AREA PLAN 2020-2023

UPDATE **2020-2021**

Kitsap County Division of
Aging and Long Term Care

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

Stacey Smith, ALTC Administrator

Sponsored by
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Introduction

Welcome to the Kitsap County Area Agency on Aging 2020-2023 Area Plan.

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

In 1965, the United States Congress enacted the Older Americans Act, and in 1973 the Older Americans Act Comprehensive Services Amendments established the Area Agencies on Aging (AAA). AAAs are responsible to plan, coordinate and advocate for the development of a comprehensive service delivery system at local levels to meet both the short- and long-term needs of older persons in their planning and service area. The AAA focuses on services that promote healthy aging and options that support aging and older adults with disabilities to live as independently, and with as much dignity as possible. There are 628 Area Agencies on Aging across the country, and 13 Area Agencies on Aging in Washington State.

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

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

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

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

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

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

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

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

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

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

The total ~~2020~~ 2022budget is approximately $~~4.6~~ million. However, the community fiscal impact – which includes AAA non-budgeted services such as in-home care by agencies and individual providers, and ancillary services – brings the total to approximately $~~21,751,000~~.

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

Update: 2020-2021

In 2021 there is a required two-year update to the four-year 2020-2023 Area Plan. The updated sections explain what has changed, what has been accomplished to date on the goals and objectives, and changes planned over the next two years.

Significant highlights and changes for the 2020-2021 period include:

- Focused efforts to accomplish objectives around Alzheimer's Dementia and Memory Care.
- Programs that were suspended due to lack of resources to support them or impacts of the COVID-19 pandemic.
- Coordination on 7.01 plans detailing Kitsap County Aging and Long-Term Care (ALTC) services to specific tribes' needs has been ongoing. The plans were updated in 2021 and are included in this Area Plan update.
- Staff turnover at ALTC that has entailed hiring and orientation of new direct social services, fiscal staff, and administrative support services staff.
- A new *COVID-19 Response Services and Supports* issue area was added. The section describes how ALTC pivoted crucial services to maintain compliance with the Major Disaster Declaration orders while engaging the local community with new services and supports to meet needs such as food scarcity, social isolation, vaccine access assistance and other local needs of older adults and caregivers.
- Updated Area Plan budget section and updated appendix sections including the organization chart, staffing plan, emergency response plan activities, Advisory Council roster, public process chart and report on accomplishments.

Questions or comments may be directed to:

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Mission, Values, Vision

Kitsap County

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

Department of Human Services

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

Aging and Long-Term Care

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

Our Objectives are to . . .

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

The Planning and Review Process

The Kitsap County Aging and Long-Term Care (ALTC) 2020-2023 Area Plan was developed as the combined product of earlier Area Plans, years of delivery and coordination of local services, needs-analysis based on community survey responses, current trends and identified needs in the aging network and Kitsap County.

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

Focus themes include:

- Healthy Aging
- Delay of Medicaid-funded Long-Term Services and Supports
- Long Term Services and Supports
- Tribal Partnerships and 7.01 plans
- COVID-19 Response Services and Supports

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

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

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

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

ALTC staff analyzed the combined body of knowledge and developed recommendations for planning issues and objectives. These results were presented for review and comment to the Advisory Council in a public meeting conducted by that body. Incorporating the Council's recommendations, ALTC staff drafted the final text for the planning objectives in the 2020-2023 Area Plan, Section C.

The 2020-2023 Area Plan Update includes accomplishments for ~~2018-2019~~ 2020-2021 and 7.01 plans for the Port Gamble S'Klallam Tribe and the Suquamish Tribe. It also includes the 202~~0~~2 Area Plan budget and cost allocation plan.

The draft plan was presented at a public Kitsap County Board of County Commissioner work study session on September 8, 2021 ~~August 14, 2019~~; and at the Aging Advisory Council for public review and comment on June 16 and August 18, 2021. ~~formal public hearing on Monday, September 9, 2019.~~ Opportunity for questions and comment is offered to all in attendance. Anyone not able to attend the public meetings or hearing could request a copy and offer comments by mail or email. It was also posted on the ALTC website from ~~August 19- September 11, 2019~~, and available in hardcopy at the ALTC office.

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

The public process for the 2020-2023 Area Plan Update is described in Appendix E.

Prioritization of Discretionary Funding

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

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

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

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

  COVID stimulus revenue is considered discretionary funding with the Washington State Major Disaster Declaration. Once the Governor lifts the declaration the stimulus funding reverts to non-discretionary funding.

Of the 202~~0~~2 annual ALTC budget, approximately ~~70%~~ is considered "nondiscretionary" 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 202~~0~~2 annual budget includes about ~~30%~~ 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.

Kitsap County traditionally had adequate discretionary resources to address services identified through the planning process as being essential to the safety and well-being of older adults and persons with disabilities. However, ~~in recent years~~ funding shortfalls occurred - even with good planning and coordination with other entities over the use of funds administered for a mutually shared target population.

Historically, reductions to SCSA experienced in 2010 have not been totally recovered. Additionally, due to Federal sequestration impacts in 2013, many programs faced reductions to services. Decreases in available Older Americans Act dollars (a major fund source and one which provides for some local discretion), placed an undue burden on SCSA (a funding source which grants us more discretionary authority). The revenue decrease impacted Senior Nutrition Services, Older Adult Counseling, and Senior Legal Services. In 2017 SCSA received a 2% vendor rate increase and an additional 2% increase in 2018. However, for 2020, SCSA received a 1% decrease in funds. Comparing SCSA funding in 2009 to 2020 there is a total 4% reduction in funding.

Beginning March 2020 COVID stimulus funding was allocated to Area Agencies on Aging to support local needs of older adults as a result of COVID public health directions. The stimulus funding included the Family First Coronavirus Response Act (FFRCA), Coronavirus Aid, Relief, and Economic Security (CARES), Coronavirus Preparedness and Response Supplemental Appropriations Act (CPRSA), Consolidated Appropriations Act (CAA)—Nutrition and AAA Vaccination Assistance funding, Coronavirus Response and Relief Supplemental Act (CRRSA) No Wrong Door Vaccine Access, SEIU Vaccine Navigation Assistance, and the American Recue Plan (ARP). Statewide the stimulus revenue totals more than $36.5 million and spans 2020 to 2024.

~~***While funding resources remain stagnant or decline, our area is experiencing increased needs of a growing older adult population.***~~

~~When considering funding reductions, this agency continues to have contingency plans. These could include 1) waiting lists, 2) reducing services, 3) raising eligibility requirements, 4) eliminating or subcontracting direct services and/or staff. Projected administrative costs that cannot be covered by applicable fund sources would require staff reduction in hours (furloughs) or elimination of positions with a consequential reassignment of workload.~~

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

There are three components in the service prioritization formula:

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

In the event of gaps in local services and with additional funding due to COVID recovery, ~~a funding shortfall~~, Aging and Long-Term Care staff, with guidance from the Advisory Council, will recommend service funding priority levels and program services.

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

SECTION B
Planning and Services
Area Profiles

B-1 Kitsap County Population Profile

Kitsap County occupies a unique portion of Washington State, directly between the urban areas of Seattle and Tacoma and the wilderness of the Olympic Mountains. It is bounded by the Hood Canal on the west, Puget Sound on the east, and Mason and Pierce Counties to the south. The Kitsap Peninsula is surrounded by water on three sides and includes two islands. Two main bridges, the Tacoma Narrows and Hood Canal floating bridge, link Kitsap to the surrounding land masses. Four ferry terminals connect Kitsap by water directly to King and Snohomish counties. In the past two years, three additional fast passenger ferries have been added to routes. Kitsap County is situated along the western shore of the central Puget Sound region. It comprises a total land mass of 393 square miles (or 0.6 percent of the state's total land mass). Kitsap County ranks 36th in geographic size among Washington counties, 6th in total general population and is the 3rd most densely populated county in the state. Kitsap County is also noted for offering the "most waterfront" among all the counties. According to the Census Reporter ~~U.S. Census Bureau 2018~~ data, the estimated population of Kitsap County is ~~269,805~~ 271,473. The County seat is in Port Orchard.

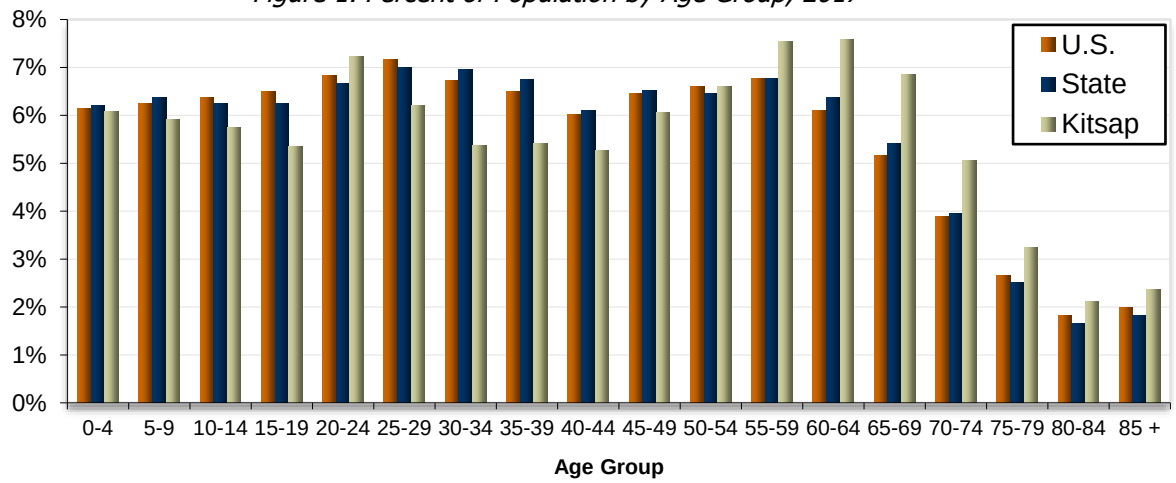
There is a distinctive military presence, active and retired, throughout the County. Naval Base Kitsap is the 3rd largest installation in the US Navy, and the largest on the west coast. According to the Kitsap Economic Development Alliance, "Kitsap is home to over one third of the region's defense workforce of which 90%+ are civilian employees. With more than 33,800 daily workers, including 16,200 military personnel, 17,600 civilian personnel and 7,500 defense contractors[1]". Kitsap veterans comprise 17.5% of the total population[2].

In Kitsap County 8.3% of the total population lives in poverty. It is important to note that while net County growth has historically been accompanied by increased economic activity, the aging of our adult population will be characterized by fixed and falling incomes. Additionally, government resources for social and health programs serving older persons have ~~experienced reductions or~~ remained stagnant, while being stretched across a rapidly expanding older population. Safe and affordable housing has become increasingly more difficult to find due to rapid general population growth as a result of fast ferries and a strong economy. According to Redfin, Kitsap County home prices were up 24.9% compared to last year and selling for a median price of $500,000. According to Kitsap Sun, the average rent grew more than 10% from last year, and more than 60% in the past six years.

[1] Kitsap Economic Development Alliance http://kitsapeda.org/key-industries/defense/ accessed July 29, 2019
[2] LiveStories Statistics https://www.livestories.com/statistics/washington/kitsap-county-veteran-demographics accessed July 29, 2019

Kitsap County continues to experience significant growth in the aging population. Figure 1 demonstrates the higher rates in comparison to state and national trends.

Figure 1. Percent of Population by Age Group, 2017



[3]

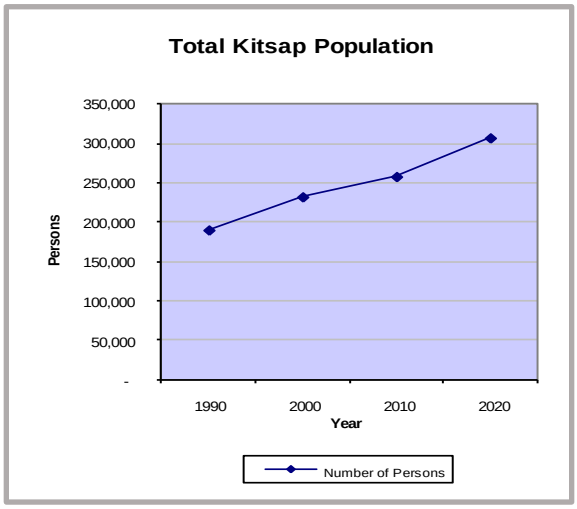
Census data from 2010 indicates that the 60+ population was 49,674 representing an increase of 51% from 2000 and 84% from 1990. The 85+ population was 4,510 representing an increase of 46% from 2000 and 137% from 1990.

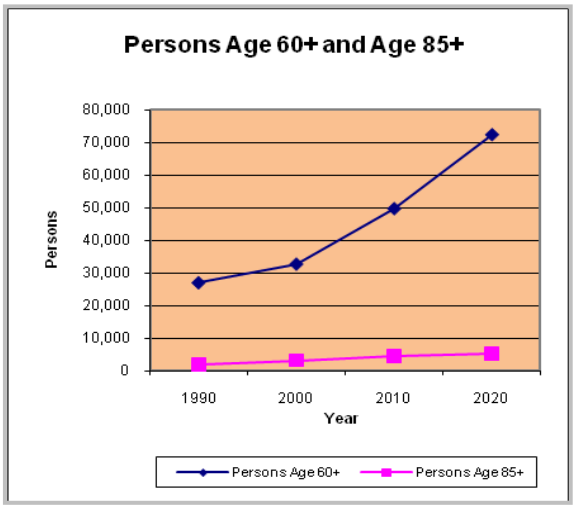
More recent 2017 census data indicates the 60+ population is 71,954, representing an increase of 45% from 2010 and 107% from 2000. Data also indicates that the 85+ population of 5,612 represents an increase of 38% from 2010 and 102% from 2000.

In 2010 of all people living in Kitsap County, 20% were older adults. It is now projected in 2020, 34% of all County residents will be 60 years of age or older.

[3] Kitsap County Data Tables – Washington Office of Financial Management, U.S. Bureau of Economic Analysis

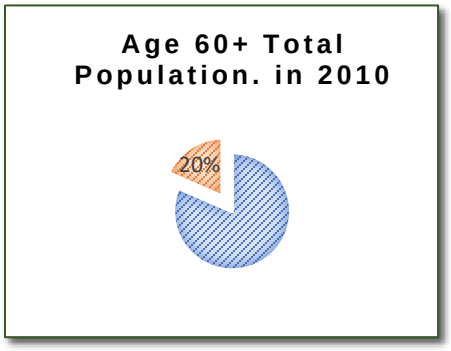
Figure 2. Kitsap County Population Trends 1990-2020

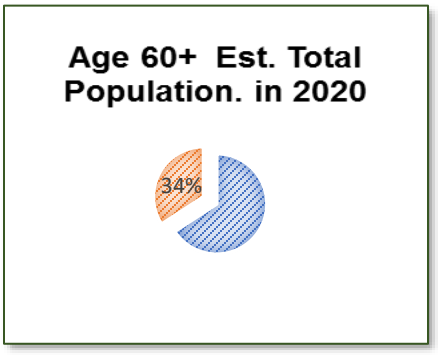




In Figure 2, we see a challenging trend. Using midpoint projections (neither the highest nor the lowest estimates) from the Washington Office of Financial Management (2000 data), growth projection for total Kitsap County is 22 percent by 2020, while the 60+ population is anticipated to grow by 46 percent. And within that statistic is the equally challenging fact that the population 85+ is already larger than data projections for 2020. These trends will continue to have severe implications for the County as a community, as well as for the shrinking service dollar.

Figure 3. Kitsap County Age 60+ Population Percentage 2010-2020





Previous population growth estimates indicated that by 2020 one in every four County residents will be over the age of 60. Today, the estimate for 2020 is one in three.

These shifting demographics are not unique to Kitsap County. As a result of the remarkable improvements in health education, medicine, nutrition and general living standards over the last century, people who reach age 60 can now expect to live almost 25 more years. Further, as life expectancy rises, the number of “oldest old” (age 85+)

also increases. For this reason, programs and policies directed to the 60+ population must consider the needs of at least two generations of older adults.

Figure 4. 2020 Kitsap County Population Age 55+[4]

Age	Population	% of total County population	Male	% total	Female	% total
55 to 59 years	18,954	7	9,314	3.4	9,640	3.5
60 to 69 years	37,841	13.75	17,936	6.5	19,905	7
70 to 79 years	26,294	9.5	12,372	4.5	13,922	5
80 and older	10,990	4	4,687	1.7	6,303	2.3
Total age 60+	94,079	34	44,309	16	49,770	18

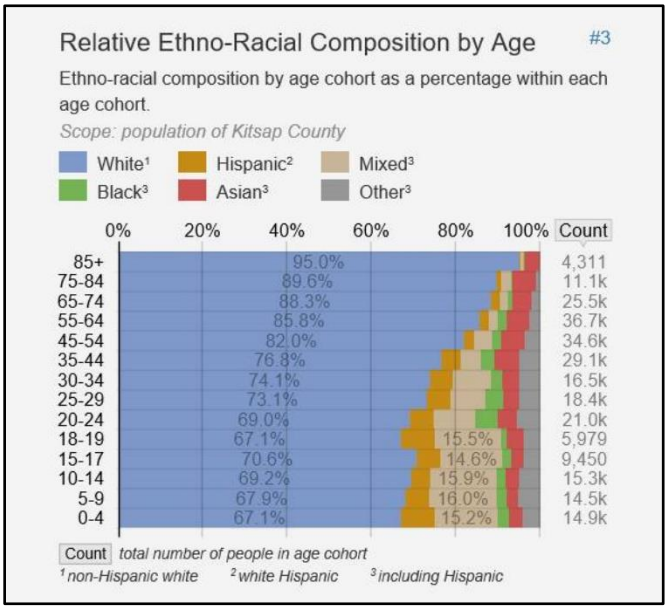
DIVERSITY AND MINORITY POPULATION CONSIDERATIONS

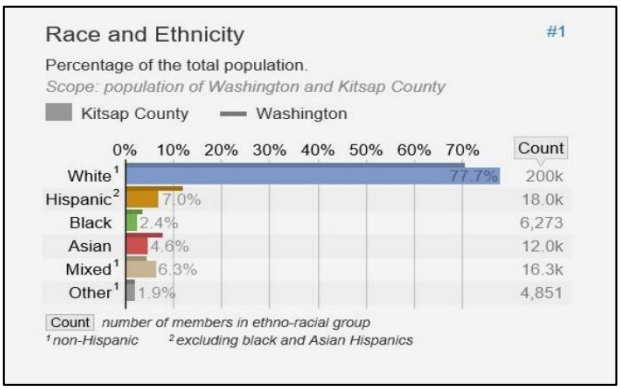
Along with the general 60+ population growth, Kitsap's older adult community continues to become more ethnically diverse as well. While the growth in minorities slowed somewhat from the decade 1980 to 1990, according to Census 2000, the growth of ethnically diverse older adults increased by over 65%, to 5.8% of the 60+ population. 2010 Census data shows even greater growth of ethnically diverse elders of 82% since 2000, to 6.91% of the 60+ population. This growth was attributable to growth within the Asian, Native Hawaiian and Pacific Island communities. In 2000; the number of elders in these groups had grown to 1,578; and in 2010 almost doubled to 2,935. The predominant ethnic/minority group identified among Kitsap's elders at the time was Asian, followed by African American, Native American and then Native Hawaiian and other Pacific Islanders.

In 2018, the predominant race and ethnic minority groups identified among Kitsap's older adults are Hispanic, followed by mixed, Black, Asian, and other. *See Figure 5*.

[4] Washington Office of Financial Management, U.S. Bureau of Economic Analysis

Figure 5. Kitsap County Population 55+ by Race – 2018 [5]





85 + .05% Hispanic, .06% Mixed, .02% Black, 3.6% Asian, .03% Other
75-85 1% Hispanic, 2% Mixed, .04% Black, 5.7% Asian, 1% Other
65-74 2% Hispanic, 1.9% Mixed, 1.2 % Black, 4.8% Asian, 1.9% Other
55-64 1.8% Hispanic, 2.4% Mixed, 1.8% Black, 5.4% Asian, 2.7% Other

From the Census's yearly American Community Survey, from 2015-2019, the most spoken languages in Kitsap were English (232,750 speakers), followed by Spanish (5,976). After that, Tagalog or Filipino (4,915), Other Asian and Pacific Island languages (2,031), Other Indo-European languages (1,170), German (1,009), Chinese (652), French, Haitian or Cajun (525). All other language groups were estimated to have less than 500 people ~~speaking them~~ in Kitsap.

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

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

[5] Percentages rounded © OpenStreetMap contributors, US Census Bureau https://statisticalatlas.com/county/Washington/Kitsap-County/Race-and-Ethnicity- accessed July 30, 2019

ALTC also recognizes the need for engagement strategies and for older Lesbian, Gay, Bisexual and Transgender (LGBT) individuals and their families. In 2016, approximately 4.1% of American adults identified as lesbian, gay, bisexual or transgender, .3% as transgender. In Washington state, 4.6% of adults in the total state population identified as lesbian, gay, bisexual or transgender.

In 2018, approximately 4.5% of American adults identify as lesbian, gay or bisexual, or transgender. Washington State is one of ten U.S. States with the highest number of adults identifying as lesbian, gay or bisexual, at 5.2% of the total state population[6].

Kitsap County Demographic Characteristics[7]

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

[6] Accessed on August 1, 2019 at https://williamsinstitute.law.ucla.edu/impact/data-in-review-2018/

[7] 2020 and 2025 data derived from Selected Population and Aging Service Utilization Forecast, Kitsap County Division of Aging & Long-Term Care. "Forecasts of the Aging Population, Dementia Prevalence and Use of Long-Term Care Services through 2030 in Washington State" Technical Report. David Mancuso, PhD and Jingping Xing, PhD June 2019 DSHS Research and Data Analysis Division Olympia, Washington.

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

Demographic	2010 ALTSA Forecast	2020 ALTSA Forecast	2025 ALTSA Forecast
Age 60+ in Rural Areas[9]	8,929	NA	NA

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

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

Changing demographics and populations represented in Kitsap County are considered throughout the Area Plan.[10]

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

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

B-2 AAA Services and Partnerships

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

ADULT DAY SERVICES:

Adult Day Care:

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

Adult Day Health:

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

BEHAVIORAL HEALTH SERVICES

Older Adult and Family Caregiver Support Mental Health Counseling:

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

Substance Abuse Counseling:

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

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

Dementia Consultation

Services include specialized consultations provided in home or facility, education and resources for caregivers, and behavioral strategies for managing care. Services are provided at no charge to individuals experiencing dementia and informal caregivers supporting a person with dementia. This service assists with community placement stabilization by providing support to care facility and informal caregivers.

This service is funded with Mental Health 1/10th of 1% tax funding.

FAMILY CAREGIVER SUPPORT PROGRAM

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

INFORMATION & ASSISTANCE/COMMUNITY LIVING CONNECTIONS:

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

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

I&A assists older adults to access necessary support services. Services are designed to achieve and maintain the maximum level of health and independence as possible. The I&A program is responsible for I&A program publicity and developing and maintaining information about community resources that serve older people and caregivers.

KINSHIP CAREGIVER SUPPORT PROGRAM:

The Kinship Caregiver Support Services Program provides referrals for services and limited financial assistance to eligible kinship caregivers (grandparents and relatives

raising children) by assisting them to obtain resources necessary to help stabilize the family. These services are frequently utilized by grandparents raising grandchildren.

LEGAL ASSISTANCE PROGRAM 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 bar associations through lectures, group discussions, and the media. The most requested service is assistance with landlord/tenant issues.

LONG TERM CARE OMBUDSMAN:

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

In 2018 the Ombudsman program provided over 10% of the total hours in Washington State while receiving only 4% of the total revenue.

MEDICAID CASE MANAGEMENT:

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

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

In 2019 ALTC had the highest client to case manager ratio in the state, 92:1.

Medicaid Transformation Demonstration:

Washington State and the Centers for Medicare and Medicaid Services (CMS) finalized a 5-year Medicaid Transformation Demonstration (MTD) agreement with goals to improve healthcare for families and control costs.

The Medicaid Alternative Care and Tailored Supports for Older Adults (MAC/TSOA) program was created to address the needs of a growing aging population through new program benefits to preserve and promote choice in receiving services, support families to care for loved ones and increase caregiver well-being, and to delay or avoid the need for more intensive and costly Medicaid-funded long-term services and supports when possible. ~~Legislative advocacy to continue the program beyond the five-year demonstration is currently underway.~~ Washington State Health Care Authority, on behalf of Department of Social and Health Services, has requested an additional extension year for calendar year 2022. Currently, ALTC staff are participating in the statewide efforts to submit a renewal Waiver for year 7 of the program, beginning calendar year 2023.

Medicare Improvements for Patients and Providers Act:

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

Nursing Services:

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

NUTRITION SERVICES:

Home Delivered Meals:

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

Community Dining Sites:

Congregate Nutrition services help meet the complex nutritional needs of older persons by providing nutritionally balanced meals and other nutrition services, including nutrition outreach and nutrition education in a group setting at local community dining sites. There are eleven meal sites at various Kitsap County locations. Ethnic-specific food is provided at three meal sites in Native American and Asian/Pacific Islander communities including: Port Gamble S'Klallam Tribal Elders and Silverdale and Port Orchard Asian/Pacific Islander sites. These sites provide a healthy meal and socialization for local older adults.

In 2020-2021, all the community dining sites closed as a result of COVID. Many sites adapted a "grab and go" model and enhanced the home delivered programs.

Senior Farmer's Market:

Low-income seniors, 60 years or older, can qualify for farmer's market checks, worth a total of $40, that can be used to buy locally grown fresh fruits and vegetables at many farmer's markets and some roadside farm stands across the state from July through October. This program promotes community connections and decreased isolation, nutrition with fresh fruits and vegetables, as well as support for local farmers.

Additionally, with support from other funding sources, homebound seniors 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.

RESPITE CARE SERVICES:

In-Home and Out-of-Home Respite Services:

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

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

SENIOR DRUG EDUCATION PROGRAM:

Senior Drug Education provides adults, age 60 and older, education and information on safe and effective use of medication (prescription drugs, vitamins and herbs) through seminars presentations, health fairs, education materials and one-to-one education and consultation.

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

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

ALTC Partnerships

Aging and Long-Term Care is involved in multi-tiered efforts to integrate local systems and services and participates in statewide and national efforts. This includes integrating community-based care with traditional partners, as well as creative outreach to non-traditional ancillary service providers. ALTC staff are involved in robust community-

based workgroups to address local needs through coordination of care approaches to reduce duplication of efforts, provide for smoother transitions and more individualized care. A list of the local workgroups is in the table below.

ALTC System Integration and Service Coordination Efforts

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

Committee Name	Purpose of Committee	Frequency of meetings
HealthCare Coalition	Facilitated by ~~Kitsap Health District and~~ 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~~ Monthly
Kitsap County Cross Continuum Care Transitions Project (KC4TP)	Formal Steering Committee that improves safety, quality of care and client satisfaction with care transitions in Kitsap County. There are several subcommittees to address local needs: • Steering Committee • Palliative Care • Patient Education • Home Health • Medication Management	~~All Partners meeting is quarterly.~~ ~~Subcommittees meet monthly.~~ Due to COVID, this meeting and subcommittee meetings have been cancelled and not re-scheduled.
Vulnerable Populations Taskforce	Co-led by Kitsap County Department of Emergency Management, Public Health, and Aging and Long-Term Care to strategize about local disaster preparedness for vulnerable individuals throughout the County.	~~Quarterly~~ Due to COVID, this meeting has been revised to the weekly Emergency Operations Command Partner Teams meeting.

Committee Name	Purpose of Committee	Frequency of meetings
Functional Assessment and Services Team (FAST)	Subcommittee that works in collaboration with local Kitsap County Department of Emergency Management and Red Cross to provide shelter and specialized services in disasters.	Due to COVID, this meeting has been cancelled and not re-scheduled.
Vulnerable Adults Taskforce	Led by Kitsap County Prosecutors Office to problem solve vulnerable populations interface with local law enforcement; policy and protocols.	~~Quarterly~~ Due to COVID, this meeting has been cancelled and not re-scheduled.
Long Term Care Alliance	Forum to share local services updates, problem-solve common community concerns, and plan annual Older Americans conference.	Monthly
Regional Resource Team (RRT)	Facilitated by DSHS Adult Protective Services ~~Attorney General office staff~~ to share system and service information for high profile "client of concern" cases.	Monthly
Provider Breakfast (local Long-Term Care Agencies)	~~Facilitated by ALTC staff to~~ Provides a formal venue to share local system and service information.	Monthly
Kitsap Healthy Eating Active Living	Facilitated by WSU. Goals include: Increase equitable access to healthy foods and opportunities for active living.	Quarterly
Kitsap Information & Referral Network (KIRN)	A network of Information and Referral professionals from human services organizations facilitated through Peninsula's 211 to share program information, network, and facilitate referrals.	Monthly
Kitsap Continuum of Care Coalition (KCOCC)	Provides leadership to end homelessness through planning, coordination among social services providers, advocacy and education.	Monthly
Voter Access Advisory Committee	Hosted by the Kitsap County Auditor's office, this is a diverse group of county residents representing advocacy groups and Kitsap County employees providing	Annual and as needed

Committee Name	Purpose of Committee	Frequency of meetings
	expertise and guidance regarding Kitsap's Voter Access Plan.	
Guardian Luncheon	Opportunity to network with local guardians to share information and establish relationships with AAA Long Term Care Ombudsman.	~~Monthly~~ Due to COVID, this meeting has been cancelled and not re-scheduled.
Kitsap Quarterly Network Provider & Partner Meeting	Facilitated by ALTC staff to review system, policy changes and enhance cross-agency communications. Incudes local HCS, DDA, APS and ALTC staff and subcontractors.	Quarterly
Ethics Board with local hospital (Harrison Memorial Hospital)	Hospital staff facilitate meeting that includes AAA Ombudsman to review current practices, protocols, and case reviews of hospital admitted patients with end of life issues.	Quarterly
Kitsap County Human Services Department-Program Managers	County Human Services Program Managers meeting to discuss and plan for DSHS, HCA, and other social service integration efforts.	Monthly
Kitsap Suicide Prevention	Facilitated by Kitsap Human Services Deputy Director to address suicide rates and prevention strategies. Attendance from schools, social services, health providers, veteran groups, League of Women voters, and Aging.	Quarterly

COVID-specific county efforts

The following COVID specific meetings began in 2020 to increase communication. Kitsap County Aging and Long-Term Care (ALTC) participates in the following meetings:

Committee Name	Purpose of Committee	Frequency of meetings
Kitsap Department of Emergency Management Partners Meeting	Facilitated by Kitsap County Department of Emergency Management to provide communication of local resources, COVID testing and vaccine sites, quarantine and isolation facilities, and other community-based partner information.	Weekly
Kitsap Public Health Board Meeting	Facilitated by the Kitsap Public Health Board of Directors to share local information with the public related to COVID.	Monthly
Kitsap Public Health Long Term Care Planning Meeting	Co-facilitated by Kitsap Public Health and Aging & Long Term Care to share information with the local long term care facilities.	As needed
Kitsap Department of Emergency Management	Facilitated by Kitsap County Department of Emergency Management to plan for COVID response and disaster planning.	Daily meeting-participate upon request
Kitsap Long Term Care Ombudsman Volunteer meetings	Facilitated by Kitsap ALTC Regional Ombudsman to communicate information to the volunteer Ombudsman about access and outbreaks to long term care facilities across Kitsap.	Weekly

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
Homes for All Leadership Committee	Address local efforts to combat homelessness through development of Tiny Homes. Facilitated by County Commissioner and attended by local community leaders and activists.	~~Monthly~~ Due to COVID, this meeting has been cancelled and not re-scheduled.
DSHS Region 3 Residential Care Services	Coordinate between Residential Services staff (licensures and investigators) and regional Ombudsman.	~~Sporadic~~ Due to COVID, this meeting has not been scheduled.
DSHS Region 3 Housing & Supportive Employment Collaborative	Coordination between state program and local providers of Housing and Supportive Employment Programs	Quarterly

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

Committee Name	Purpose of Committee	Frequency of meetings
W4A (Washington Area Agency on Aging Association)	Association of local AAA's to share information, discuss proactive solutions to common issues, and advocate for flexible system reform.	Monthly
Community Living Connections- Policy Maintenance & Recommendation Committee (PMRC)	Statewide committee involving Aging and Long-Term Support Administration (ALTSA) of Department of Social and Health Services and Area Agencies on Aging staff to review and suggest policy ~~and resource~~ standards for Community Living Connections.	Monthly
Community Living Connections- Resource Subcommittee	The CLC-GetCare Resource Directory will assist staff and provider agencies across the state to assist individuals to understand and access options. It will also be available online for anyone to view and search. In order for the directory to be accurate and relevant, a clear operational structure for coordinated statewide input and updates is imperative. As part of this, a CLC-GetCare Resource Directory Subcommittee was formed.	Monthly
Long-Term Care Ombudsman Programs	Statewide conference calls for program monitoring. Statewide meetings for continuing education and program enhancement.	Monthly ~~Annually or Bi-Annually as time and funding allow.~~ Due to COVID, these meetings have not been scheduled.

Committee Name	Purpose of Committee	Frequency of meetings
Area Agency on Aging and Aging and Long-Term Support Administration Contract Manager Meetings	Statewide webinar/conference call meetings to discuss monitoring, contracting and policy including changes, processes and best practices.	~~Quarterly or more often as needed~~ Monthly
Washington State Council on Aging (SCOA) Kitsap AAA Advisory Council member is a representative.	SCOA is a unique advocacy group for senior issues and a unified voice across Washington. Members are appointed by the Governor and AAA Advisory Councils and are charged with advising the Governor, DSHS Secretary and Assistant Secretary of ALTSA. (RCW 43.20A.695). Members are representatives of local communities, Area Agencies on Aging Advisory Councils, cities & counties, the legislature, and the long-term services and supports field. The membership provides SCOA with a built-in communications and outreach platform with statewide reach.	Monthly 8 months out of the year.

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. DSHS, working in collaboration with community partners, government agencies, tribes, and local jurisdictions, and with the support of philanthropic organizations, created Washington Connections to improve residents' access to services and benefits and easily and securely apply for services.	Quarterly

Note: Meetings were held virtually or postponed in response to COVID-19 pandemic.

B-3 Designated Focal Points- Kitsap County

Organization or Site Name	Focal Point Address	Public Contact Information	Services Coordinated at the Site
Aging & Long-Term Care Givens Community Center	1026 Sidney Ave Suite 105 Port Orchard, WA 98366	360-337-5700 *or* 1-800-562-6418 seniorinfo&asst@co.kitsap.wa.us	AAA direct services: Senior Information and Assistance Medicaid Long Term Care and Medicaid Transformation Demonstration ~~and Health Home~~ Case Management Long Term Care Ombudsman Program Additional services: Senior Center- Friends of Givens Kitsap Recovery Center
Caregiver Support Center	9857 Silverdale Way Silverdale, WA 98383	360-337-5700 *or* 1-800-562-6418	AAA Family Caregiver Support Program Scheduled Contracted Counseling meetings

Organization or Site Name	Focal Point Address	Public Contact Information	Services Coordinated at the Site
Fishline (North Kitsap)	19705 Viking Ave NW PO Box 1517 Poulsbo, WA 98370	Admin/Operations 360-779-4191 Client Services- Comprehensive Services Center 360-779-5190 info@fishlinehelps.org	AAA Family Caregiver Support Program, Senior Information and Assistance, MAC/TSOA. ~~Additional services:~~ Services at Fishline ~~services~~: Food Bank, ~~Housing, Utilities~~ Utility & Rental Assistance, Mobile Shower, Case Management/Social Work, Transportation, ~~Health/ Budgeting~~, Employment/Education, Children Services Additional Comprehensive Services Providers: Peninsula Community Health Services-Dental Kitsap Mental Health Services Department of Social & Health Services Kitsap Community Resources: Housing

Organization or Site Name	Focal Point Address	Public Contact Information	Services Coordinated at the Site
			Solutions Center, Family Development, Energy Assistance American Legion (Veteran Services Officer) Dispute Resolution Center: Mediation, Education & Behavioral Health Ombudsman Kitsap Sexual Assault Center (KSAC) Crime Victim Assistance Center (CVAC) Sound Works Job Center YWCA (Domestic Violence)

SECTION C
Issue Area Themes

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

C-1.1 Healthy Aging in an Age-Friendly Community

PROFILE OF THE ISSUE

The percentage of individuals living beyond 60 years is increasing at levels never seen in human history. We live with technology and medical advances that rapidly change. In the United States the “baby boom” generation, the largest ever born (78 million Americans), is also in the process of transforming American society as it moves into its older years. Baby boomers are changing the expectations of aging, and by necessity, highlighting the importance of communities that provide affordable and accessible opportunities for people to age in place.

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

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

The vision of an Age-Friendly Community:

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

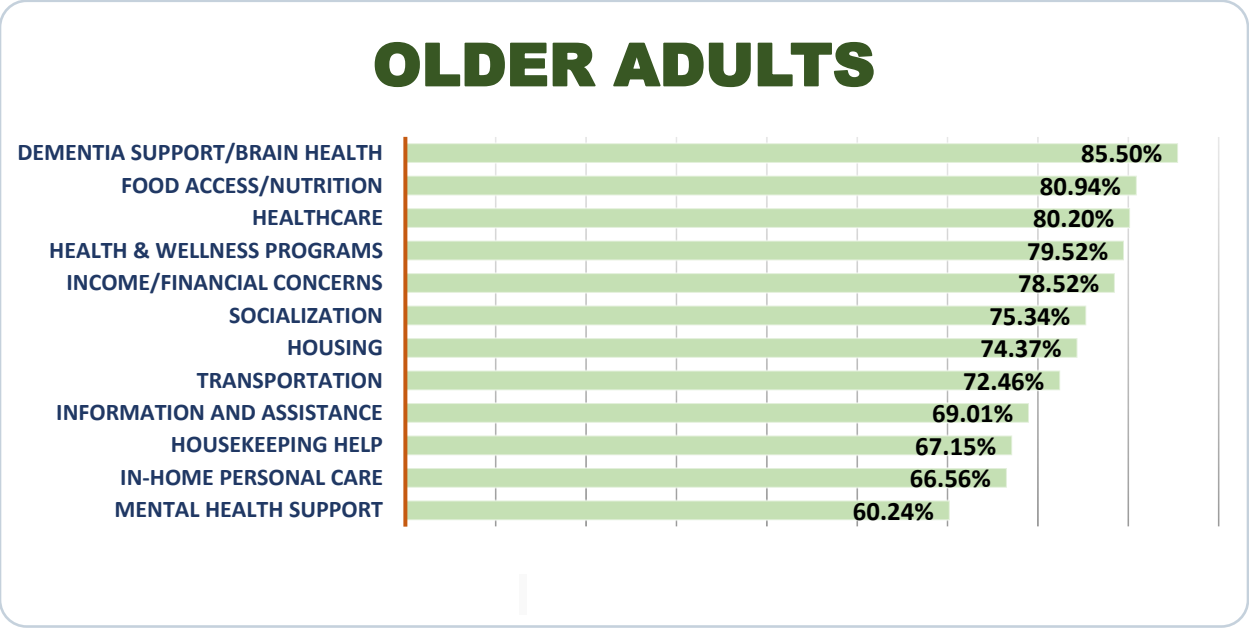
Change that enhances older adults’ quality of life will improve conditions for everyone because Age-friendly communities are good places for people of all ages and abilities to live. Age-friendly communities become communities of choice for everyone.

Kitsap County Aging and Long-Term Care surveys local public, seniors, caregivers, nutrition program participants, and providers with the goal of preparing the county to respond to growing demands. In 2019, ALTC received over 700 surveys. The objective continues to be to identify the most critical issues necessary to creating and maintaining a community that would respond to these needs and be socially enriching in the process. In the 2019 survey, and surveys completed for prior area plans, several commonly identified issues consistently surface. It is interesting to note that although issues identified by respondents may shift in priority, (needs change as the population ages in place, the economy fluctuates, transportation costs rise, and cultural perspective shifts occur), fundamentally the *overarching issues remain constant*. Therefore, they continue to be a focus. Issues are outlined below, and in the goals and objectives to be addressed over the next four-years.

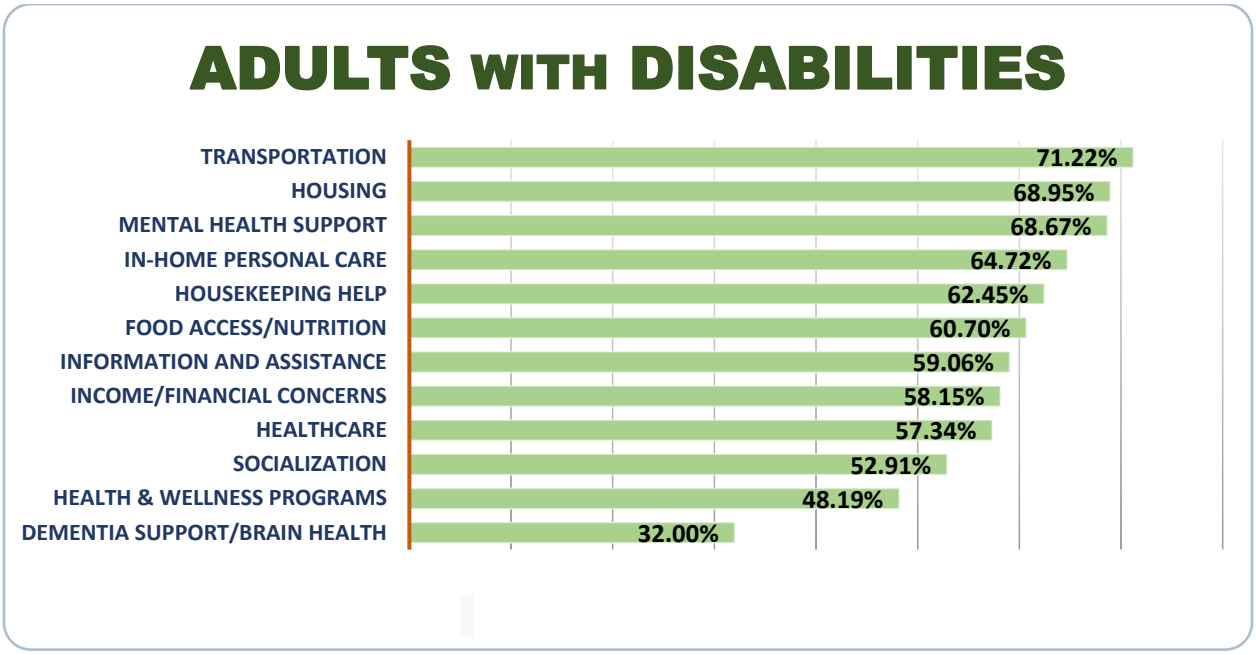
2019 Community Needs Survey: Data and Trends

PRIORITY NEEDS OF TARGET POPULATIONS

Ensuring that basic needs are met is critical for all community members. In the 2019 Area Plan Community Needs Survey, respondents were asked to identify the top three needs for older adults and adults with disabilities. Basic needs are interrelated and strongly connected to additional factors that affect all areas of a person's life. For example, the rising cost of healthcare has the potential to directly impact the ability to afford housing or food in our area. Below is a graph depicting results that the **top concerns of older adults are dementia support and brain health, food access and nutrition, health care and wellness programs, and socialization.**

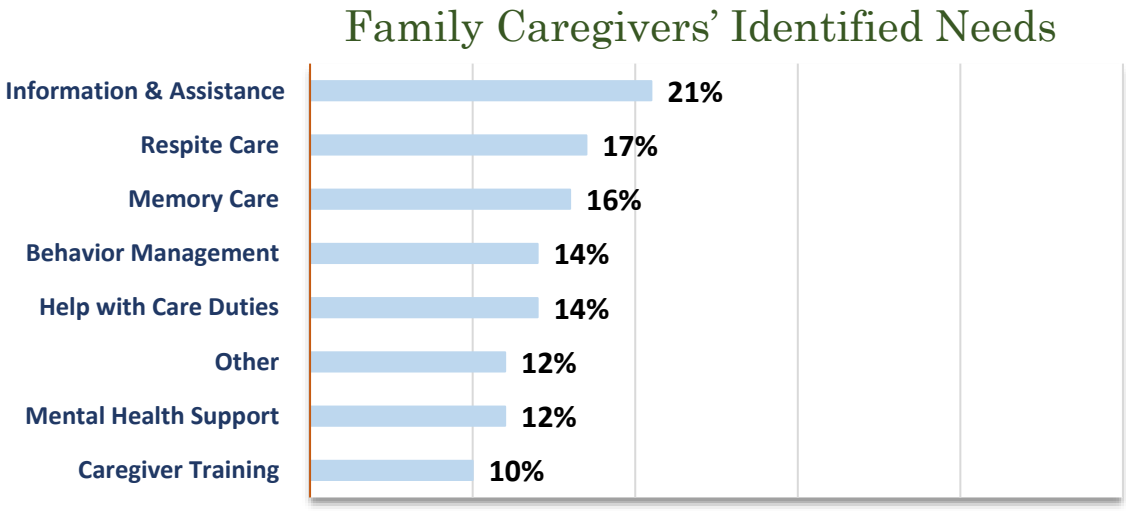


Top identified needs for adults with disabilities rated differently, as demonstrated below:



CAREGIVING

Over 30% of survey respondents provide care for an adult family member, friend or neighbor. Caregivers' priority needs are Information and Assistance, respite, and memory care/dementia resources, followed closely by help with the duties of caregiving and help managing behaviors.



Percent of Reponses to Area Plan Survey (50% Responded N/A)

The middle of the diagram reflects a 50% response option of “other”. Examples of comments from those caregivers who identified other issues included:

- “no needs at this time/not at all, [but anticipate] future needs”;
- specific family examples, like “help getting siblings involved or dealing with a difficult to care for family member”;
- home maintenance, chores, housekeeping, yardwork, transportation and;
- financial stressors, emotional strain, time and “rest”.

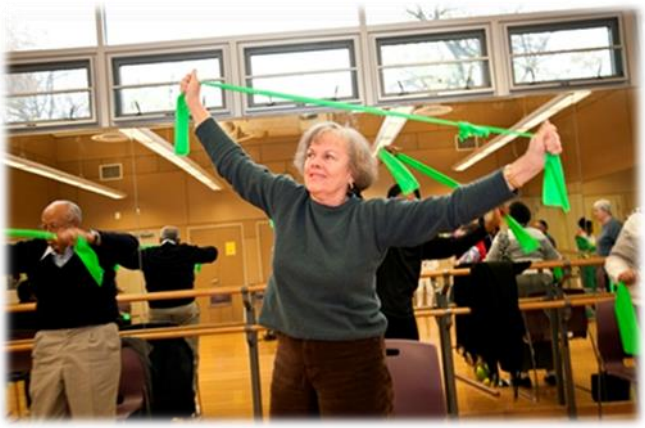
Services to support the identified needs for older adults and caregivers is detailed later in this Area plan.

WELLNESS AND COMMUNITY ENGAGEMENT

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

- A positive trend: 63% of survey respondents participate in social, cultural or religious activities in the community.

Interest in intergenerational programs is also a consistent theme in survey comments about what would make the community a more welcoming place: “Provide programs for seniors near programs for children and family programs so there is less separation between the ages, which will reduce isolation and the problems stemming from that” ...



***Another Positive Trend*:**

Almost ½ of survey respondents participate in exercise or wellness programs (43%) and 47% volunteer.

Although it is promising to see the positive trend of increased involvement in exercise and wellness programs, we know that for many older adults, falls are still a huge risk. According to the Centers for Disease Control and Prevention, 1 in 4 people 65 and older falls each year. Falls can lead to a loss of independence, but they can be preventable.

For people ages 65 and older:

- There were 709 hospitalizations from falls in Kitsap County[11] and 42 deaths from falls in 2017[12]. This was an increase over 2016, when 670 hospitalizations from falls and 37 deaths from falls occurred.

NUTRITION AND FOOD ACCESS

This topic rated in the top two identified needs for older adults in the 2019 ALTC survey. In answer to the question "How do you usually get the food you eat?", respondents replied with the following:

- 95% shop at a grocery store for their food
- 25% purchase food at a farmer's market
- 11% get their food from other sources (friends/family, housing program, facility, restaurants, grocery deliveries)
- 8% go to a food bank
- 6% eat at a congregate or community meal
- 5% receive senior program home delivered meals

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

In a Spring 2019 community survey related to food bank/food pantry access, the number of older adult participants increased from 14% percent compared to 2018. Participants surveyed accessed the South Kitsap Helpline, Bremerton Foodline, and Central Kitsap Food Bank[13].

The numbers of older adults will continue to dramatically increase, due to the Baby Boomers and increased life span. This population will be more diverse, and since health disparities exist within minority populations, chronic health problems will increase as

[11] WA Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS) 1987-2018. Washington State Department of Health, Center for Health Statistics, Community Health Assessment Tool (CHAT), July 2019.

[12] Washington State Department of Health, Center for Health Statistics, Death Certificate Data, 1990–2017, Community Health Assessment Tool (CHAT), September 2018.

[13] Survey administrator: Retired and Volunteer Senior Program of Kitsap, Andrea Dolan-Potter, RSVP Program Director Lutheran Community Services NW.

well. The cost of medical care, as well as the potential loss of the contributions of older adults due to disability, makes an emphasis on healthy aging imperative.

SERVICES USED AND BARRIERS TO ACCESS

- Services most identified as "currently used" were exercise, food banks and senior centers.
- Services Community Members would "plan to use" were in-home personal care, transportation and caregiver support.

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

TRANSPORTATION

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

- 82% drive where they need to go
- 30% ride with friends or family
- 10% ride the bus
- 7% use ACCESS
- 4% use a taxi
- 2% use a volunteer transportation program
- 1% use Paratransit

HOUSING

When asked about problems with housing, if any, the top 5 responses in order include:

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

- "Other", with examples like, home maintenance and yard care, unresponsive landlords and home location makes access to services difficult.

INDEPENDENCE FOR INDIVIDUALS WITH DISABILITIES

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

Photo courtesy Kitsap Sun, staff photographer Carolyn J. Yaschur

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

What we need are more opportunities that make individuals *"a part of the community, not apart from it"*. -LOCAL RESIDENT

PROBLEM STATEMENT

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

GOALS

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

Promote positive aging and community engagement opportunities.

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

OBJECTIVES

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

Measured by:

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

Completion Date: 12/2023

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

Measured by:

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

Completion Date: 12/2023

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

Measured by:

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

Completion Date: 12/2023

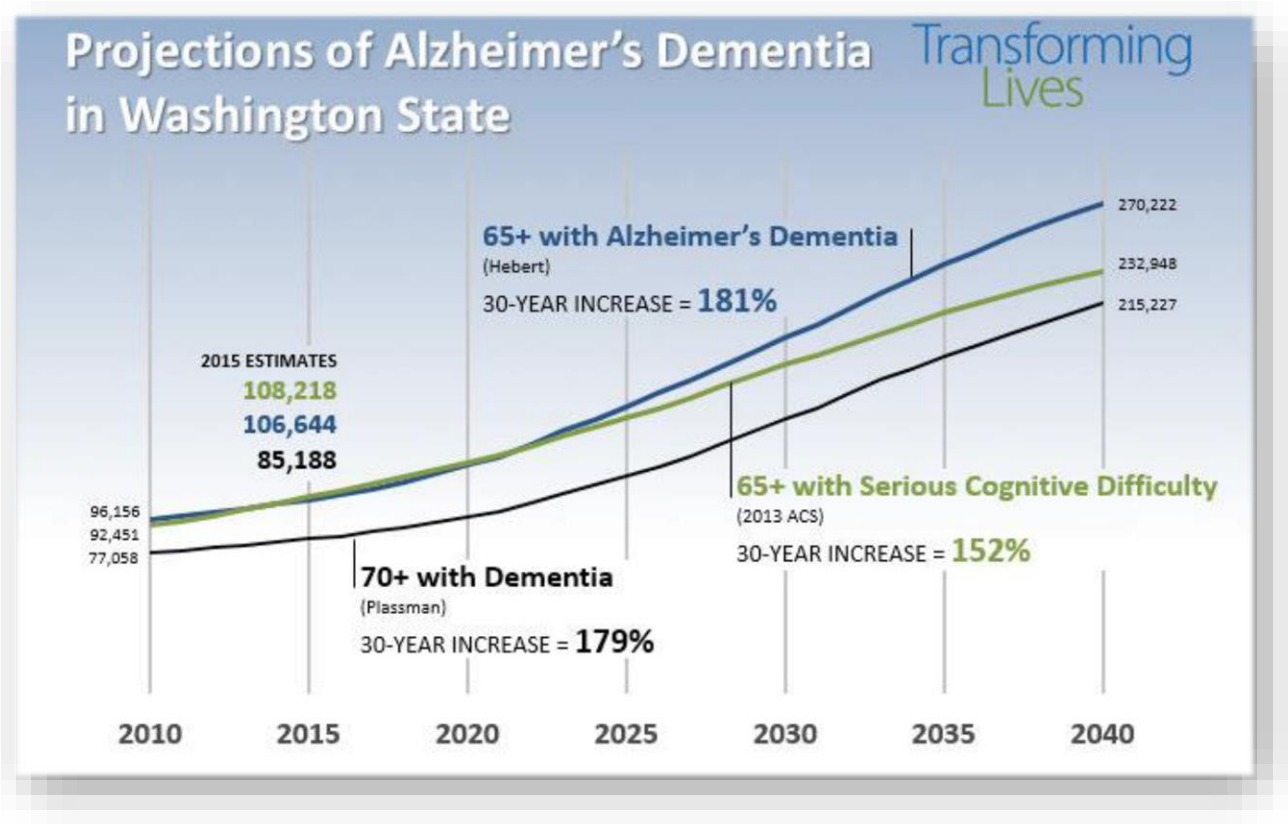
Multiple sections in this Area Plan address health and wellness goals for older adults, individuals with special needs, and caregivers across family and community systems.

C-1.2 Alzheimer's, Dementia and Brain Health

PROFILE OF THE ISSUE

In Washington State, an estimated 110,000 individuals have Alzheimer's disease or a related dementia.

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



Washington State Plan to Address Alzheimer's Disease and Other Dementias[14]

A top concern of older Americans second only to maintaining their physical health was their concern about memory loss[15].

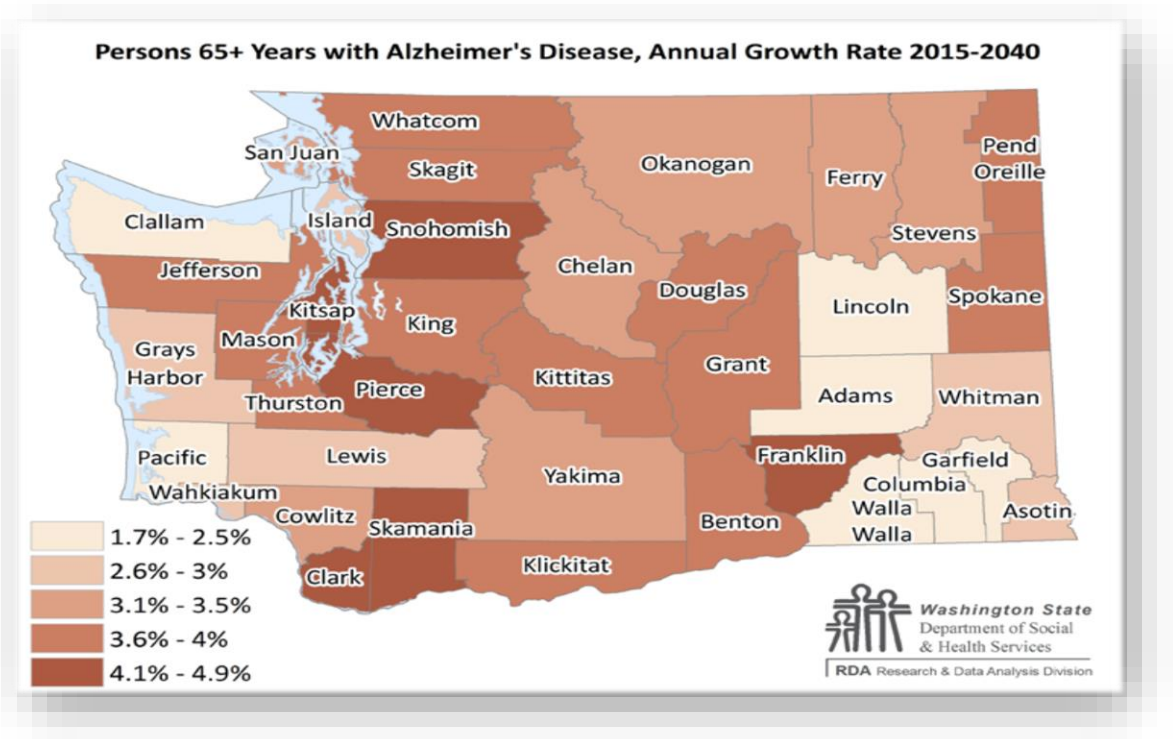
[14] Accessed on July 31, 2019 at https://alzimpact.org/uploads/media/state_plans/WA.pdf
[15] National Council on Aging- The United States of Aging Survey: 2015 Results. Accessed on August 31, 2019 at https://www.ncoa.org/uncategorized/usoa-survey/2015-results/

<u>Dementia Support/Brain Health</u> ranked highest among identified needs for older adults in the 2019 Kitsap County ALTC Area Plan Community Needs Survey. With the aging of the baby boom generation, the number of older adults with dementia is increasing. Yet services and supports are not keeping pace with the increased demand.

Alzheimer's disease is the sixth leading cause of death in the United States, and the third leading cause of death in Washington State. In Kitsap County, Alzheimer's disease is a major concern. The Centers for Disease Control rates Kitsap County Alzheimer's deaths in the "worse" quartile compared to other counties at a rate of 58.6 per 100,000 people[16].

Planning to address the needs of individuals and caregivers who may be impacted by dementia in Kitsap County is vital to the vision of a healthy community.

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% The chart below demonstrates that Kitsap County's annual growth rate is among the highest in the state when compared to other counties.



Washington State Plan to Address Alzheimer's Disease and Other Dementias [17]

[16] CDC-Community Health Status Indicators (CHSI) 2015 online web application http://www.cdc.gov/CommunityHealth/profile/currentprofile/WA/Kitsap/50011-

[17] Accessed on July 31, 2019 at https://alzimpact.org/uploads/media/state_plans/WA.pdf

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

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

The Problem:

- More than half of Washingtonians who reported that they have “memory loss that is getting worse”, have not talked to a health care professional about it.
- Fewer than half of the people who meet the clinical criteria for dementia receive a diagnosis.
- Less than 10% of Washingtonians, at time of diagnosis, were referred to an Alzheimer’s organization, just 14% were referred to information about community resources.
- Without diagnosis or post-diagnostic support, people with dementia and their families can’t get the help they need – and care ultimately becomes more costly.
- The average annual Medicaid payments per Medicare beneficiaries with dementia were twenty-three times as great as those without dementia”[18].

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

Dementia impacts families. Based on the 2019 Kitsap County ALTC Area Plan Community Needs Survey, caregivers indicated priority needs are Information and Assistance, respite, and memory care and dementia resources. These are followed closely by help with the duties of caregiving and managing behaviors of the person they care for. It is important to realize that for some caregivers, especially caregivers who deal with dementia, providing care is often more than helping with daily living activities. It can mean all of that plus learning about different behaviors and communication changes of the person they care for, struggling with role changes in relationships and at times, living with the isolation that can result. Caregiving may include trying to deal with feelings of anxiety and depression of both the person they care for and themselves.

Caregivers dealing with these issues often benefit from information, counseling and consultation with trained professionals and may also benefit from phone or online support or local support groups and workshops. Dementia support education, consultation and referral are available through the Senior Information & Assistance/Community Living Connections and Family Caregiver Support staff at ALTC.

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

Counseling services to assist individuals and caregivers is available on a limited basis also through a mental health counseling contract.

Kitsap County ALTC prioritized work investments to address the need for expanded dementia supports in the last Area Plan timeframe and this work will continue. ALTC sought new revenue to support the needs of this growing population through County Mental Health 1/10th of 1% sales tax funding.

In 2018 and 2019 Dementia services were locally funded and included dementia consultation, Alzheimer's Café expansion, support group investments and community education presentations. In 2019 ~~a plan is in place to also provide~~ local "Staying Connected" evidence-based workshop series were offered.

~~Moving forward, if funded, the~~ The 2020 and 2021 continued Partners in Memory Care project ~~will~~ provided proven successful services to Kitsap residents, and their caregivers, to address challenging behaviors and stress associated with aging and mild to major neurocognitive dementia disorders and memory impairment. The 2022 proposal goal is to sustain the Dementia Consultant service 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.

WASHINGTON STATE PLAN TO ADDRESS ALZHEIMER'S DISEASE AND OTHER DEMENTIAS

Prompted by national legislative change, states started work 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; thereby setting the direction for the state to become dementia capable.

Plan goals include:

- Increase Public Awareness, Engagement and Education about Dementia
- Prepare Communities for Significant Growth in Dementia Population
- Ensure Well-Being and Safety of People Living with Dementia and their Family Caregivers
- Ensure Access to Comprehensive Supports for Family Caregivers
- Identify Dementia Early and Provide Dementia-Capable Evidence-Based Health Care
- Ensure dementia-capable long-term services and supports available in the setting of choice

- Promote research and innovation into the causes and effective interventions for dementia.

At the local level, Kitsap County Aging and Long-Term Care plans to incorporate findings, align local goals and explore implementation of successful or new strategies and programs in future work[19].

GOALS

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

OBJECTIVES

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

Measured by:

- Grant proposal submission seeking local mental health 1/10th of 1% sales tax funding for services.
- Local advocacy for additional state and national funding to support individuals and caregivers impacted by dementia.

Completion date: 12/2023

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

Measured by:

- Provide evidenced-based Powerful Tools for Caregivers training or other training opportunities to caregivers to help caregivers manage behaviors.

[19] Washington State Plan to Address Alzheimer's Disease- Preparing Washington for the Impacts of Alzheimer's Disease and Other Dementias, developed by the Alzheimer's Disease Working Group convened by Washington State Department of Social and Health Services, Accessed on August 1, 2019 at https://www.dshs.wa.gov/altsa/stakeholders/alzheimers-state-plan

- Ongoing promotion of safety resources and educational materials for this population (such as the Information Kit “Safety Concerns for people with Dementia”, Silver Alert, and other resources).

Completion date: 2023.

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

Measured by:

- Coordination activities with Alzheimer’s Association and other community potential partners.
- Promotion of inclusive, independent, active engagement opportunities for persons with dementia.

Completion date: 12/2023

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

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

C-2.1 Community Living Connections

PROFILE OF THE ISSUE

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

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

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

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

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

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

It remains a challenge to increase community awareness and to get useful information to older people and caregivers so they can make informed choices. Area Plan 2019 survey responses indicate the top sources of information were the Internet, followed by friends or neighbors. Newspaper, AARP, Kitsap County Aging & Long-Term Care, Senior or community centers, Social Media (Facebook, Twitter, etc.), family and then Senior I&A were the next top sources.

While most satisfaction surveys and other feedback about I&A services are highly positive, often community members continue to be unaware of the Information & Assistance service. Lack of information results in delayed or less effective interventions than if consumers have access to information and support prior to a crisis or when they are preparing to make decisions. Therefore, ongoing access to information and support is critically important.

Additionally, the availability of on-line information is changing the way many consumers seek information. Given that older adults are online more, and those who may not be 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 have and will continue to be needed to provide improved access to information about choices and resources for seniors and their family members. These new efforts should complement the traditional approaches to information distribution (telephone directories, newspapers, simple brochures and directories).

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

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

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

2. ***BenefitsCheckUp*** website through National Council on Aging 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 is available through Senior I&A by phone or in-person. 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.

3. ***Medicare Improvements for Patients and Providers Act (MIPPA)*** offers beneficiaries Medicare and Medicare Part D outreach and assistance services provided by Senior I&A staff, including assistance to Medicare beneficiaries to enroll in Medicare Part D or to apply for Medicare Low-income Subsidy (LIS) and Medicare Savings Plans (MSPs). MIPPA outreach includes coordination activities and education efforts to encourage beneficiaries to participate in disease prevention and wellness activities.

4. ***Kitsap County Aging and Long-Term Care contractors***, public agencies, and other groups develop easy-to-read program materials and, through distribution to the public, they become gateways into the continuum of services. Additionally, public information is disseminated through the monthly Provider Breakfast targeted to service providers, Older Americans month activities each May and other public information activities that occur through the year.

I&A/CLC Core Components

(as defined by the Administration for Community Living)

Information, Referral, and Awareness

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

Options Counseling and Assistance

This service is provided through I&A direct service staff. Except newly hired staff, I&A/Family Caregiver staff completed Person-centered Options Counseling training.

Streamlined (Access to) Eligibility for Public Programs

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

Person-Centered Transition Support

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

Consumer Populations, Partnerships and Stakeholder Involvement

Direct services include Family Caregiver, Medicare Improvements for Patients and Providers (MIPPA), Senior Drug Education and case management for Medicaid-funded programs. Service expansion would necessitate additional staff resources and funding to put in place partnership agreements and provide expanded services to a broader population.

Quality Assurance and Continuous Improvement

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

Training

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

Partnerships

Kitsap County has strong partnerships and local community connections. Partnerships include local networking groups, cross-system referral sources, subcontractors, and local providers. Some examples are Kitsap Information & Referral Network, Provider's Breakfast, Long Term Care Alliance, Continuum of Care Coalition, Vulnerable Adult Task Force and other networking and community collaborations. ALTC plans to seek additional connections with Veterans Assistance (VA) Medical centers, the local VA clinic, and local Veteran's Home (Retsil) and military support services referral sources. We envision reaching out to a variety of community partners, providing cross training opportunities and involving stakeholders in building a strong network. Potential new partnerships could be with faith communities, providers of services to disability and advocacy groups, Long Term Care and Developmental Disability Ombudsman programs that serve a variety of target populations. Strategies to engage would include:

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

As noted above, the traditional Senior Information & Assistance service model has been evolving with the introduction of the Family Caregiver Support Program and TCARE®, Medicare Part D, Medicare Improvements for Patients and Providers (MIPPA), and 211.

Additionally, national Information & Referral (I&R) standards provide criteria for the development of comprehensive systems to meet the needs of diverse communities and consumers.

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

PROBLEM STATEMENT

1. Community members may not access services that are available because of the perception that no-cost or low-cost services are limited by eligibility criteria or are very 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 point of crisis.

2. Consumers report difficulty navigating through the many different organizations providing various pieces of information or services.

3. The “network” of options is more limited for some of the individuals who come to the program with the greatest social and economic need. At the same time, referrals demonstrate increased complexity in the family situations and presented, regardless of social and economic need.

4. Reduced or stagnant funding creates a tension between capacity and demand. While the program continues to be a priority need identified by local community members, funding will need to increase to adequately meet demands. There is not a new or sustainable revenue source to fund expansion of outreach, information, assistance, and options counseling to meet the increased demand driven by the increasing numbers of people who face aging and disability challenges. The next four years presents opportunities to continue to explore options for doing business differently and seek alternatives to help address this challenge.

GOAL

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

OBJECTIVES

1. Improve consumers' access to long term care and healthy aging information through Kitsap County ALTC website.

   Measured by:

   - Assessment and posting of relevant links/content to ALTC website.

   Completion Date: 09/2023

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

Measured by:

- Report of number of Medicare beneficiaries served and outreach activities.

Completion Date: 09/2023

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

Measured by:

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

Completion Date: 12/2023

C-2.2 Family Caregiver Support Program

PROFILE OF THE ISSUE

Family Caregiver Support Program:

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. It is estimated that family or unpaid caregivers provide 80% of this care.

Caregiver Support Center
Kitsap County Aging & Long Term Care Services

Although caregiving has an effect at all ages, the aging of the population is impacting caregiving trends as well, with 10% of the care being provided by caregivers over 75 years old[20]. These caregivers spend an average of 34 hours per week on caregiving. Almost half report caring for a spouse; the others assist siblings and other relatives, friends or neighbors, most who are also 75 or older.

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

Top priorities of *surveyed* KITSAP COUNTY CAREGIVERS

- Information & Assistance
- Respite for caregiving
- Memory care/dementia resources

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. For example, adult children who are caregivers are much more likely to seek information about the disease process, availability of community services and legal and financial information.

A caregiving spouse, on the other hand, is more likely to need help with coping skills and information about behavior management in addition to information about in-home

[20] Caregiving in the US. Executive Summary, Research Report June 2015. AARP Public Policy Institute and National Alliance for Caregiving. Accessed 9/5/19 at: http://www.aarp.org/content/dam/aarp/ppi/2015/caregiving-in-the-united-states-2015-executive-summary-revised.pdf

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

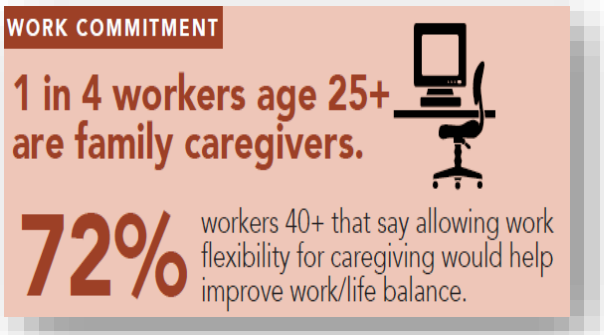
Since many persons helping and supporting care have assumed responsibilities but do not necessarily call themselves "caregivers", they may not look for services or supports targeted in that way. Understanding that, it can present a barrier because identifying as a caregiver opens doors to services and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

Another aspect of caregiving is the economic impact of providing care. Caregivers often make financial sacrifices to support the care of others. They may contribute their personal income or savings, or may sacrifice their employment, or employment position to ensure the care of their loved one. Many find they miss more days of work; it is reported that, on average, caregivers miss seventeen workdays per year due to caregiving responsibilities.

- According to 2019 NASUAD report, 6 out of 10 caregivers are employed, 90% of informal caregivers are unpaid, 1 out of 5 retirees left the workforce early to care for family, and an average of $303,880 lost income and benefits per caregiver over the age of 50 years. A caregiver is 2.5 times more likely to live in poverty[21].

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

To help offset these issues, an encouraging trend is that more employers have started offering flexible schedules, reduced hours, unpaid time off, and other creative approaches to their workers with caregiving



[21] FACT SHEET | Supporting the Critical Role of Family Caregivers: State Opportunities accessed at http://www.advancingstates.org/sites/nasuad/files/CHCS%20Family-Caregiver-Fact-Sheet_081519.pdf Accessed September 10, 2019.

responsibilities[22]. With such supports, more caregivers can provide care while remaining productive employees.

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

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 in Silverdale offers materials for on-site reading and check out. These include a comprehensive selection of books, videos, periodicals and pamphlets, as well as an Internet connection and directory of caregiver-oriented sites. Many materials are also available at the Givens Community Center in Port Orchard.

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

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

[22] 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.

KITSAP COUNTY CAREGIVERS may receive support with the following FCSP Core Elements:

- 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, services are delivered in the ALTC or counselor's office, in-home, or over the phone;
- Training- includes one-time classes, caregiver education series, and special events such as workshops or conferences. Evidence-based models that ALTC plans to provide or partner to provide are Powerful Tools for Caregiving (PTC) and Stay Active and Independent for Life (SAIL) or other prevention programs;
- Support Groups-these groups allow caregivers an opportunity to talk about their roles, problems and concerns with a peer group that may better understand their situation. Groups usually target a specific population of caregivers or are for individuals with a specific diagnosis (Alzheimer's, cancer, diabetes, etc.).
- The type of support groups supported, and how support is provided by ALTC varies as the agency responds to requests for special assistance. Examples include Alzheimer's Association groups, Parkinson's Support Group, Caregiver Support Groups, Brain Injury Support, ARC "Parent to Parent" group and education and support series such as Powerful Tools for Caregivers, etc.
- Respite Care Services: Respite gives a break to the unpaid or family caregiver by providing substitute care. Service may be provided in or out-of-home (including Adult Day Care, Adult Day Health and short-term care in a licensed nursing facility) and is offered on a sliding-fee scale.
- Supplemental Services. Services include nutrition consultation, home delivered meals, legal, counseling and durable medical equipment or supplies. Service distribution method is based on a provider authorization to deliver the service to the caregiver or care receiver. No funds are provided to individuals directly.

There are currently no AAA service limits in effect that exceed the eligibility criteria associated with TCARE® statewide policy for services and steps. However, for counseling services, at the point of referral we inform caregivers that the service is not intended to be on an ongoing basis. Counseling in a care facility is provided as a short-term transition only service based upon service and funding availability. In 2019 there ~~is~~ was a waiting list for Respite services. In 2020 and 2021 there was no waiting list.

Kinship Caregiver Support Program:

Kinship Caregivers provide primary care to a relative's child or children. Although often it is grandparents raising grandchildren, kinship care also includes care of children by other non-parent relatives. In Washington State over 42,000 grandparents are responsible caregivers for a relative's children. An estimated 3.0% of householders 30 years and over, and 4.1% of those 65 years and over, live with and are responsible for care of grandchildren. In Kitsap County, an estimated 3.3% of persons 65 years and over live with grandchildren and are responsible for care.

Kinship care may become necessary for a variety of reasons including parental substance abuse, death, incarceration, abandonment, domestic violence, mental health issues, neglect or abuse, or a teenager not ready to be a parent. Kinship caregivers are often faced with unanticipated expenses when assuming responsibility for minor grandchildren or other relatives. Costs for legal guidance, including custodial authority, and other, basic needs such as clothing, child-appropriate furniture and housing changes can add to this burden[23].

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

Examples of these needs:

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

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

Kitsap County ALTC does not currently receive funding for Kinship Navigator Services. However, Port Gamble S'Klallam Tribe is delivering these services targeted to tribal kinship families through time-limited grant funding. Providing care to relatives is a cultural and integral part of Native American life. The Indian Child Welfare Act passed

[23] U.S. Census Bureau, 2013-2017 American Community Survey 5-year Estimates. Accessed August 6, 2019. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

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 occurs.

PROBLEM STATEMENT

1. Caregivers need support and assistance at all stages of their caregiving journey. Different caregivers need different kinds of support. As more people opt for care in the home, the demand for more specialized services increases.

2. Many caregivers do not identify themselves as “caregivers,” and may not recognize that they may be eligible for assistance. Caregivers may not know what services are available or how to access them, especially in times of severe stress or emergencies. Without additional support, increased stress and health impacts may result and potentially shorten or degrade the home care option.

3. Caregivers need economic and employer support to maintain their responsibilities. Employers need support in dealing with caregiving issues in their workforce. Employed caregivers need access to education about their options.

4. Individuals from ethnic minority communities, persons with disabilities, and LGBTQ and non-traditional caregivers who may not be recognized as family may need additional support and assistance to access caregiver support services.

5. Kinship caregivers need a range of assistance in their role raising children and navigating the legal, social and economic support systems. Kinship caregivers report they need financial assistance for the children in their care. Based on program support requests, caregivers need help providing necessities and accessing medical care, affordable housing, and adequate transportation.

6. There continues to be a need across the Kitsap County service area to develop and maintain caregiver support options; including options such as community partnership development and research into volunteer opportunities that may not receive or require funding support.

GOALS

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

OBJECTIVES

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

Measured by:

- Meeting notes and recommended action(s) from coordination meeting(s) with relevant providers.
- Community outreach and education to military and Veteran Assistance providers, emergency responders, health care providers, and other potential new partners.

Completion Date: 12/2023

2. Maintain support for caregiver training through participation in and/or sponsorship of a caregiver training conference and local training opportunities. Conduct a minimum of one community-wide education or training event annually.

Measured by:

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

Completion Date: 12/2023

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

Measured by:

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

Completion Date: 12/2023

C-2.3 Medicaid Transformation Demonstration

PROFILE OF THE ISSUE

Washington State has already created a rebalanced system where individuals have community care options for Long-Term Services and Supports (LTSS). In ~~2017~~,2020 the LTSS system was ranked 2nd ~~1st~~ in the nation by AARP for high performance, while simultaneously ranking 34th in cost. 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.

The Medicaid Transformation Waiver, part of Healthier Washington, will transform 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. In December 2019, ~~January 2020,~~ the Washington Association of Area Agencies on Aging and Kitsap Aging Advisory Council ~~will begin~~ began advocating to the state legislature for sustainable program funding. Dedicated funding needs to be awarded in the 2021-2023 biennium legislative budget.

The demonstration has two main LTSS components:

1. **Medicaid Alternative Care (MAC)** - Creation of a benefit package for individuals who are eligible for Medicaid but not currently accessing Medicaid-funded LTSS. This benefit package provides services to unpaid caregivers designed to assist them in getting supports necessary to continue to provide high-quality care and to focus on their own health and well-being.

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

MAC and TSOA include the following benefits:

- **Caregiver Assistance Services:** Services that take the place of those typically performed by unpaid caregiver.
- **Training and Education:** Assist caregivers with gaining skills and knowledge to care for recipient.
- **Specialized Medical Equipment & Supplies:** Goods and supplies needed by the care receiver.

- **Health maintenance & therapies:** Clinical or therapeutic services for caregivers to remain in role or care receiver to remain at home.
- **Personal Assistance Services:** Supports involving the labor of another person to help individuals without a caregiver (only for TSOA).

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

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

The Medicaid Transformation Project Demonstration has added 2 more Initiatives to the Waiver since it was approved that include:

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

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

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 they did not wish to deal with the Medicaid Estate Recovery or co-pay requirements. However, these caregivers encounter the same limitations of lack of knowledge, resources, time, and increased stress.

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

GOALS

MAC and TSOA Benefits support the preference for older adults to age in the setting of choice and provide support for caregivers.

OBJECTIVES

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

   Measured by:

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

   Completion Date: 1/2023

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

   Measured by:

   - Analyze annual Outreach efforts; update Outreach Milestone, as needed
   - Provide T-CARE screenings & access to customized care plans for caregivers.
   - Provide person centered counseling and customized services and supports to newly identified caregivers (e.g., respite, counseling, support groups).

   Completion Date: 1/2023

3. Recruit and maintain provider network adequacy.

   Measured by:

   - Develop additional contracts to meet caregiver needs.
   - Identify and recruit local providers for new contracted services, with efficient and timely service delivery.
   - Provide technical assistance to current Family Caregiver Support Program local contract providers or interested providers, such as the local Tribes, who may be overwhelmed with the Medicaid contracting requirements.

   Completion Date: ~~1/2021~~ 12/2023

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

PROFILE OF THE ISSUE

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

- Traditional Medicaid Long Term Services Case Management
- ~~Health Homes~~

The Health Home program has been discontinued as of February 1, 2020 as result of the COVID pandemic. Face to face outreach and client engagement activities were discontinued. The one case manager assigned to the Health Home program was re-assigned to the traditional Medicaid Long Term Services Case Management program. There are no plans to fill the vacant Health Home Care Coordinator position.

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

1. To provide person-centered in-home long-term services and supports (LTSS) that are well integrated with the health care services, for seniors and adults with disabilities, in a manner that allows them to stay independent and safe.

2. To provide person-centered coordination of health and community supports for people who face significant health challenges to improve their health and reduce avoidable health care costs.

HOWEVER,

a) The number of people 65 and older (who use 75% of LTSS) is growing.

b) People of all ages are living longer with disabilities, chronic conditions and treatment option.

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

d) Individuals in Kitsap County who need LTSS are accessing community-based in-home and residential options at a lower rate than the comparable Washington State average.

e) Inadequate statewide funding for the traditional Medicaid case management program. A crisis has developed due to chronic underfunding of the in-home case management program. When compared to state funded programs, the local funding is 18% short of what is necessary to adequately maintain 75:1 caseload

ratio. Next biennium this funding gap grows to 27% shortfall, while the acuity of the caseload grows.

- In Department of Social and Health Services contracts, the state funded programs (Adult Protective Services, Home and Community Services, and Developmental Disabilities Administration) programs have increased funding by 31% since 2015.

Medicaid Case Management Program Background

According to an independent organization, AARP, in 2017 Washington state was identified as a national leader in offering home and community-based LTSS for people with significant disabilities under the Medicaid program. In 2020, AARP awarded Washington's program as 2nd in the nation. 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, group home or in a skilled nursing facility.

As would be expected, about 75% choose to reside in their home, with an agency or individual care provider. To make that choice viable it has been essential for Washington's in-home program to grow in its capacity to support people with moderate to severe physical and psychological limitations as well as those who are medically complex, often accompanied by significant behavioral and cognitive challenges.

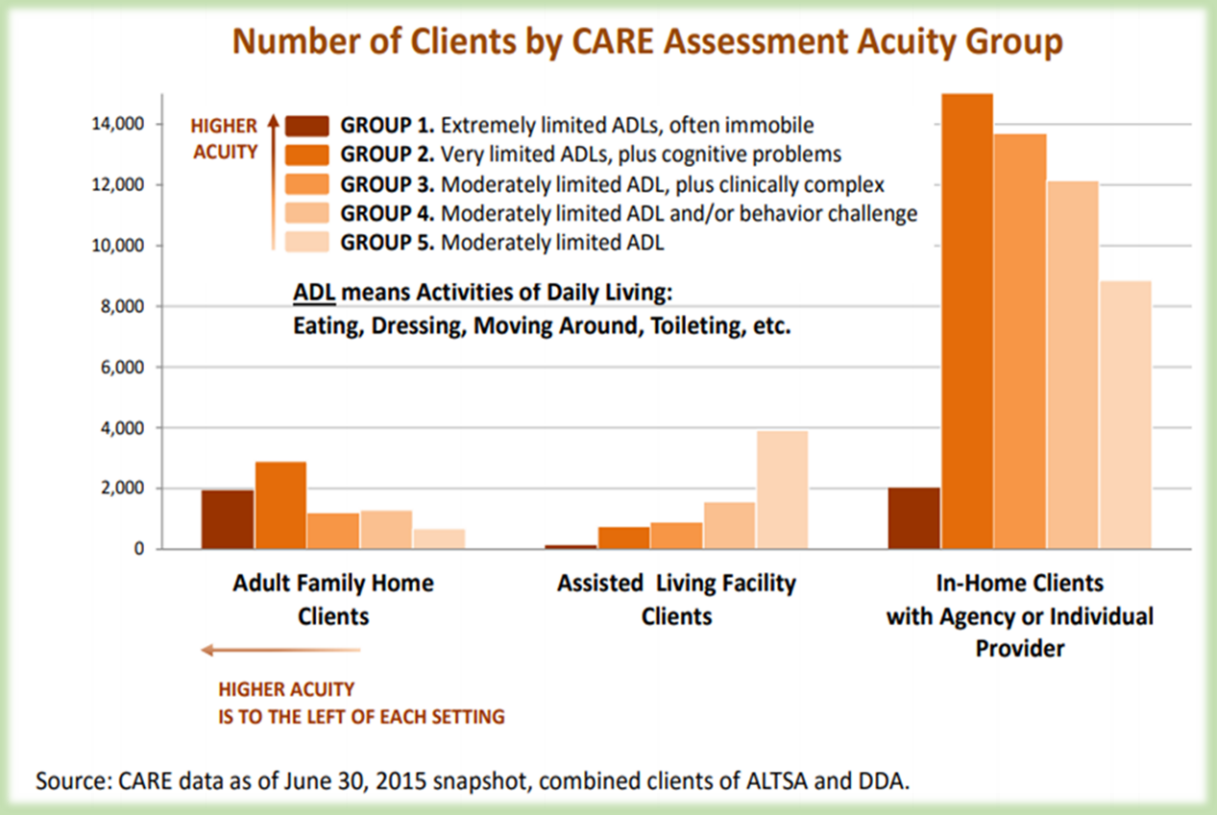
Supporting people of all acuity levels in community-based settings is key to accommodating the growing population.

Statewide there are approximately 40,000 people in the home and community-based portion of Washington's LTSS system who face a broad range of challenges to their health and independence. All need assistance to accomplish daily activities such as bathing, dressing, preparing meals, personal hygiene and moving about. With a combination of cognitive limitations and extremely limited mobility, about 30% of those individuals have very little ability to accomplish their daily activities. Another 30% are slightly more able to accomplish daily activities but are challenged by a complex combination of difficult to manage diagnoses and health conditions. Those levels of acuity have continually increased over the past decades and require increasingly sophisticated service planning, coordination, and monitoring to maintain independence, health, and safety.

- The acuity of individuals served through the Medicaid Case Management has vastly increased. The average client served has five chronic conditions, seven medications, and participates in the program for 60 months.

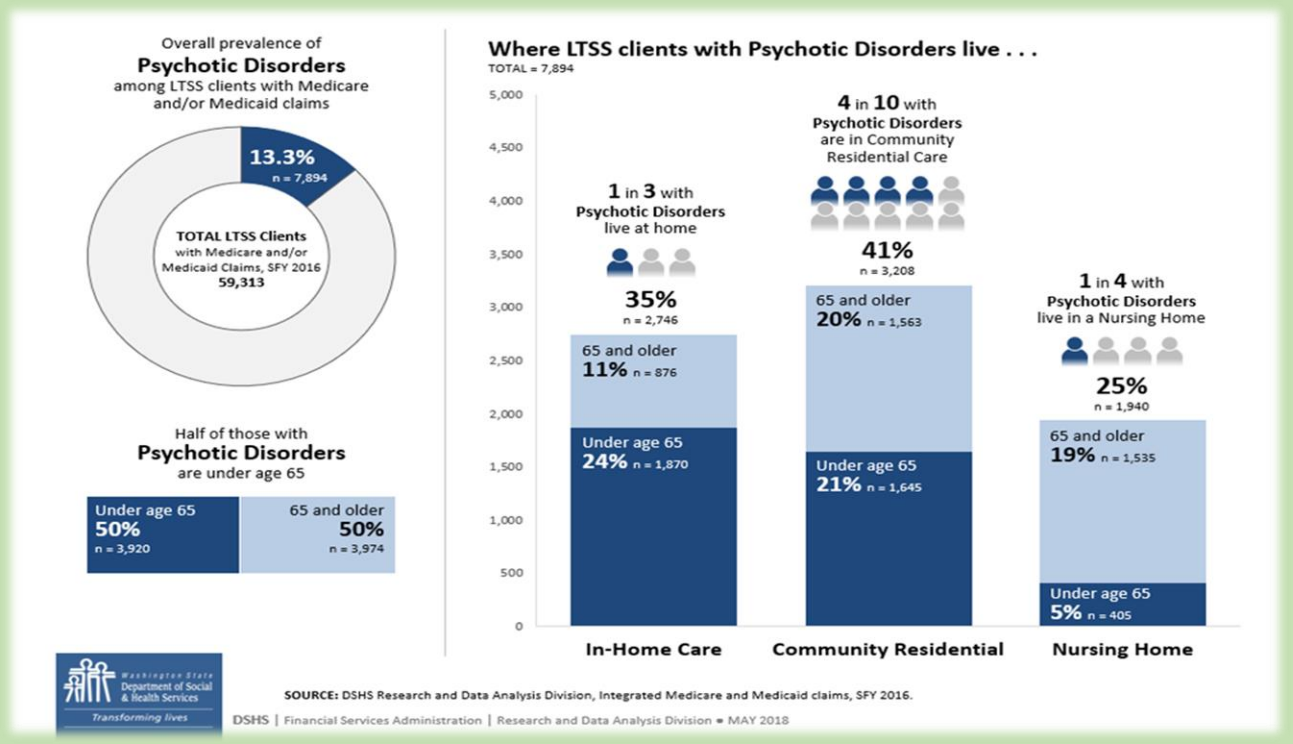
- Pre-COVID, one in four individuals discharged to long term care from a state mental hospital reside at home.

- Pre-COVID, one in three individuals with a psychotic disorder are receiving long term care resided at home[24].



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

[24] Source: DSHS Research and Data Analysis Division: 5732/1519 Measures, June 2019



Pre and during COVID, in-home care is the preferred LTSS option, safest and most cost-effective. Washington state was able to re-balance the overall costs of the statewide system by investing in the community-based system. And, rank 34th for overall costs in the nation.

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. With the COVID pandemic, the in-home long term care option underscored the preferred setting to reside safely at home versus a congregate care setting.

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

Fragmented care escalates medical cost for adults with complex, chronic medical conditions who must rely on a cross sector mix of medical, long-term care, behavioral health and social service supports. Multiple primary and specialty care physicians, pharmacies, and other healthcare professionals can result in a lack of coordination across systems and a loss of continuity in communication and care. This can result in

duplication of services. At other times, this results in gaps in service-delivery that negatively impact health outcomes. These issues can all impact successful transitions from home to care, facility to hospital, or hospital to home and result in re-hospitalizations or poor health outcomes[25].

Home Health Program Background

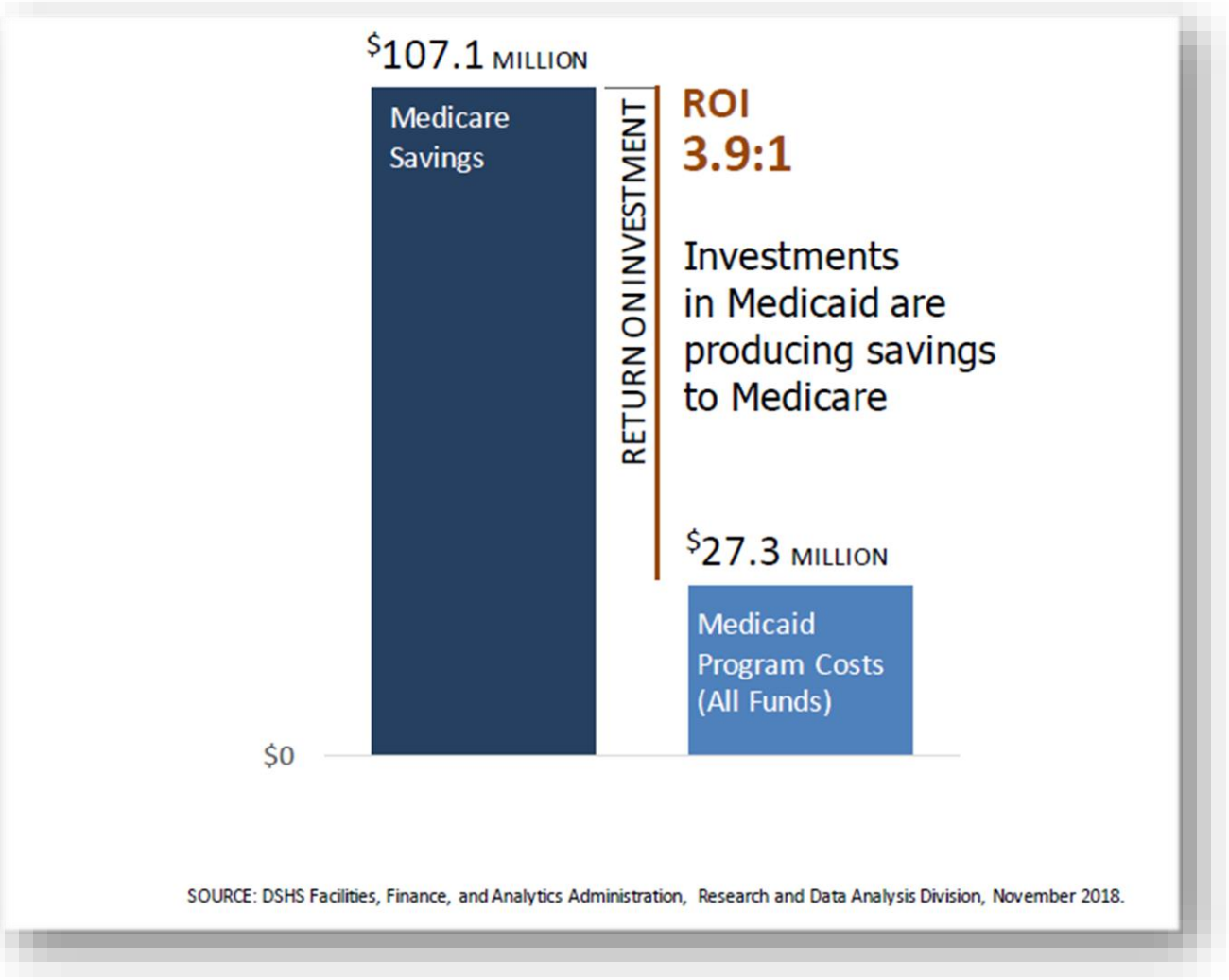
Washington's Health Care Authority launched the Health Home program to improve cross-sector care coordination, modeled on a pilot that was shown to have positive effect on health (including mortality) while at the same time lowering inpatient hospital costs and overall health costs in general. The program provides frequent contact with high cost/high risk dual eligible Medicaid- Medicare clients, care coordination among the wide range of their providers, connections to community social service supports, and uses patient engagement to target and empower clients to take charge of their health.

There are decreased hospital admissions, decreased nursing home admissions, increased use of home and community-based services, and $107.1 million savings to Medicare that was returned to Washington State.

- Year 1 gross Medicare savings of $34.9 million
- Year 2 gross Medicare savings estimate of $30.2 million
- Year 3 gross Medicare savings estimate of $42.0 million

The following table illustrates the Medicare savings relative to the Medicaid Program costs from July 2013 to December 2016.

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



The Health Home program is targeted statewide to over 50,000 individuals enrolled in Medicaid or dually eligible for Medicare and Medicaid in Washington State who constitute the top 20% of high-health risk, high-cost clients who could benefit from care coordination services across multiple provider types. That includes approximately 64% of the people who receive in-home long-term services and supports.

Existing Efforts:

- **Case Management of In-home LTSS:** Kitsap County's Medicaid Case Management program has the highest client to case manager ratio, in comparison to other service areas, in the state of Washington, at 92:1.

Through a combination of case turnover and changes in needs, Kitsap County ALTC provided over 1,166 assessments in 2018. In 2020 there were 1291 assessments completed. Of those, 856 were annual assessments, 104 were significant changes and 331 were interim assessments. Services for LTSS cases are provided through

Community First Choice Options (CFCO), Medicaid Personal Care (MPC), and Community Options Program Entry System (COPES). ~~This is slightly above the 1,119 total assessments completed in 2016~~. The 1st quarter 2021 total client count is 965 and the caseload growth allowed ALTC to add an additional Medicaid Case manager.

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

After assessment they receive an individual service plan that authorizes assistance with personal care tasks such as bathing, personal hygiene, ambulation and meal preparation. In addition, the case manager can authorize other supportive services such as home delivered meals, adult day health, personal emergency response systems, medication management devices, environmental modifications such as wheelchair ramps or stair-lifts, durable medical equipment and supplies not otherwise covered.

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

Unfortunately, stagnant funding coupled with increased inflation and oversight of care provider work week limits have threatened the integrity of the program. 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 assisting them to live independently in the community-based setting of their choice for as long as possible.

- **Health Home Care Coordination**: The ~~current~~ Kitsap Health Homes program was launched September 2018 with one Care Coordinator. This community based intensive care coordination program provides coordination of existing delivery systems, does not duplicate or change any current providers or benefits, is voluntary, at no cost to the client, and is funded through Medicaid with a Medicare savings being returned to the State for reinvestment.

Effective February 2020, the Health Home program has been discontinued. Face to face outreach and client engagement activities were discontinued as a result of COVID concerns. The one case manager assigned to the Health Home program was re-assigned to the Traditional Medicaid Long Term Services Case Management program.

~~The Care Coordinator is provided referrals from the lead organization, Olympic Area Agency on Aging, for the dual eligible populations that meet criteria and reside in Kitsap County. Currently, Kitsap County Aging and Long-Term Care is the only care coordination entity in Kitsap for the dual population.~~

~~The Care Coordinator (CC) establishes a person-centered health action plan (HAP) that drives the service coordination. The client is in a pivotal role. Clients may choose to include their families, caregivers, or others as part of their care team.~~

~~The CC provides health coaching, community and health care service referral assistance, and care coordination to link efforts of the medical, mental health, substance abuse, long-term services and supports, and community social service delivery systems together to meet the beneficiary's identified healthcare needs. CC's help establish client health goals and work with clients to assume greater levels of responsibility and confidence in the management of their own health care conditions, which is critically important to individuals with chronic illness.~~

~~The Health Home program is a key building block for innovative models promoting health, preventing and managing chronic disease, and controlling health care costs. Currently, the CC is serving 41 enrolled clients in this program.~~

GOAL

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

OBJECTIVES

1. Increase awareness, education and understanding of the traditional community-based long-term services and supports (LTSS) options available to individuals that reside at home.

2. Increase the number of eligible individuals who apply for community-based LTSS through provider education, community outreach activities and coordination with DSHS Home and Community Services.

   Measured by:

   - Increase average number of total persons served each month from 950 to 997, per the state forecast. This equates to at least 47 additional cases each month, with no attrition, by end of 12/2023.

3. Replenish the 27% shortfall in funding required to ensure high quality of clinical services provided.

A crisis has developed due to chronic underfunding of in-home case management. With current funding, increased client acuity, increased inflation, and projected reduction of funding due to Consumer Directed Employer; creating a 27% funding shortfall by 2021.

Fiscal Year 2021-2023 legislative advocacy and COVID vaccine assistance funding resulted in significant increase to the case management monthly rate reimbursement.

- From April- June 2021, the case management rate will increase from $168.84 to $178.97 monthly reimbursement in recognition of vaccine assistance provided in Calendar Year 2020 and 2021.
- Fiscal Year 2022, the case management rate will increase statewide $7,580,000.

Measured by:

- Continued legislative advocacy and action need to occur to achieve and sustain full funding to maintain quality in-home case management. Adequate funding for a 75:1 ratio will be provided, with an index to keep pace with inflation over time. Federal Matching Assistance Percentage (FMAP) may provide the vehicle for sustained funding to achieve 75:1 or lower ratio.

Completion date: 2023-2025

GOAL- HEALTH HOME PROGRAM DISCONTINUED

~~Provide person-centered coordination of health and community supports for increasing numbers of people who face significant health challenges to improve health outcomes and reduce avoidable health care costs associated with avoidable hospital visits, hospital admission, duplication of services, and emergency department visits for the Medicaid and Medicare populations.~~

OBJECTIVES

~~Specific to the Health Home Program:~~

~~1. Increase engagement and enrolled clients served each month.~~

~~Measured by: Increase of monthly average caseload to 55 served.~~

~~2. Increase awareness of the new program through community education and outreach activities.~~

~~Measured by: Three community education presentations by 12/2020~~

~~3. Advocate for increased Health Home reimbursement through shared Medicare savings. Achieve full funding to maintain quality care coordination.~~

~~Measured by: 5% increase to care coordination rates by 2021.~~

C-4 Tribal Partnerships

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

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

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

Tribal elders are defined as individuals age 55 years and older.

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. They strive 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.

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

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

Suquamish Tribe

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

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

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

Goal And Objectives

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

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

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

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

Resources

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

- Suquamish Tribe, https://suquamish.nsn.us/

2021-2022 7.01 Policy Implementation Plan
for
Kitsap County Division of Aging & Long-Term Care (PSA 13) – Area Agency on Aging
Port Gamble S'Klallam Tribe

Biennium Timeframe: January 1, 2021 to December 31, 2022

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

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Previous Year (Due Oct.1, 2022)
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, Community Services Division Director Stacey Smith, Aging Administrator Tawnya Weintraub, Aging Planner Gail Archut and Mikko Azul, Case Managers, Aging Jamie Aikman, Tribal Vulnerable Adult Investigator Sue Hanna, Elders Program Manager Andrea Rutledge, RN Sarah Shaw, RN Review Annually	Collaboration between AAA and Tribe to implement alternative meal delivery using additional COVID-19 funding. Financial support provided through FFCRA and CARES Act for increased COVID alternative shelf-stable and delivered prepared meals; purchased food warmers, coolers and additional equipment. Communication continued through the public health emergency via email, phones, and zoom meetings for Vulnerable Adult cases and nutrition service delivery planning.

				Established partner relationships made COVID response and coordination better.
2. (a) Provide specialized Information & Assistance about, and access to, caregiver support services to the Tribe. Assure recognition and respect for cultural diversity in caregiver support activities; and offer assistance in developing family caregiver support opportunities on the Port Gamble S'Klallam Tribe Reservation or geographically close locations. (b) Partner to connect Kinship Care families to training and support opportunities. The Tribal Kinship Care Navigator Program continues through this plan period. Lifespan Respite funding awarded for the Tribe to offer respite to adults and children, following staff training in May 2021.	• Increase sharing of materials, resources, and coordination by conducting coordination meetings and, where appropriate, one-on-one visits to Tribal Elders and families. • Coordinate among staff of Aging and the Tribe to provide presentations or workshops to Tribal Elders and family members based on topics identified by Tribe. • Attend annual Strong Families Fair, when notified by the Tribe. • Coordinate cross-referral opportunities. • Share ongoing updates about Kinship Caregiver Support program. • Support and explore scholarship and other funding opportunities.	Increase and enhance caregiver and kinship support information and access to services.	Cheryl Miller, Community Services Division Director Jennifer Calvin-Myers, Aging Caregiver Support Supervisor Tawnya Weintraub, Aging Planner Sue Hanna, Elders Program Manager Donna Jones, Kinship Navigator Review Annually	Kitsap AAA Case Managers continued to work with Tribal Managers in Vulnerable Adult meetings. Tribe reports caseload growth. Information on Virtual programs and training shared as they occur. Flyers and program update communications through Kinship Caregiver Support Program and Kinship Navigator program about opportunities for kinship caregivers shared throughout reporting period. September 11-12, 2020: 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. Virtual Tribal Conference May 19-21, 2021 will be attended by AAA staff.

3. Communicate and coordinate potential new community resources through the Medicaid Transformation Demonstration Project and local funding.	• Share a presentation of new AAA programs as a result of Initiative 2 funding. • Share new resources/programs as a result of other local funding.	Tribal and AAA staff are more informed about new social services resources and potential for growth and local partnerships.	Cheryl Miller, Community Services Division Director Sue Hanna, Elders Program Manager Jamie Aikman, Tribal Vulnerable Adult Case Manager Stacey Smith, Aging Administrator Tawnya Weintraub, Aging Planner Review Annually	Program MTD updates provided via electronic communications.

2021-2022 Biennium 7.01 Implementation Plan
for
Kitsap County Division of Aging & Long-Term Care (PSA 13) – Area Agency on Aging
Suquamish Tribe

Biennium Timeframe: January 1, 2021 to December 31, 2022

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, 2022)**
1. Maintain and increase coordination, identify and eliminate barriers, and increase access to services to the Elders 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. • Scheduled Kitsap Aging presentation for March 26,2021 with Tribal Program staff. • Email 2021 Kitsap Aging organization chart, with external contact list that includes email addresses. • Suquamish Tribe Human Services organization chart and contacts will be	• Improved awareness and access to services that recognize and preserve the value of the rich culture and heritage of the Elders of the Suquamish Tribe. • Tribal program staff will become familiar with Senior I&A staff and services.	Nehreen Ayub, Suquamish Tribe Human Services Director Barbara Hoffman, Suquamish Community Health Program Manager Craig Nelson, Suquamish Tribe Social Services Program Manager Stacey Smith, Aging Administrator Tawnya Weintraub, Aging Planner Jennifer Calvin-Myers, Senior I&A Supervisor Gail Archut, Aging Case Manager Brenda Francis-Thomas, OIP Regional Manager	

	shared with Kitsap Aging staff.			
2. Provide specialized 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. • Kitsap AAA staff will participate, with invitation, in community events.	• Increase sharing of materials and resources. • Increase outreach and coordination by conducting coordination meeting. • When appropriate, one-on-one visits to Tribal elders and families. • Explore topics that Senior I&A staff can present at/for the Tribal Caregiving Support group, upon request. • Aging staff participate in Suquamish Tribal Caregiver Training event.	• Increase and enhance caregiver support information and services. • Improve quality of care to Tribal Elders.	Nehreen Ayub, Suquamish Tribe Human Services Director Craig Nelson, Suquamish Tribe Social Services Program Manager Jennifer Calvin-Myers, Senior I&A Supervisor Suquamish Tribe Caregiver Training by December 31, 2022. Review annually	
3. Communicate and coordinate new community programs related to MAC/TSOA through the Medicaid Transformation Demonstration Project (MTD). MAC=Medicaid alternative Care TSOA-Tailored Services for Older Adults	Share new AAA programs and supports available through project funding.	Tribal and AAA staff are more informed about new social services resources and potential for growth.	Nehreen Ayub, Suquamish Tribe Human Services Director Barbara Hoffman, Suquamish Tribe Community Health Program Manager Craig Nelson, Suquamish Tribe Social Services Program Manager Jennifer Calvin-Myers, Senior I&A Supervisor Gail Archut, Aging Case Manager 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. *Tabled for 2021*	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 Supervisor Tawnya Weintraub, Aging Planner Gail Archut, Aging Case Manager Brenda Francis-Thomas, OIP Regional Manager Ann Dahl and Marietta Bobba, DSHS ALTSA Tribal Program Managers Review annually	A meeting focused on environmental modifications occurred July 2, 2020. Nehreen Ayub, Suquamish Tribe Human Services Director, Brenda Francis-Thomas, OIP Regional Manager, Ann Dahl, ALTSA Tribal Program Manager, and Tawnya Weintraub, Aging Planner attended. *Goal moved to "on hold" at the February 16, 2021 7.01 meeting due to COVID-19 19 high priority items.*

C-5 COVID-19 Response Services & Supports

Profile Of The Issue

Since early March 2020, Kitsap ALTC staff have worked remotely or on staggered in-office schedules due to the COVID-19 worldwide pandemic, following direction outlined in Governor Inslee's Executive Order directing all residents immediately to heed current State public health directives to stay home, except as needed to maintain continuity of operations of essential critical infrastructure sectors to protect health and well-being of all Washingtonians. All ALTC employees were deemed essential workers by the Governor's Executive Order.

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

The following services immediately closed or adapted to alternative delivery methods:

- Senior Congregate Meal sites adapted to "grab and go" meal sites
- Adult Day Health or Day Care services provided virtual programming
- Case Management home visits and wellness checks became telephonic
- Personal Care morphed to some telephonic care and/or brief visits

Additional COVID programming tasks

Early in the pandemic, ALTC completed the following tasks in preparation for client response:

- Updated all client case management crisis plans to reflect a pandemic. Emergency contact information was updated.
- Caseloads were triaged based on individual provider and home care agencies assigned to provide care, in planning for home care aides illness versus client essential care needs.
- Per DSHS request, all clients and individual providers with positive or close contact COVID were reported weekly to the Department of Social and Health Services.

Additional COVID local community tasks

Early in the pandemic, ALTC provided the following to support local community outbreak response efforts:

- ALTC management staff was re-assigned to provide direct support to the Kitsap County Emergency Command Center in creating the quarantine and isolation residential sites, connect fragile long term care facilities to local resources, and implement emergency plans for essential workers and vulnerable populations.
- ALTC was designated as a distribution site for free low income masks to community members from the Kitsap County Human Services Housing and Homelessness Division.

Stimulus Funds & Identifying Local Gaps

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

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

The stimulus funds were also used to create ALTC direct services: a warm line telephone check-in service for isolated older adults and vaccine appointment assistance with the local health district.

For current outbreak information, visit:

- Kitsap County Public Health District at https://kitsappublichealth.org/
- Kitsap Public Health Vaccine Toolkit at https://kitsappublichealth.org/communityHealth/Covid-19/CoronaVirus.php

PROBLEM STATEMENT

Clearly identify the direction the AAA will take to enhance services, enhance access for target populations, or achieve cost-effectiveness over the next four years. Goals should be broad in nature and should describe the major outcomes expected. .

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

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

GOAL

Continue to support community recovery through information sharing, delivery of services, provide vaccine assistance, and expand community-based network with organizations to address food and economic insecurity as a result of COVID.

OBJECTIVES

Specific and measurable actions or activities that will occur within the four-year planning period that link to the AAAs selected focus and goals. These should include methods of achievement, benchmarks (means of measuring progress), and month-specific timeframes for completion. The AAA may set one or several goals per issue area and one or several objectives per goal.

1. Advocacy and education activities for access to personal protective equipment (PPE) and other items to support staff and services providers to continue service provision.

   Measured by:

   - Attendance at Washington State Department of Health, Kitsap Public Health, Kitsap County Department of Emergency Management Emergency Operations Center and partner meetings, and COVID response coordination meetings;
   - Technical assistance with accessing and interpreting rapidly changing operational guidance, rates, implementation strategies, technology challenges, etc.

   - Completion date: 2023

2. Increase access to vaccinations for older adults, homebound individuals, family caregivers, and home care providers.

   Measured by:

   - Offer assistance to local Kitsap Health District as a vaccine appointment partner. Direct access to vaccine appointments for assist individuals unable to access appointments due to technology challenges.

   - Provide accurate information about local vaccine and COVID testing sites, as well as transportation options the location sites.

   - Completion date: 2022

GOAL

Utilize stimulus funding to meet local needs and expand network services.

OBJECTIVES

1. Increase availability of nutrition services for older and homebound individuals.

Measured by:

- Increase funding for increased need for number of emergency take-out and home delivered meals.
- Support acquisition of necessary supplies and equipment for safe, expanded service needs.
- Increase network service providers to include faith-based and other non-traditional senior nutrition providers to ensure alternative senior nutrition security.

- Completion date: 2024

2. Support intergenerational Kinship Caregiver households to meet basic needs.

Measured by:

- Increased funding to create more flexible service delivery options and enhanced service availability.
- Develop flexible policies to increase access to services.

- Completion date: 2024

3. Explore community partnerships and new contracts to deliver expanded services in response to COVID-19.

Measured by:

- New and expanded contracts to provide additional funding to meet emergent needs.

- Completion date: 2024

GOAL

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

OBJECTIVES

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

Measured by:

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

- Completion date: 2024

SECTION D
Area Plan Budget

Area Plan Budget Summary (pending insertion of 2022 Budget documents, 2020 retained as placeholder)

AREA AGENCIES ON AGING AREA PLAN BUDGET
AREA PLAN BUDGET SUMMARY
AAA: KITSAP COUNTY AGING and LONG TERM CARE (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

BARS CODE			Contract or Direct	Number	Unit	Persons Served	ALTSA Funding	All Other Funding	Total	Cost per Unit
AAA BUDGETED SERVICES										
555	.10	**ADMINISTRATION**					**425,924**	**0**	**425,924**	
	.11	Area Agency Planning/Administration	0				208,253	0	208,253	
	.12	Interfund Payments for Services	0				23,140	0	23,140	
	.13	Core Services Contract Management	0				194,531	0	194,531	
555	.21	**COORDINATION**	0				**35,000**	**6,176**	**41,176**	
555	.31	**LEGAL ASSISTANCE**	C	388	Hours	152	**33,000**	**5,824**	**38,824**	100.06
555	.40	**ACCESS SERVICES**					**2,469,671**	**0**	**2,469,671**	
	.41	Transportation	C	1	One-way Trips	1	2	0	2	2.00
	.42	Information & Assistance	D	6,240	Contacts	1,473	634,793	0	634,793	101.73
	.43.1	Case Management/Nursing Services - Core Services	D	997	Cases	997	1,834,876	0	1,834,876	1,840.40
	.43.2	Case Management - Aging Network	0	0	Hours	0	0	0	0	0.00
	.44	Nursing Services - DDA	0	0	Visits	0	0	0	0	0.00
	.45	Nursing Services - Aging Network	0	0	Sessions	0	0	0	0	0.00
	.46	Nursing Services - Contracted with HCS	0	0	Visits	0	0	0	0	0.00
	.49	Contracted Front Door Functions (King only)	0	0	Cases	0	0	0	0	0.00
555	.50	**IN-HOME SERVICES**					**23,788**	**4,198**	**27,986**	
	.51	Chore Services - Aging Network	0	0	Hours	0	0	0	0	0.00
	.52	Personal Care Services - Aging Network	0	0	Hours	0	0	0	0	0.00
	.53	Home Health	0	0	Hours	0	0	0	0	0.00
	.54	Health Maintenance	0	0	Hours	0	0	0	0	0.00
	.55	Bath Assistance	0	0	Hours	0	0	0	0	0.00
	.56	Visiting and Telephone Reassurance	0	0	Contact	0	0	0	0	0.00
	.57	Minor Home Repair and Maintenance	0	0	Contact	0	0	0	0	0.00
	.58	Adult Day Care	0	0	Hours	0	0	0	0	0.00
	.59	Volunteer Services	0	0	Hours	0	0	0	0	0.00
	.50	Other In-home Services (Mental Health)	C	385	Hours	85	23,788	4,198	27,986	72.69
	.50	Other In-home Services	0	0	(Enter Unit)	0	0	0	0	0.00
555	.60	**NUTRITION SERVICES**					**510,925**	**74,410**	**585,335**	
	.61	Congregate Meals	C	31,828	Meals	771	202,056	33,468	235,524	7.40
	.63	Nutrition Education & Outreach	C	250	Sessions	3,000	4,500	706	5,206	20.82
	.64	Home Delivered Meals	C	39,790	Meals	532	272,924	40,236	313,160	7.87
	.65	Shopping Assistance	0	0	Assists	0	0	0	0	0.00
	.66	Registered Dietitian	0		Hours		0	0	0	
	.67	Senior Farmer's Mrkt (SFMNP) Food/Checks	C	693	Participants	693				40.00
	.67.1	Food Purchased					0	0	0	
	.67.2	Checks Received					27,720	0	27,720	
	.67.3	Service Delivery					3,725	0	3,725	
555	.70-.80	**SOCIAL & HEALTH SERVICES**					**490,139**	**117,358**	**607,497**	
	.71	Adult Day Health Services	0	0	Hours	0	0	0	0	0.00
	.72	Geriatric Health Screening	0	0	Sessions	0	0	0	0	0.00
	.73	Medication Management	0	0	Sessions	0	0	0	0	0.00
	.74	Senior Drug Education	D	10	Trainings	250	12,612	0	12,612	1,261.20
	.75	Disease Prevention/Health Promotion	0	0	Sessions	0	0	0	0	0.00
	.76	Elder Abuse Prevention	0	0	Hours	0	0	0	0	0.00
	.77	Mental Health (Powerful Tools)	C	24	Hours	12	15,976	0	15,976	665.67
	.78	Kinship Care								
	.78.1	Kinship Caregivers Support Program								
	.78.1a	Service Delivery					6,394	0	6,394	
	.78.1b	Goods and Services	C	92	Items/Services	52	29,973	0	29,973	325.79
	.78.2	Kinship Navigator Services	0	0	Contacts/Activities	0	0	0	0	0.00
	.79	Family Caregiver Support Program								
	.79.1	Information Services	D				82,000	0	82,000	
	.79.2a	Access Assistance	D				180,163	0	180,163	600.54
	.79.2b	Support Services	C				14,013	333	14,346	47.82
	.79.3	Respite Care Services	C				124,516	0	124,516	30.56
	.79.4	Supplemental Services	C				12,100	333	12,433	7.87
	.79.5	Services to Grandparents/Relatives								
	.79.5a	Information Services	0				0	0	0	0.00
	.79.5b	Access Assistance	0				0	0	0	0.00

See the FCSP Services Tab to Complete the Number, Units & Persons Served

	.79.5c	Support Services	0				0	0	0	0.00
	.79.5d	Respite Care Services	0				0	0	0	0.00
	.79.5e	Supplemental Services	0				0	0	0	0.00
	.79.6	Memory Care and Wellness Services	0				0	0	0	0.00
	.84	Health Appliance/Limited Health Care	0	0	Contacts	0	0	0	0	0.00
	.88	Long Term Care Ombudsman	D	500	Investigations	2,500	12,392	116,692	129,084	258.17
	.89	Newsletters	0	0	Issues	0	0	0	0	0.00
555	.90	**OTHER ACTIVITIES**					**5,002**	**190,000**	**195,002**	
		Disaster Relief					2	0	2	
		Foot care	0	0	Sessions	0	0	0	0	0.00
		Peer Counseling	0	0	Hours	0	0	0	0	0.00
		Outreach	0	0	Contacts	0	0	0	0	0.00
		Aging & Disability Resource Center (ADRC)	0	0	Contacts	0	0	0	0	0.00
		MIPPA	D	60	Applications	60	5,000	0	5,000	83.33
		Chronic Disease Self Management Program (CDSMP)	0	0	(Enter Unit)	0	0	0	0	0.00
		Home Care Referral Registry (HCRR)	0	0	(Enter Unit)	0	0	0	0	0.00
		Veterans Directed Home Services	0	0	Clients	0	0	0	0	0.00
		Other (Mental Health 1/10th)	C	300	Consultations	300	0	90,000	90,000	300.00
		Other (Health Home Coordinator)	D	55	Cases	55	0	100,000	100,000	1,818.18
		Other (Enter Title)	0	0	(Enter Unit)	0	0	0	0	0.00
		Sub-Total - AAA Budgeted					**3,993,449**	**397,966**	**4,391,415**	
		AAA NON-BUDGETED SERVICES								
		Caregiver Training						220,000	220,000	
		Agency Workers' Health Insurance and CGT for Respite/Non-Core						30,000	30,000	
		Other Funding (Enter Description)		0	0	0		0	0	
		Sub-Total - AAA Non-Budgeted					**0**	**250,000**	**250,000**	
		Total AAA - Budgeted and Non-Budgeted					**3,993,449**	**647,966**	**4,641,415**	

Notes: Non-Budgeted funds include all those reimbursed services over which the AAA has no discretion on spending.
The services are either entitlement in nature, or specific spending requirements established by the source of the funds.

Expenditure Detail by Funding Source

AREA AGENCIES ON AGING AREA PLAN BUDGET
EXPENDITURE DETAIL BY FUNDING SOURCE
AAA KITSAP COUNTY AGING and LONG TERM CARE (FSA# 10)
BUDGET PERIOD: January 1- December 31, 2020

BASIS CODE		Contact or Direct Number	Unit	CFDA# Persons Served	93.044 Title III B	93.045 Title III C1	93.045 Title III C2	93.052 Title III E	93.043 Elder Abuse	Other Americans Act DoA	Total	NSIP	OSNS Allocated Title XIX MFP/Chore 93.778/0,781	Title XIX MFP AAA Requested 93.778/0,781	Matched by SCSA Local	SCSA	State Family Caregiver	Kinship Caregiver Support	Kinship Navigator	Sr Farmers Market State	Sr Farmers Market Fed 10.576	Total Sr Farmers Market	Medicaid Transformation 93.778	Other ALTSA Funding	Total ALTSA	Non-ALTSA Funding Sources	Grand Total	Description
855 10	ADMINISTRATION				37,795	20,000	20,000	10,500		88,295			194,891		42,000	35,822	3,256	0	0	0	0	40,000	10,250	425,534	0	425,534	
11	Area Agency Planning/Administration				34,045	18,000	18,000	9,450		79,495					44,000	31,629	3,228	0	0	0	0	40,000	6,225	200,253	0	200,253	Other ALTSA-Admin = $10,250 Caregiver Training Admin of 6%
12	Interfund Payments for Services				3,750	2,000	2,000	1,050		8,800					4,886	3,059	360	0	0	0	0	4,000	1,025	23,140	0	23,140	SHIP/MIP Admin passed to subcontractor
13	Core Services: Contract Management												194,891											194,891	0	194,891	Based on projected caseload of 667
855 21	COORDINATION				35,000					35,000														35,000	6,175	41,175	Coordination activities of Mental Health 1115b Incial grant
855 21	LEGAL ASSISTANCE	C 388	Hours	425	33,000					33,000														33,000	5,534	38,534	Pro-Bono services
855 40	ACCESS SERVICES				160,104					160,104			1,934,076		24,000	239,411							170,880	2,488,471	0	2,488,471	
41	Transportation	C 1	One-way Trips	1							1													2	0	2	
42	Information & Assistance	0 6,240	Contacts	1,473	160,103						160,103				24,000	239,410							170,880	594,393	0	594,393	Other = 3.9 Admin - AltSA by pay month
43.1	Case Management/Nursing Services - Core Services	0 987	Cases	987									1,934,076		0	0								1,934,076	0	1,934,076	Based on projected caseload of 667
43.2	Case Management - Aging Network	0	Hours	0																				0	0	0	
44	Nursing Services - DOA	0	Visits																					0	0	0	
45	Nursing Services - Aging Network	0	Sessions	0																				0	0	0	
46	Nursing Services - Contracted with NCS	0	Visits																					0	0	0	
48	Contracted Front Door Functions (King only)	0	Cases	0									0											0	0	0	
855 50	IN-HOME SERVICES				23,788			0		23,788													0	23,788	4,988	27,986	
51	Chore Services - Aging Network	0	Hours	0	0					0														0	0	0	
52	Personal Care Services - Aging Network	0	Hours	0																				0	0	0	
53	Home Health	0	Hours	0																				0	0	0	
54	Health Maintenance	0	Hours	0				0																0	0	0	
55	Bath Assistance	0	Hours	0																				0	0	0	
56	Visiting and Telephone Reassurance	0	Contact	0																				0	0	0	
57	Minor Home Repair and Maintenance	0	Contact	0																				0	0	0	
58	Adult Day Care	0	Hours	0																				0	0	0	
59	Volunteer Services	0	Hours	0																				0	0	0	
60	Other In Home Services (Mental Health)	C 396	Hours	96	23,788					23,788													0	23,788	4,988	27,986	Unsupported client contact costs = MICS Counseling
60	Other In Home Services	0 0	(Enter Unit)	0	0			0		0														0	0	0	Unsupported client contact costs = MICS Counseling
855 60	NUTRITION SERVICES				191,851	250,000	0			441,851														441,851	74,410	516,261	
61	Congregate Meals	C 31,228	Meals	771	191,851					191,851	11,425				24,443	7,502								235,221	74,410	309,631	
63	Nutrition Education & Outreach	C 265	Sessions	3,000	0	2,000	0			2,000					1,000	0								3,000	0	3,000	
64	Home Delivered Meals	C 39,790	Meals	622		228,000				228,000	24,236				2,000	0								254,236	0	254,236	
65	Shopping Assistance	0	Assists	0		0	0			0					0	0								0	0	0	
66	Registered Dietitian	0	Hours	0		0	0			0					0	0								0	0	0	
67	Senior Farmer's Mkt (SFMNP) Food Checks	C 560	Participants	560															0	21,400	2,403	23,803		23,803	0	23,803	
67.1	Food Purchased																			6,240	1,295	7,535		7,535	0	7,535	
67.2	Checks Received																			21,400	2,403	23,803		23,803	0	23,803	
67.3	Service Delivery																			6,240	1,295	7,535		7,535	0	7,535	
855 70.80	SOCIAL & HEALTH SERVICES				5,382	95,976	94,533	2,090		197,981					5,000	318,259	36,357	0	0	0	0	0		557,579	0	557,579	
71	Adult Day Health Service	0	Hours	0																				0	0	0	
72	Geriatric Health Screening	0 0	Sessions	0																				0	0	0	
73	Medication Management	0 0	Sessions	0			0			0														0	0	0	
74	Senior Drug Education	0 45	Trainings	250																				0	0	0	
75	Disease Prevention/Health Promotion	0 0	Sessions	0			0			0														0	0	0	
76	Elder Abuse Prevention	0 0	Hours	0				0																0	0	0	
77	Mental Health (Powerful Tools)	C 24	Hours	12		95,976				95,976														95,976	0	95,976	Evidence Based program - MICS Counseling
78.1	Kinship Caregivers Support Program																6,394							6,394	0	6,394	
78.1a	Series Delivery																29,973							29,973	0	29,973	
78.2	Kinship Navigator Services	C 60	Items/Events	45														0						0	0	0	
79	Family Caregiver Support Program	0 0	Contacts/Activities	0	0					0					3,000									3,000	0	3,000	
79.1	Information Services					37,000				37,000					1,000	0								38,000	33,466	71,466	$33,466 volunteer labor, $33,000 project incomes (85A/91Kitsap Tribe)
79.2a	Assist Assistance	0		0		54,885				54,885					2,000	125,178				600		600	6,289	188,952	700	189,652	Volunteer Labor - Elemention Services Association ($50)
79.2b	Support Services	0		0		546				546					0	13,455								14,001	40,239	54,240	$10,950 volunteer labor, $30,000 project incomes (85A), Other = $39,289
79.3	Respite Care Services	C		0		1,000				1,000					0	152,616			0	21,400	2,403	23,803		177,419	0	177,419	
79.4	Supplemental Services	C		0		1,000				1,000					0	11,100			0	6,240	1,295	7,535		19,635	333	19,968	
79.5	Services to Grandparents/Relatives		See the ECSP Services Tab to Complete this Number. Units & Personnel Served																0	21,400	2,403	23,803		23,803	0	23,803	
79.5a	Information Services					0				0									0	6,240	1,295	7,535		7,535	0	7,535	
79.5b	Access Assistance					0				0														0	0	0	
79.5c	Support Services					0				0														0	0	0	
79.5d	Respite Care Services					0				0														0	0	0	
79.5e	Supplemental Services					0				0														0	0	0	
79.6	Memory Care and Wellness Services (MCWS - WA and King only)	0		0																				0	0	0	
84	Health Application Unlimited Health Care	0 0	Contacts	0		0				0					0	0								0	0	0	
88	Long Term Care Ombudsman	0 500	Investigations	2,500	5,382	0		2,090		7,382					5,000	0								12,382	116,982	129,364	LTCOP = $76,982; Kitsap County General Fund = $40,000
89	Newsletters	0 0	Issues	0		0		0		0						0								0	0	0	
855 90	OTHER ACTIVITIES																										
	Disaster Relief			1							1													1	0	1	
	Fall care	0	Sessions	0							0													0	0	0	
	Peer Counseling	0 0	Hours	0							0													0	0	0	
	Outreach	0 0	Contacts	0							0													0	0	0	
	Aging & Disability Resource Center (ADRC)	0 0	Contacts	0							0													0	0	0	
	MIPPA	0 60	Applications	60																			5,000	5,000	0	5,000	MIPPA Extension
	Chronic Disease Self Management Program (CDSMP)	0 0	(Enter Unit)	0							0													0	0	0	
	Home Care Referral Registry (HCRR)	0 0	(Enter Unit)	0							0													0	0	0	
	Veterans Directed Home Services	0 0	Clients	0							0													0	0	0	
	Other (Mental Health 1115b)	C 330	Consultations	330																				0	90,000	90,000	Mental Health 1115b Incial grant
	Other (Health Home Coordinator)	C 45	Cases	45																				0	100,000	100,000	Health Home Coordinator
	Other (Other Title)	0 0	(Enter Unit)	0	0			0		0														0	0	0	
	Total Services				252,205	191,851	250,000	45,976	94,533	2,090	836,655																	
	Total Expenditures				300,000	211,851	250,000	45,976	106,033	2,090	898,670	35,641	1,934,076	24,000	347,412	316,259	36,357	0	24,443	7,502	31,945	170,880	74,010	3,387,445	397,965	3,785,410	

Formulas

AREA AGENCIES ON AGING AREA PLAN BUDGET
AREA PLAN FORMULA WORKSHEET
AAA: KITSAP COUNTY AGING and LONG TERM CARE (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

MATCH REQUIREMENT COMPUTATION

	Title 3B Supportive Services	Title 3C1 Congregate Meals	Title 3C2 Home Delivered Meals	Title 3D Disease Prevention / Health Prom.	Title 3E Nat'l Family Caregiver Support	OAA Total	TXIX/MFP Matched by SCSA/Local	Total Match
Administration Match	12,598	6,667	6,667		3,500	29,432	0	29,432
Services Match	46,271	33,821	40,588		31,511	152,191	0	152,191
Total Match	58,870	40,487	47,255		35,011	181,623	0	181,623

REQUIRED MATCH

	Title 3B	Title 3C1	Title 3C2	Title 3D	Title 3E	OAA Total
% of Admin. Match Budgeted (OAA Min. 25%)	25.00%	25.00%	25.00%			
% of Services Match Budgeted (OAA Min. 15%)	15.00%	15.00%	15.00%			
% of Total Match Budgeted (T3E only, Minimum 25%)					25.00%	

ADMINISTRATION EXPENDITURE LIDS

	Title 3E	OAA Total
T3E - must not exceed 10%. OAA Total - Must be exactly 10% if Coordination is budgeted. OAA Total - Must not exceed 10% if Coordination is not budgeted.	10.00%	10.00%

OAA MINIMUM FUNDING LEVEL

T3B Funds	AAA Level
Access Services (Minimum 15%)	55.01%
Legal Services (Minimum 11%)	11.00%
In-Home Services (Minimum 1%)	7.93%

LIDS

	SCSA	SFCSP	Title 3E	KCSP	KinNav
Administration (SCSA 16.5% Max., SFCSP and KinNav 10% Max.)	16.50%	10.00%			0.00%
FCSP - Respite Services (53% Max. SFCSP, 35% Max. Title 3E Funds)		34.93%	0.95%		
KCSP - Admin and Service Delivery (20% total Max.);				25.00%	

Staff Full Time Equivalent (FTE) Breakout

AREA AGENCIES ON AGING AREA PLAN BUDGET
Staff Full Time Equivalent (FTE) Breakout
AAA: KITSAP COUNTY AGING and LONG TERM CARE (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

FTE Distribution			Cost Pools								Direct Charge									
Position Title	Total FTE		1902 Admin	1902 Contract Mgmt	Enter Pool Name	Enter Pool Name	Enter Pool Name	Enter Pool Name	Non ALTSA Pool	Subtotal Pools	Coord (1902)	LTCOP (1903)	MIPPA (1903)	I&A (104)	SENIOR DRUG (1904)	FCSP (1905)	MTD (1906)	XIX (1907)	Non ALTSA Cost Center	Subtotal Direct Charge
Director/Administrator	1.00	ok	0.76	0.03						0.79	0.20								0.01	0.21
Office Support Supervisor	1.00	ok	0.55							0.55		0.01	0.01	0.05		0.02		0.36		0.45
Program Supervisor (Planner/Monitor)	1.00	ok	0.42	0.56						0.98									0.02	0.02
Office Support Specialist	1.50	ok	0.70	0.80						1.50										0.00
Fiscal Support Specialist	1.00	ok	0.90	0.10						1.00										0.00
Program Supervisor (I&A/FC/MTD)	1.00	ok								0.00				0.50		0.25	0.25			1.00
Program Supervisor (CORE)	1.00	ok								0.00								1.00		1.00
Program Specialist (CORE) Case	11.50	ok								0.00								11.50		11.50
Program Analyst (CORE RN)	0.50	ok								0.00								0.50		0.50
Office Support Assistant	4.75	ok	0.56							0.56		0.01	0.01	0.20		0.20	0.05	3.72		4.19
Program Specialist I&A/FC Case	4.00	ok								0.00				2.00		2.00				4.00
Program Tech (I&A Assist Worker)	1.00	ok								0.00			0.03	0.45	0.02		0.50			1.00
Program Analyst (LTC Ombudsman)	0.95	ok								0.00		0.14							0.81	0.95
Program Specialist (Health Home	1.00	ok								0.00									1.00	1.00
Program Specialist (MTD Case Manager)	1.00	ok								0.00							1.00			1.00
Enter Position Title	0.00	ok								0.00										0.00
Enter Position Title	0.00	ok								0.00										0.00
Enter Position Title	0.00	ok								0.00										0.00
Enter Position Title	0.00	ok								0.00										0.00
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Enter Position Title	0.00	ok								0.00										0.00
Enter Position Title	0.00	ok								0.00										0.00
Enter Position Title	0.00	ok																		
Total FTEs	32.20		3.89	1.49	0.00	0.00	0.00	0.00	0.00	5.38	0.20	0.16	0.05	3.20	0.02	2.47	1.80	17.08	1.84	26.82

Total FTE Equals the Total FTE Reported on Reconciliation Tab: YES

AAA Individual Direct Service Worksheets

AREA AGENCIES ON AGING AREA PLAN BUDGET
AAA INDIVIDUAL DIRECT SERVICES WORKSHEET
AAA KITSAP COUNTY AGING and LONG TERM C
BUDGET PERIOD: January 1 - December 31, 2020

COST CENTER OR COST POOL: ADMINISTRATION (1902)

		OLDER AMERICAN'S ACT							DSHS ALLOCATED																	
	TOTAL	Title 3B	Title 3C1	Title 3C2	Title 3D	Title 3E	Elder Abuse Prevention	NSIP	Core Svcs Contract Management	TXIX / MFP / Chore CMNS	Nurse Services DDA	Nurse Svcs Contracted With HCS	Contract Front Door	Matched by SCSA Local	Medicaid Transformation Demonstration	SCSA	State Family Caregiver	Kinship Caregiver Support	Kinship Navigator	Senior Farmers Market	Other ALTSA Funding	Non - ALTSA LTCOP	Non - ALTSA COUNTY	Non - ALTSA MH 1/10	Non - ALTSA Home Hlth
Full Time Equivalents:																										
Total FTEs	5.41																									
Direct Services:																										
10 Salaries & Wages	365,452	22,227	11,762	11,762	0	6,175	0	0	114,404	107,909	0	0	0	0	26,465	28,752	20,796	2,115	0	0	6,026	0	0	7,057	0
20 Personnel Benefits	168,527	10,250	5,424	5,424	0	2,848	0	0	52,757	49,762	0	0	0	0	12,204	13,259	9,590	975	0	0	2,780	0	0	3,254	0
30-80 All Other Costs	26,291	1,538	814	814	0	427	0	0	7,917	7,468	0	0	0	0	1,831	1,990	1,440	146	0	0	417	0	0	489	0
90 Interfund Pmts for Service	62,142	3,780	2,000	2,000	0	1,050	0	0	19,453	18,349	0	0	0	0	4,500	4,899	3,536	360	0	0	1,025	0	0	1,200	0
Total Direct Expenditures	**621,412**	**37,795**	**20,000**	**20,000**	**0**	**10,500**	**0**	**0**	**194,531**	**183,488**	**0**	**0**	**0**	**0**	**45,000**	**48,900**	**35,362**	**3,595**	**0**	**0**	**10,250**	**0**	**0**	**12,000**	**0**

ALTSA/Non-ALTSA Breakout Section

	ALTSA	Non-ALTSA	Total	
Percentage	98%	2%	100%	
FTE	5.31	0.10	5.41	Correct
Funding	$ 609,412	$ 12,000	$ 621,412	Correct

AREA AGENCIES ON AGING AREA PLAN BUDGET
AAA INDIVIDUAL DIRECT SERVICES WORKSHEET
AAA KITSAP COUNTY AGING and LONG TERM CARE (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

COST CENTER OR COST POOL: COORDINATION (1902)

		OLDER AMERICAN'S ACT							DSHS ALLOCATED																	
	TOTAL	Title 3B	Title 3C1	Title 3C2	Title 3D	Title 3E	Elder Abuse Prevention	NSIP	Core Svcs Contract Management	TXIX / MFP / Chore CMNS	Nurse Services DDA	Nurse Svcs Contracted With HCS	Contract Front Door	Matched by SCSA Local	Medicaid Transformation Demonstration	SCSA	State Family Caregiver	Kinship Caregiver Support	Kinship Navigator	Senior Farmers Market	Other ALTSA Funding	Non - ALTSA LTCOP	Non - ALTSA COUNTY	Non - ALTSA MH 1/10	Non - ALTSA Home Hlth
Full Time Equivalents:																										
Total FTEs	0.20																									
Direct Services:																										
10 Salaries & Wages	20,584	20,584	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20 Personnel Benefits	9,492	9,492	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
30-80 All Other Costs	1,424	1,424	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
90 Interfund Pymnts for Servic	3,500	3,500	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Direct Expenditures	**35,000**	**35,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

ALTSA/Non-ALTSA Breakout Section

	ALTSA	Non-ALTSA	Total	
Percentage	100%	0%	100%	
FTE	0.20	0.00	0.20	Correct
Funding	$ 35,000	$ -	$ 35,000	Correct

AREA AGENCIES ON AGING AREA PLAN BUDGET
AAA INDIVIDUAL DIRECT SERVICES WORKSHEET
AAA KITSAP COUNTY AGING and LONG TERM CARE (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

COST CENTER OR COST POOL: LONG TERM CARE OMBUDSMAN (1903)

		OLDER AMERICAN'S ACT							DSHS ALLOCATED																	
	TOTAL	Title 3B	Title 3C1	Title 3C2	Title 3D	Title 3E	Elder Abuse Prevention	NSIP	Core Svcs Contract Management	TXIX / MFP / Chore CMNS	Nurse Services DDA	Nurse Svcs Contracted With HCS	Contract Front Door	Matched by SCSA Local	Medicaid Transformation Demonstration	SCSA	State Family Caregiver	Kinship Caregiver Support	Kinship Navigator	Senior Farmers Market	Other ALTSA Funding	Non - ALTSA LTCOP	Non - ALTSA COUNTY	Non - ALTSA MH 1/10	Non - ALTSA Home Hlth
Full Time Equivalents:																										
Total FTEs	0.97																									
Direct Services:																										
10 Salaries & Wages	75,915	3,165	0	0	0	0	1,182	0	0	0	0	0	0	0	0	2,941	0	0	0	0	0	45,103	23,524	0	0
20 Personnel Benefits	35,010	1,460	0	0	0	0	545	0	0	0	0	0	0	0	0	1,358	0	0	0	0	0	20,799	10,848	0	0
30-80 All Other Costs	5,251	219	0	0	0	0	82	0	0	0	0	0	0	0	0	201	0	0	0	0	0	3,121	1,628	0	0
90 Interfund Pymnts for Servic	12,908	538	0	0	0	0	201	0	0	0	0	0	0	0	0	500	0	0	0	0	0	7,669	4,000	0	0
Total Direct Expenditures	**129,084**	**5,382**	**0**	**0**	**0**	**0**	**2,010**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5,000**	**0**	**0**	**0**	**0**	**0**	**76,692**	**40,000**	**0**	**0**

ALTSA/Non-ALTSA Breakout Section

	ALTSA	Non-ALTSA	Total	
Percentage	10%	90%	100%	
FTE	0.09	0.88	0.97	Correct
Funding	$ 12,392	$ 116,692	$ 129,084	Correct

AREA AGENCIES ON AGING AREA PLAN BUDGET
AAA INDIVIDUAL DIRECT SERVICES WORKSHEET
AAA KITSAP COUNTY AGING and LONG TERM CARE (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

COST CENTER OR COST POOL: MIPPA (1903)

		OLDER AMERICANS ACT							DSHS ALLOCATED																		
	TOTAL	Title 3B	Title 3C1	Title 3C2	Title 3D	Title 3E	Elder Abuse Prevention	NSIP	Core Svcs Contract Management	TXIX / MFP / Chore CMNS	Nurse Services DDA	Nurse Svcs Contracted With HCS	Contract Front Door	Matched by SCSA Local	Medicaid Transformation Demonstration	SCSA	State Family Caregiver	Kinship Caregiver Support	Kinship Navigator	Senior Farmers Market	Other ALTSA Funding	Non-ALTSA LTCOP	Non-ALTSA COUNTY	Non-ALTSA MH 1/10	Non-ALTSA Home Hlth
Full Time Equivalents:																											
Total FTEs	0.05																										
Direct Services:																											
10 Salaries & Wages	2,941	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,941	0	0	0	0
20 Personnel Benefits	1,356	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,356	0	0	0	0
30-80 All Other Costs	203	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	203	0	0	0	0
90 Interfund Pymnts for Servic	500	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	500	0	0	0	0
Total Direct Expenditures	**5,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5,000**	**0**	**0**	**0**	**0**

ALTSA/Non-ALTSA Breakout Section

	ALTSA	Non-ALTSA	Total	
Percentage	100%	0%	100%	
FTE	0.05	0.00	0.05	Correct
Funding	$ 5,000	$ -	$ 5,000	Correct

AREA AGENCIES ON AGING AREA PLAN BUDGET
AAA INDIVIDUAL DIRECT SERVICES WORKSHEET
AAA KITSAP COUNTY AGING and LONG TERM CARE (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

COST CENTER OR COST POOL: INFORMATION and ASSISTANCE (1904)

		OLDER AMERICANS ACT							DSHS ALLOCATED																		
	TOTAL	Title 3B	Title 3C1	Title 3C2	Title 3D	Title 3E	Elder Abuse Prevention	NSIP	Core Svcs Contract Management	TXIX / MFP / Chore CMNS	Nurse Services DDA	Nurse Svcs Contracted With HCS	Contract Front Door	Matched by SCSA Local	Medicaid Transformation Demonstration	SCSA	State Family Caregiver	Kinship Caregiver Support	Kinship Navigator	Senior Farmers Market	Other ALTSA Funding	Non-ALTSA LTCOP	Non-ALTSA COUNTY	Non-ALTSA MH 1/10	Non-ALTSA Home Hlth
Full Time Equivalents:																											
Total FTEs	3.20																										
Direct Services:																											
10 Salaries & Wages	268,116	97,056	0	0	0	0	0	0	0	0	0	0	0	14,114	0	140,797	0	0	0	0	16,149	0	0	0	0
20 Personnel Benefits	123,641	44,757	0	0	0	0	0	0	0	0	0	0	0	6,509	0	64,928	0	0	0	0	7,447	0	0	0	0
30-80 All Other Costs	18,556	6,717	0	0	0	0	0	0	0	0	0	0	0	977	0	9,744	0	0	0	0	1,118	0	0	0	0
90 Interfund Pymnts for Servic	45,590	16,503	0	0	0	0	0	0	0	0	0	0	0	2,400	0	23,941	0	0	0	0	2,746	0	0	0	0
Total Direct Expenditures	**455,903**	**165,033**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**24,000**	**0**	**239,410**	**0**	**0**	**0**	**0**	**27,460**	**0**	**0**	**0**	**0**

	ALTSA	Non-ALTSA	Total	
Percentage	100%	0%	100%	
FTE	3.20	0.00	3.20	Correct
Funding	$ 455,903	$ -	$ 455,903	Correct

AREA AGENCIES ON AGING AREA PLAN BUDGET
AAA INDIVIDUAL DIRECT SERVICES WORKSHEET
AAA KITSAP COUNTY AGING and LONG TERM CARE (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

COST CENTER OR COST POOL: SENIOR DRUG RX (1904)

		OLDER AMERICANS ACT							DSHS ALLOCATED																		
	TOTAL	Title 3B	Title 3C1	Title 3C2	Title 3D	Title 3E	Elder Abuse Prevention	NSIP	Core Svcs Contract Management	TXIX / MFP / Chore CMNS	Nurse Services DDA	Nurse Svcs Contracted With HCS	Contract Front Door	Matched by SCSA Local	Medicaid Transformation Demonstration	SCSA	State Family Caregiver	Kinship Caregiver Support	Kinship Navigator	Senior Farmers Market	Other ALTSA Funding	Non-ALTSA LTCOP	Non-ALTSA COUNTY	Non-ALTSA MH 1/10	Non-ALTSA Home Hlth
Full Time Equivalents:																											
Total FTEs	0.02																										
Direct Services:																											
10 Salaries & Wages	4,525	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,525	0	0	0	0
20 Personnel Benefits	2,087	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,087	0	0	0	0
30-80 All Other Costs	6,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6,000	0	0	0	0
90 Interfund Pymnts for Servic	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Direct Expenditures	**12,612**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**12,612**	**0**	**0**	**0**	**0**

ALTSA/Non-ALTSA Breakout Section

	ALTSA	Non-ALTSA	Total	
Percentage	100%	0%	100%	
FTE	0.02	0.00	0.02	Correct
Funding	$ 12,612	$ -	$ 12,612	Correct

AREA AGENCIES ON AGING AREA PLAN BUDGET
AAA INDIVIDUAL DIRECT SERVICES WORKSHEET
AAA KITSAP COUNTY AGING and LONG TERM CARE (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

COST CENTER OR COST POOL: FAMILY CAREGI VER (1905)

		OLDER AMERICAN'S ACT							DSHS ALLOCATED																
	TOTAL	Title 3B	Title 3C1	Title 3C2	Title 3D	Title 3E	Elder Abuse Prevention	NSIP	Core Svcs Contract Management	TXIX / MFP / Chore CMNS	Nurse Services DDA	Nurse Svcs Contracted With HCS	Contract Front Door	Matched by SCSA Local	Medicaid Transformation Demonstration	SCSA	State Family Caregiver	Kinship Caregiver Support	Kinship Navigator	Senior Farmers Market	Other ALTSA Funding	Non - ALTSA LTCOP	Non - ALTSA COUNTY	Non - ALTSA MH 1/10	Non - ALTSA Home Hlth
Full Time Equivalents:																									
Total FTEs	2.47																								
Direct Services:																									
10 Salaries & Wages	154,178	0	0	0	0	54,096	0	0	0	0	0	0	0	0	0	0	100,082	0	0	0	0	0	0	0	0
20 Personnel Benefits	71,098	0	0	0	0	24,946	0	0	0	0	0	0	0	0	0	0	46,152	0	0	0	0	0	0	0	0
30-80 All Other Costs	10,670	0	0	0	0	3,744	0	0	0	0	0	0	0	0	0	0	6,926	0	0	0	0	0	0	0	0
90 Interfund Pymnts for Servic	26,217	0	0	0	0	9,199	0	0	0	0	0	0	0	0	0	0	17,018	0	0	0	0	0	0	0	0
Total Direct Expenditures	**262,163**	**0**	**0**	**0**	**0**	**91,985**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**170,178**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

ALTSA/Non-ALTSA Breakout Section

	ALTSA	Non-ALTSA	Total	
Percentage	100%	0%	100%	
FTE	2.47	0.00	2.47	Correct
Funding	$ 262,163	$ -	$ 262,163	Correct

AREA AGENCIES ON AGING AREA PLAN BUDGET
AAA INDIVIDUAL DIRECT SERVICES WORKSHEET
AAA KITSAP COUNTY AGING and LONG TERM CARE (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

COST CENTER OR COST POOL: MTD (1906)

		OLDER AMERICAN'S ACT							DSHS ALLOCATED																
	TOTAL	Title 3B	Title 3C1	Title 3C2	Title 3D	Title 3E	Elder Abuse Prevention	NSIP	Core Svcs Contract Management	TXIX / MFP / Chore CMNS	Nurse Services DDA	Nurse Svcs Contracted With HCS	Contract Front Door	Matched by SCSA Local	Medicaid Transformation Demonstration	SCSA	State Family Caregiver	Kinship Caregiver Support	Kinship Navigator	Senior Farmers Market	Other ALTSA Funding	Non - ALTSA LTCOP	Non - ALTSA COUNTY	Non - ALTSA MH 1/10	Non - ALTSA Home Hlth
Full Time Equivalents:																									
Total FTEs	1.80																								
Direct Services:																									
10 Salaries & Wages	105,205	0	0	0	0	0	0	0	0	0	0	0	0	0	105,205	0	0	0	0	0	0	0	0	0	0
20 Personnel Benefits	48,515	0	0	0	0	0	0	0	0	0	0	0	0	0	48,515	0	0	0	0	0	0	0	0	0	0
30-80 All Other Costs	7,281	0	0	0	0	0	0	0	0	0	0	0	0	0	7,281	0	0	0	0	0	0	0	0	0	0
90 Interfund Pymnts for Servic	17,889	0	0	0	0	0	0	0	0	0	0	0	0	0	17,889	0	0	0	0	0	0	0	0	0	0
Total Direct Expenditures	**178,890**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**178,890**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

ALTSA/Non-ALTSA Breakout Section

	ALTSA	Non-ALTSA	Total	
Percentage	100%	0%	100%	
FTE	1.80	0.00	1.80	Correct
Funding	$ 178,890	$ -	$ 178,890	Correct

AREA AGENCIES ON AGING AREA PLAN BUDGET
AAA INDIVIDUAL DIRECT SERVICES WORKSHEET
AAA KITSAP COUNTY AGING and LONG TERM CARE (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

COST CENTER OR COST POOL: HEALTH HOMES (1908)

		OLDER AMERICAN'S ACT							DSHS ALLOCATED																
	TOTAL	Title 3B	Title 3C1	Title 3C2	Title 3D	Title 3E	Elder Abuse Prevention	NSIP	Core Svcs Contract Management	TXIX / MFP / Chore CMNS	Nurse Services DDA	Nurse Svcs Contracted With HCS	Contract Front Door	Matched by SCSA Local	Medicaid Transformation Demonstration	SCSA	State Family Caregiver	Kinship Caregiver Support	Kinship Navigator	Senior Farmers Market	Other ALTSA Funding	Non - ALTSA LTCOP	Non - ALTSA COUNTY	Non - ALTSA MH 1/10	Non - ALTSA Home Hlth
Full Time Equivalents:																									
Total FTEs	1.00																								
Direct Services:																									
10 Salaries & Wages	58,810	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	58,810
20 Personnel Benefits	27,120	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	27,120
30-80 All Other Costs	4,070	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,070
90 Interfund Pymnts for Servic	10,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10,000
Total Direct Expenditures	**100,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**100,000**

ALTSA/Non-ALTSA Breakout Section

	ALTSA	Non-ALTSA	Total	
Percentage	0%	100%	100%	
FTE	0.00	1.00	1.00	Correct
Funding	$ -	$ 100,000	$ 100,000	Correct

AREA AGENCIES ON AGING AREA PLAN BUDGET
AAA INDIVIDUAL DIRECT SERVICES WORKSHEET
AAA KITSAP COUNTY AGING and LONG TERM CARE (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

COST CENTER OR COST POOL: MEDICAID XIX (1907)

		OLDER AMERICANS ACT							DSHS ALLOCATED																	
	TOTAL	Title 3B	Title 3C1	Title 3C2	Title 3D	Title 3E	Elder Abuse Prevention	NSIP	Core Svcs Contract Management	TXIX / MFP / Chore CMNS	Nurse Services DDA	Nurse Svcs Contracted With HCS	Contract Front Door	Matched by SCSA Local	Medicaid Transformation Demonstration	SCSA	State Family Caregiver	Kinship Caregiver Support	Kinship Navigator	Senior Farmers Market	Other ALTSA Funding	Non-ALTSA LTCOP	Non-ALTSA COUNTY	Non-ALTSA MH 1/10	Non-ALTSA Home Hlth
Full Time Equivalents:																										
Total FTEs	17.08																									
Direct Services:																										
10 Salaries & Wages	942,618	0	0	0	0	0	0	0	0	942,618	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20 Personnel Benefits	434,685	0	0	0	0	0	0	0	0	434,685	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
30-80 All Other Costs	65,235	0	0	0	0	0	0	0	0	65,235	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
90 Interfund Pymnts for Servic	160,282	0	0	0	0	0	0	0	0	160,282	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Direct Expenditures	**1,602,820**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,602,820**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

ALTSA/Non-ALTSA Breakout Section

	ALTSA	Non-ALTSA	Total	
Percentage	100%	0%	100%	
FTE	17.08	0.00	17.08	Correct
Funding	$ 1,602,820	$ -	$ 1,602,820	Correct

Reconciliation

AREA AGENCIES ON AGING AREA PLAN BUDGET

AAA TOTAL DIRECT SERVICES WORKSHEET INCLUDING SUBCONTRACTED COSTS

AAA KITSAP COUNTY Aging and LONG TERM CARE (PSA #13)

BUDGET PERIOD: January 1 - December 31, 2020

PLEASE ENTER ALL SUBCONTRACTED COST BY FUNDING SOURCE ON LINE 30 BELOW

		OLDER AMERICANS ACT						DSHS ALLOCATED																								
	TOTAL	Title 3B	Title 3C1	Title 3C2	Title 3D	Title 3E	Elder Abuse Prevention	NSIP	Core Svcs Contract Management	TxIX / MFP / Chore CMNS	Nurse Services DOA	Nurse Contracted With HCS	Contract Front Door	Matched by SCSA Local	Medicaid Transformation Demonstration	SCSA	State Family Caregiver	Kinship Caregiver Support	Kinship Navigator	Senior Farmers Market	Other ALTSA Funding	Non-ALTSA LTCOP	Non-ALTSA COUNTY	Non-ALTSA MH 1/10	Non-ALTSA Home Hlth							
Full Time Equivalents:																																
Total FTEs	32.20																															
Direct Services:																																
10 Salaries & Wages	1,998,344	143,032	11,762	11,762	0	60,271	1,182	0	114,404	1,050,527	0	0	0	14,114	131,670	172,490	120,879	2,115	0	0	29,643	45,103	23,524	7,057	58,810							
20 Personnel Benefits	921,531	65,959	5,424	5,424	0	27,794	545	0	52,757	484,447	0	0	0	6,509	60,719	79,545	55,742	975	0	0	13,670	20,799	10,848	3,254	27,120							
30-80 All Other Cost	143,381	9,898	814	814	0	4,171	82	0	7,917	72,703	0	0	0	977	9,112	11,935	8,366	146	0	0	7,738	3,121	1,628	489	4,070							
90 Interfund Payments for Service	339,028	24,321	2,000	2,000	0	10,249	201	0	19,453	178,631	0	0	0	2,400	22,389	29,330	20,554	360	0	0	4,271	7,669	4,000	1,200	10,000							
Total Direct Expenditures	**3,402,884**	**243,210**	**20,000**	**20,000**	**0**	**102,485**	**2,010**	**0**	**194,531**	**1,786,308**	**0**	**0**	**0**	**24,000**	**223,890**	**293,300**	**205,540**	**3,596**	**0**	**0**	**55,322**	**76,692**	**40,000**	**12,000**	**100,000**							
Total Subcontracted Expenditures	807,257	56,790	191,651	230,000	15,976	2,548	0	35,641	0	48,568	0	0	0	0	0	3,002	148,081	38,367	0	31,945	18,688	0	0	78,000	0							
Total Other Subcontractor Resources	91,274	16,198	33,821	40,589	0	606	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0							
ALTSA/Non-ALTSA Breakout Section																																
Total Expenditures[1]	**4,391,416**	**316,198**	**245,472**	**290,589**	**15,976**	**105,699**	**2,010**	**35,641**	**194,531**	**1,834,876**	**0**	**0**	**0**	**24,000**	**223,890**	**296,302**	**353,621**	**39,963**	**0**	**31,945**	**74,010**	**76,692**	**40,000**	**90,000**	**100,000**							

[1] **The Total Expenditures line shown above must equal the Grand Total line on the Expenditure/Revenue Detail By Funding Source worksheet.**

ALTSA/Non-ALTSA Breakout Section

	ALTSA	Non-ALTSA	Total
Percentage	93%	7%	100%
FTE	30.22	1.98	32.20
Funding $	3,174,192	228,692	3,402,884

Correct
Correct

Reconciliation

Grand Total Line from Expenditure Detail	4,391,416	316,198	245,472	290,589	15,976	105,699	2,010	35,641	194,531	1,834,876	0	0	0	24,000	223,890	296,302	353,621	39,963	0	31,945	74,010	76,692	40,000	90,000	100,000							
Difference	4,391,416	316,198	245,472	290,589	15,976	105,699	2,010	35,641	194,531	1,834,876	0	0	0	24,000	223,890	296,302	353,621	39,963	0	31,945	74,010	76,692	40,000	90,000	100,000							
	Error	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Error	Correct	Correct	Correct	Correct							

If error, amount is due to rounding, ignore error amount

Family Caregiver Support Program Services

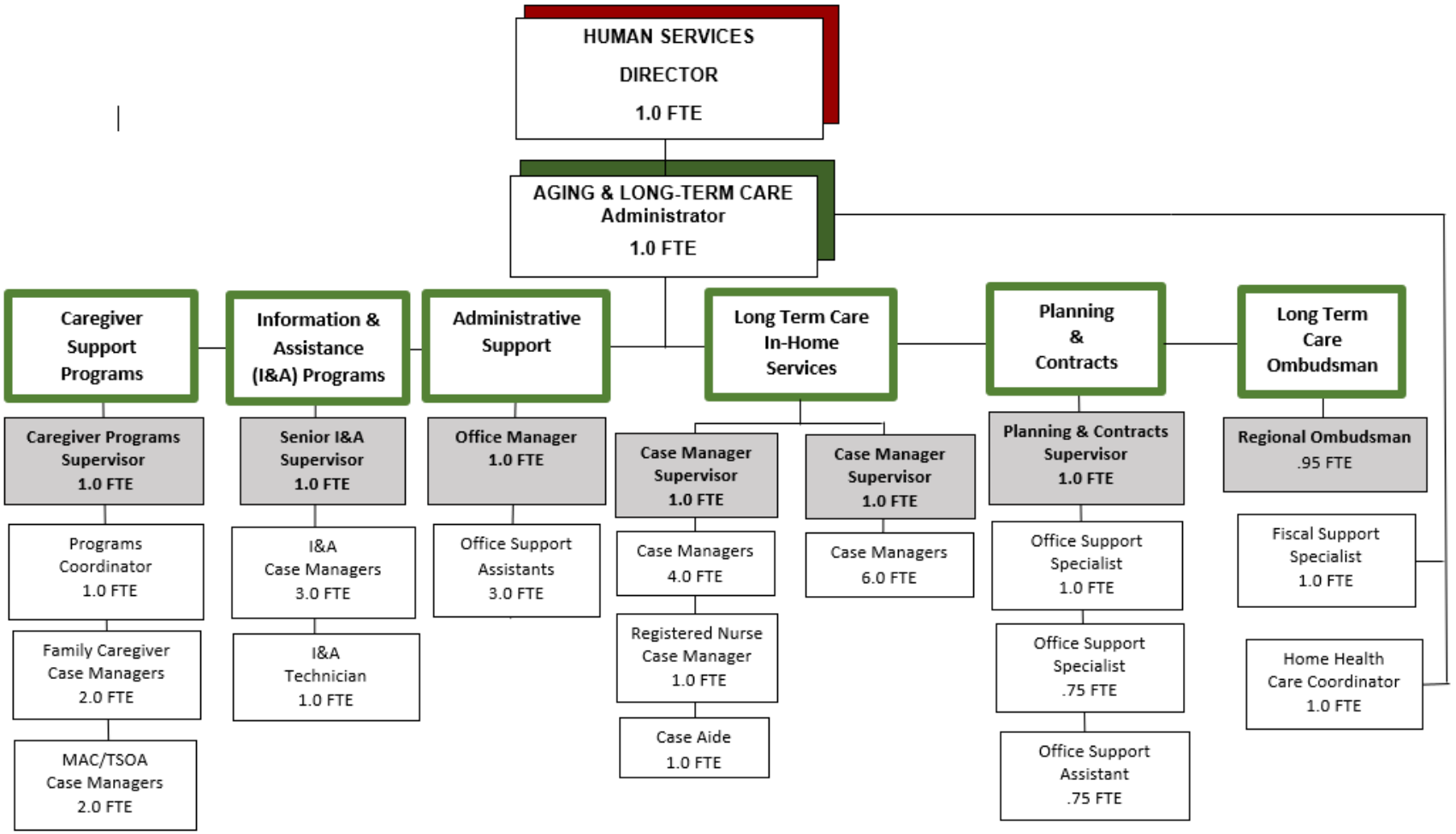
AREA AGENCIES ON AGING AREA PLAN BUDGET
Family Caregiver Support Program - Number of Units and Persons Served
AAA: KITSAP COUNTY AGING and LONG TERM CARE (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

.79	Family Caregiver Support Program	Contract or Direct	Number	Service Units	Persons Served
.79.1	Information Services	D	64	Outreach Activities	5,000
.79.2a	Access Assistance		300		300
		D	300	Contacts	300
		D	125	Screenings	125
		D	125	Assessment/Coordination/Care Plan	125
.79.2b	Support Services				
		C	30	Counseling Sessions	30
		D	2	Training Sessions	50
		0	0	Support Group Sessions	0
.79.3	Respite Care Services	C	4,074	Hours	56
.79.4	Supplemental Services	C	1,580	Services/Hours/Units	25
.79.5	Services to Grandparents/Relatives				
.5.a	Information Services	0	0	Outreach Activities	0
.5.b	Access Assistance				
		0	0	Contacts	0
		0	0	Screenings	0
		0	0	Assessment/Coordination/Care Plan	0
.5.c	Support Services				
		0	0	Counseling Sessions	0
		0	0	Training Sessions	0
		0	0	Support Group Sessions	0
.5.d	Respite Care Services	0	0	Hours	0
.5.e	Supplemental Services	0	0	Services/Hours/Units	0

APPENDICES

Organization Chart

July 2021



Area Agency on Aging Staff

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
Director, Dept. of Human Services	.1 FTE	• Evaluates and supervises the Kitsap Division of Aging and Long-Term Care (ALTC) Administrator.
Human Services Senior Manager (ALTC Administrator)	1 FTE	• Organizes, directs, coordinates and executes administrative and functional activities of the Area Agency on Aging. • Supervises administrative and direct service staff activities. • Develops policies, procedures, and oversight of budgets. • Serves as liaison with Department of Social and Health Services-ALTSA, CSO, HCS and DDA, and County Commissioners, County Departments, outside agencies and the public. • Advocates with state and local officials on behalf of older persons. • Represents the Division in selected special projects in collaboration with other Aging Network entities. • Responds to grievances. • Serve as current Chair to Washington Association of Area Agencies on Aging (W4A) • Lead staff to Aging & Long-Term Care Advisory Council • Co- lead staff to Ombudsman Advisory Council • Tracks, reports, and resolves HIPAA and Medicaid Compliance issues. • Disaster Response Coordinator for ALTC.

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
Human Services Supervisor (ALTC Planner)	1 FTE	• Manages the Planning, Contracts and Evaluation Unit; assigns/supervises work of staff. • Develops and updates the Area Plan. • Evaluates and monitors programs and provides technical assistance. • Responsible for contract negotiations, RFP and oversight of contracting process. • Oversight of Medicaid Waivered Services contract process and evaluation of subcontractors. • Coordinates with management staff to develop policies, procedures and special projects. • Staff to Advisory Council, special committees and legislative advocacy. • Advocates with state and local officials on behalf of older adults as Advisory Council staff. • Other management, planning and coordination activities as assigned.
Office Support Supervisor	1 FTE	• Supervises Fiscal, Long Term Care Support Unit and volunteer support staff. • Timekeeper for Division and support to Management staff. • Provides administrative support for agency sponsored groups. • Liaison for Division in coordination of employee orientations, benefits, and county workplace policies. • Conducts studies, reports as needed. • Provides oversight of Individual Provider (IP) Training compliance. • Designated Provider 1 and IP Provider 1 Coordinator. • Periodically assists with Waiver Services contracting and process. • Back-up for Kitsap County Public Disclosure Coordinator. • Oversight of Senior Employment Program Participant

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
Fiscal Support Specialist	1 FTE	• Develops agency budget for Administrator review. • Performs fiscal desk monitoring and assists Planner with fiscal on-site monitoring of subcontractors. • Processes and verifies reimbursement requests and prepares vouchers for payment. • Prepares monthly and quarterly fiscal reports. • Prepares billings to funding sources. • Processes and coordinates county and grant budget changes. • Development and maintenance of Cost Allocation Plans. • Maintains Agency and provider inventories. • Manages computer assets and purchasing computer equipment. • Prepares MIS reports and state program reports. • Oversees Administration and subcontractor expenditures, analyzes utilization patterns. • Assistant to Timekeeper. • Payroll processing- includes maintaining back-up records and recording of direct program time.
Office Support Specialist Contracts	~~.75~~ 1.0 FTE	• Assists Planner with projects of the Planning, Contracts and Evaluation Unit. • Performs subcontract desk monitoring and program on-site evaluation. • Maintains files and subcontract control documents for monitoring purposes. • SharePoint Project Center backup. • Schedules meetings and events, records minutes. • Assists Planner with coordinating community events and activities. • Provides support to Administrative Support Unit • Web Content Editor

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
Office Support Specialist Contracts/Medicaid Waiver Services	.75 FTE	• Assists Planner with projects of the Planning, Contracts and Evaluation Unit. • Drafts and processes Medicaid Waiver Services contracts. • Performs Medicaid Waiver Services and subcontract desk monitoring and program on-site evaluation. • Maintains files and subcontract control documents for monitoring purposes. • Maintains SharePoint Project Center. • Schedules meetings and events, records minutes. • Assists Fiscal and Administrative staff with database reporting and prepares fiscal monitoring and overpayment documents. • Provides support to the Administrative Support Unit. • ~~Web Content Editor~~ Processes Accounts Payable
Office Support Assistant (Primary Reception)	1 FTE	• Front reception- Receives and routes telephone calls and directs visitors. • Assists persons desiring information. • Provides support to Medicaid Case Managers. • Backup for processing forms and ordering materials. • Backup for Provider1 Individual Provider (IP) training input. • Processes incoming IP files received from out of county and Home and Community office. • Sets up IP files and enters the information into Automated Contracting Database (ACD) emails status updates to case managers, supervisors and support staff team. • Provides support for special projects as needed.
Office Support Assistant	.75 FTE	• Assists to maintain files and subcontract control documents for monitoring purposes. • Coordinates materials for outreach Senior Information & Assistance (I&A) events.

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
(.50 Administrative/ .25 Senior I&A)		• Maintains Senior I&A resource directory. • Enters surveys and assessments into databases. • Provides support to Administration; prepares and sends mailings. • Staff to Advisory Council, administratively supports Council.
Office Support Assistant (Individual Provider Training Coordinator)	1 FTE	• Receives and routes telephone calls and directs visitors. Backup to reception • Processes contracts for new Individual Providers (IP) as back up. • IP Training Coordinator. Tracks IP training, Accesses Department of Health and Home Care Aide Certifications, and Training Partnership to ensure accuracy. • Receives daily reports from Training Partnership and updates the office master report and emails to Medicaid case manager, case manager supervisors and support staff team. • Distributes IP master report weekly. • Supports supervisor with employment program timesheets as requested.
Office Support Assistant (Backup Reception)	1 FTE	• Maintains Individual Provider (IP) files and updates information in ACD database. • Mails IP contract, background check renewal notifications and updates to case managers, supervisors and support staff. • Processes contracts for renewing IPs. • Generates IP reports for compliance. • Provides backup telephone coverage.
Supervisor ~~Senior Information & Assistance and~~ Caregiver Programs	1 FTE	• Manages ~~Senior Information & Assistance (I&A)/~~Caregiver Support, Medicaid Alternative Care (MAC), Tailored Supports for Older Adults (TSOA) and other ancillary projects and assigns and supervises work of 4 paid staff.

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
(Community Living Connections)		• Coordinates with management staff to develop policies, procedures and special projects. • Develops, implements volunteer support. • Reviews client records. • Implements service delivery programs. • Serves as liaison between the County and public for ~~I&A~~, Caregiver Support and MAC and TSOA programs. • Identifies, implements programs to meet staff training needs. • ~~Coordinates outreach and media activities including Caregiver conference, County Fair events, Wellness Fairs and other community outreach.~~ • Lead staff on Community Living Connections (CLC) database
Supervisor Senior Information & Assistance	1 FTE	• Manages Senior Information & Assistance (I&A) assignments and supervises work of 4 paid staff. • Coordinates outreach and media activities including Caregiver conference, County Fair events, Wellness Fairs and other community outreach.
Case Management Supervisor (Medicaid Long Term Care Unit)	2 FTE	• JRP duties • Fair Hearing Coordinators • Quality Assurance and clinical oversight • Network home care agency liaison.

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
Case Manager	17 FTE	Case Managers: • In-depth screening, both by telephone and in person. • Provides information and referrals for service. • Comprehensive assessments. • Develops Service Plan, implements, follow-up. • Supportive case management functions. • Plans termination and implementation. • Local level of complaint resolution.
Registered Nurse	1 FTE	• Schedules and performs nursing consultation and visits. • Ensures best practices used by caregivers, upon request. • Maintains documentation and quality assurance for Nursing Services. • Manages casework for targeted medically complex or unstable clients. • Provides nurse consultation throughout programs to agency staff. • Participates in targeted contract monitoring of nursing and nurse delegation services.
Assistance Specialist	1 FTE	• Provides routine information and referrals for service. • Interviews clients to collect information. • Perform outreach activities and field visits. • Maintains records. • Assists case managers with implementation of service plans.
Office Support Assistant-Case Aide	1 FTE	• Provides clerical support to Case Managers. • Contacts clients and caregivers on established schedule to check status of client and care plans. • Limited non-clinical field work.

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
		• Aids in special/short-term projects, including Client Satisfaction Surveys.
LTC Regional Ombudsman	.95 FTE	• Identifies, investigates, and resolves complaints. • Mediates disputes. • Recruits, trains, support and supervise 25 volunteer ombudsmen. • Documents computerized reporting system. • Co-lead to Ombudsman Advisory Council • Participates in statewide Ombudsman forums and legislative advocacy.
~~Health Home Coordinator~~	~~1 FTE~~	~~• Accepts referrals for dual eligible clients~~ ~~• Provides outreach to potential clients~~ ~~• Engages clients through successfully completing a Health Action Plan and other required assessments~~ ~~• Provides on-going care coordination billable activities~~ ~~• Development of program protocols~~

Total number of staff (section pending revision) = ~~33~~ 35
Total number of full time, 40 hours per week staff = ~~29~~ 32
Total number of part-time staff = ~~4~~ 3
Total number of minority staff = 6
Total number of staff over age 60 = 11
Total number of staff self-indicating with a disability = 0

Emergency Response Plan

Update:
Due to 2020 COVID response and other demands on the Kitsap County Department of Emergency Management, this document has not been finalized.

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

The Northwest Response Network provided another avenue for coordinated hospital and healthcare setting communication. Weekly hospital surge capacity reports and monthly meetings provided updated information related to COVID and recovery efforts.

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

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

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

The original Annex, finalized in November 2014, is currently under revision to include the comprehensive response to a variety of disasters for vulnerable individuals. It is informed by guidance from the Federal Emergency Management Act (FEMA), US

Department of Health and Human Services Toolkit for Aging & Disability Network in Emergency Planning, Northwest Healthcare Response Network System Emergency Response Plan, and May 2019 Kitsap Public Health Emergency Planning Assessment of Access and Functional Community Needs in Kitsap County.

Vulnerable Populations Taskforce and Local Partners

Kitsap County's Department of Emergency Management (KCDEM) convenes and chairs the Vulnerable Population Task Force (VPTF) to coordinate the development response strategies. Developed in 2009, the mission of VPTF is to enhance preparedness and to coordinate response efforts in disasters by fostering connections between CBOs, local government, and private sectors. With representation of over 20 organizations, VPTF members provide services to various populations with access and functional needs throughout the County.

It's expressed mission is to increase communication and collaboration with agencies providing services to access and functional needs populations, specifically those populations who are homeless, disabled, with mental health/addiction disorders, and seniors.

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

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

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

Criteria for Vulnerable Populations

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

The elderly, children, and persons with disabilities or in isolated or homeless situations (at-risk, vulnerable populations) can experience communication and transportation barriers and as a result, often suffer disproportionately from disasters. Individuals who

have high risk for harm from an emergency event due to significant limitations in their personal care or self-protection abilities, mobility, vision, hearing, communication, or health status. These limitations may be the result of physical, mental, or sensory impairments or medical conditions. Some of these individuals may be reliant on specialized supports such as mobility aides (wheelchairs, walkers, canes, or crutches), communication systems (hearing aids, TTY's, etc.), medical devices (ventilators, dialysis, pumps, or monitors), prescription medication, or personal attendants. For some individuals, loss of these supports due to emergency-related power and communication outages or transportation and supply disruptions may be the primary or only risk factor.

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

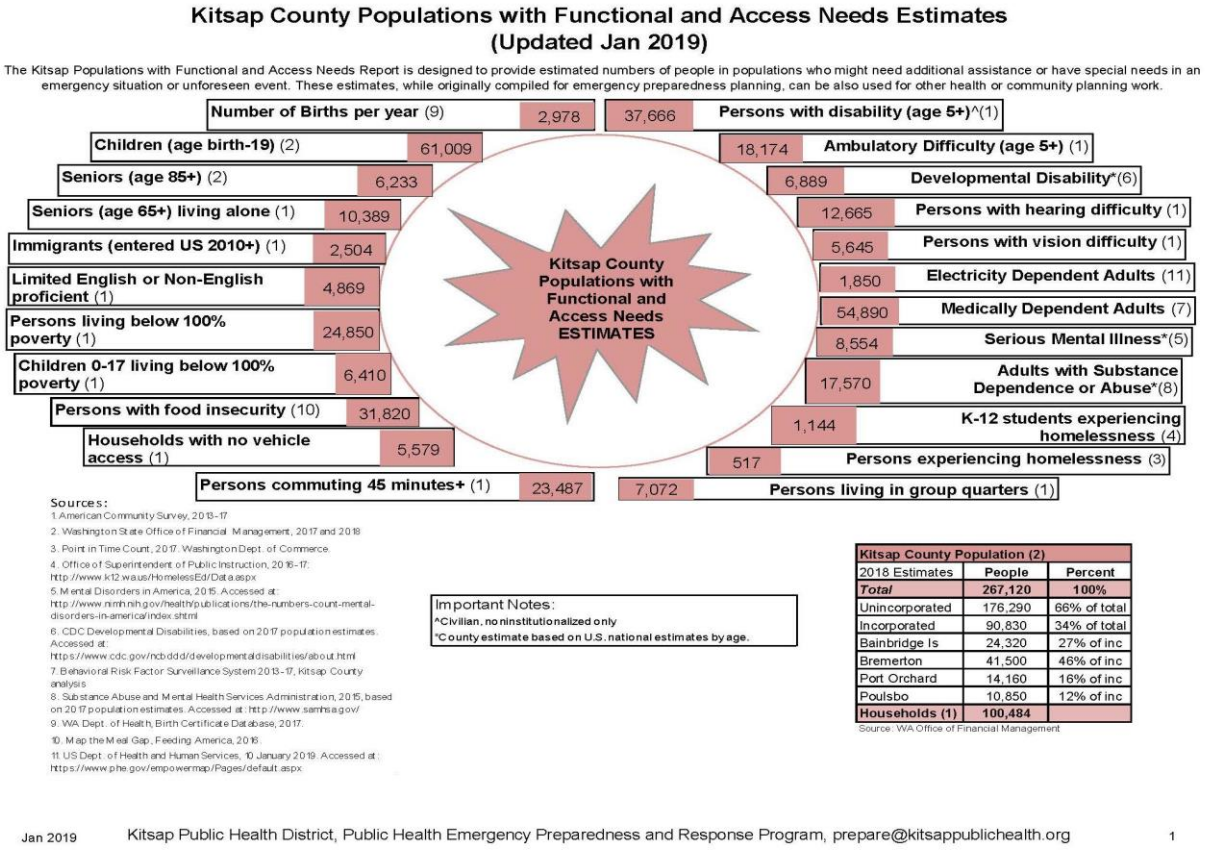
Effectively and quickly serving the "whole community" during an emergency is more achievable if public health responders know which groups are at risk to more adverse impacts and if responders recognize their preferred ways of receiving urgent information and emergency medications (CDC, 2015).

A Closer View of the Kitsap County Region

The region for this research project is Kitsap County. As shown in Attachment A, the Kitsap region is in the Pacific Northwest across the Puget Sound, west from the Seattle-Tacoma Metropolitan area in Washington State. The area includes the growing incorporated Cities of Bremerton (the largest population), Bainbridge Island, Port Orchard, and Poulsbo. Many parts of the region are **geographically isolated** by water most noticeably on Bainbridge and Blake Islands and much of the peninsula and isolated areas are reliant on transportation offered by four Washington State Ferry routes, three Kitsap Transit Ferry routes, and aging bridges (Agate Pass). An estimated 267,120 total persons call Kitsap County home.

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

The following table illustrates population estimates for vulnerable populations in the county who may have specific access and functional needs.



Plan for contacting high risk individuals

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

The Division of Aging and Long-Term Care maintains a hard copy and electronic list of individuals that receive case management services, such as through the Community First Choice/COPES/ Medicaid Personal Care, Family Caregiver, Medicaid Alternative Care and Tailored Supports for Older Adults, and Health Home programs. The paper copies of caseload lists would be transported to the Emergency Command Center (EOC) by Division staff during an emergency to facilitate contact and outreach efforts.

Media and Social Media

In the event of an emergency, the County will alert the media and will make information available to the public. The KCDEM keeps a list of key contacts for radio, television, emergency text alerts, daily newspapers, and specialized publications. The designated County Public Information Officer is tasked with connecting to the various media outlets to ensure that information is accessible and relevant to individuals with access and functional needs. They can also send community blasts through emergency alert text and highway reader boards.

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

Preparedness Activities

The Vulnerable Population Annex will be reviewed and exercised at least once every three years. It is currently under revision to meet the changing requirements and community coordination efforts.

Public agencies cannot wait until they are in the middle of a disaster to start planning and training their staff to address access and functional needs. Planning will foster collaboration between agencies and the non-governmental organizations and community before, during, and after disasters.

Community Education

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

Training and Drills

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

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

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

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

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

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

Advisory Council

NAME	REPRESENTING
Steve McMurdo, Chair	District 1 – Poulsbo
Barbara Paul	District 1 – Poulsbo
Shawn Gibbs	District 1 – Kingston
Karol Stevens	District 1 – Keyport (member at large)
Michaelene Manion	District 2 – Port Orchard
~~Mari Van Court, Chair~~ Linette Zimmerman	District 2 – Port Orchard
~~Richard Larkin~~ Elizabeth Safsten	District 2 – ~~Port Orchard~~ Olalla
Charmaine Scott	District 2 – Port Orchard (member at large)
Al Pinkham~~, Vice Chair~~	District 3- Silverdale
~~Gail Campbell-Ferguson~~	~~District 3 - Silverdale~~
~~Jean Schanen~~ Susan Kerr	District 3 – Bremerton

Vacant Council Member seats:

- One in District 3 (current recruitment)

Public Process

Activity	Date	Location	Group
7.01 Meeting	January 15	Elders Center, Port Gamble S'Klallam Tribe	Port Gamble S'Klallam Tribe and Area Agency on Aging (AAA) Staff and Regional Manager with The Office of Indian Policy at Department of Social and Health Services (DSHS)
Public Notice of Advisory Council Meeting and Area Plan presentation	March 13	Area Agency on Aging Advisory Council website	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers
Area Plan Development Presentation Advisory Council/Public Meeting	March 20	Givens Community Center, Cascade Room	Advisory Council, public, staff, providers
ALTC Meeting	March 25	Waterfront Park Community Center, Bainbridge Island	Board, ALTC staff, W4A/AAA Director staff
Area Plan Survey press releases, announcements	April Multiple dates	Press, media, social media, website posting, email, In the Loop employee newsletter feature	Public, staff, county employees
Area Plan Survey Review, posting, distribution.	Posted April 1 Closed May 1	Online, email distribution, mail, in-person deliveries	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers

Activity	Date	Location	Group
Board of County Commissioners (BOCC) Work study session	April 10	Kitsap County Administrative Building	BOCC, Human Services Director, ALTC Administrator, Advisory Council, Public
Public Forum Announcements	June (multiple dates)	Online, email distribution, mail, in-person deliveries	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers
Public Notice of Advisory Council Meeting with Area Plan presentation	June 12	Area Agency on Aging Advisory Council website	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers
Advisory Council/Public Meeting	June 19	Givens Community Center Cascade Room	Advisory Council and public, staff, providers
7.01 Tribal Meeting	Meet and Greet June 20	Human Services Building, Suquamish Tribe	Suquamish Tribe and Area Agency on Aging (AAA) Staff and Regional Manager with The Office of Indian Policy at Department of Social and Health Services (DSHS)
7.01 Meeting	June 25	Human Services Building, Suquamish Tribe	Suquamish Tribe and Area Agency on Aging (AAA) Staff and Regional Manager with The Office of Indian Policy at Department of Social and Health Services (DSHS)
Public Forum	June 26	Poulsbo - Fishline	Public, ALTC staff, community partners
Area Plan presentation and work study session/	August 14	Kitsap County Administrative Building	Kitsap County Aging and Long-Term Care staff, Director of Human Services, and

Activity	Date	Location	Group
Board of County Commissioners (BOCC) Session- open to the public			Board of County Commissioners, public
Press Release and Facebook posting of Area Plan Draft for public review	August 19	Press, media, social media and online	Public, providers and community partners, staff, council members
Area Plan Draft posted for public comment	August 19- September 11	Online: Aging and Long-Term Care website	Public, providers, community partners, staff, and council members
Legal Notice for Public Hearing	August 26	Online, press release	Public, providers, community partners, staff, and council members
Board of County Commissioners (BOCC) Presentation and Public Hearing	September 9	Kitsap County Commissioner's Chambers	Kitsap County Board of Commissioners, Aging and Long-Term Care staff, Advisory Council members, public.
Aging and Long-Term Care Advisory Council/Presentation and Public Meeting- Advisory Council Area Plan Approval	September 18	Givens Community Center, Port Orchard	Advisory Council, public, staff, providers
Board of County Commissioners (BOCC) Public Meeting BOCC approval/sign Final Area Plan	September 23	Kitsap County Commissioner's Chambers	Kitsap County Board of Commissioners, Aging and Long-Term Care staff, Advisory Council members, public. 2020-2023 Area Plan submitted to DSHS/ALTSA by 10/4/2019.

Activities for the 2020-21 Update to 2020-23 Area Plan

Activity	Date	Location	Group
7.01 Meeting	February 16, 2021	Human Services Building, Suquamish Tribe	Suquamish Tribe and Area Agency on Aging (AAA) Staff and Regional Manager with The Office of Indian Policy at Department of Social and Health Services (DSHS)
7.01 Meeting	April 13, 2021	Elders Center, Port Gamble S'Klallam Tribe	Port Gamble S'Klallam Tribe and Area Agency on Aging (AAA) Staff and Regional Manager with The Office of Indian Policy at Department of Social and Health Services (DSHS)
Public Notice of Advisory Council Meeting and Area Plan presentation	June 9, 2021	Area Agency on Aging website, NeoGov notification	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers
Area Plan Update Presentation Advisory Council/Public Meeting	June 16, 2021	Virtual Meeting	Advisory Council, public, staff, providers, community partners,
Area Plan Update announcements, press releases	June 2021, Multiple dates	Press, media, social media, website posting, email	Public, staff, county employees
Area Plan Update Review, posting, distribution.	Posted June 16, 2021 Closed July 16, 2021	Online, email distribution, mail, in-person deliveries	Public, Aging and Long-Term Care Advisory Council, staff, community partners, providers

Report on Accomplishments of 2020-2021 Area Plan

Issue Area C-1.1 **Healthy Aging in an Age-Friendly Community**
Goal: Encourage further development of an Age-Friendly Community through increased awareness of changing demographics and the dramatic increase in the aging population. Work with individuals, community members, providers, business and government in efforts to meet the basic needs of older adults and caregivers. **Promote positive aging and community engagement opportunities.** **Advocate for funding and creative resource development for services targeted to older adults and caregivers**

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
1. Promote positive aging, socialization opportunities, and wellness, exercise and prevention activities. Increase the number of eligible individuals who apply for community-based LTSS through provider education, community outreach efforts and coordination with DSHS Home and Community Services. 2. Continue and further develop the advocacy campaign regarding issues that impact older adults and caregivers. 3. Continue to participate in local housing and transportation planning.	• Outreach and special campaign materials utilized in community education. • Explore partnership and funding opportunities focused on fall prevention and wellness and exercise programs. • Promote events, socialization, and exercise and wellness activities at various senior and community centers and other sites across the county. • Advisory Council meetings and W4A Legislative committee meeting minutes. • Support of issues at legislative forums, town halls and other activities. • Develop and promote training for the community to be senior advocates. • Facilitate meetings with elected officials. • Partnering with existing organizations with common issues.	**2020** • Ongoing: Started 10/2020, Senior Social Check-In Phone Calls through AAA staff. • Ongoing review of meeting minutes and agenda for Kitsap Housing and Homelessness Coalition meetings and distributing internally for staff to share with clients, general public, and professional inquiries. • Ongoing: Monthly attendance at Kitsap Information and Referral Network (KIRN) including information and sharing resources for housing, employment, and public benefits • December added Social Isolation section to bottom of home page on ALTC website and on scrolling bar at top of homepage. Ongoing attendance at variety of community meetings: • NAACP Vitale Communications meetings (weekly) • Kitsap Emergency Operations Partners meetings (weekly) • Long-Term Care Alliance (monthly) Facilitation of the following community-based meetings: • Kitsap Quarterly Provider & Partner meetings (quarterly)

	• 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: 12/2023	Presentations about Aging services to the following local groups in 2019-2020: • Kitsap Aging Advisory Council • Tribal Community Services staff • Faith-based Caregiver programs 2020 Advocacy Campaigns included Aging Council Member involvement at: • 2020 w4a Advocacy webinar • 2020 Fall Senior Lobby virtual event • Individual meetings with local and state elected officials throughout 2020 and January 2021 Active participant in the local 2020 Census Communication committee and subcontractor for community education. Housing: Kitsap Aging Administrator appointed to Kitsap County Department of Community Development as a representative to the Planning Commission to represent needs of individuals served through Aging, such as affordable housing and transportation needs. Housing and Shelters: Kitsap Aging participates in monthly Kitsap County Human Services Program sharing. Housing & Homelessness program and Aging share information. This was a key strategy to identifying community needs (COVID). Transportation: Local Puget Sound Regional Council (transportation) invited to May 2021 Kitsap Aging Advisory Council to present information and request feedback from Council members.

		Due to COVID, in 2020 and 2021: • 2020: Active role at Kitsap County Emergency Command Center developing shelters, quarantine and isolation centers, and vaccine assistance • 2021: Active participation with local Health District to assist vulnerable adults, Long Term Care workforce, and homebound individual vaccines • Outreach to variety of senior nutrition providers and food banks to offer flexible CARES funding to address local needs. Developed CARES subcontracts for MOW, PGST, and St. Vincent De Paul meal programs. • Outreach to current Older American subcontractors to offer flexible CARES funding to address increased demand. Developed CARES subcontracts for MCS Counseling and Kinship programs. • Outreached to faith-based community to support current efforts to develop and deliver monthly essential food and supplies to older adults.

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 / Measured By**	**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	• Grant proposal submission seeking local mental health 1/10th of 1% sales tax funding for services. • Local advocacy for additional state and national funding to support individuals and caregivers impacted by dementia. • Provide evidenced-based Powerful Tools for Caregivers training or other training opportunities to caregivers to help caregivers manage behaviors. • Ongoing promotion of safety resources and educational materials for this population (such as the Information Kit "Safety Concerns for people with Dementia", Silver Alert, and other resources). • Coordination activities with Alzheimer's Association and other community potential partners. • Promotion of inclusive, independent, active engagement opportunities for persons with dementia. Completion Date: 12/2023	• 2020-2021 Powerful Tools events sponsored by ALTC, offered through MCS Counseling. • Dementia Consultation events 2020: • 4/14 Cascades – Potential referral via emails • 5/28 Officer Bass, Port Orchard LE – Elderly couple at risk for self-neglect and DTS. Recommended behavioral interventions and DCR • 9/14 Bainbridge Island Seniors – Dementia types & Dementia services in Kitsap County • 9/16 Compass & Clock-Ask an Expert – Dementia Specialist Services • 12/18 The Arbor, Bremerton – Introduction, Contract • 12/29 ECHO, UW Seattle – Introduction, Inquiry **2021** • 1/14 ECHO Dementia Action Collaborative – Introductions to programs, Contract, Resources • 1/27 MCS Counselor– Introductions to programs, Contract, Resources • 2/15 Kitsap Home of Compassion – Dementia referrals, resources for residents aging in place • 4/15 ACT III Abundant Life, Four Square Church Group – Reviewed Dementia Specialist service and 10 Warning Signs of Dementia and Types of Dementia

		2020 • 05/26 Brain Health- The Basics (CDC/ACL/NIH) Virtual presentation to members of Bainbridge Island Senior Center. • 07/16 NW Family Practice Residency Program Outreach Presentation- Promoted AAA Dementia Specialist service. • 09/18/ Bainbridge Island Psychotherapy Guild Outreach Presentation- Promoted AAA Dementia Specialist service. • 11/05 Hosted- Dementia Legal Planning Toolkit Overview (w/NJP)- Education Presentation • 11/09 “Caregiving in Crisis” edition of AAA Caregiver Newsletter- Promoted Alzheimer Association link for resources and education classes for caregivers and/or person with memory loss. • 12/03 AAA Caregiver Newsletter- “Classes and Connections” article promoting Alzheimer Association education classes for Dec. 2020 and Jan. 2021 for caregivers and/or person with memory loss. **2021** • 02/04/2021 “Apps & Workshops” article in AAA Caregiver Newsletter- promoted “Wellness Wednesdays” workshops through UW Memory & Brain Wellness Center and Alzheimer’s Association. • 02/04/2021 “Apps & Workshops” article in AAA Caregiver Newsletter- promoted two workshops by Alzheimer’s Association in California for black history month. 1. Black Women and Dementia: Two Sides of the Story. 2. Black Men and Dementia.

		2019, 2020, and 2021: Awarded local Kitsap County 1/10th BH sales tax funding for Dementia Consultant and community outreach services **2022** • Planning underway for submitting continued funding for 2022 • The Dementia Consultant has provided collective impact and collaboration with law enforcement navigators, Poulsbo EMS CARES program, DRCs (designated crisis response workers), and a bridge to other social services (such as Alzheimer's Association). Promotion of Dementia Roadmap and Legal brochures. • May 2021 Older Americans Month: Dementia Friendly workshop ("How to talk with your doctor") Posted Alzheimer Association virtual workshops on Kitsap Aging website and email distribution to community partners. 2021: Exploring Falls Prevention subcontract, along with in-home safety assessment

Issue Area C-2.1
Community Living Connections- Information and Assistance Services

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

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
1. Improve consumers' access to long term care and healthy aging information through Kitsap County ALTC website.	• Assessment and posting of relevant links/content to ALTC website. Completion Date: 09/2023	Ongoing monthly: • updated menu for Meals on Wheels • program data dashboard • ALTC Advisory Council meeting agenda **2020** • January Banner, Property Tax Exemption Info • January Main page About Us- Update to Org chart • January Resources- Social Security section. New- Scams • March Main Page, Office location closures due to covid-19 • March Main Page Health News section- Corona Virus Fact Sheet • April Main Page Health News section- Kitsap Cares (covid-19) website link • May Banner, Older Americans Month activities • May, Main Page- Sr. Farmer's Market Apps (multiple languages) • June Main Page, Flyer- MOWK Sr. Farmers Market • July Events Calendar, New- Alzheimer's virtual events for July • July Banner, New- Free Masks opportunity • August, Main Page, Caregiver Support Program Outreach BKAT video of services posted (white board) to website.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• August 2020 Events Calendar- Powerful Tools for Caregivers Workshop Series • 8/11 Volunteer Opportunities, Update- SHIBA section for new sponsor agency information • 10/8 ALTC Family Caregiver Support, Update- Version TCare Survey • 10/28 Banner and Events calendar, New-Dementia Legal Planning Toolkit Overview Workshop • 10/28 Banner and Events calendar, New- Health & Wellness for Caregivers, Quick At-Home Activities Workshop • 10/28 Banner and Events calendar, New- Listen to Me! Talking with Your Dr Workshop • October Events Calendar, Powerful Tools for Caregivers Workshop Series • October Resources area- AARP, How to videos • October Events Calendar- virtual activities • 12/20 Created new social isolation category and banner on website, New- Resource Eldercare Locator • December Kinship, Update flyer **2021** • 1/8/ Main page N4A Update -2021 N4A Membership • February, Social Isolation resource area- Eldercare Locator: Expand Your Circles-Precent Isolation and Staying Connected Technology

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update

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).	• Report of number of Medicare beneficiaries served and outreach activities.
	
	Completion Date: 09/2023
		2020
		• 47 beneficiaries provided individualized education, eligibility screening, and/or application assistance during the year
		• 2/4 Parkinson's Support Group, General MIPPA Outreach 12 attendees
		• 7/16 NW Family Practice Residency Program, General MIPPA Outreach 10 interns/attendees
		• 8/13 MIPPA Electronic Newsletter/Bulletin, Topic: Medicare Savings Program & LIS outreach and education and contact Information for application assistance at AAA.
		  • Delivered to 1945 members of various county human services electronic notification/news subscriber groups.
		• 10/15 MIPPA Electronic Newsletter/Bulletin, Topic: Medicare Open Enrollment outreach and contact Information for application assistance at AAA.
		  • Delivered to 1945 members of various county human services electronic notification/news subscriber groups.
		
		2021
		• 13 beneficiaries provided individualized education, eligibility screening, and/or application assistance during the year (as of March 31, 2021)

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update

		• 01/19 MIPPA Electronic Newsletter/Bulletin, Topic: Medicare Advantage Plan Open Enrollment outreach and education, and contact Information for application assistance at AAA.
		  • Delivered to 2966 members of various county human services electronic notification/news subscriber groups.
		
		• 03/22 MIPPA Electronic Newsletter/Bulletin, Topic: Medicare Part D Financial Help (LIS) outreach and education, and contact Information for application assistance at AAA.
		  • Delivered to 2920 members of various county human services electronic notification/news subscriber groups.

3. Advocate for sustained or increased Senior Citizen Services Act (SCSA) funding and new funding opportunities to support Senior I&A/CLC services.	• Advisory Council Minutes.
	• Meetings with elected officials.
	• Public Forum(s) and other community input opportunities.
	
	Completion Date: 12/2023
		2020 Advocacy Campaigns to request additional funding included Aging Council Member involvement at:
		  • 2020 w4a Advocacy webinar
		  • 2020 Fall Senior Lobby virtual event
		  • Individual meetings with local and state elected officials throughout 2020 and January 2021
		
		Due to COVID,
		  • 2020 flexible CARES funding came available
		  • 2021 flexible RESCUE ACT funding
		  • 2021-2022 increased federal Older Americans Act funding
		
		Due to increased funding, I&A team will be expanding staff capacity to address increased call volumes in 2021, vaccine assistance and local coordination.

Issue Area C-2.2 **Family Caregiver Support Program**
Goal: To raise the level of awareness about caregiving, develop a continuum of support options for caregivers, and provide resources and supports for family and kinship caregivers in Kitsap County.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
1. Identify and develop an array of primary and supplemental caregiver support services to assist caregiver populations. Conduct up to three planning or community partnership meetings to explore additional support options.	• Meeting notes and recommended action(s) from coordination meeting(s) with relevant providers. • Community outreach and education to military and Veteran Assistance providers, emergency responders, health care providers, and other potential new partners. Completion Date: 12/2023	**2020** • 5/13 Veterans Advisory Board- presentation to members scheduled; did not occur due to Covid-19 • 7/16 NW Family Practice Residency Program, caregiver support programs outreach • 09/18/ Bainbridge Island Psychotherapy Guild Outreach Presentation- Shared about location of TCare Screening on our website to share with their clients by sharing printed copies or directing clients to access and submit as an option to start process to connect with our office. **2021** • 02/23 Poulsbo CARES (fire department internal referrals) Outreach- Promoted Family Caregiver Support Program and MAC/TSOA programs. Provided brochures and Caregiver Survey to share with their clients as initial referral step to our FCSP. • 02/23 Poulsbo Police Behavioral Health Navigator Promoted Family Caregiver Support Program and MAC/TSOA programs. Provided brochures and Caregiver Survey to share with their clients as initial referral step to our FCSP 2019 & 2020: November Caregiver Virtual workshops for caregivers (variety of topics and dates)

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		2022: Explore expanding supportive services to caregivers that may include robotic pets, personal response unites, virtual workshops, and partnership with Poulsbo EMS CARES programs for follow-up to caregivers with non-urgent issues.
2. Maintain support for caregiver training through participation in and/or sponsorship of a caregiver training conference and local training opportunities. Conduct a minimum of one community-wide education or training event annually.	• Schedule of caregiver education and/or training event(s). • Dedicated efforts and outreach to notify caregivers about available training opportunities. Completion Date: 12/2023	2020: November Caregiver Virtual workshops for caregivers (variety of topics and dates) 2020 MCS Powerful Tools workshop dates 2020 November and 2021 May: MCS Powerful Tools virtual workshop overview offered **2020** • Nov.- Hosted Family Caregiver Month Workshop Series • 11/5 Dementia Legal Planning Toolkit Review with NJP (virtual) • 11/10 Health & Wellness for Caregivers, Kitsap Physical Therapy • 11/18 Listen to Me-Talking with Your Doctor, Denise Hughes Dementia Specialist Advertised above through electronic notification system, GovDelivery, ALTC website, internal caseloads. • 11/09 “Caregiving in Crisis” edition of AAA Caregiver Newsletter- Provided Alzheimer Association link for resources and education classes for caregivers and/or person with memory loss.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• 12/03 AAA Caregiver Newsletter- “Classes and Connections” article highlighting Alzheimer Association education classes for Dec. 2020 and Jan. 2021 for caregivers and/or person with memory loss. **2021** • 02/04 “Apps & Workshops” article in AAA Caregiver Newsletter- promoted “Wellness Wednesdays” workshops through UW Memory & Brain Wellness Center and Alzheimer’s Association. • 5/20 Review of Powerful Tools for Caregivers Class Series, MCS Counseling • April- Promote NJP Free Legal Clinic for adults 60+ or any age living with Dementia (including caregivers) to complete power of attorney forms. Email to tribes, LTC partners (HCS, DDA, internal case managers) senior centers, posted on ALTC website
3. Continue outreach to the faith, business and healthcare professional communities to provide information to members and employees regarding caregiver support services, including kinship care. Conduct a minimum of two presentations or participate in two events targeting faith communities, healthcare professionals, and employers annually.	• Schedule of presentations and copies of reports. • Community and partner education about programs to support individuals and families. Completion Date: 12/2023	**2020** • 03/07 Port Orchard United Methodist Church Health and Senior Resource Fair- Resource booth- Print materials at table, no staff due to covid-19 • 07/16 NW Family Practice Residency Program Outreach- Promoted AAA Dementia Specialist service. • 09/18/ Bainbridge Island Psychotherapy Guild Outreach Presentation- Overview of ALTC services & programs

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• Drive-through Flu Vaccine Clinic Suquamish Tribe- Print AAA Rack Card noting all ALTSA services & programs in “goody bag” given to attendees. • Monthly participation at NAACP Bremerton chapter meetings **2021** • 02/23 Poulsbo CARES (fire department internal referrals) Outreach- Review of all ALTC services & programs . • 02/23 Poulsbo Police Behavioral Health Navigator Reviewed all ALTC services & programs • April: 2021 Annual Kitsap County DDA Resource Fair- Dedicated Website for Month-long Virtual Fair- Links to KC ALTC Website • 4/15: “Overview of Caregiver Services” to Foursquare church (ALTC FCSP Manager and Dementia Consultant) Also shared office as contact for any questions relating to aging. • Monthly participation at NAACP Bremerton chapter meetings.

Issue Area C-2.3 **Medicaid Transformation Demonstration**		
Goal: MAC and TSOA Benefits support the preference for older adults to age in the setting of choice and provide support for caregivers.		
Measurable Objectives	**Key Activities / Measured By**	**Accomplishment or Update**
1. Increase the caregivers served through collaboration with ALTC staff, Department of Social and Health Services Aging and Long Term Supports Administration, and local provider networks to engage potentially eligible individual.	• Analyze annual Outreach efforts; update Outreach Milestone, as needed. • Provide staff and local provider network training/ program information. • Staff and Advisory Council program promotion to community agencies, via presentations & contacts to schools, medical service providers, discharge planners, churches, etc. • Identify opportunities to include new program information in ALTC resource lists. Completion Date: 01/2023	The Outreach plan submitted for 2021 has a list of completed outreach for 2020 and 2021. 2019, 2020, 2021: Quarterly AAA, HCS, and DDA Provider & Partner meetings to share program updates and reminders. Annual reviewed and updated MDT milestones; analyzed trends, barriers, and churn of clients. 2021: Requested and recruited for an increased MDT case manager to assist with program growth. Presentations about Aging services to the following local groups in 2019-2020: • Kitsap Aging Advisory Council • Tribal Community Services staff • Faith-based communities
2. Target program outreach to caregivers to increase caregiver dyads served.	• Analyze annual Outreach efforts; update Outreach Milestone, as needed • Provide T-CARE screenings & access to customized care plans for caregivers.	2019, 2020, 2021: Quarterly AAA, HCS, and DDA Provider & Partner meetings to share program updates and reminders for dyad growth Annual reviewed and updated MDT milestones; analyzed trends, barriers, and churn of clients. **2020** Mailed out approx. 90 TCare Surveys to newly identified caregivers, from I&A contacts.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
	• Provide person centered counseling and customized services and supports to newly identified caregivers (e.g., respite, counseling, support groups). Completion Date: 01/2023	Approximately 260 newly identified caregivers were provided caregiver support specific information & assistance through I&A **2021** Mailed out approx. 40 TCare Surveys to newly identified caregivers, from I&A contacts (as of 4/15/21) Approximately 120 newly identified caregivers were provided caregiver support specific information & assistance through I&A (as of March 31, 2021).
3. Recruit and maintain provider network adequacy.	• Develop additional contracts to meet caregiver needs. • Identify and recruit local providers for new contracted services, with efficient and timely service delivery. • Provide technical assistance to current Family Caregiver Support Program local contract providers or interested providers, such as the local Tribes, who may be overwhelmed with the Medicaid contracting requirements. Completion Date: 01/2021	**2021-2022** Explore expanding provider network of supportive services to caregivers that may include robotic pets, personal response unites, virtual workshops, and partnership with Poulsbo EMS CARES programs for follow-up to caregivers with non-urgent issues. **2020** Conducted meeting to explore Medicaid Waiver subcontract options and local community referrals in meeting with Suquamish Tribe, ALTSA Tribal Program Manager, and Office of Indian Policy representative. **2021** 7.01 Planning meetings offered technical assistance and presentation of AAA services available to Tribal staff (Suquamish and Port Gamble S'Klallam) . **2020-2021** Increased coordination with Tribal staff to assist Tribal members with MDT programs.

Issue Area C-3 **Home and Community-Based Services: Case Management and Systems Coordination**
Goal: Support an increasingly growing number of people, with increased acuity, who need long-term services and support (LTSS) to remain stable in their home or a community-based setting.

Measurable Objectives	Key Activities / Measured By	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.	• Increase average number of total persons served each month from 950 to 997, per the state forecast. This equates to at least 47 additional cases each month, with no attrition, by end of 12/2023. Completion Date: 12/2023	The current total client count is 965 and the caseload growth allowed us to add an additional LTC Case manager. In 2020 there were 1291 assessments completed. Of those, 856 were annual assessments, 104 were significant changes and 331 were interim assessments. Interim assessments could be completed to make a correction, but their primary use is to add a request for a piece of equipment that does not result from a change in the client's condition. So far, in 2021, we have 218 annual assessments, 36 Significant change and 60 interims. Assessments since March of 2020 have been conducted telephonically due to the PHE. 2019-2021: General upward trend of client caseloads.
3. Replenish the 27% shortfall in funding required to ensure high quality of clinical services provided. A crisis has developed due to chronic underfunding of in-home case management. With current funding, increased client acuity, increased inflation, and projected reduction of funding due to Consumer Directed Employer; creating a 27% funding shortfall by 2021.	• Legislative advocacy and action need to occur to achieve and sustain full funding to maintain quality in-home case management. Adequate funding for a 75:1 ratio will be provided, with an index to keep pace with inflation over time. Completion Date: 2021-2023	2019-2020 Advocacy Campaigns to increase funding shortfall included Aging Council Member involvement at: • 2019 & 2020 w4a Advocacy webinar • 2019 & 2020 Fall Senior Lobby virtual event • Individual meetings with local and state elected officials throughout 2020 and January 2021. With additional funding, in 2021 a new Medicaid case manager was hired to meet the increased demand.

Goal: Provide person-centered coordination of health and community supports for increasing numbers of people who face significant health challenges to improve health outcomes and reduce avoidable health care costs associated with avoidable hospital visits, hospital admission, duplication of services, and emergency department visits for the Medicaid and Medicare populations.		
Measurable Objectives	**Key Activities / Measured By**	**Accomplishment or Update**
1. Increase engagement and enrolled clients served each month.	• Increase monthly average caseload to 55 served. Completion Date: 12/2023	Due to COVID, face to face outreach and home visits were cancelled. The Health Home case manager requested a transfer to the Medicaid case management unit. Hence, the Health Home Program was closed. To date, there are no plans to re-open the Health Home program.
2. Increase awareness of the new program through community education and outreach activities.	• Three community education presentations by 12/2020. Completion Date: 12/2020	Due to COVID, the Health Home Program was closed. To date, there are no plans to re-open the Health Home program.
3. Advocate for increased Health Home reimbursement through shared Medicare savings. Achieve full funding to maintain quality care coordination.	• 5% increase to care coordination rates by 2021. Completion Date: 01/2021	Due to COVID, the Health Home Program was closed. To date, there are no plans to re-open the Health Home program.

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 / Measured By	Accomplishment or Update
1. Create and complete 7.01 plan with Port Gamble S'Klallam Tribe.	• Coordination, meetings and plan finalization. Completion Date: 12/2023	7.01 Planning meeting occurred 4/13/2021.
2. Create and complete 7.01 plan with Suquamish Tribe.	• Coordination, meetings and plan finalization. Completion Date: 12/2023	7.01 Planning meeting occurred 2/16/2021.

Statement of Assurances and Verification of Intent

For the period of January 1, 2020 through December 31, 2023, the Kitsap County Aging and Long-Term Care accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (P.L. 114-144,42 USC 3001-3058ff) 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. The Kitsap County Aging and Long-Term Care assures that it will:

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

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

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

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

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

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

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

Provide assurances that the Area Agency on Aging, in funding the State Long Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of Title III funds expended by the agency in fiscal year 2000 on the State Long Term Care Ombudsman Program.

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

Date	Stacey Smith, Administrator Kitsap County Aging and Long-Term Care
Date	Steven McMurdo, Advisory Council Chair Kitsap County Aging Advisory Council
Date	Robert Gelder, Chair Kitsap County Board of County Commissioners
Date	Charlotte Garrido, Commissioner Kitsap County Board of County Commissioners
Date	Edward Wolf, Commissioner Kitsap County Board of County Commissioners