

District of Columbia State Plan on Aging



Fiscal Years 2013 - 2015

provided by



District of Columbia Office on Aging

 Government of the District of Columbia
Vincent C. Gray, Mayor

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VERIFICATION OF INTENT

The District of Columbia State Plan on Aging is hereby submitted for Fiscal Years 2013 - 2015. The plan includes all assurances and plans to be conducted by the District of Columbia Office on Aging (DCOA) under provisions of the Older Americans Act of 1965 as amended in 2006 (Public Law 109-365).

The State Agency, named herein, has been given the authority to develop and administer the State Plan on Aging 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. For example, 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, accordingly, is hereby approved by the Mayor and constitutes authorization to proceed with activities under the Plan upon approval of the Assistant Secretary on Aging.

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

_____ (signed) _____
Date State Unit on Aging Director/
Executive Director, District of Columbia
Office on Aging

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

_____ (signed) _____
Date Mayor
Government of the District of Columbia

Executive Summary

Plan's Purpose

The District of Columbia State Plan on Aging is the blueprint for services to be provided through the Office on Aging and covers the next three years (October 1, 2012 to September 30, 2015).

The State Plan on Aging paints a clear picture of the District of Columbia Office on Aging (DCOA) roles and responsibilities, challenges and new focus. The plan will provide quality health and social support services to older adult residents 60 years of age and older under DC Law 1-24, and federal funding under the Older Americans Act (OAA) of 1965 (P.L. 89-73) as amended in 2006.

In 2008, DCOA, through a Memorandum of Understanding (MOU) with the Department of Health Care Finance (DHCF), began to manage and operate the Aging and Disability Resource Center (ADRC), a one stop resource for long-term care information, benefits and assistance which has expanded the agency's role to provide services to persons living with disabilities 18 years of age and older.

Senior Service Delivery System

DCOA administers the provisions of the Older Americans Act (OAA) through a Senior Service Network Providers (SSN) of twenty (20) community-based non-profit organizations through a competitive grant making and procurement process. Specifically, DCOA administers OAA core programs from Title III and Title VII that consist of thirty three (33) programs. Crucial to this network are Lead Agencies that offer a broad range of legal, nutrition, social and health services. The goal of these agencies is to enhance the quality of life for older adults and their families throughout all eight wards of the District of Columbia. The agencies accomplish this goal through widespread distribution of information about the variety of services and programs offered to seniors throughout the city and ways to access them.

Development of the Plan

The development process for the State Plan on Aging was initiated in fiscal year 2012, following the guidelines and program instructions issued by the U.S. Administration on Aging (AOA). Community leaders and stakeholders look to the DCOA for guidance in designing sustainable models of service, collection of data to assess critical needs, and to assure oversight and accountability of the service delivery system. The process for developing the State Plan on Aging included the input from citywide stakeholders inclusive of members of the DC Commission on Aging, the Senior Service Network, formal and informal caregivers, consumers, residents, advocacy groups and organizations, health and human services providers, community-based and nonprofit organizations, faith-based institutions, older persons living with disabilities, and many others (see Attachment B which outlines the community participation process).

DCOA's New Direction

Given the economic challenges nationally and locally, the State Plan will be consistent with the City's Budget Development principles. They are: (1) continue to prioritize strategic investments in education, public safety,

and workforce development; (2) protect our most vulnerable residents; (3) ensure a structurally balanced budget on use of fund balance; and (4) balance the budget with no new taxes or fees.

DCOA's new focus is to operate the agency like a State Unit on Aging and provide less direct services leaving this role to our SSN Providers. Additionally, DCOA's leadership believes in empowering seniors, persons with living with disabilities, and caregivers to make informed decisions so that they can remain in their own homes for as long as they choose. Fostering "empowerment" begins with seeking the recommendations, opinions and feedback of our older residents and persons living with disabilities. The DCOA works in partnership with community-based organizations and other stakeholders in order to provide the essential services that seniors and persons living with disabilities need.

The city has recently adopted a strategic framework entitled "Cradle to Career" which outlines the continuum of services and support for children through adulthood. Using this framework, DCOA is looking to adapt a "Career to Golden Years" framework to better prepare adults for their future outcomes which includes end of life decisions (see Attachment F).

Federal and State Cohesion

The DCOA strategic goals match those established by the AOA in its Strategic Action Plan for the years 2007-2013. The shared goals are listed below:

1. Make it easier for older adults to access and integrate an array of health, social supports and long-term care options.
2. Promote home and community-based support services for older adults and caregivers.
3. Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.
4. Ensure the rights of older people and prevent their abuse, neglect and exploitation.
5. Maintain effective and responsive management.

In the Plan, these goals are matched with shared goals, strategies and outcomes. They are:

- Objective A:** Enhance and expand the programs and services of the DCOA/ADRC to be integrated with core programs.
- Objective B:** Link underserved, special needs, populations to the appropriate Home and Community Based services.
- Objective C:** Improve seniors' utilization of technology devices.
- Objective D:** To provide caregiver support service and assistance to families.
- Objective E:** Provide person-centered care transition supportive services.
- Objective F:** Provide support to community based initiatives.
- Objective G:** Identify opportunities within the Affordable Care Act mandated program areas.
- Objective H:** Provide employment, training, placement, and volunteer opportunities to seniors.
- Objective I:** Support the Older Americans Nutrition Program service elements.
- Objective J:** Establish healthy aging and self-care wellness practices.

- Objective K:** Provide assistance and education to recognize, reduce, and prevent the abuse, exploitation and neglect of the elderly.
- Objective L:** Assist older persons with understanding public benefits and entitlements and their legal rights.
- Objective M:** Improve the quality of life and care for frail elderly residents of nursing facilities, assisted living and community residence facilities.
- Objective N:** Ensure accountability and delivery of superior service of SSN Providers.
- Objective O:** Prepare and respond to emergencies that affect the lives, health and safety of seniors.

Through these goals, objectives, strategies and outcomes, DCOA and its SSN Providers are moving towards a truly integrated system, which utilizes many entry portals. Internet access is crucial but does not stand alone. Information, advocacy and services will become easily accessible whether by phone, internet, or through person-to person contact. Peer-counseling and care management become important components. Client services provided through Medicaid waivers, while diminishing, remain a critical and important element of service to the most fragile and at risk.

Additional opportunities supporting entrance into a comprehensive community-based, long-term care system through “systems change” include: (1) Emphasis on integration of grantee/government agency/provider network with the ADRC; (2) Increased capability to assess client need based on reports generated by a service delivery data entry system; and (3) Opportunities made available through collaboration with Centers for Medicare and Medicaid Services (CMS) and U.S. Administration on Aging (AoA) regarding nursing home diversion and Money Follows the Person facilitation of consumer choice, more wide-spread use of evidence based strategies and implementation of performance-based business approaches to improve outcomes.

Challenges

Drafting this three-year State Plan continues to be challenging, due to the uncertain status of the local and national economy and the growing number of seniors in the city. The possibility of federal cuts in spending, as part of the legislative requirement to reduce the federal deficit, now poses the greatest risk to the District’s economic and fiscal outlook and negatively impact funding for the programs and service of the DCOA. Additionally, financial ripple effects from the ongoing European debt crisis, rising fuel costs, or a downturn in the still fragile national economy could all derail the District economic recovery. In addition to these economic factors, there is a growing need for basic necessities such as food, transportation and affordable housing for seniors and people living with disabilities in the District of Columbia.

Narrative

Mission Statement

The mission of the District of Columbia Office on Aging (DCOA) 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.

Vision

DCOA vision for the future embraces a strategic direction that incorporates past goals and objectives, new and innovative programs that consider trends and baby boomer needs, as well as programs that work harmoniously with existing ones to enhance outreach, advocacy and coordination of services, and meet the special needs of low income and multicultural populations.

District of Columbia Office on Aging

DCOA operates a comprehensive coordinated range of aging programs and services in Washington, DC, through a city-wide network of 20 community-based non-profit organizations (operating 33 programs) and two private sector businesses. The mission of DCOA is to advocate, plan, implement, and monitor programs in health, education, employment, and social services which promote longevity, independence, dignity, and choice for the city's elder citizens. The primary customers of DCOA are D.C. residents, 60 years of age or older. The DCOA works with other partners and stakeholders including:

- DC Commission on Aging
- Caregivers and families
- The Senior Service Network
- Disability Service Networks
- Senior advocacy groups
- Program participants
- DC residents
- Faith based organizations
- Civic and neighborhood associations
- Regional and federal agencies (CMS and Administration for Community Living)
- Gatekeeper organizations
- Senior villages
- Local hospitals
- Local nursing facilities and group homes
- District government city agencies
- Other nontraditional groups

In fiscal year 2012, the spending for services to the elderly under the auspices of the DCOA equals \$25.5 million, which includes \$16 million in District funds, \$8.1 million in federal funds, and \$1.3 in intra-district funding.

In 2013, the proposed DCOA budget is \$25.1 million, which includes \$16 million in District funds, and \$7.3 in federal funds, and \$1.6 in intra-district funds. This represents a 1.4 percent reduction versus FY 2012.

The elderly population has increased 5 percent since 2005. In 2011, 34,890 clients were served by DCOA and its grantee agencies. The most requested services by seniors were congregate and home delivered meals, in-home support, case management, assisted transportation, and health and wellness services. By comparison, the most utilized services were congregate and home delivered meals, wellness programs and transportation.

The aforementioned programs and services are crucial to allowing seniors to age in place within their communities. Additionally, the following services provide support for seniors to remain independent and age in place i.e. counseling, case management, caregivers support, legal assistance, advocacy, employment, group homes, one stop resource center, group housing, senior center activities, long-term care, and geriatric daycare. DCOA has food service operation vendors that prepare and deliver meals to seniors throughout the city. The agency has six senior wellness centers with an additional center expected to open within the current fiscal year.

In 2008, the DCOA through a MOU with the DHCF began to manage and operate the ADRC. The ADRC has expanded the agency's role to provide information, assistance, coordination and access for persons living with disabilities 18 to 59 years of age.

Legislative Authority

Legal Basis: DCOA is designated by the Mayor as the State and Area Agency on Aging under D.C. Law 1-24; therefore the DCOA is responsible for the administration of programs under the Older Americans Act. With this responsibility come the coordination and the development of the State Plan on Aging to receive federal funding under the Older Americans Act as amended.

D.C. Law 1-24, codified as amended at D.C. Official Code §§ 7-501.01 (2001) *et seq.*, states that 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.” D.C. Official Code § 7-501.01 (2001).

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 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.” DC Official Code § 7-503.01 (2001).

DC Law 1-24 as amended also established the Commission on Aging, a citizen's 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.

Local Statistics and Trends

The District of Columbia has a growing population of 617,996 residents. From 2010 to 2011, the Census reported that the District's population increased by 17,000 persons, stretching its already burdened health care resources. Numbers of older adult residents continue to increase. The population that is 60 years of age and older is now 101,787 (15 percent of total population), with 10,616 persons 80 years of age and older.

As often discussed in relation to the impending growth of the aging population due to baby boomers coming of age, the older population of the United States will more than double, bringing us to 76 million persons. They are the largest birth cohort ever born in the U.S. By 2030, all surviving baby boomers will be 66 to 84 years old and predicted to represent 20 percent (one in five) of the population at that time. In 2008, baby boomers made up 29.8 percent of the Districts' population, evidence of a critical need for all kinds of aging services necessary to foster the health of this burgeoning population group.

In its 68.5 square miles, the District of Columbia is comprised of a diverse population. The District's population trend reflects historical changes from 1950 through 2010. The total population declined continuously from 1950 through 2000, but began an upward trend since 2000 paralleling a robust economy with unprecedented commercial and residential construction. The senior population (65 years and over) generally rose in number and percent of the total population from 1950 through today.

In 1950, there were 56,687 (seven percent) District residents 65 years and older. Like the nation, the District has been aging. The senior population represents a larger share of the District's population today than 50 years ago, as persons 65 years of age and older are 11.9 percent of the total population. The number and percent of residents over 65 years of age are projected to increase exponentially by 2025, as the "baby boom" generation matures. Since 2006 (first year of the baby boomers turning 60), the population 60 years of age and older has been increasing by 1.6 percent each year. This is expected to continue to increase its proportion of the city's population for at least the next 15 years.

Presently, a typical senior in Washington, D.C. is a black female, 73 years of age living 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), utilizing or requiring 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/or have a chronic disability that may limit her activities of daily living.

The population 60 years since 2006 (first year of the baby boomers) has been steadily increasing almost 2 percent per year. If current city demographic trends continue the senior population will see the greatest growth from both ends of the age continuum; youngest seniors (age 60-69) and oldest (85 years of age and older) seniors. It is projected by 2015, almost 17 percent of the population could be at least 60 years of age and older, that is one out of every seven residents.

**DISTRICT OF COLUMBIA
POPULATION AND HOUSEHOLDS 60 YEARS OLDER, 2010**

Characteristic	Number	Percentage
Population 60 years +	98,512	100.0%
Population 65 years +	68,809	69.8%
Population 60+ Minority Non White	65,225	66.2%
Population 60 years+, African American	59,537	60.4%
Population 60 years +, Female	57,423	58.3%
Population 60 years+, Male	41,689	41.7%
Population 65+ with Disability living at home*	23,373	37.7%
Population 65 years+, Veteran*	12,068	17.1 %
Population 85 years +	10,315	10.4%
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	4,365	4.4 %
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	

2010 Official U.S. Census Count for District of Columbia

* 2008 American Community Survey for District of Columbia

In addition to using Census and Special Reports, DCOA recently conducted a Senior Needs Assessment Initial Data Collection Survey of seniors and stakeholders. The full report will be released in fiscal year 2012.

Abuse, Neglect and Financial Exploitation

The National Elder Abuse Incidence Study has shed new light on the significant problem with the finding that approximately 450,000 elderly persons in domestic settings were abused and/or neglected. When elderly persons who experienced self-neglect are added, the number increases to approximately 551,000. In the absence of a large-scale, national tracking system, studies of prevalence and incidence of abuse, neglect, and exploitation of older Americans conducted over the past few years by independent investigators have been crucial in helping to understand the magnitude of this problem. In 2010, the District of Columbia Adult Protective Services (APS) reported 856 cases of abuse, not inclusive of undocumented incidences. To help combat this problem the DCOA will be coordinating with APS to identify prevention and training projects to assist service providers, advocates and other elderly stakeholders.

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 years old and older use the internet. This represents a smaller number than the next-oldest group (70 percent of adults ages 50-64) and a significantly lower rate of internet adoption than the general population (74 percent).

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 percent of all adults). 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 (e.g., access to health information, decreased isolation and greater mental stimulation) and the ability to maintain their independence for longer periods of time.

Aging in Place Support

In many cases, older adults cannot afford to move. Nearly 75 percent of all Americans 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 millions of baby boomers start to retire, the number of people aging in place will swell as never before. The city offers many advantages for seniors. At many community meetings, long-time residents express the desire to stay in their neighborhoods, even when their primary residence is no longer suitable to their changing needs. Many seniors feel that they will have to move out of the city due to the lack of continuing care retirement community developments and lack of community support for their needs. Through the City’s Comprehensive Plan and “A Vision for a Growing Inclusive City” goals, objectives and policies should be adopted to make this a livable and desirable city for an aging population, i.e. making transportation affordable and accessible, improving and modifying street patterns and sidewalks, creating affordable housing, modernizing senior wellness centers, designing age friendly parks and open space, having access to arts and culture events. Making the city more age friendly and creating more senior villages will help older persons to age in place in their own communities.

Alzheimer’s Disease

Alzheimer’s is a progressive disease, where dementia symptoms gradually worsen over a number years. In its early stages, memory loss is mild, but with late stage Alzheimer’s, individuals lose the ability to carry on a conversation and respond to their environment. Alzheimer’s is the sixth leading cause of death in the United States and the fifth leading cause of death for those 65 years of age and older in Washington, D.C. The number is projected to increase by 10 percent by 2025. The DCOA is currently working with Alzheimer stakeholders in the city to create a five year plan.

Caregiving

More than 65 million people, 29 percent of the U.S. population, provide care for a chronically ill, disabled or aged family member or friend during any given year and spend an average of 20 hours per week, providing care for their loved one. Caregiving families (families in which one member has a disability) have median incomes that are more than 15 percent lower than non-caregiving families. In every state and Washington, D.C. the poverty rate is higher among families with members suffering from a disability than among families without. The District of Columbia Office on Aging (DCOA) and the Aging and Disability Resource Center (ADRC) are spearheading efforts to increase access to respite services and improve quality of respite care while making services affordable for caregivers across the lifespan. The project elements are adaptations of an award-winning consumer choice model and a successful national quality intervention. DCOA/ ADRC is 1) implementing a

Lifespan respite Flew Account system to address affordability barriers; and 2) fostering commitments to quality practices through the formation of the DC Respite Quality Campaign.

In addition, DCOA/ADRC and National Respite Coalition will co-facilitate the DC Respite Summit. This will be a working meeting to learn more about Lifespan respite, coalition building, and to enhance and find continued support for the coordinators within the District of Columbia's Lifespan Respite system.

Disability

The overall percentage (prevalence rate) of people with a disability ages 65 to 74 was 31 percent, i.e., 11,000 of the 37,000 individuals ages 65 to 74 years of age, in D.C. reported one or more disabilities. Among the six types of disabilities identified, the highest prevalence rate was "Physical Disability," at 24 percent. The lowest prevalence was for "Mental Disability," at seven percent. The overall percentage (prevalence rate) of people with a disability 75 years of age and older was 49 percent, i.e. 16,000 of the 32,000 individuals 75 years of age and older in D.C. reported one or more disabilities. Among the six types of disabilities identified, the highest prevalence was for "Physical Disability," at 40 percent. The lowest prevalence was for "Mental Disability," at 13 percent.

Federal Entitlement Programs

AARP Public Policy Institute reported that 74,000 of the District's older persons were Medicare beneficiaries, or 13 percent of the population, compared to 15 percent in the nation. For Medicaid enrollment, the combined elderly and disabled percentage for the District is 27 percent compared to 24 percent nationally.

The Medicare program currently covers 95 percent of our nation's aged population, as well as many people who are on Social Security because of disability. Medicare beneficiaries who have low incomes and limited resources may also receive assistance from the Medicaid program. For such persons who are eligible for full Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under the District's Medicaid program, according to eligibility category. 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, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always the "payer of last resort." The Medicare prescription drug benefit (2006) provides drug coverage for Medicare beneficiaries, including those who also receive coverage from Medicaid. In addition, individuals eligible for both Medicare and Medicaid receive the low-income subsidy for the Medicare drug plan premium and assistance with cost sharing for prescriptions. Medicaid no longer provides drug benefits for Medicare beneficiaries. According to AARP "Across the State Profiles of Long-term Care and Independent Living", 2009 report Medicaid expenditures for DC older residents and adults with physical disabilities were \$5,143 and for those under the Elderly and Physically Disabled Waiver (EPD) program was \$7,405.

Behavioral Health and Risk Factors

The Centers for Disease Control (CDC) funded a model telephone survey study that was used by the District of Columbia Department of Health's (DOH) Behavioral Risk Factor Surveillance System (BRFSS) for 2007-2008 of randomly selected adults within households in the District of Columbia. Results show the rates of persons 65 years old and older with arthritis, diabetes, high blood pressure, asthma, healthy weight, consuming fruits and the vegetables prevalence rates of smoking and drinking.

According to the survey study results:

- As age increased, the percentage of adults with arthritis increased; 3 percent of adults aged 18-24 had arthritis compared to 58 percent of adults aged 65 and older (52 percent) and aged 65 and over (53 percent).
- As age increased, so did the likelihood that adults had diabetes; 1 percent or less of adults aged 34 and younger had diabetes, compared to 20 percent of adults aged 65 and over.
- As age increased, so did the percentage of adults with high blood pressure; 10 percent of adults 34 years of age and younger had the disease, compared to 62 percent of adults 65 years of age and older.
- There is a steady increase in the percentage of adults who have high blood cholesterol starting at age 35 from 25 percent for adults 35-44 years of age, to 51 percent for adults 65 years of age and older.
- Between the ages of 18 to 54, the prevalence of asthma increased—8 percent for adults 18-24 years of age compared to 12 percent for adults 45-54 years of age. The prevalence of asthma for adults 55-64 years of age and 65 years of age and older was 8 percent.
- For the flu vaccine, as age increased, so did the likelihood that an adult had the vaccine within the past year; 27 percent of adults 18-24 years of age had the vaccine compared to 61 percent of adults 65 years of age and older.
- As age increased, the likelihood of adults being a healthy weight decreased; 57 percent of adults 18-24 years of age were of a healthy weight compared to 40 percent of adults 65 years of age and older.
- Adults 55-64 years of age were more likely to be overweight (38 percent), and adults 45-54 years of age were more likely to be obese (29 percent) as age increased, the likelihood of adults being obese.
- Adults 35-44 years of age were least likely than all other age groups to consume five fruits and vegetables or more servings per day, at 29 percent. This compares to 33-35 percent for all other age groups.
- As age increased, from 18 to 54, prevalence rates of smoking increased— 18 percent of adults aged 18-24 currently smoked cigarettes, compared to 21 percent of adults 45-54 years old. From 55-64 years old and 65 years old and older, prevalence rates of smoking decreased—20 percent of adults 55-64 years old smoked cigarettes, compared to 11 percent of adults 65 years of age and older.
- As age increased, the number of alcoholic beverages consumed on one occasion decreased. While only 28 percent of adults 18-24 years of age consumed one drink on average, 64 percent of adults 65 years old and older had done so.

Health Care and Chronic Disease

The rates of obesity, heart disease, diabetes, kidney disease, and cancer are predicted to continue to rise; and by 2013 an estimated 40 percent of the American population would be diagnosed with one or more chronic degenerative disease. Common behaviors such as sedentary lifestyles increase the risk of heart disease, high blood pressure, osteoporosis, diabetes, arthritis, and obesity. To compound these health trends cited below, in 2008, 11 percent (approximately 11,000) of adults 50-64 years old in the District of Columbia reported having no health care coverage.

HIV/AIDS

According to *DC Department of Health HIV/AIDS Epidemiology 2010 Annual Report* persons over the age of 50 accounted for a third (34.6%) of the 16,513 living HIV/AIDS cases in the District. Of that 1,480 or 9% 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 aging. By 2015, the majority of the persons living with HIV will be aged 50 and older. DCOA in collaboration with DC Department of Health has launched an HIV education and prevention targeting Older Adults. The campaign will be showcased at the International World AIDS Conference to be held in July 22-27, 2012 in Washington D.C.

Housing

Since 1999, there have been over 2,000 public and privately subsidized units reserved for seniors. The city now has over 50 apartment developments totaling over 7,000 units. Many seniors are aging in place in these facilities and will require in-home support services. According to D.C. Department of Housing and Community Development's (DHCD) Five Year Consolidated Action Plan for fiscal years 2011-2015, the goal for special needs housing for elderly, disabled and homeless is 895 units. There are four senior projects that are slated to develop over 200 units within the next three years.

The reduction in the number of the federal rental housing vouchers has greatly impacted seniors. In addition, over half of elderly homeowners live in homes over 30 years of age. Most do not have handicapped features or amenities, and are "house rich but cash poor." Twenty-nine percent (29 percent) of elderly headed households have incomes 80 percent below the area median family income.

Hospice

Hospice provides end of life care services of patients and their families who are faced with a life-threatening illness. They give medical, psychological and spiritual support. The goal of the care is to help people who are dying have peace, comfort and dignity in their environment of choice and/or appropriateness (home, hospice center, hospital or skilled nursing facility). The caregivers try to control pain and other symptoms so a person can remain as alert and comfortable as possible. 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 percent occurred at home.

Literacy and Educational Levels

Seniors who have lower educational level are often victimized because of their inability, to read, write, and comprehend, technological computer skills. This affects their ability to perform basic life skills and other activities of daily living. This is true for those who have little or no formal schooling.

Mortality

According to the DOH Vital Statistics in 2009, the five leading causes of death for DC residents aged 60 years and over were heart disease, malignant neoplasm (cancer), cerebrovascular diseases (stroke), chronic lower respiratory diseases (CLRD), and essentially hypertension. All of these diseases require expensive health care services and often older patients have more than one serious health care problem.

Transportation

All people, including the elderly, want to maintain their independent lifestyle and this means having

transportation options. A recent survey by the American Public Transportation Association determined that 82 percent of respondents 65 years of age or older are very concerned about becoming "stranded" and unable to travel short distances when they can no longer drive. According to 2010 Census, over one third (37 percent) of elderly in Washington, D.C. had no personal vehicle at their disposal. Many will require door-to-door and other forms of specialized transportation to get and from medical and other essential appointments as well as recreation and social outings. DCOA is doing a study that would assess the resources and deficiencies within the citywide transportation system. This project will be completed in 2012.

Results of Objectives for Previous State Plan, 2011-2012

From 2011-2012 and continuing to the present, DCOA continued to focus on areas of needs and concerns identified by staff and stakeholders. The plan focused on activities in the areas of in-home services, strengthening families, public safety, consumer assistance, long-term care, legal services, public and private partnerships, prevention and alternatives to institutional care, targeting and outreach strategies, health promotion/disease prevention, employment and new opportunities and initiatives. During the period of this plan several initiatives were started such as the program enhancement of ADRC and the Diabetes Self Management training was held.

In spite of a flat budget for the last few years, this agency was able through careful planning and strategizing, to meet or exceed over 80 percent of its goals and objectives. Additionally, the agency was able to service and accommodate those elderly residents most in need of supportive services. DCOA will aggressively seek new sources of funding to offset the reduction in local and federal dollars.

Expansion of Home and Community-Based Services

The expansion of home and community-based long-term care programs remains one of DCOA's key initiatives. As the numbers of District lower income, multicultural, older adults increase, along with multiple chronic health care needs, DCOA is committed to supporting and expanding long-term care services to prepare for the onslaught of the boomers and to serve its current residents and working with all of the offices within the state system to make the necessary action steps occur, for example our work with all emergency preparedness programs; and the Department of Health Care Finance.

Continuing its interest in keeping seniors healthy, the District has added one new Senior Wellness Center to the five existing centers. These wellness centers are community focal points for health and wellness activities.

In recent years, DCOA has noted trends in our evolving customer base that have influenced our choices regarding existing and proposed programs. For example, our staff throughout the District has reported stronger service- use by those who use English as a second language, gays and lesbians, veterans, the blind and hearing impaired and persons who are developmentally and mentally challenged.

Additional changes and improvements to services have set the stage for the continuing and the new objectives of the State Plan on Aging:

AoA Discretionary Grants and Enhancements such as:

- Chronic Disease Management Program
- Hospital Discharge Planning
- Options Counseling
- Life Span Respite
- .

Future Direction in Meeting Stated Goals

Several objectives have been developed to meet the five strategic goals established by the AOA in its Strategic Action Plan for the years 2013-2015. The objectives target measurable results of the programs and services listed in the summary section that support seniors along the health care continuum. The objectives are listed in measurable terms along with the strategies for accomplishing them and are listed under the primary goal that they support.

C. Goals, Objectives, Strategies and Outcomes

Goal 1: Make It Easier for Older Adults to Access an Integrated Array of Health Services, Social Supports and Long-Term Care Options.

DCOA is modernizing its long-term care system by integrating the ADRC at the community level. This new decentralization will assist senior residents with accessing services within their communities. Language, culture, transportation, access to technology and health literacy can be impairment to access.

Objective A:

Enhance and expand the programs and services of the ADRC to be integrated with DCOA core programs by:

Strategies:

- A-1 Enhancing the system of outreach to include two types of primary activities: (a.) publicity, screening and information on availability of services that will reach persons; and (b.) special efforts to identify isolated, impaired, high-risk, hard-to-reach older persons with the greatest social/economic need.
- A-2 Providing older residents, families, caregivers, and adults with disabilities and service professionals with appropriate information and resources that are designed to help them make informed health care decisions.

- A-3 Promoting the use of internet-based search tools for locating available services.
- A-4 Maintaining a list of informal support caregivers to distribute to seniors and disabled adults.
- A-5 Fostering and strengthening partnerships with partnering agencies to increase services at the ADRC.
- A-6 Holding SSN Intake Workers information sharing seminar quarterly.
- A-7 Developing and conducting an ongoing marketing campaign plan that would incorporate education, training and outreach.
- A-8 Facilitating bi-monthly meetings with Hospital Discharge Planners to ensure ongoing collaboration and exchange of information.
- A-9 Developing a sustainability plan for the Lifespan Respite Care Program.
- A-10 Ensuring representation at community fairs and other city events and events to increase awareness of ADRC services.
- A-11 Implementing the goals and objectives of the ADRC's Five Year State Plan.
- A-12 Facilitating and hosting periodic interagency group meetings to ensure ongoing collaboration and exchange of information between ADRC discretionary grants and DCOA core programs.
- A-13 Providing information and assistance to consumers and others on the Affordable Care Act and other health insurance options and changes.
- A-14 Facilitating the Healthy Aging Coalition Meetings which is a component of the Diabetes Self Management Program.
- A-15 Revising continuously the DCOA and ADRC web pages to incorporate immediate, interactive linkages with SSN agencies.
- A-16 Opening a community based ADRC satellite office in each of the eight wards.
- A-17 Conducting presentations on the Health Insurance Counseling Program (HICP) for seniors, caregivers and family members.
- A-18 Increasing and enhancing the health insurance counselor workforce by conducting a mini-grant training program at community-based organizations. 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.
- A-19 Conducting an outreach and publicity campaign targeting low and middle-income Medicare beneficiaries with the greatest need for assistance. The campaign will educate low-income Medicare beneficiaries of the financial assistance available to them.
- A-20 DCOA/ADRC and National Respite Coalition will co-facilitate the DC Respite Summit that build coalitions with the service networks.

Outcome(s):

- Reduction in re-hospitalization and premature institutionalization as a result of options counseling, care transition assistance, information and assistance and self advocacy.
- Enhanced system of outreach to include two types of primary activities: (a.) publicity, screening and information on availability of services that will reach persons; and (b.) special efforts to identify isolated, impaired, high risk, hard-to-reach older persons with the greatest social and/or economic need.

Progress/Status:

In the District 8,532 persons age 65 and older have a mental disability and 66,823 persons age 65 and over have some type of physical disability. 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. Last year, ADRC received enhancements to expand life span respite, caregiving services, option counseling and assistance, implemented an extensive marketing and outreach education, hospital discharge planning, interagency collaboration partnerships, marketing and outreach campaign and incorporated Older Americans core services information and assistance into its unit. This will expand greatly the number of persons that DCOA can assist. Also, continue to fund through the established HICP which 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 B:

Identify and link underserved, special needs populations to the appropriate home and community-based services by:

Strategies:

- B-1 Conducting Americans with Disabilities Act (ADA) training session updates with the SSN managers and staff
- B-2 Providing services, linkages and partnerships to services and programs for hearing and visually impaired seniors.
- B-3 Providing cultural competency training for service providers within the SSN on gay, lesbian, bisexual and transgender (GLBT) issues.
- B-4 Holding cultural competency Language Access Training to SSN service staff especially public contact personnel.
- B-5 Addressing the issues as outlined in the DC Alzheimer's State Plan with particular emphasis on those who are socially isolated and financially insecure.
- B-6 Providing service linkages to Veterans who are elderly and/or living with disabilities through the ADRC and collaborations with the Office of Veterans Affairs.
- B-7 Developing partnership collaborations and linkages with Mental Health Services Network.
- B-8 Continuing to provide language access services to English as a second language population through Language Access line.
- B-9 Continuing to hold town hall and community engagement meetings with Limited English Proficient (LEP) and Non English Proficient (NEP) communities.
- B-10 Providing HIV/AIDS culturally competency training for service providers within the SSN especially public contact personnel.
- B-11 Providing service linkages and collaborations for seniors living with HIV through partnerships with the Department of Health and the ADRC.
- B-12 Continuing to hold town and community engagement meetings about the issues with seniors and HIV.
- B-13 Expanding participation and role of SSN to be part of Department of Health's HIV Working Group.

- B-14 Co-sponsoring and participating the DOH HIV and Aging conferences and workshops.
- B-17 Working with the DC Center to identify collaborations that would increase older GLBT access and inclusion to services.
- B-18 Holding and participating in community meetings and outreach events with LEP and NEP language populations especially those languages that are required under the Language Access Law (Spanish, Chinese, French, Vietnamese, Amharic, Korean and French).
- B-19 Continue providing specific programs and services for LEP/NEP as identified as meeting three percent of the total population.
- B-20 Ensuring that the agency vital documents are in the different required languages.
- B-21 Collecting and updating unduplicated data by “language spoken” of DCOA Constituents in order to assess the effectiveness of DCOA programs and services for LEP/NEP populations served.
- B-22 Implementing an outreach plan to recruit bilingual employees for DCOA and its SSN.

Outcome(s):

- Individuals traditionally not served or underrepresented will have greater accessibility of available supportive services.
- Increased cultural competency among service providers.

Progress/Status:

DCOA recognizes the increased diversity within the aging population, and because of this will continue to look for innovative opportunities for addressing cultural and other special needs for staff recruitment, access to services, training, cultural competency and service delivery in the aging network.

DCOA continues to meet the requirements of the Language Access Law and our subsequent agency biennial plan which calls for staff recruitment, access to services, training, cultural competency, outreach and service delivery in the SSN. Currently, we are funding the Asian and Pacific Islander Service Center and the Vida Senior Centers to provide direct services to LEP/NEP communities citywide that represent at least three percent of the senior population.

Objective C:

Improve seniors’ utilization of technology devices by:

Strategies:

- C-1 Collaborating with the Office of the Chief Technology Officer (OCTO) on developing broadband wireless network services for senior public housing facilities.
- C-2 Establishing and maintaining a computer training program at the senior wellness centers.
- C-3 Maintaining a computer station with internet access in Older Worker Employment Training Program (OWETP) unit.
- C-4 Working with non-profit groups i.e. Byte Back, Jewish Council on Aging, AARP and DC Public Library to provide more training for seniors.

Outcome(s):

- Increase the availability of technology training opportunities available to the seniors.
- Increase the availability of computers to access information regarding aging services.

Progress/Status:

Continue to work with community-based organizations such as the DC Public Library and the University of District of Columbia to ensure seniors have access to information technology.

Goal 2: Promote Home and Community-Based Support Services for Older Adults and Caregivers.

DCOA is providing strategies, activities and outcomes that will 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.

Objective D:

To provide caregiver support service and assistance to families by:

Strategies:

- D-1 Providing case management services to caregivers through the Caregivers Institute.
- D-2 Recognizing caregivers by holding a caregivers’ reception annually during National Caregivers Month.
- D-3 Providing seniors with services through the Caregivers Respite Escort Transportation (CREST demonstration program).
- D-4 Strengthening the partnership with the Department of Human Services to support grandparents raising for grandchildren through its Kinship Navigator program.
- D-5 Advocating for the continuance of the Grandparents Subsidy Program which provides financial assistance to grandparents rearing grandchildren.
- D-6 Collaborating with community stakeholder agencies to strengthen caregiver coalition building efforts and develop infrastructure to support Lifespan Respite initiatives.
- D-7 Collaborating with local agencies and SSN to enhance public and private transportation systems citywide by exploring best practice models in other states, including funding resources.
- D-8 Providing caregivers with information and access, counseling, respite care and supplemental services to complement the care provided by funds supported by the National Family Caregivers Act.

Outcome(s):

- Creating advocacy and support around caregiver issues.
- Providing appropriate in-home services.

Progress/Status:

Since 2011, the District of Columbia has witnessed a fundamental change in its long-term care policy for caregivers. It is a transformation that is directed at giving more people better control over their care and providing greater support for those who are caregivers. Through the National Family Caregivers Act, ADRC is providing family caregivers information and access, counseling, respite care and supplemental services to complement the care provided by them.

Objective E:

Provide persons-centered care transition supportive services by:

Strategies:

- E-1 Providing case management services to frail and functionally impaired seniors.
- E-2 Maintaining four geriatric day care programs that include opportunities for intergenerational programming involving toddlers, youth, and frail elderly
- E-3 Offering four 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.
- E-4 Maintaining extended hours of operation at geriatric day care program for caregivers providing their own transportation who benefit from the flexibility of an earlier program opening or a later program closing.
- E-5 Providing home delivered meals through a new vendor.
- E-6 Providing home care services through homecare partners.
- E-7 Providing heavy housekeeping services (caregiver spring cleaning).
- E-8 Providing transportation assistance through the Caregivers Respite Escort Transportation Service Demonstration Program.
- E-9 Identifying and implementing best practices in assisting male caregivers with their preferable role as providing administrative support for loved ones.
- E-10 Collaborating with DC Mental Health, CMS and other entities with social workers to develop strong intern programs with area universities to help strengthen DCOA case management efforts.

Outcome(s):

- Decrease premature nursing home placement.

Progress/Status:

Efforts will be made to collaborate with home health agencies to develop cultural awareness and sensitivity to improve client satisfaction. DCOA continues to fund three adult day care programs that served over 200 seniors.

Objective F:

Provide support to community-based initiatives by:

Strategies:

- F-1 Working with community-based organizations in facilitating the development of new senior villages.
- F-2 Advocating and working with government agencies and community groups to identify goals and objectives to make the District of Columbia a more age friendly city.
- F-3 Developing and recruiting from groups and programs that may have youth and/or young adults as volunteers for DCOA special projects i.e. minor home repair and yard maintenance.
- F-4 Working with the Commission on Aging’s Intergenerational Poster Graphic Contest to raise public school participation.
- F-5 Developing a proposed public affairs program for public access television that focuses on home and community based services.
- F-6 Developing a strategy that will incorporate the “Career to Golden Years Partnership Success Roadmap” to provide support at different continuum for adults and seniors. (see Attachment F)

Outcome (s):

- Participating on the committees of partnering agencies and organizations.

Progress/Status:

At many community meetings, residents in Naturally Occurring Retirement Communities (NORC) expressed the desire to age in place in their communities. Making the city more age friendly in terms of land use, zoning, accessibility, etc., and developing more senior villages will help older persons remain in their communities. The DCOA has been engaged with city government as well as community groups to facilitate and advocate for these changes.

Goal 3: Empower Older People to Stay Active and Healthy through Older Americans Act Services and the New Prevention Benefits under Medicare.

DCOA is building capacity within the long-term care efforts in the District by increasing 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 under Medicare.

Objective G:

Identify opportunities within the Affordable Care Act mandated program areas by:

Strategies:

- G-1 Applying for available funding from the Affordable Care Act activities.
- G-2 Participating in meetings of the Insurance Banking Health Insurance Exchange Board and pertinent committee meetings, to monitor activities and evaluate the effect of Affordable Care Act benefits and changes on DCOA programming and planning.

Outcomes

- Enhanced services offered under the Affordable Care Act will provide underserved residents with access to preventive and cost effective health services.

Progress/Status:

DCOA is represented on the DC Health Reform Implementation Committee. We will continue to work with DC Department of Insurance Securities and Banking to provide outreach to the senior communities. DCOA will continue to leverage current funding by using existing data and reports that will support evidence based programs from other public and private resources.

Objective H:

Provide District residents 55 years of age and older with assistance in acquiring skills that meet employment market demands through government subsidized classroom training, on-the-job training (OJT), job search assistance, job development, and volunteer programs by maintaining and building on existing legislated programs by:

Strategies:

- H-1 Continuing to maintain, expand, and link the Older Workers Employment and Training Program (OWETP) with the Senior Community Services Employment Program to jointly enroll customers.
- H-2 Continuing to maintain a system to register and conduct employment intake and assessment of seniors recruited for the OWETP.
- H-3 Continuing to maintain a system to provide customers with vocational assessment, counseling and training through classroom instruction, and job search assistance.
- H-4 Continuing to maintain a system to develop employment opportunities to meet the needs of customers enrolled in program.
- H -5 Continuing to maintain a system of customer follow-up and participant monitoring, to improve the retention rate of customers placed in employment and/or job training.
- H-6 Maintaining a database system Client Services Tracking and Reporting System (CSTARS) that tracks the registration and service delivery of customers.
- H-7 Providing customers with vocational assessment, counseling, training, job search assistance, and employment opportunities.
- H-8 Expanding the pool of public partnerships with businesses or local agencies.
- H-9 Collaborating with the ADRC to provide joint services for seniors with disabilities who are seeking employment.
- H-10 Implementing and expanding a senior job club designed to offer ongoing support to seniors seeking employment.
- H-11 Developing and maintaining on-line access to OWETP by posting the intake application and other information related to seeking employment.
- H-12 Coordinating and collaborating with Court Services and Offender Supervision Agency (CSOSA) and other organizations that have wraparound services for ex-offenders.

Outcome(s):

- The seniors are offered opportunities for economic, professional and social growth, gaining independence and self-esteem. The city wins when people are gainfully employed.
- The unemployment rate decreases among the older worker workforce.

Progress/Status:

The OWETP provided placement, counseling, referrals and training to over 400 older workers. The DCOA is an active participant and partner with SERVE DC – The Mayor’s office on volunteerism, as outlined the 2010 – 2013 District of Columbia State Service Plan.

Objective I :

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:

Strategies:

- I-1 Continuing congregate meal services for eligible persons at strategically located nutrition sites in all eight wards of the city.
- I-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.
- I-3 Continuing weekend congregate meal services in at least one site.
- I-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.
- I-5 Conducting semi-annual follow-up nutrition screening and intervention for those eligible persons previously screened at high nutritional risk.
- I-6 Continuing to provide 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.
- I-7 To facilitate a working group of food and nutrition groups and advocates to enhance collaboration between public and private food resources citywide by exploring best practice models in other states.

Outcome(s):

- Preventing hunger for those who are at risk for nutrition deficiency.
- Providing a source to supplement senior’s dietary allowance.

Progress/Status:

Given the challenge of not having a permanent food vendor contract, we continue to provide 1,350 meals at 46 congregate meal sites and 1,200 meals daily to the homebound elderly.

Objective J :

Establish healthy aging and self-care, wellness practices by:

Strategies:

- J-1 Conducting lifestyle surveys at all wellness centers, to appropriately plan and to conduct programs
- J-2 Improving the fitness level and nutrition knowledge of seniors who participate in programs offered at the senior wellness centers.
- J-3 Measuring fitness levels and nutrition knowledge by a pre and post-test using the *Healthstyle Inventories* at participating senior wellness centers.
- J-4 Continuing to fund and operate six senior wellness centers.
- J-5 Implementing evidence based programs in all wellness centers
- J-6 Implementing HIV peer training program at senior wellness centers.
- J-7 Providing training programs to expand the train-the-trainer model of delivery for each evidence-based program.
- J-8 Holding in-service trainings and conference calls to respond to inquiries, provide program updates, foster mentoring relationship, share resources, and offer leaders an opportunity to network.
- J-9 Holding immunization clinics at wellness centers and other senior service centers.
- J-10 Facilitating health screenings such as cardio-vascular screenings, asthma, glaucoma, etc., at senior congregate housing and program sites.
- J-11 Promoting senior water aquatics programs through community-based organizations.
- J-12 Facilitating diabetes self-management workshops.

Outcome(s):

- The use of evidence-based programs that illustrate the positive impact of health and wellness programs on seniors well being.
- The use of evidence-based programs to reduce hospitalizations due to illnesses and diseases.

Progress/Status:

Last year, over 1,000 seniors attended senior wellness centers. The 123 persons have completed the Diabetes Self Management Training Program. The DCOA, in partnership with the DOH implemented a mass media campaign to educate seniors about their risks for HIV and AIDS.

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

To facilitate the integration of Older Americans Act, Title VII, Elder Rights Programs into SSNsystem by improving the identification and utilization of measurable consumer outcomes for elder rights programs and fostering quality implementation.

Objective K:

To recognize, reduce and prevent abuse, exploitation and neglect of the elderly by:

Strategies:

- K-1 Providing information to families, residents, and the community about the importance of reporting incidents of abuse and neglect.
- K-2 Convening regularly, the DC 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.
- K-3 Working with appropriate agencies to conduct a citywide campaign to prevent elder abuse.
- K-4 Conducting training sessions, workshops and other outreach campaigns through the Adult Abuse Prevention Committee and Long-Term Care Ombudsman program, to provide education and information about elder abuse prevention (including the Karyn Barquin Adult Protective Services Expansion Act of 2005 covering self-neglect).
- K-5 Continuing to partner with Metropolitan Police Department to train seniors for the Senior Citizens Police Academy as community ambassadors.

Outcome(s):

- Increase public awareness that will result in the number of reported cases of abuse, neglect and exploitation.

Progress/Status:

As the District's population ages, that portion considered frail, elderly and at-risk will grow. Consequently, there arises the susceptibility to physical, psychological and sexual abuse, self neglect or caregiver neglect and financial exploitation. The challenge for Adult Protective Services (APS) will be continuing to keep these individuals living independently while protecting their right of self-determination. The Elder Abuse Committee continues to provide training, workshops, conference, outreach campaign and advocacy for consumers and providers.

Objective L:

To assist older persons to exercise their legal rights and obtain public benefit entitlements by:

Strategies:

- L-1 Providing legal consultation services that addresses problems raised by seniors at various community sites.
- L-2 Informing and educating seniors of their rights, benefits, and legal services, through presentations, media events, and distribution of self-help and other materials.
- L-3 Holding community fraud workshops in conjunction with the DC Department of Insurance Securities and Banking and the Office of Attorney General.
- L-4 Providing information and assistance to local efforts to educate older citizens about tax relief programs, Medicaid rules, retirement planning, and long-term care insurance.
- L-5 Launching ADRC Benefits Checkups program.

Outcome:

- The number of seniors having more access to legal assistance.
- Increased awareness of their rights and benefits.

Progress/Status:

The DCOA continues to fund legal services to provide workshops and seminars.

Objective M:

To improve the quality of life and care for the frail elderly residents of nursing facilities, assisted living residences, and community residential facilities by:

Strategies:

- M-1 Providing nursing home and assisted living residents with a copy of a pamphlet about the Long-term Care Ombudsman Program.
- M-2 Visiting by Ombudsman to long-term care facilities and meet with residents on a regular basis.
- M-3 Providing Ombudsman contact posters and resident rights information to all long-term care facilities and encourage staff to prominently display them.
- M-4 Working with the media to inform the general public about long-term care resident rights and the Long term Care Ombudsman Program.
- M-5 Continuing to provide in-service trainings to long-term care provider staff.
- M-6 Recruiting, training and assigning volunteer ombudsman to all nursing homes and assisted living facilities.
- M-7 Presenting training seminars on long-term care and community-based services and rights that may affect institutionalized long-term residents with a focus to train volunteer advocates, paraprofessionals, professionals, Government officials, and the general public interested in long-term care.
- M-8 Investigating 100 percent of all problems or complaints from residents of nursing homes, assisted living, and community residence facilities.
- M-9 Fulfilling all requests for information about long-term care.
- M-10 Reviewing discharge notices from nursing homes and community residence facilities and challenging inadequate involuntary discharges.
- M-11 Advocating for quality care and the implementation of assisted living services for community-based and other in-home services and other options that enhance consumer choice through the ADRC, Money Follows the Person Program (MFP) and other relevant advisory committees (including nursing home and assisted living resident and family councils for input) to address improvement and systems change in long-term care.
- M-12 Maintaining and expanding an active long-term care ombudsman program that serves approximately 4,500 residents.

M-13 Transitioning persons back into the community through MFP Program.

M-14 Seeking funding source(s) for the implementation of the expansion of the long-term care ombudsman program into home health care that will provide advocacy (individually and systemically); investigations and resolutions to complaints of home health services; monitoring the quality of care and services provided in accordance with applicable District and federal laws; and, education to residents as to their rights as recipient of services.

Outcome(s):

- The improvement in quality of care and monitoring for nursing home, and community residential facilities residents and those who utilize home health care agencies.
- Track number of substantiated complaints received about long-term care facilities and the number of referrals and actual prosecutions of criminal cases.

Progress/Status:

Investigations have shown that the chief causes of neglect in long-term care facilities are due in part to low staffing levels and inadequate staff training. Also, the incidents of financial exploitation by family and or friends continue to increase. Most of the complaints for financial abuse come to the DCOA. DCOA will continue to work with the Long-term Care Ombudsman Office on such cases.

Goal 5: Maintain Effective and Responsive Management.

Promoting best management practices, including the use of performance-based standards and outcomes within the SSN and supporting agencies that are administering emergency preparedness and response for older people.

Objectives N

Ensure accountability and delivery of superior service of SSN providers under the Older Americans Act by:

Strategies:

- N-1 Sharing with service providers and encourage the use innovations and best practices in service delivery and outsourcing.
- N-2 Holding community engagement meetings with seniors as well as clients of service providers.
- N-3 Supplying technical assistance on fiscal issues and other topics.
- N-4 Holding monthly project directors meeting to share and address issues.
- N-5 Offering assistance to AAA staff and their service providers as they manage their work to ensure accurate and timely data collection through the use of CSTARS software.
- N-5 Providing training by subject matter experts on a variety of topics, including Information and Assistance, Care Management, Language Access and Cultural Diversity.

- N-6 Reviewing and updating agency adherence to grant requirements
- N-7 Conducting desk review of the required documentation and perform an onsite assessment visit to each provider every year.
- N-8 Conducting additional on-site assessments as necessary.
- N-9 Completing e-post-assessment activities: i.e., review agency corrective actions, provide technical assistance, and prepare final assessment letter and report.
- N-10 Monitoring agency spending and reviewing agency's annual official audit.
- N-11 Implementing ADRC Consumer Flow Chart (see Attachment E)
- N-12 Keeping community and government stakeholders informed about current news and issues through a biweekly E- Blast and the monthly Spotlight on Aging newsletter.

Outcome(s):

- Ensuring that the SSN are providing superior and innovative services to customers.
- Improved lines of communication between the service providers and DCOA.
- Trained personnel in new and innovative best practices in aging.

Progress/Status:

Ongoing support and training for the SSN agencies is critical to ensure the best possible service delivery for District of Columbia seniors their programs and services under the OAA. There have been new management changes of providers over the past few years. DCOA will continue to provide orientation, ongoing in-service training, on-site assistance and information exchange, to help new agencies implement best practices for effective service delivery. As part of the annual process, each service provider completed an evaluation of the agency's performance and identified areas for improvements. Feedback was valuable. Through onsite visits, quarterly and year end annual performance and financial reports, the office can track the service provider and their progress in meeting the objectives outlined in their grant or contract.

Objectives O:

To prepare and respond to emergencies that affect the lives, health and safety of seniors by:

Strategies:

- O-1 Encouraging seniors, through website postings, newsletters and other methods, to enroll in DC Alert, emergency alert email and texting system.
- O-2 Working with service providers to establish and maintain local databases of vulnerable individuals who may need special assistance in an emergency.
- O-3 Providing shelf-stable meals to those participating in the home delivered meal program for use during an emergency.
- O-4 Continuing to hold training sessions for SSN agencies on emergency preparedness.
- O-5 Reviewing on a yearly basis the emergency plans of our 20 SSN agencies.
- O-6 Continuing to participate in the Homeland Security and Emergency Management Agency (HSEMA) task force and work groups in identifying and responding to seniors at risk in emergencies.
- O-7 Continuing to update HSEMA weather emergency and response plans as it relates to seniors.
- O-8 Facilitating pilot program with Department of Youth Rehabilitation Services (DYRS) for

emergency snow removal and grass cutting services for seniors.

O-9 Continuing to participate in DOH's Health Emergency Preparedness Response Administration (HEPRA) Points of Dispensing (POD) Initiative.

O-10 Continuing to participate in Department of Human Services Mass Care Work Group.

O-11 Coordinating workshops, seminars and events with Senior Citizens Police Academy.

Outcomes(s):

- SSN and elderly stakeholders are better prepared in emergencies.
- Elderly stakeholders are registered with the DC Alert.

Progress/Status:

The DCOA continues to participate in HSEMA committees, as part of the emergency response team and training to help better prepare to respond to natural disasters and other emergencies. DCOA will continue to make sure that our SSN providers have operable business contingency plans to be implemented during emergencies. In addition, we will continue to encourage their participation in shelter simulation and disaster drills; distribute information on preparedness to seniors; and participate in other citywide initiatives such as DC Alert, 311, and snow removal, grass cutting, etc.

Appendix

Attachment A

FY 2012 State Plan Guidance, Assurances, Required Activities and Information Requirements

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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

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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;

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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.

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(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

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(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

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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.

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(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.

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- (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

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Attachment B

Community Participation in the State Plan Development Process

DCOA hosted several community meetings in different quadrants of the city. The meetings were informative and provided valuable information that aided the development of this plan.

Public Input Meetings on Aging on the State Plan on Aging

DCOA hosted with the DC Commission on Aging numerous community meetings on the Draft State Plan on Aging. The meetings commenced in April and concluded in June at various locations. Over 300 persons attended these meetings.

April 11 at Cleveland Park Library
April 13 at Anacostia Library
April 26 at Martin Luther King Jr. Memorial Library
May 7 at Bernice Fonteneau Senior Wellness Center
May 14 at Asian Service Center
May 16 at Hattie Holmes Senior Wellness Center
May 22 at Washington Seniors Wellness Center
May 23 at Model Cities Senior Wellness Center
May 24 at Vida Spanish Senior Center,
June 5 at Congress Heights Senior Wellness Center

At the public meetings, DCOA received comments and completed surveys detailing the importance of continued funding for programs and services for older adults. Representatives from District agencies, public and private community-based organizations and federal agencies as well as the general public attended the meetings.

At these meetings issues were raised and the following recommendations were made.

Issue: More awareness and choices for residents on end of life and hospice care is needed?

Recommendation: Educate and advocate for end of life options in community-based services to prevent isolation and enable older Washingtonians to stay involved in their communities.

Issue: Lack of transportation for seniors who want to come to attend special events and other activities and meetings.

Recommendation: Utilize local companies to provide transportation services to fill in the gaps.

Issue: Seniors and the Digital Divide:

Seniors are afraid of using the internet. In some instances it may have to do with the literacy rate of the senior.

Recommendation: Recognition of the literacy gaps among seniors and adapting a special program to deal with seniors with lower educational level. Offer assistance to seniors with using computers and navigating the internet.

Recommendations: Expanded internet access particularly to those in senior housing and other dwellings.

Recommendations: Approach GSA and other computer providers to provide computers for seniors

Recommendation: Recognize some seniors will not ever use the internet and explore other ways for them to get assistance with the internet. (i.e., intergenerational connection)

Recommendation: Offer specialized literacy programs for seniors using the computer as well as to address senior literacy issues. Many seniors have difficulty in filling out applications.

Issue: Public Awareness of Programs and Services available to seniors.

Recommendation: Develop a cable show on public access or DC Government channel on aging.

Issue: Make GLTB (Gay, Lesbian, Bisexual and Transgender) feel more comfortable when accessing programs and services?

Recommendations: Service Providers to be more culturally competent and service friendly towards GLTB.

Issue: How do we address the growing number of seniors impacted by HIV and AIDS?

Recommendations: Working closely with service providers and have ongoing campaigns targeting seniors most at risk, for example those living in the senior apartment buildings.

Issue: How do we increase public awareness of different issues that impact seniors?

Recommendation: Designate a month and focus on a specific issue throughout the month.

Issue: How to address the issue of employment and housing of older residents returning from prison?

Recommendations: Better coordination with other groups and organizations that have wraparound services.

Topic: Lack of development of senior housing throughout the city?

Recommendations: Advocate for more senior housing and look at other housing choices for seniors to reside in the community.

Topic: Seniors Utility and Energy Assistance

Recommendation: More attention to seniors who may be experiencing symptoms of early stages of dementia. More assistance is needed to assist seniors in money management counseling and to assist seniors who can pay utilities and other household bills.

Recommendation: Direct seniors to Legal Counsel for Elderly Services such as property tax assistance, foreclosure, tenant advocacy, elderly buddy program, etc.

Recommendation: Make more social workers, case management and gateway services available to assist the growing number of homebound and vulnerable seniors.

Recommendation: Better connection with lead agency is needed.

Issue: The status of the waiting list for homebound meals?

Recommendation: Work on eliminating the waiting list as soon as the contract is approved as soon as the contract is approved.

Issue: How can the senior village be tied into on the end of life care?

Recommendation: By establishing more villages that can assist individuals with end of life care.

Issue: There are not enough resources for the HCB Medicaid Waiver Program? Increase the number of hours needed for a person to stay in their own homes?

Issue How can the Office on Aging address projected increases in the aging population?

Recommendation: Looking at best practices and identify other resources to assist the elderly like the senior village.

Issue: Making the community aware of what the ADRC provides.

Recommendation: Make sure that information on resources is current.

Comment: that ADRC will have community satellite offices that will help in spreading the word.

Issue: More Employment opportunities are necessary for experienced workers

Issue: The need to establish a working group to deal with congregate sites.

Issue: The monitoring of the home health care agencies.

Recommendations: DCOA should seek funding sources for the implementation of the expansion of the long-term care ombudsman program into home health care.

Issue: Recognize the needs of Baby Boomers and the differences.

Issue The need for better space in Public Library and Parks and Recreation facilities

Issue: Better communication with Front line workers in distribution of information.

Recommendation: A suggestion box at each location to capture comments and complaints.

Issue: The need to expand aquatic programs throughout the city for seniors

Issue: Better coordination and inter-agency cooperation in the delivery of services to older residents;

Issue: Cultural competency for home health care workers

Issue: Look at the idea of Cluster Care in Senior Buildings for home health aides.

Issue: Better interagency response and timeframe for emergency situations such as seniors in distress, hoarders, etc.

Recommendation: Develop a Memo of Understanding between Office on Aging, Adult Protective Services and others that will help expedite response time.

Issue: The need for extended hours at wellness centers- evenings and weekends particularly for those who work.

Issue: The need for more affordable housing

Issue: The waiting list for home delivered meals.

Issue: Transportation assistance for groups trips in and outside of city

Issue: The waiting time to get transportation assistance.

Issue: The assistance with legal problems and concerns

Issue: Help for seniors who don't qualify financially for in-home services;

Issue: Greater variety of daily activities at senior nutrition centers

Issue: The quality of the food at the different sites.

Issue: Addressing the complaints about home health workers and their agencies.

Issue: The Seniors with mental illness and declining health at wellness centers

Issue: More Services for caregivers

Issue: Help for seniors who don't qualify for government assistance.

Issue: Outreach to find and identify isolated seniors living alone at home.

Issue: Help with home repairs and lawns

Issue: Snow removal assistance for frail isolated seniors.

Issue: Sensitivity training of staff at centers.

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

NOTICE OF STATE PLAN PROCESS

The media and mailings to stakeholders were used to make persons aware of the State Plan process. In addition notices were sent directly to organizations and groups such:

Civic Associations

Advisory Neighborhood Commissions

City Agencies

Church Groups and Ministries

Mini Commission on Aging Members

AARP local chapters

Senior Social Clubs

Senior Apartment Tenant Building Associations

Senior Clubs and Centers

Senior Service Network Agencies

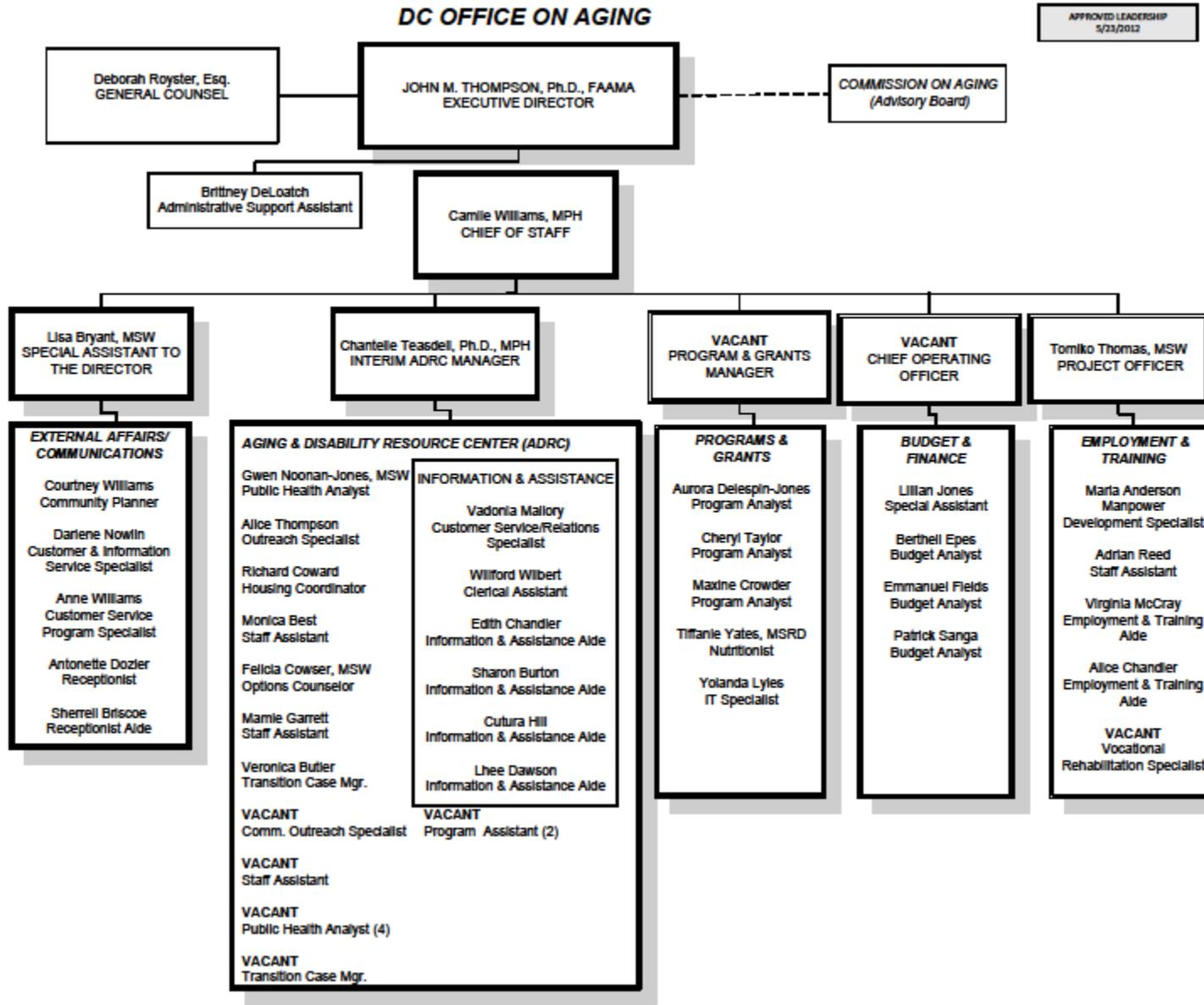
Health Care Facilities and Agencies

The survey and notices of meeting was also distributed at community health fairs and special events. Through these contacts we were able to reach several thousand persons.

Attachment C

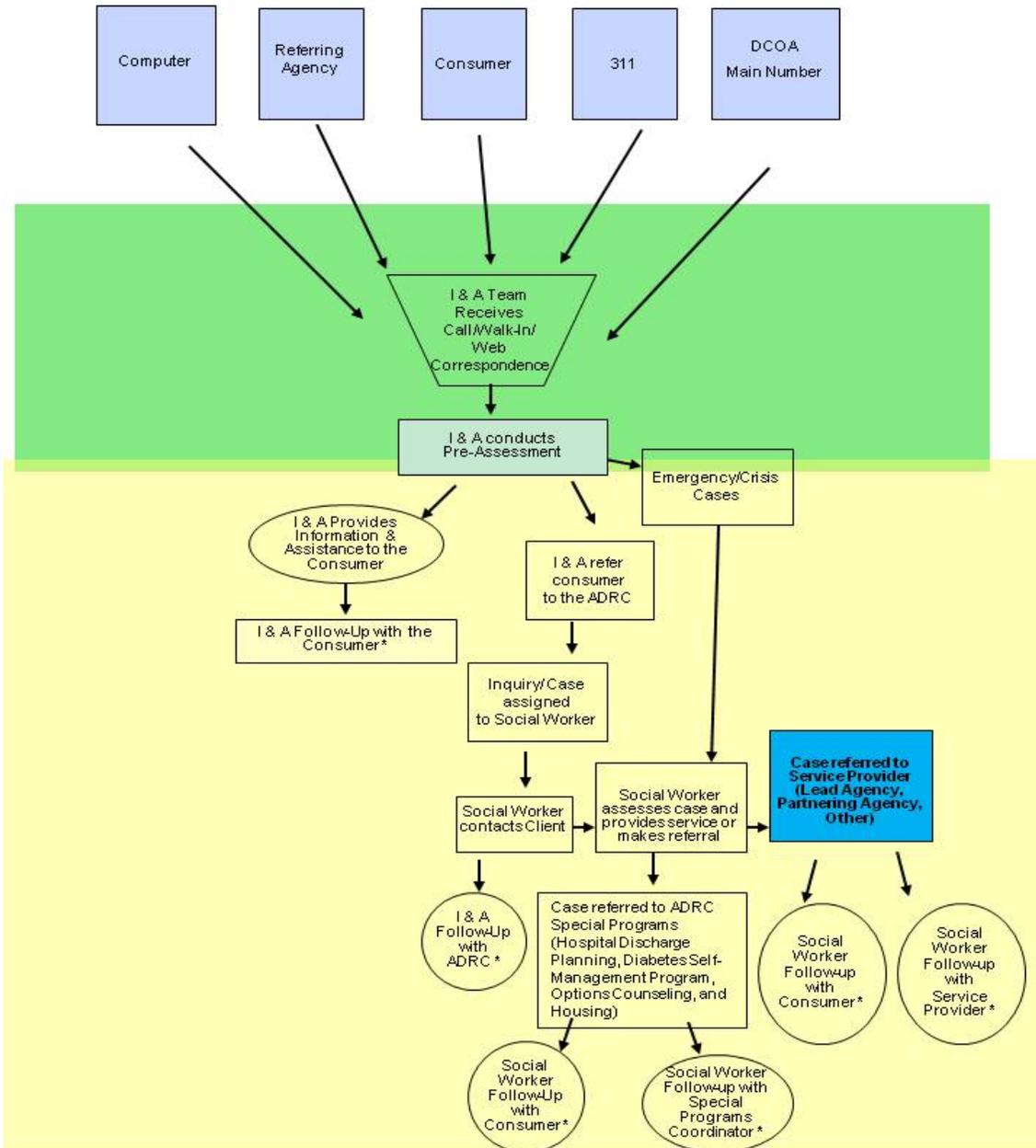
Attachment D

DCOA Organization Chart



Attachment E

DCOA/ADRC Consumer Flow Chart



*All follow-up will be made within 24 to 48 hours

Attachment F

Career to Golden Years Roadmap

Vision		Healthy, thriving, empowered, independent seniors.						
Mission		Advocate and ensure that seniors are aware and linked to cost effective long-term care services and supports that promote longevity and independence during their golden years.						
Goals	Every working adult will work towards eating healthy, being physically active, being financially prepared for retirement and will engage in estate planning.	Every working adult 50+ and new retiree will be educated about preventive health measures, long-term care services and supports (LTSS), long-term care insurance, Medicare, and resources for caregiver support.	Every senior will have access to resources to aid them in maintaining a productive, independent lifestyle.	Every senior newly diagnosed with a chronic disease will be offered training to manage the progression of the disease through a self-management program.	Every vulnerable senior will be linked to home and community-based services to assist the individual with aging in place and to remain as independent as possible.	Vulnerable, hospitalized seniors or seniors residing in nursing homes will be linked to a community transition program to prevent premature institutionalization and help them regain independence.	Every vulnerable senior who is unable to remain safely in the community will be linked to institutional care.	
Outcomes	Baseline: ____% of people saving for retirement ____% of working professionals engaged in nutrition education and/or physical fitness programs Target: TBD	Baseline: ____% of working adults 50+ aware of LTSS ____% of new retiree aware of LTSS ____% of employers receiving LTSS and other pertinent information from DCOA	Baseline: ____% of seniors attending wellness centers ____% of seniors receiving vascular screenings ____% of seniors receiving eye screenings ____% of seniors receiving ear screenings ____% of seniors participating in volunteer opportunities ____% of seniors gaining employment via the OWETP ____% of seniors who are socially isolated ____% of seniors connected with a senior village ____% of seniors requiring medical transportation ____% of seniors participating in nutrition programs ____% of seniors abused, neglected, and exploited ____% of seniors with high school diploma ____% of seniors with college education ____% of seniors employed	Baseline: ____# of seniors completing a CDSMP or similar program ____# and % of adults (by age categories) diagnosed with arthritis ____# and % of those (by age categories) who report that "During the past 30 days, to what extent has your arthritis or joint symptoms interfered with your normal social activities, etc." ____# and % of residents (by age categories) who have been diagnosed with cancer ____# and % of residents (by age categories) who report that they "have you ever taken a course or class in how to manage your diabetes yourself?"	Baseline: ____ Average length of time to secure home care services for seniors including DCOA funded homemaker services, Medicaid PCA services, private pay services, and/or community hospice services ____ Average length of time to secure EPD waiver services for seniors ____% of seniors on the homebound meal program	Baseline: ____% of seniors linked to the hospital discharge planning program ____# of Moneys Follow the Person participants ____# of residents referred by nursing home discharge planners to the ADRC through the Minimum Data Set (MDS) Section Q request for community transition	Baseline: ____ Average age of seniors admitted into nursing homes	
Measurement Tools/Sources	Department of Labor, Social Security Administration, U.S. Securities and Exchange Commission, AARP, American Savings Education Council, Certified Financial Planner Board of Standards, Consumer Federation of America, and The Investor's Clearinghouse	District of Columbia Office on Aging, Department of Health Care Finance, Children and Family Services Administration, and the Department of Youth Rehabilitation Services	District of Columbia Office on Aging, Department of Health Care Finance, Adult Protective Services, Metropolitan Police Department, and the U.S. Attorney's Office	District of Columbia Office on Aging and the Senior Service Network Department of Health Care Finance, and the Department of Health's BRFS (Behavioral Risk Factor Surveillance Survey)	District of Columbia Office on Aging, Department of Health Care Finance, and District of Columbia Department of Health.	District of Columbia Office on Aging, Office of Disability Rights, the Centers for Medicare & Medicaid Services, District of Columbia Health Care Association, District of Columbia Hospital Association, District hospitals, and DelMarva	District of Columbia Department of Health Care Finance, Centers for Medicare & Medicaid Services, Long-Term Care Ombudsman Office, and District of Columbia Department of Health's (DOH) BRFS (Behavioral Risk Factor Surveillance Survey)	
(Example) Contributing Indicators	<ul style="list-style-type: none"> Working adults will receive outreach materials about preparing for retirement Working adults will attend a pre-retirement seminar on "Planning for Your Future: Retirement" Working adults will learn about senior villages and will be recruited as volunteers Working adults will be provided with information on the benefits of obtaining long-term care insurance as a long-term care solution purchase long-term care insurance Stakeholders will receive a report on long-term care services and supports options through BenefitsCheckUp The District government and the Federal government will offer long-term care insurance to their employees. 	<ul style="list-style-type: none"> Working adults and new retirees will receive outreach materials about long-term care services and supports and will be invited to a seminar on the topic Working adults and new retirees will learn about senior villages and will be recruited as volunteers Recent retirees will receive materials about part-time jobs and volunteer opportunities Employers will assign dedicated staffs to handle long-term retirement cases (i.e., seniors who have been retired 30-40 years) to ensure that seniors have access to appropriate documentation District and federal government offer employees long-term care insurance 	<ul style="list-style-type: none"> Percentage of seniors prematurely placed into institutional settings Percentage of seniors on the homebound meal program Percentage of seniors without a primary care physician or access to healthcare and wellness service options Types of barriers preventing seniors from leading active, quality lives Grandparents raising grandchildren will be linked to support services Recent retirees will receive materials about part-time jobs and volunteer opportunities Seniors will receive a report on long-term care services and supports options through BenefitsCheckUp Formal educational offerings and ongoing training programs will be made available to seniors Increase the public's awareness about fraud, abuse, 	<ul style="list-style-type: none"> Percentage of seniors unsuccessful in controlling their chronic disease tracked by hospital readmissions for the same diagnosis Percentage of seniors who are not participating in a CDSMP Seniors will receive a report on long-term care services and supports options through BenefitsCheckUp Average age of seniors living independently Participant satisfaction surveys assessing quality of rendered services 	<ul style="list-style-type: none"> Average length of time for seniors to secure HCBS Percentage of seniors waiting for HCBS and who are socially isolated Number of seniors who are prematurely placed into nursing homes Seniors will receive a report on long-term care services and supports options through BenefitsCheckUp Participant satisfaction surveys assessing quality of rendered services 	<ul style="list-style-type: none"> Percentage of seniors readmitted to hospitals within 90 days post hospital discharge for the same diagnoses Seniors will receive a report on long-term care services and supports options through BenefitsCheckUp Percentage of seniors in nursing homes Participant satisfaction surveys assessing quality of rendered services # of MDS Section Q participants successfully transitioned into the community 	<ul style="list-style-type: none"> # of seniors who are prematurely admitted into institutional settings Avg. age of seniors admitted into an institutional setting Participant satisfaction surveys assessing quality of services The DOH's State Health Planning and Development Agency has authority to survey health care utilization services of all health care providers in the city. The Agency could routinely survey hospice facilities for use by District residents to ensure proper linkages to care. 	
High level of independency								High level of dependency

Attachment G

OFFICE ON SERVICES AND PROGRAMS

During the next three years, DCOA will continue to support these goals and strategies during the next three years which identify older person's needs by four program categories: the dependent elderly, the semi-independent elderly, the independent elderly, and staff training, planning and monitoring. Listed below are highlights by each of the four categories. Programs that offer these services along with strategies, incomes and performance measures are discussed in detail later in the report. Note that many services cross-cut categories and are asterisked, but are only listed once.

1. Services for the Dependent Elderly

- Access *
- Advocacy for those 60+*
- ADRC*
- Elder abuse and neglect
- Home health aides*
- Nursing Home Advocacy and Services

2. Services for Semi-Independent Elderly

- Adult Day Care Programs
- Companion & Respite Care for Caregivers *
- Counseling and Case Management Services*
- District of Columbia Caregivers' Institute*
- Health Insurance Assistance*
- Home bound and Congregate Meals*
- Independent Living Skill Training for Visual and Hearing Impaired*
- In- Home Support*
- Light and Heavy Housekeeping
- Special Needs Services for Persons Living with Disabilities*
- Transportation*

3. Services for the Independent Elderly

- Access and Training for Information Technology*
- Later Life Learning and Educational Opportunities
- Discount Drug Information*
- Employment Training and Placement
- Health and Wellness Activities*
- Emergency Group Housing*
- General Information and Technical Assistance*

- Lead Agency Support
- Legal Assistance
- Money Management*
- Nutrition Counseling and Education*
- Outreach and Advocacy*
- Recreation and Socialization Activities*
- Limited English Proficiency (Spanish and Asiatic Languages) Outreach and Services*
- Volunteer Opportunities*
- Senior Wellness Centers Activities and Services*
- Housing Assistance

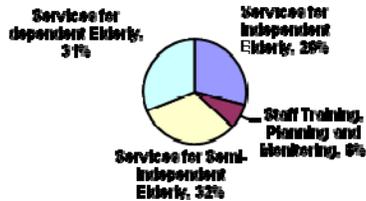
4. Staff Training, Planning and Monitoring

- Automated Client Information Sharing System
- Boomer Services Planning and Implementation
- Outreach to At-Risk Seniors
- Planning and Implementing Special Events (Workshops, Meetings, Fairs)

APPENDIX H

INDICES AND POPULATION STATISTICS

Figure 5.1. Percentage of Dollars Spent FY 2010



SOURCE: The DC government publishes INDICES - A Statistical Index of District of Columbia Government Services, every two years. The primary goal of INDICES is to provide a snapshot of government operations.

Table 7.8. Number of Persons Receiving Services in FY 2010

Persons Served	35,107
Counseling	6,676
Congregate Meals	5,098
Transportation	3,831
Homemaker	428
Home-Delivered Meals	2,661
Wellness Services	1,934
Geriatric Day Care	190
Comprehensive Assessment and Case Management	2,437
TransEscorts	2,003
TransSites	2,540

Source: FY'09-10 DCOA Client Service Tracking and Reporting System (CSTARS)

Table 7.9. Units of Services Provided in FY 2010

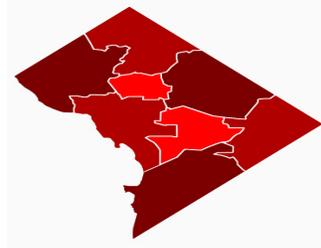
Counseling	97,315
Congregate Meals	389,462
Transportation	104,769
Homemaker	81,351
Home-Delivered Meals	501,324
Wellness Services	302,496
Geriatric Day Care	95,863
Comprehensive Assessment and Case Management	

Management	26,154
TransEscorts	80,447
TransSites	342

Source: FY'09-10 DCOA Client Service Tracking and Reporting System

SOURCE: The DC government publishes INDICES - A Statistical Index of District of Columbia Government Services, every two years. The primary goal of INDICES is to provide a snapshot of government operations.

**DISTRICT OF COLUMBIA POPULATION 60 YEARS AND OLDER BY AGE
GROUPS BY WARDS
2010 CENSUS**



Ward	60yrs+ #	60 yrs+ %	60-64	65-69	70-74	75-79	80-84	85 yrs+
1	8,091	8.2	2,711	1,922	1,303	825	684	646
2	9,914	10.1	3,148	2,392	1,568	1,068	852	886
3	16,146	16.4	4,866	3,787	2,380	1,775	1,480	1,858
4	16,049	16.3	4,478	3,093	2,506	2,033	1,900	2,039
5	15,530	15.8	4,189	2,867	2,305	2,075	1,879	2,215
6	11,095	11.3	3,666	2,662	1,661	1,223	928	955
7	13,183	13.4	3,745	2,790	2,279	1,832	1,307	1,230
8	8,504	8.6	2,900	1,975	1,479	989	675	486
TOTAL	98,512	100.0	29,703	21,488	15,481	11,820	9,705	10,315

District of Columbia Population
60 Years and Older by Age Groups, 2000 - 2011

