Questions & Answers Fall 2023

New England Yearly Meeting – Are you considering offering your own Foundations program?

Who provides funding for Kevin's oversight?

How can you find other resources in NEYM to supplement Patti's skill set?

We are not currently planning to offer a separate NEYM Foundations workshop. While NYYM has used Foundations as the main entryway into engagement with ARCH/participation in other ARCH workshops, we prefer to have many entry ways including conversations about specific topics of interest. So, rather than ask Friends to participate in Foundations first and then learn about other opportunities, we are trying the approach of incorporating the themes explored in Foundations into topic-specific opportunities. We still will share with NEYM Friends when Foundations is being offered as it is of interest to some Friends/is still the entryway that makes sense for some. Does that multiple entryway distinction make sense?

I'll do my best to speak to the second question about funding for Kevin's oversight but feel as though I may
be missing some context. Kevin, as ARCH Director, provides content specific support and direction to Patti (NEYM's Aging Resources Coordinator) in terms of facilitating her connection with other ARCH network resources including the circle of practice that is the ARCH Coordinators circle. In exchange for Kevin's time, NYYM and NEYM have worked out an MOU where NEYM would use $1500 of FFA granted funds to pay NYYM. As I understand it, Kevin and Steve Mohlke (NYYM General Secretary) established the rate used in the MOU based on the proportion of resources needed to support Kevin's role that would be appropriate for NEYM (currently via FFA) to provide, given the approximate amount of his time that is directed towards this New England-focused effort. My understanding is that this rate reflects not only the direct cost of Kevin's wages but also some in-direct costs such as a (very) small portion of the oversight that makes Kevin's work possible. Does this answer the question the board is asking?

For the third question about identifying New England based resources that complement Patti's skill set: that is a major priority in Patti's outreach and listening work now. We're clear that Patti's conversations with local meetings and individuals are not just about identifying needs/places where meetings and individuals are yearning for more that we could help to provide/facilitate connections, but also about identifying what resources local meetings have to offer Friends more widely, especially in terms of Friends with particular areas of expertise and insight. For example, Patti invited a Friend (Mary) who is a retired social worker with much experience supporting caregivers to co-facilitate a workshop at Sessions which was very well received. Patti is now in discussion with Mary to see if the drop-in Reflection Group model being used with a focus on End of Life can also be used to bring together Friends looking to connect with other Friends about the impact of caregiving for older family members on their spiritual journey. One

of Patti's top goals for the year ahead is to nurture more of these sorts of widely-beneficial collaborations with the many resource people in our midst.

I hope these responses are helpful and if there is more from us that is needed to help the board better understand our proposal, please do let me know. Having built an initial foundation in this first year, we're excited for all that is possible in year two.

New York Yearly Meeting – How can you measure concrete outcomes for a conceptual program? Is NYYM supporting Kevin's time when helping other meetings?

How can you measure concrete outcomes for a conceptual program?

I am curious about the framing of ARCH as a 'conceptual program'. The program has identified a concept at its center, and because of this, we are able to create concrete programming and opportunities for Friends to connect around their own aging. The concept allows the program to be rooted, yet nimble to respond to what is needed by the community of older and disabled Friends in NYYM.

We have been measuring the number of Friends who register and come to our workshops and groups, and meetings who request our programming. The outcomes of this work are measured by the feedback we get from Friends around the programming. I attempted to make these quantitative and qualitative metrics legible in the report/grant we submitted.

Just as we are always reflecting on and attempting to improve our offerings, our data collection methods are also changing. In 2023 NYYM emphasized stories as data, and ARCH is still learning how to collect and uplift stories from those who have been supported by the program. Participant's 'baselines', such as 'How closely do you feel connected to your Quaker community' or 'What are your feelings about your own aging' are important data sets that we are also implementing in the surveys we create for feedback.

Our collaboration with NEYM will be positive in terms of measurement of programmatic effectiveness, as the staff, particularly Nia, have true gifts for collecting and working with data. Personally, I hope to take a workshop or class in 2024 on best practices in measurement and data collection, skills I did not get in my MDiv or chaplaincy training.

Is NYYM supporting Kevin's time when helping other meetings? Or do you get funds from them?

I am employed by NYYM as a salaried full-time Director of the ARCH Program. When working with other yearly meetings, NYYM's policy is to create Memorandums of Understanding (MOUs), outlining the scope of the collaboration and any agreed contribution of funds. For NYYM's 2023 collaboration with NEYM, the General Secretaries of both Yearly Meetings signed a MOU that included a contribution of $1,500 from NEYM to NYYM. This will be the same for 2024. For ARCH's work with PYM to create the 'Spirituality and Aging Workshop' for the Quaker Aging Resources page, an MOU with $1,375 suggested as a contribution for services provided by ARCH was completed by both Yearly Meetings. These have been the two substantial collaborations between ARCH and other Yearly Meetings in 2023.

Beacon Hill Friends House – Can you share the CVs of Jennifer and Greg? Greg Woods is a skilled facilitator and workshop leader with more than 15 years of experience. Since 2020, Jen Newman and he have developed and refined the Living Your Call: Vocational Discernment program. He has worked in ministry for a variety of Quaker organizations and served as a founding board member for Quaker Voluntary Service. Greg is also an accomplished writer with numerous articles in *Friends Journal* and chapters in the *Cambridge Companion to Quakerism* and *The Quaker World*. Currently, he serves as a Program Consultant for Beacon Hill Friends House. He holds degrees from Earlham College and Princeton Seminary.

Jennifer Newman is a Quaker, theologian, writer, activist, and the Executive Director at Beacon Hill Friends House. Formerly the Program Director for BHFH, she has facilitated more than 100 workshops to diverse, ecumenical audiences, where she focuses her facilitation on interactive and experiential spaces, using Quaker principles and practices in ways that help audiences connect with their own inner wisdom. She is a member of Beacon Hill Friends Meeting, New England Yearly Meeting, holds a Master of Theological Studies from Vanderbilt Divinity School, and spent several years working in advocacy around human rights, the public interest, and the environment before coming to BHFH. In addition to her work, Jen is a regular contributor for the Barclay Press *Illuminate* series. Recent programs include:

- A workshop for Pendle Hill's Quaker Institute in May 2023 on "The Ministry of Space" alongside Todd Drake of the Penington Friends House and Anton Flores-Maisonet of Casa Alterna.
- I presented at a lecture ran by BHFH called "Friendly Witness: The Spiritual Ground of Social Action" in April 2023 (which we have been invited to submit for publication as a special issue of *Quaker Studies* — although I'm not sure how much we're allowed to share about that at this time).
- I have been a regular presenter for Pendle Hill and Barclay Press's "Illuminate" series (based on the Bible series in which I am a regular contributor).
- I was a panelist for FCNL's Quaker Changemakers series in 2021 on "Strengthening Quaker community."

I have also facilitated workshops for non-Quaker audiences in a variety of settings and capacities — predominantly in undergrad and graduate school. For example, I used to run Non-Violent Direct Action trainings for volunteers with Amnesty International.

Hickman – Are you able to continue the MIL program from the operating budget?

The Hickman is able to continue progress towards GOLD status from the remaining funds granted from FFA in 2022. The 2022 grant funded CARD's participation through GOLD status and The Hickman operating funds are supporting ancillary costs. Establishing self-reliance is a cornerstone toward GOLD status. Self-transfer is a basis of self-reliance. If residents cannot get out of chairs and lounges in a timely fashion, soiling accidents increase which lead to increased isolation and diminished participation. Reducing isolation, increasing participation, and facilitating independence are base lines for achieving GOLD status. Existing furniture is aged beyond its years and its design does not support multiple cleanings. The request details how the furniture facilitates the acquisition of GOLD status as the current

furniture is not designed with cognitive impairment in mind.

Can you elaborate further on your request for an in-person meeting? Stacey and Crystal are referring to the potential in-person collaboration with other Quaker homes implementing MIL, perhaps with your attendance as well. The intent of the visitation request is to share practical methodologies beyond what CARD outlines. Understanding peers' daily tactics improves the performance of all MIL teams. Your opinions and consent add credibility.

Were there additional sources of income for the MIL program, how did the actuals compare to budget for last year?

Actuals and budget are matching as reported in the budget report attached to the grant request. We did not have additional sources of income for the MIL program beyond operating funds which covered miscellaneous expenses.

ARTZ – Is the manual to be a data-filled report or a how-to manual so others can replicate the program?

When will manual be complete--final?

What is your printing and distribution plan?

1. Bilingual (Spanish-English) how-to manual for the purpose of enabling replication (also including supporting data, quotations, etc where appropriate and supportive of the how-to).

2. Assuming full funding for the project from the various sources to which we are applying/have applied, we anticipate completing a thorough first draft by December 2024 and a finalized version able to be printed and distributed by December 2025 at the latest. Going slowly because take each step back to advisory committee, and minimal funding.

3. Printing and distribution plan: multiple strategies and steps
a. Initial print run of 500 to be shared with the outlets listed below, among others:
-- community advisors in both ARTZ in the Neighborhood pilot neighborhoods (Hunting Park and NW Philadelphia)
-- staff at partner organizations throughout the Greater Philadelphia region (including Esperanza Health Center and Center in the Park, our two community partnership hubs for the ARTZ in the Neighborhood project);
-- continued outreach and distribution via professional conference presentations related to aging and cultural diversity
-- staff at arts and culture organizations throughout the region through multiple workshops involving both ARTZ staff and AiN community advisors
-- colleagues at PA Department of Aging, distributed through Troy Dunston, Caregiver Support Program Coordinator | Bureau of Aging Services; colleagues at Philadelphia Corporation for Aging, including Cheryl Clark, Care Manager Supervisor we would plan to seek Troy Dunston's help in promoting the availability of the manual to all Pennsylvania Area Agencies on Aging, not just the PCA.
-- seeking assistance from funding organizations with whom we have ongoing relationships and who specialize in funding services for historically underserved older community members (funders such as Friends Foundation for the Aging, Ralston Foundation, The Philadelphia Foundation) in offering to their other grantees for whom the model of service would be relevant
-- seeking assistance from corporate program sponsors, including Acadia Pharmaceuticals and Janssen Pharmaceuticals, in distributing to their other grantees and community partners

We will also be using the manual ourselves to guide the launch of new neighborhood projects in partnership with Philadelphia's Chinese and Haitian communities, where we already have connections.

Interfaith Caregivers – Is Neighbors Helping Neighbors one of your programs or your whole program?

Neighbors Helping Neighbors is our main initiative, but we have other programs. To clarify, I have attached two files, one for the Neighbors Helping Neighbors Program budget ($351,952) and a second for the entire ICGMC Agency Budget ($462,189).

Jewish Family Services – How many people will be served? Are some helped once without becoming long-term care coordination clients? We are serving 75 in total, 25 of whom will receive the longer term supportive services.

Montgomery Co SAAC – Do you offer discussion topics and speakers to your groups?

Yes, last year we had two guest presenters from the field that spoke about "Caregiver Networking" and "Building Your Village".
The other topics presented were as follows:
Caregiver Burnout
Importance of Self-care
Community Resources
Celebrating "Small Wins"
Asking for Help Early
Crisis Planning
Developing a Village
Thinking Outside of the Box
Brainstorming How to Prioritizing Self-Care
Making Time for What Matters
Working Smart, Not Hard
Being the Hope for Other and Yourself
Preventing Isolation and Abuse
Organization and Time Management
Sharing Your Story
Recognizing Your Impact

What strategies will you use to connect with ACLAMO and Jaisohn populations?

In line with our ongoing commitment to serving senior citizens from diverse backgrounds, we are excited to expand our collaborations with ACLAMO and Jaisohn, two respected organizations that align with our mission. Both partnerships allow us to share resources and best practices to maximize the impact of our respective grants aimed at enriching the lives of senior community members.

Strategies for Connecting with ACLAMO
Community Outreach Programs: Given that we already share space and support ACLAMO's programming, we propose to create co-branded outreach materials specifically targeted at the Hispanic senior community and the caregivers. This could include multilingual flyers, social media campaigns, and direct mailings.

Family Inclusion Programs: Since many families connected to ACLAMO have multigenerational homes, we could develop workshops and webinars aimed at educating the entire family on the value and logistics of virtual counseling for seniors.

Strategies for Connecting with Jaisohn

Cultural Sensitivity Training: Understanding the unique needs of the Korean community is paramount. We can spearhead cultural sensitivity training sessions for our staff to provide effective and respectful counseling services.

Resource Sharing: Given our long-standing relationship with Ambler Korean Presbyterian Church, we will utilize this shared space for hosting informational sessions related to our virtual counseling initiative, particularly appealing to Jaisohn's caregivers and senior constituents.

Collaborative Events: Utilizing grants that both organizations have recently received, we can co-host events focusing on healthcare and family services to provide a one-stop solution for seniors.

Data Sharing & Best Practices: With the consent of all involved parties, we aim to share anonymized data and success stories to identify trends and opportunities for service optimization for caregivers.

In summary, the synergies we aim to create with ACLAMO and Jaisohn will result in a more robust, diverse, and culturally sensitive approach to virtual counseling for caregivers of senior citizens. These collaborations will not only leverage each organization's strengths but also pave the way for future joint initiatives, ensuring the holistic well-being of our senior community members.

Are there other sources of funding for this program? There are not any current funding sources directly to support this program, however, we will encourage the group to continue to meet and utilize general funds to support the needs.

SOWN – Have you considered a group for men?

We did groups for men for 1 year. Here is what we learned. Older men did not want to share their feelings and challenges with other men. They wanted 1:1 meetings with their female group facilitators. They were ok about talking about the Phillies, Eagles etc. That isn't what we provide. We employ LCSWs so that group participants receive counseling from highly trained facilitators and support from their peers. We do imagine that in the future men who are younger now as they age may be more interested in sharing feelings and challenges with their peers.

Can you elaborate on your comments in the report on barriers (top of p 2)?

The barrier of referrals from the CHC system is one that we continually work on by regular contact with staff in those networks. Unfortunately there is frequent staff turnover so it is an ongoing challenge to maintain those relationships to encourage referrals. We have been using unrestricted funds to support women who either don't qualify for CHC or who have been discharged by the CHC providers from that system. As cray as it is to say CHCs don't seem to want participants to receive ongoing

services. So that this population, the most vulnerable, gets service for a limited amount of time. Crazy, huh?

Do the social workers provide 1-1 support when there is a crisis? Are they involved in other programs as well?

Our staff of highly trained LCSW social workers does provide 1:1 for seniors. This is done in more than just crisis situations. Housing, family relationships, in-home provider issues, health care options, access to services are a few of the more common 1:1 needs. Crisis needs tend to be about death, loss, finances, and family crises. No fee involved. This is how we use some of the general operating funds we receive.

Lutheran Settlement – Will you serve non-members?

Do the social workers spend all of their time or part with EW?

Can you collect data to compare to the National EW outcomes?

- Yes, EnhanceWellness (EW) is open to members and non-members, alike; we hope the growth of this program will attract new folks to our Center!
- Yes, we can collect data to compare to the national EW outcomes – I think our partners at EW would be excited to see us collect comparison data, particularly since we are the first group to implement the program using Community Health Workers (CHWs).
- Our CHW EW Health Coach will spend 100% of their time working on the EW program. Our Center Social Worker will support the program (20% of their time) by helping participants access information and resources supportive of their Individualized Health Action Plan goals.

Center for Hope – Missing an executive summary.

What makes a person "appropriate" for services?

A: While Hospice care is an available option for those with a terminal illness; Palliative Care helps the many who choose continued treatment, as well as those whose chronic, debilitating conditions, require aggressive symptom management for Pain, Shortness of Breath, or other distressing effects of decline from illness. Palliative care is available as a stand-alone service but helps to coordinate the efforts of others to improve the overall quality of life for the patient

Can they keep their own doctors?

A: Yes, in fact the goals of Palliative Care include close coordination with the patient's historic primary care provider and other specialized care that may be involved.

What is the average length of service for a palliative care client?

A: The length of stay on Palliative Care service is entirely individualized to the patient's needs and the availability of related services the patient can access. Average experience to date shows most patients requiring at least monthly follow up to adjust their treatment plans for between 3-6 months. But, there is no outer limit and patients can be visited again after months of inactivity during which their symptoms have remained stable.

Do you have any problems getting patients to agree to palliative care?

A: Generally not. Palliative care does not require patients to make any decisions about discontinuing any other medical care. So, focusing on the patient's own goals and comfort, few patients find cause to resist the extra support provided by a Palliative Care practitioner.

Do you serve undocumented people?

A: Yes; all programs of Center for Hope Hospice and Palliative Care are open to any and all within our area of service, regardless of citizenship or documentation status.