AREA PLAN 2020-2023

Kitsap County Division of Aging and Long Term Care

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

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Table of Contents

Cover Page

Table of Contents....3

SECTION A Area Agency on Aging Planning and Priorities 5

Introduction 6

Mission, Values, Vision 9

The Planning and Review Process....10

Prioritization of Discretionary Funding....12

SECTION B Planning and Services Area Profiles 14

B-1 Kitsap County Population Profile 15

B-2 AAA Services and Partnerships....22

B-3 Designated Focal Points- Kitsap County 33

SECTION C Issue Area Themes 35

C-1 Health and Wellness in an Age-Friendly, Dementia-Friendly Community 36

C-1.1: Healthy Aging in an Age-Friendly Community....37

C-1.2: Alzheimer's, Dementia and Brain Health....46

C-2 Service Options that Support Older Adults and Family Caregivers 54

C-2.1: Community Living Connections....55

C-2.2: Family Caregiver Support Program....63

C-2.3 Medicaid Transformation-Demonstration 70

C-3 Home and Community-Based Services: Case Management and Systems Coordination....73

C-4 Tribal Partnerships 82

SECTION D Area Plan Budget ... 95
Area Plan Budget Summary ... 96
... 97
Expenditure Detail by Funding Source ... 98
Formulas ... 99
Staff Full Time Equivalent (FTE) Breakout ... 100
AAA Individual Direct Service Worksheets ... 101
Reconciliation ... 105
Family Caregiver Support Program Services ... 106
APPENDICES ... 107
Organization Chart ... 108
Area Agency on Aging Staff ... 109
Emergency Response Plan ... 118
Advisory Council ... 124
Public Process ... 125
Report on Accomplishments of 2018-2019 Area Plan ... 128
Statement of Assurances and Verification of Intent ... 165

SECTION A
Area Agency on Aging
Planning and Priorities

Introduction

elcome to the Kitsap County Area Agency on Aging 2020-2023 Area Plan. Kitsap County Aging and Long-Term Care (ALTC) - a Division of Kitsap County Department of Human Services- and the designated Area Agency on Aging for Kitsap County, is responsible for the planning, development, coordination, and delivery of a comprehensive system of services to promote healthy aging and choices that support aging and older adults with disabilities to live as independently and with as much dignity as possible.

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). The purpose of the act is to aid in the development of new or improved programs for older persons. 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. There are 622 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

This link and 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, which establishes Area Agencies on Aging, 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) 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 to promote quality of life. Our plan incorporates suggestions from the Advisory Council as well as other partners in the community.

The resulting Area Plan sets the stage for the work of 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 older or who need long term care.

The Area Plan reflects our needs as a community and highlights our goals for developing age-friendly, dementia-friendly communities while preparing for an increase in the aging population. 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

As we work to meet these goals for older adults, additional services and advocacy activities are 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. Services include: information, referral and assistance, case management and nurse oversight for individuals receiving Medicaid-funded in-home care, case management for Health Home participants, and family caregiver support. ALTC also sponsors the Long-Term Care Ombudsman program, which receives, investigates, and resolves complaints from residents of long-term care facilities.

Services provided through subcontracts with local agencies include: adult day services, legal assistance, nutrition including home-delivered meals, community dining sites, nutrition education and Senior Farmers Market programs, kinship care, behavioral health counseling and support, respite for caregivers, dementia services and supports, in-home personal or household care and assistance with activities of daily living.

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

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. Additionally, time-limited special project grants are another revenue source, when awarded.

The total 2020 budget 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.

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, a

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 of older adults and adults with disabilities.

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;
- 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 applied 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;

Developing Age-Friendly communities has been an ongoing goal. An Age-Friendly community is supportive of the needs of older adults and can provide elders with 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. A survey was 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 at community outreach events. In addition, service providers assisted with distribution to their clients, including community dining site, home-delivered meal and senior farmer's 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 computerized client tracking system that provides detailed demographic and service statistics regarding those persons who already use aging and disability services in Kitsap County. This data, combined with additional service information from Department of Social and Health Services (DSHS) such as 1519 measures and Research and Data Analysis supplemental information, population data provided by 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 included 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 Aging Advisory Council in a public meeting conducted by that body. Incorporating the Council's recommendations, ALTC staff draft the final text for the planning objectives in the 2020-2023 Area Plan, Section C.

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

The draft plan was presented at an open Kitsap County Board of County Commissioner work study session on August 14, 2019; as well as a 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 of the draft and offer comments by mail and email. It was also available on the ALTC website from August 19- September 11, 2019.

Recommendations for modifications to the Area Plan were evaluated and those 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.

Of the 2020 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 2020 annual budget also includes about 30% in "discretionary funding" from the Federal Older Americans Act (OAA) and the 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 that have been 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 - even with good planning and coordination with other entities over the use of funds administered for a mutually shared target population, funding shortfalls occurred.

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

Therefore, when considering funding reductions, this agency continues to have contingency plans for reducing programs. 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 formula under which services are prioritized.

1. *Community 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?"
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 a funding shortfall and if there is a tie between services, the Aging and Long-Term Care Advisory Council, after careful consideration, shall recommend service funding priority levels and program services to older adults with the greatest economic needs, social needs, disabilities, or are low-income minority, or older adults with limited English proficiency and those residing in rural areas.

Throughout this plan it was necessary to balance needs, goals and objectives with the reality of a growing target population, increased costs and 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. 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). As such, 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 U.S. Census Bureau 2018 data, the estimated population of Kitsap County is 269,805. 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. 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.

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

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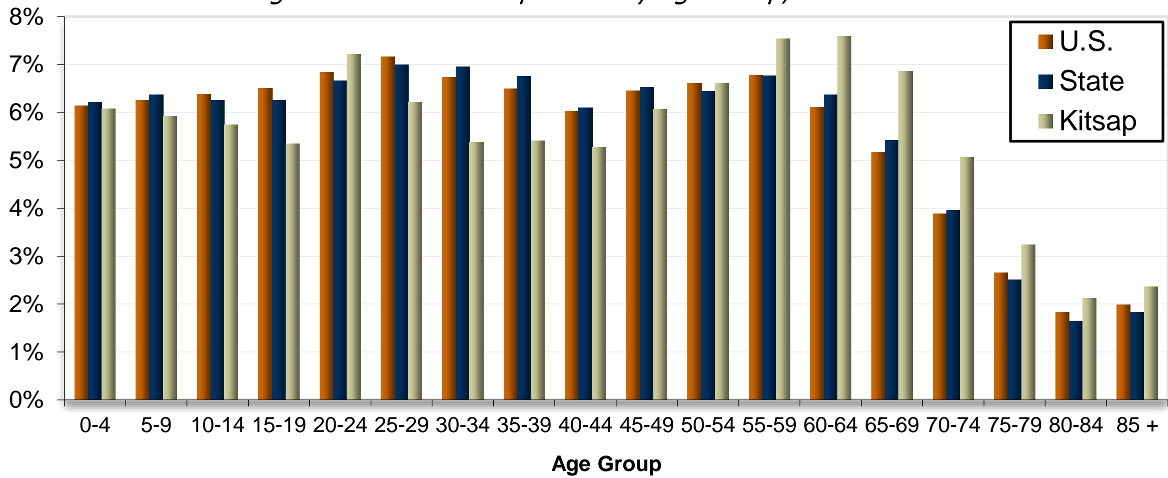
1 http://kitsapeda.org/key-industries/defense/ accessed July 29, 2019

2 https://www.livestories.com/statistics/washington/kitsap-county-veteran-demographics accessed July 29, 2019

Figure 1. Percent of Population by Age Group, 2017[3]



The 2010 census data indicates that the 60+ population was 49,674 representing an increase of 51% from 2000 and 84% from 1990. Data also indicates that 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 was 5,612 representing 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.

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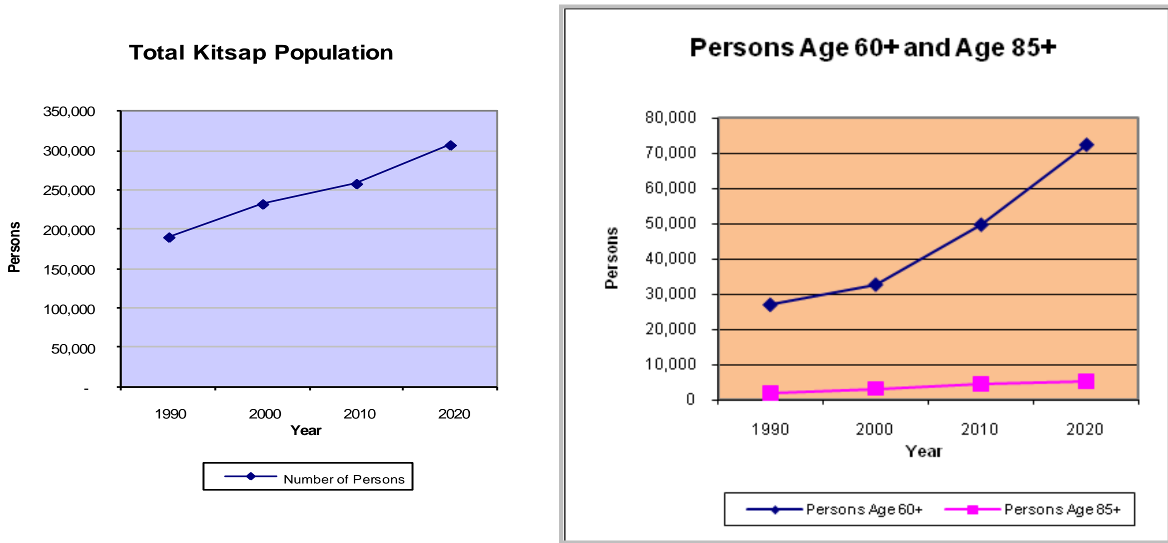
[3] Kitsap County Data Tables – Washington Office of Financial Management, U.S. Bureau of Economic Analysis

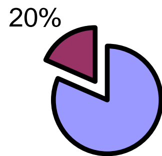
Figure 2. Kitsap County Population Trends 1990-2020



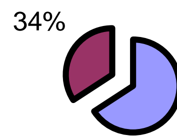
Referencing Figure 2, we see a challenging trend. Using midpoint projections (neither the highest nor the lowest estimates) from the Washington Office of Financial Management (2000 data), growth projection for total Kitsap County is 22 percent by 2020, while the 60+ population is anticipated to grow by 46 percent. And within that statistic is the equally challenging fact that the population 85+ is already larger than current 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

Age 60+ Total Population. in 2010



Age 60+ Est. Total Population in 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, however. 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.

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

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.*

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

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.

ALTC also recognizes the need for engagement strategies for people under 60 with disabilities and their family caregivers, 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

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

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. (https://williamsinstitute.law.ucla.edu/impact/data-in-review-2018/)

Kitsap County Demographic Characteristics[6]

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 the 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[7]	5,038	6,467
Age 60+ with Alzheimer's disease, Dementia or other Cognitive Impairment	4,571	6,052	7,303
Age 18+ with Cognitive Impairment	11,087	13,274	14,549
Age 60+ At risk for institutional placement	998	1,079	1,200
Age 60+ Limited English Proficiency	1,682	2,723	3,330
Age 55+ American Indian/Alaska Native	518	780	862
Native American Tribes	2	2	2
Tribes with Title VI Funding	2	2	2
Age 60+ in Rural Areas[8]	8,929	NA	NA

[6] 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.

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

[8] 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, Bainbridge Island is entirely incorporated as its

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[9]

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own city, but the figure provided includes 690 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

[9] 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:

These mental health services offer 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 older persons gain access to needed mental health and other community services. Specialized training, consultation and education are made available to community organizations to improve services and increase public awareness of mental health issues.

Substance Abuse Counseling:

Specialized consultation for professional ALTC staff and assessments for persons age 60 and above 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.

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**

Family Caregiver Support Program

Trained Case Managers and Assistance Specialists provide multifaceted systems of support services for unpaid Family caregivers .Services provided include: information about available services; assistance in gaining access to the services; individual counseling, and caregiver training to assist caregivers in making decisions and solving problems relating to their caregiving roles; respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; assist target communities with developing and maintaining family caregiver and supplemental services.

Information & Assistance/Community Living Connections:

Information & Assistance (I&A) is an integrated system of functions designed to locate and 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 a publicly recognized access point for receiving referrals, services, and consultation. Functions of the I&A program include information giving, service referral, assistance, 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 also 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; identify and seek 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 Ombuds 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 has 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.

MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT:

The 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:

The Medicaid-funded in-home care programs include Registered Nurse Consultant (RNC) services. The RNC role is to provide nursing expertise to case managers and ensure 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 Nutrition Services program provides nutritious meals and other nutrition services to older persons who are homebound by reason of illness, disability, or are otherwise isolated. 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:

The Congregate Nutrition Services program helps 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 in 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.

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 baskets of similar content through the Home Delivered Meals program.

Nutrition Education:

Nutrition Education Services provides 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 families or other caregivers of adults with functional care or supervision needs. Both in-home and out-of-home respite care is available and 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 the needs of the 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. This includes the following tasks: caregiver screening and assessment for eligibility, developing a TCARE® service plan, authorizing the level and amount of respite care services to be provided, arranging for care with the respite service program, and maintaining contact with client/participant for reassessment and referral to other programs and services.

SENIOR DRUG EDUCATION PROGRAM:

Senior Drug Education provides adults age 60 and over 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.

ALTC Partnerships

Aging and Long-Term Care is involved in multi-tiered efforts to integrate local systems and services, as well as participate 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	Co- 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
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.
Vulnerable Populations Taskforce	Co-lead by Kitsap County Department of Emergency Management, Kitsap Public Health, and Kitsap County Aging and Long-Term Care to strategize for local disaster preparedness for vulnerable individuals throughout the County.	Quarterly
Functional Assessment and Services Team (FAST)	Subcommittee that works in collaboration with local Red Cross to provide shelter and specialized services in Disasters.	Bi-monthly
Vulnerable Adults Taskforce	Led by Kitsap County Prosecutors Office to problem solve vulnerable populations interface with local law enforcement; policy and protocols.	Quarterly
Long Term Care Alliance	Forum to share local services updates, problem solve common community	Monthly

Committee Name	Purpose of Committee	Frequency of meetings
	concerns, and plan annual Older American conference.	
Regional Resource Team (RRT)	Facilitated by 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 provide a formal venue to share local system and service information.	Monthly
Kitsap Information & Referral Network (KIRN)	A network of Information and Referral professionals from human services organizations facilitated through Peninsula's 211 to share information on programs, 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 Kitsap county residents representing advocacy groups, Kitsap County employees providing expertise and guidance regarding Kitsap's Voter Access Plan.	Annual and as-needed
Guardian Luncheon	Networking with local guardians; share information and establish relationships with AAA Ombudsman.	Monthly
Kitsap Network Provider Meeting	Facilitated by ALTC staff to review system, policy changes and enhance cross-agency communications. Incudes local HCS, DDA 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 to discuss and plan for DSHS, HCA, and other social service integration efforts.	Monthly

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 activist.	Monthly
DSHS Region 3 Residential Care Services	Coordinate between Residential Services staff (licensures and investigators) and regional Ombudsman.	Sporadic

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 Resource Team and Policy Team	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 implementation of Community Living Connections.	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.
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
Washington State Council on Aging (SCOA) Kitsap AAA Advisory Council member is a representative.	SCOA is a unique advocacy group in the arena of senior issues and a unified voice across Washington for senior citizens. Members are appointed by the Governor and AAA Advisory Councils and are charged with advising the Governor, the DSHS Secretary and the Assistant Secretary of ALTSA. (RCW 43.20A.695). Members are representatives of local	Monthly 8 months out of the year.

Committee Name	Purpose of Committee	Frequency of meetings
	communities, from 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.	
Washington Connection Advisory Committee	The Advisory Committee provides recommendations to the Executive Sponsor on short and long-term 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 the Washington Connections benefit portal to improve residents' access to services and benefits and easily and securely apply for services.	Quarterly or as scheduled

B-3 Designated Focal Points- Kitsap County

Organization or Site Name	Focal Point Address	Public Phone # & E-Mail (if applicable)	Services Coordinated at this 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 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 Contracted Counseling as scheduled

Organization or Site Name	Focal Point Address	Public Phone # & E-Mail (if applicable)	Services Coordinated at this Site
Fishline (North Kitsap)	19705 Viking Ave NW PO Box 1517 Poulsbo, WA 98370	Admin/Operations 360-779-4191 Client Services 360-779-5190 info@fishlinehelps.org	AAA Family Caregiver Support Program Additional services: Fishline services: Food, Housing, Utilities, Transportation Health/ Budgeting, Employment / Education, Children Peninsula Community Health Services Kitsap Mental Health Services Department of Social & Health Services

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 un-paid roles for the benefit of both the individual and the community at large.
6. Promotes flexibility in the workplace to accommodate and support the vital role played by family caregivers.
7. Promotes flexibility in the workplace to accommodate and support the vital role played by an increasingly aging pool of workers.

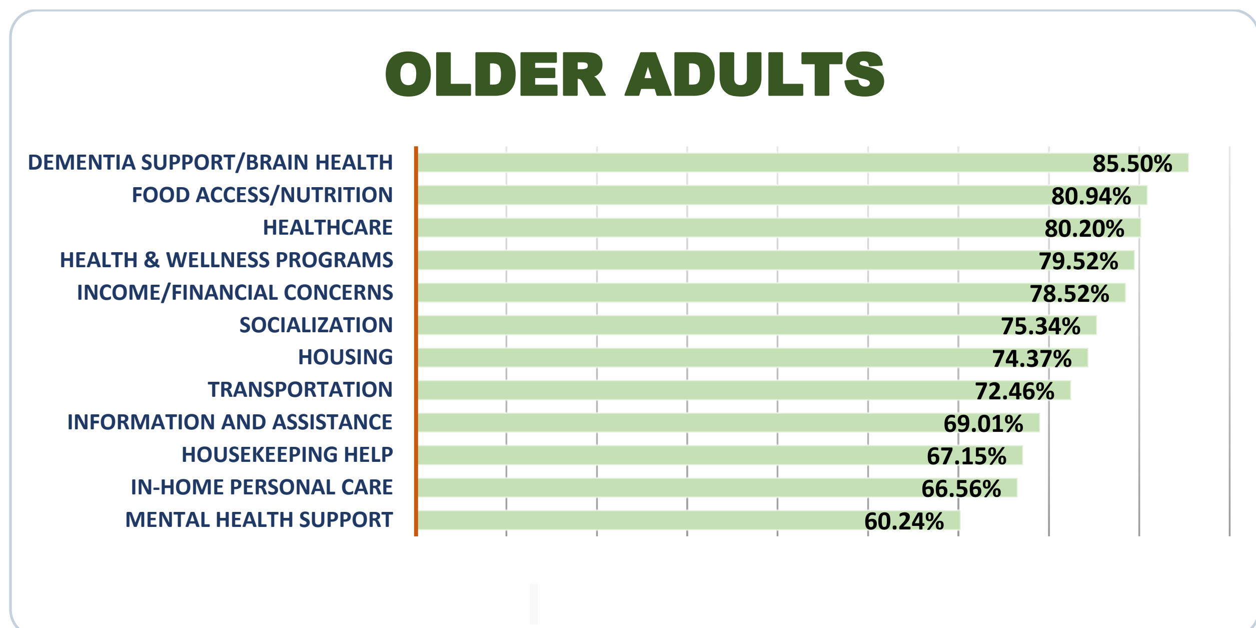
Change that enhances older adults’ quality of life will improve conditions for everyone because Age-friendly communities are good places for people of all ages and abilities to live. Age-friendly communities become communities of choice for everyone.

With this information in mind, Kitsap County Aging and Long-Term Care (ALTC) surveyed local public, seniors, caregivers, nutrition program participants, and providers with the goal of preparing the county to respond to growing demands. There were over 700 completed 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. Because of the 2019 survey, and surveys completed for prior area plans, several commonly-identified issues consistently surfaced. It is interesting to note that although issues and subsets of issue areas 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 during the coming years. These issues are outlined below, and in the goals and objectives to be addressed over the next four-year plan period.

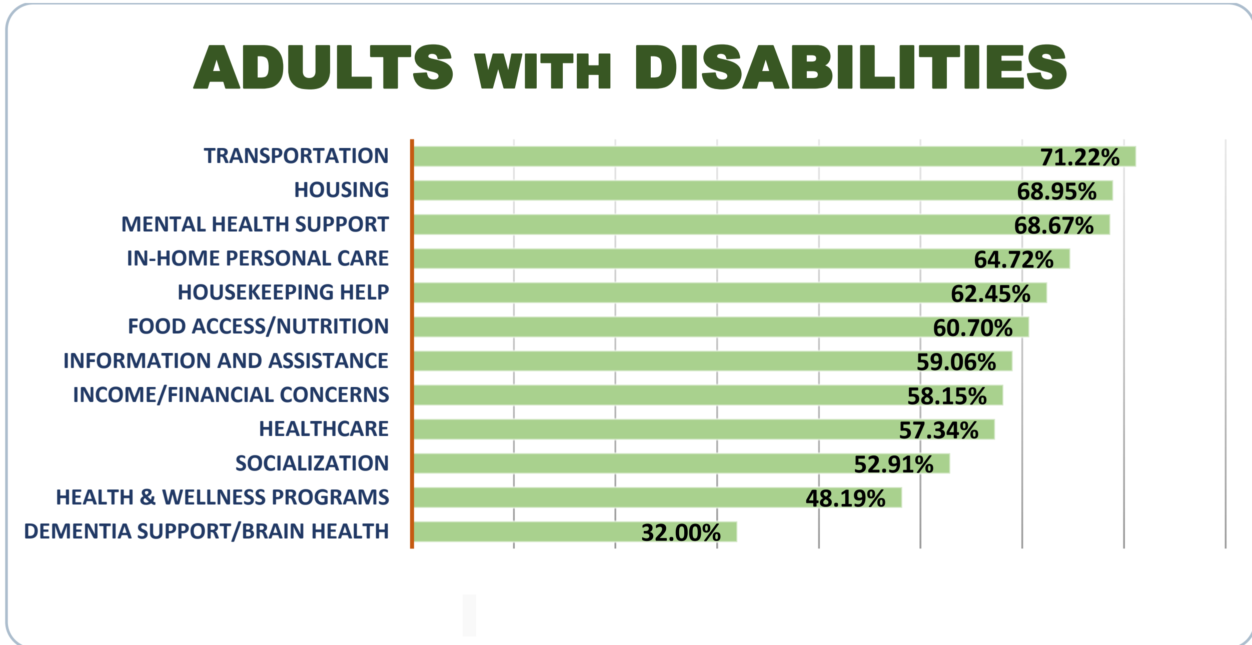
2019 Community Needs Survey: Data and Trends

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.**

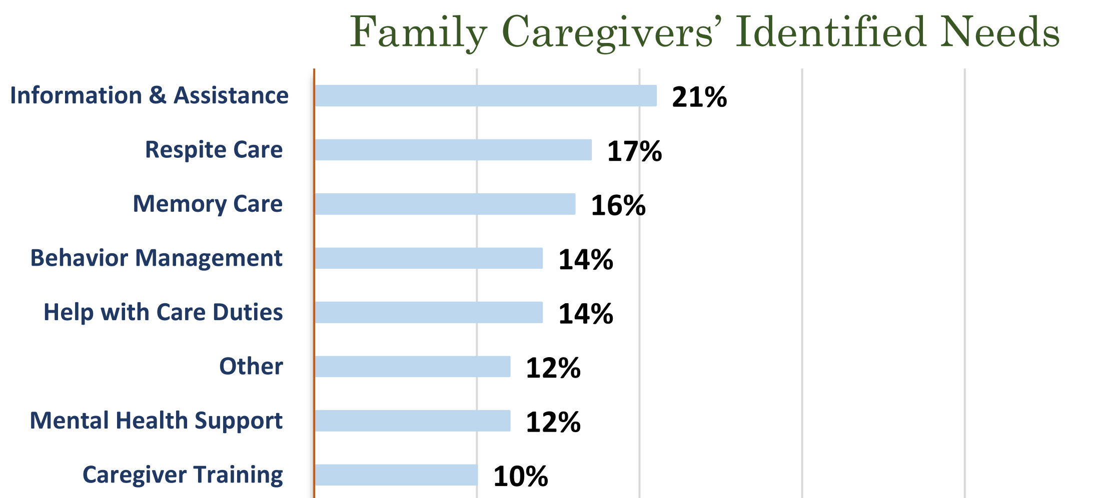


Top identified needs for adults with disabilities rated differently, as demonstrated below:



CAREGIVING

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



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;
- 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 was 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 and 42 deaths from falls in 2017. 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.(Survey administrator: Retired and Volunteer Senior Program of Kitsap, Andrea Dolan-Potter, RSVP Program Director Lutheran Community Services NW).

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

Services used and barriers to access

- Services 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.

Continue to 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. Advocate for sustained and additional services that support healthy aging, including funding for nutrition services. Seek opportunities through ALTC programs to connect individuals to nutrition resources.

Measured by:

- Outreach and education reports for the community and food bank and nutrition providers.
- Records of health and wellness information provided through Nutrition Education services or other programs.
- Shared data provided by the Nutrition Risk Assessment Tool, which includes the diabetes risk assessment component.

Completion Date: 12/2023

3. Conduct and participate in outreach and education in the community to support service providers and businesses in their efforts to become a more Age-Friendly, Dementia-Friendly community.

Measured by:

- Partner to plan and organize a community forum or other event.
- Conduct and promote educational and training events.
- Organize outreach to business and civic entities.
- Sharing "Best Practices"
- Advisory Council meeting minutes.
- Local advocacy trainings/forums.

Completion Date: 12/2023

4. 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

5. Continue to prioritize involvement in local housing and transportation issues.

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

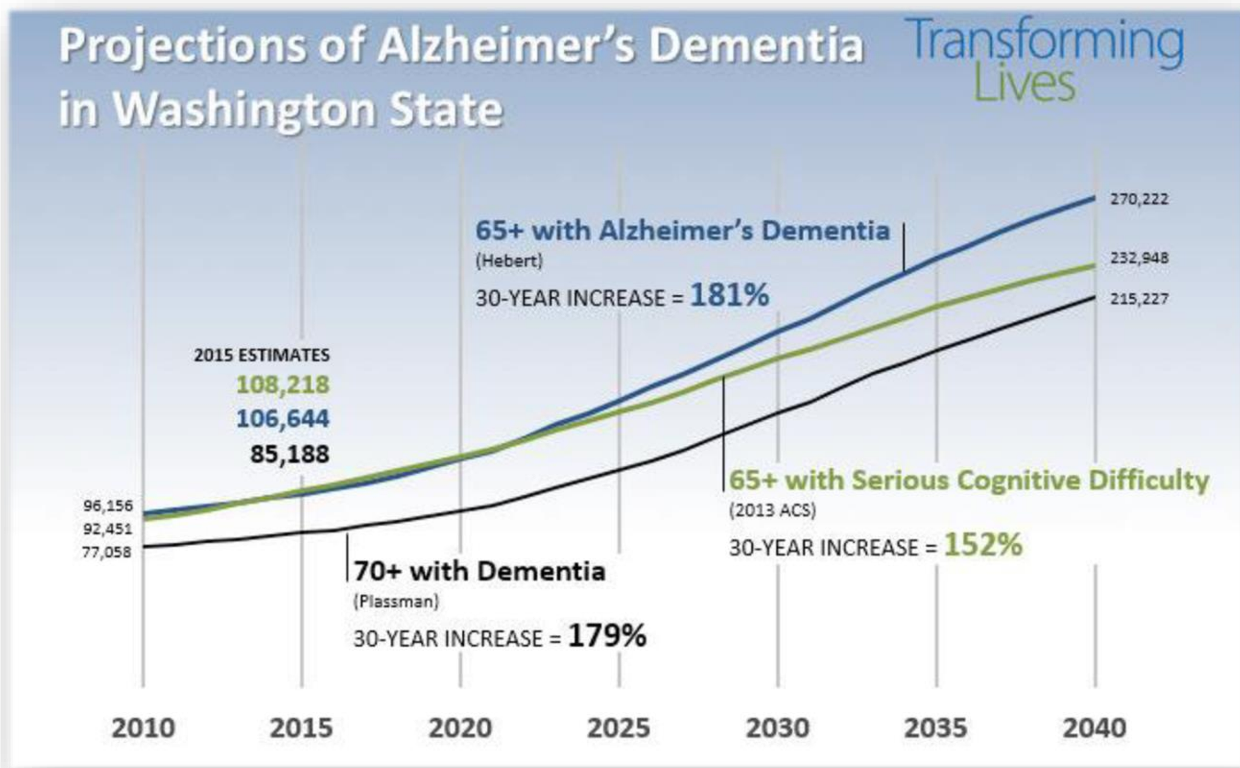
Multiple sections in this Area Plan address health and wellness goals for older adults, individuals with special needs, caregivers and across family and community systems.

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 those ages 65 and older with serious cognition, 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[10]

According to a National Council on Aging 2015 survey, a top concern of older Americans second only to maintaining their physical health was their concern about memory loss.

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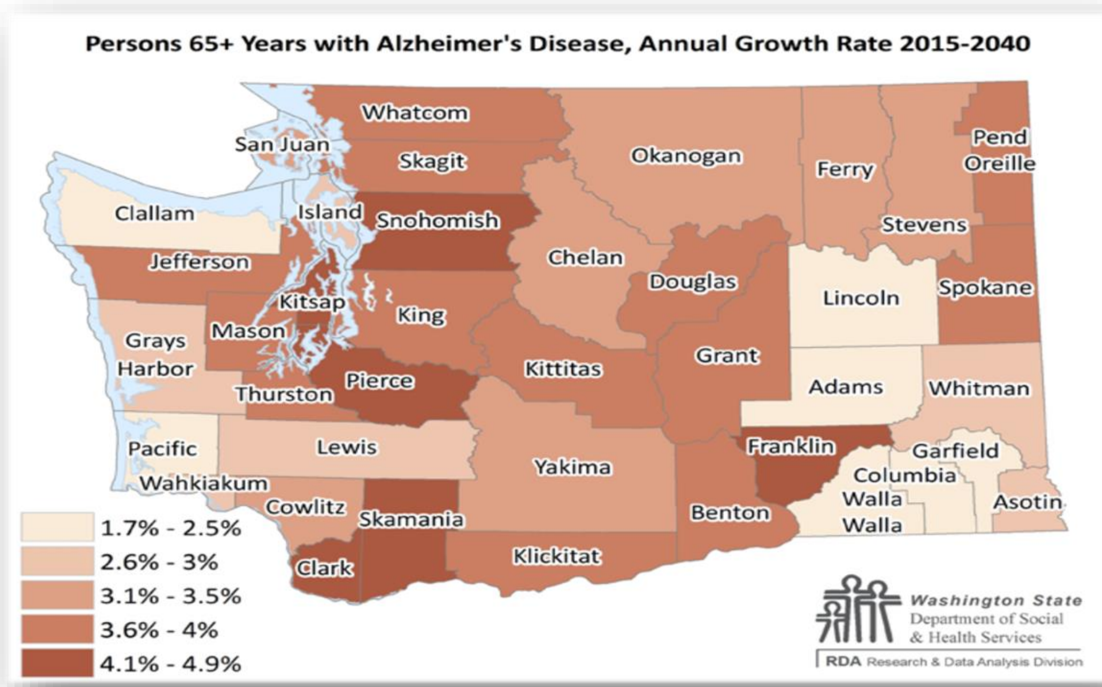
[10] Accessed on July 31, 2019 at https://alzimpact.org/uploads/media/state_plans/WA.pdf

Dementia Support/Brain Health 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.

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 annual growth rate in the chart below demonstrates that Kitsap County's 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 [11]

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[11] 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".
  ("Meeting Dementia Head On", Dementia Action Collaborative Washington State January 18, 2019. Online, accessed 7/24/19. https://www.dshs.wa.gov/altsa/dementia-action-collaborative)

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 is available through the Senior Information & Assistance/Community Living Connections and Family Caregiver Support staff at ALTC. 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.

Moving forward, if funded, the 2020 continued Partners in Memory Care project will provide 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 2020 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.

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. Promote brain health and the importance of early detection.

Measured by:

- Dissemination of brain health and early detection information at outreach events.
- Cross-promotion of local memory screening events.
- Celebration and promotion of proactive health activities and volunteer or other community engagement opportunities that decrease social isolation.

Completed annually through 2023.

2. 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.

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

3. Coordinate with partner organizations and local professionals to offer workshops conference, and other education opportunities to individuals with memory loss and caregivers caring for someone with Alzheimer's disease or dementia.

Measured by:

- Offer one dementia-specific or memory loss workshop over the next four years.
- 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).

Completed bi-annually through 2023.

4. Research and develop feasible dementia/memory care respite and support service options.

Measured by:

- Meeting records and recommended action(s) from coordination meeting(s) with healthcare providers and Alzheimer’s Association, Adult Day services, social day services and caregiver support groups, etc.
- Documented outcomes of research to develop referral and authorization options with local providers. Options may include dementia-services contracts or referral agreements for respite, socialization or other supplemental supports for individuals with dementia or their caregivers.
- Advocacy efforts to support and partner across providers of different levels of care to explore options for funding and community involvement to increase public knowledge about local supports and promote potential options for new or expanded services.

Completion date: 12/2023

5. Explore and support local development of new 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

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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. In the 2019 Area Plan survey, the highest number of responses indicated the top source of information was 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)*** for Beneficiary Outreach and Assistance offers Medicare and Medicare Part D outreach and assistance services that Senior I&A staff provide, 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 have 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

Staff with I&A/Family Caregiver staff is 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 ALTSA 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. Veterans Assistance (VA) Medical centers, the local VA clinic, and local Veteran's Home (Retsil) and military support services are referral sources we plan to seek additional connections with. 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 Ombuds and 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 (AAA), like Kitsap County ALTC, 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. Often, 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 have increased complexity in the family situations and needs that are 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 our local community members, funding will need to increase to adequately meet the 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:

   a. Maintain the Kitsap County ALTC Senior I&A Internet Web Site with timely updates of information relevant to consumers.

   Measured by:

   - Assess opportunities for links to ALTC website.
   - Enhance consumer-driven service capacities for a user-friendly experience.
   - Analysis of website data tracking and user suggestions to support resource decisions.
   - Utilization of "Contact Us" in online referrals.

   Completion Date: 12/2023

   b. Maintain a searchable computerized information-and-referral database system. Measured by:

   - Assessment of needs for dedicated staff support to update and maintain databases.
   - Successful updating and maintenance of CLC to include all relevant programs.

   Completion Date: 12/2023

   c. Utilize Person-Centered Options Counseling strategies and tools as appropriate with individuals requesting this assistance with long term support service planning. Measured by:

   - Training for newly hired I&A/Family Caregiver/CLC/MAC TSOA program staff.
   - Planning and implementation meeting notes, records.

   Completion Date: 12/2023

2. Continue ongoing coordination with established networks and other Kitsap Information and Referral partners; participate in community meetings to educate and inform residents about CLC and leverage existing systems to meet community needs. Measured by:

   - Schedule of I&R Coordination meetings.
   - Kitsap County BenefitsCheckup reports and consumer results.

- Schedule of ALTC staff meetings to plan and coordinate CLC and partner database updating processes.

Completion Date: 12/2023

3. Continue to strengthen and improve visibility of Senior I&A/CLC as the primary entry point for the local system. Conduct a minimum of 12 Outreach events annually.

   Measured by:

   - Visible, linked Internet presence.
   - Records of outreach presentations and events.
   - Samples of marketing materials and presentations.

Complete annually through 12/2023

4. Facilitate partnerships and increase coordination with community services that may generate referrals and support services coordination work (I.E., cultural centers, faith communities, community centers, employers, non-profit organizations, military support centers, medical services providers, and first responders. Conduct a minimum of one coordination meeting with a different community partner annually.

   Measured by:

   - Schedule of coordination meetings and public events hosted or attended.

Completion Date: 12/2023

5. Conduct Medicare and Medicare Part D outreach and education including disease prevention and wellness activities topics and assist Medicare beneficiaries to enroll in Medicare Part D or apply for Medicare Low-income Subsidy (LIS) and Medicare Savings Plans (MSPs).

   Measured by:

   - Reports of activities assisting Medicare beneficiaries with applications and enrollment for LIS and MSP benefits.
   - Records of outreach and enrollment events targeting Medicare beneficiaries.

Completion Date: 09/2023

6. 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.

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 the age of 75. 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 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

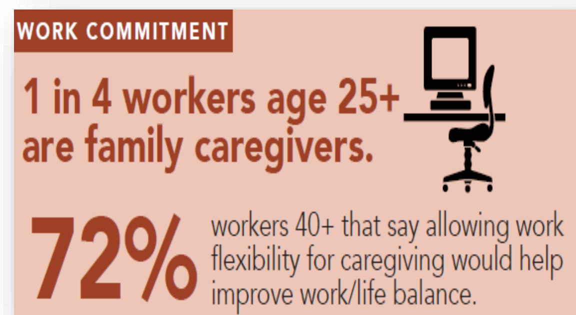
combined with support services are available to help meet that goal with family caregivers.

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. www.NASUAD.org

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, one 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 responsibilities. 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; in part due to financial considerations and in part due to perceptions about 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.

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-Mental health counseling services are available in Kitsap County. Depending on need, they are delivered in the counselor's office, in-home, in ALTC offices 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. These 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 they are supported 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. This 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. Supplemental services include nutrition consultation, home delivered meals, legal, counseling and durable medical equipment or supplies. The service distribution method is based on an authorization to the provider who delivers 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 a waiting list for Respite services.

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. (footnote: 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)

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);
- Supplement school supplies when other resources 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 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 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 a community care options for Long-Term Services and Supports (LTSS). In 2017, the LTSS system was ranked 1st in the nation by AARP for its 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 its commitment to a robust Medicaid LTSS system for those that need it.

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 January 2020, The Washington Association of Area Agencies on Aging will begin advocating to the state legislature for sustainable program funding. The 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 will 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.

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.

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 particular 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 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

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

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. 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 that Washington's in-home program has grown 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.

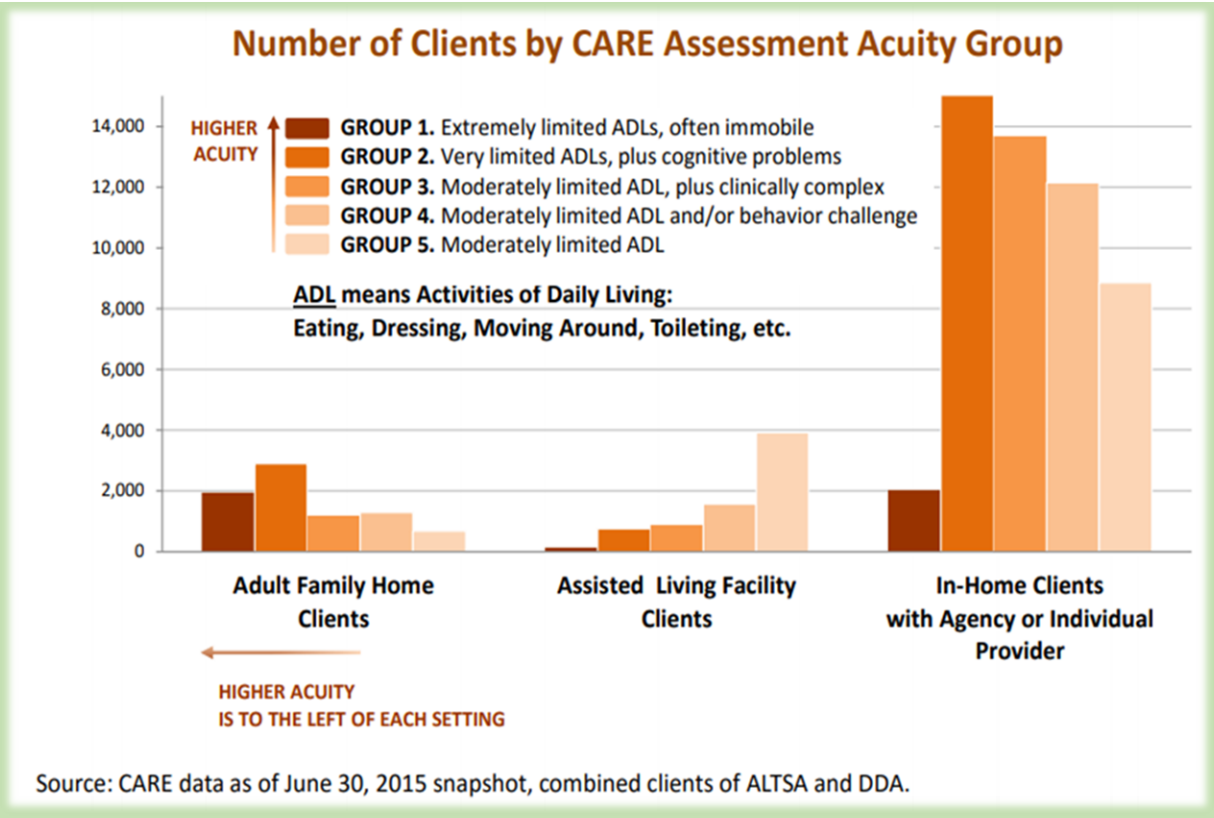
Supporting people of all acuity levels in community-based settings is key to accommodating the growing population.

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.

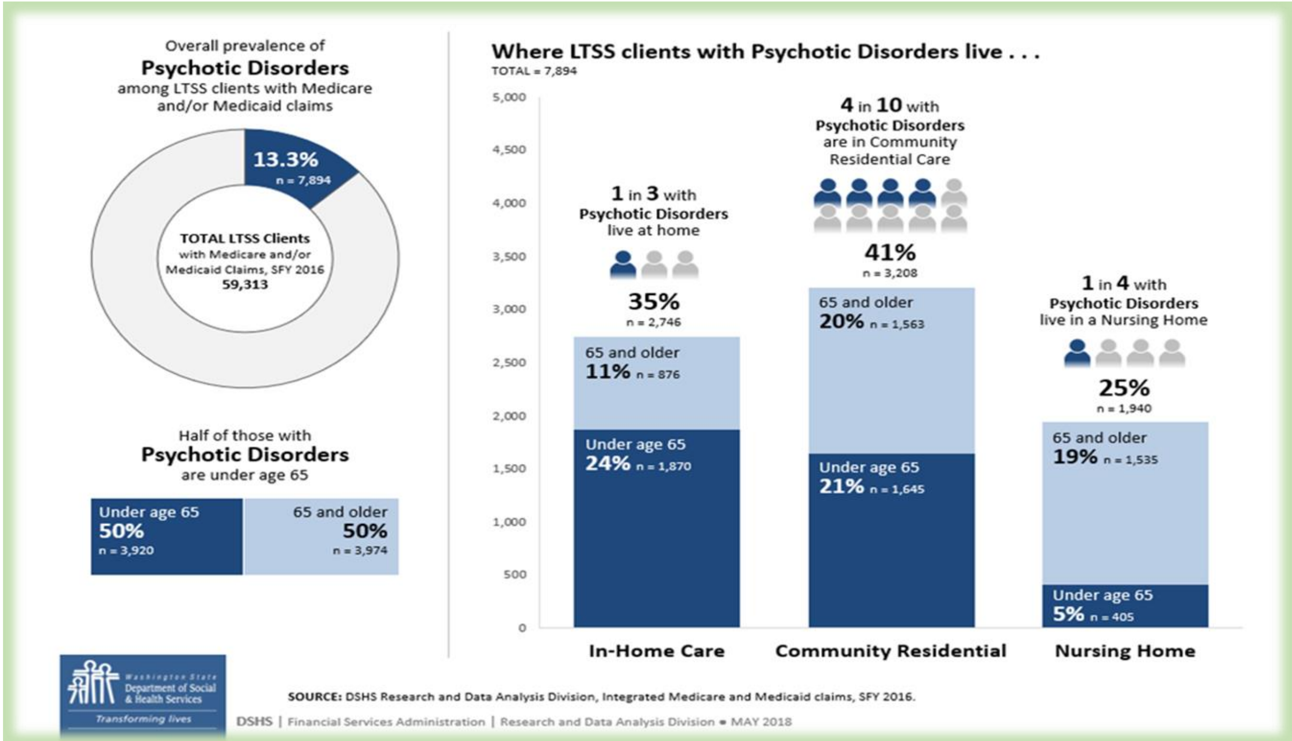
- The acuity of individuals served through the Medicaid Case Management has vastly increased. The average client served has five chronic conditions, seven medications, and participate in the program for 60 months.

- One in four individuals discharged to long term care from a state mental hospital reside at home.

- One in three individuals with a psychotic disorder are receiving long term care resided at home.



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



Not only is in-home care the preferred LTSS option, it is the most cost-effective. Washington state was able to re-balance the overall costs of the statewide system by investing in the community-based system. Thus, ranking 34th for overall costs in the nation.

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

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

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

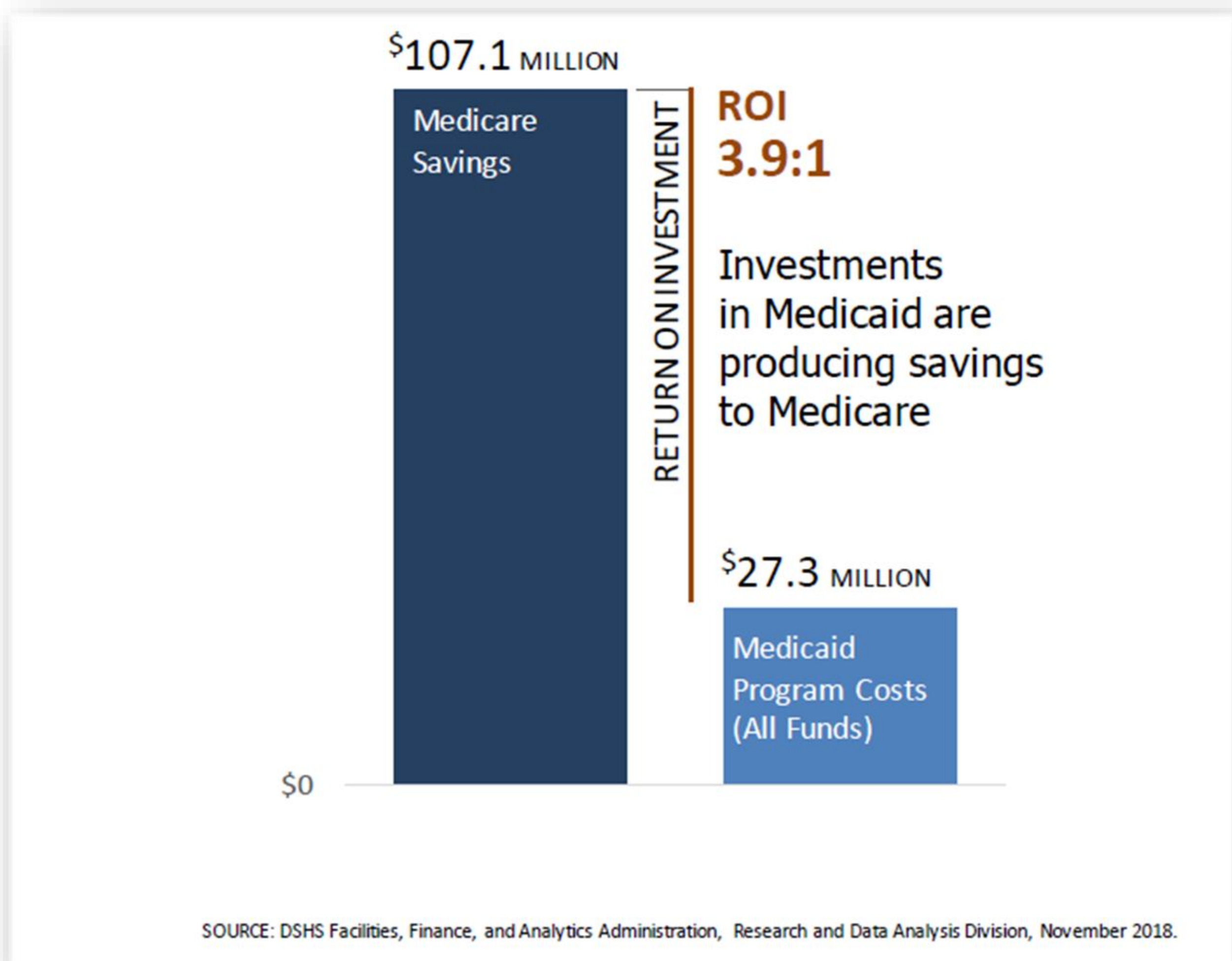
Home Health Program Background

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 the Medicaid Program costs from July 2013 to December 2016.



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. 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.

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 client's independence by offering assistance to 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.

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 deliver quality in-home LTSS case management support and services.

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.

Measured by:

- 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

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.

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.

RESOURCES:

- Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chart-book 2012.
- DSHS Research and Data Analysis Division: 5732/1519 Measures, June 2019.
- DSHS Research and Data Analysis Division: Integrated Medicare and Medicaid claims, SFY 2016.
- Health Homes Program National Governors Association presentation slide deck by Bea Rector, May 2019.
- Washington State Health Care Authority: Health Homes website

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. "Firsts" include the first tribal Temporary Assistance to Needy Families (TANF) program in Washington, the first TANF Tribe in the state to operate a federally funded child support program, an award-winning health clinic and an acclaimed dental clinic.

The Tribal Elders program prepares and provides five meals per week at the Elders Center. The Tribe blend 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.

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. 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/

2019 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, 2019 to December 31, 2020

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 Oct.1, 2020)**
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.	Improved 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, Aging Case Manager Jamie Aikman, Tribal Vulnerable Adult Case Manager Sue Hanna, Elders Program Manager Beth Nichols, RN	

			Sarah Golda, RN Review Annually	
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 Tribe established a Tribal Kinship Care Navigator Program that continues through this plan period. Aging subcontracts the Kinship Caregiver Support Program and a new Kinship Caregiver Pilot project.	• 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. • Coordinate cross-referral opportunities. • Share ongoing updates about Kinship Caregiver Support program and support scholarship and 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 Review Annually	
3. Communicate and coordinate potential new community resources through the Medicaid Transformation Demonstration Project and local funding.	• Share 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 Stacey Smith, Aging Administrator	

			Tawnya Weintraub, Aging Planner Review Annually	

Completed/Tabled Items

(1) Goals/Objectives	(2) Activities	(3) Expected Outcome	(4) Lead Staff and Target Date	(5) Status Update for the Previous Year
2018-2019 Goal: Continue to provide Senior Farmers' Market Nutrition Program Services to the S'Klallam Tribe.	Provide vouchers for redemption for produce at Kitsap County Farmers Markets, and home delivered produce through the Senior Nutrition Program Service Provider.	Increased availability of fresh fruits, vegetables and other produce to Tribal Elders.	Cheryl Miller, Community Services Division Director Tawnya Weintraub, Aging Planner Seasonal and ongoing	Goal Accomplished. The joint coordination efforts have been successfully integrated in routine operations.

2018-2019 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, 2018 to December 31, 2019 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 Fiscal Year Starting Last January 1**

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.	• 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 Kathy Kinsey, Suquamish Tribe Human Services Social Worker Supervisor Barbara Hoffman, Suquamish Community Health 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	

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 the annual Tribal Community Health Fair scheduled for October 2019.	• 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.	• Increased and enhance caregiver support information and services. • Improve quality of care to Tribal Elders.	Nehreen Ayub, Suquamish Tribe Human Services Director Kathy Kinsey, Suquamish Tribe Human Services Social Worker Supervisor Jennifer Calvin-Myers, Senior I&A Supervisor Suquamish Tribe Caregiver Training by November 2019 Review annually	
3. 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.	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 Kathy Kinsey, Suquamish Tribe Human Services Social Worker Supervisor	New goal

2018-2019 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, 2018 to December 31, 2019

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 Fiscal Year Starting Last January 1**
			Tawnya Weintraub, Aging Planner Gail Archut, Aging Case Manager Brenda Francis-Thomas, OIP Regional Manager Ann Dahl and Marietta Bobba, DSHS ALTSA Tribal Program Mangers Review annually	

2018-2019 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, 2018 to December 31, 2019

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 Fiscal Year Starting Last January 1**
4. 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 Kathy Kinsey, Suquamish Tribe Human Services Social Worker Supervisor Barbara Hoffman, Suquamish Tribe Community Health Program Manager Jennifer Calvin-Myers, Senior I&A Supervisor	

2018-2019 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, 2018 to December 31, 2019

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 Fiscal Year Starting Last January 1**
			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
2018 Goal: Tabled Seek to establish joint planning and coordination around Kinship Care support for Suquamish Tribal members raising grandchildren. Mutually decided to table this goal for 2019.	• Conduct coordination and training meetings with Tribal Human Services, Tribal Child Welfare, Youth Center, School and Health Care staff. • Provide access to one-on-one services to Tribal members, as appropriate. • Suquamish Tribe will invite AAA staff to a Tribal Historical (Multi-Generational) Trauma training.	Improved access to and information concerning Kinship Care services.	Kathy Kinsey, Suquamish Tribe Human Services Social Worker Supervisor Jennifer Calvin-Myers, Senior I&A Supervisor Subcontractor: Kitsap Community Resources	Due to staff changes and leadership vision- This goal is being tabled for 2019.
2018 Goal: Completed/Tabled Continue to provide excellent Community First Choice Plus (previously referred to as COPES) Case Management services to Tribal members. Because this goal been achieved and is included in the 1st overarching goal, it is being discontinued as a standalone goal.	• On-going coordination meetings with Suquamish Tribe Human Services staff. • Identify 5 potential IPs from the Tribe (or North-end residents) interested in training.	• Minimization of difficulties with assessment and follow up process. • Remove distance and cultural barriers of IP certification	Kathy Kinsey, Suquamish Tribe Human Services Social Worker Supervisor Gail Archut, Aging Case Manager	Tribal staff shared excellent service from dedicated Kitsap AAA case manager, Gail Archut. There is a statewide Tribal subcommittee discussing IP disqualifying crimes exemptions for Tribal members.

2018 Goal: Completed Continue to provide Senior Farmers' Market Nutrition Program Services to the Suquamish Tribe.	Provide vouchers for redemption for produce at Kitsap County Farmers Markets, and home delivered produce through the Senior Nutrition Program Service Provider.	Increased availability of fresh fruits, vegetables and other produce to Tribal Elders.	Tawnya Weintraub, Aging Planner Seasonal	Completed

SECTION D
Area Plan Budget

Area Plan Budget Summary

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 (PSA #13)
BUDGET PERIOD: January 1 - December 31, 2020

BARS CODE		Contract or Direct	Number	Unit	CFDA# Persons Served	Older Americans Act 93.044 Title 3B	93.045 Title 3C1	93.045 Title 3C2	93.043 Title 3D	93.052 Title 3E	93.041 Elder Abuse	OAA Total	NSIP 93.053	DSHS Allocated Title XIX MFP/Chore 93.778/93.791	Title XIX MFP AAA Requested 93.778/93.791 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 Demonstration 93.778	Other ALTSA Funding	Total ALTSA	Non-ALTSA Funding Sources	Grand Total	Description
555 .10	ADMINISTRATION					37,795	20,000	20,000		10,500		88,295		194,531		48,890	35,362	3,596	0	0	0	0	45,000	10,250	425,924	0	425,924	
.11	Area Agency Planning/Administration					34,015	18,000	18,000		9,450		79,465				44,001	31,826	3,236	0	0	0	0	40,500	9,225	208,253	0	208,253	Other ALTSA Admin = $10,250 Caregiver Training Admin of 5%
.12	Interfund Payments for Services					3,780	2,000	2,000		1,050		8,830				4,889	3,536	360	0	0	0	0	4,500	1,025	23,140	0	23,140	SFMNP admin passed to subcontractor
.13	Core Services Contract Management													194,531											194,531	0	194,531	Based on projected caseload of 997
555 21	COORDINATION					35,000						35,000													35,000	6,176	41,176	Coordination activities of Mental Health 1/10th local grant
555 31	LEGAL ASSISTANCE	C	388	Hours	152	33,000					0	33,000				0									33,000	5,824	38,824	Pro-Bono services
555 40	ACCESS SERVICES					165,034						165,034		1,834,876	24,000	239,411							178,890	27,460	2,469,671	0	2,469,671	
.41	Transportation	C	1	One-way Trips	1	1						1				1									2	0	2	
.42	Information & Assistance	D	6,240	Contacts	1,473	165,033						165,033			24,000	239,410							178,890	27,460	634,793	0	634,793	Other = 3-B Admin - ADSA to pay match
43.1	Care Management/Nursing Services - Core Services	D	997	Cases	997									1,834,876	0	0									1,834,876	0	1,834,876	Based on projected caseload of 997
43.2	Care Management - Aging Network	0	0	Hours	0	0						0				0									0	0	0	
.44	Nursing Services - DDA	0	0	Visits	0									0											0	0	0	
.45	Nursing Services - Aging Network	0	0	Sessions	0	0						0				0									0	0	0	
.46	Nursing Services - Contracted with HCS	0	0	Visits	0									0											0	0	0	
.49	Contracted Front Door Functions (King only)	0	0	Cases	0									0											0	0	0	
555 50	IN-HOME SERVICES					23,788			0			23,788				0								0	23,788	4,198	27,986	
.51	Chore Services - Aging Network	0	0	Hours	0	0						0				0									0	0	0	
.52	Personal Care Services - Aging Network	0	0	Hours	0	0						0				0									0	0	0	
.53	Home Health	0	0	Hours	0	0						0				0									0	0	0	
.54	Health Maintenance	0	0	Hours	0	0			0			0				0									0	0	0	
.55	Bath Assistance	0	0	Hours	0	0						0				0									0	0	0	
.56	Visiting and Telephone Reassurance	0	0	Contact	0	0						0				0									0	0	0	
.57	Minor Home Repair and Maintenance	0	0	Contact	0	0						0				0									0	0	0	
.58	Adult Day Care	0	0	Hours	0	0						0				0									0	0	0	
.59	Volunteer Services	0	0	Hours	0	0						0				0								0	0	0	0	
.50	Other In-home Services (Mental Health)	C	385	Hours	85	23,788						23,788				0									23,788	4,198	27,986	Uncompensated contractor costs = MCS Counseling
.50	Other In-home Services	0	0	(Enter Unit)	0	0						0				0									0	0	0	
555 60	NUTRITION SERVICES					0	191,651	230,000	0			421,651	35,641			3,000				24,443	7,502	31,945		18,888	510,925	74,410	585,335	
.61	Congregate Meals	C	31,828	Meals	771		189,651					189,651	11,405			1,000									202,056	33,468	235,524	$33,468 volunteer labor; $28,000 project income (BSA/S'Klallam Tribe)
.63	Nutrition Education & Outreach	C	250	Sessions	3,000	0	2,000	2,000	0			4,000				0				500		500			4,500	706	5,206	Volunteer labor - Bremerton Services Association (BSA)
.64	Home Delivered Meals	C	39,790	Meals	532			228,000				228,000	24,236			2,000								18,888	272,924	40,236	313,160	$40,236 volunteer labor; $50,000 project income (BSA); Other = SB5736
.65	Shopping Assistance	0	0	Assists	0		0	0				0				0									0	0	0	
.66	Registered Dietitian	0	0	Hours	0		0	0	0			0				0									0	0	0	
.67	Senior Farmer's Mkt (SFMNP) Food/Checks	C	693	Participants	693																				0			
67.1	Food Purchased															0				0		0			0	0	0	
67.2	Checks Received															0				21,480	6,240	27,720			27,720	0	27,720	
67.3	Service Delivery															0				2,483	1,262	3,725			3,725	0	3,725	
555 70-80	SOCIAL & HEALTH SERVICES					5,382			15,976	94,533	2,010	117,901				5,000	318,259	36,367	0					12,612	490,139	117,358	607,497	
.71	Adult Day Health Services	0	0	Hours	0	0						0				0									0	0	0	
.72	Geriatric Health Screening	0	0	Sessions	0	0			0			0				0									0	0	0	
.73	Medication Management	0	0	Sessions	0	0			0			0				0									0	0	0	
.74	Senior Drug Education	D	10	Trainings	250																			12,612	12,612	0	12,612	
.75	Disease Prevention/Health Promotion	0	0	Sessions	0	0			0			0				0									0	0	0	
.76	Elder Abuse Prevention	0	0	Hours	0	0					0	0				0									0	0	0	
.77	Mental Health (Powerful Tools)	C	24	Hours	12	0			15,976			15,976				0									15,976	0	15,976	Evidence Based program - MCS Counseling
.78	Kinship Care																								0			
78.1	Kinship Caregivers Support Program																								0			
78.1a	Service Delivery																	6,394							6,394	0	6,394	
78.1b	Goods and Services	C	82	Items/Services	52													29,973							29,973	0	29,973	
78.2	Kinship Navigator Services	0	0	Contacts/Activities	0	0						0							0						0	0	0	
.79	Family Caregiver Support Program																								0			
79.1	Information Services	D	See the FCSP Services Tab to Complete the Number, Units & Persons Served							37,000		37,000				0	45,000								82,000	0	82,000	
79.2a	Access Assistance	D				0				54,985		54,985				0	125,178								180,163	0	180,163	
79.2b	Support Services	C				0				548		548				0	13,465								14,013	333	14,346	Uncompensated contractor costs = MCS Counseling
79.3	Respite Care Services	C				0				1,000		1,000				0	123,516								124,516	0	124,516	
79.4	Supplemental Services	C				0				1,000		1,000				0	11,100								12,100	333	12,433	Pro-Bono services
79.5	Services to Grandparents/Relatives	0																							0	0	0	
79.5a	Information Services									0		0													0	0	0	
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 - NW and King only)	0															0								0	0	0	
.84	Health Appliance/Limited Health Care	0	0	Contacts	0	0			0			0				0									0	0	0	
.88	Long Term Care Ombudsman	D	500	Investigations	2,500	5,382					2,010	7,392				5,000									12,392	116,692	129,084	LTCOP = $76,692; Kitsap County General Fund = $40,000
.89	Newsletters	0	0	Issues	0	0			0		0	0				0									0	0	0	
555 90	OTHER ACTIVITIES					1			0			1				1								5,000	5,002	190,000	195,002	
	Disaster Relief					1						1				1									2	0	2	
	Foot care	0	0	Sessions	0	0			0			0				0									0	0	0	
	Peer Counseling	0	0	Hours	0	0						0				0									0	0	0	
	Outreach	0	0	Contacts	0	0						0				0									0	0	0	
	Aging & Disability Resource Center (ADRC)	0	0	Contacts	0	0						0												0	0	0	0	
	MIPPA	D	60	Applications	60							0												5,000	5,000	0	5,000	MIPPA Extension
	Chronic Disease Self Management Program (CDSMP)	0	0	(Enter Unit)	0							0												0	0	0	0	
	Home Care Referral Registry (HCRR)	0	0	(Enter Unit)	0							0												0	0	0	0	
	Veterans Directed Home Services	0	0	Clients	0							0												0	0	0	0	
	Other (Mental Health 1/10th)	C	300	Consultations	300																			0	0	90,000	90,000	Mental Health 1/10th local grant
	Other (Health Home Coordinator)	D	55	Cases	55	0						0				0								0	0	100,000	100,000	Health Home Coordinator
	Other (Enter Title)	0	0	(Enter Unit)	0	0						0				0								0	0	0	0	
	Total Services					262,205	191,651	230,000	15,976	94,533	2,010	796,375	35,641	1,834,876	24,000	247,412	318,259	36,367	0	24,443	7,502	31,945	178,890	63,760	3,567,525	397,966	3,965,491	
	Total Expenditures					300,000	211,651	250,000	15,976	105,033	2,010	884,670	35,641	2,029,407	24,000	296,302	353,621	39,963	0	24,443	7,502	31,945	223,890	74,010	3,993,449	397,966	4,391,415	

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							
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
Director/Administrator	1.00	ok	0.76	0.03						0.79
Office Support Supervisor	1.00	ok	0.55							0.55
Program Supervisor (Planner/Monitor)	1.00	ok	0.42	0.56						0.98
Office Support Specialist	1.50	ok	0.70	0.80						1.50
Fiscal Support Specialist	1.00	ok	0.90	0.10						1.00
Program Supervisor (I&A/FC/MTD)	1.00	ok								0.00
Program Supervisor (CORE)	1.00	ok								0.00
Program Specialist (CORE) Case	11.50	ok								0.00
Program Analyst (CORE RN)	0.50	ok								0.00
Office Support Assistant	4.75	ok	0.56							0.56
Program Specialist I&A/FC Case	4.00	ok								0.00
Program Tech (I&A Assist Worker)	1.00	ok								0.00
Program Analyst (LTC Ombudsman)	0.95	ok								0.00
Program Specialist (Health Home	1.00	ok								0.00
Program Specialist (MTD Case Manager)	1.00	ok								0.00
Enter Position Title	0.00	ok								0.00
Enter Position Title	0.00	ok								0.00
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Enter Position Title	0.00	ok								0.00
Enter Position Title	0.00	ok								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

	Direct Charge									
Position Title	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	0.20								0.01	0.21
Office Support Supervisor		0.01	0.01	0.05		0.02		0.36		0.45
Program Supervisor (Planner/Monitor)									0.02	0.02
Office Support Specialist										0.00
Fiscal Support Specialist										0.00
Program Supervisor (I&A/FC/MTD)				0.50		0.25	0.25			1.00
Program Supervisor (CORE)								1.00		1.00
Program Specialist (CORE) Case								11.50		11.50
Program Analyst (CORE RN)								0.50		0.50
Office Support Assistant		0.01	0.01	0.20		0.20	0.05	3.72		4.19
Program Specialist I&A/FC Case				2.00		2.00				4.00
Program Tech (I&A Assist Worker)			0.03	0.45	0.02		0.50			1.00
Program Analyst (LTC Ombudsman)		0.14							0.81	0.95
Program Specialist (Health Home									1.00	1.00
Program Specialist (MTD Case Manager)							1.00			1.00
Enter Position Title										0.00
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Enter Position Title										
Total FTEs	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	6,028	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	25,291	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	4,889	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**	**48,890**	**35,362**	**3,596**	**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
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
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
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
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**

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 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	0.05																								
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 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	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 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	0.02																								
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 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	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
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
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
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
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**

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 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
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
20 Personnel Benefits	921,531	65,959	5,424	5,424	0	27,794	545	0	52,757	484,447	0	0	0
30-80 All Other Cost	143,981	9,898	814	814	0	4,171	82	0	7,917	72,703	0	0	0
90 Interfund Pymnts for Service	339,028	24,321	2,000	2,000	0	10,249	201	0	19,453	178,631	0	0	0
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**
Total Subcontracted Expenditures	897,257	56,790	191,651	230,000	15,976	2,548	0	35,641	0	48,568	0	0	0
Total Other Subcontractor Resources	91,274	16,198	33,821	40,589	0	666	0	0	0	0	0	0	0
ALTSA/Non-ALTSA Breakout Section													
Total Expenditures[1]	**4,391,415**	**316,198**	**245,472**	**290,589**	**15,976**	**105,699**	**2,010**	**35,641**	**194,531**	**1,834,876**	**0**	**0**	**0**

	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												
Direct Services:												
10 Salaries & Wages	14,114	131,670	172,490	120,878	2,115	0	0	29,643	45,103	23,524	7,057	58,810
20 Personnel Benefits	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	977	9,112	11,935	8,366	146	0	0	7,738	3,121	1,628	489	4,070
90 Interfund Pymnts for Service	2,400	22,389	29,330	20,554	360	0	0	4,271	7,669	4,000	1,200	10,000
Total Direct Expenditures	**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	0	0	3,002	148,081	36,367	0	31,945	18,688	0	0	78,000	0
Total Other Subcontractor Resources	0	0	0	0	0	0	0	0	0	0	0	0
ALTSA/Non-ALTSA Breakout Section												
Total Expenditures[1]	**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	Correct
Funding	$ 3,174,192	$ 228,692	$ 3,402,884	Correct

Reconciliation

	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
Grand Total Line from Expenditure Detail	4,391,415	316,198	245,472	290,589	15,976	105,699	2,010	35,641	194,531	1,834,876	0	0	0
Difference	4,391,415	0	0	0	0	0	0	0	0	0	0	0	0
	Error	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Correct
If error amount is due to rounding, ignore error amount	0	0	0	0	0	0	0	0	0	0	0	0	0

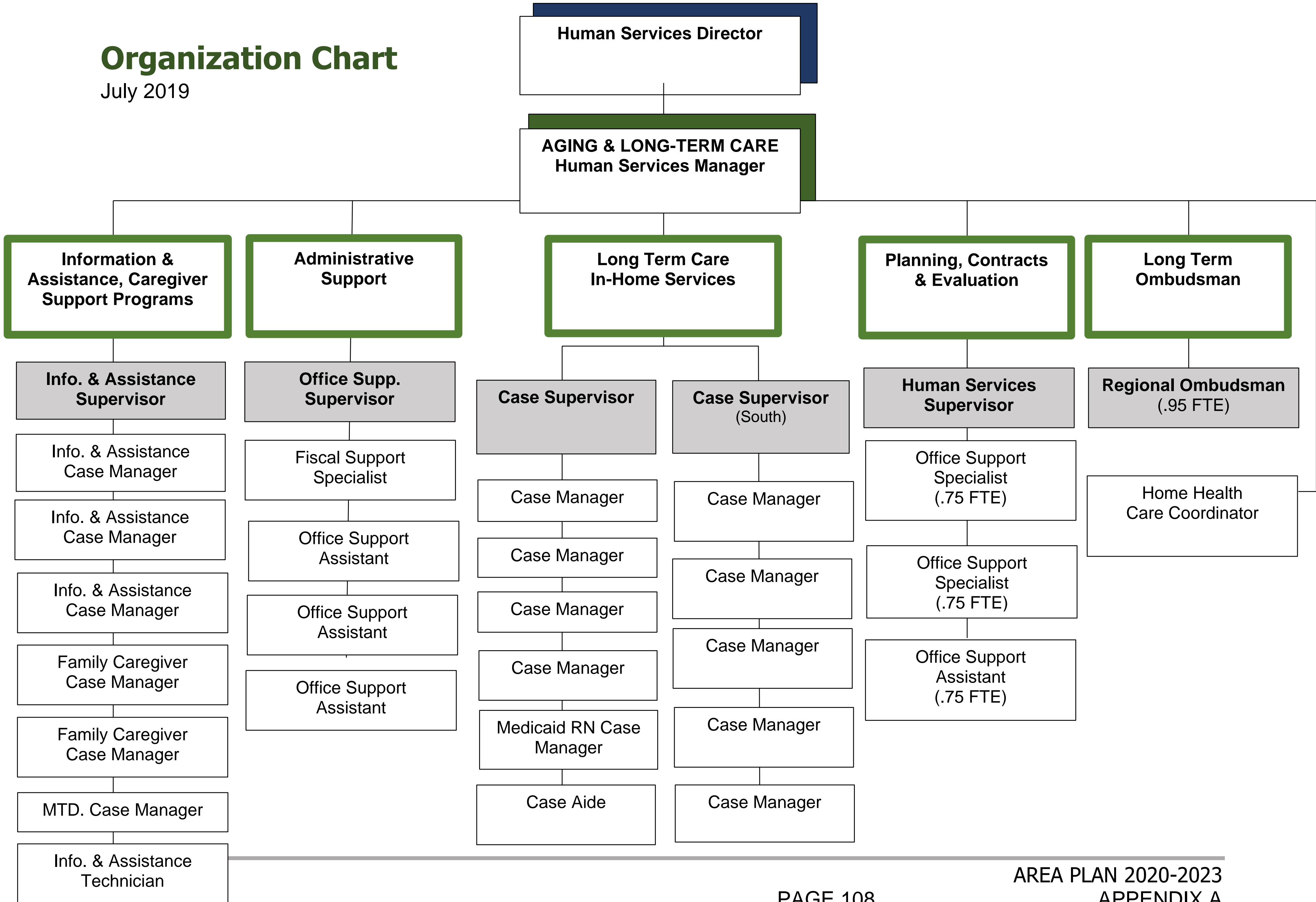
	Matched by SCSA Local	Medicaid Transformation Demonstration	SCSA	State Family Caregiver	Kinship Caregiver Support	Kinship Navigator	Senior Farmers Market	Other ALTSA Funding	Non - ALTSA LTCOP	Non - ALTSA COUNTY	Non - ALTSA MH 1/10	Non - ALTSA Home Hlth
Grand Total Line from Expenditure Detail	24,000	223,890	296,302	353,621	39,963	0	31,945	74,010	76,692	40,000	90,000	100,000
Difference	0	0	0	0	0	0	0	0	0	0	0	0
	Correct	Correct	Correct	Correct	Correct	Correct	Correct	Error	Correct	Correct	Correct	Correct
If error amount is due to rounding, ignore error amount	0	0	0	0	0	0	0	0	0	0	0	0

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 2019
Human Services Director
AGING & LONG-TERM CARE
Human Services Manager
Information & Assistance, Caregiver Support Programs
Administrative Support
Long Term Care In-Home Services
Planning, Contracts & Evaluation
Long Term Ombudsman
Info. & Assistance Supervisor
Info. & Assistance Case Manager
Info. & Assistance Case Manager
Info. & Assistance Case Manager
Family Caregiver Case Manager
Family Caregiver Case Manager
MTD. Case Manager
Info. & Assistance Technician
Office Supp. Supervisor
Fiscal Support Specialist
Office Support Assistant
Office Support Assistant
Office Support Assistant
Case Supervisor
Case Manager
Case Manager
Case Manager
Case Manager
Medicaid RN Case Manager
Case Aide
Case Supervisor
(South)
Case Manager
Case Manager
Case Manager
Case Manager
Case Manager
Human Services Supervisor
Office Support Specialist
(.75 FTE)
Office Support Specialist
(.75 FTE)
Office Support Assistant
(.75 FTE)
Regional Ombudsman
(.95 FTE)
Home Health Care Coordinator

Area Agency on Aging Staff

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
Director, Dept. of Human Services	.1 FTE Doug Washburn	• Evaluates and supervises the Kitsap Division of Aging and Long Term Care (ALTC) Administrator.
Human Services Senior Manager (ALTC Administrator)	1 FTE Stacey Smith	• 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 Ombuds 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 Tawnya Weintraub	• 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 Vicki Hanson	• 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 Wanda Vliet	• 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 FTE Judy Clark	• 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 Kristy Day	• 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
Office Support Assistant (Primary Reception)	1 FTE Sami Loop	• 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 Vacant	• 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)		• Backup to maintain agency website. • Maintains and updates 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 Desirae Ada	• 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 Tina Hart	• 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	1 FTE Jennifer Calvin-Myers	• Manages Senior Information & Assistance (I&A)/Caregiver Support, Medicaid Alternative Care (MAC), Tailored Supports for

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
Caregiver Program (Community Living Connections)		Older Adults (TSOA) and other ancillary projects and assigns and supervises work of 7 paid staff. • 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
Case Management Supervisor (Medicaid Long Term Care Unit)	2 FTE Adeanna Hume Rochal Roach-George	• JRP duties • Fair Hearing Coordinators • Quality Assurance and clinical oversight • Network home care agency liaison.
Case Manager	15 FTE Gail Archut Mikko Azul	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.

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
	Angie Del Grosso-Thompson Guenther Franzen Carolina Garcia Estrada Myriah Howard Janet Larson Ruh MacBradaigh Victoria Mastel Alissa Minton Marguerite McCann Steffan Omray Dorothy Putnam K. Walker-Santos Stephanie Watson	• Local level of complaint resolution.
Registered Nurse	1 FTE Nancy Ourada	• Schedules and performs nursing consultation and visits. • Ensures best practices used by caregivers, upon request. • Maintains documentation and quality assurance for Nursing Services.

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
		• 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 Vanessa Gothreau	• 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 Lisa-Marie Williams	• Provides clerical support to Case Managers. • Contacts clients and caregivers on established schedule to check status of client and care plan. • Limited non-clinical field work. • Provides assistance on special/short-term projects including Client Satisfaction Surveys.
LTC Regional Ombudsman	.95 FTE Dana Gargus	• Identifies, investigates, and resolves complaints. • Mediates disputes. • Recruits, trains, support and supervise 25 volunteer ombudsmen. • Documents computerized reporting system. • Co-lead to Ombuds Advisory Council • Participates in statewide Ombuds forums and legislative advocacy.

TITLE	TOTAL STAFF FTE	POSITION DESCRIPTION
Health Home Coordinator	1 FTE Hannah Ander	• 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 = 33
Total number of full time, 40 hours per week staff = 29
Total number of part-time staff = 4
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

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.

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

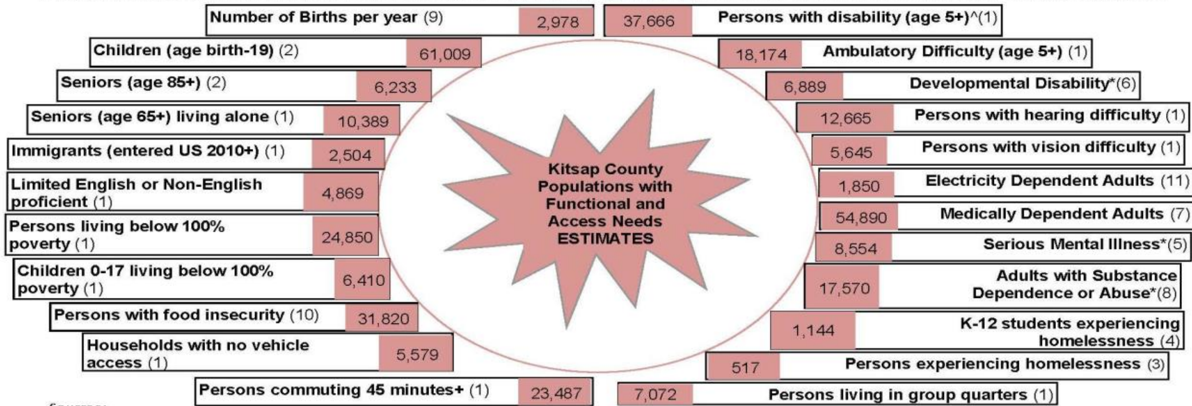
The region for this research project is Kitsap County. As shown in Attachment A, the Kitsap region is in the Pacific Northwest across the Puget Sound, west from the Seattle-Tacoma Metropolitan area in Washington State. The area includes the growing incorporated Cities of Bremerton (the largest population), 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.

Kitsap County Populations with Functional and Access Needs Estimates
(Updated Jan 2019)

The Kitsap Populations with Functional and Access Needs Report is designed to provide estimated numbers of people in populations who might need additional assistance or have special needs in an emergency situation or unforeseen event. These estimates, while originally compiled for emergency preparedness planning, can be also used for other health or community planning work.



Sources:
1. American Community Survey, 2013-17
2. Washington State Office of Financial Management, 2017 and 2018
3. Point in Time Count, 2017. Washington Dept. of Commerce.
4. Office of Superintendent of Public Instruction, 2016-17: http://www.k12.wa.us/HomelessEd/Data.aspx
5. Mental Disorders in America, 2015. Accessed at: http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml
6. CDC Developmental Disabilities, based on 2017 population estimates. Accessed at: https://www.cdc.gov/ncbddd/developmentaldisabilities/about.html
7. Behavioral Risk Factor Surveillance System 2013-17, Kitsap County analysis
8. Substance Abuse and Mental Health Services Administration, 2015, based on 2017 population estimates. Accessed at: http://www.samhsa.gov/
9. WA Dept. of Health, Birth Certificate Database, 2017.
10. Map the Meal Gap, Feeding America, 2016.
11. US Dept. of Health and Human Services, 10 January 2019. Accessed at: https://www.phe.gov/empowermap/Pages/default.aspx

Important Notes:
^Civilian, noninstitutionalized only
*County estimate based on U.S. national estimates by age.

Kitsap County Population (2)		
2018 Estimates	People	Percent
Total	**267,120**	**100%**
Unincorporated	176,290	66% of total
Incorporated	90,830	34% of total
Bainbridge Is	24,320	27% of inc
Bremerton	41,500	46% of inc
Port Orchard	14,160	16% of inc
Poulsbo	10,850	12% of inc
Households (1)	**100,484**	

Source: WA Office of Financial Management

Jan 2019 Kitsap Public Health District, Public Health Emergency Preparedness and Response Program, prepare@kitsappublichealth.org 1

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 ahead 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 particular 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
Barbara Paul Karol Stevens	District 1 – Poulsbo District 1 – Keyport (member at large) District 1 – Vacant District 1 - Vacant
Mari Van Court, Chair Michaelene Manion Richard Larkin Charmaine Scott	District 2 – Port Orchard District 2 – Port Orchard District 2 – Port Orchard District 2 – Port Orchard (member at large)
Al Pinkham, Vice Chair Gail Campbell-Ferguson Jean Schanen	District 3- Silverdale District 3 - Silverdale District 3 – Bremerton

Vacant Council Member seats:

- 2 District 1 (current recruitment)

Public Process

Activities for the Development of the 2020-2023 Area Plan

Activity	DATES	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,

Activity	DATES	Location	Group
			community partners, providers
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

Activity	DATES	Location	Group
Area Plan presentation and work study session/ Board of County Commissioners (BOCC) Session-open to the public	August 14	Kitsap County Administrative Building	Kitsap County Aging and Long-Term Care staff, Director of Human Services, and 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) Presentation and 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.

Report on Accomplishments of 2018-2019 Area Plan

Issue Area C-1 **Long Term Services and Supports: Care Management**		
Goal: ALTC's goal is to allow an increasingly greater number and proportion of people who need long-term services and support to get them in their home or in a community-based setting (HCBS).		
Measurable Objectives	**Key Activities / Measured By**	**Accomplishment or Update**
1. Increase individual and family member awareness, education and understanding of community-based LTSS options. 2. 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. 3. Continuous improvement of LTSS case management services demonstrated by positive client satisfaction surveys. 4. Achieve full funding to maintain quality in-home case management so that individuals receive stabilized care that allows them to	•17% more people will receive LTSS with enough funding to achieve a 1:75 case manager to client ratio. (Current service utilization rate in Kitsap County is 64%, statewide average is 81%. Current caseload ratio is 1:92). This equates to an additional 155 more cases on average monthly caseload by end of 12/2019. • Client Satisfaction Surveys will be analyzed for implementation of applicable recommendations. Review will occur at 6-mos intervals to identify training or system improvement needs through 12/2019. • The rate will be increased to cover costs. Completion date: 12/2017. Extended to 12/2019.	2017-2018: • ALTC provided education to LTSS partners regarding MTD, updated Medicaid Waivered Services Provider list, BCCU to BCS changes and local respite needs at 2 Quarterly Provider meetings. ALTC and DSHS HCS, APS and DDA staff report system changes and highlight areas for community partner discussion at quarterly meetings. • Satisfaction surveys summary results for July- December 2017 were revised for case managers so results are easier to understand. Satisfaction surveys summary results for 2018 were summarized for each Medicaid CM and distributed. Per Survey results, no client concerns or trends noted. Case managers are doing an extremely good job handling high caseloads. The implemented client satisfaction survey process will continue. Case aide contacts clients to thank them for returning their signed service plans and to inform they will receive a satisfaction survey. This strategy increased the survey return rate, allowing for a broader review of feedback. 2018-2019: • Medicaid Personal Care (MPC) meeting with Salish BHO to discuss how to request MPC funding for LTSS. On-going system training occurred in the fall. • The legislative Consumer Directed Employment (CDE) bill was supported because it lessens the burden of case managers to

stay in home services if that is their choice.		manage Individual Provider employment issues and allows more time devoted to clinical issues. An estimated $13 million is saved statewide to AAAs through CDE. • The fiscal year 2018 clinical ratio of case managers to clients was 1:92- the highest in the state. ALTC staff and advisory council participated in W4A Advocacy Day in Olympia in 2018 and requested support for increased case management funding in the supplemental budget. • In early 2019 W4A Advocacy focused on requesting additional funding to address the high caseloads and increased acuity and increased mental health diagnosis on current caseload, statewide. Minor additional funds were added from the Governor's Mental Health Initiative to assist with increased complexity of caseloads. However, the 2019 Clinical Ratio caseload in Kitsap County is 1:91. Insufficient increased funding to case rate and/or inadequate increase to program participants have resulted in lack of funding to impact caseload.

Goal: To provide person-centered coordination of health and community supports for increasing numbers of people who face significant health challenges in a manner that improves their health and reduces avoidable health care costs.		
Measurable Objectives	**Key Activities / Measured By**	**Accomplishment or Update**
Specific to potential Health Home clients who are also in community-based LTSS: **1.** Increase availability of care coordination throughout the county. **2.** Increase engagement and effectiveness of care coordination services. **3.** Increase awareness of local health care options including Urgent Care Centers. **4.** Increase awareness of palliative care options and support for people at the end of life. **5.** Initiate and sustain partnerships with other care providers. **6.** Achieve full funding to maintain quality care coordination. (Note: At current levels of funding it will not be possible to accomplish the above activities).	• Minutes and records of coordinated meeting and training opportunities among existing Health Home providers to improve communication and coordination, understanding of roles and appropriate referrals and to develop partnership opportunities. At least one every six months through 12/2017. • The "all cause" readmission rate (22% in Kitsap) will be closer to the statewide average of 16% by 12/2019. • The Emergency Department visit rate will decrease by at least 10% towards of goal of getting closer to the statewide average of 89.2 per 1000 members. Completion date: 12/2019. (Note: Dependent upon continued Health Home funding).	Coordination Meetings: Ongoing: • Attend monthly meetings with Adult Protective Services and the community interdisciplinary team to discuss the most vulnerable adults. 2018: • Quarterly meetings with HCS/AAA Pierce County to better coordinate care between counties. Resumed annual meetings with Kitsap County Contracted Care Providers to better address issues and concerns within / between the Home Care Agencies and ALTC. • KC4TP All Partners meeting. Discussed lack of improvement to avoidable Emergency Department visits. • KC4TP Steering committee additional meeting, discussion continued, for creating a sub-group to explore strategies that included connecting to OCH projects. • Health Home Revenue Contract • Legislative bill to support proviso funding to increase the Health Home provider reimbursement rate by 20% with a 5% incentive increase. • January 2018- Kitsap AAA submitted request to hire 1 FTE Health Home Coordinator. • May 2018- Established First Responder referrals from 3 fire districts (Bremerton, North Kitsap, and South Kitsap) • July 2018- signed Optum Health Home Care Coordination Organization contract. ALTC presentation to Harrison Social

		Workers (emergency department, general admission, and special programs). • September 2018- hired Health Home Coordinator. December 2018- transitioned Health Home lead to AAADSW. February 2019- transitioned Health Home lead to Olympic Area Agency on Aging. • January 2019 ALTC presentation to Harrison Care Management (SW & RNS) Discharge Team. • Jan- June 2019: Health Home presentations to community partners; to encourage referrals and care coordination.

Issue Area C-2.1 **Community Living Connections- Information and Assistance Services**
Goal: **To assure that older adults, other persons with long term care needs, families and community members have access to the Information & Assistance they need to meet the goal of many which is to continue to live in the community as independently as they are able. Another goal is to continue to identify program strengths, challenges and needs for transitioning to Community Living Connections.**

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
1. Improve consumers' access to long term care and healthy aging information a. Maintain and expand the Kitsap County ALTC & Senior I&A Internet Web Site.	• Assess opportunities for Community Living Connections (CLC) links to ALTC website. • Expand marketing of the ALTC website. • Enhance website data tracking. • Enhance consumer-driven service capacities. • Review and suggestions by users.	2018: • Aging website revised. Aging video was added, and information was reformatted for easier community member experience. New agency-wide rack card which included waclc.org and ALTC websites was completed in 2017.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
	• Increased “Contact Us” in online referrals. Completion Date: 12/2019	• “Contact Us” Cognito form was placed on Aging webpage. 2019: • Caregiver video placed on website to expand visibility of programs.
b. Develop and maintain a searchable computerized information-and-referral database system.	• Data conversion meetings and outcomes. • Updated resource database converted into the new CLC searchable database. • Assessment of needs for dedicated staff support to update and maintain databases. • Successful rollout of CLC to include all relevant programs. Completion Date: 12/2016-Extended to 12/2019. Data conversion completed. Maintenance need will continue 2020-2023.	2017: • An ongoing maintenance plan created in the summer for CLC entries to be updated on an annual rolling schedule and as needed when changes exists prior to a listing’s annual update due date. • At I&A/FCSP team meeting; plan revised to address staff involved in updates to resources in database and paper versions and timing for routine and early updates. • ALTC staff attended CLC GetCare resource directory meetings July- December, as available. 2018: • Coordination discussions between supervisors regarding ongoing dedicated staff capacity for resource database maintenance. Office Specialist position assigned for database updates. • Data conversion meetings and activities completed in previous reporting periods. • CLC Resource Database Meetings on hold September 2018 to June 2019.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
c. Implement locally the CLC client tracking system in coordination with the statewide rollout efforts.	• Planning and implementation meeting notes, records. • Data conversion from existing systems into new system. • Revised policy and procedures. • End user (staff) training schedule. Completion Date: 12/2016-completed	
d. Utilize Person-Centered Options Counseling strategies and tools as appropriate with individuals requesting this assistance with long term support service planning.	• Training for all I&A/FCSP/CLC staff. • Planning and implementation meeting notes, records. Completion Date: 12/2016-extended to 12/2019	2017: • Person Centered Options Counseling Training for two staff was previously reported. • I&A/FCSP team meeting to discuss using person-centered conversations when talking with people in-depth about their long-term care goals and plans for future (when introducing MAC/TSOA programs and other topics). 2018: • ALTC inquiry to ALTC about access to upcoming training opportunities and local need. • Person-Centered Planning background shared with Bainbridge Island Senior Center, a potential partner for training location for volunteers and our staff. Planned follow-up into 2019. • Implemented Person-centered tracking mechanism for MAC/TSOA discussions to capture I&A costs.
2. Continue ongoing coordination with established networks and other Kitsap Information and Referral partners; maintain the BenefitsCheckup program with regular resource updates; participate in community meetings to educate and inform residents about CLC and coordinate with	• Schedule of I&R Coordination meetings. • Kitsap County BenefitsCheckup reports and consumer results. • Schedule of WIN2-1-1 meetings. • Scheduled information and planning meetings following program launch of Community Living Connections to coordinate database updating processes.	2017: • Staff participated in 4 total KIRN meetings 2018:

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
WIN2-1-1 (Washington Information Network).	• Completion Date: 12/2019	• Met with 211 about shared agency resource update form, DDA Parent Coalition meeting, and City of Bremerton Employee Wellness presentation. 2018-2019: • Ongoing monthly attendance at KIRN 2019: • Aging Advisory Council overview of services presentations listed below.
3. Continue to strengthen and improve visibility of Senior Information & Assistance/Community Living Connections (CLC) as the primary entry point for the local system. Conduct a minimum of 12 Outreach events annually.	• Visible, linked Internet presence. • Updated I&A outreach materials. • Records of outreach presentations and events. • Samples of marketing materials and presentations. Complete annually through 12/2019	Presentations: 2017: • Provider Breakfast, Area Plan public presentation, Military Retiree Appreciation Fair, "Social Security; Everything you Need to Know" hosted at Kitsap Co Commissioners Chambers, Women and Cancer Support Group FCSP, MAC/TSOA Local Planning Area Presentation, Bainbridge Island Senior Center Resource Committee, Kitsap Regional Library Sylvan Way, MultiCare Hospice, Social Security office 2018: • St. Anthony's Episcopal Church, Kaiser Community Resource Specialist, to Harrison Social Workers (ED, general admission, and special programs), Hansville Neighbors Community Lunch, Caregiver Support DSHS CSO Staff Meeting, 2019:

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• YMCA chronic conditions/wellness staff, CHI Care Managers (SW/RN), North Kitsap Fishline, Visually Impaired Persons Support Group, New Life Church, CHI Outpatient Care Coordinators, CSO Financial Staff (MTD/FCSP specific outreach), Retired Public Employees Council, Social Security Office, Helpline House & Island Volunteers Staff Meeting, Village Green Luncheon, OAA month Port Orchard United Methodist Church, Aging Advisory Council (Area Plan), Aging Advisory Council (overview of services) Resource Booths: 2017: • Military Retiree Appreciation Fair, Village Green Community Center Open House, VA Whole Health Fair 2018: • Project Connect in Port Orchard, DDA Resource Fair, Senior Health & Resource Fair, Church Caregiver Panel, Bainbridge Island Senior Center Resource Fair, DDA Parent Coalition Meeting, City of Bremerton Employee Wellness, Better Breathers Club, Older Americans Month Conference, The Pearl on Oyster Bay Senior Health & Resource Fair, Suquamish Women's Health Fair, Senior Lounge Kitsap Co Fair & Stampede, Bremerton Farmers Market- Healthy Communities Event, VA Whole Health Day, Kingston Community Open House, Port Orchard United Methodist Church, Navigating HealthCare, Kitsap Co Employee Benefits Fair, Port Orchard United Methodist Church, Caregiver Support Conference 2019: • Project Connect, Port Orchard United Methodist Health & Resource Fair, Harpers Church Women's Group Caregiver

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		Support, Brain Health, YMCA Silverdale Balance Testing, Bainbridge Island Senior Center Resource fair, OAA month YMCA Bremerton Lifelong Wellness, South Kitsap Safety Fair Program Promotion Activities 2017: • Aging Rack cards created 2018-2019: • Aging website revision, Aging rack cards are re-ordered and updated continuously when changes in programs occur. Ongoing: • ALTC program brochures are provided, such as I&A brochure, FCSP, LTCO, Dementia Specialist, and Dementia Café brochures with dates, times and locations. Alzheimer educational series information is provided. All the above is announced at the meetings and brochures are disseminated. Monthly Provider Breakfast meetings hosted with presenter and program topic.
4. Facilitate partnerships and increase coordination with community resources (i.e., ethnic cultural centers, faith communities, community centers, employers, non-profit organizations and associations) providers for medical services, military families and first responders such as police, sheriff, fire, EMT's, etc., which may be	• Schedule of coordination meetings and public events hosted or attended. • Completion Date: 12/2019	Advisory Council Activities Ongoing: • Outreach to Peninsula Community Health Services • Caregiver outreach in faith-based settings and through church Pastoral Care group • Local healthcare, state and federal advocacy

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
appropriate alternative points of referral for consumers. Conduct a minimum of one coordination meeting with a different community partner annually.		2017: • Chair outreached to four community groups on “Navigating the Healthcare System” and caregiving. • Chair planned and completed an eight-week series on “Aging in Place” at Silverdale United Church. • Members attended a briefing with the Olympic Community of Health, met with deacon about Catholic Community Services, and volunteered at the Port Orchard Farmer’s Market. • Outreach to North Kitsap Senior Center in Poulsbo. • Members participated in the Senior Lounge at the Kitsap County Fair. • Facilitated a meeting between the Senior Center and U.S. Congressman Derek Kilmer • Members actively work with other community groups, such as the Kitsap Parent Coalition, Bainbridge Island Senior Center, Givens Senior Center, • Members attended the League of Women Voters Homeless Conference, Fall Senior Lobby Day, • Attended meetings throughout the year with community partners such as a Citizens in Action 2018: • Members received training on public speaking • Chair participated in 2018 Caregiver Conference and presented a “Navigating Healthcare” training at Crista Shores • Chair presented at “Death & Dying” event and a Caregiver Support Group. • Actively advocating for an Inclusionary Housing ordinance and independent senior living on Bainbridge Island. • Members involved in homelessness advocacy. • Members actively involved in community through the Keyport Improvement Club, local fire department connections, Bainbridge Island Senior Center, the State Council on Aging, Helpline, B.I. City Council, and the Kitsap Veterans Council.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• Chair presented at the Older Americans Conference in May and other members were in attendance. • Member participated in local networking through attendance at 1/10th Mental Health Citizens Advisory Council, Sons of the American Revolution meetings, a local suicide prevention event, UW School of Nursing "Ignite Aging 2018" event, and a Homeless Action Team meeting. • Member co-staffed an Aging booth at The Pearl Wellness Senior Fair. • Member continues ongoing outreach with the lobbying group R.E.S.U.L.T.S. • Members attend the SCOA Fall Conference. • Members were actively working with community network in disaster preparedness planning and implementation. • Chair continued presented "Navigating Healthcare" at the Caregiver Conference and presented at several community meetings and local Caregiver support groups. 2019: • Members continue to work within the community for disaster preparedness • Members participate in Spring Lobby Day and attend the State Council on Aging advisory meetings • Chair spoke at a Grief & Caregiving support group • Chair continues community outreach involving HIPPAA and making new connections, such as New Life Ministries. • Chair met with State Representative, Michelle Caldier • Member began web-based outreach through Nextdoor "Digest" • Member continues to research how to get resource materials to isolated individuals. • Members participated in the Severe Weather shelters, Kitsap County Parent Coalition for families with disabilities meetings, 019 Spring Senior Lobby Day, and Board of County Commissioners meetings.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• Members provide resource information to local hospital navigators for dissemination. • Chair attended the South Kitsap Safety Fair • Member published a letter in the Kitsap Sun on Kitsap County Aging & Long-Term Care programs. • Member attends 1/10th Citizens Advisory meetings. ALTC Staff Activities: 2017: • DDA and AAA Staff Meet N Greet • Kitsap Transit and I&A/FCSP meeting 2018: • Added SKFD to the use of EMS referral form to AAA office (I&A) and began providing monthly feedback to SKFD. • Administrator met with SKFD to discuss use of referral form. • ALTC presentation to Harrison Social Workers 2019: • Coordination meeting with CHI/Harrison SW/RN Care Managers/Discharge planners. • Met with CSO Financial staff for MTD/FCSP awareness and referral coordination. • Met with a YMCA staff to inform of services for awareness and to coordinate referral to our services. • Community de-brief of snowstorms and maintaining vital services.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
5. Conduct Medicare and Medicare Part D outreach and education activities including topics of disease prevention and wellness activities and access to benefits and aid Medicare beneficiaries with enrollment in Medicare Part D or to apply for Medicare Low-income Subsidy (LIS) and Medicare Savings Plans (MSPs).	• Reports of activities assisting Medicare beneficiaries with applications and enrollment for LIS and MSP benefits. • Records of outreach and enrollment events targeting Medicare beneficiaries. Completion Date: 09/2017-Extended to 2019 contingent upon funding.	2017: • 18 MIPPA contacts (LIS and MSP application assistance) • Seven MIPPA events 2018: • 15 MIPPA contacts (LIS and MSP application assistance, detailed prescription manufacturer assistance, benefit explanations) • Outreach and Enrollment Events ○ Better Breathers Club (Part D MSP/LIS and WA state Rx assistance) ○ Older Americans Conference (MIPPA, LIS, Wellness) ○ Getting Ready for Medicare Event (SHIBA) ○ Medicare Monday drop in session (SHIBA) ○ Getting ready for Medicare event (SHIBA) ○ NARFE Meeting for Medicare outreach including LIS/MSP and SHIBA volunteer recruitment. ○ Medicare event (SHIBA spec. contract) ○ Hansville Community Lunch ○ County Employee Benefits Fair ○ Discussed and established SHIBA Special Project funding to enable additional staff to be used to meet expansion goal and a one-time event. ○ 76 MIPPA contacts made (all types) July 2018-June 2019. 2019: • Project Connect resource fair • CHI Care Management staff meeting • SSA Office Staff • Port Orchard United Methodist Church group

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• SHIBA Special Events contract • SHIBA transition meeting with Office of Insurance Commissioner and Peninsula Community Health Clinic
6. Coordinate and/or participate in training on the under 60 population and disability specific topics and Community Living Connections (CLC) rollout.	• Schedule of unit trainings and meetings. Completion Date: 12/2019	Ongoing: • DDA training opportunities forwarded monthly to subcontractors, community partners 2017: • DDA/AAA "Meet and Greet", program overview meeting 2018: • March: Alzheimer's Disease-Relias • A Day in the Life of Henry: A Dementia Experience, Relias • April: A practical Update on Genetic Testing, Diagnosis, and Next Generation Treatment • May: Behavioral Health Issues in Older Adults, Relias • Challenging Behaviors of Adults with Dementia, Relias • June: Fundamentals of Fetal Alcohol Spectrum Disorders, Relias • Information & Referral: Serving People with Mental Health Disorders, Relias • July: Guardianship; How to Talk About Elder Abuse, and Exploitation & Medicare Fraud • August: respite training for dementia • DDA Strengths, Adaptive Resources • November: Social Security webinar, "Benefits you didn't know" • December: Impact Medicaid Work Requirements (national) 2019:

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• February: SAGE Discharge Planning, DCD Permits (local county) • March: Palliative Care, Progression of Dementia (Teepa Snow) • April: DDA Hoarders Training
7. Advocate for sustained Senior Citizen Services Act (SCSA) funding and new funding opportunities to support Senior I&A services and CLC development.	• Advisory Council Minutes • Meeting with elected officials • Public Forum(s) and other community input opportunities. Completion Date: 12/2019	2017: • BOCC work session to discuss Area Plan goals and advocacy work tied to funding. 2018: • W4A discussion for 2019-2021 legislative funding requests. • Advisory Council met with WA state elected officials in Olympia from 23rd, 26th, and 35th districts. • Aging Advisory Council involved in federal advocacy for Older Americans Act reauthorization and additional funding. 2019: • Aging Advisory Council federal advocacy for Older Americans Act re-authorization and additional funding.
8. Conduct a comprehensive assessment of the current Senior I&A Program using the CLC Readiness Assessment Tool available on the CLC Technical Assistance Exchange website	• Obtain, review, and complete CLC Readiness Assessment Tool and summarize assessment results; • Contact state and national resources; and conduct research and review of potential I&A and systems change options for successful CLC realignment; • Conduct staff and stakeholder forums and workgroups to develop a plan for implementation of CLC contingent upon funding and organizational capacity;	Deleted goal December 2017

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
	• If funding is available, finalize plan after public input and Advisory Council review and provide plan to ALTSA, upon approval, prepare implementation; • Evaluate plan progress and outcomes. Adjust plan as necessary. Re-evaluate after the end of each year. Assessment conducted above as measured by: • Assessment summary • Work group plan and meeting minutes • Report on progress and outcomes • Completion Date: 12/2019-Deleted 2017	

Issue Area C-2.2 **Family Caregiver Support Program**
Goal: **To raise the level of awareness of caregiving in Kitsap County, develop a continuum of support options for caregivers, and assess the needs of 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 expanded array of primary and supplemental caregiver support services and information to assist caregiver populations. Conduct a minimum of three planning meetings to study the emerging issues of:
 	
a. Caregiving-related critical stress and assess the need and viable options for emergency relief.
b. The need to support additional and existing support groups, with topic-specific outreach to the groups and coordination on conference, training, and other FCSP opportunities to address family and kinship caregiver challenges as identified through Caregiver Support Center and other community partners.
Measured by:
 	
• Records of meetings, presentations and training activities.
	• Minutes and recommended action(s) from coordination meeting(s) with relevant providers.
	• Outreach and education to emergency response and medical professionals.
	• Community and partner education about the Silver Alert system and FCSP and I&A programs as a support to individuals and families.
	
	Completion Date: 12/2019
		2017:
		
		• ALTC was awarded MH 1/10th grant to support caregivers dealing with challenging behaviors associated with dementia diagnosis
		  ○ Dementia consultant (new)
		  ○ Powerful Tools – training facilitators and scheduled 3 workshops in CY 2018
		  ○ Expanded Alzheimer's Support groups and increased Dementia Cafes'
		
		2018:
		
		• Faith Community Bible Church caregivers meeting/panel discussion of caregiver needs. Ongoing support group was established
		• Alzheimer's Association added BEMA Dementia Day activity
		• ALTC presentation to Harrison Social Workers (ED, general admission, and special programs)
		• Applied for Kinship Caregiver Pilot Project funding to deliver workshops and respite. Successfully awarded, 2019 implementation.
		• Dementia Support Group
		• Port Orchard United Methodist Church Grief & Loss Support Group- Caregiver Support program options.
		
		2019:
		
		• Alzheimer's Support Group- Caregiver Support Program review
		• Port Orchard UMC Caregiver Support Programs

2. Maintain support for caregiver training through participation in and/or sponsorship of a regional caregiver training conference and	• Schedule of caregiver education and/or training event(s). • Special efforts and	Ongoing: • FCSP brochures and T-Care Workshop series flyers are provided at monthly Provider Breakfast meetings.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
local training opportunities. Conduct a minimum of one community-wide education or training event annually.	outreach to include caregivers in target populations. Completion Date: 12/2019	• The T-Care Workshop series flyers are provided at LTC Alliance 2017: • Local Caregiver Conference • Support Kinship Caregivers Training 2018: • “Death and Dying” and caregivers talk at Crista Shores • Stafford Suites Support Group presentation on caregiving journey/challenges • “Navigating Healthcare” presentation at Older Americans Conference • Contracted Dementia Specialist presented dementia overview to family of residents at The Ridge. • Paid registration fee and respite for caregiver attendance at Alzheimer’s Discovery Conference. • Paid registration for caregiver to attend Giving Care Taking Care Conference. • Employee Wellness-Side Effects of Caregiving, Relias Online training • Trained 3 staff and 2 additional facilitators for “Powerful Tools for Caregivers” workshops • 3 “Powerful Tools for Caregivers” workshops scheduled • Caregiver Conference- Dementia Overview, small group sessions (navigating healthcare, caregiver grief & guilt, dementia) • Older Americans Month Conference- some topic workshops were “Interacting with the Health Care System”, “Advance Directives”, “Power of Attorney and Durable Power of Attorney” 2019: • Promoted Giving Care Taking Care state caregiver conference.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• Alzheimer's Discovery Conference- paid registration fee for caregiver support program clients. • Started a Powerful Tools for Caregivers workshop-cancelled after 1st class due to low attendance. • Older Americans Month was done differently, partnering with Senior Centers and local YMCA's. YMCA's topics presented were "Dance for Brain Health", "Falls Prevention Clinic", "Lifelong Wellness", and a Resource Fair. This met the 2019 Older Americans Theme of Connect, Create and Contribute. I&A brochures were provided, Exercise and Wellness brochures, FCSP brochures, Pill Boxes, "Managing your Medications" charts were available at these events. • 2 free scheduled • Added a Mental Health subcontracted provider to deliver a 3rd Powerful Tools for Caregivers Workshops in 2019.
3. Revise Caregiver Support, local internet page to include TCARE® resources, links to support groups and additional updated resources.	• Revised Caregiver Support Web page. Completion Date: 12/2017-Extended to 12/2019	2018: • TCare Survey/Screening posted on new county website, English/Spanish versions. 2019: • Revised FCSP webpage
4. Continue outreach to the faith and business and professional communities to provide information to members and employees regarding caregiver support services by conducting a minimum of two presentations or participation in events targeting that demographic annually.	• Schedule of presentations and copies of reports. Completion Date: 12/2017-Extended to 12/2019	2017: • Kitsap Co Employee Benefits Fair (resource table). • Meeting with Kitsap County HR about FCSP. 2018: • St. Anthony's Episcopal Church.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• Advisory Council Chair outreach to Faith Community Bible Church panel. • Port Orchard United Methodist Church, ALTC Overview-Navigating Healthcare Systems • Port Orchard United Methodist Church, Caregiver Support Overview • City of Bremerton Employee Wellness Program and "Lunch and Learn". • City of Bremerton Employee Wellness Program. • DSHS CSO Financial Workers, Caregiver Support MTD/FCSP • Waddell and Reed, overview of services 2019: • New Life Church, Caregiver Support and all programs • Harpers Church Women's Group Caregiver Support • Aging Advisory Council recruitment resulted in one retired pastor connecting with Council who has been instrumental in connecting AC with local pastors/churches.
5. Increase outreach and coordination activities on behalf of elder ethnic minority populations and other target populations to provide adequate information about, and access to, caregiver support services, while assuring recognition and respect for ethnic and cultural diversity in caregiver support activities. Conduct a minimum of six coordination meetings. Increase caregiver support services.	• Records of meetings with Tribes, minority organizations, and other relevant stakeholders. • Client tracking records, presentation and outreach tracking. • Provision of TCARE® to underserved communities in Kitsap County. Completion Date: 12/2019	Ongoing: • Staff attends Kitsap Mesa Redonda meetings • Gail participates in the PGST Vulnerable Adults workgroup. 2017: • Met with ALTSA/AAA's on Kinship Caregiver Support Program updates, needs, opportunities, exceptions to policy, reporting and outreach practices. • ALTC Staff attended annual Tribal Meeting and "Money Follows the Person Conference" 2018:

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• 7.01 Tribal Meeting with Port Gamble S'Klallam Tribe • 7.01 Tribal Meeting with Suquamish Tribe • Port Gamble Strong Families Fair 2019: • 7.01 Tribal Meeting with Port Gamble S'Klallam Tribe • 7.01 Tribal Meeting with Suquamish Tribe • Posted various ethnic, gender and generational MTD posters throughout community. • Port Gamble Strong Families Fair
6. Participate in the ongoing statewide review of the Family Caregiver Support Program.	• Records of relevant trainings and meetings. • Completion Date: 12/2019-Met 2017.	Completed December 2019

Issue Area C-2.3 **Alzheimer's, Dementia and Memory Care**
Goal: **Increase awareness about Alzheimer's disease, memory care and wellness; increase access to existing services earlier in the disease process and enhance service options to offer more dementia-specific education, counseling, training, and respite options for individuals with memory loss and their caregivers.**

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
1. Develop dementia and memory care out-of-home respite and support services service options as feasible.	• Minutes and recommended action(s) from coordination meeting(s) with health care providers and Alzheimer's Association, Adult Day health, social day services and caregiver support groups, etc. • Formal referral and authorization options developed with local providers which may include both specific dementia services contracts, respite and support services. • Documented outcomes of research and work with Adult Day programs or local care facilities offering day-respite as a care and socialization opportunity for individuals with dementia and memory care needs and as a break to their primary caregivers. • Coordination with state FCSP policy team regarding exploration of flexible authorization options and contracting. Completed by: 12/2019	2017: • Awarded MH 1/10th grant to increase interventions to individuals with challenging behaviors associated with dementia diagnosis and their caregivers. Project implementation in 2018 included: ○ Dementia consultant (new) ○ Powerful Tools – training and workshops (new) ○ Expanded Alzheimer's Support groups and Dementia Cafes' • ALTC planning meeting with Alzheimer's Association • MH 1.10 Project Implementation Meetings 2018: • ALTC planning meeting with Alzheimer's Association • MH 1.10 Project Implementation Meetings. • Released RFP for Dementia Consultant, contract in place. • Grant awarded for 2019 Dementia Consultation services, 2 Staying Connected evidence-based workshop series, and 4 Alzheimer's education events. • Alzheimer Association presented on local programs at Provider Breakfast. 2019: • Partners in Memory Care projects presented at Quarterly Provider meeting. • Martha & Mary overnight respite contract for FCSP (Memory Unit available). • Applied for MH 1/10th Dementia Consultant funding into 2020.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
2. Promote brain health and the importance of early detection.	• Dissemination of brain health and early detection information at outreach events. • Cross-promotion of local memory screening events. • Celebration and promotion of proactive health activities and volunteer opportunities. Completed by: 12/2019	Ongoing: • All Alzheimer's Dementia and Memory Care, Dementia Café and Dementia Specialist flyers and brochures are announced and provided at the monthly LTC Providers Breakfast meeting. 2017: • Alzheimer's Town Hall, Bremerton 2018: • Kitsap AAA Powerful Tools Facilitator Volunteer opportunity. Training completed by 5 facilitators. • BOCC presentation of annual accomplishments; highlighted local need for dementia services/prevalence. • Alzheimer Association presented on local programs at Provider Breakfast. 2019: • "Dance to Boost Brain Health" offered by Dementia Consultant. • Community Memory Screening events posted in community centers. • "Healthy living for the Brain and Body" presented at 2 locations, and "Know the Ten Warning signs" and "Understanding Alzheimer's and Dementia. Events provided through the Alzheimer's Association.
3. Continue supporting local development of dementia specific support groups and creative approaches to local partnership development to	• Coordination with Alzheimer's Association and other professional organizations and local first responders.	Ongoing:

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
enhance options to meet the needs of this population.	• Promotion of Silver Alert and other safety options for this population. • Completed by: 12/2019	• Inform caregiver support community of Safe Return program through Alzheimer's Association. Researching option to provide as paid service for enrolled FCSP clients. 2017: • Awarded MH 1/10th grant to increase interventions to individuals with challenging behaviors associated with dementia diagnosis and their caregivers • Expanded Alzheimer's Support groups and Dementia Cafes' • Identified potential site, satisfaction survey and support tools 2018: • Dementia Specialist presented resources and services to 39 ancillary providers • Dementia Specialist gave seven community presentations in 2018. • BEMA Docent program established • Established First Responder referrals from 3 fire districts (Bremerton, NK, and SK) • ALTC presentation to Harrison Social Workers (ED, general admission, and special programs) 2019: • January- Awarded funding to expand Alzheimer Association EBP "Staying Connected" workshops and community educational presentations. • June- Subcontracted with Alzheimer Association to provide 4 community presentations

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• Dementia Specialist presented resources and services to 10 groups so far in 2019.
4. Coordinate to provide Early Stage Memory Loss (ESML) or other workshops such as "Let's Talk Dementia" to caregivers caring for someone with Alzheimer's disease or dementia. Provide conference opportunities or workshops for individuals with memory loss.	• One dementia-specific or memory loss workshop offered at least bi-annually over the next four years. • Provide evidenced-based Powerful Tools for Caregivers training or other training opportunities to caregivers to help caregivers manage behavioral symptoms of their care recipient with Alzheimer's disease or dementia. • Completed by: 12/2019	Ongoing: • All Alzheimer events are shared with the LTC Alliance via email, announcements at meetings and community flyers. 2018: • Kitsap AAA Powerful Tools Facilitator Volunteer opportunity with 3 workshops offered • Paid registration fee and respite for caregiver attendance at Alzheimer's Discovery Conference. • Paid registration for caregiver to attend Giving Care Taking Care Conference. • Dementia Consultant presented overview of types of Dementia at Caregiver Support Conference • 3 Powerful tools workshops completed, July, Sept., Oct. 2018. 2019: • January- Awarded funding to expand Alzheimer Association EBP "Staying Connected" workshops and community educational presentations. • June- Subcontracted with Alzheimer Association to provide 4 community presentations

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
5. Coordinate with local partner organizations on implementing the Alzheimer's state plan with a focus on communities of color.	• Minutes and recommended action(s) from coordination meetings. • Completed by: 12/2019	2018: • January- Dementia Action Collaborative Webinar • April- June Denise (Consultant) has provided me monthly activity reports that reports all her outreach presentations to facility staff and organizations. I can provide this for input here, if applicable. • April- September 2018: Requested and distributed DAC Roadmaps to community through Dementia consultant services. 2019: • April- Educated the Advisory Council on Dementia Action Collaborative (DAC) Road Map resource.

Issue Area C-2.4 **Elder Readiness and Planning for Age-Friendly Communities**
Goal: **Encourage the development of an Age-Friendly Community by promoting the awareness of changing demographics and the dramatic increase in the aging population. Work with seniors, community members, providers, business and government to meet the basic needs of seniors and disabled adults. Continue to advocate for a fair share of resources and services targeted to seniors and disabled adults.**

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
1. Conduct and participate in outreach and education in the community regarding age-friendly planning in the community.	• Partner to plan and organize a community forum or other event. • Conduct educational and training events. • Evaluate and share data provided by the Nutrition Risk Assessment Tool, which includes the diabetes risk assessment component, provide diabetes information through Nutrition Education. • Share formal training tool developed to accompany the Nutrition/Diabetes Risk Assessment Tool. • Organize outreach to business and civic entities. • Participate in the Vulnerable Adults Workgroup. Completion Date: 12/2019	Ongoing: • Meetings with Department of Emergency Management Vulnerable Populations Taskforce. • Dana and Rochal also participate on a Vulnerable Adults workgroup. 2018: • February: Distributed community-wide survey to gather feedback about Taskforce. • Met with BISC to discuss their age-friendly program, planning, and status. 2018-2019: • BOCC overview presentation of Aging that included demographics. 2019: • March: Administrator and Planner met with Bainbridge Island Senior Center Board to discuss age-friendly community planning. • July: Outreach to West Sound Tech Skills Center
2. Support local service providers, businesses and agencies in their efforts to become a more 'Elder Ready' and Age and Disability-Friendly community.	• Sharing "Best Practices" • Advisory Council meeting minute. • Local advocacy trainings/forums. Completion Date: 12/2019	2018: • WDC, SSEP, Initiative 3 meeting • Ombuds attended planning meetings with BI Village (Island Neighbors) in support of their efforts in 2018. • Older American Conference focus is on self-advocacy within the medical system, cyber safety, driver safety, situational awareness, and advance directives.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		2019: • Hosted four Older American activities in the community in partnership with YMCA and local Senior Centers.
3. Continue and further develop the advocacy campaign regarding senior issues.	• Advisory Council meeting and AC 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. • Meetings with elected officials. • Partnering with existing organizations with common issues. • Completion Date: 12/2019	2017: • Joined "Kitsap Homes for All" coalition (monthly meetings) to solve homelessness in Kitsap. The coalition created a local Tiny Homes movement. Advocated for seniors and dedicated safe senior housing. 2018: • W4A Advocacy Day – individual meetings with elected officials advocating for seniors • Senior Lobby Day • Commissioner Garrido attended Advisory Council meeting • Advisory Council and staff met with BOCC during work session • Participated in Alzheimer Association Town Hall meetings 2019: • Participated in W4A Advocacy Day • Participated in Spring Lobby • BOCC Presentation

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
4. Promote positive aging and opportunities for socialization.	• Outreach and special campaign materials utilized. • Advisory council meetings across the county at various senior centers and other sites that promote socialization opportunities. Completion Date: 12/2019	Ongoing: • Senior congregate meal sites • Volunteerism and recruitment for Ombuds, SHIBA, and Advisory Council 2018: • 2018 Older Americans Conference provided socialization opportunities with long term care providers in the community and other community members. 2019: • Four Older Americans Month Events: ○ Village Green Luncheon, Dance to Boost Brain Health & resource table ○ YMCA Silverdale Balance Testing- Resource table ○ Bainbridge Island Senior Center Resource fair, res table ○ YMCA Bremerton Lifelong Wellness Resource table
5. Continue to prioritize involvement in local housing and transportation issues.	• Meetings with local housing providers and advocates through Kitsap Continuum of Care; coordination with Kitsap County Human Services Department homelessness/housing Planner. • Meetings with local transportation providers and representing Kitsap County issues and needs on regional transportation planning committees. • Representation at public meetings and councils as appropriate.	Ongoing: • "Kitsap Homes for All" coalition (monthly meetings) to solve homelessness in Kitsap. The coalition created a local Tiny Homes movement. Advocated for seniors and dedicated safe senior housing. 2017: • Spoke with Commissioners about public bus service concerns for seniors.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
	Completion Date: 12/2019	2017-2018: • Council members attend local transit meetings 2018: • Introduction meeting with “Gather Together Grow Together”, a new nonprofit offering transportation. • Facilitated “Statewide Housing Crunch” workshop at W4A Staff Development conference. • MTD Initiative 3 explored FCSP Supported Housing subcontractor role.

Issue Area C-3 Service Integration and System Coordination
Goal: **Maintain the quality of care to older adults and adults with disabilities while working towards continuous improvement of delivery systems.** **Work with local partners, ACH, DSHS, HCA to implement strategies that expand health care access, improved health outcomes and reduce health-care costs for all clients – with a special emphasis on the high cost/high risk individuals.**

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
1. Promote strategies to expand access to appropriate medical care, improve client health outcomes, and reduce overall medical service delivery cost.	• Advisory Council, local committee and Olympic Community of Health meeting minutes. • Review and identify evidence-based strategies (e.g., Chronic Disease Self-Management, Community-Based Care Transitions, etc.) in Kitsap County Completion Date: 12/2019	2018: • Olympic Community of Health (OCH) meeting • Three OCH Natural Community of Health (NCC) meetings: Developed Shared Change Plan • ALTC presentation to Harrison Social Workers (ED, general admission, and special programs) • Established First Responder referrals from 3 fire districts (Bremerton, NK, and SK) • KC4TP Steering Committee: participation while mission is revised/ updated to reflect transitions of care from hospital to home. • New "Powerful Tools for Caregivers" EBP training 2019: • New "Staying Connected" workshops
2. Review and implement applicable recommendations from the Needs Assessment Survey, such as improved transportation options.	• Analyze 2015 Needs Assessment Survey • Advisory Council, staff and Community based committee meeting notes. Completion Date: 12/2016	2017: • Advisory Council member attended a Kitsap Parent Coalition meeting where Kitsap Transit held a forum • Advisory Council member attended Kitsap Transit meeting 2017-2018: • Council members attend local transit meetings 2018: • Advisory Council member presented overview of a recent Kitsap Transit meeting she attended to the Board and discussed the possibility of a community van program in Kitsap County that requires a van driver coordinator

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
3. Continue to identify gaps in services or types of support needed in relation to clients with multi-system and services related to first responders, primary care, behavioral health, and local ancillary providers.	• Local, regional, and statewide meeting notes. • Area Plan Updates, including survey results. • Completion Date: 12/2016-Extended to 2019	2017: • Two KC4TP All Partners meetings • Four KC4TP Steering meetings • Three Kitsap Homes for All meetings • Two Northwest Healthcare Response Network meetings (disaster prep) • MH 1/10th grant proposal: panel interview 2018: • One KC4TP All Partners meeting • One KC4TP Steering meeting • One OCH meeting • Three OCH NCC meeting • Two Northwest Healthcare Response Network meetings (disaster prep), one was a presentation at the Quarterly Provider meeting. • One “Kitsap Homes for All” meeting • MH 1/10th grant proposal: Performance Data Benchmark meetings (Dementia-specific information requested) • ALTC presentation to Harrison Social Workers (ED, general admission, and special programs) • Established First Responder referrals from 3 fire districts (Bremerton, NK, and SK) • BHO meeting to explore strategies for better coordination of care • Hired Health Home Coordinator and launched program 2019: • Co-located to North Kitsap Fishline to offer services to the North end of the County in a community social service building. Share space with Salish BHO staff. • Meeting with CHI Care Management staff to orient to programs and referral process.

Issue Area C-4 **Older Native Americans and 7.01 Plans** **Port Gamble S'Klallam Tribe and Suquamish Tribe**
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 AAA staff, action steps to address each concern, and provide a yearly summary of the progress.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
Create and complete 7.01 plan with Port Gamble S'Klallam Tribe	Coordination, meetings and plan finalization.	2018-2019: • Annual 7.01 Plan meetings
Create and complete 7.01 plan with Suquamish Tribe	Coordination, meetings and plan finalization. Completed by: 12/2019	2018-2019: • Annual 7.01 Plan meetings 2019: • Suquamish first meeting with new Human Services Director and follow-up meeting for 7.01 planning.

ISSUE AREA C - 5

MEDICAID TRANSFORMATION PROJECT DEMONSTRATION (MTPD)

C - 5 GOAL: Medicare Alternative Care (MAC) and Tailored Services for Older Adults (TSOA) Benefits support additional caregivers to care for their family members.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
1. Conduct outreach and provide customized client centered support and services to family caregivers.	• Train FCSP I&A and other KCALTC staff • Promote MAC & TSOA programs with appropriate local community agencies, via presentations & contacts to schools, medical service providers, discharge planners, churches, etc.; • Support / facilitate referrals from hospitals, discharge planners, physicians' offices, schools, churches, etc. Develop new referral resources as they are identified across Kitsap County; • Provide T-CARE assessments & customized care plans for family caregivers; • Provide customized services & supports to newly identified caregivers (e.g., respite, counseling, support groups) • Develop and implement an Outreach Plan	Ongoing: • Receive referrals from CHI SW & Kaiser Outpatient staff 2017: • MTD webinar- updates and follow up training with ALTSA • Advisory Council Meeting • Quarterly Network Provider Meeting • Cancer Support Group, including Social Workers • Bainbridge Island Senior Center Resource Committee • LPA (Local Planning Area) Meeting-multiple social service providers • Area Plan presentation with focus on FCSP and MTD to Board of County Commissioners, BKAT televised. • Services and Steps MTD training webinar • Outreach plan developed and implemented • Provider Breakfast • S'Klallam Vulnerable Adult Task Team (VATT) meeting. • Pretraining videos (Intro, overview, benefits and person-centered prework) Case Managers and I&A staff on MTD • In-person training for other KCALTC staff • W4A Development Conference (MTD focus theme)

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• Webinar “End to End” Training • 8 additional webinar trainings to MTD Case Manager and Supervisor 2018: • Multimedia Press Release RE: MTD • Newspaper article- Kitsap Sun • St. Anthony’s Episcopal Church • Established First Responder referrals from 3 fire districts (Bremerton, NK, and SK) • ALTC presentation to Harrison Social Workers (ED, general admission, and special programs) • MTD Case Manger position was expanded from .5 FTE to 1.0 FTE. • Met with local CSO Financial staff- program overview 2018-2019: • Dementia Specialist provides TCare screenings to clients as appropriate as first step to access program. 2019: • Met with HCS Financial workers to coordinate referral process and application communication for MTD • Outreach plan updated and submitted to ALTSA • Met with local CSO Financial staff- MTD
2. Assure systems alignment and provider network adequacy.	• Learn about and develop contract tools • Identify and contract with enough providers to facilitate efficient and timely service provision. • Provide technical assistance and encouragement to current FCSP and new small contract providers who may be	2017: • ALTC Network Adequacy Meeting • Meeting with new OT provider (PSS, CTTS contracts) • MTD referrals and rollout initial phone meeting with home care agencies

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
	reluctant to commit to the Medicaid contracting requirements. Completed by 12/2019	• Meeting with HCS Resource Development Coordinator • Meeting with Nutrition Services Provider • ALTC and Home Care Agency onsite meeting re: MTD • Submitted Network Adequacy milestone 2018-2019: • Submitted Milestones Reimbursement Plan deliverable annually • Annual MTD network adequacy report to ALTSA annually
3. Inform and collaborate with ALTC staff, ALTSA, and provider networks to rollout the new services and engage potentially eligible individuals.	• Implementation meetings and information distribution notes • Staff and provider network training • Inclusion of new referral options in ALTC resource lists Completed by 12/2019	Ongoing: • Updates to Medicaid-contracted services lists, distribution to AAA, HCS and DDA staff and providers. 2017: • Council (area plan) presentation, public hearing • Quarterly Provider meeting, information updates • MTD referrals and rollout initial phone meeting with home care agencies 2018: Quarterly Provider Meeting, information updates Three Quarterly Provider meetings- program overview and referral information provided 2018-2019: • Monthly phone calls with Regional AAAs and HCS Intake staff.

Measurable Objectives	Key Activities / Measured By	Accomplishment or Update
		• Met with local CSO Financial staff- program overview 2019: • Met with HCS Financial workers to coordinate referral process and application communication for MTD • Met with local CSO Financial staff- MTD
4. Participate in Initiative 1 Olympic Communities of Health (Kitsap County's regional Accountable Community of Health) proposal development and project implementation.	• Proposal development and review meetings, conferences and information distribution records. • Once projects selected, fully participate in implementation via community outreach, education, and other roles defined in final projects-measured through meeting notes and records of implementation activities and outreach work. Completed by 12/2019	2018: • OCH Regional Assessment and Health Priorities (RAHP) committee meetings attended through June 2018 • OCH Payment and Progress webinar • OCH Community meetings: overview • Participated in 6 total OCH Natural Community Convening meetings • OCH Executive payment portal established. • Received first community-based service organization payment. 2019: • Declined additional subcontracts due to low reimbursement rate. On-going participation as ancillary community partner.

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 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 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	____________________________ Mari Van Court, Advisory Council Chair Kitsap County Aging Advisory Council
______________________ Date	____________________________ Edward E. Wolfe, Chair Kitsap County Board of County Commissioners
______________________ Date	____________________________ Charlotte Garrido, Commissioner Kitsap County Board of County Commissioners
______________________ Date	____________________________ Robert Gelder, Commissioner Kitsap County Board of County Commissioners