DISTRICT OF COLUMBIA STATE PLAN ON AGING
2011 -2012

A Plan for Choice, Access, Responsiveness and Efficiency (CARE)
For An Aging Population

DISTRICT OF COLUMBIA OFFICE ON AGING

Adrian M. Fenty
Mayor

Clarence Brown, PhD
Executive Director

Prepared by the D.C. Office on Aging
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GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE ON AGING

VERIFICATION OF INTENT

The District of Columbia State Plan on Aging is hereby submitted for the District of Columbia for Federal Fiscal Years 2011 – 2012 by the District of Columbia Office on Aging (DCOA). The State Plan includes all assurances and plans to be conducted by the District of Columbia under provisions of the Older Americans Act of 1965, as amended during the period of October 1, 2010 through September 30, 2012.

The State Agency named herein has been given the authority to develop and administer the State Plan on Aging for the District of Columbia in accordance with all requirements of the Act and is primarily responsible for the coordination of all state activities related to the purposes of the Act, i.e., the development of comprehensive and coordinated community based systems for the delivery of supportive services, including multipurpose senior centers and nutrition services, and to serve as the effective and visible advocate for the elderly in the State.

The Plan is hereby approved by the Mayor and constitutes authorization to proceed with activities under the Plan, upon approval by the Assistant Secretary on Aging.

The State Plan on Aging hereby submitted has been developed in accordance with all federal statutory and regulatory requirements.

6/30/'10
Date

Clarence Brown, Ph.D.
Executive Director
District of Columbia Office on Aging

I hereby approve this State Plan on Aging and submit it to the United States Assistant Secretary on Aging for approval.

6/30/2010
Date

Adrian M. Fenty
Mayor
District of Columbia

EXECUTIVE SUMMARY

The District of Columbia Office on Aging (DCOA) is both the designated State and Area Agency on Aging, or a single planning and service area (PSA), under the Older Americans Act (OAA) of 1965, as amended, and is responsible for administering OAA core programs in the District of Columbia. DCOA was established in 1975 by D.C. Law 1-24, as amended, "to ensure a full range of health, education, employment and social services shall be available to the aged in the District of Columbia, and the planning and operation of such programs will be undertaken as a partnership of older citizens, families, community leaders, private agencies, and the District of Columbia Government." With this responsibility and as a requirement to receive federal funding, the state agency must coordinate and develop the State Plan on Aging. The State Plan outlines the current and planned efforts of the DC Office on Aging to meet the needs of District of Columbia residents age 60 and older and persons with disabilities.

The development process for the State Plan was initiated in FY 2009 following the guidelines and program instructions issued by the Administration on Aging (AoA). The process for developing the State Plan on Aging allowed input from all relevant and significant stakeholders in the District of Columbia, including the DC Commission on Aging, Mini-Commissions on Aging, the Senior Service Network, formal and informal caregivers, customers, residents, advocacy groups and organizations, health and human services providers, community-based non-profit organizations, faith-based institutions, older persons with disabilities, and others.

The State Plan development process included the following significant tasks and activities:

- Two environmental scans on trends and issues in aging and disability in the District;
- Four town hall meetings co-hosted with the DC Commission on Aging;
- Distribution of a State Plan Survey Questionnaire with on-line access;
- Review of DC Council Legislative and Committee Policy Reports;
- Input from Advisory Neighborhood Commissions;
- Meetings with specific senior populations, including Asian and Pacific Islanders, Hispanics, residents who are blind and hearing-impaired, Gay, Lesbian, Bisexual and Transgender (GLBT) residents, and public housing residents and leaders;
- Review of the District of Columbia Department on Disability Services Rehabilitation Services Administration's (RSA) District-Wide Comprehensive Needs Assessment Final Report (2008);
- Review of committee reports and minutes of the District's Olmstead Planning Council;
- Review of the District of Columbia Department of Health 2007 Annual Report, Behavioral Risk Factor Surveillance Survey (BRFSS);
- Review of "Advancing Medicaid HCBS Policy: From Capped Consumer to Consumer-Directed," a discussion brief by the Rutgers Center for State Health Policy (2008); and
- Distribution of a Draft State Plan on Aging for stakeholders' review and comment.

Currently, DCOA administers OAA Core Programs including Title III (Supportive Services, Nutrition, Disease Prevention/Health Promotion and Caregiver Programs) and Title VII (Elder Rights Programs). DCOA administers a broad range of thirty-three (33) programs and services through its Senior Service Network of twenty (20) community-based, non-profit organizations

and private sector businesses. The service providers are funded through DCOA's competitive grant-making and procurement process. DCOA has also received external competitive grant funds to support OAA core services such as senior transportation for medical needs, escort service for persons with disabilities, transportation outreach to persons with disabilities and local funding to support two (2) new senior wellness centers in Wards 1 & 6. A new locally-funded headquarters building for the DC Office on Aging (DCOA) will open in 2010 and will be connected to the Ward 6 Senior Wellness Center.

The District's current Administration on Aging Discretionary Grants are: the Life Span Respite Care Program; the Diabetes Self Management Program (DSMP); and the Hospital Discharge Planning and Family/Informal Caregivers Services Project. These discretionary grants will strengthen and expand OAA Core Programs in the District during the next two years and will be fully integrated within the District's Senior Service Network. Other discretionary grants such as the Medicare Improvements for Patients and Providers Act for Beneficiary Outreach and Assistance (MIPPA) awarded to DCOA/ADRC (2009-2011) will also complement programs and services to reach older persons likely to be eligible for the Low-Income Subsidy program (LIS), Medicare Savings Program (MSP), and the Medicare Part D Prescription Drug program. Through DCOA's greatly enhanced collaborative working relationship with the District's Medicaid Agency, the Department of Health Care Finance (DHCF), more than $2.7 million has been spent on nursing home quality of care improvement projects administered by DCOA. These projects have greatly enhanced the quality of care for residents at the District's nineteen (19) nursing homes, including two District-owned facilities. Furthermore, DCOA will continue to work with DHCF in its efforts to perform oversight and monitor complaints from home health agencies.

In terms of Consumer Control and Choice, DCOA continues to explore methods to maximize consumer control and choice among its Title III and VII programs and with other programs such as the District's Medicaid waiver programs. DCOA and its Aging and Disability Resource Center (ADRC) represent a significant collaboration among all the District Government's health and human services agencies and community-based organizations through co-location and centralized operations. DCOA has been responsible for managing and operating the one-stop long-term care resource center funded by District's Medicaid agency (DHCF) since 2008 under a Memorandum of Understanding. DCOA/ADRC is now a fully functioning, single entry point system designed around consumer direction, choice and control for long-term care services. Options counseling, case management, public benefits, private pay services, caregivers and respite support services, independent living for persons with disabilities, and other services and information are accessible through one point of contact. DCOA/ADRC also conducts extensive staff outreach and public marketing of available resources, including Money Follows the Person (MFP) -- a program designed to transition persons from nursing homes back into the community jointly funded by both agencies. DCOA/ADRC and DHCF will continue to explore other consumer-directed models to increase consumer control and choice beyond case management. For example, within the next three years, caregiver services and support will be centralized within the ADRC based on the single entry point system and using consumer choice. Currently, these programs are fragmented and dispersed throughout the Senior Service Network.

In FY 2009, DCOA/ADRC was selected by the US Department of Health and Human Services to participate in the "Own You Future" campaign, for which the agency developed a "District of Columbia Planning Guide for Long-Term Care." This guide was mailed to 70,000 residents between the ages of 40-70 with information related to long-term care resources and planning options for District residents. Additional copies (50,000) have been disseminated to residents through on-going community outreach and education. The guide reflects a consumer-directed approach and presents information for informed decision-making. DCOA/ADRC will continue to develop proposals to pilot and demonstrate consumer-directed and community-based long-term care options. As the reauthorization of the Older Americans Act proposes to build on consumer choice to strengthen the nation's capacity to promote the dignity and independence of older people, the District will be in step with the national strategy.

Over the next two years, DCOA will continue to provide more than thirty-three (33) home and community-based programs and services which are essential for District residents to remain independent. The services will include, but are not limited to: counseling; case management; congregate and home-delivered meals; in-home care; caregivers/respite support; legal services; advocacy; employment and training; senior centers; transportation; adult day care; long-term care ombudsman; elder abuse and neglect prevention ; nutrition counseling and education; outreach and education; volunteer opportunities; housing assistance; information and referrals; emergency housing; health promotion and disease prevention; and a one-stop resource center for long-term care services. DCOA will continue to evaluate the priority needs of older persons and persons with disabilities by conducting a comprehensive needs assessment to better understand the characteristics, issues, and community assets to serve its target population.

The District's State Plan on Aging for 2011-2012 will build on past State Plans' strategies designed to promote the dignity and independence of the District's 100,870 older residents and help the District prepare for a growing elderly population. The District's State Plan thus outlines goals, measurable objectives and strategies which are aligned with strategic goals identified in AoA's 2007-2012 Strategic Action Plan and are related to the three focus areas.

- **Goal 1**: Empower older people, their families, and other consumers to make informed decisions about, and be able to easily access, existing health and social services and long-term care options.
- **Goal 2**: Enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers.
- **Goal 3**: Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.
- **Goal 4**: Ensure the rights of older people and prevent their abuse, neglect and exploitation.
- **Goal 5**: Maintain effective and responsive management.

The District of Columbia State Plan for 2011-2012 is designed to strengthen our current capacity to provide access to information and support services for the District's older residents and persons with disabilities, and to pilot new programs that will improve the quality of life for District seniors, their families and caregivers.

A. CONTEXT

Legal Basis

The District of Columbia Office on Aging (DCOA) is designated by the Mayor as the State and Area Agency on Aging, the office responsible for the administration of programs under the Older Americans Act of 1965, as amended. DCOA is structured to carry out advocacy, leadership, management, program, and fiscal responsibilities. With this designation comes the responsibility for the coordination and the development of the State Plan on Aging to receive federal funding under the Older Americans Act, as Amended.

In accordance with D.C. Law, (codified as amended at D.C. Official Code §§ 7-501.01 (2001) *et seq.*), the District of Columbia Government "shall insure a full range of health, education, employment, and social services shall be available to the aged in the District of Columbia, and the planning and operation of such programs will be undertaken as a partnership of older citizens, families, community leaders, private agencies, and the District of Columbia government." The law established the Office on Aging as the "single administrative unit, responsible to the Mayor, to administer the provisions of the Older Americans Act (P.L. 89-73, as amended), and such other programs as shall be delegated to it by the Mayor or the Council of the District of Columbia, and to promote the welfare of the aged."

District law also established the Commission on Aging, a citizens' advisory group that advises the Executive Director of the Office on Aging, the Mayor, and the Council of the District of Columbia on the needs and concerns of older Washingtonians.

Mission Statement

The mission of the District of Columbia Office on Aging is to advocate, plan, implement, and monitor programs in health, education, employment, and social services which promote longevity, independence, dignity, and choice for our senior citizens.

Programs, Services and Organizational Structure

The D.C. Office on Aging operates a broad range of aging programs and services in the District of Columbia, through a city-wide network of twenty (20) community-based non-profit organizations and two (2) private sector businesses that are responsible for providing more than thirty-three (33) programs and services for elderly District residents. The primary customers of DCOA are District residents who are 60 years of age and older.

DCOA works with multiple public and private partners and stakeholders to provide these programs and services including:

- The DC Commission on Aging
- The Senior Service Network
- Caregivers of the elderly
- Families

- Program Participants
- District residents
- Churches and Faith-Based Organizations
- Gatekeeper and Advocacy Organizations
- Civic Associations
- Regional and Federal Agencies

In FY 2008, spending for programs and services by the DC Office on Aging was $24.8 million, of which $6.6 million was federal funds. In FY 2009, the agency's budget increased to $26.9 million, including $6.9 million in federal funds. The budget for FY 2010 is $24 million, (excluding AoA discretionary grants and some intra-district program funds such as Money Follows the Person and the Homeless Day Center), of which $6.7 million was federal funds.

In 2008, more than 28,956 clients were served by DCOA and its grantee agencies and partners. Based on the numbers reported for the FY 2009 National Aging Program Information Systems (NAPIS), 29,003 clients were served, according to a new customer services database. The most requested services by District seniors were counseling, congregate and home-delivered meals, transportation, wellness services and case management. The most utilized services were congregate and home-delivered meals, wellness programs and transportation.

The District of Columbia provides numerous programs and services crucial to allowing District seniors to age in place in their communities. These services include counseling, case management, congregate and home-delivered meals, in-home support, caregivers support, legal services and advocacy, wellness centers, employment, group homes, one stop resource center, group housing, senior center activities, long-term care, transportation and geriatric day care. The District has built four state-of-the-art senior wellness centers, of which the latest opened in FY 2008 in Ward 4. These wellness centers promote healthy lifestyles, sound nutrition, exercise, and general wellness among the aging population in the District. Two new wellness centers will open in late 2010 in Wards 1 and 6 and the Office of Aging will be relocated to the Ward 6 Senior Wellness Center.

Federal and Local Shared Goals

The District of Columbia's 2011-2012 State Plan on Aging strategic goals match those established by the U.S. Administration on Aging in its Strategic Action Plan 2007-2012. These shared goals are:

Goal 1: Empower older people, their families, and other consumers to make informed decisions about, and to be able to easily access, existing health, social services and long-term care options.

Goal 2: Enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers.

Goal 3*:* Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.

Goal 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation.

Goal 5: Maintain effective and responsive management.

These goals are also directly related to the three (3) focus areas—Older Americans Act (OAA) Core Programs, AoA Discretionary Grants, and Consumer Control and Choice—required of each State Plan. Further, these goals reflect the input and analysis from stakeholders, caregivers, residents, advocates and persons with disabilities solicited during the community planning process.

Demographics

The District of Columbia has a growing population of 599,657 residents (as of 2009). From 2007 to 2008, the Census reported that the District's population increased by 3,965 persons. At the same time, the number of older District residents has also increased. The population that is age 60 and older is now 100,870 (almost 17% of total population) and 19,910 residents are over 80 years old. This growth impacts the District's already burdened health and social services resources.

Nationally, the 76 million baby boomers that were born in the U.S. from 1946 to 1964 represent the largest birth cohort ever born in the U.S. In 2008, baby boomers made up 29.8 percent of the District's population, evidence of a critical need for comprehensive aging services necessary to foster the health and welfare of this burgeoning population group. By 2030, all surviving baby boomers will be 66 to 84 years old and are predicted to represent 20% (1 in 5) of the national population.

Across its 68.5 square miles, the District of Columbia is comprised of a diverse population – including great diversity among its senior residents. Although the District's total population declined between 1950 and 2000, the city has shown an upward growth trend since 2000 - reflecting a robust economy with unprecedented commercial and residential construction. The senior population (age 65 years and older), on the other hand, grew in total numbers and percent of the total population across the period between 1950 and 2009. In 1950, there were 56,687 District residents over the age of 65 (7% off the total population); today, the senior population represents a larger share of the District's population than it did 50 years ago, as persons over the age of 65 represent 12% of the total population (as of 2009). The number and percent of residents over 65 years is projected to increase significantly by 2030 as the baby boomer generation matures. The percentage of District residents is projected to grow to 13% of the total District population by 2030.

The typical senior in the District is a black female, 73 years of age, living at home in a single-family home, on a retirement income (mostly Social Security and/or pension), in a family setting (husband or living with other relatives), and utilizing or desiring programs and services in order to maintain her independence as she ages. Her major asset is her home. As her life expectancy expands, the chances increase that she may spend some of her remaining years alone and have a chronic disability that may limit her activities of daily living.

DISTRICT OF COLUMBIA
2008 POPULATION AND HOUSEHOLDS 60 YEARS OLDER

Characteristic	Number	Percentage
Population 60 years +	98,977	100.0%
Population 65 years +	70,648	71.4%
Population 60+ Minority Non White	64,640	64.9%
Population 60 years+, African American	59,712	61.6%
Population 60 years +, Female	58,811	59.4%
Population 60 years+, Male	40,166	40.6%
Population 65+ with Disability living at home*	23,373	37.7%
Population 65 years+, Veteran*	12,068	17.1 %
Population 85 years +	11,144	11.2%
Population 65 years + living at or below poverty level*	9,700	13.7%
Population 65+ in nursing homes& other group quarters*	4,482	6.3%
Population 60 years +, Hispanic Origin	4,141	4.2 %
Households with someone 60 yr+*	72,544	100%
Households with someone 65 yrs +	52,073	71.8%
Households with Renters 60 yrs+*	39,166	53.9%
Households with 60 yrs+ living alone/non relatives *	38,206	52.7 %
Households with 65 yrs+ with no personal vehicle*	19,185	36.8%
Households 65 yrs+ with less than $15,000 per year*	10,254	19.7%
Households with grandparents 60 yrs+ with grandkids*	7,278	10.0%
Median Household Income, 65 years+*	$41,335	

2008 U.S. Census Estimates for District of Columbia
* 2008 American Community Survey for District of Columbia

Projections, Trends and Issues

If current city demographic trends continue, the District's senior population will see growth from both ends - youngest seniors (age 60-69) and oldest seniors (85 years and older). It is projected by 2015, 20 percent- or one out of every five residents - could be at least 60 years and older.

In 2008, the DC Office on Aging conducted an extensive environmental scan on the topics of (1) Aging and (2) Disability Issues. Issues and trends that surfaced in the scan were incorporated into the future planning for the DCOA. Some of the findings from the Environmental Scan are discussed below.

Abuse and Neglect

It is not clear how many older Americans are being abused, neglected, or exploited. While evidence accumulated to date suggests that many vulnerable older adults have been harmed, there are no official national statistics, as comprehensive national data are not collected. This lack of specific data is often related to varying definitions of elder abuse vary - it is difficult to pinpoint exactly what actions or inactions constitute abuse, and the problem remains greatly hidden. State statistics also vary widely. In the absence of a large-scale, nationwide tracking system, studies of prevalence and incidence conducted over the past few years by independent investigators have been crucial in helping to understand the magnitude of the problem. A particular focus should be placed on identifying and countering instances of elder neglect and

abuse, including physical, mental and financial exploitation, as well as neglect in institutional settings.

Alzheimer's Disease

According to the Alzheimer's Association *2010 Alzheimer's Disease Facts and Figures*, 5.3 million people in the United States have Alzheimer's disease, including 5.1 million people aged 65 and older. Alzheimer's is also the seventh leading cause of death in the U.S. and the fifth leading cause of death for those aged 65 and older. Furthermore, the Association predicts that the number of Americans in the U.S. suffering from Alzheimer's and other dementias will increase significantly each year with the steady growth of the baby boom generation. The number of Americans aged 65 and older with Alzheimer's disease is estimated to reach 7.7 million in 2030 — more than a 50 percent increase from the 5.1 million aged 65 and older currently identified with the disease. In the District of Columbia, there are 9000 District residents aged 65 and older with Alzheimer's disease (Alzheimer's Association 2010 estimate); that number is projected to reach 10,000 by 2025. Most people with Alzheimer's disease and other dementias live at home, usually with help from family and friends. In 2009, there were approximately 10.9 million unpaid caregivers of older adults with Alzheimer's disease nationally, including 18,803 in the District. Because people with Alzheimer's and other dementias constitute a large proportion of older residents who receive in-home care, adult day care services, assisted living and nursing home care, the increased numbers of people with Alzheimer's will undoubtedly have a significant impact on states' healthcare systems, families and caregivers.

Cancer and Cardiovascular/Heart Disease

Twenty-one percent of all deaths in the District of Columbia in 2005 were due to cancer. By 2007, the American Cancer Society estimated that 2,540 new cases of cancer were diagnosed in District of Columbia, including 270 new cases of colorectal cancer and 320 new cases of breast cancer in women. Cancer is the second leading cause of death among the elderly in the District. Cardiovascular and heart disease accounted for 28% of deaths in District of Columbia in 2005, while stroke caused 4% of deaths.

Chronic Disease and Mortality

The rates of chronic disease, including obesity, heart disease, diabetes, kidney disease, and cancer will also continue to rise; by 2010, an estimated 40% of the American population will be diagnosed with one or more chronic diseases. Inactivity increases the risk of heart disease, high blood pressure, osteoporosis, diabetes, arthritis, and obesity. According to the D.C. Department of Health Vital Statistics (2008), the five leading causes of death for D.C. residents aged 60 and over were heart disease, malignant neoplasms (cancer), cerebrovascular diseases (stroke), chronic lower respiratory diseases (CLRD), and hypertension. All of these diseases require expensive healthcare services and often older patients have more than one serious healthcare problem. As the District's aging population grows, so will the needs to provide services for this largely sedentary population's chronic healthcare problems.

Physical and Mental Disability

As of 2006, in the District the overall percentage of people aged 65 to 74 with a disability was 31.1 percent, as11,000 of the 37,000 individuals ages 65 to 74 in the District reported one or

more disabilities. Among the six types of disabilities identified, the highest prevalence rate was "Physical Disability," at 24.0 percent.. The lowest prevalence rate was for "Mental Disability," at 6.8 percent. The overall percentage of people aged 75 and older with a disability ages 75 and older was 48.6percent or 16,000 of the 32,000 individuals ages 75 and older in DC reported one or more disabilities. Among the six types of disabilities identified, the highest prevalence rate was for "physical disability," at 40 percent. The lowest prevalence rate was for "mental disability" at 13.1percent (The Rehabilitation Research and Training Center, 2007).

HIV/AIDS

According to D.C. Department of Health HIV/AIDS Epidemiology 2008 Annual Report, persons over age 50 accounted for a third (32.6%) of the 15,120 living HIV/AIDS cases in the District. Of that number, 1,218 (or 8.1%) were persons 60 years and older. Many of these individuals have been living with HIV/AIDS for a long time and present new challenges to the management of HIV as they develop other conditions associated with the disease and with aging more generally. By 2015, the majority of the persons living with HIV in the District will be aged 50 and older.

Health Behavioral and Risk Factors

The Centers for Disease Control (CDC) funded a model telephone survey study that was used by the D.C. Department of Health. The 2007-2008 Behavioral Risk Factor Surveillance Survey (BRFSS) of randomly selected adults within District households revealed significant rates of arthritis, diabetes, high blood pressure, and asthma, as well as other factors such as healthy weight, consuming fruits and vegetables, and rates of smoking and drinking among persons age 65 and older.

The Behavioral Risk Factor Survey found that:

- As age increased, the percentage of adults with **arthritis** increased; 3% of adults aged 18-24 had arthritis compared to 58% of adults aged 65 and older.
- As age increased, so did the likelihood that adults had **diabetes;** 1% or less of adults aged 34 and younger had diabetes, compared to 20% of adults aged 65 and over.
- As age increased, as did the percentage of adults with **high blood pressure**; 10% of adults aged 34 and younger had the disease, compared to 62% of adults aged 65 and older.
- Older District adults are also more likely to have high blood cholesterol — 25% of adults age 35-44 reported high blood cholesterol, compared with 51% of adults aged 65 and older.
- Between the ages of 18 to 54, **the prevalence of asthma** increased—8% for adults aged 18-24 compared to 12% for adults aged 45-54. The prevalence of asthma for adults aged 55-64 and 65 and older was 8%.
- For the **flu vaccine**, as age increased, so did the likelihood that an adult had the vaccine within the past year; 27% of adults aged 18-24 had the vaccine compared to 61% of adults aged 65 and older.
- As age increased, the likelihood of adults having a **healthy weight** decreased; 57% of adults aged 18-24 were of a healthy weight compared to 40% of adults aged 65 and older. Adults aged 55-64 were more likely to be **overweight** (38%) and adults aged 45-54 were more likely to be **obese** (29%).

- As age increased, from 18 to 54, **rates of smoking** increased; 18% of adults aged 18-24 reported smoking cigarettes, compared to 21% of adults aged 45-54. From age 55-64 and 65 and older, prevalence rates of smoking decreased—20% of adults aged 55-64 smoked cigarettes, compared to 11% of adults aged 65 and older.
- As age increased, the number of alcoholic beverages consumed on one occasion decreased. While only 28% of adults aged 18-24 **consumed one drink** on average, 64% of adults aged 65 and older had done so.

Housing

Since 2000, there have been over 2,000 public and privately subsidized units reserved for seniors in the District. The city now has 50 apartment developments totaling over 7,000 units targeted/reserved for seniors. Many seniors are aging in place in these facilities and will require in-home support services. The reduction in the number of the federal rental housing vouchers has greatly impacted seniors while demand continues to increase for more units, particularly one bedroom units. In addition, over half of elderly homeowners live in homes over 30 years old. Most do not have accessible features or modifications. According to the Department of Housing and Community Development (DHCD) Annual Action Plan for FY 2009, there were five prospective senior projects slated for development over the next two year totaling 227 units.

Hospice Care

Hospice provides end of life care services for patients and their families who are faced with a life-threatening illness, providing medical, psychological and spiritual support. The goal of hospice care is to help people who are dying have peace, comfort and dignity in their environment of choice and/or an appropriate environment (e.g., home, hospice center, hospital or skilled nursing facility). Hospice programs also provide services to support a patient's family. In 2008, it was estimated that 1.45 million persons nationally received hospice care, of which 69% occurred at home.

Health Insurance

A recent study, conducted by The Urban Institute for the District of Columbia Department of Health Care Finance (DHCF), found that only 6.2% of D.C. residents are uninsured. The majority, 55%, of District residents have health insurance through their employers. Nearly one-third are covered by public programs such as Medicaid, the Alliance, or Medicare and only approximately 1% of District residents aged 65 and over reported having no health insurance coverage. Nationwide, 46.3 million (15.4%) Americans lacked health insurance in 2008, including 646,000 (1.7%) of elderly Americans (age 65 and older). Thus, the District of Columbia is a leader in providing health coverage to its residents. Nationally, un-insurance is rare among elderly adults as most people become eligible for Medicare at age 65. In the District, 14% reported having Medicare only and 10% reported having Medicare or some other form of public health insurance. Among the elderly, Medicare is the primary source of coverage, with supplemental coverage provided most often by private coverage or Medicaid. The share of elderly adults with such supplemental coverage, however, is generally related to income levels and in the District, with high numbers of low-income residents, it is critical that elderly residents have information and access to the application processes for available forms of health insurance coverage.

The District provides Medicare health care coverage for eligible residents, which may be supplemented by services available under the District's Medicaid program. These additional services may include, for example, nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. For persons enrolled in both programs, services that are covered by Medicare are paid first before any payments are made by the Medicaid, since Medicaid is considered the "payer of last resort." A relatively new Medicare prescription drug benefit (since 2006) provides drug coverage for Medicare beneficiaries, including those who also receive coverage from Medicaid. In addition, low-income individuals eligible for both Medicare and Medicaid receive subsidies for the Medicare drug plan and assistance with cost-sharing for prescriptions.

While the District provides a variety of options for health care coverage for its residents, The Urban Institute study found that many of the uninsured who might be eligible for public programs offered by the District (eg., Medicaid and the Alliance) reported that they either were not aware of public insurance programs or did not know how to enroll. Because of the relationship between age and the need for health services, information and coverage that facilitates access to health care becomes especially critical for the District's elderly. The Office on Aging seeks to address this need in large part through services located within the ADRC – including case management; co-location with District Government agencies and health insurance counseling groups (e.g., George Washington Health Insurance Counseling Project);and outreach and awareness activities.

Access to Technology

As of December 2009, research from the Pew Internet & American Life Project revealed that 38 percent of U.S. adults age 65 and older go online. This represents a smaller number than the next-oldest group (70 percent of adults aged 50-64) and a significantly lower rate of internet adoption than the general population (74%). Only 26 percent of U.S. adults age 65 and older have home broadband access, compared with 56 percent of adults age 50-64 years old (and 60% of all adults). However, some of the highest growth rates in broadband use are happening among the elderly. The Pew Research Center found that broadband use for those 65 and older increased from 19 percent in May 2008 to 30 percent in April 2009. Since 2005, broadband use has tripled in that group. Generally, the Pew studies found that older internet users are more likely to "stay in the shallow end of the internet activities pool" – using email and internet searches. Researching health information is the third most popular online activity with the most senior age group, after email and online search. Older internet users are also significantly more likely than younger users to look online for religious information and to visit government websites in search of information.

The gap in the numbers of seniors with access to technology as compared to their total number is largely attributable to education and income levels, or to mental and physical disabilities that the elderly confront. In the District, higher poverty rates likely impact senior internet access rates. With research findings that greater access to technology has the potential to enhance the lives of older citizens – including certain health benefits (eg., access to health information, decreased isolation and greater mental stimulation) and the ability to maintain their independence for longer periods of time. Although the District's elderly residents face significant challenges with access to technology, DCOA's efforts to provide wireless services through the Senior Service Network, establish computer access and training at our senior wellness centers and maintain

information and resources on the DCOA and ADRC websites will contribute to greater access for the District's seniors.

Senior Living Communities and Age in Place Programs

Naturally Occurring Retirement Communities (NORCs) are places where community residents have either aged in place (having lived in their homes over several decades) or are the result of significant migrations of older adults into the same housing constructs or neighborhoods where they intend to spend the rest of their lives. In many cases, older adults cannot afford to move. But even those who have the means to move to areas that cater to retirees tend to desire to age in place near family and friends. Nearly 75% of all Americans age 50 and older want to remain in their current homes for as long as possible, and this desire increases with age. This means that as seniors start to retire, the number of people aging in place will swell significantly.

At many community meetings in the District, long-time residents expressed the desire to remain in their community even when their principal residence was no longer suitable for their changing needs and desires. Many District seniors expressed fear that they will have to move out of the city because of the lack of NORC-type community developments. We recognize that plans, policies, and programs should be developed to make this a livable and desirable city for its aging residents, including addressing transportation and street patterns, housing, planning and zoning, parks and open space, human and health services, arts and culture. As part of this response, the District has added two new senior wellness centers to the four existing centers. These centers promote healthy lifestyles, sound nutrition, exercise, and general wellness; the goal is to have a center to serve residents in each Ward as part of a new initiative to provide services that focus on keeping seniors as healthy as possible within their own communities.

B. GOALS, OBJECTIVES AND STRATEGIES

Future Direction

In recent years, DCOA has noted trends in our evolving customer base that have influenced our choices regarding existing and proposed programs. Data reveals stronger service use by residents for whom English is a second language, gays and lesbians, residents who are blind and sensory impaired, and residents with physical and mental disabilities. As the numbers of lower income, multicultural, older adults in the District increase, along with their multiple chronic health care needs, the expansion of home and community-based long-term care programs remains a major priority. DCOA is committed to supporting and expanding long-term care services to prepare for the growth of older residents and to serve its current seniors, working in partnership with health and human services agencies in District Government and with non-governmental organizations.

The District Government's interest and activities in support of services to help *all* District seniors "age in place" through the expansion and improvement of home and community-based services (HCBS) is evident by establishment and staffing of the new Department of Health Care Finance (formerly the Medical Assistance Administration), the creation of the DC Office of Disability Rights to oversee the implementation of the 1995 Federal Americans with Disabilities Act

(ADA) and the Aging and Disability Resource Center (ADRC), which provides a single point of entry for District residents seeking long-term care services.

DCOA's vision for the future embraces a strategic direction that incorporates past goals and objectives, new programs that consider trends and the baby boomers' needs, as well as programs that can be integrated with existing activities to enhance outreach, advocacy, coordination, and meet the needs of low income, multicultural populations.

The Office on Aging has developed numerous objectives to meet the five strategic goals established by the U.S. Administration on Aging in its Strategic Action Plan for the years 2007-2012. The objectives target measureable results of the programs and services that support seniors along the healthcare continuum (as listed in the Summary section). Objectives are listed along with the strategies for accomplishing them under the primary goal that they support.

GOALS, OBJECTIVES AND STRATEGIES

Goal 1: : Empower older people, their families, and other consumers to make informed decisions about, and to be able to easily access, existing health, social services and long-term care options.

The District will work to assist senior District of Columbia residents, their family, friends and providers to access programs and systems that empower those who are in immediate need and those who have the ability to plan ahead to easily access information, make informed decisions, and take more ownership of their health and long-term care options. The District will incorporate specific planning for emerging special populations (eg., language minority, residents with disabilities and those lacking access to technology).

AGING AND DISABILITY RESOURCE CENTER (ADRC)

In the District 8,532 persons age 65 and over have a mental disability and 66,823 persons age 65 and over have some type of physical disability. The prevalence of elderly with mental health disabilities in the community can range from 5-20%, depending on the population studied. This includes disabilities such as dementia, depression, paranoia, substance abuse, schizophrenia, and others. The ADRC provides case management for clients on referral. These individuals have difficulty with access to services, many are below the poverty level, and many live alone. Established as a division of the DC Office on Aging, and co-located with District Government health and human service agencies and other non-governmental organizations, the ADRC is a "no wrong door" program which provides programs, information and services about long-term care for older adults (age 60 and older) and persons with intellectual and physical disabilities in collaboration with other government agencies and private organizations in one central location.

Objective/Strategy A: To develop and implement consumer directed programs through the ADRC that increase the number of families who are supported in their efforts to care

for their loved ones at home and in the community, through partnering with numerous organizations and individuals by:

A-1 Maintaining a system of outreach to include two types of primary activities: (a.) publicity, screening and information on availability of services that will reach 12,000 persons; and (b.) special efforts to identify 2,000 isolated, impaired, high risk, hard-to-reach older persons with the greatest social/economic need who would benefit from the service and assistance provided by the program annually or through September 30, 2012.

A-2 Establishing an advocacy system to intervene on behalf of 13,429 individuals to assist in establishing eligibility for benefits and needed services annually through September 30, 2012.

A-3 Placing 15 families in permanent housing annually through September 30, 2012.

A-4 Coordinating one (1) Senior Service Network Intake Workers information sharing seminar quarterly through September 30, 2012.

A-5 Developing a marketing campaign plan for the DCOA/ADRC that would incorporate education, training and outreach and continuing to update the plan through September 30, 2012.

A-6 Providing information and assistance to 4,929 clients ages 18-59 with disabilities annually through September 30, 2012.

A-7 Establishing ADRC satellite sites in each of the eight city wards by September 30, 2012.

A-8 Integrating person-centered hospital discharge planning into the DCOA/ADRC in order to reduce rates of re-hospitalization, starting with five pilot hospitals during the first eighteen months beginning in October 2010 and extending to all District hospitals in three years by September 30, 2012.

A-9 Developing a consumer cost model to accompany hospital discharge services and planning designed to show cost effective options that can save time and avoid frequent re-hospitalizations by September 30, 2012.

A-10 Distributing the District of Columbia's "Own Your Future: Planning Guide for Long-Term Care" to encourage seniors and caregivers to for long-term care needs through September 30, 2010.

EMERGING SPECIAL POPULATIONS

The District's population is becoming increasingly diverse and different groups of seniors, including those who may be gay or lesbian and persons with physical and mentally disabilities requesting services. According to the BRFSS study, seven percent of all adults identified themselves by sexual orientation other than heterosexual. Five percent of adults age 55-64 identified themselves this way and 3% of adults 65 years identified themselves other than heterosexual. Lesbian, gay, bisexual, and transgender adults (GLBT) are at increased risk for suicide, eating disorders, substance abuse, and breast and anal cancer. Many of these risks are never addressed because adults and physicians do on communicate with each other about sexual orientation, nor do physicians fully understand the health care issues specific to non-heterosexuals. According to a report "Outing Age: Public Policy Issues Facing Gay, Lesbian, Bisexual, and Transgender Elders," many GLBT elders face unique concerns as they age. GLBT elders often do not access adequate health care, affordable housing, and other social services that they need, due to institutionalized heterosexism. In addition, conditions and situations that we

associate with a younger population are impacting older persons such as substance abuse, HIV, mental illness, violence, and caring for children.

Objective/Strategy B: Identify and represent the comprehensive needs of emerging culturally, physically and mentally challenged and socially diverse persons; implement philosophical and policy changes in the creation and design of programs; and normalize, to the greatest extent possible, the day-to-day experiences of them within the aging network by:

B-1 Conducting an Americans with Disabilities Act (ADA) training session update with the Senior Service Network managers and staff annually through September 30, 2012.
B-2 Providing at least 25 hearing-impaired seniors with recreation/socialization and counseling on a weekly basis through September 30, 2012.
B-3 Providing at least 25 blind and visually-impaired seniors with recreation/socialization and counseling on a weekly basis through September 30, 2012.
B-4 Standardizing the collection and analysis of data on the number of GLBT residents receiving service through CSTARS (Client Service Tracking and Reporting System) by September 30, 2012
B-5 Convening a working group within the senior service network to address GLBT issues by September 30, 2011.
B-6 Working with groups to establish a volunteer peer advocacy group for GLBT in community residential facilities (CRF) and nursing homes by September 30, 2012.

HEALTH INSURANCE COUNSELING

The D.C. Office on Aging, in collaboration with The George Washington University, provides a comprehensive health insurance assistance program for the District's senior population through the GW Health Insurance Counseling Program (HICP). HICP provides insurance counseling (e.g., Medicaid and Medicare), outreach activities, training, and direct representation for seniors. This program enables seniors to understand and make informed choices about health insurance coverage under Medicare, Medicaid, Medigap and Long-Term Care Insurance and to understand their rights and protections.

Objective/Strategy C*:* To educate and counsel older residents in the District of Columbia on health insurance options through an established Health Insurance Counseling Program by:

C-1 Conducting 67 presentations on the Health Insurance Counseling Program for 2,600 seniors, caregivers and family members annually through September 30, 2012.
C-2 Increasing and enhancing the health insurance counselor workforce by conducting a mini-grant training program at 8 community-based organizations by September 30, 2012. Staff members of these agencies will participate in a comprehensive training program at HICP, focusing on low-income subsidy programs and on reaching Medicare beneficiaries with diagnosed mental disabilities, in order to provide assistance with selecting and enrolling in Medicare-approved prescription drug plans.

C-3 Conducting outreach and a publicity program targeted to low and middle-income Medicare beneficiaries with the greatest need for assistance to inform low-income Medicare beneficiaries of the financial assistance available to low-income beneficiaries annually through September 30, 2012.

C-4 Providing high quality counseling services to 1,600 beneficiaries contacting the HICP hotline annually through September 30, 2012.

INFORMATION, ASSISTANCE AND ACCESS SERVICES

The DC Office on Aging Information and Assistance Branch and the ADRC disseminate information about available programs and services for persons 60 years and older and persons 18-59 with a disability, as well as make appropriate referrals for services. They serve as the primary source of referral and connection to public and private organizations, including District-funded Senior Service Network grantees that provide support for seniors and adults with disabilities.

Information is collected and disseminated at the local, regional, and national levels through telephone contacts, written requests, and information from walk-in clients, speaking engagements, outreach activities, e-mail and the Eldercare Locator, a national database for locating senior services. In addition, these units collect, organize, and share available information and data to support needs assessments and to plan activities. Information and Assistance services are implemented through a variety of methods, including: counseling and referral, follow-up, advocacy/intervention, public education, outreach, client data collection and a community resource classification database.

Objective/Strategy D: To provide the District of Columbia's older residents, families, caregivers, adults with disabilities, and service professionals with the appropriate information and resources that are designed to help them make informed healthcare decisions by:

D-1 Maintaining a system of counseling, assistance and referral activities to support 40 providers in District, federal, and private agencies address the needs of 8,500 older persons and their caregivers annually through September 30, 2012.

D-2 Implementing a system of follow-up activities to ensure that 8,500 elderly persons have been linked successfully to needed services and provided follow-up assistance as needed through September 30, 2012.

D-3 Maintaining a system of outreach to include two primary activities: (a) publicity, screening and information on availability of services that will reach 12,000 persons each year; and (b) special efforts to identify 2,000 isolated, impaired, high risk, hard-to-reach older persons with the greatest social/economic need who would benefit from the service and assistance provided by the program annually through September 30, 2012.

D-4 Establishing an advocacy system to intervene on behalf of 13,429 individuals to assist in establishing eligibility for benefits and needed services annually through September 30, 2012.

D-5 Participating in 40 community fairs and events to distribute general information on aging programs and services annually through September 30, 2012.

D-6 Placing 15 families in permanent housing annually through September 30, 2012.
D-7 Providing information, assistance and resources for the DCOA/ADRC's four annual special events annually through September 30, 2012.
D-8 Coordinating one (1) Senior Service Network Intake Workers information sharing seminar quarterly through September 30, 2012.
D-8 Developing a marketing campaign plan for the DCOA/ADRC that incorporates education, training and outreach and continuing to update the plan through September 30, 2012.
D-9 Providing information and assistance to 4,929 clients ages 18-59 with disabilities annually through September 30, 2012.
D-10 Establishing ADRC satellite sites in each of the eight city wards by September 30, 2012.
D-11 Developing a pre and post satisfaction questionnaire of informal caregivers by December 1, 2011.
D-12 Developing a DC Lifespan Respite Care web site by December 1, 2012.
D-13 Developing caregiver survival and therapeutic engagement kits for caregivers by September 30, 2012.
D-14 Developing a plan for sustaining the Lifespan Respite Care Program beyond the 3-year grant period by September 30, 2013.

INFORMATION TECHNOLOGY

Ready, convenient, and familiar access to new computer technologies and their practical applications and benefits are beyond the reach of many older seniors. Many senior participants in the District's Senior Service Network appear to dislike and resist the demand that they learn new technologies. Although recent Environmental Scan statistics have shown computer use on a significant rise among seniors, average to low-income minority persons are significantly less likely than members of other racial and ethnic groups to own a home computer, be able to afford computer service and/or internet training, or have daily access to a computer.

Objective/Strategy E: To bridge the "digital divide" for District seniors, and increase their level of comfort with, and access to, new computer technologies, applications and benefits by:

E-1 Maintaining a computer internet work station within the Older Workers' Employment and Training unit at DCOA for employment information and assistance to aid 200 or more seniors in their job search annually through September 30, 2012.
E-2 Providing broadband wireless services in Senior Service Network program sites by September 30, 2012
E-3 Continuously revising the DC Office on Aging and Aging and Disability Resource Center web pages to incorporate immediate, interactive linkages with Senior Service Network agencies through September 30, 2012.
E-4 Establishing a computer learning service at our two newest senior wellness centers in Wards 1 and 6 that will teach seniors how to email and navigate the internet by September 30, 2012.

LANGUAGE AND CULTURAL ADVOCACY

For well over a decade, demographic information has indicated that the American population has become increasingly diverse – ethnically and culturally. In recent years, the largest numbers of immigrants have been those who speak Spanish or an Asian or Pacific Islander language. Often language acts as a significant barrier to obtaining needed services, particularly among low-income and non-English-speaking individuals. Those who have a limited ability to understand English and communicate it are less likely to participate in programs which are designed to help them out of poverty and avoid to homelessness. The District of Columbia Language Access Act, passed in 2004, mandates that all District agencies provide translation, interpretation, outreach and materials in languages besides English. These services must be provided to residents with limited or no English proficiency. Currently, the Office on Aging funds two centers which serve as focal points for services to Asian and Hispanic elderly populations.

Objective/Strategy F: To identify, access and recommend changes to address the language and cultural-specific needs of District seniors for whom English is a second language by:

F-1 Holding annual town hall meetings with limited English proficient (LEP) and non-English proficient (NEP) Asian and Hispanic elderly on their needs through September 30, 2012.

F-2 Translating the Senior Service Network Fact Sheet and other vital agency documents into Chinese, Korean, Vietnamese, Aramaic and Spanish and French as needed through September 30, 2012.

F-3 Conducting at least one language access workshop for Office on Aging Senior Service Network providers annually through September 30, 2012.

F-4 Collecting and updating data on language spoken by DC Office on Aging customers in order to assess the effectiveness of DC Office on Aging programs and services for LEP/NEP populations served annually through September 30, 2012.

F-4 Implementing an outreach plan to recruit bilingual employees for DC Office on Aging and its Senior Service Network through September 30, 2012.

F-5 Providing two language access-related trainings for Agency staff by September 30, 2012.

F-6 Participating in at least two outreach activities that target LEP/NEP populations annually through September 30, 2012.

GOAL 2: **Enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers**.

The District will strengthen its capacity to provide resources and information that enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers.

CAREGIVERS SUPPORT SERVICES

As the senior population ages, the chances are that older persons will need formal and informal supports in order to stay in their own homes. Only five percent of seniors live in institutional settings; the remainder live in the community. Two-thirds of the care provided to seniors in need is provided by a family member-caregiver. Caregiving may range from personal care activities such as bathing, dressing, grooming, feeding and toileting to household management activities such as cooking, cleaning, shopping, bill paying, errand running and taking the senior to medical appointments. In addition to hands-on care, caregivers tend also to the emotional needs of their relatives. Caregiving, on average, can consume 25 to 30 hours each week of the caregiver's time, and years of their lives. Fifty-nine percent of non-institutionalized persons 80 years and older live with others, usually with relatives, and most commonly with their off-spring who provide the care they need.

On the other hand, there are an increasing number of seniors raising and caring for their grandchildren and other relatives. At the last Census, it was found that over 8,000 children are being reared in the homes of their grandparents. In addition, four percent of the District's children (2,691) lived with aging relatives in the District. In 2006, the city enacted a subsidy program to help provide financial assistance to grandparents rearing grandchildren. Under the National Family Caregivers Support Act, funding was provided to the District of Columbia for family caregivers and for grandparent or older individuals who are relative caregivers. The services funded under this Act include information and access, counseling, respite care and supplemental services to complement the care provided by caregivers.

Objective/Strategy G: To provide services for caregivers in three categories: (1) those designed to benefit caregivers primarily; (2) those designed to benefit elders primarily, but which incidentally benefit the caregiver as well; and (3) special programs for elders and caregivers, by:

G-1 Maintaining an enrollment of least 126 participants in the Caregivers Institute annually through September 30, 2012.
G-2 Providing case management services to at least 112 caregivers through the Caregivers Institute annually by September 30, 2012.
G-3 Recognizing caregivers by holding an annual caregivers' reception during National Caregivers Month by November 30, 2012.
G-4 Updating the Caregiver Resource Directory and printing 1,000 copies for distribution by September 30, 2011.
G-5 Providing 80 seniors with services through the Caregivers Respite Escort Transportation Service CRETS demonstration program which is scheduled to end December 1, 2010.
G-6 Developing and implementing a single entry point (SEP) for Family/Informal Caregivers in the District as part of DCOA/ADRC with an Administration on Aging discretionary grant, by September 30, 2012.

CASE MANAGEMENT SERVICES

The Office on Aging funds eight Case Management programs - (1) Barney (2) Family Matters, (3) Emmaus, (4) IONA, (5) Seabury Aging Resources, (6) South Washington FSC, (7) East of River FSC and (8) Downtown Clusters. These case management programs provide

comprehensive assessment, case management and coordination to older persons with diminished functioning capacities, personal circumstances or conditions which require the provision of services by formal service providers. The activities of case management include assessing needs, developing a care plan, coordinating services with providers and the reassessment of clients' needs. The provision of these services will enable seniors to continue to live at home and avoid premature institutionalization. More licensed social workers, including Spanish-speaking social workers, are needed to provide case management services, to seniors in the District of Columbia. Additionally, the salaries of the licensed social workers must be more competitive to reduce the high rate of staff turnover, thereby increasing the level of continuity and quality of the case management services provided to seniors.

Objective/Strategy H: To increase the delivery of case management services, despite challenges posed by an aging population with increasing numbers of persons living alone, in need of assistance in obtaining public benefits or living longer with physical, developmental and mental illnesses by:

H-1 Providing case management services to 1,200 frail and functionally-impaired seniors annually through September 30, 2012.

H-2 Enabling 95 percent of seniors receiving comprehensive assessment and case management services to remain in their own homes for one year, annually, through September 30, 2012.

GERIATRIC DAY CARE SERVICES

The DCOA supports geriatric day care programs that serve functionally-impaired individuals and those persons with Alzheimer's disease or related disorders. These programs provide therapeutic and supportive services such as art therapy, music therapy, physical therapy, and regular health monitoring. These geriatric day care programs enable seniors to maximize their limited functional abilities and maintain their dignity. The geriatric day care programs are also a great source of respite for caregivers who are often elderly themselves.

Objective/Strategy I: To continue to expand and implement geriatric day care programs that seniors, their caregivers and/or family members, and the community will utilize and value that enable frail seniors, including those with Alzheimer's and other related dementias, to maximize and maintain their physical and social functioning levels by:

I-1 Maintaining four (4) geriatric day care programs that include opportunities for intergenerational programming involving toddlers, youth, and frail elderly through September 30, 2012.

I-2 Offering four (4) Montessori-based programs for functionally-impaired seniors including persons with Alzheimer's disease and other related disorders; and a wide range of social and recreational activities, annually through September 30, 2012.

I-3 Maintaining extended hours of operation at one geriatric day care program for caregivers providing their own transportation so that they may benefit from the flexibility of an earlier program opening or a later program closing, annually through September 30, 2012.

I-4 Promoting and providing hospice services presentations to senior wellness centers through September 30, 2012.

IN-HOME SERVICES

While only about five percent of the elderly population in the District resides in institutional facilities such as nursing homes, assisted living and supportive group housing, the fastest growing numbers of elderly living alone are those over age 75; these individuals are particularly at high risk due to age and disability. DCOA targets home care and caregiver assistance to especially vulnerable populations. The Office on Aging's in-home service program focuses attention on strengthening and supplementing community support systems that enable senior citizens to remain in their own homes for as long as possible and avoid unnecessary, premature and costly institutionalization. In-home caregiver services provided by certified home care aides include personal care assistance, light housekeeping, laundry, meal preparation, shopping, escort to appointments, caregiver education, and supervision for seniors with cognitive impairments and caregiver respite services. Providing in-home services allows the District to marshal resources carefully to maximize funding dollars in light of the rising numbers of the "oldest-old" population (those 75 and older) and enhances the quality of life for seniors who prefer to remain in their own home. Seniors who have dementia and other cognitive impairments, but who remain at home (either cared for by another or living alone) constitute another segment of the hidden, high risk population. DCOA focuses on those with Alzheimer's and related diseases through an Al-Care program providing an array of services including case management, home care services, medical linkage, caregiver education, and respite assistance. In addition, DCOA will continue to work with organizations that promote end-of-life quality services such as hospice and palliative care.

Objective/Strategy J: To maintain the current level of in-home services for the vulnerable elderly by:

J-1 Providing home-delivered meals to 1,600 homebound seniors annually through September 30, 2012.
J-2 Providing 475 seniors with homecare services through Homecare Partners annually through September 30, 2012.
J-3 Providing 12 seniors with heavy housekeeping services annually through September 30, 2012.
J-4 Providing 80 seniors with transportation assistance through the Caregivers Respite Escort Transportation Service (CRETS) demonstration program through December 1, 2010 .

INTERGENERATIONAL ACTIVITIES

Older adults are outnumbering children in our society for the first time and they have a wealth of knowledge and experiences that can be useful to younger generations. Through the sharing of such experiences, seniors and the young can share perceptions about their life stages; develop positive attitudes for one another; eliminate stereotyping, and modify inaccurate perceptions; develop a desire to communicate and share ideas, feelings and life experiences; develop an awareness of and a sensitivity to the aged while stimulating the young to consider their own

aging process; establish ongoing, one to one relationships; and work together to provide a needed service or assistance. The majority of DCOA's Senior Service Network agencies incorporate intergenerational activities in their programming.

Objective/Strategy K: To develop Intergenerational activities encouraging links between the generations will be fostered by:

K-1 Encouraging participation of at least five percent of public schools in the Commission on Aging-sponsored Intergenerational Poster Contest annually through September 30, 2012.
K-2 Attracting 100 high school students to volunteer for DCOA special events such as citywide holiday and outdoors events annually through September 30, 2012.
K-3 Distributing a brochure targeting high school students in need of community service credits and distributing it to the 17 public high schools in the District of Columbia by September 30, 2012.

TRANSPORTATION

The District of Columbia has approximately 100,000 persons 60 years of age or older, which represents about 17% of the total population. Over half of the elderly do not drive nor have private transportation. They depend instead on other modes of transportation – taxi, bus, rail, and relatives/friends with cars to get from place to place. Many elderly, especially those over 75 years of age, have some form of disability or live in areas where public transportation is either inconvenient or sporadic. These factors prevent many seniors from having easy access to public transportation. Lack of transportation has prevented some seniors from attending socialization and recreational activities and essential medical appointments, which may adversely impact their quality of living. The Washington Elderly Handicapped Transportation Services (WEHTS) Program and door-to-door taxi service through the Call 'N' Ride Program provide locally-funded life-sustaining transportation service to the elderly and disabled, using a sliding fee scale of discount coupons that allows seniors to call a taxi for transport.

Objective/Strategy L: To provide access to adequate and affordable transportation would enable more seniors to remain active and independent, by:

L-1 Implementing a 75-100% fleet replacement plan for medical and adult day care transportation (WEHTS) and home-delivered meals by September 30, 2012.
L-2 Conducting a transportation needs assessment to determine if the same need exists as in past years by September 30, 2012.
L-3 Providing transportation for the two new senior wellness centers by September 30, 2011.

Goal 3: Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.

The District will increase the use of evidence-based Disease and Disability Prevention Programs for older people at the community level and promote the use of the prevention benefits available under Medicare.

EDUCATIONAL OPPORTUNITIES

Creativity in later life – both its potential and its prevalence – has been greatly under-recognized as a source of satisfaction for older citizens. There is no age limit to the development and encouragement of intellectual growth, potential and ability. The sources of knowledge, activity and well-being that not only influence how society views and nurtures its elder members, but also how society benefits from the wisdom, experience and contributions of its older citizens. The early recognition of creative potential also affects how younger community members prepare for their own future development. Opportunities need to exist for senior Washingtonians to continue to learn beyond their retirement years, for seniors who did not have the benefits of certain educational opportunities, and for those who want to continue learning and growing through the rest of their lives.

Objective/Strategy M: To provide educational opportunities for older persons to continue to learn, grow, and contribute by:

M-1 Developing and distributing (through the Senior Service Network) a manual or brochure that identifies available educational opportunities in the District for older adults by September 30, 2012.

EMPLOYMENT, TRAINING AND PLACEMENT

The District of Columbia's unemployment rate for older workers 55 years of age and older is increasing. As a result, many seniors are seeking assistance entering or re-entering the work force. The District's Older Worker Training and Employment Program (OWTEP) is designed to promote the hiring of seniors through the development and implementation of public/private partnerships with companies who have expressed an interest in hiring seniors. OWTEP also partners with the University of the District of Columbia's Institute of Gerontology to provide training. This training is designed to enhance the skills level of seniors to help them keep up with current labor market demands such as office technology and management. In addition, this program collaborates with D.C. Aging and Disability Resource Center to assist seniors with moderate to severe disabilities who are seeking employment.

Objective/Strategy N: To provide District residents 55 years of age and older with assistance in acquiring skills that meet employment market demands through classroom training, on-the-job training, job search assistance, job development, and volunteer (internship) programs through maintaining and building on existing legislated programs by:

N-1 Continuing to maintain, expand, and link the OWETP with the federal Senior Community Services Employment Program operated by DOES to jointly enroll 35 customers annually through September 30, 2012.

N-2 Continuing to maintain a system to register and conduct employment intakes and assessment of 350 seniors recruited for the OWETP annually by September 30, 2012.

N-3 Continuing to maintain a system to provide 300 customers with vocational assessment, counseling and training needs through classroom training and/or job search assistance annually through September 30, 2012.

N-4 Continuing to maintain a system to develop 120 employment opportunities to meet the needs of customers enrolled in the program (which program?) annually through September 30, 2012.

N -5 Continuing to maintain a system of customer follow-up and monitoring, which will improve the retention rate of 120 customers placed in employment and/or job training annually through September 30, 2012.

N-6 Maintaining DCOA's client information system (CSTARS) to track the registration and service delivery of 250 customers annually through September 30, 2012.

N-7 Providing 250 customers with vocational assessment, counseling, training, job search assistance, and/or employment opportunities annually through September 30, 2012.

N-8 Expanding the pool of public/partnerships with businesses or agencies by three annually by 2012 (9 total for years 2011-2013).

N-9 Collaborating with the ADRC to provide joint services to at least 10 seniors with disabilities who are seeking employment annually through 2012 (30 total for years 2011-2012).

NUTRITION, CONGREGATE/HOME DELIVERED MEALS

For the past 34 years, the District of Columbia has provided nutrition services under Title III, Part C, of the Older Americans Act, as amended, to its senior population and other eligible individuals. The Older Americans Nutrition Program provides a range of related services including nutrition screening, assessment, education, and counseling. These services are offered to congregate setting and home-delivered meal program participants to identify their nutritional needs related to health concerns such as heart disease, cancer, diabetes, hypertension, stroke, renal insufficiency, osteoporosis, obesity, malnutrition and food insecurity. Persons whose nutrition screening is indicative of high nutritional risk are offered nutritional counseling by licensed nutritionists and referred for other professional services as needed. For the past 34 years, the District of Columbia, for the past 34 years, has provided nutrition services under Title III, Part C, of the Older Americans Act, as amended, to its senior population and other eligible individuals

Objective/Strategy N: To support the Older Americans Nutrition Program service elements as outlined in Title III, Part C, subpart 1 (Congregate Nutrition Services) and Part C, subpart 2 (Home Delivered Nutrition Services) of the Older Americans Act of 1965, as amended by:

O-1 Continuing congregate meal services for eligible persons at strategically located nutrition sites in all eight wards of the city, serving 350,000 meals annually through September 30, 2012.

O-2 Continuing weekday home-delivered meal services for eligible persons experiencing limitations that have an impact on their ability to prepare their own meals or to attend congregate nutrition sites, serving at least 500,000 meals annually through September 30, 2012.

O-3 Continuing weekend congregate meal services in at least one site, serving 6,500 meals annually through September 30, 2012.

O-4 Continuing initial (and annually thereafter) nutrition screening and assessment on every eligible individual receiving congregate meals, home-delivered meals, nutritional counseling or case management services by September 30, 2012.

O-5 Conducting semi-annual follow-up nutrition screening and intervention for those eligible individuals previously screened and determined to be at high nutritional risk by September 30, 2012.

O-6 Continuing to provide 10,000 eligible persons with activities and services that support their quest for maximum independence including but not limited to health promotion, nutrition education, recreation and socialization annually through September 30, 2012.

O-7 Collecting and reporting initial assessment results for persons who participate in the Enhanced Fitness Program and senior wellness centers in order to establish baseline reporting by September 30, 2012.

VOLUNTEER OPPORTUNITIES

The complex needs of the elderly as they age have increased substantially over the years, without a commensurate increase in resources – either in dollars or manpower. To help alleviate this concern, the pool of available volunteers must be increased. DCOA must intensify efforts to reach out and attract capable and motivated volunteer personnel to the aging network to assist with the delivery of services. For these reasons, there is a vital need to formalize the volunteer mechanisms currently used to assist those elders who require a comprehensive array of services.

Objective/Strategy P: To conduct an assessment of the Senior Service Network's volunteer needs, using the results to strengthen existing service systems and identify new areas of need and opportunities for volunteer service assignments for the elderly by:

P-1 Developing an assessment of DCOA's network volunteer needs by September 30, 2011.

P-2 Developing and distributing a brochure on DCOA's network volunteer needs by May 31, 2011.

P-3 Working with Serve DC (the Mayor's Office on Volunteerism) and other stakeholders to develop an outreach plan to make the case to expand and enhance existing programs targeting adults age 55 and older in service and to build on best practices to develop new service opportunities by September 30, 2012.

P-4 Creating an active partnership with Serve DC with priority areas of disability inclusion, civic engagement, and emergency preparedness for persons 55 years and older as outlined the 2010 – 2013 District of Columbia State Service Plan.

WELLNESS, HEATH PROMOTION AND DISEASE PREVENTION

The Centers for Disease Control (CDC) funded a model telephone survey study that was used by the DC Department of Health Behavioral Risk Factor Surveillance Survey (BRFSS). This 2007-2008 survey of randomly selected adults within households the District of Columbia provide information on the rates of arthritis, diabetes, high blood pressure, asthma, healthy weight, fruit and vegetable consumption, and smoking and drinking among persons aged 65 and older,. These results indicate how strong the need is for health promotion and disease prevention programs, both now and in the future, as the aging population increases.

Promoting health and wellness is itself a disease deterrent. As stated in Healthy People 2010, "the prevention agenda is to improve the health of all Americans, eliminate disparities in health and improve years and quality of life." Disease prevention and health and wellness promotion are an integral part of the DCOA mission to advocate, plan, implement, and monitor programs in health, education, employment, and social services which promote longevity, independence, dignity and choice for our senior citizens. Improving and enhancing the quality of life for seniors is achieved by providing ample, accessible high quality programs and services in an environment that encourages seniors' participation. The District has made strategic decisions to keep seniors healthy by building senior wellness centers across the wards of the city. DCOA also has a partnership with the Department of Health to provide immunizations and information at the senior wellness centers and other DCOA-sponsored special events. The District's federal stimulus funding under the American Recovery and Reinvestment Act (ARRA) has also allowed DCOA to provide more home-delivered and congregate meals.

Objective/Strategy Q: To establish "wellness" healthy aging and self-care practices as community-wide mandates for elderly individuals, and to assist those who have physical or mental limitations to remain as independent as possible by:

Q-1 Conducting lifestyle surveys at all wellness centers, to appropriately plan and to conduct programs based on at least 500 participants' needs annually through September 30, 2012.

Q-2 Improving by 10% the fitness level and nutrition knowledge of at least 200 seniors who participate in programs offered by the senior wellness centers annually through September 30, 2012.

Q-3 Measuring fitness levels and nutrition knowledge by a pre and post-test using the Healthstyle Inventories in participating senior wellness centers annually through September 30, 2012.

Q-4 Continuing to operate four (4) senior wellness centers in Wards 4, 5, 7 and 8 annually through September 30, 2012.

Q-5 Establishing two new fully-operational senior wellness centers in Wards 1 and 6 by September 30, 2013.

Q-6 Identifying wellness needs of Ward 2 seniors by September 30, 2011.

Q-7 Identifying new private sector partnerships for the operation of the two new wellness centers by September 30, 2012.

Q-8 Increasing the visibility of senior wellness centers by initiating a citywide media campaign by September 30, 2012.

Q-9 Implementing evidence-based programs in all senior wellness centers annually through September 30, 2011

Q-10 Reevaluating health and wellness components in the congregate sites by September 30, 2011.

Q-11 Implementing a Diabetes Self Management Program in all senior wellness centers by September 30, 2011.

Goal 4: Ensure the Rights of Older People and Prevent their Abuse, Neglect and Exploitation

The District will facilitate the integration of elder rights programs into Senior Service Network efforts by improving the identification and utilization of measurable consumer outcomes for elder rights programs and fostering quality implementation of new Older Americans Act provisions supporting elder rights.

ABUSE, EXPLOITATION AND NEGLECT SUPPORT

Abuse, exploitation and neglect of seniors are troubling, under-reported phenomena that cause undeserved physical, emotional and financial harm to vulnerable individuals. Reported incidents have increased steadily, compounded by the fact that an estimated one out of six cases goes unreported. For financial exploitation, estimates are that only one in 25 cases is reported. Those who lose their life savings suffer a physical and emotional toll as well as a financial toll. They may become fearful, develop health issues, become depressed and even consider suicide. According to a study from the National Aging Resource Center on Elderly Abuse, perpetrators of elder abuse are most often adult children, spouses, siblings, friends and neighbors, in that order. The senior population in Washington, DC, and their families want and deserve protection from crime, abuse, exploitation, neglect and self-neglect at home and in their communities. Seniors who live alone are at higher risk for abuse, exploitation and neglect.

The DC Adult Abuse Prevention Committee, convened by the DC Office on Aging, annually develops a work plan that outlines the adult abuse, neglect and exploitation prevention initiatives that will occur each year. The committee is comprised of representatives from the government and community-based organizations that are involved in adult abuse prevention or intervention. The work plan changes each year based on the input of the committee members and comments received through various other means outlined in this plan, but generally includes conferences, targeted training, outreach initiatives and small pilot programs. Title VII Ombudsman Funds are directed to Legal Counsel for the Elderly (LCE), the designated Long-Term Care Ombudsman Program entity in the District. The work of the DC Adult Abuse Prevention Committee is funded with Title VII Elder Abuse funds. The committee was established when these funds became available to the District and remain the committee's sole funding source.

Objective/Strategy R: To strengthen community education efforts and social support for seniors to recognize, reduce and prevent abuse, exploitation and neglect of the elderly by:

R-1 Regularly convening the D.C. Adult Abuse Prevention Committee to develop and implement an annual work plan to help prevent elder abuse and offer effective interventions in identified cases of abuse, annually through September 30, 2012.

R-2 Working with appropriate agencies to conduct a citywide campaign to prevent elder abuse by September 30, 2011.

R-3 Through the DC Adult Abuse Prevention Committee and Long-Term Care Ombudsman Program, conducting training sessions, workshops or other outreach campaigns to provide education and information about elder abuse prevention (including the Karyn Barquin Adult Protective Services Expansion Act of 2005 covering self-neglect), to at least 200 seniors, their families or caregivers, service providers and professionals, annually through September 30, 2012.

R-4 Continuing to partner with the Metropolitan Police Department to train 25 seniors for the Senior Citizens Police Academy annually through September 30, 2012.

LEGAL RIGHTS AND PUBLIC BENEFITS ENTITLEMENTS

Seniors, especially those who are eligible for and dependent on a variety of public benefits for support, frequently encounter problems for which they require legal advice and assistance. However, seniors, particularly those with low and modest incomes, often have difficulty accessing legal services. Their legal problems may include: securing Social Security disability, Supplemental Security Income or Medicaid benefits; landlord-tenant problems; identity theft and consumer fraud; money management challenges; and the loss of long-held homes through tax proceedings.

Objective/Strategy S: To assist older persons in exercising their legal rights, ensure access to and enforcement of these rights and benefits, and to further expand legal services to low-income elderly by:

S-1 Providing legal services addressing legal problems raised by 750 seniors at various community sites through September 30, 2012.

S-2 Informing and educating at least 25,000 seniors of their rights, benefits, and available legal services, through presentations, media events, and distribution of self-help and other materials, annually through September 30, 2012.

LONG-TERM CARE ADVOCACY

The fastest growing segment of the District's population is the "oldest-old" age group, people who are 75 years and older. In 2008, those 75 years and older comprised 34% of the senior population in the District and that proportion continue to increase. People in this age cohort typically have significantly lower incomes and frequently suffer from chronic diseases. There are approximately 4,548 residents in licensed nursing facilities and community residence facilities in the District. Assisted living facilities provide another option for residents not requiring nursing home care but unable to remain in their own homes. Residents in nursing

homes, community residential facilities and assisted living residences frequently have complaints about the type and quality of care in these facilities. The D.C. Long-Term Care Ombudsman Program is the legal representative and an advocate mandated by both federal and local laws for the residents of long-term care facilities to investigate and resolve complaints, review and challenge insufficient discharge notices, encourage citizen education and involvement, and monitor the development and implementation of laws, rules and policies affecting long-term care facility residents.

DCOA administers Nursing Home Quality of Care Fund projects valued at $2.7 million in the District's eighteen (19) nursing homes. These projects focus on: streamlining daily care documentation; redesigning work to improve communications; reducing in-house pressure ulcer rates; providing geropsychology services using a multidisciplinary approach; physician and nursing staff training; and a nursing home bed bulletin board to assist hospitals to electronically obtain real time information on availability.

Objective/Strategy T: To improve the quality of life and the quality of care for vulnerable elderly residents of nursing facilities, assisted living residences, and community residence facilities in the District of Columbia by:

T-1 Presenting approximately 200 training seminars on long-term care and community-based services and rights that may affect institutionalized long-term residents with a focus on training volunteer advocates, paraprofessionals, professionals, government officials, and the general public interested in long-term care annually through September 30, 2012.

T-2 Investigating 100% of all problems or complaints from nursing home, assisted living facility, and community residence facility residents annually through September 30, 2012.

T-3 Fulfilling 100% requests for information about long-term care annually through September 30, 2012.

T-4 Reviewing approximately 3,000 discharge notices from nursing homes and community residence facilities and challenging inadequate involuntary discharges annually through September 30, 2012.

T-5 Advocating for quality care and the implementation of community-based and other in-home services/options that enhance consumer choice through the Aging and Disability Resource Center, Money Follows the Person Rebalancing Initiative and other relevant advisory committees (including involving nursing home, assisted living resident and family councils for input) to address long-term care systems change through September 30, 2012.

T-6 Maintaining and expanding an active long-term care ombudsman program that serves approximately 4,500 residents per year through September 30, 2012.

T-7 Transitioning 50 persons back in the community through Money Follows the Person Rebalancing Initiative annually through September 30, 2012.

T- 8 Developing the Washington Center for Aging Services nursing home campus by providing the aging and disabled community with a full continuum of care options along with affordable senior housing by September 30, 2012.

T-9 Administering and monitoring nursing home initiatives that will help improve and enhance quality of care provided to residents throughout the city through September 30, 2012.

T-10 Providing appropriate housing and wrap-around services to twenty-five (25) nursing home residents who are no longer suited for nursing home level of care by September 30, 2012.

T-11 Executing a ground lease option for the two District-owned nursing homes that will foster a public-private partnership by September 30, 2011.

T-12 Expanding the DC Long-Term Care Ombudsman Program by identifying additional program supports, funding, and amending the Ombudsman Program's Law to include home health advocacy and legal assistance by September 30, 2012.

Goal 5: Maintain Effective and Responsive Management

The District will promote state-of-the-art management practices, including the use of performance-based standards and outcomes within the Senior Service Network and by supporting agencies that administer emergency preparedness training and response for older people.

EMERGENCY PREPAREDNESS AND RESPONSE

The District of Columbia's Emergency Plan has indicated that there are 15 hazards that could potentially affect the District. The hazards could include, but are not limited to: terrorism, severe weather, urban fire, transportation, special events, demonstrations, urban floods, water supply failure, critical resources shortages, utility and power failures, hurricanes, radiological and hazardous materials incidents, prison/jail incidents, civil disorders, explosions and earthquakes. The recent hazard/issues that have impacted our readiness and response include: terrorist attacks, Bird flu pandemic, H1N1, internet hacking, and food and water contamination.

The Office on Aging has been active participant in citywide emergency preparedness and response exercise trainings. As a member of the Mayor's Command Center Emergency Team, DCOA is a support agency to the Department of Human Services for mass care during emergencies. During a declared emergency, DCOA staffs the Emergency Command Center by providing information and assistance to seniors. The Office on Aging requires Senior Service Network agencies to have emergency plans that address shelter in place, service disruption and identifying the frail and vulnerable in their service areas. Our case management and lead agencies currently have a registry of persons who are vulnerable and at risk during emergencies. Internally, the Office on Aging has a plan for sheltering in place during an emergency.

Objective/Strategy U: To prepare and respond to emergencies that affects the lives, health and safety of seniors by:

U-1 Conducting a training session for Senior Service Network agencies on emergency preparedness by September 30, 2012.

U-2 Reviewing on a yearly basis the emergency plans of our 21 Senior Service Network agencies through September 30, 2012.
U-3 Participating in two (2) fire drill trainings for Office on Aging staff annually through September 30, 2013.
U-4 Continuing to participate in the Homeland Security and Emergency Management (HSEMA) task force and work groups to identify and respond to seniors at risk in emergencies through September 30, 2012.
U-5 Continuing to annually update HSEMA weather emergency and response plans as they relates to seniors through September 30, 2012.
U-6 Conducting a community fraud workshop in conjunction with the DC Department of Insurance, Securities, and Banking, annually through September 30, 2012.

PUBLIC/PRIVATE PARTNERSHIPS

The formal support and outreach seniors receive from programs financed by the Older Americans Act ensure that services such as in-home and congregate meals, transportation, homemaker services and case management are available in the community. But with recent federal and local budget constraints and an incredibly challenging economy, the past few years have witnessed a substantial increase in services needed by seniors, without concomitant increases in public funding to provide those services. Increasingly, aging organizations have had to look to private sector support to help cover the shortfalls in service delivery. Locally, businesses and churches have had longstanding traditions of active civic and community involvement. Also, the notion of "giving something back" has led many local companies to support a wide range of community activities and causes. Private sector in-kind and monetary support is crucial to leverage and stretch dollars needed for supportive services for the aging population. Private sector and faith-based community support of Senior Service Network programs can help improve the lives of seniors, allowing them to be involved with and benefit from public/private partnerships that make a difference. Traditional and nontraditional businesses can contribute to increasing funding, services and support for District seniors.

Objective/Strategy V: To provide avenues for the private sector to partner with the Office on Aging Senior Service Network by:

V-1 Having at least five new private sector organizations participating at our annual citywide events (Senior Spring Festival and Holiday Celebration) through September 30, 2012.
V-2 Holding a forum for faith-based organizations on accessing and developing programs and services by September 30, 2012.
V-3 Soliciting at least four new prospective grantee applicants annually through September 30, 2012.

DATA COLLECTION AND ANALYSIS

As a community plans to meet the needs of its older citizens, some first steps include: (1) identifying and obtaining available data and reference materials; (2) documenting general characteristics about the elderly population; and (3) identifying planning areas and neighborhoods within the city where there are concentrations of older residents. Information

from various sources helps us evaluate service needs and desires on a yearly basis. Sources such as Census data, environmental scans, reports, focus groups, town meetings, and customer satisfaction surveys are vital to this process. In addition, it is important to ensure accurate data on the use of DCOA services by using and providing training on use of DCOA's Client Service Tracking and Reporting System (CSTARS). CSTARS includes data on intake, case management, service planning, service provision, service invoicing, and the federal reports mandated under the Older Americans Act known as the National Aging Program Information System (NAPIS). DCOA analyzes this data to assess the characteristics and needs of senior residents and the implications for future aging services.

DCOA also measures the quality of care providing in its programs, by soliciting feedback from seniors and providers. As discussed, this feedback is collected through emails, committee meetings, online surveys, telephone surveys, town hall meetings, program evaluations for individual activities, and focus groups. The feedback is discussed in DCOA staff meetings during the year, and process and quality improvements are made on an ongoing basis.

Objective/Strategy W: To compile and analyze statistical and reporting data and other information that will be useful in future program planning and development by:

W-1 Developing and distributing a demographic profile from data released from the 2010 Census to our grantee agencies through September 30, 2012.

W-2 Conducting a comprehensive needs assessment on the District's elderly residents and persons with disabilities by September 30, 2012.

W-3 Conducting an ongoing online survey of needs for older adults on the DCOA website through September 30, 2012.

W-4 Conducting at least three citywide town hall meetings for seniors, providers and the general public annually to offer feedback on aging issues and concerns annually through September 30, 2012.

W-5 Analyzing and preparing summaries of relevant national and local organization/committee reports that affect the plans and programs for aging adults as needed through September 30, 2012.

W-6 Analyzing data from Senior Service Network agencies' annually through September 30, 2012.

W-7 Compiling and reviewing Language Access Act statistics on persons with limited English proficiency who access services through our Senior Service Network agencies by September 30, 2012.

W-8 Updating the State Plan on Aging, as appropriate, based on the analysis of up-to-date Census data and other statistics annually through September 30, 2012.

APPENDIX A

FY 2011 State Plan Guidance
Attachment A
STATE PLAN ASSURANCES, REQUIRED ACTIVITIES AND INFORMATION REQUIREMENTS

Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances, required activities and information requirements as stipulated in the Older Americans Act, as amended in 2006.

ASSURANCES

Sec. 305(a) - (c), ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b) (5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306 (a), AREA PLANS

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-
(A) services associated with access to services (transportation, health services **(**including mental health services**)**, outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);
(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) Legal assistance;
and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);
(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--
(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).
(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:
in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.
(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older 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 this title;
(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; 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.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--
(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-
(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

Sec. 307, STATE PLANS
(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.
(7)(B) The plan shall provide assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant

to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--
(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—
(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and
(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—
(A) to utilize in the delivery of outreach services under section 306(a) (2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and
(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—
(A) identify individuals eligible for assistance under this Act, with special emphasis on—
(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iv) older individuals with severe disabilities;
(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall
(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made--
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS
(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)
(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order.

REQUIRED ACTIVITIES

Sec. 307(a) STATE PLANS

(1)(A)The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and
(B) The State plan is based on such area plans.
Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:
(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

(5) The State agency:
(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--
(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or
(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

INFORMATION REQUIREMENTS

Section 102(19)(G) – (required only if the State funds in-home services not already defined in Sec. 102(19))
The term "in-home services" includes other in-home services as defined by the State agency in the State plan submitted in accordance with Sec. 307.

Section 305(a)(2)(E)
provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

Section 306(a)(17)
Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Section 307(a)

(2) The plan shall provide that the State agency will:
(C) Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306
(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) *(Note: those categories are access, in-home, and legal assistance).*

Section (307(a)(3)

The plan shall:
(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning distribution of funds); *(Note: the "statement and demonstration" are the numerical statement of the intrastate funding formula, and a demonstration of the allocation of funds to each planning and service area)*

(B) with respect to services for older individuals residing in rural areas:

(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

Section 307(a)(8)) (Include in plan if applicable)

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

Section 307(a)(10)

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

Section 307(a)(21)
The plan shall:

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title *(title III),* if applicable, and specify the ways in which the State agency intends to implement the activities .

Section 307(a)(28)
(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.
(B) Such assessment may include—
(i) the projected change in the number of older individuals in the State;
(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;
(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and
(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

Section 307(a)(29)
The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

Section 307(a)(30)
The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

Section 705(a)(7)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6). *(Note: Paragraphs (1) of through (6) of this section are listed below)*

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:
(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;
(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;
(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;
(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;
(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);
(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3--
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order.

_____ _____

Signature and Title of Authorized Official Date

APPENDIX B

Community Participation Process in the State Plan Development Process

Distribution of the Draft State Plan on Aging

Starting in 2009, a Draft State Plan on Aging was widely distributed to District senior residents, caregivers, service providers and other stakeholders through the Senior Service Network, public libraries, on radio and television, on the Internet, and local newspapers. Through these contacts, DCOA was able to reach several thousand residents. Specifically, the state plan was distributed to:

Civic Associations
Advisory Neighborhood Commissions
City Agencies
Church Groups and Ministries
Senior Social Clubs and Centers
Senior Apartment Tenant Building Associations
DCOA Senior Service Network agencies
Health Care Facilities and Agencies
Community Health Fairs
AARP local chapters
Office on Aging Special Events

In addition, a survey questionnaire that could be completed on line was distributed. The results of the 282 surveys collected appear in Appendix C.

Meetings with the DC Commission on Aging and Mini Commissions on Aging

D.C. Commission on Aging provided critical input into the development of the draft state plan. At the Commission's public meetings, DCOA received comments and completed surveys.

The top priorities identified by the Commissioners included:

- **Access to Services**: Including information and assistance, transportation, and information on special events.
- **Support Services**: Including home modification, affordable and accessible housing, coordination of health care and social needs, sufficient home care workers, physical and mental health promotion, insurance issues, and caregiver services.
- **Funding**: More funding and expanded eligibility for home care services.

DCOA Town Hall Community Meetings

DCOA co-hosted (with the Commission) four community meetings on the Draft State Plan on Aging. The meetings were held on May 12, 2009 at Emery Recreation Center; May 19, 2009 at Guy Mason Recreation Center; May 27, 2009 at Greenleaf Recreation Center; and June 5, 2009 at the Washington Seniors Wellness Center. Representatives from District agencies, public and private community-based organizations, as well as the general public attended the meetings. Each person received a draft copy of the State Plan, and was encouraged to provide comments and suggestions on the Plan during the meetings, or after the meeting, orally or in writing on a form provided by DCOS.

The Draft State Plan was well-received by those who provided input, many of whom praised the Office on Aging for developing forward-looking strategies to address the needs of the elderly in the District of Columbia. The most significant areas/issues raised for future planning focused on:

- Need for a comprehensive needs assessment
- Need for more adequate and affordable housing
- Funding for long-term care services
- More vehicles for transportation services to and from hospitals, doctors' offices, and for group trips
- Assistance with legal problems and concerns
- Expanded in-home services;
- Better coordination and inter-agency cooperation in the delivery of services; and
- Greater variety of daily activities at senior nutrition centers
- Regulation of home health care agencies
- Services for caregivers
- Preparing seniors for emergencies related to natural disasters and terrorism
- Outreach to find and identify isolated seniors living alone at home.
- Help with home repairs and lawns
- Snow removal assistance for frail isolated seniors.

Many of these ideas are incorporated, as appropriate, in the State Plan.

APPENDIX C

DCOA - State Aging Plan Survey 2010

Summary Report

Date: 4/13/2010
Total number of responses collected: 282

Awareness:

Below find a list of specific programs the OFFICE ON AGING offers.

1. On a scale of 1 to 5 with **5 being very aware** and **1 being not aware at all**, please indicate how aware you are of the DC Office on Aging.

(Respondents could only choose a **single** response)

Response Chart Frequency Count

1	(not aware at all)	9.6%	27
2		11.3%	32
3		27.7%	78
4		19.1%	54
5	(very aware)	32.3%	91

Mean 3.532

Services:

2. Below, find a list of general services the office currently offers. On a scale of 1 to 5 with **5 being very important** and **1 being not important at all,** please indicate how important they are to you**.**

1 2 3 4 5 **Total**

Services:

Caregiver Support & Training

	1	2	3	4	5	Total
Count	34	10	34	38	**138**	**254** 3.929 1.429
% by Row	13.4%	3.9%	13.4%	15.0%	**54.3%**	**100.0%**

Congregate Meals and Nutrition Education Programs

	1	2	3	4	5	Total
Count	26	14	33	45	**144**	**262** 4.019 1.338
% by Row	9.9%	5.3%	12.6%	17.2%	**55.0%**	**100.0%**

Counseling & Case Management (Social Workers)

	1	2	3	4	5	Total
Count	24	17	33	52	**134**	**260** 3.981 1.319
% by Row	9.2%	6.5%	12.7%	20.0%	**51.5%**	**100.0%**

Disaster and Emergency Preparedness for Vulnerable Seniors

	1	2	3	4	5	Total
Count	29	9	30	50	**136**	**254** 4.004 1.353
% by Row	11.4%	3.5%	11.8%	19.7%	**53.5%**	**100.0%**

District of Columbia Caregivers' Institute

	1	2	3	4	5	Total
Count	35	12	39	45	**118**	**249** 3.799 1.434
% by Row	14.1%	4.8%	15.7%	18.1%	**47.4%**	**100.0%**

Elder Abuse and Neglect (Elder Rights Protection)

	1	2	3	4	5	Total
Count	26	14	34	29	**157**	**260** 4.065 1.361
% by Row	10.0%	5.4%	13.1%	11.2%	**60.4%**	**100.0%**

Employment Training & Placement

	1	2	3	4	5	Total
Count	39	16	38	45	**126**	**264** 3.769 1.466
% by Row	14.8%	6.1%	14.4%	17.0%	**47.7%**	**100.0%**

Health Promotion and Disease Prevention

	1	2	3	4	5	Total
Count	12	5	34	50	**165**	**266** 4.320 1.064
% by Row	4.5%	1.9%	12.8%	18.8%	**62.0%**	**100.0%**

Health Insurance Help (Medicare,Medicaid, Long Term Care)

	1	2	3	4	5	Total
Count	25	9	17	36	**173**	**260** 4.242 1.297
% by Row	9.6%	3.5%	6.5%	13.8%	**66.5%**	**100.0%**

Home Delivered Meals

	1	2	3	4	5	Total
Count	44	12	28	33	**140**	**257** 3.829 1.537
% by Row	17.1%	4.7%	10.9%	12.8%	**54.5%**	**100.0%**

Housing Renovations and Adaptation (Improvements)

	1	2	3	4	5	Total
Count	34	15	35	53	**115**	**252** 3.794 1.419
% by Row	13.5%	6.0%	13.9%	21.0%	**45.6%**	**100.0%**

In-Home Personal Care (Home Health Aide)

	1	2	3	4	5	Total
Count	38	8	25	49	**137**	**257** 3.930 1.445
% by Row	14.8%	3.1%	9.7%	19.1%	**53.3%**	**100.0%**

Independent Living Skill

	1	2	3	4	5	Total
	33	9	26	45	**131**	**244** 3.951 1.419
% by Row	13.5%	3.7%	10.7%	18.4%	**53.7%**	**100.0%**

Lead Agency (Service Providers) Support and Staffing

	1	2	3	4	5	Total
Count	28	13	38	51	**121**	**251** 3.892 1.357
% by Row	11.2%	5.2%	15.1%	20.3%	**48.2%**	**100.0%**

Legal Assistance

	1	2	3	4	5	Total
Count	19	16	36	49	**137**	**257** 4.047 1.262
% by Row	7.4%	6.2%	14.0%	19.1%	**53.3%**	**100.0%**

Light and Heavy House Cleaning

	1	2	3	4	5	Total
Count	34	13	35	57 **1**	**23**	**262** 3.847 1.398
% by Row	13.0%	5.0%	13.4%	21.8%	**46.9%**	**100.0%**

Nursing Home Services

	1	2	3	4	5	Total
Count	36	13	31	45	**126**	**251** 3.845 1.452
% by Row	14.3%	5.2%	12.4%	17.9%	**50.2%**	**100.0%**

Outreach and Advocacy

	1	2	3	4	5	Total
Count	21	13	46	44	**121**	**245** 3.943 1.292
% by Row	8.6%	5.3%	18.8%	18.0%	**49.4%**	**100.0%**

Senior Activities & Special Events (Ex. Elderfest, Holiday Celebration)

	1	2	3	4	5	Total
Count	22	18	38	53	**133**	**264** 3.973 1.295
% by Row	8.3%	6.8%	14.4%	20.1%	**50.4%**	**100.0%**

Senior Wellness Centers

	1	2	3	4	5	Total
Count	17	11	35	38	**168**	**269** 4.223 1.201
% by Row	6.3%	4.1%	13.0%	14.1%	**62.5%**	**100.0%**

Recreation and Socialization

	1	2	3	4	5	Total
Count	16	7	40	55 **1**	**53**	**271** 188 1.147
	5.9%	2.6%	14.8%	20.3%	**56.5%**	**100.0%**

Respite & Adult Day Care Programs

	1	2	3	4	5	Total
Count	26	6	24	29	**127**	**212** 4.061 1.391
% by Row	12.3%	2.8%	11.3%	13.7%	**59.9%**	**100.0%**

Transportation (medical, Leisure time & public benefits)

	1	2	3	4	5	Total
Count	23	7	24	33	**173**	**260** 4.254 1.266
% by Row	8.8%	2.7%	9.2%	12.7%	**66.5%**	**100.0%**

Volunteer Services Count 19 17 41 64 **119** **260** 3.950 1.240

	1	2	3	4	5	Total
% by Row	7.3%	6.5%	15.8%	24.6%	**45.8%**	**100.0%**

Total Count	**660**	**284**	**794**	**1088**	**3315**	**6141** N/A N/A
	10.7%	**4.6%**	**12.9%**	**17.7%**	**54.0%**	**100.0%**

Familiarity:

4. The District government's new Aging and Disability Resource Center (ADRC), a one-stop resource for public and private information and assistance related to long-term care services for persons with disabilities , age 18 and older and seniors 60 years and older, is operated by the DC Office on Aging and the Department of Health Care Finance. On a scale of **1 to 5 with 5 being very familiar** and **1 being not familiar at all**, please indicate how familiar you are with the ADRC.

(Respondents could only choose a **single** response)

Response Chart Frequency Count
1 32.1% 69
2 16.3% 35
3 16.3% 35
4 12.6% 27
5 22.8% 49
Not Answered 67
Mean 2.777
Standard Deviation 1.564
Valid Responses 215
Total Responses 282

Baby Boomers:

7. Baby Boomers, persons born between 1946–1964, are reaching the age of 60 and older at a rapid rate. Do you consider yourself a baby boomer?

(Respondents could only choose a **single** response)

Response Chart Frequency Count
Yes 25.0% 66
No 75.0% 198
Not Answered 18
Mean 1.750
Standard Deviation 0.434
Valid Responses 264
Total Responses 282

Programs:

8. If you are a baby boomer, what programs and services would you like the DC Office on Aging to Provide?
(Comments taken from DC State Survey Form)

- Seniors need to have better opportunities for DC Govt and Federal Government employment
- Need better job training opportunities that will lead to much better jobs with benefits
- Full time and part time jobs that don have the physical work duties are the best jobs for seniors. For some of us seniors, hotel training is an excellent chance to obtain jobs.
- Educational opportunities of higher learning for senior with bachelor degree who would like to obtain master degree.
- Seniors with college degrees should offered much better jobs and much better jobs opportunities
- DC Pension provider provide investment and money management assistance to seniors. This company is "ING" and the city is already contracting with them in human resources department.
- Help for 50 yrs+
- The baby boomers services that I like to see: Handy man repair services, home hospice care, home health attendants, meal delivered to home, health insurance and tax counseling, transportation, wellness centers, recreation, elder rights protection and house cleaning

Sex:

12. Sex

(Respondents could only choose a **single** response)

Response Chart Frequency Count

Male 21.8% 58
Female 78.2% 208
Not Answered 16
Mean 1.782
Standard Deviation 0.414

Valid Responses 266
Total Responses 282

13. Sexual Orientation

(Respondents could only choose a **single** response)

Response Chart Frequency Count

Gay 3.8% 9
Lesbian 3.8% 9
Heterosexual 88.0% 206
Other 4.3% 10
Not Answered 48
Mean 2.927
Standard Deviation 0.480
Valid Responses 234
Total Responses 282

Ethnic Group:

14. Ethnicity

(Respondents could only choose a **single** response)

Response Chart Frequency Count

African American	75.5%	200
American Indian or Native Alaskan	0.4%	1
Asian/Pacific Islander	1.1%	3
Hispanic/Latino	0.8%	2
White	18.9%	50
Other	3.4%	9

Not Answered 17
Mean 1.974
Standard Deviation 1.746
Valid Responses 265
Total Responses 282

Residency:

15. Ward in which you reside

(Respondents could only choose a **single** response)
Response Chart Frequency Count

1	13.5%	36
2	7.5%	20
3	1.9%	5
4	13.1%	35
5	12.7%	34
6	3.4%	9

7	30.0%	80
8	4.1%	11
Don't Know	10.9%	29
Not a resident of the District	3.0%	8

Not Answered 15
Mean 5.408

Description:

16. Which Best Describes You? (more than one can be selected)

(Respondents were allowed to choose **multiple** responses)

Response Chart Frequency Count

A senior citizen (age 60 and older)		
	53.5%	**151**
A senior citizen with a disability	28.4%	80
A non-senior citizen with a disability	2.5%	7
A caregiver for a senior citizen	7.1%	20
A relative of a senior that needs care	9.2%	26
A neighbor of a senior that needs care	7.4%	21
I work as a provider of services to older persons. Describe:	5.7%	16
None of the Above Describe	4.3%	12

Valid Responses 282
Total Responses 282

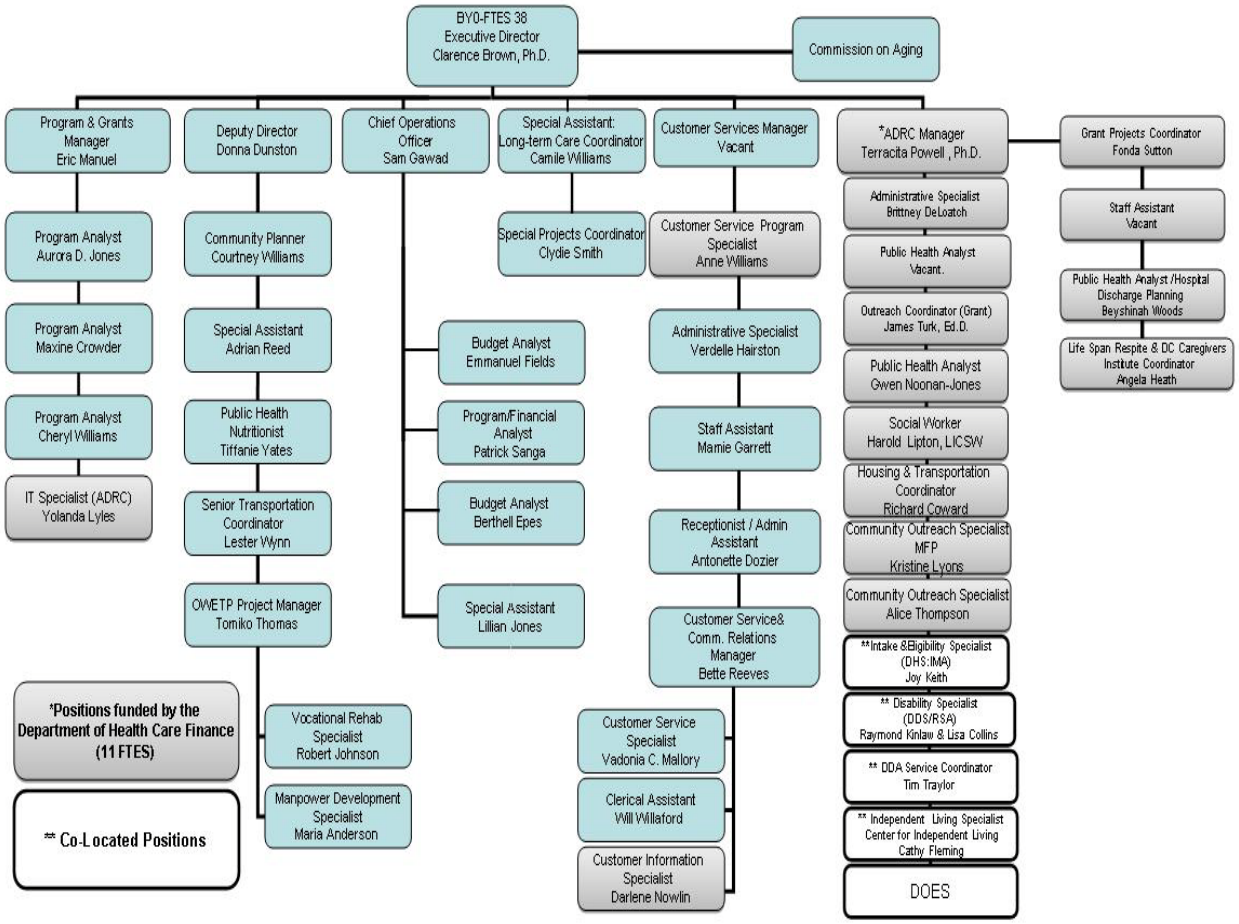
Additional Respondent Comments

-Seniors need to have much better housing, cheaper housing and more assistance with getting proper clothes and shoes for both men and women.
-Help for person with disability with lifting heavy household items or
-More police in the neighborhood
-Protect independent seniors from fraud -Discounted health service and coverage for other items.
-seniors in retirement community don't know about your services
-Affordable housing
-Job and job training
-Volunteer opportunities
-Literacy and counseling to seniors
-Computer literacy help
-Cell phone program
-Fraud awareness -Transportation for grocery shopping
-Better Street lighting in areas where seniors live
-Monthly activities for senior buildings.
-Mental agility programs
-Alternative medicine
-Ageism
-Some people with disabilities that re able could make added income without penalty
-Knowing my sexual orientation is unimportant because it has nothing to do with my health or activities or special events.
-More Transportation and food banks
-I was unaware of the services that you provided
-New to city and was unaware of the services. -I already have services listed by dcoa, so I marked them unimportant
-I know nothing about the ADRC programs -Special programs- sewing room, exercise room, arts and crafts, pool and chess for men
-More wheelchair vans

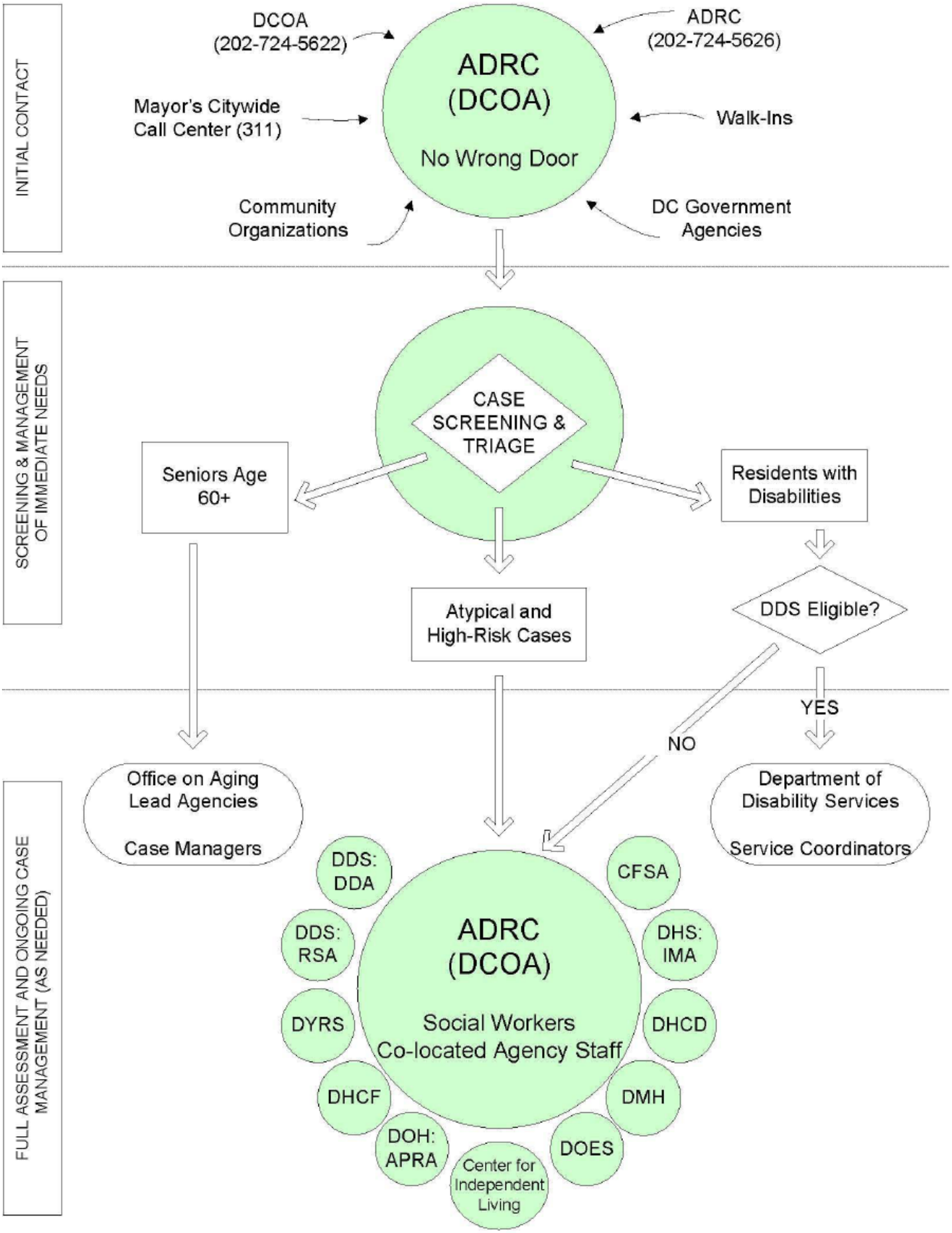
-Do not cut or reduce out meal and recreation, transportation and socialization programs at my building.
-More publicizing of availability of transportation particularly metroaccess
-Exercise in pool, dancing, large print
-Training for non related and relations care providers
-This survey made me more aware of the services that I might need.
-Find out about senior events at the last minute. -
Church activities, trips, special program visit on the telephone
-City need to learn how to shovel snow properly.
-Someone to shovel snow and cut grass.
-Need more social security- need a raise
-Aerobics and weight training
-More detail about your programs
-Provide more info to those from diverse communities -
Checking on seniors living alone regularly and in bad weather
-I feel people that need help and insurance don't pay (meals, cleaning and nursing)
-Seniors are important and I have been going to center regularly
-Long waiting list for Home repair and utility assistance
-Someone to do yard work
-Where to find Mental health services for elderly in the care of relatives
-Way for person to get into psych treatment unless they are violent or suicidal.
-A fear of being investigated because of the care who deemed improper.
-New wellness center concepts should be encouraged.
-More Yoga and exercise classes
-More involvement by police in neighborhood
-Better housing development for seniors with disabilities- wheelchair accessibility
-Free transportation to visit doctor

APPENDIX D

DCOA/ADRC Organizational Chart



APPENDIX E
DCOA/ADRC Service Model Flow Chart



APPENDIX F

INDICES OF SERVICES TO THE ELDERLY

Programs and Service

The District of Columbia provides a variety of comprehensive programs and services for senior citizens, primarily through the D.C. Office on Aging (DCOA), which administers funds under the federal Older Americans Act of 1965, as well as locally-appropriated funds. DCOA funds 20 public and private community-based non-profits, as well as local government agencies that operate 33 programs for senior citizens. These programs and services are crucial to allowing seniors to age in place in their communities and include counseling, and case management; congregate and home-delivered meals; in-home support for seniors and their caregivers; legal advocacy; assistance applying for public benefits; employment; transportation; housing assistance; senior wellness centers, geriatric day care; and special events. DCOA also provides oversight for the two city-owned nursing homes (J.B Johnson and Washington Center for Aging Services); and a food service operation that prepares and delivers meals to seniors throughout the city. The District has four Senior Wellness Centers, of which the latest opened in 2008 in Ward 4. Since 2008, DCOA has managed and operated the District's Aging and Disability Resource Center (ADRC) - a one-stop resource center - through an agreement with the Department of Health/Health Care Finance Agency.

Through the activities of the D.C. Commission on Aging, elderly residents participate in promoting, planning and assessing the District's senior services and programs. The Commission consists of 15 members appointed by the Mayor (and approved by the D.C. Council). The members serve as a citizens advisory group to the Mayor, the Council and DCOA. The Commission has sponsored a citywide intergenerational poster contest and participated in Office on Aging special events, forums and strategic planning for services. They also testified and lobbied on transportation, utilities, housing, crime prevention, fare increases, kinship care, and nursing home reform legislation affecting the elderly, as well as the DCOA budget.

Other District government agencies offering specific services to seniors in the District of Columbia include the DC Housing Authority, Metropolitan Police Department, DC Public Library, DC Housing and Community Development, DC Fire and Emergency Services, DC Department of Health, DC Department of Human Services, Office of Tax and Revenue, DC Parks and Recreation, Arts and Humanities Commission, Department of Motor Vehicles and the University of the District of Columbia.

Funding

In FY 2008, DCOA spending for programs and services was $24.8 million, of which $6.6 million was federal funding. DCOA and its grantee agencies served more than 28,956 clients in 2008. In 2009, with a budget of $26.9 million (including $6.9 million in federal funds), DCOA served more than 29,003 clients. Data from the new Client Service Tracking and Reporting System (CSTARS) show that the most requested service by seniors were counseling, congregate and home delivered meals, transportation, wellness services and case management. By comparison, the most utilized services were congregate and home delivered meals, wellness programs and transportation.

In FY 2008 the average age of the participants in DCOA programs was 79. About 74 percent of participants were women and 18 percent lived alone.

Table 1. Number of Clients Served

	FY 2008	FY 2009
Congregate Meals	3,927	5,159

Home-Delivered Meals	3,661	3,926
Transportation	1,662	2,018
Homemaker	490	465
Nutrition Counseling	423	876
Day Care	274	208
Case Management	1,396	2,269
Total Clients Served[i]	**28,956**	**29,003**

Source: D.C. Office on Aging Client Service Tracking and Reporting System (CSTARS)

Table 2. Units Of Services Provided		
	FY 2008	**FY 2009**
Congregate Meals	368,700	439,133
Home-Delivered Meals	601,139	508,739
Transportation	877,302	85,000
Homemaker	96,811	92,872
Nutrition Counseling	4,539	2,308
Day Care	89,843	77,864
Case Management	24,379	24,519

Source: D.C. Office on Aging Client Service Tracking and Reporting System (CSTARS)

APPENDIX G

District of Columbia Ward Map and Population Data by Ward and Age Cohort

POPULATION 60 YEARS AND OLDER BY AGE DISTRIBUTION based on 2000 CENSUS					
Age Range	**Total Persons 60+**	**60-64**	**65-74**	**75-84**	**85+**
Ward 1	7,727	2,062	2,957	1,943	765
Ward 2	8,346	2,155	3,212	2,104	875
Ward 3	13,454	2,990	4,630	3,961	1,873
Ward 4	16,906	3,532	6,654	4,978	1,742
Ward 5	15,021	3,112	5,890	4,537	1,482
Ward 6	10,579	2,685	4,257	2,765	872
Ward 7	13,059	3,208	5,378	3,428	1,045
Ward 8	6,788	2,236	2,942	1,288	322
TOTAL	91,880**	21,980	32,978	25,004	8,976

ESTIMATE OF POPULATION 60 YEARS AND OLDER BY AGE DISTRIBUTION 2008					
Age Range	**Total Persons 60 +**	**60-64**	**65-74**	**75-84**	**85+**
Ward 1	7,905	2,204	2,946	1,904	851
Ward 2	9,679	2,674	3,751	2,280	974
Ward 3	14,357	3,413	4,926	4,037	1,981
Ward 4	17,679	3,697	6,821	5,226	1,935
Ward 5	15,288	3,179	5,802	4,652	1,655
Ward 6	10,530	2,768	4,140	2,696	926
Ward 7	13,647	3,448	5,470	3,509	1,220
Ward 8	7,212	2,460	3,092	1,311	349
TOTAL	96,294*	23,844	36,946	25,613	9,891

Source: U.S Census 2000 and 2008 for the District of Columbia

APPENDIX H

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