or who are homeless. 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. Enhanced senior nutrition is provided to individuals 60 years of age and older.

Health-Related Social Needs (HRSN) – Nutrition Services

HRSN offers services that can have a positive impact on health, service details are described above. Program eligibility requires enrollment in a covered Medicaid program.

PERSONAL EMERGENCY RESPONSE SYSTEMS

Personal emergency response systems services are authorized through the Family Caregiver Support Program to monitor homebound older adults or disabled adults using an electronic communication link with a response center.

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 are 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 provider and caregiver, and maintaining contact with caregiver for reassessment and referral to other services.

SENIOR DRUG EDUCATION PROGRAM

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

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 health and fitness: 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. Aging and Long-Term Care currently contracts with one community-based agency to provide this service.

Social Check-in Calls

Check-in calls are available for Kitsap residents aged 60+ who would like a friendly phone call. Calls are social in nature to address social isolation. 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 ALTC.

Memory Screening

This service is offered through a partnership with the Alzheimer's Foundation. Memory screenings are free and scheduled by calling the Aging and Disability Resources Network Senior Information and Assistance. Trained 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. Screening is not intended to diagnose but can lead to discussions between participants and their care team.

VETERAN-DIRECTED HOME SERVICES

This is a participant directed program for Veteran Administration (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. Case coordination for this program is provided through the ALTC Medicaid Case Management unit.

WA CARES FUND

Effective July 1, 2026, Washington residents who apply and become eligible for their WA Cares Fund (WCF) benefit will be able to access their benefits to pay for Long Term Services and Supports.

ALTC provides beneficiary navigation support through the Aging and Disability Resource Network. Provider network development and contract management is through the ALTC contracts unit.

- 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 pay privately.

For further information regarding a specific service, please call Aging and Disability Resource Network at 360-337-5700 or 1-800-562-6418 or visit our ALTC website at **www.agingkitsap.com**

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 noted 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-Emergency Preparedness	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.	Quarterly
"ESF-8" Meeting	Co-led by Kitsap Public Health and Kitsap County Department of Emergency Management for medical and social services community agencies to respond to local disasters, prepare for known events (like heat, snow and smoke) and share information.	Quarterly
Long-Term Care Alliance	Forum to share local services updates and problem-solve common community concerns. Includes Skilled nursing, assisted living, and adult family homes, DSHS HCS, APS, hospital, Kitsap Aging and emergency response representatives.	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.	Monthly
Kitsap Network Provider & Partner Meeting	Facilitated by ALTC staff to review system, policy changes and enhance cross-agency communications. Includes local HCS, DDA, APS and ALTC staff and subcontractors.	Annual

Committee Name	Purpose of Committee	Frequency of meetings
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 Health Department to address suicide rates and prevention strategies. Attendance from schools, social services, health providers, veteran groups, League of Women voters, and Aging.	Quarterly
Care Transitions	Co-facilitated by local hospital administration (St. Michael and St. Anthony's) and Kitsap Aging Administrator, along with Care Transitions staff.	Quarterly
Kitsap Housing & Homelessness Coalition	Co-facilitated by the Bremerton Housing Authority and Kitsap County Housing program coordinator. Discuss local issues supporting vulnerable population with housing insecurity.	Monthly
Fall Prevention Coalition	Facilitated by Kitsap Public Health Chronic Disease team. Participants include Department of Health Fall Prevention, Kitsap Aging, local emergency management services (Fire & Rescue), Cares programs, and community partners.	Quarterly
Nourishing Network	Kitsap foodbank coalition members (7 food banks) and community partners address food insecurity throughout Kitsap County.	Monthly
Kitsap Equity Collaborative	Facilitated by Kitsap Public Health to address health disparities in identified population groups. Kitsap Aging represents the older adult population.	Monthly
Provider Breakfast	For profit local businesses meet to network about services focused on supporting older adults. Participants include real estate brokers, elder law specialists, skilled nursing and memory care facilities.	Monthly; sporadic attendance

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 Leadership Meeting: Bremerton Office	Coordination between Home & Community Services assessment and financial teams for LTSS, MTP, and PE cases.	Quarterly
DSHS Region 3 Housing & Supportive Employment Collaborative	Coordination between state programs and local providers of Housing and Supportive Employment Programs	Quarterly
Olympic Community of Health (ACA)- Board of Directors	The local accountable community of health that includes Kitsap, Jefferson and Clallam Counties. Kitsap Aging is a Board member that represents the older adult sector.	Every other month
Olympic Community of Health (ACA)- Advisory Council	The local accountable community of health that includes Kitsap, Jefferson and Clallam Counties. The advisory council provides technical expertise to projects and hub coordination platform (Olympic Connect).	Quarterly

Statewide efforts

Kitsap County Aging and Long-Term Care 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 AAAs to share information, discuss proactive solutions to common issues, and advocate for flexible system reform.	Twice a month
Community Living Connections- Policy Maintenance & Recommendation Committee (PMRC)	Statewide committee involving Aging and Home & Community Living Connections (HCLA) and Area Agencies on Aging staff to review and suggest policy standards for Community Living Connections.	Monthly

Committee Name	Purpose of Committee	Frequency of meetings
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. Provides a consistent, clear operational structure for input and updates.	Monthly
w4a, Area Agency on Aging and Home & Community Living Connections Contract Manager Meetings	Statewide meetings to discuss monitoring, contracting and policy including changes, processes, and best practices.	Monthly
w4a, Area Agency on Aging and Home & Community Living Connections Fiscal Manager Meetings	Statewide meetings to discuss items related to fiscal operations and share best practices.	Every other month
w4a, Area Agency on Aging and Home & Community Living Connections Medicaid Clinical Directors Meetings	Statewide meetings to discuss items related to Medicaid Title 19 program and share best practices.	Monthly
w4a, Area Agency on Aging (AAA) and Home & Community Living Connections Unpaid Caregiver Collaboration (UPCC)	Statewide meetings to discuss items related to unpaid Family Caregivers and Medicaid Transformation Program and to share best practices.	Monthly
Washington State Council on Aging (SCOA) Kitsap AAA does not have a representative.	SCOA is an advocacy group for senior issues and a unified voice across Washington. 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

Committee Name	Purpose of Committee	Frequency of meetings
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
w4a, Area Agency on Aging and WA Cares: Leadership	Statewide meetings to provide oversight of the protocols and mutual system expectations for program launch readiness	Monthly
w4a, Area Agency on Aging and WA Cares: Beneficiary Assistance	Statewide meetings to provide training and technical assistance for program launch readiness. Trainings	As needed
w4a, Area Agency on Aging and WA Cares: Network Development	Statewide meetings to provide training and technical assistance for program launch readiness. Trainings	As needed
w4a, Area Agency on Aging and HRSN: Leads	Statewide meetings to provide oversight of the protocols and mutual system expectations for program launch and service delivery.	Monthly
w4a, Area Agency on Aging and Presumptive Eligibility program launch (July 1, 2026)	Statewide meetings to provide training and technical assistance for program launch readiness. Trainings	As needed

3.1 The Planning and Review Process

The Kitsap County Aging and Long-Term Care (ALTC) 2027-2030 Area Plan was developed as the combined product of earlier Area Plan data, years of delivery and coordination of local services, and needs-analysis based on available community surveys and the 2026 Aging and Disability survey responses. Plan development also considered input from the public, staff, providers, and Advisory Council, and current trends and identified needs in health and social services systems, 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 key issue areas in this plan apply not only to Kitsap County, but all 13 Area Agencies on Aging in Washington State.

Key Issue Areas include:

- Greatest Social and Greatest Economic Need
- Expanding Access to Home and Community Based Services
- Caregiving
- Tribal Partnerships and 7.01 planning

Developing Age-Friendly communities, supportive of the needs of older adults and that can provide a safe, healthy, and productive environment for all is an ongoing goal. 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 and links to the online survey were distributed to the public in a variety of ways: social media campaigns, online posting to Aging and Kitsap Public Health District website, automated County email distribution lists, direct emails, 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 and were included in the plan goals and objectives.

Aging and Long-Term Care uses a service recording system that provides detailed demographic and service statistics regarding persons who already use services in Kitsap County. This data, combined with service information from the Washington State 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.

Aging and Long-Term Care 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 recommendations, ALTC staff completed the planning goals and objectives for the 2027-2030 Area Plan.

The 2027-2030 Area Plan includes a report on accomplishments for the previous plan through 2026.

Community survey results and the draft plan information were presented for public review and comment at an Aging Advisory Council meeting on June 17, and August 19, 2026; a public forum in Silverdale on July 14, 2026; a Kitsap County Board of County Commissioner work study session on August 24, 2026; and a Board of County Commissioners public hearing on September 14, 2026. Anyone not able to attend the public meetings or the 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 10-September 10, 2026 and was available in hardcopy at the ALTC office and also the Kitsap County Fair designated Senior Lounge area from August 26-30, 2026.

Recommendations for modifications to the Area Plan were evaluated and modifications accepted by the Advisory Council were made prior to Advisory Council and Board of County Commissioner approval and signatures, followed by submission to Washington State Department of Social and Health Services, Home and Community Living Administration, for final approval.

The public process for the 2027-2030 Area Plan is described in Appendix C

3.2 Demographics: PSA Profile and Data Trends

Kitsap County occupies a unique portion of Washington State, 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. It is located between Hood Canal, Admiralty Inlet and Puget Sound, making transportation difficult and ferries and bridges vital to the community 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. More than half of all ridership on Washington State ferries originates or ends in Kitsap County[1].

Situated along the western shore of the central Puget Sound region, Kitsap County comprises a total land mass of 395 square miles (0.6% of the state's total land mass). Kitsap County ranks 36th in geographic size among Washington counties, seventh in total general population and is the fourth most densely populated county in the state. Kitsap County is also noted for offering the "most waterfront" among all the counties. The population has increased steadily, and the estimated population of Kitsap County is 286,100 (see Table 1 below). The expected growth rate by 2030 is 0.49%[2].

In Kitsap County, there are four incorporated cities, which make up 36% of the total population in 2024. While Bremerton makes up the largest percentage of the population, Port Orchard is the fastest growing due to population migration and annexation. From 2010 to 2024, there was a 64% 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 2024 but have only grown 8% since 2010 and 2% since 2020 compared to the growth of incorporated areas by 26% and 6% since 2010 and 2020 respectively (Table 1)[3].

Table 1. Population Growth by Location, Kitsap County

	Census 2010	Census 2020	2024 Estimate	% of Total 2024
Total	**251,133**	**275,611**	**286,100**	**100%**
Unincorporated	170,022	179,719	184,070	64%
Incorporated	81,111	95,892	102,030	36%
Bainbridge Island	23,025	24,825	25,330	9%
Bremerton	37,729	43,505	45,390	16%
Port Orchard	11,157	15,587	18,300	6%
Poulsbo	9,200	11,975	13,010	5%

1 Washington State Employment Security Department, Kitsap County Profile, Updated January 2026, https://esd.wa.gov/jobs-and-training/labor-market-information/reports-and-research/labor-market-countyprofiles/kitsap-county-profile

2 Kitsap County Economic Development Alliance. (2025).*Community Profiles*. Kitsapeda.Org. https://www.kitsapeda.org/lifestyle/community-profiles/p/item/1060/kitsap-county. Accessed July 26, 2026

3 Washington State Office of Financial Management, http://www.ofm.wa.gov/

POPULATION TRENDS

The population of Kitsap has been increasing steadily. In 2024, the population was an estimated 286,100 which was about a 4% increase from the population in 2020. There were 71,321 older adults (60 and older) in Kitsap County in 2020, making up 26% of the population. This increased to 79,162 older adults in 2024, making up 28% of the population. There were 4,901 people who were 85 and older (1.8% of the population) in 2020, which increased slightly in 2024, with 5,353 people 85 and older making up 1.9% of the population. This represents an 11% increase in adults 60 and older and a 9% increase in adults 85 and older from 2020 to 2024. The total number of people who are 60 and older is projected to increase 16% from 2025 to 2040.[4]

Figure 1. Population of Kitsap County, 2010-2024

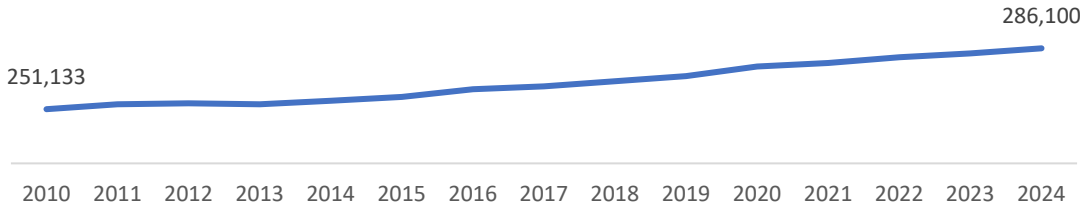


Figure 2a. Population by Age Group, Kitsap County, 2020

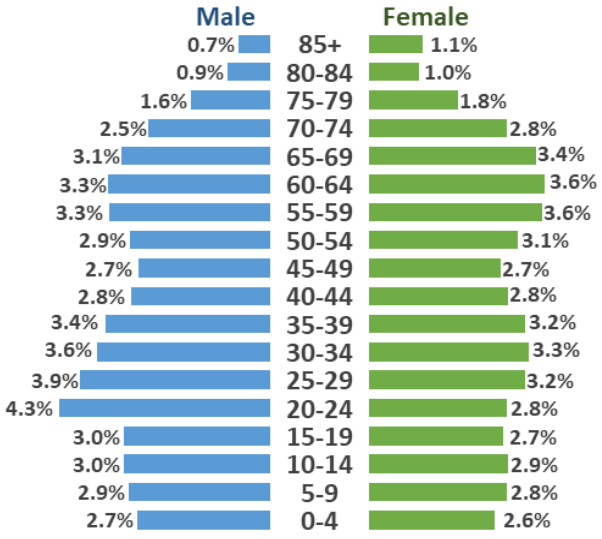
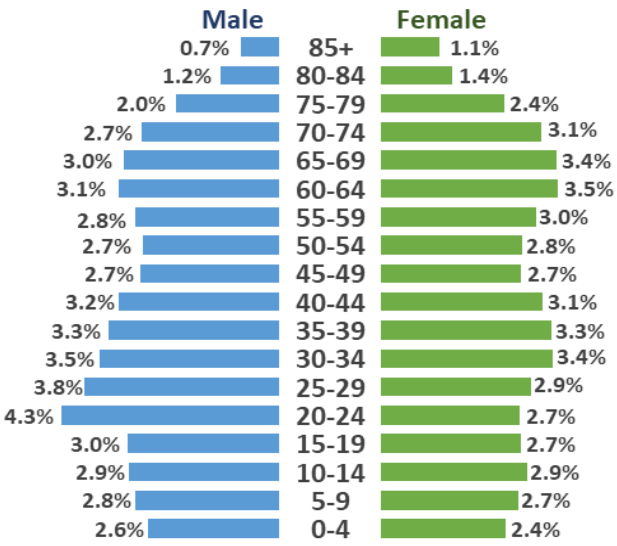


Figure 2b. Population by Age Group, Kitsap County, 2024



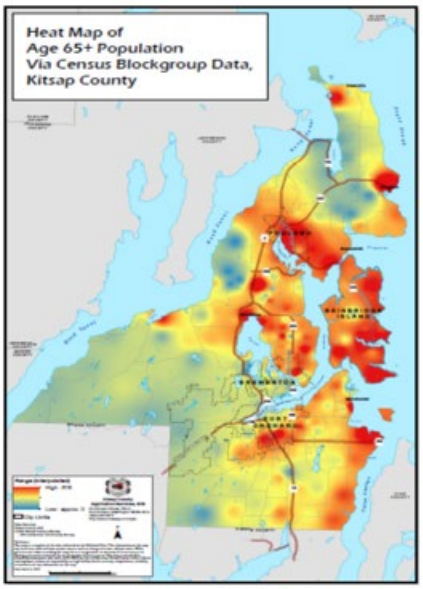
In 2024, the largest age group was 20-24, making up 7.0% of the population in Kitsap County (Figure 2b). This was similar to 2020, as the age groups 20-24 and 25-29 were the largest at that time, both making up 7.1% of the population (Figure 2a)[1].

4 Selected Population and Aging Service Utilization Forecast, Kitsap County Division of Aging & Long-Term Care. "Forecasts of Use of Long-Term Services and Supports, the Aging Population, and Dementia Prevalence through 2040 in Washington State" Technical Report. Bailey Ingraham, PhD, Katherine Bittinger, PhD and David Mancuso, PhD September 2025 DSHS Research and Data Analysis Division Olympia, Washington

Overall, from 2020-2024 the median age of Kitsap County residents was 40.2 years, which was older than the state median of 38.3 years. The median age of males in Kitsap County was 38.6 years while the median age of females was 42.

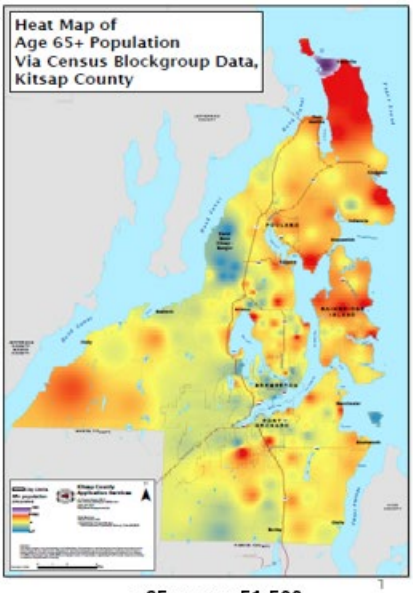
The following maps illustrate the concentration of older adults over time across Kitsap County, according to United States Census Bureau census and American Community Survey data. The Kitsap County GIS team used census tracks to identify areas of higher concentration of older people aged 60 years and older. The map scales colors illustrate the interpolated range, with purple representing the most concentration (on 2025 map). The 2015 map shades of green show where the younger populations reside, while in 2025 we see "we are all aging together" and the concentration is more widespread across the County.

2015



+65 years: 37,000

2025



+65 years: 51,500

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 employer, with 20,000 civilian personnel, 11,000 military personnel, and thousands of associated contractors and indirect employees."[5]

Veterans in Kitsap County comprise 15.1% of the total population. This is more than double the rate in

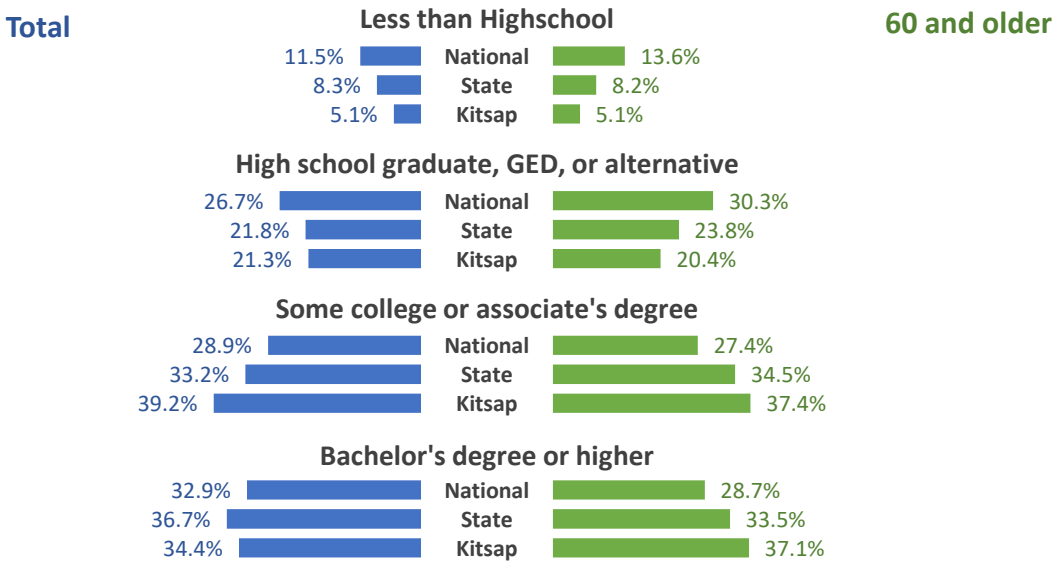
5 Kitsap Economic Development Alliance http://kitsapeda.org/key-industries/defense/. Accessed July 2, 2026

Washington: 7.3% and nearly triple the rate in United States: 5.9%.

EDUCATION LEVEL

The chart below provides data about total population and older adults. 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.[6]

Figure 3. Percentage of Population by Education Level, 2016-2020



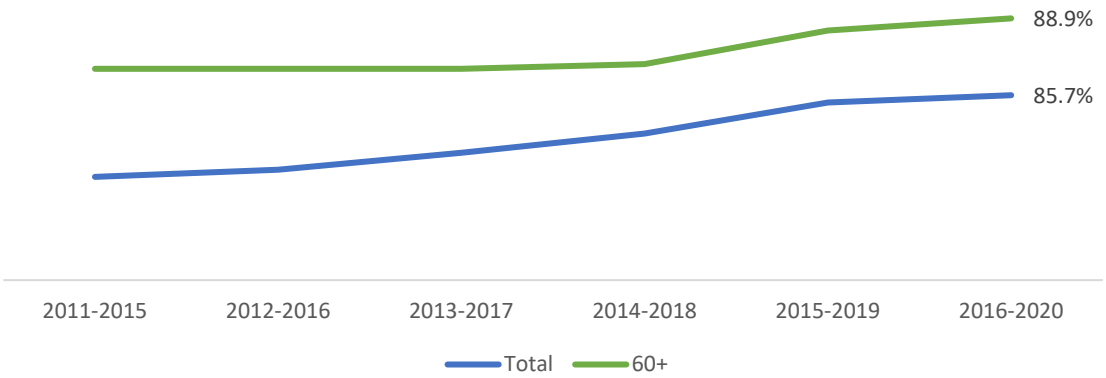
INCOME AND POVERTY

Median household income is $109,052. This is about 10% higher than the amount in Washington state.

In Kitsap County 7.3% of persons live below 100% of the poverty level. Of the total population, the number decreased by 1.3% from the prior plan period. Per Figure 4 below, 85.7% of the total population, and 88.9% of seniors 60 and older, are at or above 150% of the federal poverty level, of seniors 65 and over, 5% live below the poverty line.[7]

6 U.S. Census Bureau, American Community Survey (ACS), https://www.data.census.gov/
7 U.S. Census Bureau (2024). American Community Survey 5-year estimates. Retrieved from "Census Reporter Profile page for Kitsap County, WA" http://censusreporter.org/profiles/05000US53035-kitsap-county-wa/>

Figure 4. Percentage of population at or above 150 percent of the poverty level, Kitsap County, 2011-2020



The 2023 Kitsap Community Health Assessment indicates that disparities are seen in economic stability (income) by geography and race and ethnicity. Among Bremerton community members nearly one in three (32%) lived below 200% of the Federal Poverty Level (FPL) in 2021 (about $53,000 annual income for a family or household of four). This was the highest percentage of any Kitsap County region.[8]

This information will be used to inform how ALTC will prioritize the greatest economic needs.

HOUSING

Kitsap County overall reported a higher percentage of home ownership (70%) when compared to the national (65%) and state (64%) levels. Within Kitsap County, Bainbridge Island (81%) had the highest percentage of residents who reported owning their housing unit, while Bremerton (54%) had the lowest percentage.[9]

The Property Tax Rate in Kitsap County is ranked 16th most expensive out of 39 counties; higher than 23 other counties.[10]

For the 30% of the population who do not own a home, safe and affordable housing, including affordable rental options, has become increasingly more difficult to find. “Kitsap renters spent more than 30% of their monthly income toward housing costs more frequently than Washington renters overall. In 2021, more than one in two (52%) renter-

8 Kitsap Public Health District. 2023 Kitsap Community Health Assessment Executive Summary (p. 5). Retrieved July 26, 2026, from https://0ce87ad7-0ab7-4ccb-9ec0-b245feebd35d.usrfiles.com/ugd/461036_332a93574b8348a099725d44803c644b.pdf
9 U.S. Census Bureau, American Community Survey (ACS), https://www.data.census.gov/.
10 Kitsap County, WA Latest Property Taxes. Ushousingdata.Com. https://www.ushousingdata.com/property-taxes/kitsap-county-wa. Accessed July 2, 2026

occupied housing units in Kitsap spent more than 30% of their monthly income toward housing costs, which was higher than Washington (49%)".[11]

Among renter-occupied housing units from 2017 to 2021, the percentage of households burdened by the cost of housing (more than 30% of their monthly income spent on housing costs) ranged from 33% in Bainbridge Island to 53% in Bremerton. Across Kitsap County, the percentage of households burdened by the cost of housing was higher among renter-occupied housing units than owner-occupied units.[12]

Kitsap County has a 42.7% higher Fair Market Rent for 2-Bedroom housing ($2,057) than the average of Washington ($1,441) and therefore a higher gross rent.

Kitsap County is the 3rd most expensive county in terms of Fair Market Rents, ranked 3rd out of 39 counties. This means the Fair Market Rents, or in other words, the gross rent, is higher than 36 other counties. This has gone up compared to 2023, when it was the 5th most expensive.

Kitsap's population experiencing homelessness from 2014 to 2022 has increased. In January 2022, two in every 1,000 Kitsap residents (a total of about 563 people) were experiencing homelessness.[10]

There are 2 Housing Authorities that service Kitsap County, Bremerton Housing Authority and Housing Kitsap.

Diversity and Minority Population Considerations

According to the Kitsap Economic Development Alliance, the diversity index of Kitsap County is 54.2, meaning that there is a 54% chance that any two people selected out of 100 residents will be of different race or ethnicity from one another.[13]

Of the 60+ population in 2010, 10% reported their race or ethnicity as something other than White. This increased to 13% in 2020. This percentage has continued to increase, as 15% of the 60+ population in 2024 identified as something other than white, representing a 21% increase since 2020.

11 Kitsap Public Health District. 2023 Kitsap Community Health Assessment Executive Summary (p. 5). Retrieved July 26, 2026, from https://0ce87ad7-0ab7-4ccb-9ec0-b245feebd35d.usrfiles.com/ugd/461036_332a93574b8348a099725d44803c644b.pdf
12 Kitsap County, WA 2025 Fair Market Rent. USHousingData.com. https://www.ushousingdata.com/fair-market-rents/kitsap-county-wa. Accessed July 2, 2026
13 Kitsap County Economic Development Alliance. (2025). *Community Profiles*. Kitsapeda.Org. https://www.kitsapeda.org/lifestyle/community-profiles/p/item/1060/kitsap-county. Accessed July 26, 2026

From 2020 to 2024, this growth primarily occurred in the Hispanic or Latino (24% increase) and multiracial populations (23% increase). The second largest increase occurred among those who identified as Asian (21% increase), Native Hawaiian and Other Pacific Islander, or NHOPI (19% increase), and Black (18% increase). American Indian/Alaska Native (AIAN) and white populations grew by 9% and 10% respectively. The largest race and ethnicity minority groups of the 60+ population were Asian followed by multiracial, Hispanic or Latino, Black, AIAN, and NHOPI (Figure 5). Figure 6 shows how diversity increases with decreasing age.[14]

Figure 5. Population by Race/Ethnicity (Ages 60+), Kitsap County, 2010-2024

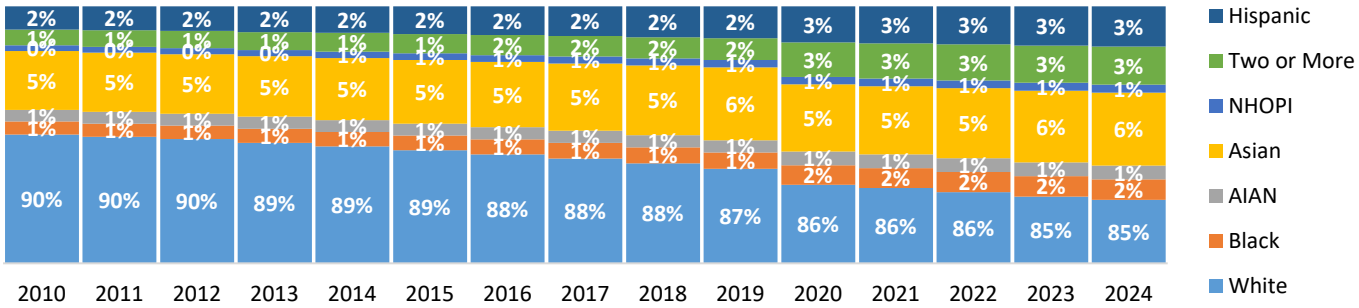
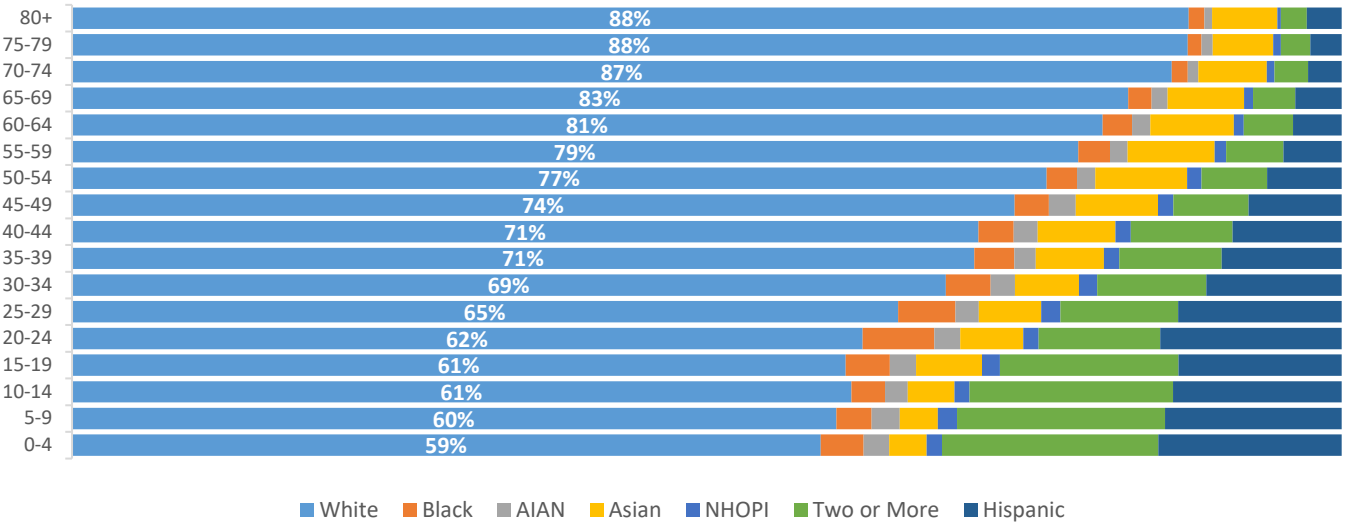


Figure 6. Population by Race/Ethnicity and Age Group, Kitsap County, 2024



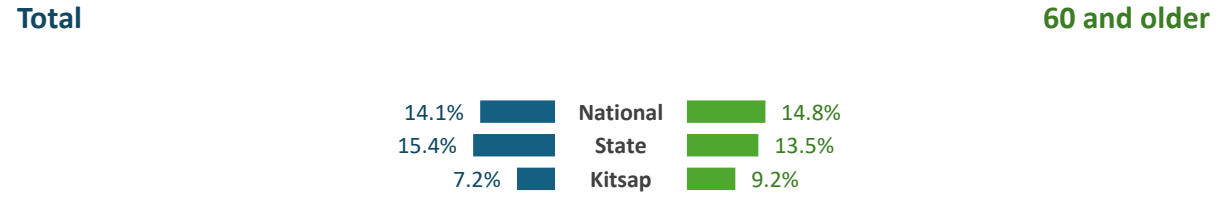
The following charts compare the 60 and older population to the total population (including 60 and older). These data represent the 2020-2024 period.

A smaller percentage of Kitsap County's general population was born in a country other than the United States compared to both the State and National percentages. In Kitsap,

14 Washington State Office of Financial Management, http://www.ofm.wa.gov/

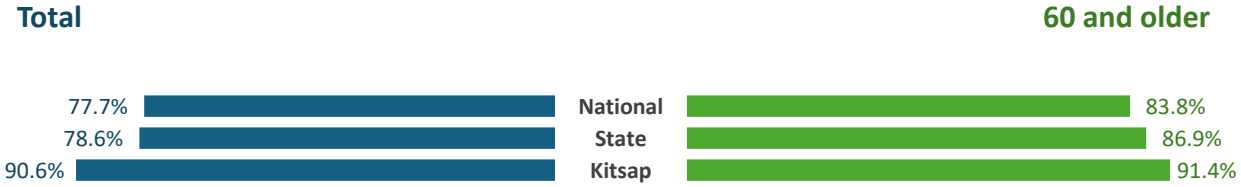
older adults more commonly reported being born outside of the United States compared to the total population.[15]

Figure 7. Percentage of Population that is Foreign Born, 2020-2024



From 2020-2024, 91.4% of older adults in Kitsap County reported speaking English at home. Approximately 2.9% of older adults in Kitsap County reported speaking English less than "very well."[15]

Figure 8. Percentage of Population that Speaks English at Home, 2020-2024



In 2024, 5-year estimates show that the most common languages spoken at home among those 5 and older were Spanish (9,900 people), followed by Tagalog or Filipino (4,747), Other Asian/Pacific Island languages (3,003), Other Indo-European Languages (1,540), Chinese including Mandarin, Cantonese (844), Korean (699), Russian, Polish or other Slavic (577), and German or other West Germanic (521).[15]

Aging and Long-Term Care 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."[16]

From 2014-2024, 3.8% of adults 60 and older in Kitsap County and 3.6% in Washington identified their sexuality as something other than heterosexual. Additionally, 0.3% of older

15 U.S. Census Bureau, American Community Survey (ACS), https://www.data.census.gov/
16 U.S. LGBT Identification Steady at 7.2%, Jeffrey M. Jones, February 22, 2023. http://news.gallup.com. Accessed August 3, 2023.

adults in Washington identified as transgender or gender nonconforming from 2020-2024.[17] These rates are slightly higher for older adults and lower overall than the US data information quoted above.

KITSAP COUNTY LIFE EXPECTANCY

Average life expectancy in Kitsap County is consistent with Washington state as a whole, at 80 years. In North Kitsap life expectancy sits at 81 years, Central Kitsap at 80 years, and South Kitsap at 78 years. Gender, race and ethnicity also impact life expectancy.[18]

As people are living longer, and prevention is key to health education and intervention efforts, it is important to know about leading causes of death and if there are opportunities for positive impact.

The top 5 leading causes of death in 2024 for Kitsap residents, in order, were Cancer, Heart Disease, Accidents, Cerebrovascular diseases (stroke), and Alzheimer's Disease. These were followed by chronic lower respiratory disease, diabetes mellitus, and chronic liver disease and cirrhosis, infection disease, with suicide, Parkinsons, and nutritional deficiencies tying for 10th leading cause.[19]

ALTC focuses on future Healthy Aging and Age-Friendly initiatives to promote a positive reframing of aging. We work with partners to create positive collective impacts to address the needs identified through this demographic data.

17 Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS) Data.
18 St. Michael Medical Center. (2026). *Community Health Needs Assessment*(p. 45). https://www.vmfh.org/content/dam/vmfhorg/pdf/legacy-chi/website-files/about-us/chna/2026-CHNA-REPORT-SMMC.pdf
19 St. Michael Medical Center. (2026). *Community Health Needs Assessment*(p. 49). https://www.vmfh.org/content/dam/vmfhorg/pdf/legacy-chi/website-files/about-us/chna/2026-CHNA-REPORT-SMMC.pdf

3.3 Target Population: Serving Older Adults in Greatest Social and Economic Need

Older adults make up 31% of the Kitsap County population.

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 multiple generations of older adults. ALTC also provides services to individuals with disabilities and their caregivers, and Kinship caregivers.

Below is a snapshot specific to Kitsap County of trends related to aging, income, disabilities of adults, language, and information about forecasted growth of American Indian/Alaska Native 55+ rates as well as Tribes and funding for local Tribes.

Demographic	2010 ALTSA Forecast	2020 ALTSA Forecast[1]	2030 ALTSA Forecast[2]
Age 60+	49,885	74,292	88,254
Age 60+ Minority	5,577	8,933	11,540
Age 60+ Low Income (at or below federal poverty level)	1,990	3,077	5,584
Age 60+ Low Income Minority	535	620	441
Age 60+ with Disabilities	10,639	14,300	16,144
Adults age 18+ with Disabilities	17,401	21,292	21,732
Age 65+ with Dementia	2,962 (70+)	5,038	5,290
Age 60+ with Alzheimer's disease, Dementia, or other Cognitive Impairment	4,571	6,052	7,190
Age 18+ with Cognitive Impairment	11,087	13,274	15,308
Age 60+ At risk for institutional placement	998	1,079	1,680
Age 60+ Limited English Proficiency	1,682	2,723	918
Age 55+ American Indian/Alaska Native	518	780	1,821 (60+)
Native American Tribes	2	2	2
Tribes with Title VI Funding	2	2	2

1 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.

2 Selected Population and Aging Service Utilization Forecast, Kitsap County Division of Aging & Long-Term Care. "Forecasts of Use of Long-Term Services and Supports, the Aging Population, and Dementia Prevalence through 2040 in Washington State" Technical Report. Bailey Ingraham, PhD, Katherine Bittinger, PhD and David Mancuso, PhD September 2025 DSHS Research and Data Analysis Division Olympia, Washington.

INCOME

From 2020-2024, 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 $27,389. The average income of those who 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 had 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[3].

HOUSING

In this section, "a housing unit may be a house, an apartment, a mobile home, a group of rooms or a single room that is occupied as separate living quarters."

From 2020-2024, 83.0% of adults 60 and older in Kitsap County reported being the owner of their housing unit (as opposed to renting), which was higher compared to all adult homeowners (70.1%) in Kitsap.

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[3].

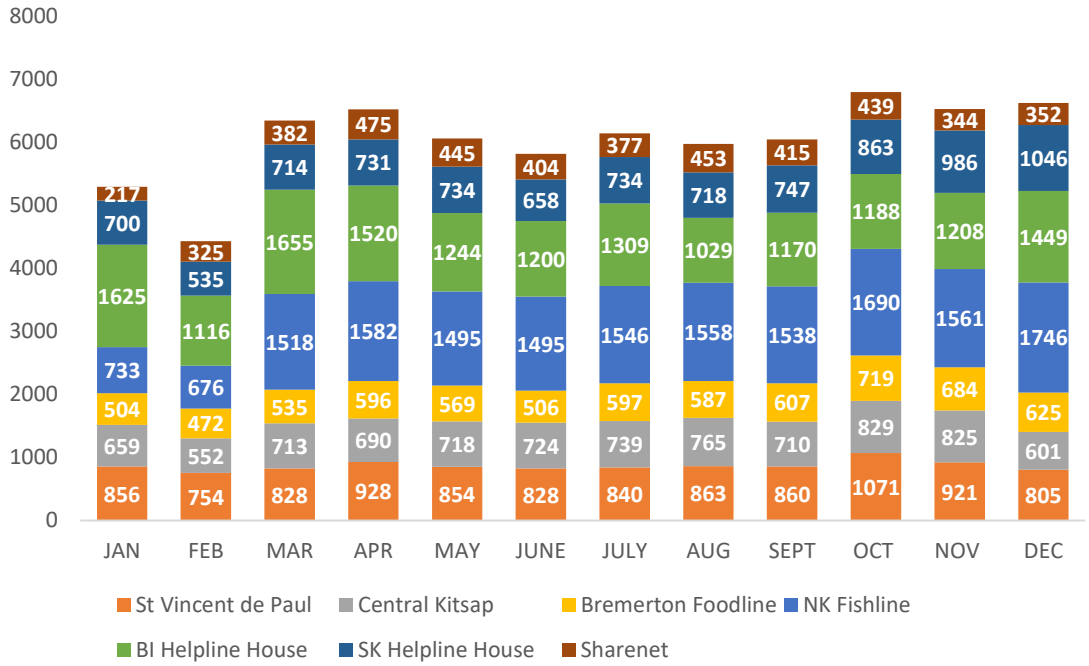
FOOD INSECURITY

In 2025, there were a total of 72,579 visits to the food banks of Kitsap County by older adults (aged 55 and older). This is a substantial increase from 2024, which had a total of 59,706 visits.

3 U.S. Census Bureau, American Community Survey (ACS), https://www.data.census.gov/

The food banks experienced the most visits among older adults in October 2025 with a total of 6,799 across all organizations. The most visited food bank among older adults in Kitsap County in 2025 was North Kitsap Fishline with a total of 17,138 visits[4].

Figure 9. Food Bank Participation by Organization, Kitsap County, 2025



Additionally, a total of 8.7% of older adults in Kitsap County reported receiving Supplemental Nutrition Assistance Program (SNAP) funding from 2020-2024. The highest rate of SNAP funding was among residents of Bremerton (17%)[4].

INDIVIDUALS WITH DISABILITIES

As noted in the St. Michael Medical Center *Community Health Needs Assessment* "Disabilities can involve or relate to any of six functions: hearing, vision, cognitive, ambulatory, self-care, and independence. Disabilities can pose unique challenges for the individual and provide opportunities for tailored healthcare.

The prevalence of disability in Kitsap (16%) was higher than the state (14%) in 2024. Within the county, American Indian and Alaska Native residents had a higher percentage experiencing disability compared to all other race/ethnicity groups except for residents who identified as white. No differences were seen by sex.

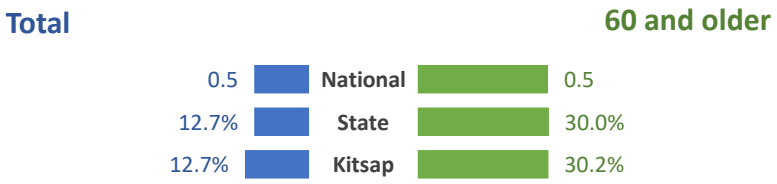
Disability was more common in older age groups. Residents of Bremerton had a higher percentage compared to all other subcounty geographic regions except South Kitsap.

4 Felicia Kolhage, St. Vincent de Paul, Email Communication.

The most common type of disability was an ambulatory disability, followed by cognitive and independent living[5]."

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[6].

Figure 10. Percentage of Population with a Physical, Emotional, or Mental Disability, 2016-2020



Chronic Disease and Injury

In 2024, there were approximately 86.9 fall-related deaths per 100,000 Kitsap County residents ages 65 and older. This number has been increasing in Kitsap since 2000 and was similar to Washington's rate in 2024. Additionally, from 2020-2024, Kitsap County's rate of fall-related hospitalizations of 1,761 per 100,000 residents ages 65 and older was statistically significantly lower than Washington's rate of 2,164 per 100,000 residents ages 65 and older[7,8].

The risk of hospitalization or death due to fall-related injuries 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 aged 85 and older were nearly 23 times more likely to die due to a fall-related death and about 6 times more likely to be hospitalized due to a fall-related injury[7,8].

Additionally, from 2020-24 there were approximately 21.3 deaths and 24.1 hospitalizations due to self-inflicted injuries per 100,000 adults 65 and older in Kitsap County[7]. In 2024, an estimated 17.3% of older adults (65 and older) in Kitsap reported having been told by a healthcare professional that they have a depressive disorder. While the percentage of older adults in Washington State who reported having been told they have a depressive

5 St. Michael Medical Center. (2026). *Community Health Needs Assessment* (p. 27). https://www.vmfh.org/content/dam/vmfhorg/pdf/legacy-chi/website-files/about-us/chna/2026-CHNA-REPORT-SMMC.pdf

6 U.S. Census Bureau, American Community Survey (ACS), https://www.data.census.gov/

7 Washington State Department of Health, Center for Health Statistics, Death Certificate Data, Community Health Assessment Tool (CHAT).

8 WA Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS). Washington State Department of Health, Community Health Assessment Tool (CHAT).

disorder decreased from 2020 (20.1%) to 2024 (17.4%), this decrease was not statistically significant[9].

Among Medicare beneficiaries, there is very little change in the percentage of chronic conditions between 2021 and 2023 (see table 2). In 2023, the percentage of Kitsap Medicare beneficiaries with depression and diabetes was lower compared to Medicare beneficiaries in the United States and Washington overall. Medicare beneficiaries in Kitsap and Washington had the same percentage of ischemic heart disease, which was lower compared to the United States overall[10]. 6% of Kitsap Medicare beneficiaries had Alzheimer's Disease or a related dementia, which is projected to increase to 8% in 2040.

Table 2. Prevalence of Common Chronic Conditions among Medicare Beneficiaries

	2021			2023		
Chronic Conditions	United States	Washington	Kitsap County	United States	Washington	Kitsap County
Alzheimer's Disease, Related Disorders, or Senile Dementia	7%	6%	6%	7%	6%	6%
Cancer (Colorectal, Breast, Lung, Prostate)	11%	10%	10%	11%	10%	11%
Depression	19%	16%	16%	19%	17%	15%
Diabetes	26%	21%	21%	26%	21%	20%
Ischemic Heart Disease	20%	15%	15%	21%	15%	15%

OTHER CONDITIONS: HIV

In 2024, the percentages of people living with HIV who are age 60 and older and under 60 years of age was nearly identical between Washington and Kitsap (around 0.2%)[11]. While these percentages were similar to the United States overall, these estimates cannot be directly compared due to differing years (2022 vs 2024).

Table 3. Estimated People Living with HIV

	United States (2022)	Washington (2024)	Kitsap County (2024)
Age 60+	0.4%	0.2%	0.2%
Under 60 years	0.3%	0.2%	0.1%

9 Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS) data.

10 Centers for Medicare and Medicaid Services, https://data.cms.gov/tools/mapping-medicare-disparities-by-population.

11 Kitsap and Washington counts: Washington State Department of Health (direct email/data request). U.S. data: Centers for Disease Control and Prevention. (2024, April 22). Fast Facts: HIV in the United States. https://www.cdc.gov/hiv/data-research/facts-stats/index.html.

SUBSTANCE USE

In 2024, adults 60 and older accounted for a small percentage of substance users in Kitsap County, making up less than 1% of deaths and non-fatal emergency department (ED) visits due to any drug type and opioids (table 4). Out of the 779 non-fatal ED visits, approximately 21% of those visits were adults 60 and older. The percentage of the total number of deaths due to any drug (0.02%) and opioids (0.03%) is small in Kitsap overall and among adults 60 and older. However, it is important to note that opioids caused the majority of these deaths, accounting for 83% and 76% of all drug overdoses in Kitsap overall and for adults 60 and older respectively[12].

Table 4. Substance use in Kitsap County (2024)

	All Kitsap residents	Kitsap adults 60+
Non-fatal ED visits for any drug overdose	0.34%	0.51%
Non-fatal ED visit for opioid overdose	0.81%	0.22%
Deaths due to opioids	0.02%	0.02%
Deaths due to any drug	0.03%	0.02%

**Note: Data will include duplicate ED visits if a resident visits the ED more than once for a non-fatal overdose*

Medication management considerations in the statistic above for adults 60+ is not clear in the data, but an acknowledged health and safety issue resulting in the need for education and outreach for seniors and family caregivers.

Aging and Long-Term Care 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 facing disparities in access to services and supports. 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, are at highest risk for social isolation, and those who are at risk of institutional placement.

Aging and Long-Term Care 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.

Trends and changing demographics and populations represented in Kitsap County are considered throughout the Area Plan[13].

12 Kitsap Public Health District, Assessment & Epidemiology Program (March 18, 2026). Drug Overdoses in Kitsap County.
13 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.

4.1 Greatest Social Need and Economic Need

The Older Americans Act requires services to be targeted to older individuals and family caregivers with the greatest economic need and greatest social need. In the previous Kitsap County profile and target population sections 3.2 and 3.3, trends, demographics, and economic and social needs were described.

Outreach and programs for target populations are addressed throughout the plan.

Prioritization of Discretionary Older Americans Act 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: The funding resources that the Area Agency on Aging has the authority to decide locally the purpose for which the funds should be used.

Of the 2026 annual ALTC budget, approximately 79% 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 2026 annual budget includes about 21% 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, with the additional consideration of services not otherwise being available.

For prioritization of local services, Greatest Economic Need and Greatest Social Need as defined in accordance with 45 CFR 1321.3 are utilized. Resources are allocated to those services deemed most critical before those that are lower in priority.

There are three components in service prioritization:

- *Service to the Target Population.* This classifies how well a service reaches those individuals in the greatest social and economic need. Services that screen individuals on indicators identifying these needs rank highest in this category.
- *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 be a higher priority than socialization, recreation, or minor support services. The primary question addressed is "how well could they get along without this service?"
- *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, ALTC 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.

4.2.1 Healthy Aging and Older Americans Act Core Programs

PROFILE OF THE ISSUE

Older Americans Act Core programs focus on programs and services that promote health and independence for older adults. The United States the "baby boom" generation, the largest ever born (76 million Americans[1]), is transforming American society as it moves into its older years. Expectations about aging are changing, 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 ongoing investments to advocate for and develop the kind of community services, programs, housing options and environment needed to respond to these changes.

Issues relevant to an age, dementia, and disability friendly community need to continue to be brought to government, business, and civic leaders, and the larger community to continue to advocate for positive change.

An Age-Friendly Community:

- Encourages people of all ages to prepare for retirement and life beyond 60 years.
- Develops "age sensitive" service infrastructures that support people as they age.
- Establishes and adapts existing services to recognize and accommodate the needs of older adults and adults with disabilities.
- Builds and adapts physical infrastructures that support people as they age.
- 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.
- Promotes flexibility in the workplace to accommodate and support family caregivers.

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.

1 Boomer Generation Statistics in US 2026 | Numbers, Demographics & Facts – The Global Statistics. https://www.theglobalstatistics.com/boomer-generation-statistics-in-us/. Accessed August 9,2026.

2026 Community Needs Survey: Data and Trends

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 2026, ALTC received over 715 survey responses. Input and information were also received through forums, meetings, and other community survey reviews. 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 offer viable choices for individuals and families.

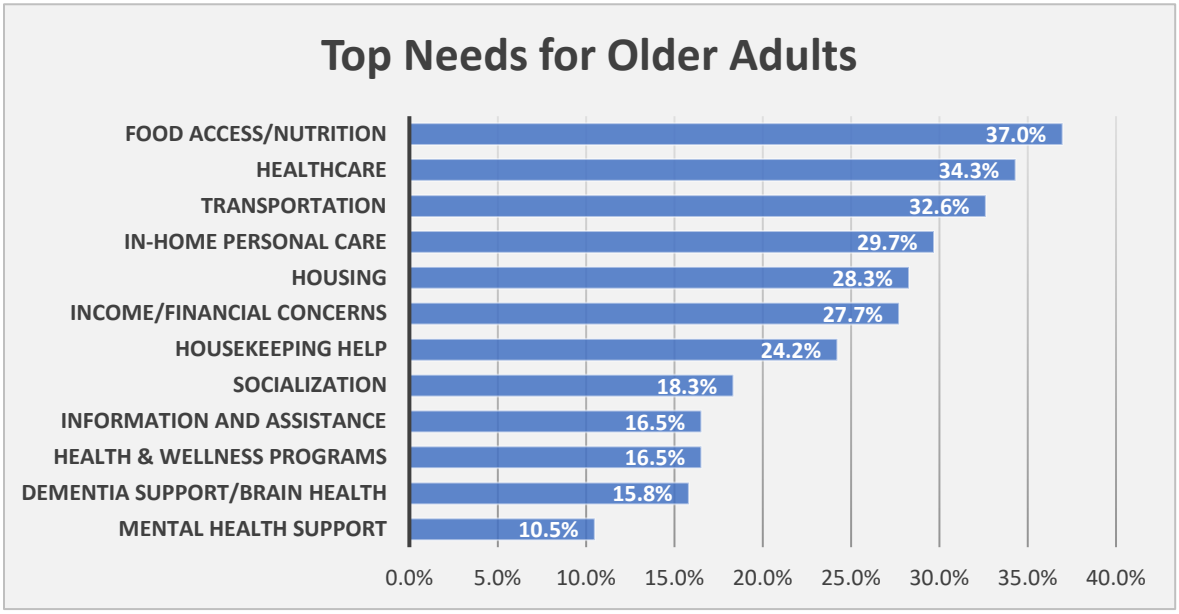
Several commonly identified issues consistently surface in survey results. Although they may shift in priority, fundamentally the overarching issues remain constant. Prioritization may change as the population ages in place, the economy fluctuates, transportation costs rise, and social and cultural perspective shifts occur. Priority needs are outlined below, and in the Area Plan goals and objectives to be addressed over the next four years.

Priority Needs of Target Populations

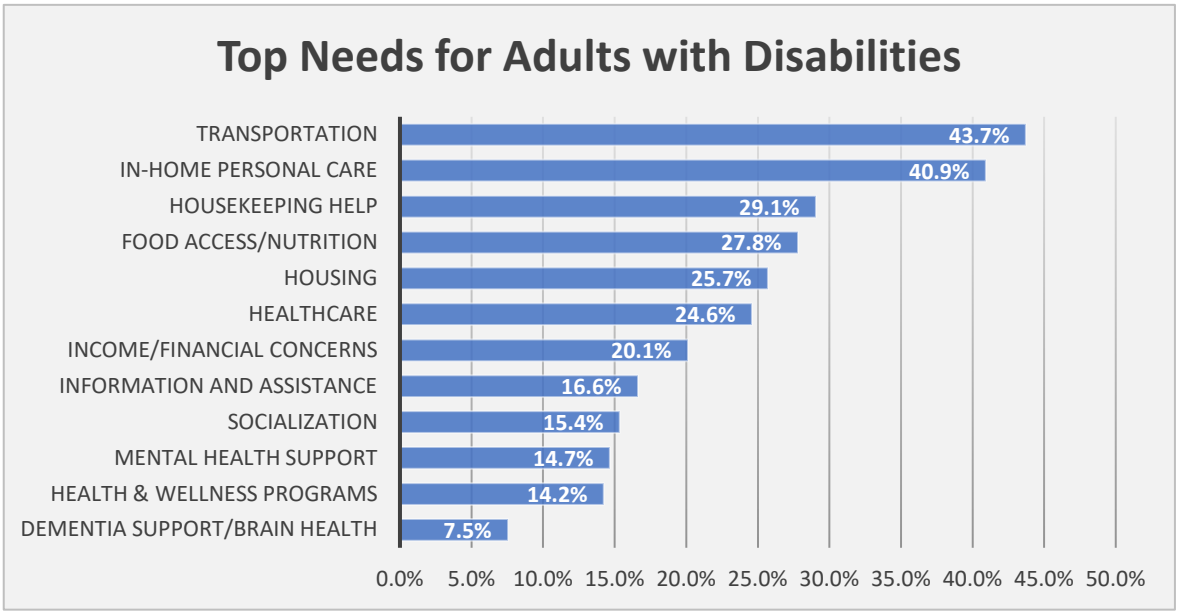
Ensuring that basic needs are met is critical for all community members. Basic needs are interrelated and strongly connected to additional factors that affect all areas of a person's life. For example, rising costs of healthcare or transportation has the potential to directly impact the ability to afford housing or food in our area. In the 2026-Area Plan Community Needs Survey, respondents were asked to identify the top three needs for older adults and adults with disabilities.

In the 2026 Area Plan Community Needs Survey, respondents were asked to identify the top three needs for older adults and adults with disabilities.

Below is a graph depicting results that the **top concerns of older adults** identified through the survey are **food access and nutrition, healthcare, and transportation**, followed closely by in-home personal care, housing, and income & financial concerns. Previously healthcare, in-home personal care and food access & nutrition were top three, followed closely by housing, transportation, and financial concerns. Of note, response choices are close together, reflecting needs outside just one or two areas.



Top identified needs for adults with disabilities rated differently, as demonstrated below. There was no change to the top three from the previous Aprea Plan period, however, food access and nutrition jumped up from six to the fourth highest need, followed by housing.



NUTRITION AND FOOD ACCESS

This topic was the #1 priority identified need for older adults in the 2026 ALTC survey.

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

- 91% shop at a grocery store for their food
- 27% eat at restaurants
- 20% purchase food at a farmers market
- 18% get food from personal or community gardens
- 15% get their food from other sources (friends/family, housing program)
- 15% go to a food bank
- 12% receive senior program home delivered meals
- 9% get meal delivery from the grocery store or pre-packaged
- 7% eat at a congregate or community meal

Survey respondents that utilize a food bank went up from 7% in the prior plan period to 15%, **more than double**. Home delivered meals went up from 6% to 12% and community or congregate dining up from 3% to 7% as well.

Individuals who ate smaller portions or skipped meals listed, in order, these reasons: too physically or mentally fatigued to prepare food, poor appetite, health issues, dental problems, not enough money to purchase food, unable to prepare food, couldn't get to the grocery store, and couldn't get to a meal site.

Food Insecurity

In 2025, there were a total of 72,579 visits to the food banks of Kitsap County by older adults (aged 55 and older). This is a substantial increase from 2024, which had a total of 59,706 visits, and 2022 total of 41,058[2].

The food banks experienced the most visits among older adults in October 2025 with a total of 6,799 across all organizations. The most visited food bank among older adults in Kitsap County in 2025 was North Kitsap Fishline with a total of 17,138 visits[2].

2 Felicia Kolhage, St. Vincent de Paul, Email Communication.

Additionally, a total of 8.7% of older adults in Kitsap County reported receiving Supplemental Nutrition Assistance Program (SNAP) funding from 2020-2024. The highest rate of SNAP funding was among residents of Bremerton (17%).[3]

Home Delivered Meals, Community Dining and Meal Pick-up Sites

Home Delivered Meals remain an important nutrition intervention, and check-in with older adults, countywide. *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[4].*

Aging and Long-Term Care contracts with Bremerton Services Association dba Meals on Wheels Kitsap for Older Americans Act funded home delivered meals and congregate/community dining sites for adults 60 and older who meet program eligibility. ALTC also has an interlocal agreement with Port Gamble S'Klallam for community dining for tribal elders 55+ and older adults 60+ at the Elder's Center. Meal site locations as of July 2026 are listed below.

Community dining sites:

- Asian Pacific Islanders/Fil-Am Seniors (3rd Sunday monthly)
- Bainbridge Island Senior Center (Thursday and Friday)
- Bremerton Senior Center (Thursday and Friday)
- Burley Community Hall (Monday, Wednesday, Friday)
- Pinewood Manor (Monday-Friday)
- Port Gamble S'Klallam Tribe Elders Center (Wednesday-Thursday)

Meals on Wheels Kitsap carry-out meals "to go":

- Conifer Ridge Apartments (Tuesday)
- Hostmark (Wednesday)
- Silverdale United Methodist (Thursday)

Port Gamble S'Klallam Tribe offer meals on alternate days to eligible Tribal Elders through other funding sources.

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

Changes to frequency or location of congregate/community dining sites are approved through ALTC.

Medicaid-funded home delivered meals for eligible program participants are authorized for delivery through Medicaid Waiver Services contracted providers.

In 2026 ALTC is launching the new Health Related Social Needs (HRSN) program for individuals on Medicaid, of all ages, who meet eligibility. The focus on new nutrition options is based on nutrition interventions that can impact social determinants of health and provide more healthy outcomes. Eligibility screening and authorization is through ALTC. Service options based on eligibility may include Medically Tailored Meals, nutrition counseling, fresh fruit and vegetable provisions and pantry restocking.

Senior Nutrition funding and Health Related Social Needs funding is expanding access to nutrition through contracts with local food banks in Kitsap County, as well as existing nutrition providers, as another means to address food insecurity.

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.

TRANSPORTATION

Most survey respondents, 71%, 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.

- 37% ride with family, friends, neighbors or family
- 12% Walk or bike
- 12% use ACCESS
- 9% other public transit
- 7% ride the bus
- 3% use a taxi
- 3% use a volunteer transportation program
- 3% use a Transit shuttle or other accessible service
- 2% use Paratransit

A snapshot comparative from prior year surveys demonstrates a 14% decrease in individuals driving, and an over 10% increase in riding with family friends, neighbors or family, as well as increased use of Access (up 9%), other public transit, or using the bus. The additional costs associated with vehicle ownership is a major factor.

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, caregiver support, and senior and community centers.

Barriers*: 47% answered that they had no challenges accessing their community without a car. For those that did, poor or no sidewalks was the largest barrier to community access, followed by physical ability, "few amenities near my home" and personal safety.*

Caregiving

In-home personal care was in the top 5 of identified needs for Older Adults and Adults with Disabilities. Care may be provided through paid services such as home care agencies or individual providers, or unpaid support from caregivers. About 31% of the ALTC survey respondents provide care for an adult family member, friend, or neighbor. This is an increase from 29% from the prior 2023 survey. Caregivers' priority needs in order are respite care and help with caregiving duties, followed by information & assistance, managing behaviors, memory care and dementia resources.

More needs across choices for support were seen in 2026 compared to the prior survey. Services to support the identified needs for older adults, individuals with disabilities, and caregivers is detailed later in this Area plan.

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 responses in order included:

1. Yardwork
2. Housekeeping
3. Need minor home repairs
4. Affordability
5. Property taxes
6. Legal Support

The Aging and Disability Resource Network and program case managers provide education, materials, tools, and referrals about housing options, the property tax exemption program, and legal support for housing issues in Kitsap County

Wellness, Social Connection 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%).

Nearly one third (30%) are volunteering. Of those that marked “other activities” they were involved in, activities with family and friends and work or school activities were at the top.

- **Transportation, cost, and poor health ranked as the top 3 identified reasons involvement was difficult.**

When respondents marked “other” (11%) to reasons participation may be difficult, the top reasons were physical health issues, caregiving, and location, followed closely by limited availability and mental health.

Social Isolation and Support

As stated in the *St. Michael Medical Center Community Health Needs Assessment 2026*: "Strong social ties are essential for overall well-being, contributing to mental, emotional, and physical health. Loneliness has a profound impact on health, significantly reducing life expectancy. Its effects are comparable to smoking 15 cigarettes per day and exceed the health risks associated with obesity."[5]

To help combat social isolation:

- ALTC ADRN offers a social connection phone program. Meals on Wheels Kitsap also provides this service.
- The Aging and Disability Resource Network maintains lists of senior and community centers and senior activities in Kitsap and surrounding counties to share with the public. It includes contacts for Suquamish Tribe Elders Lodge and Port Gamble S'Klallam Tribe Elders Center.
- Adult Day Services are offered at Gateway in Bremerton to support community inclusion and offer social and health supports.
- Caregiver support case managers and the ALTC dementia consultant services provide referrals to options that may decrease isolation reported by caregivers due to their caregiving duties.

Mental Health and counseling

"In 2024, over a quarter of adults in Kitsap reported ever being told they had a depressive disorder". Rates were higher among females at 33.9% compared to males at 18.1%. Amongst age groups, higher rates were in younger age groups, 32.4% 18-34, 26.8% 35-6 and 17.6% 65 and older.[5]

Suicide rates in 2024 were about 13 deaths for every 100,000 residents in Kitsap, after adjusting for age. Male rates were higher at 24.5% compared to females at 7.2%. Rates were highest, both around 21% for age ranges 18-34 followed by 65 and older[5].

Case management and ADRN programs provide referral information for individuals seeking support. Additional options are needed to support mental health wellbeing. Efforts to recruit providers for available contracted services through Medicaid continue.

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 risk. According to the Centers for Disease Control and Prevention, more than 1 in 4 people 65 and older fall each

5 St. Michael Medical Center. (2026). Community Health Needs Assessment (p. 56-64). https://www.vmfh.org/content/dam/vmfhorg/pdf/legacy-chi/website-files/about-us/chna/2026-CHNA-REPORT-SMMC.pdf

year. Falls can lead to a loss of independence, but they can be preventable. Evidence based fall prevention programs and other exercise and prevention options exist. *For falls data specific to Kitsap County, see the target population data in section 3.3 of this plan*. ALTC's Aging and Disability Resource Network team provides fall prevention materials and referral options. In addition to education and materials available about fall prevention, there are also opportunities available at local businesses. Enhanced Fitness is an evidence-based program offered through the YMCA of Pierce and Kitsap Counties. Attendees at Gateway Adult Day Services can access SAIL, Stay Active and Independent for Life exercises.

INDEPENDENCE AND ACCESS FOR ALL

Maximizing independence is vital to the health of our communities. A community that can offer accessible and affordable transportation, adequate in-home services and choices in community activities and supports offers its residents opportunities to be active and involved. Prevention interventions that can support healthy living are important now and to future outcomes for all.

Universal Design

Universal design is an inclusive and holistic approach that prioritizes usability, safety, and accessibility for all ages and abilities. It is intentional planning to ensure everyday environments and products are beneficial to the widest range of people. It aims to create spaces and products that are naturally easier for everyone versus adapting spaces as an afterthought. Principles include a design that is useful to people with diverse abilities, accommodates a wide preference, is simple and intuitive- doesn't require experience or specific language or skill to use, minimizes hazards, and is operational regardless of body size or mobility level. As we live longer and healthier lives, age-inclusive infrastructure is essential to ensure we all have access to resources and opportunities as we age together.

Kitsap Aging and Long-Term Care has actively participated and plans to continue advocating for universal design in local, regional and state plans. These plans are used as guides through the establishment of vision statements, goals, objectives, policies, and implementing actions.

In 2024-2025, Kitsap Aging and Long-Term Care staff and advisory council participated in:

- Kitsap County Department of Community Development 20-year Comprehensive Plan that identifies strategies to meet local needs associated with population growth and community planning.
- Kitsap Public Health District Health Priorities for addressing brain health, healthy aging, chronic disease, and active living.

- Kitsap County Accessible Communities Advisory Council to identify local projects to address accessibility challenges and inclusivity across Kitsap County, such as purchasing beach strollers and hosting the annual "Bikes for All" event through local parks.
- Puget Sound Regional Council's Transportation subcommittee to strengthen the essential regional accessible transportation plan across Kitsap, King, Pierce and Snohomish Counties. Comments provided highlighted the regional plans' potential impact on older adults in Kitsap areas.
- Washington State Plan on Aging to support the choice and independence of older adults through an array of long-term services and supports.
- Washington Governor Inslee's Multi-Sector on Aging to promote health, well-being, and inclusion across the lifespan.

Universal design emphasizes creative solutions to ensure we all thrive as we age. Age friendly community resources improve all our lives and provide opportunities for people to contribute and benefit regardless of their age.

Problem Statement

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, health disparities exist within minority populations, and health problems can increase with age. An emphasis on healthy aging is imperative.

Goals

Impact health by reducing food insecurity experienced by older adults, and individuals with health-related needs, and reducing barriers to access; and improve information about and access to transportation options and services for older adults, persons with disabilities, and other special needs populations.

Objectives and Strategies

1. Increase awareness of services available to meet the nutrition needs of low income older adults and individuals with chronic conditions or on Medicaid.
2. Increase staff capacity to respond to demand for more nutrition options through home delivered meals, community dining sites, and local food banks.
3. Enhance and sustain nutrition contracts through providers to address food insecurity.
4. Collaborate with community partners to develop or sustain service options that reduce barriers to access like transportation or other barriers.

5. Participate in local, county, regional and state transportation planning efforts.

Measured by:

- A minimum of 12 outreach events per year to target populations.
- Staff development, training and activities for new programs and nutrition services.
- Reports demonstrating number of providers and increased number of participants accessing nutrition services.
- Meeting minutes and contract statement of work deliverables that address transportation and other barriers.
- Advisory council and staff representation in transportation and accessibility committees, meetings and other activities to represent needs of target populations.

Completion Date: 12/2028

4.2.2 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. By 2040 that number is projected to increase to more than 270,000[1].

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[2]. 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 24% of caregivers and a priority for 16% of older adults in the 2026 Kitsap County Aging and Long-Term Care Survey.

Dementia is not always diagnosed, even as individuals experience memory loss or other changes. Based on the 2023 Behavioral Risk Factor Surveillance System (BRFSS) for People Aged 45 Years and Older, "Subjective Cognitive Decline (SCD) is self-reported memory problems that have been getting worse over the past year."

Results from the BRFSS survey for Washington indicate that:

- 58% of adults aged 45 years and older are worried about it and 17% are experiencing Subjective Cognitive Decline
- 21% Live alone, almost 20% are Veterans.
- 39% of people with SCD say it causes difficulties, (limitations with social activities or work, and household)
- Only 43% have talked with a health professional about it, although those who experience functional difficulties with work, social, or household activities are more likely to (57.8%).
- 30% of people with SCD need help with household tasks[3]

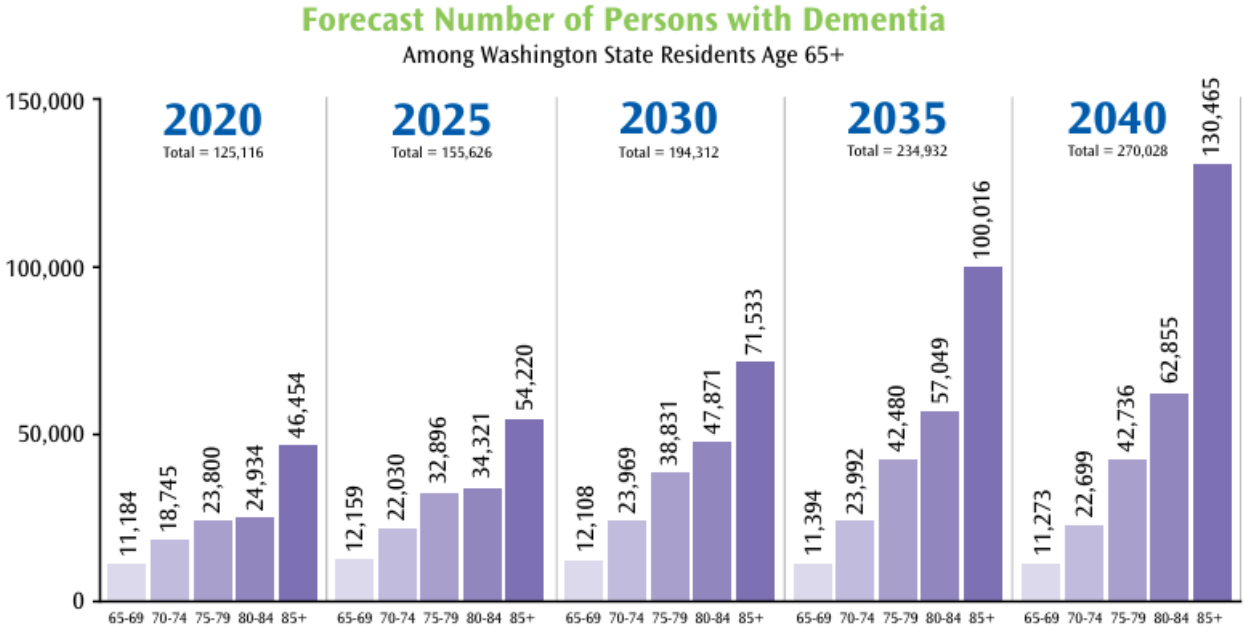
1 Washington State Department of Social and Health Services, Washington State Plan to Address Alzheimer's Disease and Other Dementias 2023-2028, https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/AD/Washington%20State%20Plan%20to%20Address%20Alzheimer%E2%80%99s%20Disease%20and%20Other%20Dementias%202023-28.pdf . Accessed July 2,2026

2 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 5, 2026.

3 Alzheimer's Association. Cognitive Decline in Washington. https://www.alz.org/getmedia/79ca01c9-e83b-4d0a-9f15-fe10d919ae87/washington-cog-brfss-fact-sheet.pdf.pdf Accessed August 7, 2026.

Nationally, Alzheimer's disease is the most feared disease of older adults, most expensive disease to treat and 6th leading cause of death[4]. Currently it is the 4th leading cause of death in Washington State, and 4th in Kitsap County[5].

As seen in the chart below, over the next 20 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 116 percent. The number of people with dementia who are age 70 years and older is expected to increase by 127 percent[6].



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. On the other hand, some individuals who suspect memory loss may not talk to their health care professional about it. Early diagnosis is critical; it promotes early planning, risk reduction and opportunities for savings and impact.

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

4 CDC. (2025). Leading Causes of Death. In Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm
5 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 5, 2026
6 Washington State Department of Social & Health Services Aging and Long-Term Support Administration. (2023). Washington State Plan on Aging 2023–2027
https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/agingplan/WA%20State%20Plan%20on%20Aging.pdf

dementia-specific services addressing brain health, prevention, social engagement and needs at all stages of diagnosis are critical as well.

“Maintaining a healthy lifestyle including engaging in lifelong learning and socialization along with managing related chronic conditions is good for your overall physical health, helps and improves brain health and may help decrease the risk of dementia or slow its progression.

This encouraging news published in The Lancet shows that through the lens of a life course model, nearly 40% of all dementias might be prevented or delayed. Since dementia takes years to develop, there are opportunities throughout one’s life to develop and maintain healthy lifestyle habits that could reduce your risk of dementia or slow its progression[7].”

It’s estimated there are more than 213,000 unpaid family care partners of people living with dementia in Washington[7].

For those friend and family caregivers taking care of a person with dementia, although it can be rewarding, impacts can be significant too. 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 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.

Dementia support education, consultation and referral are available through the Aging and Disability Resource Network/Community Living Connections, Care Transitions 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 support in the previous Area Plan timeframes and this work continues.

Dementia Consultant services continue for Kitsap residents and their caregivers to offer support addressing challenging behaviors and stress associated with aging and mild to major neurocognitive dementia disorders and memory impairment. Services are also dedicated to providing community-based personalized education and strategies to

7 Washington State Department of Social and Health Services, Washington State Plan to Address Alzheimer's Disease and Other Dementias 2023-2028, https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/AD/Washington%20State%20Plan%20to%20Address%20Alzheimer%E2%80%99s%20Disease%20and%20Other%20Dementias%202023-28.pdf . Accessed July 2,2026

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.

Kitsap Aging and Long-Term Care also offers memory screenings to older adults aged 60 and older. Memory screenings are free and can be scheduled by calling the Aging and Disability Resource Network. This is available through a partnership with the Alzheimer's Foundation. Kitsap County ALTC staff use the Brief Alzheimer's Screening (BAS) to accomplish this[8]. 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 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, 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.

Dementia Action Collaborative plan goals 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

8 "What is a Memory Screening?" Alzheimer's Foundation of America, alzfdn.org. https://alzfdn.org/memory-screening/what-is-memory-screening/. Accessed August 5, 2026

- 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[9].

At the local level, Kitsap County ALTC plans to incorporate findings, align local goals and explore implementation of successful or new strategies and programs in future work.

Programs that support technology and built environment opportunities, are seen as helpful for people living with dementia and/or their family members too. For example, "the most useful assistive technologies identified are those that track location if a person were to wander away from home, detect falls or medical emergencies in the home, provide connectivity to family and friends, and remind individuals to take their medications. Similarly, the built environment is important when considering aging in place. The built environment includes spaces that people interact with during everyday life including the bedroom, kitchen, bathroom, living room, front and back yard, and the community. The literature shows that the built environment contributes to well-being of people, including people living with dementia; it impacts how people socialize, feel, and respond[9]."

ALTC service expansions of staff training to complete free memory screening, work to continue access to a dementia consultant and access to Personal Emergency Response technology through the caregiver support program continues.

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 AND STRATEGIES

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.

9 Source: Washington State Department of Social and Health Services, Washington State Plan to Address Alzheimer's Disease and Other Dementias 2023-2028, https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/AD/Washington%20State%20Plan%20to%20Address%20Alzheimer%E2%80%99s%20Disease%20and%20Other%20Dementias%202023-28.pdf . Accessed July 2,2026

Measured by:

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

Completion date: 12/2030

2. 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:

- Development of a dementia-capable new program, hiring one employee dedicated to this work utilizing Rural Health Transformation funding.
- Memory screening support and information and assistance activities.
- Provide evidence-based or other training or support opportunities for caregivers.
- Coordination activities with Alzheimer's Association, Alzheimer's Foundation and other community potential partners.
- Promote inclusive, active engagement opportunities for persons with dementia.
- Support of statewide efforts addressing workforce shortages impacting access to care and respite.

Completion date: 12/2030

4.3.1 Access to Home and Community-Based Services (HCBS)

PROFILE OF THE ISSUE

Kitsap County Aging and Long-Term Care (ALTC) offers multiple Medicaid-funded case management programs:

- Traditional Medicaid Long Term Services and Supports Community First Choice(CFC) Community Options Program Entry System (COPES), and Medicaid Personal Care (MPC). Presumptive Eligibility for in-home services was added July 1, 2026 to expedite service delivery.
- Medicaid Transformation Project programs, addressed in the Caregiving section in this plan.

Additional programs with alternative funding that receive case management through the ALTC's Medicaid case management team include Veteran Directed Care, and Roads to Community Living.

Expanded services now part of case management programs include coordination and referral to supportive housing and supported employment.

New programs launched in 2026 that impact the Medicaid Long-Term Care unit case management teams, and the Aging and Disability Resource team, include Presumptive Eligibility, Health Related Social Needs and WA Cares.

Aging and Long-Term Care's case management programs have two primary goals:

1. To provide person-centered in-home services and supports that are well integrated with the health care services for older adults and adults with disabilities, in a manner that allows them to stay as independent and safe as possible, in a living arrangement of their choice.
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 options.

c) The healthcare system provides fragmented care, struggles with adequate workforce and is confusing, particularly for those with complex conditions.

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.[1] 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.

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 remains key to accommodating the growing population of individuals seeking service options.

Statewide as of September 2025, there are about 92,101 people served in the Medicaid long term services and supports Washington State Home and Community Based programs. That is close to 18% growth seen just since March of 2023. Of those, 92% are served in home and community-based settings and 8% are in skilled nursing facilities.[2] 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 care need 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. The highest number of individuals served across long-term care and Developmental Disabilities Administration (DDA) systems reflects that Activities of Daily Living (ADL's) are very

1 "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.
2 Aging and Long-Term Support Administration Department of Social and Health Services 2024-2025 Strategic Plan Metrics November 2025 p. 5. https://www.dshs.wa.gov/data/metrics/ALTSA_SP.pdf. Accessed April 26, 2026.

limited, and include cognitive problems, or moderately limited ADLs plus clinically complex, or moderately limited ADLs and or behavior challenges[3].

Washington statewide data about prevalence of severe mental illness in the long-term care service population reflects that:

- one in four individuals discharged to long-term care from a state mental hospital reside at home, and
- one in three individuals with a psychotic disorder are receiving long-term care resided at home.[4]

In-home care continues to be the preferred community-based option and is also the 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.

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[5].

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[5].

3 Care Data snapshot as of July 30,2020. Combined Home and Community Services Living Administration and Division of Developmental Disabilities.
4 Source: Washington State Department of Social and Health Services, Research and Data Analysis Division: 5732/1519 Measures, June 2019
5 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.

EXISTING EFFORTS

- **Case Management of In-home LTSS:** Kitsap County's Medicaid Case Management program added full-time positions with increased funding since the last Area Plan period. However, some positions still need recruitment due to a combination of growing caseloads, new program expansion, and staff attrition. In April of 2026 the clinical caseload ratio considering all caseload touching staff was 76:1, up from 70:1 in August of 2023.

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.

ALTC staff provided 1,622 total assessments in 2025. There were 1,026 annual, 107 significant changes, 403 interims and 4 Veteran Directed Care assessments. In first quarter 2026 there were 290 annual, 39 significant changes, 90 interim, and 1 Veteran Directed Care. If this trend continues, we will again exceed the number of assessments completed per year by 2026 end, projected at 1,680.

The number of people served through these ALTC services increased to 1,298 as of July 2026. This is up from an average of 984 three years prior, reflecting a **27.7%** increase in caseload growth.

With the rollout of Presumptive Eligibility (PE) Phase 2, launched July 1, 2026, additional casework is expected. There is not a maximum caseload, but there is a case rate and maximum revenue per month per the State Fiscal Year 2027 State/Federal revenue contract with Washington State Department of Social and Health Services. Based on PE modeling, ALTC can serve an average of 21 cases per month over the 12 month period. If maximums are met though, PE services may be placed on pause and/or there would need to be a request for additional funding.

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 an assessment a person receives 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, 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

coordinates other services in the community. To monitor care and help maintain safety of individuals receiving services, the case manager makes home visits and maintains contact with family and providers to monitor the effectiveness of the individualized 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. As a person's care needs change or they request a different care setting, case managers update the care plans and facilitate transitions to other settings ensuring services and supports are updated to meet current needs.

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 AND STRATEGIES

1. Grow and maintain case management staffing and develop creative approaches to meet higher demand for Medicaid LTSS.

Measured by:

- Increased staffing for new program needs and to maintain adequate caseload ratios per contract due to continued caseload growth.
- Explore and create alternative ways to implement new program rollout and support cross-team coordination for Presumptive Eligibility phase 2 launching July 2026.

2. Proactively plan for new and diverse programming and training needs with new program rollout for Presumptive Eligibility phase 2 and expanded service choices through Health Related Social Needs and potential WA Cares impacts for individuals on Medicaid long-term care services.

Measured by:

- Implementation of a successful process from screening to caseload creation and maintenance for Presumptive Eligibility phase 2.
- Support staff development through ALTC's initial and ongoing education and training opportunities responsive to new program information and changes through

program rollout. Training may be as-needed to respond to change, through Long-Term Care Manual chapter reviews, and as part of regularly scheduled meetings.

- Continued attendance of available HCLA training for new Presumptive Eligibility phase 2, WA Cares, and Health Related Social Needs specific to individuals served through the Medicaid Long Terms Services and Supports programs.
- Caseload counts comparative analysis based on available reports.

Completion Date: 12/2028

4.3.2 Aging and Disability Resource Network & Community Living Connections

PROFILE OF THE ISSUE

Kitsap County Aging and Disability Resource Network (ADRN) is a renaming and expansion of services from what was previously known as the local Senior Information and Assistance, part of Community Living Connections programs statewide. Program expansion and the growing populations of different ages, and needs of individuals and families being served necessitated a change to more accurately reflect service delivery.

Background

Kitsap County Aging and Long-Term Care (ALTC) made a major commitment to increase visibility and expand services through our public-facing entry point for information and assistance over the last 20+ years. As part of the Long Term Services and Supports service spectrum, these 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. Additionally, with a focus on healthy aging and prevention, social connections, and access to new programs addressing options for broader consumer populations and social determinants of health, the ADRN services continue to expand.

Aging and Long-Term Care staff providing direct service receive training in Person-Centered Options Counseling. This interactive process provides guidance to individuals needing supports and services. Through a personal interview, staff help 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 assist with consumer choice and independence, consumers can search for resource information, complete an assessment, and self-refer to programs and services utilizing GetCare through Community Living Connections. 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. ADRN 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. In the 2026 survey, the need for information and assistance was identified in the top ten for older adults. As we think about targeting outreach in Kitsap, 59% of survey respondents indicated they get

services about older adults and caregivers online, up from 43% just 3 years prior. This was followed by friends and neighbors, Aging and Long-Term Care, health care provider, family, Senior Information & Assistance/ADRN, Senior or Community Centers, direct email, then AARP). ALTC being in the top three indicates more survey participants identifying ALTC as a trusted source of information.

However, Community members may continue to be unaware of ADRN services. 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. Access to information and support is important.

Additionally, the availability of online information is changing the way many consumers seek information. Given that people 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. These efforts should complement the traditional approaches to information distribution (i.e. brochures, and resource lists and directories).

Finally, as we work to improve service delivery options – plus expand upon the existing programs by serving a wider population – it is critical that adequate funds are sustained for these services.

Services available in Kitsap County

- **Aging Disability Resource Network (ADRN)** a program that is an entry point to access services. It is an integrated system designed to locate and identify people who need services and link them with the most appropriate resources. The ADRN program provides information, screening for program eligibility, service referral, assistance, and advocacy. The program also includes information about and referral to Family Caregiver Support and the other services listed below. The ADRN 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 ADRN. 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.
- **Care Transitions** offers support to adults with acute needs to transition home from the hospital. Kitsap County Division of Aging and Long-Term Care employs one full-

time employee (FTE) in the role of a case manager. The goal of this program is to reduce future hospital visits. The Hospital Care Transitions Case Manager accomplishes this through receiving referrals from local hospitals, meeting with individuals to complete an assessment, and development and implementation of an individual plan of care with brief interventions. Examples of support may include assistance with referral to caregiving programs, coordinating transportation to doctor appointments, support with applying for programs offering nutrition and more on-going support, and establishing and working with natural supports. The goal of this program is to reduce hospital readmissions as well as frequent use of the Emergency Department with brief intervention (from 3-6 weeks on average). The Hospital Care Transitions team values client voice and choice and each intervention is individually tailored to each client.

- **Health Related Social Needs (HRSN)** is a new set of services and supports offered to people receiving Apple Health (Medicaid). and not currently being served through the Medicaid long-term care system. In Kitsap, these services focus on non-medical needs -such as *food and housing adaptative devices* - that have a significant impact on health. These services are part of Washington's Medicaid Transformation Project 2.0 and are available through June 30, 2028. Aging and Long-Term Care is working with local providers to offer a range of these services. The Aging and Disability Resource Network (ADRN) intake team acts as a "front door" for screening for eligibility and authorization; and provide additional options counseling for those that do not qualify. ADRN Intake and staff from other programs (Hospital Care Transitions and WA Cares) are trained on how to assess eligibility. An ADRN staff member will coordinate directly with service providers. Data will be recorded to Washington Community Living Connections.

  Rollout of these services began Spring 2026 and continue to expand. Services available early in 2026 were focused on nutrition support, utilizing the current network of providers. Medically Tailored Meals (MTM) provide meals tailored to support individuals for health-related conditions for which nutrition supports would improve health outcomes. Meals will be recommended by a registered nutritionist after a detailed assessment. These meals will be delivered to the home of recipients. Fruit and Vegetable Provisions provides fruits & vegetables from participating local food vendors and farms. These may be fresh, frozen, or canned. Pantry Stocking allows an individual to receive an assortment of foods to promote improved nutrition. For both prior options, food can be picked up or delivered when delivery service is available. Nutrition Counseling is a combination of educational strategies designed to motivate and facilitate food choices and nutrition-related behaviors conductive to health and well-being.

  Starting in fall of 2026, home adaptation services will be launched. Kitsap Aging and Long-Term Care staff is tracking people served monthly and will identify a baseline for total people served through HRSN by fall 2026. The goal will be to increase

eligible people served in subsequent months as long as the program remains active. If the program cannot be sustained beyond 2028, staff will provide options counseling to recipients to help them identify other community resources to meet their needs.

- **Medicare Improvements for Patients and Providers Act (MIPPA)** offers beneficiaries Medicare and Medicare Part D outreach and assistance services provided by Aging and Disability Resource Network 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. A majority of the outreach events are in coordination with the local State Health Insurance Benefits Advisers local subcontractor, Peninsula Community Health Services.
- **Medicaid Presumptive Eligibility (PE)** is another process the ADRN Intake team supports. ADRN Intake workers have access to partner accounts via Washington Connection and are able to help individuals complete Medicaid applications. Medicaid PE will speed up the process for individuals to receive support from Medicaid by starting services before financial eligibility has been completed by a worker with the Department of Social and Health Services Home and Community Services (HCS). ALTC is promoting Medicaid PE through overview presentations and attendance at outreach events. The first months of PE have demonstrated a strong preference by community members to utilize PE as “their front door”. The goal is to provide a new services utilizing existing staff and manage the workload; without exceeding the monthly average of 21 individuals served per month. Another fundamental goal of this program is to better support the HCS team through strengthening rapport and sharing workload as a point-of-entry.
- **WA Cares Fund,** also known as Washington State’s Long-Term Care Fund, ensures all working Washingtonians can earn access to long-term care when they need it. Working, non-Federal, employees in Washington State are eligible for this benefit if they are actively paying into it (0.058% of their paycheck). At Aging and Long-Term Care three full-time employees are responsible for community education and outreach (to employers and employees), screening for eligibility, and providing beneficiary application and technical assistance. When benefits went live on July 2026, beneficiary assistance requests have been lower than projected, statewide. Through community outreach and engagement, the program goal is to increase application assistance each year as measured through subsequent updates. Employers and employees in Kitsap County will have a solid understanding of what the WA Cares Fund is, how it operates, and how to get additional information.
- **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 ALTC website, and one-to-one

education and consultation. The goal of this program is to make sure individuals within Kitsap County are aware of information on how to dispose of medication and have the tools to independently manage their medication (as prescribed by their licensed clinician).

- **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 ADRN. The goal of this service is to reduce social isolation in older adults.

For all programs through the ADRN, the following core components as defined by the Administration for Community Living are integral to service delivery:

- Information, Referral, and Awareness
- Options Counseling and Assistance
- Streamlined (Access to) Eligibility for Public Programs
- Person-Centered Transition Support
- Consumer Populations, Partnerships and Stakeholder Involvement
- Quality Assurance and Continuous Improvement

2027-2030 Training and Partnership Development Spotlight

Training

Due to expanded service options through Health Related Social Needs, WA Cares and Presumptive Eligibility Medicaid Application Assistance, ALTC will be offering more support to individuals of different ages and their families. 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 and working with Aging and Long-Term Care.

Additional training may be provided to staff via internal training developed by supervisors with ALTC, WorkDay (self-paced, covering a range of topics), InformUSA (formerly referred to as AIRS), and Washington Community Living Connections (CLC). Training topics include Options Counseling, strategies to work with diverse populations, process-specific (HRSN, WA Cares) via State training (DSHS WA Cares team, DSHS HRSN team), and related to additional community resources and supports. Additionally, ALTC's staff will seek out information and advice from other community partners that know about diverse populations. Community stakeholders and members of other organizations will be invited to present information on their programs at Aging Disability Resource Network monthly team meetings.

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, Long-Term Care Alliance, Kitsap Housing and Homeless Coalition (KHHC), Nourishing Network (via Bremerton Foodline), Olympic Communities of Health (OCH), Senior Centers, Kitsap Foodbank Coalition, WorkSource, Vulnerable Adult Task Force and other networking and community collaborations. See section 2.2 in this plan for additional listings.

Kitsap County ALTC 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. Examples of 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, attendance at local health fairs, Veterans Stand Downs, and other public information activities that occur through the year. Outreach is intended to support older adults and adults with disabilities.

Aging and Long-Term Care has strengthened partnerships with the Veterans Administrations (VA) Medical centers, local VA clinics, local Veteran's Home (Retsil), Veterans of Foreign Wars (VFW), and Supportive Services for Veteran Families (SSVF). ALTC is collaborating with the Kitsap County Veterans program.

The traditional Senior Information & Assistance service model has continued to evolve with the new Aging and Disability Resource Network branding and addition of the multiple new programs and services discussed above. Additionally, national Aging Disability Resource Network (ADRN) 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 CLC/ADRN 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 services and 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. 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.
3. Inquiries and requests for assistance from the public have increased significantly over the last decade. In 2025 the ADRN had 1,811 unduplicated calls. While the program continues to be a priority need identified by local community members, funding will need to increase to 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.

   Kitsap County Aging and Long-Term Care has placed an emphasis on informing the public about our range of services and supports. Between January 1 -12/31 of 2025, Kitsap Aging and Long-Term Care participated in a total of 59 outreach events with a total attendance of 836 individuals. In the first 6 months of 2026, an additional 28 events serving 836 individuals were accomplished.

GOAL

To provide older adults, individuals with disabilities, and families with access to 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 AND STRATEGIES

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

Measured by:

- Assessment and posting of relevant links and content to ALTC website.
- A minimum of 12 targeted outreach events per year.
- Information and Assistance call outcome summaries.
- Quarterly reports of outreach, partnership development and Medicare beneficiaries served through MIPPA program.

Completion Date: 12/2030

GOAL

To expand new services and supports for younger adults, adults with disabilities and their families.

OBJECTIVES AND STRATEGIES

1. Coordinate and implement staff training for multiple new program rollouts.
2. Increase outreach to highlight newer (WA Cares, Health Related Social Needs, Presumptive Eligibility) and revised (Hospital Care Transitions) programs for residents of all ages while also increasing resources and partnerships of organizations and services for those under 55 years of age.

Measured by:

- Records of training activities through Home and Community Living Administration, local specific service-delivery development and training.
- Calls documented in Washington Community Living Connections (CLC) of or about those under 55 years of age.
- Events and attendance (aggregate) documented in Event Manager in CLC
- Outreach events and attendance recorded to Service Recording in CLC on a monthly basis.
- Total number of individuals supported through WA Cares and HRSN to be posted to dashboard section of ALTC website.

Completion Date: 12/2028

4.4 Caregiving: Enhancing Services and Supports for Caregivers

PROFILE OF THE ISSUE

Similar to the national percentage, about 22% of adults provided caregiving across Washington in 2025.

- Although caregiving can affect all ages, the aging of the population is impacting caregiving trends as well. Most caregivers provided care for a parent (44%), were on average 52 years old, and cared for someone 67 years old on average.
- The majority of caregivers in Washington were female (56%) and provided care to someone due to a long-term physical condition (55%).
- Similar to the national average, 22% of caregivers in Washington spent at least 40 hours a week providing care, and nearly half (49%) reported experiencing at least one negative financial impact due to their caregiving responsibilities[1].

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.

Most caregivers of adults care for a relative (89 percent), typically a parent or parent-in-law (47 percent), spouse or partner (15 percent), grandparent or grandparent-in-law (8 percent), or adult child (6 percent), though 11% provide care to a friend or neighbor[2].

About one in four caregivers reported caring for more than one person in the past 12 months. On average, caregivers reported providing care for 5.5 years[2].

1 The National Alliance for Caregiving and AARP (October 2025). "Caregiving in the US 2025: Washington" https://www.aarp.org/content/dam/aarp/ppi/topics/ltss/family-caregiving/cgus-2025-caring-across-states/caregiving-in-the-us-2025-washington.doi.10.26419-2fppi.00383.032.pdf

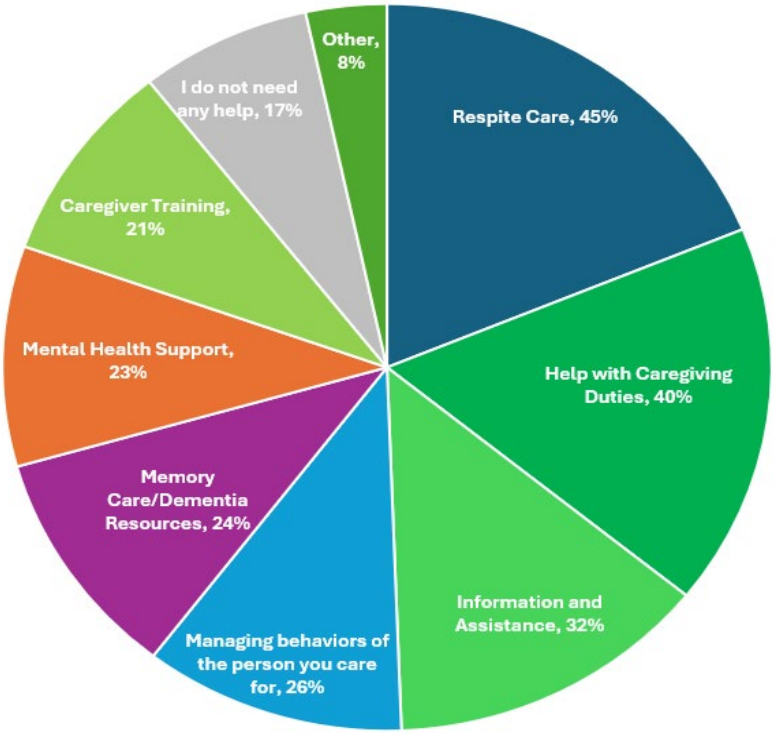
2 AARP & National Alliance for Caregiving. (July 2025). *Caregiving in the US 2025*. https://www.caregiving.org/wp-content/uploads/2026/02/Final-2025-CGUS-Report.pdf

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 are 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

Identified Needs



Percentages have increased. Mental health support needs from 17% to 24%, managing behaviors from 25% to 26%, respite care from 38% to 45%, help with caregiving duties from 36% to 40%, information and assistance from 30% to 32%, caregiver training from 16% to 21%. Close to 20% of caregivers in the prior period indicated they did not need any support, with only 17% selecting that option in the 2026 survey.

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.

Providing care can have economic impacts. 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)*[3].
- *Five in 10 have experienced at least one financial impact as a result of their caregiving (49 percent).*
- *Most commonly, nearly 4 in 10 have stopped saving (37 percent), 3 in 10 left bills unpaid or paid late (28 percent), and 1 in 5 have taken on more debt (19 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*[4].

Six in 10 caregivers report working while caregiving (60 percent). Most working caregivers report going in late, leaving early, or taking time off to accommodate care (56 percent). Nearly one in 10 working caregivers have had to give up work entirely or retire early (9 percent), while nearly 1 in 5 had to reduce their hours from full to part-time (18 percent).[5]

Caregiving also takes a financial toll on employers. It is estimated that Alzheimer's disease 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[6]. 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

3 AARP & National Alliance for Caregiving. (July 2025). Caregiving in the US 2025. https://www.caregiving.org/wp-content/uploads/2026/02/Final-2025-CGUS-Report.pdf
4 The National Alliance for Caregiving and AARP (October 2025). "Caregiving in the US 2025: Washington" https://www.aarp.org/content/dam/aarp/ppi/topics/ltss/family-caregiving/cgus-2025-caring-across-states/caregiving-in-the-us-2025-washington.doi.10.26419-2fppi.00383.032.pdf
5 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.
6 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.

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.

KITSAP COUNTY 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 selection of books, videos, periodicals, and pamphlets, as well as an Internet connection and directory of caregiver-oriented sites.
II. Caregiver Case Managers are available to help caregivers decide what assistance they need and 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, Mental Health resources, 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. ALTC is currently maintaining a waitlist for respite and supplemental services due to high demand.

MEDICAID TRANSFORMATION PROJECT

PROFILE OF THE ISSUE

The Medicaid Transformation Project (MTP) is Washington's, Section 1115 Medicaid demonstration waiver, between the Health Care Authority (HCA) and 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. The Health Care Authority and DSHS received an extension and then an approved renewal on June 30, 2023, which means this continued and expanded long-term services and supports (LTSS) offered under MTP's Medicaid Alternative Care and Tailored Supports for Older Adults programs[7] .

A key benefit to the MAC/TSOA programs is presumptive eligibility. Presumptive eligibility means services can begin sooner. Instead of waiting for the full eligibly process,

7 Source: 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

individuals or dyads who appear likely to qualify can receive services right away, reducing delays in getting needed support.

The demonstration project has two main components:

1. **Medicaid Alternative Care (MAC)**-Benefit package for individuals who are eligible for Medicaid but not currently accessing Medicaid-funded Long Term Services and Supports (LTSS). Provides services to unpaid caregivers designed to assist them in getting supports necessary to continue to provide care and to focus on their own health and well-being.
2. **Tailored Supports for Older Adults (TSOA)**-Benefit package for individuals "at risk" of future Medicaid LTSS use with or without an unpaid caregiver, 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. Services to unpaid caregivers are designed to assist them in getting supports necessary to continue to provide care and to focus on their own health and well-being. 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, as available.
    - **Personal Assistance Services**: Supports involving the labor of another person to help individuals without a caregiver (only for TSOA).
    - **Housework and Errands** services authorized to provide for household areas normally cleaned by the caregiver; completing errands for trips that the caregiver is unable to perform; or providing these services to benefit an individual on TSOA.

Approved benefits in 2023 and expanded services provided options such as pest eradication, adult day services, client training, and for TSOA-home delivered meals. ***However, effective December of 2025, there is a statewide hold on new referrals and waitlist for MAC and TSOA programs with no estimate on when it will end. Individuals and families previously eligible remain on services and continue to receive case management through ALTC.***

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:** Provides supports to assist individuals to remain in their setting of choice. The goal is to increase independence and stability for the individual and to avoid costly and disruptive institutional stays or homelessness.
- **Supported Employment:** Provides supports to assist individuals with functional disabilities to become job-ready and maintain employment.
- **Initiative 4: Substance Use Disorder:** This allows people receiving substance use disorder treatment in a more than 16 bed inpatient setting to use Federal funds to support services.
- **Initiative 5: Inpatient Mental Health Services:** This allows mental health treatment in a more than 16 bed 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 2023 the LTSS system was ranked 2nd in the nation by AARP, and 6th for supporting family caregivers, both in the first tier as "best"[8]. 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.

Kitsap County ALTC Advisory Council advocates for sustained funding for family caregiver programs. There is a Washington State DSHS-led team working on strategies to support the professional caregiver workforce. The ALTC Administrator joins AAAs from across the state through the Washington Association of Area Agencies on Aging in working on issues related to programs and the needs of target populations.

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

8 AARP. (n.d.). *Washington | Long-Term Services and Supports State Scorecard* . Accessed July 31, 2026, https://ltsschoices.aarp.org/scorecard-report/2023/states/washington

or co-pay requirements associated with the traditional Long-Term Care programs. Caregivers outside formal LTSS programs can encounter limitations of lack of knowledge of complex systems or approaches and options for care, 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 for agencies to recruit and retain an adequate number of care providers. With the growing population of older adults and caregiving needs, professional caregiver shortages may make it difficult to continue to meet needs.

GOALS

1. MAC and TSOA benefits will support older adults in Kitsap County to age in the setting of their choice and provide support for caregivers. The Medicaid Transformation Programs (MTP) "Medicaid Alternative Care" (MAC) and "Tailored Supports for Older Adults" (TSOA) program staff will assist adults age 55 + and their Caregivers age 18+ in their homes by providing support to current program participants and assess supports for individuals placed on the waiting list due to the statewide program referral hold.
2. The FCSP program will expand access to and utilization of caregiver services while providing guidance to help caregivers navigate available options. As a result of efforts, the program will empower family caregivers to identify their needs and achieve their personal caregiving goals through coordinated support, education, and access to resources.

OBJECTIVES AND STRATEGIES

MTP Goal Measured by:

- Standardizing referral protocols, training staff, cross-team coordination with contracts staff to maintain strong resource networks, and tracking referral rates to ensure caregivers are consistently and promptly connected to alternative supports.
- Coordinate continuity of support for existing MAC and TSOA clients through ongoing reassessment, person-centered care planning, and coordinated services that respond to the evolving needs of both clients and their caregivers

Completion Date: 12/2030

FCSP Goal Measured by:

- Provide T-CARE screenings & access to customized care plans for caregivers. Complete standardized needs assessments within 30 days of enrollment and personalized goal plans. Ongoing follow-up will be conducted through regular check-ins to monitor progress and adjust supports as needed.

- Provide person-centered counseling and customized services and supports to newly identified caregivers (e.g., respite, counseling, support groups).

Completion Date: 12/2030

KINSHIP CAREGIVER SUPPORT PROGRAM:

Kinship Care is defined as full-time care provided by a child's relative or close family friend[9]. Although most often it is grandparents raising grandchildren, kinship care also includes care of children by other non-parent relatives.

In 2024, approximately 7.8 million children in the United States were living with grandparents or other relatives. This type of household structure is referred to as kinship care, which is defined as full-time care provided by a child's grandparents, other relatives, or close family friend[10]. **In 2024, 8.2% of children from Washington lived with their grandparents or other relatives. Similarly, from 2020-2024, approximately 7% of children from Kitsap County lived in this type of household structure[11]**.

A 2023-2024 survey completed in collaboration with the Department of Children, Youth, and Families and the Research and Data Analysis Division of the Department of Social and Health Services asked 884 kinship caregivers in Washington State questions about their experiences. Among these participants, 28% were aged 40-49, the majority (86%) of respondents identified as female, and 20% of respondents reported a household income between $25,000 to $49,999.

In terms of resources, most respondents wanted more information about stipends/cash benefits, followed by medical care, and child and respite care. Overall, 78% reported they almost or usually receive adequate information about the children in their care[12].

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's 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.

9 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
10 Grandfamiles & Kinship Support Network: A National Technical Assistance Center, https://www.gksnetwork.org/kinship-data/, accessed January 2026.
11 U.S. Census Bureau, American Community Survey (ACS), https://www.data.census.gov/.
12 Washington State Department of Children, Youth, & Families (December 2024). 2024 Caregiver Survey Report. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-7-127.pdf

Examples of these needs may include:

- 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 the 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.

Kinship Navigator Programs

The Kinship Navigator program provides information and assistance functions and system navigation, along with supportive listening, to grandparents and other relatives who are raising relatives' children (under the age of 18 years) or planning to do so. They connect kinship caregivers over the age of 18 to community resources, such as health, financial, legal assistance, support groups, training, and urgently needed goods and services and explain how to apply for federal and state benefits. ALTC contracts these to the local community action agency and supports outcomes through case consult, policy review, and service recording.

Port Gamble S'Klallam Tribe delivers 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.

Problem Statement

1. Caregivers need support and assistance at all stages of their caregiving journey. Different caregivers need different kinds of support.
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. 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.
4. Caregivers need economic and employer support to maintain their responsibilities and access to education about their options. Employers need support in dealing with caregiving issues in their workforce.
5. Kinship caregivers need a range of assistance in their role raising children and navigating support systems. Based on program support requests, caregivers need financial assistance for the children in their care, help providing necessities and accessing medical care, affordable housing, and adequate transportation.

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 AND STRATEGIES

1. 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 events.
- Dedicated efforts and outreach to notify caregivers about available training opportunities.

Completion Date: 12/2030

2. 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 targeted presentations, education and outreach activities, and copies of reports.

Completion Date: 12/2030

4.5 Tribal Partnerships and 7.01 Plans

There are two Tribes in the Area Agency on Aging (AAA) planning service area in Kitsap County, the Port Gamble S'Klallam Tribe and the Suquamish Tribe. As the local AAA, Aging and Long-Term Care (ALTC) works to collaborate with the Tribes to help address the health and social needs of Native Americans in Kitsap County for tribal elders age 55 years and older, and those with disabilities requiring in-home care and support. And, with new programs with expanded, younger populations served, also those who may qualify for programs and benefits the AAA provides directly or contracts to provide.

Each Tribe has their own values and traditions within the distinguishing different government and social service structures. Kitsap County ALTC has a history of working collaboratively with both Tribes to meet the needs of Tribal people. 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 to tribal members with long-term care needs receiving Medicaid-funded in-home care, ALTC assigns a culturally-sensitive case manager.

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 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.

The Tribal Elders program provides meals 5 days per week at the Elders Center. Elders also may opt to carry out meals, and some elders receive meals delivered by Tribal staff. The Tribe blends the subcontracted Older Americans Act nutrition funds from ALTC and Title 6 federal nutrition funds to provide these services. The Tribe welcomes eligible seniors from

the community at this site. Examples of other services provided through the tribe include Tribal navigators, kinship program, case management for vulnerable adults, special needs advocate, protective payee, chore service referrals, information, assistance and referrals to other services, as well as hosting-activities at the Elders Center[1].

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.

The Elders Program "coordinates appropriate health, social and cultural services for Tribal Elders and spouses". The Elders Lunch Program provides Tribal Elders, their spouses, and anyone over 55 who lives on the Port Madison Reservation, nutritious meals five days per week. Meal delivery is also an option for homebound elders, spouses or disabled members who reside on the Port Madison Indian Reservation. Examples of other services includes case management, caregiver services, aged and disabled program, veterans' program, protected payee, vulnerable adult and adult protective services, foot care, among others[2].

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.

Below are the latest 7.01 Plans with the Port Gamble S'Klallam Tribe and Suquamish Tribe. Plans outline mutually agreed upon focus areas, activities, and expected outcomes with dates. Both 7.01 Planning meetings included Tribal, ALTC and Office of Indian Policy representatives. 7.01 Plans are reviewed at least annually or as scheduled with agreement between all parties. They are considered "living documents" that can be revised and updated as agreed .

1 Port Gamble S'Klallam Tribe. https://pgst.nsn.us/

2 The Suquamish Tribe. https://suquamish.nsn.us/

2026 7.01 Plan
for
Kitsap County Division of Aging & Long-Term Care (PSA 13) – Area Agency on Aging
Port Gamble S'Klallam Tribe

Timeframe: January 1, 2026 to December 31, 2026

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**
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 Child & Family Services (CFS) Director Maria Huynh, Tribal CFS Assistant Director Stacey Smith, Aging Administrator Tawnya Weintraub, Aging Planner Mikko Azul, Aging Case Manager Laura Murphy, Tribal Vulnerable Adult Case Manager Sue Hanna, Tribal Elders Program Manager Sandy Walker, Tribal RN Review Annually	2025-2026 Tribal Vulnerable Adult Multi-Disciplinary Team: Kitsap Aging staff regularly attended meetings.

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Previous Year
2. (a) Provide specialized Aging Information & Assistance about, and access to, caregiver support services to the Tribe. (b) Partner to connect Kinship Care families to training and support opportunities. Tribe created Lifespan Respite training. (c) Tribe continue to provide CD-WA option for family caregivers (primarily for CHORE services)	• 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 Aging & Tribal Kinship Caregiver Support programs.	Increase and enhance caregiver and kinship support information and access to services. 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.	Cheryl Miller, Tribal CFS Director Maria Huynh, Tribal CFS Assistant Director Tawnya Weintraub, Aging Planner Carrie Mulcahy, Aging Caregiver Programs Supervisor Laura Murphy, Tribal Vulnerable Adult Case Manager Sue Hanna, Tribal Elders Program Manager Star Hagen, Tribal Kinship Navigator Review Annually	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. 2025 Strong Families Fair: Kitsap Aging staff attended event on May 21, 2025

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Previous Year
3. (a) Provide specialized Aging Information & Assistance about, and access to, caregiver support services to the Tribe. (b) Partner to connect Kinship Care families to training and support opportunities. Tribe created Lifespan Respite training. (c) Tribe continue to provide CD-WA option for family caregivers (primarily for CHORE services)	• 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 Aging & Tribal Kinship Caregiver Support programs.	Increase and enhance caregiver and kinship support information and access to services. 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.	Cheryl Miller, Tribal CFS Director Maria Huynh, Tribal CFS Assistant Director Tawnya Weintraub, Aging Planner Carrie Mulcahy, Aging Caregiver Programs Supervisor Laura Murphy, Tribal Vulnerable Adult Case Manager Sue Hanna, Tribal Elders Program Manager Star Hagen, Tribal Kinship Navigator Review Annually	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. 2025 Strong Families Fair: Kitsap Aging staff attended event on May 21, 2025

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4. Communicate and coordinate potential new community resources and local funding.	• Share a presentation of AAA programs. • Share new or reduced resources/programs as a result of future funding.	Tribal and AAA staff are more informed about services resources and local partnerships.	Cheryl Miller, Tribal CFS Director Maria Huynh, Tribal CFS Assistant Director Sue Hanna, Tribal Elders Program Manager Laura Murphy, Tribal Vulnerable Adult Case Manager Stacey Smith, Aging Administrator Tawnya Weintraub, Aging Planner Jason Doty, Aging Senior Information & Assistance Supervisor Review Annually	Continue to coordinate on resources and funding, as needed.
5. Emergency Preparedness: Communication and coordination of local activities	• Kitsap County and Tribal DEM participate in local disaster planning meetings.	Tribal government and local County governments participate in local emergency preparation meetings. Kitsap Aging and Tribal service staff are informed of resources and drill events. During a disaster, Tribal service staff know who and how to communicate needs of community members they serve.	Cheryl Miller, Tribal CFS Director Maria Huynh, Tribal CFS Assistant Director Nickolas Miller, Tribal Emergency Safety Coordinator Dave Rasmussen, Kitsap County Department of Emergency Management Stacey Smith, Aging Administrator Review Annually	2026 New goal

HISTORY - past 3 years		
(1) Goals/Objectives	**(3) Expected Outcome**	**(5) Status Update for the Previous Year**
2025: On-going overarching goals-activities are updated to reflect progress		NA- 7.01 Plan was not updated
2024: On-going overarching goals-activities are updated to reflect progress	1. 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. 2. Increased and enhanced caregiver and kinship support information and access to services. 3. Communicate and coordinate potential new community resources and local funding.	• Kitsap Aging participation in the local Tribal Vulnerable Adults Multi-disciplinary team meetings. • 3/2024 Kinship Navigator and Caregiver contract shared with Tribe. • 7/2024 Onsite nutrition services monitoring at Elders Center. Technical assistance provided to program and fiscal staff throughout calendar year as requested. • 10/2024 Kitsap Aging shared community caregiver workshops flyer • Kitsap Aging offered overview meeting to explain existing and new services • Attended annual Strong Families Fair.
2023: On-going overarching goals-activities are updated to reflect progress	1. 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. 2. Increased and enhanced caregiver and kinship support information and access to services. 3. Communicate and coordinate potential new community resources and local funding.	• Kitsap Aging offered advocacy and outreach to the Port Gamble S'Klallam Tribe through presentations and services. • Kitsap Aging continued to share information and technical assistance to eliminate barriers to services. • Meeting to share new resources/programs as a result of new funding. • Attended annual Strong Families Fair.
2022: On-going overarching goals-activities are updated to reflect progress	1. 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. 2. Increased and enhanced caregiver and kinship support information and access to services. 3. Communicate and coordinate potential new community resources and local funding.	• November 18, 2021: AAA staff participated in Virtual Tribal-ALTSA-HCS-AAA Fall Summit, including the Kinship Navigator workshop that included PGST Tribal Kinship Navigator Program presentation by Cheryl Miller. • The Lifespan Respite staff training was delayed. Due to delays. COVID also had an impact. There was a lot of communication between involved parties as they worked through training issues. Ultimately, the funding was extended • MTD MAC/TSOA program updates provided via electronic communications.

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 enhanced 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 has 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 no 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.				

2027-2030 Emergency Response Plan

This document is an overview of the Kitsap Aging and Long-Term Care (ALTC) emergency response plan. Kitsap Aging and Long-Term Care is a division under the Kitsap County Human Services Department within Kitsap County government. Thereby, Kitsap County Department of Emergency Management (KCDEM) is the lead entity for coordinated disaster preparedness and response activities that involves Kitsap County government.

As a social service organization, ALTC also participates in the Northwest Regional Healthcare Response Network (NWHRN) which coordinates medical providers and resources to local jurisdictions in emergencies and disasters under the oversight of Washington State Department of Health. ALTC participates in regional quarterly virtual meetings with the NWHRN and receives weekly Washington State Healthcare Situational Awareness Briefs which reports healthcare access and capacity information, such as hospital census, as well as region-specific concerns.

The Northwest Response Network provided another avenue for coordinated hospital and healthcare setting disaster prevention and disaster response communication. Weekly hospital surge capacity reports and bi-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, COVID-19, etc.).

The previous 2024-2027 Area Plan Disaster Plan referenced information about the Vulnerable Populations Emergency Response Plan, a conceptual framework and operations reference for local emergency response. The Plan was 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 support of all populations is integrated into the ongoing disaster planning overseen by KCDEM. When a large emergency or disaster triggers the activation of the Kitsap County Emergency Operations Center (EOC), KCDEM provides the overarching coordination of agencies and organizations with the objective of life safety incident stabilization and preservation of property and restoration of society.

KCDEM now uses FEMA Community Lifelines as the organizational framework to provide a timely and effective response to an emergency or disaster. Community Lifelines (CLL) focus on the restoration of infrastructure and services needed to sustain a local community. Community Lifelines are supported by Emergency Support Functions (ESF's) which provide the plans, capability, and capacity to restore infrastructure and service essential to life safety, stabilizing the incident, preservation of property, and restoration of society after the disaster.

Staff members from organizations included in the ALTC are members of the EFS 6 (Mass Care) and ESF 8 (Public Health & Medical) groups and will contribute to both the Health & Medical CLL as well as the Food, Hydration & Shelter CLL at the Kitsap County EOC with the goal of sustaining and supporting their clients through the crisis in partnership with Kitsap Public Health District (KPHD), NWHRN, other state and local agencies, and non-profit organizations active in disaster response.

Contributing to the Kitsap County EOC would be either in person at 8900 SW Imperial Way, Bremerton, at a different designated location or virtually/hybrid on Microsoft Teams.

Designated Staff- Roles and Responsibilities

With Kitsap Aging & Long-Term Care within Kitsap County government, the following table identifies designated staff, Department, and role for response and recovery activities. In the event of the Kitsap County EOC activation, the Director would designate staff to respond to the EOC or have liaison with the EOC. The Aging Administrator may be designated to respond for direction and oversight of activities related to older and disabled populations through the ESF 8 assignment.

Kitsap County		
	Designated Staff	Role
Department of Emergency Management	Brian Nielson, Coordinator of Health & Medical Lifeline planning Dave Rasmussen, Coordinator of Human Services (Mass Care) planning	Kitsap County ESF 8 Lead Kitsap County ESF 6 Co-lead
Department of Human Services	Doug Washburn, Department Director	Kitsap County ESF 6 Co-Lead, Department Lead
Division of Aging & Long-Term Care (AAA)	Stacey Smith, Aging Administrator	Aging Lead

Kitsap County Department of Emergency Management

KCDEM plans for emergencies that can harm the people, property, economy, and environment of the region. To make this happen, Kitsap County through KCDEM has set goals to develop public awareness of disaster hazards and promote self-sufficiency after disaster strikes, develop responder capabilities, provide reasonable procedures for emergencies and disasters, and create an atmosphere of interagency cooperation in emergency and disaster operations. KCDEM is responsible for developing inter-agency

agreements with local emergency operations leadership that include role and responsibilities.

KCDEM facilitates public awareness campaigns to inform all the risks and dangers in our area, such as landslides to pandemics, flooding to cyber threats, a wide range of natural hazards and human-made threats. KCDEM also provides education on creating a plan for two weeks of self-sufficiency in the event of an emergency. That means different things for families, those with special needs, and community organizations.

KCDEM is the designated lead organization for inter-departmental activities. KCDEM directs the departments within Kitsap County in disaster preparedness and response. KCDEM coordinates Countywide drills and exercises, facilitates local meetings (such as ESF 6 and ESF 8), and closely communicates with all County departments.

Department of Human Services

The Department of Human Services designated lead is the Director, Doug Washburn. Human Services Director participates in Health & Medical Lifeline planning meetings and Food, Hydration & Shelter (Mass Care) planning meetings to ensure close communication with all programs and services offered through the Human Services Department, including special populations served.

Division of Aging and Long-Term Care

The ALTC designated lead is the Administrator, Stacey Smith. ALTC participates in the ESF 6 and ESF 8 meetings to ensure populations served are included in planning, including accommodation for older adults, adults with disabilities and their caregivers.

ALTC ensures staff and individuals served have emergency contact information on file. ALTC participates in the Countywide drills, as well as actively participates in the County's Safety committee.

ESF 6 & 8

KCDEM staff co-lead the ESF 8 meetings in partnership with Kitsap Health Department. These regular meetings coordinate the development of response strategies for social and medical services. This meeting brings together private and public organizations, local government, and public health to address various populations with access and critical/ functional needs throughout the County. The mission is to increase communication and collaboration with agencies providing services to access and critical/ functional needs populations. Kitsap County Human Services Director and Aging and Long-Term Care Administrator participate in the ESF 8 / ESF 6 meetings.

Local Partners & Coordination

Internal County safety and emergency planning activities, as well as ESF 8 and NWHRN meetings, provide a framework for local communication and coordination with community partners. These meetings provide a communication structure, platform for regular exercises and tabletop drills, de-brief sessions, and lessons learned training. We share knowledge and learn from one another.

Criteria for "Access to critical needs individuals"

History shows that disasters disproportionately impact populations with access and critical 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.

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 aids (wheelchairs, walkers, canes, or crutches), communication systems (hearing aids, TTY's, etc.), medical devices (ventilators, dialysis, pumps, monitors), prescription medication, or personal care aides. 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.

Kitsap Aging and Long-Term Care considers all individuals assigned to a case manager as meeting the criteria for high risk with "access to critical needs" in the community.

Plan for contacting high risk individuals

In the event of a disaster, Kitsap ALTC plan calls for contacting high risk individuals as follows:

- Ensure ALTC staff are safe and able to contact their clients (access to power, laptop with internet access to County/ DSHS servers).
- The assigned case manager would begin contacting, most likely calling, all individuals impacted by the emergency/ disaster. Prioritizing those that live in an impacted area or triaged as the highest critical/ functional needs without support.
- Once an individual is contacted, the case manager will identify unmet critical needs, as well as needs being met. Critical scenarios would be communicated to

911; noncritical issues would be communicated to supervisor or directly to Administrator.

Providing information during 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.

The Division of Aging and Long-Term Care maintains updated hard copy and electronic lists 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 Operations 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.

Cooperation with entities when areas of unmet need are identified

Unmet needs are part of the recovery phase. KCDEM will work in cooperation with Washington State Emergency Management Department and local non-profits like Salvation Army (for case work) to address unmet needs. KCDEM will coordinate, through ESF 6 and ESF 8, outreach to Aging is a specific need is identified.

Training and Drills
One objective of KCDEM is to train and educate County employees on issues pertaining to Emergency Operations Centers. The County, collectively, ensures that training is inclusive of populations with access and critical 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 critical needs populations, development and participation to post-exercise evaluation, debriefing and after-action reports.

System for Tracking Unanticipated Expenditures

The Kitsap County EOC has a dedicated finance section to oversee and document the steps needed for reimbursement for unanticipated expenditures during a disaster and recovery phase. Collectively, we all use the Kitsap County financial tools, staff and resources.

If needed, Kitsap 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 ALTC is aligned with KCDEM operations and protocols. The agency back-up systems are coordinated with the Kitsap County's EOC 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 funneled through Kitsap 1, or an alternate call center service, will be relayed to transferred to the Emergency Operations 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. ALTC would resume back to normal business operations as directed by Kitsap County leadership and the County Administrator.

Policy and procedures developed due to the COVID-19 pandemic

The lessons learned from the COVID-19 response improved and accelerated communication using Microsoft Teams and other virtual platforms. State and community partners became trusted partners and freely share resources.

Coordination between Title 3 and Title 6

Kitsap Aging and Long-Term Care added a disaster planning goal to the 7.01 plans and discussions. Both Tribes that reside in Kitsap County have designated staff that actively collaborate with Kitsap County Department of Emergency Management. They participate in local drills, meetings, and provide valuable connections to the Tribal communities in preparation and response to disaster emergency threats.

Advisory Council

Name	Representing
Steven McMurdo, Chair	District 1 – Poulsbo
Linda Navage	District 1 – Bainbridge Island
Dr. Kenneth Klein	District 1 – Bainbridge Island
Charmaine Scott	District 2 – Port Orchard
Linette Zimmerman	District 2 – Port Orchard
Vacant	District 2
Ranae Beeker	District 3 – Bremerton
Laney Calhoon, Vice Chair	District 3 – Silverdale
Theresa Lambert	District 3 – Seabeck
Susan Nolan	District 1 – Poulsbo (member at large)
Vacant	(member at large)

2027-2030 Area Plan Public Process

Activity	Date	Location	Group
Area Plan Survey press releases, announcements	February 27, 2026 Multiple dates February-March 2026 February 27-March 31, 2026 March 20, 2026	GovDelivery alert, media release, social media, ALTC and Kitsap Public Health website postings, email, partner distribution lists	Public, staff, county employees
Area Plan Survey Review, posting, distribution.	Posted March 1, 2026 Closed April 1, 2026	Email distribution, mail, in-person deliveries, social media posting (Facebook, X, Instagram, Next Door)	Public, Aging and Long-Term Care (ALTC) Advisory Council, staff, community partners, providers
7.01 Meeting with Port Gamble S'Klallam Tribe	March 23, 2026	(Virtual) Meeting with Port Gamble S'Klallam Tribe	Port Gamble S'Klallam Tribe, Area Agency on Aging (AAA), DSHS HCLA, and Office of Indian Policy
Board of County Commissioners (BOCC) Work study session for Aging's Annual Review. (Informed of Area Plan year and plan for upcoming public hearings)	June 10, 2026	Kitsap County Administrative Building	BOCC, Human Services Director, ALTC Administrator, Planner, Public
7.01 Meeting with Suquamish Tribe	To be determined	Human Services Building or virtual Suquamish Tribe	Suquamish Tribe, Area Agency on Aging (AAA), DSHS HCLA, and Office of Indian Policy
Public Notice of Advisory Council Meeting with Area Plan presentation	June 10, 2026	GovDelivery email notification, Area Agency on Aging Advisory Council, ALTC website	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers

Activity	Date	Location	Group
Public Forum Announcements	June 22, 2026 releases (emails multiple dates)	GovDelivery, ALTC website, email distribution	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers
Public Forums	June 17, 2026 July 14, 2026	South Kitsa (during Advisory Council meeting) Central/North Kitsap Silverdale Library	Public, Aging and Long-Term Care staff, community partners
Forum presentation to Aging and Long-Term Care Teams	July 28, 2026	Virtual Meeting	Direct Service Subject Matter Experts-ALTC teams
Press Release and social media announcements for posting of Area Plan Draft for public review	Media Release date August 10, 2026 Plan posted August 10-September 10, 2026	GovDelivery notifications: Aging and Long-Term Care website. Area Plan Draft posted to ALTC website	Public, providers, community partners, staff, and council members
Public Notice of Advisory Council Meeting	August 12, 2026	GovDelivery email notification, Area Agency on Aging Advisory Council, ALTC website	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers, public
Advisory Council/Public Meeting	August 19, 2026	Hybrid-virtual/ Port Orchard-Givens Announcement of Release of Draft Area Plan for input.	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 24, 2026	Kitsap County Administrative Building	Kitsap County Aging and Long-Term Care staff, Director of Human Services, and Board of County Commissioners, public

Activity	Date	Location	Group
Legal Notice for Public Hearing	August 28, 2026	Online, press release	Public, providers, community partners, staff, and council members
Board of County Commissioners (BOCC) Presentation and Public Hearing	September 14, 2026	Kitsap County Commissioner's Chambers	Kitsap County Board of Commissioners, public, Director of Human Services, Aging and Long-Term Care staff, Advisory Council members
Aging and Long-Term Care Advisory Council/Presentation and Public Meeting-Advisory Council Area Plan Approval	September 16, 2026	Hybrid-virtual/Givens Community Center, Port Orchard	Advisory Council, public, staff, providers
Board of County Commissioners (BOCC) Regular Meeting, approval of Plan Public Meeting BOCC approval/sign Final Area Plan	September 28, 2026	Kitsap County Commissioner's Chambers	Kitsap County Board of Commissioners, Director of Human Services, Aging and Long-Term Care staff, Advisory Council members, and public 2027-2030 Area Plan submitted to DSHS/ HCLA by October 1, 2026

Report on Accomplishments: Area Plan 2024-2026 Updates

Issue Area C-1.1 **Health and Wellness in an Age-Friendly, Dementia-Friendly Community** **Healthy Aging**		
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. Support food access efforts and nutrition resources. 2. Promote positive aging, socialization opportunities, and wellness, exercise, and prevention activities. 3. Continue and further develop the advocacy campaign regarding issues that impact older adults and caregivers. 4. Continue to participate in local housing and transportation planning.	• 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. • 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.	Kitsap Advisory Council advocates for statewide senior nutrition funding. Fiscal year 2025 Kitsap AAA was awarded flexible state senior nutrition funding that expanded funding to the Kitsap Food Bank coalition. Healthy Aging & Exercise: Fiscal year 2025 – Maintained YMCA Fall prevention Enhance®Fitness classes and developed a new Healthy Aging monthly e-newsletter. Social Isolation: January 2025 – Kitsap Aging participated in the Kitsap Public Health Social Isolation community forum. Calendar year 2025 – Aging Advisory Council included preventing social isolation in their workplan as a high priority. They committed to identifying strategies for safe social connections for older adults. Advocacy: January 2024 and February 2025 – Advisory Council meetings with Washington legislators to advocate for senior food insecurity and older adults' programs. Conferences: <u>2024:</u> • July – Kitsap AAA staff attended the 2024 USAging Conference in Tampa, FL. • June – Kitsap AAA staff attended the w4a Development Conference.

	• 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. • 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	• February – November 2024, and February 2025 Kitsap Aging Advisory Council attended the Senior Lobby Conference. <u>2025</u>: • March – Aging and Disability Resource Network Supervisor provided ALTC Overview presentation to Suquamish Advisory Council along with Steve McMurdo (Aging's Council Chair). Housing: Work in cooperation with the Kitsap Housing Transitional program opening in Port Orchard, January 2025. Transportation needs: Kitsap Aging Advisory Council includes a DOT ADA Transpiration expert. In 2024, the Council met with Kitsap Transit to comment on their strategic plan. In 2024 and 2025, the Council met with the Puget Sound Regional Council Transpiration team and provided comments on their plans. Representation at meetings: • 2020-2024 Kitsap Aging & Long-Term Care Director participated as a Kitsap County Department of Community Development Planning Commissioner representing older adults and individuals on fixed incomes. • 2022 – Present Kitsap Aging & Long-Term Care Director is a Board member of the Olympic Community of Health (OCH), an accountable community of health, representing AAAs in the region. • Kitsap Aging & Long-Term Care Director represents older adults residing at home in Kitsap Public Health ESF-8 Disaster planning. • Kitsap Aging represented at monthly Kitsap Provider Breakfast meetings. • Attendance at Kitsap Information & Referral Network • Kitsap Housing Homelessness Coalition • Kitsap Suicide Awareness Coalition • Kitsap Health Equity Collaborative

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 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.	• 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. • Provide evidence-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. • Memory screening support activities delivered by ALTC staff. • Coordination activities with Alzheimer's Association and other 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	2024 RFP awarded to Sound Self, LLC for Dementia consultation services, 2025-2027 subcontract for services using existing funding. 2025 researched mini-grants through the Dementia Action Collaborative to sustain or expand services. (EBP) Spring 2025: Offered Powerful Tools caregiver workshops available at no cost through UW virtual classes. Share Dementia Action Collaborative (DAC) resources with community. March 2025: Explore DOH and DAC mini-grant to diversify Dementia Consultation services (Workforce issues) Kitsap hosted the Kitsap Partner & Provider meetings on May 16, 2024 and April 3, 2025. Home care agencies report on workforce capacity and recruitment efforts. Increased home care agencies in the network (from 4 to 7) have improved workforce availability. w4a invited the DSHS Workforce Development Team to present project outcomes for statewide pilot programs and new Workforce Navigator services available to assist individuals interested in caregiving workforce. CDWA contract requires hiring benchmarks to improve hiring practices and caregiver availability.

Issue Area C-2.1 **Service Options that Support Older Adults and Family Caregivers** **Community Living Connections**		
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.	• 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: 12/2027	Healthy Aging & Exercise: Calendar year 2025 – Developed a new Healthy Aging monthly e-newsletter. Outreach events exceeded minimums per year.
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)	• Quarterly reports of number of Medicare beneficiaries served. • Quarterly reports of health and wellness outreach and partnership activities. Completion Date: 12/2025	Consistently met all Office of Insurance Commissioner contact targets for MIPAA outreach. Hired a SHIBA-certified staff member to provide MIPAA LIS and MSP outreach activities. There is strong coordination with Statewide Health Insurance Benefits Advisors local provider, Peninsula Community Health Services.
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: 12/2027	Fall 2024: Goal placed on pause due to federal funding threats and challenges to existing programs. Washington State legislature and local County government are struggling with budget deficit- no new programming or new funding available. Kitsap ALTC Advisory Council workplan high priority goals include meeting with elected officials and advocating for increasing funding in 2025, and sustaining funding in 2026. Advocacy Campaigns include: • w4a Legislative Advocacy webinar • Spring & Fall Senior Lobby virtual events • Fall State Council on Aging and w4a annual conference

		• Individual meetings with local and state elected officials throughout legislative sessions in 2024-2026

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, provide resources and supports for family and kinship caregivers, and strengthen stabilization in the caregiver population of 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 additions 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. • Increasing available supplemental services provided to enrolled Family Caregiver participants Completion Date: 12/2025	2024 – Present: Continue to offer support services to caregivers that include robotic pets, memory screenings, and a monthly educational newsletter. FCSP Increasing Available Supplemental Services: 2024 & 2025 – PERS services available for Family Caregiver Support program clients with Safetyline & Lifeline. Contract ended in July 2024 with Lifeline; Safetyline option continues for Family Caregiver Support Program clients. FCSP Community Outreach: October 2024 – Presentation and Q&A with Central Kitsap/North Kitsap & South Kitsap Cares re: Caregiver Programs eligibility and referral process. November 2024 & 2025 –National Caregiver Month activities: flyers listing scheduled workshops/presentations delivered by hand and/or emailed to Aging Advisory Board, Bainbridge Island Helpline House, Bainbridge Island Senior Center, East Bremerton Home & Community Services, Kitsap Regional Library – Bremerton/Silverdale/Poulsbo, Meal on Wheels Kitsap, East Bremerton Senior Center, Bremerton St. Vincent de Paul, East Bremerton YMCA, All Ways Caring Home Care, Catholic Community Services, CHI home health & hospice, Monthly Caregiver E-newsletter, Kitsap Aging website, the Kitsap County Long-Term Care Ombudsman, Easterseals, Family Resource Home Care, FCSP Caregivers and MAC/TSOA Dyad Caregivers, Dementia Specialist, Kitsap Information & Referral Network, Kitsap Home Care Services, Korean Women's Association, Kitsap County Long-Term Care Alliance, MultiCare Home Health & Hospice, St. Michael & St. Anthony Hospitals, Northwest Justice Project, Tim's

		Home Medical, Gig Harbor YMCA, Port Gamble S'Klallam Tribe, Kingston ShareNet Food Bank, Kingston Village Green Senior Center, Care Plus Home Health, Givens Senior Center, South Kitsap Helpline, Fishline, Poulsbo Senior Cener, Central Kitsap Food Bank, Suquamish Tribe, Bremerton DDA office, Bremerton Foodline, Bremerton Home & Community Services, Peninsula Community Health Services. November 2024 – Events/Community Presentations for National Caregiver Recognition Month (All in-person offerings): *Memory Loss & Communication for Caregivers* with Sound Self, LLC presenting. *Caregiver Support Programs & Resources* with Caregiver Support Programs Supervisor presenting. *Residential Care overview for long-term care* with Kitsap County Long-Term Care Ombuds presenting. *Applying for Medicaid* presented by Northwest Justice Project. Attendance for all presentations was doubled from the year before. 2025: May – Caregiving Overview at Port Orchard Kitsap Regional library with Caregiver Support Programs Supervisor presenting. November – National Caregiver Month: *Dementia 101* presentation with Dementia Specialist of Sound Self, LLC presenting. *Unpaid Caregivers in the Home* presentation at Port Orchard Library with Caregiver Programs Supervisor presenting.

		2026: April – Bainbridge Island Senior Center Aging in Place Forum with Caregiver Program Supervisor and ADRN Supervisor presenting.
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.	• 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	Ongoing: Development of Caregiver Presentation and community presentation Distribution of monthly Caregiver newsletter through GovDelivery <u>2024</u>: June – LGBTQ & Family Caregiver Resources July – Long-Term Care Options September – Suicide & Falls Prevention Awareness October – Cybersecurity November – Family Caregiver Month December – Self Care for the Holidays <u>2025:</u> January – Kitsap Aging & LTC February – Identifying when help may be needed March – Caregiver Burnout & Compassion Fatigue April – Virtual offering of *Powerful Tools for Caregivers* through The Goldstein Institute. May – Older Americans Month June – Alzheimer's and Brain Awareness Month July – Balancing Work and Caregiving August – Emergency Preparedness September – Fall Prevention October – Medicare Open Enrollment November – Family Caregiver Month December – Holiday Self Care <u>2026:</u> January – Kitsap Aging & Long-Term Care Services February – Identifying when help may be needed March – Nutrition
3. Continue outreach to the faith, business, and healthcare professional	• Schedule of presentations and copies of reports.	April 2024 – Caregiver Program overview North Point Church, Poulsbo to their Parkinson Disease Support Group ADRN & Caregiver Program supervisors presenting

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.	• Community and partner education about programs to support individuals and families. Completion Date: 12/2027	April 2024 – Caregiver Program overview presentation to PEO Sisterhood (Philanthropic Educational Organization) Silverdale Chapter. Caregiver Program Supervisor & Lead presenting. January 2025 – Zoom meeting with St. Anthony & St. Michael Case Management teams on Presumptive Eligibility for MAC & TSOA Programs and making referrals. March 2025 – Two ALTC program overviews, including Family Caregiver and MAC/TSOA programs, held at the Suquamish Church of Christ and Brownsville United Methodist Church.

Issue Area C-2.3 **Medicaid Transformation Demonstration (MTD)**		
Goal: MAC and TSOA benefits will support older adults in Kitsap County to age in the setting of their choice and provide support for caregivers.		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
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.	• 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	7.01 Planning – Identified Port Gamble S'Klallam Tribe Tribal interest in MTD programs. ALTC outreached to offer a program overview. 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 turnover of clients. January 2025 – Zoom meeting with St. Anthony & St. Michael Case Management teams on Presumptive Eligibility for MAC and TSOA Programs and making referrals. Continuous outreach and support to community members by ALTC Advisory Council members.
2. Target program outreach to caregivers to increase caregiver dyads served.	• Offer pre-screening for TSOA Dyad services for all newly completed TCARE	2024-2025: Care Transitions Care Coordinator will identify days for outreach.

	screenings received at AAA level. • Provide TCARE 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	2024 and 2025 (annually): ALTC provided MTD program overview to medical community (St. Michael and St. Anthony's) staff. 2024-2025: AAA, HCS, and DDA Provider & Partner meetings to share program updates and reminders for dyad growth <u>Program Staffing:</u> 2024 Case manager program attrition, 75% staff turn-over and recruitment 2025 – 25% turnover/recruitment 2026 – 25% turnover/recruitment paused due to MTP enrollment pause <u>Services:</u> Mailed out approximately 70 TCARE Surveys to newly identified caregivers, from I&A contacts. Number is down from prior year related to loss of COVID dollars. (2024) Approximately 175 caregivers were provided specific caregiver support information through Senior I&A contacts. (January-December 2024) <u>FCSP Referrals processed by Caregiver programs:</u> 2024 – 42 Completed TCARE surveys received for new referrals 2025 – 58 Completed TCARE survey received for new referrals 2026 – 30 Completed TCARE surveys received for referrals <u>MTP Dyad Referrals processed by Caregiver Programs:</u> 2024 – 10 Dyad referrals 2025 – 21 Dyad Referrals 2026 – Zero dyad referrals due to statewide MTP enrollment pause Caregiver Program Breakdown of incoming referrals (total referrals includes all initial outreach to incoming referrals for *all Caregiver programs*. August 2025 – Current: ADRN 69 Self-Referred 19 Dementia Care Specialist 3

		Care Transitions Coordinator 14 Website 2 CG CM 2 Kaiser 2 Home & Community Services 26 Total to March 2026=134 Ongoing: Offering pre-screening for TSOA Dyad services (NFLOC as appropriate) for TCARE screenings received after optional counseling completed. Screenings and access to care planning for caregivers. Person centered counseling with customized services to support newly identified caregivers. Counseling options provided based on income, resources, level of need.
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 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	Kitsap hosted the Kitsap Partner & Provider meetings on May 16, 2024, April 3, 2025, and February 3, 2026. Home care agencies report on workforce capacity and recruitment efforts. Increased home care agencies in the network (from 4 to 7) have addressed a majority of workforce shortages. w4a invited the DSHS Workforce Development Team to present project outcome for statewide high pilot programs and new Workforce Navigator services available to assist individuals interested in caregiving workforce. CDWA contract requires hiring benchmarks to improve hiring practices and caregiver availability. June 2024 – CDWA Systems and Functionality training for TSOA Case Managers with access to CDWA individual providers and Carina Care beginning in July 2024. July 2024 to Present: 24 MAC/TSOA individuals have found caregivers through CDWA 2024 – 3 2025 – 20 2026 – 1 Clients have the option to be linked to a Caregiver through CDWA via the CARINA process of pairing with a caregiver via the app. Others have a caregiver in mind and

		are linked through CDWA based on their preferred caregiver's completion of training and hiring status. When clients are unable to navigate this process, they will choose an agency to provide in-home care. TSOA individual clients are eligible for CDWA independent providers.

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).	• Increased average number of total persons served each month from 984 (June 2023) to 1008, per the state forecast. This equates to at least 24 additional cases each month, by the end of 12/2024. Completion Date: 12/2024	July - November 2024, monthly Medicaid caseloads have exceeded 1,140 each month. Transfer of eligible clients, with and without a caregiver (early transfer pilot), has resulted in a consistently higher caseload each month. Kitsap AAA has requested a contract amendment to ensure we are reimbursed in full for all these cases (that exceed the FY 2025 contract monthly caseload maximum of 1,146). July 1, 2025: The program continues to grow. Caseloads are averaging 1,255 per month. As of March 3, 2026, there are 1,259 clients currently being served by the Title XIX program. During the month of February, 47 clients were transferred to Kitsap AAA and assigned.
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.	• 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	Kitsap hosted the Kitsap Partner & Provider meetings on May 16, 2024, April 3, 2025, and February 3, 2026. Home care agencies report on workforce capacity and recruitment efforts. Increased home care agencies in the network (from 4 to 7) have improved workforce shortages. w4a invited the DSHS Workforce Development Team to present project outcome for statewide high pilot programs and new Workforce Navigator services available to assist individuals interested in caregiving workforce. CDWA contract requires hiring benchmarks to improve hiring practices and caregiver availability.

		Fall 2025: Increased home care caregiving training subcontract reimbursement amounts due to increased number of trainings hours with increased workforce. CDWA has reduced hiring timeline to hire 90% of individual providers within 30 days and are working to reduce that to 21 days. This has reduced the number of clients waiting on providers through this source.

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: 12/2025	7.01 planning meeting occurred March 23, 2026.
2. Create and complete 7.01 plan with Suquamish Tribe.	• Coordination, meetings, and plan finalization. Completion Date: 12/2025	Coordination efforts occurring through Office of Indian Policy. As of July 2026, a mutually agreed upon meeting date is not established.

Issue Area C-5 **COVID-19 Response Services & Supports**		
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.		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
1. Continue availability of nutrition services and other social services for older and homebound individuals.	• 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	Beginning July 2024, remaining American Rescue Act, existing Older Americans Act, and new state nutrition funding was used to expand nutrition subcontractors to add the Kitsap Food Bank Coalition members (7) to develop or sustain senior nutrition services in food banks. January 2025 additional state nutrition funds were provided to the Port Gamble S'Klallam Tribe's elders program to meet emergency needs.

	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: 12/2025	Analyzed expenditures to ensure all ARP funds were expended by September 30, 2025. Submitted final reimbursement for stimulus funds. All funds were spent, effective October 1, 2025. SFY 2026-2027 the Washington State legislature passed a biennial budget to include new state funding older adult nutrition funds. These funds have been subcontracted to continue the COVID food bank programs. These funds have also expanded home delivered meals and Tribal Elders programs.

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 55% staff turnover since January 2020.		
Measurable Objectives	**Key Activities**	**Accomplishment or Update**
1. Maintain adequate staffing and timely recruitment of vacancies to continue to provide direct services and expand the network.	• 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: 12/2024	Developed remote working protocols for positions that allow flexible remote work office location up to 3 days a week, with remaining days of the week in the office. A majority of positions require at least 2 days a week in the office. Following probation, countywide compressed work weeks and flexible work hours have remained consistently available. ALTC has adopted a hybrid work schedule that allows most staff to flexibility to work from home up to 3 days a week, with 2 days a week in the office. Fall 2024, the Medicaid team piloted sharing cubicles for staff that only worked minimum days in the office. The hybrid work location flexibility has allowed for staff capacity expansion within existing space through office desk sharing for staff that work from home on alternating days. Alternate office locations to Port Orchard (Poulsbo, Bremerton) offer options for staff that decrease commuting. They also improve public access and enhance working relationships across programs. In 2025, recruitments from posting to filled position takes on average 7 weeks. As of March 2025, all posted direct service positions were filled. January 2025, there was a Countywide compensation study and wage increase to retain and recruit.

Statement of Assurances and Verification of Intent

For the period of January 1, 2027, through December 31, 2030, 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) (as amended through 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 goal objectives with emphasis on older individuals and unpaid family caregivers who have the greatest social and economic need.

All agreements with providers of OAA services shall require the provider to specify how it intends to satisfy the service needs of older individuals and unpaid family caregivers who have the greatest social and economic need within the Planning and Service Area.

Provide information and assurances concerning services to older individuals who are American Indians, including:

Information concerning whether there is a significant population of older American Indians 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 American Indians 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 American Indians.

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 the base fiscal year 2026 on the State Long-Term Care Ombudsman Program.

Kitsap County Aging and Long-Term Care has received approval from the State Unit on Aging, Home and Community Living Administration to directly provide certain Title III services using OAA funding consistent with sections 307(a)(8)(A) of the OAA and 45 CFR 1321.65(b)(7).

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/HCLA. 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.

Stacey Smith, Administrator Kitsap County Aging and Long-Term Care	Date
Steve McMurdo, Advisory Council Chair Kitsap County Aging Advisory Council	Date
Oran Root, 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	Date