Iowa
State Plan on Aging
FFY 2010 to 2013

Balancing Long-Term Care for Aging Iowans

A Blueprint for the Future

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VERIFICATION OF INTENT

The Iowa Department on Aging hereby submits this State Plan on Aging effective October 1, 2009 for the FFY 2010-2013 as required under Title III of the Older Americans Act of 1965, as amended. The Plan was developed in accordance with all rules and regulations specified under the Older Americans Act and the Code of Iowa 231.31.

The Plan includes all required assurances and plans to be carried out by the Iowa Department on Aging, which is the state agency on aging and has been given authority to develop and administer the State Plan on Aging in accordance with all requirements and purposes of the Act. The Iowa Commission on Aging has reviewed the State Plan and resultant changes have been incorporated into the State Plan.

John McCalley, Director
Iowa Department on Aging

Date 6/16/09

Daniel Ernst, Chair
Iowa Commission on Aging

Date 6/16/09

The State Plan on Aging for FFY 2010-2013 is hereby submitted to the Governor and constitutes authorization to proceed with activities under the Plan upon approval by the Administration on Aging.

I hereby approve the State Plan on Aging and submit the Plan to the Administration on Aging for approval.

Chester J. Culver, Governor
State of Iowa

Date 6/22/09

A Message from the Director

June 2009

Dear Fellow Iowans:

On behalf of Governor Chet Culver and Lt. Governor Patty Judge, I am pleased to present Iowa's State Plan on Aging for the period October 1, 2009 to September 30, 2013.

The challenges and opportunities that we face in the coming four years are significant. Iowa ranks 5th in the country in the percentage of residents age 65 and older and has the fastest growing number of centenarians per capita. Iowa's older population is increasing rapidly and will continue to soar as the leading edge of the baby boomers reach retirement age. At the same time, Iowans tend to stay put when they retire, providing vital anchors to families and rural communities.

Older Iowans are an asset to our State as employees, volunteers, caregivers, mentors, and in the many other ways that they contribute to the strength of our State. Most older Iowans are home owners and through property taxes support schools and education, counties and municipalities. Annually, Social Security retirement benefits alone contribute in excess of $5 billion to the Iowa economy. As the population ages, we must recognize older Iowans as a valuable resource while providing services and supports needed by older adults, their families and caregivers.

In the State Plan on Aging, Iowa intends to expand upon the small, but important strides it has made toward balancing the array of support and services available in most communities. The Iowa Department on Aging also intends to build upon such innovative successes as our Iowa Healthy Links Chronic Disease Self-Management Program and Iowa's Aging and Disability Resource Center, which in addition to its virtual data base, currently includes two demonstration programs that utilize options counseling to assist Iowans in remaining healthy and independent as they age.

This plan was developed with input from the aging network, surveys and research, and evidence-based initiatives in addition to the department's own data collection systems. The goals, objectives and strategies presented in the plan highlight the importance of collaboration among the many agencies and organizations in Iowa's aging network.

Much of the work envisioned in this plan is focused on addressing the documented unmet needs of older Iowans both now and in the future. It highlights our efforts to protect the rights and maintain the safety of vulnerable adults. In short, it represents our commitment to prepare for the aging of all Iowans.

We look forward to working with government and non-government partners in the years ahead to ensure Iowa is ready to respond to the needs of older adults.

Respectfully Submitted,

John McCalley
Director
Iowa Department on Aging

Executive Summary

Remarkable events occurred during the spring and summer of 2008. Iowa experienced natural disasters in epic proportion including F-5 tornados and flooding reminiscent of the 500-year floods. 85 of Iowa's 99 counties were declared federal disaster areas resulting in an estimated cost of $8.10 billion in damage. Iowans of all ages struggled to understand the magnitude of the disasters that so greatly impacted their homes, families and loved ones. A bit later in the year, the full reality of the economic downturn began to hit citizens across the country and here in Iowa. It is against this backdrop that we write the State Plan on Aging that will guide our department's priorities and set an aging agenda for the State of Iowa from FFY 2010 to 2013.

A Blueprint for the Future represents Iowa's direction for the future, and lays out an action plan for how the Department on Aging will achieve its goals, objectives, strategies and expected outcomes as it continues to focus on modernizing long-term care options for aging Iowans, their families and caregivers. The key principles that move Iowa's State Plan forward include (1) empowering older Iowans to make informed decisions about, and easily access, existing health and long-term care options; (2) providing comprehensive, coordinated and cost effective services to support living independently in the community, (3) engaging health promotion and disease prevention programs that help older Iowans better manage and cope will illness; and (4) ensuring the rights of older Iowans by working to prevent their abuse, neglect, and exploitation.

The Iowa Department on Aging will also focus on providing clear, effective and responsive management to the various stakeholders in Iowa's Aging Services Network. The Department will partner with national and state associations on aging to support public policy initiatives, and advocate to encourage federal and State legislators to support Project 2020 and other public policy initiatives that protect and support independence for older Iowans.

The Department will continue to work with Area Agencies on Aging to develop and implement an emergency preparedness plan to provide coordinated response and recovery efforts to older Iowans with particular attention to the special needs of Iowans with disabilities. Additionally, the Department will work diligently and collaboratively with Iowa's Area Agencies on Aging, government, business and community partners to address the dramatic and rapidly growing unmet service needs of Older Iowans that are likely to reach near crisis level over the next few years. This situation will require a heightened emphasis to address and promote independent living for Iowa's most vulnerable aging population including Iowans from diverse backgrounds, income levels and disability levels.

There is much work to be done. Our plan will serve as a blueprint to guide us. Through the implementation of this plan, the Iowa Department on Aging seeks to engage older Iowans, their families and caregivers, and to provide greater education and understanding of the choices and opportunities that exist to enhance the quality of life for all older Iowans.

State Plan Vision and Purpose

The Iowa Department on Aging is required to develop and submit to the Federal Administration on Aging a State Plan on Aging every four years. The plan is mandated by both Federal and State law, and is required in order for the State to receive Federal funds under the Older Americans Act of 1965, as amended. Section 307(a)(1) of the Older Americans Act mandates the State Plan be based on area plans and also adhere to Sections 305(a)-(c); 306(a); 307; 308; and 705.

The Code of Iowa directs the Department on Aging to "develop, and submit to the Iowa Commission on Aging for approval a multiyear State plan on aging" and requires that "the State plan on aging shall meet all applicable federal requirements." (Code of Iowa, 231.31)

A Blueprint for the Future represents Iowa's direction for the future, and lays out an action plan for how the Department on Aging will achieve its goals, objectives, strategies and outcomes for FFY 2010-2013 as it continues to focus on modernizing the Aging Services Network in Iowa. The plan clearly helps to structure the department's priorities and sets an aging agenda for the State of Iowa.

Our Vision, Mission and Core Values

The Iowa Department on Aging's vision is to "*be a place of choice for older individuals to live, work, and retire.*" Our mission is *"to provide advocacy, educational, and prevention services for older Iowans."* The five goals and associated objectives in the 2010-2013 State Plan define how the department will fulfill its commitment to older Iowans by structuring our priorities and setting an aging agenda for our work. The department's core commitments to Advocacy, Health and Resource Management are well represented in *A Blueprint for the Future*, and demonstrate our commitment to older Iowans, their families and caregivers.

The Iowa Department on Aging's State Plan supports the mission of the Older Americans Act to help older Iowans maintain independence and dignity in their homes and communities. Among other activities, the State Plan also builds upon the Area Plans on Aging submitted to the Department by Iowa's thirteen Area Agencies on Aging. The Plan closely aligns with and supports the Federal Administration on Aging's 2007-2012 Strategic Action Plan and the agency's long-range vision to see evidence-based programs available to older adults in "every community across the country."

Developing the State Plan

As an initial step in developing the State Plan, the Iowa Department on Aging reviewed the Older Americans Act Amendments of 2006, the Administration on Aging's Strategic Action Plan for FY 2007-2012 and its Program Instruction (AoA-PI-09-01), the National Association of State Units on Aging's Technical Assistance Support Center, (NASUA; TASC Planning Zone), and the Department on Aging's 2008 Strategic Plan and Performance Report. In addition to these resources, the Department worked with the State of Iowa's Data Center to review current demographic statistics, and with the Department's senior analysts to identify consumer data that most effectively tells the story of Iowa's aging population.

Over the course of several months, the State Plan Development team met with department program staff to develop the goals, objectives, strategies, and expected outcomes that define how the Department will fulfill its commitment to older Iowans by structuring our priorities and setting an aging agenda for our work. The department's core commitments to Advocacy, Health Care and Support Services, and Resource Management are well represented in *A Blueprint for the Future*, and demonstrate our commitment to transparency, accountability and excellence.

The development of the FFY 2010-2013 State Plan involved significant efforts to gather input from older Iowans and partners in the Aging Services Network, including but not limited to the activities listed below:

1) The Department reviewed Area Plans submitted by Iowa's thirteen Area Agencies on Aging. Examples of a Rural and Urban Area Plan are located in Appendix B.

2) In 2008, the Department commissioned the Center for Social and Behavioral Research (CSBR) at the University of Northern Iowa (UNI) to conduct a telephone survey of over 8,000 Iowans age 60 and older to assess their need for services. The purpose of the project was to provide information from each of Iowa's 16 Planning and Service Areas (PSAs) regarding the use of various services within the past 12 months, current service needs, and future needs of older Iowans living in

private residences. The Executive Summary from the *Service Needs of Older Iowans* report is located in Appendix C.

3) The Department contracted with Thomson Reuters Healthcare in 2008 to conduct an assessment of Iowa's long-term support system. The research produced a comprehensive, high-level assessment of Iowa's progress toward a balanced long-term care system that relies less on individual institutional services and provides greater opportunities for the in-home and community-based services that most people prefer. The Executive Summary from the *Iowa State Profile Tool* is located in Appendix D.

4) The Department partnered with outside entities to do significant work on two one-time legislative assignments. The first focused on Alzheimer's disease and the second dealt with the concept of a "single point of entry" for Iowans to more easily access reliable information on long term care and community service options. *The Alzheimer's Disease Task Force Report* is located in Appendix E. *The Single Point of Entry Long-Term Living Resource System Team Report* is located in Appendix F.

5) Public Hearings were held in 2009. Comments are located in Appendix N.

Goals, Objectives, Strategies and Expected Outcomes

The goals, objectives, strategies and expected outcomes that follow highlight the importance of collaboration among the many agencies and organizations in Iowa's aging network. Together they represent the blueprint or action plan that will guide the work of the Department as it moves forward to address the documented unmet needs of older Iowans both now and in the future.

Table 1. Iowa State Plan on Aging FFY 2010-2013 Goals, Objectives, Strategies, Expected Outcomes	
Activity Timelines: Goals, Objectives, Strategies and Expected Outcome activities occur on an ongoing basis throughout FFY 2010-2013 unless otherwise stated.	
GOAL 1	**Enable older Iowans, their families and caregivers to make informed decisions about, and be able to easily access, existing home and long-term care options.**
Objective 1.1	**Partner with national and State associations on aging to support public policy initiatives.** It is important to empower individuals to make informed decisions and to extend their own resources, including consumer directed options for care in the community and improve State and national health and social service efficiencies. The department will work with the National Association of State Units on Aging, the National Association of Area Agencies on Aging, and Iowa's Area Agencies on Aging to support public policy initiatives, such as *Project 2020*. **Strategy**: Advocate to encourage federal and State legislators to support Project 2020 and other public policy initiatives that protect and support independence for older Iowans. **Expected Outcome**: Track the number of Iowa and national bi-partisan congressional sponsors, the progress of congressional committees and floor action.
Objective 1.2	**Implement an earned media campaign to raise awareness about long term services and supports for older Iowans, their families and caregivers through radio spots, television appearances, and newspaper articles including guest editorials.** According to the 2008 Iowa Single Point of Entry Long-Term Living Resource System Team Report, "A 2007 US Dept of Health and Human Services report found 7 out of 10 nursing home residents say they are there in part because they didn't know there were options." (See Appendix F for a copy of the Report.) Implementing a public awareness initiative is vital to educating Iowans about the existence of the full range of long term support options in their communities. **Strategy**: Target communication to media outlets about the array of long term services and supports for older Iowans, their families and caregivers. **Strategy**: Conduct editorial campaigns that highlight long term services and supports in urban and rural newspapers.

Objective 1.2 (cont)	**Strategy**: Participate in community outreach events with organizations such as faith-based groups, the Lion's Club, chambers of commerce, Rotary Clubs, retiree groups and other community organizations to raise awareness about long term services and supports. **Expected Outcome**: Monthly track the relationship between earned media activities and increased requests for information about long term services and supports from the media, consumers, website hits, requests for event speakers and the number of stories run as a result of department efforts.
GOAL 2	**Enable older Iowans to remain in the setting of their choice 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 2.1	**Enhance institutional diversion strategies by supporting an array of home and community based services and supports that help older Iowans remain in the setting of their choice who may otherwise reside in a nursing home or institutionalized setting.** Iowa is #1 in the country in the percent of nursing facility residents who are paying for their nursing facility care through private resources. A comprehensive network of community-based services will enable more of these Iowans (as well as Iowans receiving public assistance) to remain in their homes longer, thereby diverting expensive, premature institutionalization. (Source: Minimum Data Set Active Resident Information Report (2009, First Quarter). Baltimore, MD: Centers for Medicare and Medicaid Services. Retrieved May 29, 2009. To read the report, visit: http://www.cms.hhs.gov/MDSPubQIandResRep/04_activeresreport.asp?isSubmitted=res3&var=A7g&date=26.) **Strategy:** Evaluate the array of home and community based services and supports available to older Iowans, their families and caregivers, and where necessary and as funding allows, services available to better serve the needs of older Iowans. **Strategy:** Advocate for preservation and expansion of funding currently provided by the Senior Living Program. **Strategy:** Apply for federal grant opportunities to provide innovative tools to build capacity of home and community based services. **Expected Outcome:** Increase the number of older Iowans receiving home and community based services who may otherwise reside in a nursing home or institutionalized setting.

Objective 2.1 (cont)	**Expected Outcome:** Increase the average number of months to 24 months that a client's independent living status is maintained, before being discharged due to institutionalization or death, because of the Case Management Program for Frail Elders (CMPFE).
Objective 2.2	**Promote and provide caregiver training and support activities.** Family and informal caregivers are the backbone of our long-term care system. Data available through AARP projects that there are an estimated 300,000 informal caregivers in Iowa at any given time. The economic value of this informal care is calculated to be $3.4 billion which is about 50% more than the total for all public long-term support spending in Iowa ($2.2 billion). Equipping caregivers with the necessary education and support is essential to strengthening the entire long term care structure. (Source: Houser, Ari and Gibson, Mary Jo. *Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update.* AARP Public Policy Institute: November 2008.) **Strategy**: Provide Family Caregiver educational programs to State of Iowa employees by partnering with the Department of Administrative Services and the Human Resource Enterprise. **Strategy:** Conduct a satisfaction survey of State of Iowa employees that participate in the Powerful Tools for Caregivers educational programs. **Expected Outcome**: Number of registered clients that receive assistance from the National Family Caregiver Support Program. (Standard: 4800 clients) **Expected Outcome**: Percent of participants satisfied with the Powerful Tools for Caregivers educational programs.
GOAL 3	**Empower older Iowans to stay active and healthy through Older Americans Act services including evidenced based disease prevention programs.**
Objective 3.1	**Promote health and wellness initiatives for older adults.** The Chronic Disease Self Management Program (CDSMP) in Iowa has documented not only improvement in participants' quality of life but also significant fiscal benefits as well. It is projected that if just 1% of Iowa's seniors with arthritis were helped by attending/graduating the six CDSMP workshops over a one year time frame, the estimated hospital patient cost savings would be $46,352,372 (based on CDC data of 55% Iowans 65+ years reporting arthritis = 3,212 seniors).

Objective 3.1 (cont)	**Strategy:** Collaborate with Area Agencies on Aging and other organizations to provide health and wellness programs for older adults. **Strategy:** Communicate and encourage the use of evidenced based programs such as the Chronic Disease Self Management Program, Enhance Fitness, Matter of Balance and Eat Better & Move More through newsletters and other media channels, DEA website, and participation in meetings and taskforces. **Expected Outcome:** Increase in the number of individuals age 60+ who participate in evidenced based health promotion programs, such as the Chronic Disease Self Management Program, Matter of Balance and Enhanced Fitness. (Standard determined via grant data.) **Expected Outcome:** Increase improvement in self-rated health by participants of Chronic Disease Self Management Programs using change from baseline to six months for self-rated health and self-efficacy. (Standard: Self-rated health decrease of 0.2 and self-efficacy increase of 0.6 on a ten point scale from baseline to six months using August 2008 data from Des Moines University.)
Objective 3.2	**Improve the provision of and access to nutritious meals for older Iowans through the congregate and home-delivered meal programs.** The Iowa Behavioral Risk Factor Surveillance System reports generated from 2002-2007 show a 26.9% decline in the percent of Iowans over age 65 that eat 5 or more portions of fruits and vegetables per day. Pursuing mechanisms to increase older Iowans access to and awareness of nutritious meals and health promotion options will further the goal of helping older adults to stay active and healthy. (Source: Behavioral Risk Factor Surveillance System Annual Reports 2002-2007. Des Moines, IA: Department of Public Health. Retrieved May 29, 2009 from: http://www.idph.state.ia.us/brfss/default.asp.) **Strategy:** Identify the perspectives of older Iowans regarding the characteristics they want in a nutrition program using an online survey in 2010 and conducting focus groups representing diverse demographic and geographic populations in 2011. **Strategy:** Provide best practice examples for providing congregate and home delivered meals to Iowa Area Agencies on Aging via newsletter. **Strategy:** Assist area agencies in promoting the health benefits of the congregate and home delivered nutrition programs including the development of messages and articles for newsletters and other media campaign.

Objective 3.2 (cont)	**Strategy:** Assist area agencies in developing alternative meal delivery models including partnerships with the business community. **Expected Outcome:** Develop a proposal for an alternative meal delivery model for use by Area Agencies on Aging. **Strategy:** Work with Area Agencies on Aging, Iowa Department on Aging staff, and others to expand cultural competencies as needed. **Expected Outcome:** Percent of clients determined to be at high nutritional risk who receive congregate meals, home delivered meals and nutrition counseling and maintain or improve their nutrition risk scores. (Standard: 78%) **Expected Outcome:** Track the percent of change in # of unduplicated clients receiving congregate and home delivered meals using NAPIS data. (Standard: 65,082 unduplicated clients)
Objective 3.3	**Promote independent living by sponsoring civic engagement and employment opportunities through the Senior Community Service Employment Program (SCSEP) to qualifying older Iowans who want to re-enter the workforce.** The unemployment rate for older workers is the highest in history. In Iowa, about 19% of unemployment claims were from workers aged 55 and over. The Senior Community Service Employment Program is an increasingly important opportunity for older Iowans to return to the work force. Third quarter program results ending March 30, 2009 report that 72% of employed participants remained employed in the third quarter of the year after exit and earned an average of $9.52 per hour. (Source: Eller, Donnelle (2009, May 23). "More older workers confront unfamiliar task: Finding a job." *The Des Moines Register.* Retrieved May 29, 2009 from: http://www.desmoinesregister.com/article/20090523/BUSINESS/905230339.) **Strategy:** Pursue partnerships and collaborative opportunities with the business community. **Strategy:** Advocate for increased clarity at the federal level and the Older Americans Act regarding the scope and target population of the program. **Expected Outcome**: Percent of employed participants who remain employed in the 3rd quarter of the year after exiting SCSEP SIP program.

Objective 3.4	**Improve the quality of life for older Iowans, their families and caregivers, with or at risk for, Alzheimer's disease and related dementias as directed by Senate File 2341, Iowa Code 231.62, to the extent of the funding appropriated or otherwise made available.** The impact of Alzheimer's disease and related dementias on Iowans and their caregivers is profound and growing. A recent Alzheimer's Disease Task Force Report projected that: "In Iowa in 2000, there were nearly 65,000 people with a diagnosis of Alzheimer's disease and a potential 6% increase by 2010 resulting in an estimated 69,000 people." The strategies identified will serve to move the State forward in preparing for the escalating needs of Iowans with dementia and those who provide their care. (See Appendix E for a copy of the Alzheimer's Disease Task Force Report.) **Strategy:** Work collaboratively with aging network partners to support the development and implementation of innovative programs that support older Iowans, with or at risk for, Alzheimer's disease and related dementias. **Strategy:** Improve the training and education module for professional and nonprofessional persons who address the needs of Iowans, their families and caregivers with, or at risk, for behavior health issues, Alzheimer's disease and related dementias. **Strategy:** Conduct a survey to identify and quantify the numbers of persons with Alzheimer's disease and related dementias at the community level, and to determine the number of physicians and geropsychiatric units available in the State to provide treatment and services to such persons. **Expected Outcome:** More Iowans, their families and caregivers, with or at risk for, Alzheimer's disease and related dementias will receive services at an early stage in the disease.
GOAL 4	**Ensure the rights of older Iowans and prevent their abuse, neglect, and exploitation.**
Objective 4.1	**Utilize the Long-Term Care Ombudsman Office and Resident Advocate Committees to support and enhance the lives of long-term care facility residents.** Data from *Nursing Facilities, Staffing, Residents and Facility Deficiencies,* reports a 47% increase in the percent of Iowa nursing facilities that received a deficiency for actual harm or jeopardy. During that same time period, there was a 36% drop in nursing

Objective 4.1 (cont)	facilities that were deficiency free. Protection of Resident Rights and prevention of abuse in facility settings is a critical component in ensuring the emotional and physical safety of nursing facility residents. (Source: Harrington, C. (2008) *Nursing Facilities, Staffing, Residents and Facility Deficiencies*. Department of Social and Behavioral Sciences, University of California, San Francisco, CA.) **Strategy:** Work to resolve complaints to the satisfaction of residents and their families in an efficient and timely manner. **Expected Outcome:** The long-term care ombudsmen will resolve 70% or more of the complaints brought forth by, or on behalf of, residents and tenants living in long-term care facilities. **Strategy:** Advocate for increased funding to recruit and hire additional local long-term care ombudsmen in order to expand operational capacity of the office to provide direct assistance to Iowans living in licensed and certified facilities (i.e., nursing homes, elder group homes, residential care facilities, assisted living facilities and boarding homes). **Expected Outcome:** Double the number of the long-term care ombudsmen from 6 to 12 to meet the mandates in the Older Americans Act and Iowa Code 231C. **Strategy:** Advocate for funding to implement a volunteer ombudsman program. **Expected Outcome:** Identify, recruit and train 20 volunteer ombudsmen. **Strategy:** Conduct two surveys of current long-term care residents and future consumers of aging services. **Expected Outcome:** Utilize and incorporate as appropriate survey responses into the next State planning process.
Objective 4.2	**Focus on the prevention, intervention, detection and reporting of elder abuse, neglect, and exploitation.** The National Elder Abuse Incident Study reports that across almost all categories of abuse and self-neglect, the greatest percent of victims are over age 80.[1] Iowa is currently ranked #3 in the country in the percent of the population over 85 and this number is projected to grow by 36% by 2030.[2] Since its inception, the Elder Abuse Initiative in Iowa has demonstrated repeated success in intervening to protect older adults from abuse, neglect, and exploitation. Failure to expand this program as

Objective 4.2 (cont)	demand increases will leave more vulnerable at risk adults without protective intervention. (Sources: [1] National Elder Abuse Incident Study Final Report. Washington, DC: American Public Human Services Association in collaboration with Westat, Inc., September, 1998. [2] Houser, A., Fox-Grage, W. & Gibson, M. Across the States 2009: Profiles of Long-Term Care and Independent Living. (2009, March). Washington, DC: AARP. Retrieved May 29, 2009: http://www.aarp.org/research/longtermcare/trends/d19105_2008_ats.html.) **Strategy:** Expand the Elder Abuse Initiative to 11 additional counties. **Expected Outcome:** Increase elder abuse referrals from 2400 to 3000 in FFY 2010 and to 4000 referrals by 2013.
Objective 4.3	**The Legal Service Program will provide quality advice, representation and referral to Iowans 60+ years of age at the greatest social and economic need.** The past four years have seen continued growth in the need for legal services for older adults in Iowa. Reports from the Area Agencies on Aging and Title IIIB legal providers document that the number of individuals who had legal needs that could not be addressed by current resources has increased by 86% since 2005. In 2008, this translated into 1,934 hours of legal assistance services that were needed but could not be provided due to inadequate funding resources. **Strategy:** Increase program income by 50% to build capacity of the Legal Service Program. **Strategy:** Conduct analysis of Legal Service Program data to identify the legal service issues of Older Iowans. **Strategy:** Distribute data summary report of priority issues to the legal service program community, Area Agencies on Aging and to State and Federal legislators. **Expected Outcome:** Publish and distribute an annual report that informs legal program service providers, Area Agencies on Aging, and State and Federal legislators about the legal service needs that impact the lives of older Iowans.
GOAL 5	**Maintain effective and responsive management.**
Objective 5.1	**By March 2010, create, conduct and oversee a quality assurance design that includes an annual monitoring process to review and document area agency compliance with federal, State and contractual requirements and to provide technical assistance to AAAs as appropriate to ensure efficient delivery of quality programs and services to older Iowans.**

Objective 5.1 (cont)	**Strategy:** Create a monitoring tool to be used by the Iowa Department on Aging during annual visits to Area Agencies on Aging. **Strategy:** Train monitoring team to conduct visits to Area Agencies on Aging. **Strategy:** Conduct 13 onsite monitoring visits to area agencies. **Strategy:** Review and analyze the process used for monitoring visits with Area Agencies on Aging. **Expected Outcome:** Implement process improvements as appropriate.
Objective 5.2	**Identify unmet service needs that require greater emphasis to address and promote independent living for older Iowans.** **Strategy:** Conduct analysis of unmet service needs of older Iowans to compare and contrast data from the 2008 *Service Needs of Older Iowans* Report (consumer perspective) with unmet needs data from the Case Management Program for the Frail Elderly (CMPFE) and service providers under contract with the Area Agencies on Aging, **Expected Outcome:** 100% of Area Agencies on Aging demonstrate utilization of unmet service needs data in their area plan amendments.
Objective 5.3	**Ensure that all Iowa Area Agencies on Aging develop and implement an emergency preparedness plan in collaboration with the Iowa Department on Aging to provide coordinated response and recovery efforts to older Iowans, their families and caregivers with particular attention to the special needs of Iowans with disabilities.** **Strategy:** By September 2009, require all Area Agencies on Aging to develop and implement their version of the *Roadmap to Emergency Preparedness.* **Strategy:** Beginning April 1, 2010, require all Area Agencies on Aging to include the *Roadmap to Emergency Preparedness* as a required element in their area plan submission to the Iowa Department on Aging. **Expected Outcome:** Include the *Roadmap to Emergency Preparedness* in the area plan due April 1, 2010 by area agencies.

Objective 5.4	**Use data resources available to the Department, including but not limited to evidenced based data, NAPIS and SEAMLESS data, to ensure the timely delivery of home and community based services to older Iowans.** **Strategy:** Conduct webinars to train and assist area agency staff and other partners to improve data collection accuracy. **Expected Outcome:** Improve the data collection process by Area Agencies on Aging.
Objective 5.5	**Improve systems to enhance functional efficiencies and to increase the quality of services the Iowa Department on Aging provides to the aging network.** **Strategy:** Identify operational efficiencies within the Department on Aging and among the Executive Branch agencies including but not limited to Iowa Workforce Development, the Department of Public Health, the Department of Management, the Department of Inspection and Appeals, the Governor's Office, and Iowa Medicaid Enterprise. **Expected Outcome:** Track the number of operational efficiency opportunities between the departments and the opportunities taken advantage of between departments. **Strategy:** Maximize State and Department on Aging resources dedicated toward supporting an array of services that enable older Iowans, their families and caregivers to remain independent, safe and healthy in the setting of their choice. **Expected Outcome:** By January 2009, mobilize a team of community volunteers to assist Department on Aging staff with department projects.

State Plan Focus Areas

As part of the focus on long-term care modernization, the Administration on Aging asks states to include their activities in five strategic areas. Iowa will focus on three of the five specific areas within its function as a State Unit on Aging. Those areas are vulnerable elder rights protection, disaster preparedness and health care system coordination.

Elder Rights Protection Activities

LEGAL ASSISTANCE PROGRAM The Legal Assistance Program provides a valuable service to older Iowans in need of legal assistance and information. In State fiscal year 2008, the program served 3,099 clients and provided 8,864 hours of service to persons 60 and older. Of the 3,099 clients served, 2,158 were in economic or social need, while 241 were minorities. Older Iowans most generally seek assistance from the legal program for issues such as wills and estates, Medicaid eligibility and information, debt collection concerns and miscellaneous issues. An additional 1,595 older Iowans received information and assistance by attending community legal education forums presented by the Legal Assistance Program providers.

The statistics also show that even though 3,099 individuals were served, there were another 457 older Iowans with unmet needs for legal assistance. These 457 individuals needed 1,934 hours of service. The need for this legal assistance could not be addressed by the legal providers and aging network due to inadequate funding availability.

The Iowa Legal Assistance Program provides an array of services to meet the legal needs of older Iowans. The program:

1) Educates about the law and how it applies;

2) Helps prevent legal problems and makes appropriate referrals;

3) Disseminates information to allow individuals to self-advocate; and

4) Assists with direct legal representation, counsel and advice, when necessary.

ELDER ABUSE INITIATIVE In Fiscal Year 2002, the Department of Elder Affairs launched the Elder Abuse Initiative. This partnership with Area Agencies on Aging, the Department of Human Services and other stakeholders in the community provides enhanced prevention, detection and reporting of abuse while also offering local advocacy and system coordination to ensure the protection of older Iowans. Currently the initiative operates in 30 counties through the local Area Agencies on Aging. In 2008, 1,718 referrals were received, a 34.7% increase from 2005.

Currently the initiative operates by means of Regional Prevention Coordinators (Area Agency on Aging staff) within the following Area Agencies on Aging and counties: Southwest 8 Senior

Services (Cass, Fremont, Harrison, Mills, Montgomery, Page, Pottawattamie & Shelby), Heritage Area Agency on Aging (Benton, Cedar, Iowa, Johnson, Jones & Linn); Hawkeye Valley Area Agency on Aging (Black Hawk, Buchanan, Grundy, Hardin, Marshall, Poweshiek & Tama); and Northwest Aging Association (Buena Vista, Clay, Dickenson, Emmet, Lyon, O'Brien, Osceola, Palo Alto & Sioux).

The efforts of this Initiative have been to:

1) Assist the Department of Human Services in assessing service needs and level of dependency of person's 60 and over;
2) Allow for interventions by the aging network in cases that may not be abuse under the law;
3) Introduce vulnerable Iowans to the aging service network via outreach efforts;
4) Utilize funds provided through the Senior Living Trust, Older Americans Act and other resources, which allow individuals to safely remain in their home;
5) Coordinate mandatory reporter training to professionals in our community; and
6) Provide community awareness about elder abuse and the solutions the Initiative offers.

As a result, the system for protecting vulnerable older adults functions more efficiently, effectively and assists more Iowans.

LONG-TERM CARE OMBUDSMAN PROGRAM Complaints received by the Office of the State Long-Term Care Ombudsman rose dramatically during the past year. 2,336 complaints were investigated by the local long-term care ombudsmen, resulting in 889 cases. This represents a 39% increase in complaints for Federal fiscal year 2008.

Iowa still ranks near the bottom of 53 ombudsman programs in the nation for ratio of paid staff to residents with one ombudsman for each 7,400 residents compared to the national average of one ombudsman for each 2,174 residents. The seven local ombudsmen have put tremendous effort into improving the lives of the more than 50,000 people who live in 840 long-term care facilities. Local ombudsmen spent over 5,400 hours in facilities during 2008.

The Resident Advocate Committee volunteer program has been in existence for 30 years. There are over 2,400 volunteers throughout the ninety-nine counties in Iowa. This makes annual training, education and support challenging. The program will be evaluated throughout 2009 to determine how to provide the necessary training, education and support to meet the needs of people living in long-term care facilities.

Disaster Preparedness

The Iowa Department on Aging is actively involved in emergency management planning and operations to provide coordinated response and recovery efforts to older Iowans. An Emergency Response Team has been appointed by the Director. At least one member of the Team can be reached on a 24-hour basis by the State Emergency Management Agency. The team's primary duties are to:

1) Staff the State Emergency Operations Center when requested by the State Emergency Operations Center (SEOC);

2) Keep the Director and Iowa Department on Aging staff advised of emerging events as appropriate;

3) Facilitate communication between the State and local levels on aging-related emergency issues; and

4) Help ensure the special needs of older Iowans are met during emergencies, especially those who are consumers of home and community based services.

Iowa's Incident Command Structure closely follows that of the Stafford Act Support to States. Immediately after a major incident, local first responders respond to the incident and assess the situation. When appropriate, responders notify elected officials who may in turn activate the local Emergency Operations Center (EOC). The Governor may then activate the State Emergency Operations Center, which assesses the damage caused by the disaster, and requests as appropriate, interstate mutual aid as well as requests for Presidential declaration. Federal Emergency Management Agency staff (FEMA) arrive on scene in the event of a federal disaster declaration to evaluate the situation and review requests from the Governor. FEMA staff make recommendations to the FEMA administrator. After assessment and consideration of the Governor's requests, the administrator may recommend a Presidential Declaration for specific communities or counties, and deploys response teams and other resources to disaster location(s). The Joint Field Office (JFO) provides unified coordination of response resources.

The Iowa Department on Aging is responsible for supporting the Iowa Emergency Management Agency's activities and is specifically identified as a support agency. Iowa's Area Agencies on Aging are similarly responsible for supporting their respective County Emergency Management Agencies. The work of the Iowa Department on Aging's Emergency Response Team in communicating information from the State Emergency Operations Center to Area Agencies on Aging and vice-versa is considered an important redundancy that complements the standard Incident Command Structure for the State of Iowa.

Nineteen percent of Iowans age 60 years of age and older were affected by disasters in 2008. Forty-two percent of this population lived in rural areas making their identification difficult and the delivery of goods and services tenuous. Over 3 billion dollars in unmet needs were identified during the first 45 days immediately following the disasters.

From this disaster grew a more closely defined system that allows for the sharing of collective experience and knowledge between the Department on Aging, the Area Agencies on Aging, and strategic partners. Highlights include the following activities:

1) During the immediate six months that followed the disasters, weekly conference calls were held between the Department on Aging, the Area Agencies on Aging, and regional Administration on Aging partners. Thereafter, the calls continued on a bi-weekly basis and still have purpose today as the State of Iowa prepares for the next round of summer floods and other unpredictable weather and non-weather related disasters.

2) Close collaboration with the Federal Emergency Management Agency resulted in the release of electronic lists of disaster victims and their contact information to be used solely by the Department on Aging and the Area Agencies on Aging to locate victims.

3) A Disaster Summit with Area Agencies on Aging, Iowa Association of Area Agencies on Aging, and the Administration on Aging was held in December 2008 by the Department, which created a Disaster Summit Work Group. Members of the Work Group included Area Agency directors and staff, board members and Department on Aging staff.

   The Work Group developed a *Roadmap to Emergency Preparedness*, which is intended to be a flexible, living document that adapts to each Area Agency's needs during a disaster and a document that coordinates with the Area Agency's Continuity of Operations Plan (COOP). The *Roadmap* is located in Appendix G.

   The purpose of the *Roadmap* is to strengthen collaboration and coordination in emergency preparedness, and response and recovery between nonprofits, businesses and government. It is based on the four critical areas of (A) Planning and Training, (B) Networks and Partnerships, (C) Communication and Coordination, and (D) Response and Recovery.

   The *Roadmap* will be implemented by Area Agencies on Aging during the Fall of 2009, and will become a permanent part of the Area Plan on Aging submission process beginning with the April 1, 2010 submission.

4) The Department on Aging and the Area Agencies on Aging are required to have an updated Emergency Operations Plan that is reviewed annually.

5) To support the importance of the *Roadmap to Emergency Preparedness*, Goal 5 of the State Plan on Aging includes Objective 5.3, the purpose of which is to: "Ensure that all Iowa Area Agencies on Aging develop and implement an emergency preparedness plan in collaboration with the Iowa Department on Aging to provide coordinated response and recovery efforts to older Iowans with particular attention to the special needs of Iowans with disabilities."

Health Care System Coordination

The Department on Aging has consistently been a recognized voice in State efforts to move forward in reforming Iowa's long term health care delivery system. The department continues an active and expanding role in shaping long term care policy, examples of which follow.

1) The Iowa Legislature designated the Department on Aging as the lead agency for the *Single Point of Entry Long-Term Living Resource System Team*. The team was established in 2008 House File 451 to "make recommendations regarding the structure of and best means of providing a single point of entry to the long-term living resources system." The final report of this workgroup has established a comprehensive foundation upon which to structure a single point of entry system for Iowa.

2) The Department has served as a member of the Expanding Community Option Workgroup that created Iowa's Money Follows the Person (MFP) initiative. The legislative charge to the workgroup was to "enhance alternatives for community-based care for individuals who would otherwise require care in an intermediate care facility for persons with mental retardation" including older adults. The workgroup's concepts and recommendations shaped the State's successful application to the Centers for Medicare and Medicaid Services for an MFP grant.

3) The Department has worked in partnership with the State's Senior Health Insurance Information Program (SHIIP) to expand the availability of health information assistance to older Iowans across the State. Recent initiatives include implementation of the "Medicare Improvements for Patients and Providers Act (MIPPA) for Beneficiary Outreach and Assistance" and a partnership with the Iowa Department of Commerce, Insurance Division, to participate in the "Own Your Future" project.

4) The Aging and Disability Resource Center has built a network of collaborative linkages that have expanded the department's presence to encompass agencies and organizations that define policies and advocacy for the disability community.

5) With funding from the Centers for Medicare and Medicaid Services, the Department conducted an expansive, multi-agency data collection and analysis project that explored public long term care expenditures and services across all population groups. The final report, called the *Iowa State Profile Tool* is the most comprehensive review of the long term care system that has been undertaken in Iowa. Information included in the report has been used to shape policy direction for the Department and other partner agencies.

State Plan Context

Iowa's Aging Services Network

IOWA COMMISSION ON AGING The Iowa Commission on Aging is the policy-making body of the Department. The Commission consists of seven members appointed by the Governor and confirmed by the Iowa Senate and four ex-officio, nonvoting members appointed by the Iowa General Assembly. The duties of the Commission consist of approving the State plan on Aging and Area Plans on Aging, adopting policies to implement the mandates of The Older Americans Act, adopting administrative rules and other responsibilities. A listing of Commission members is located in Appendix H.

IOWA DEPARTMENT ON AGING The Iowa Department on Aging is a Cabinet-level State agency whose director is appointed by the Governor and confirmed by the Senate. The agency is responsible for the application and receipt of Federal Older Americans Act funds as well as State appropriations. The Department is a focal point for all activities related to the needs and concerns of older Iowans.

The Iowa Department on Aging's responsibilities as the State Unit on Aging include:

- Coordinating all State activities related to the purposes of the Older Americans Act;
- Developing a State Plan on Aging;
- Serving as an effective and visible advocate for older persons by:
    - Reviewing and commenting upon all State plans, budgets and policies that affect elders.
    - Providing technical assistance to any agency, organization, association or individual representing the needs of elders.
- Assuring that preferences for services will be given to older individuals with greatest economic or social needs; and
- Assuring that preference for services will be given to low-income minority and rural older adults.

The Director oversees the activities listed above to ensure that all programs for older Iowans are implemented consistent with management decisions of the Governor, policy decisions of the Iowa Legislature, Commission for the Department on Aging, and all Federal and State laws and regulations. The Director's office is responsible for obtaining input from, coordinating activities

with, and being an advocate for older Iowans with other departments of State government, the Iowa Legislature, the Iowa Area Agencies on Aging, organizations representing older persons, and the general public.

IOWA AREA AGENCIES ON AGING The Iowa Department on Aging works in partnership with thirteen area agencies on aging designated by the Commission. The area agencies serve as the central point for older Iowans within the community by monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions that will affect older adults. The area agencies deal with hundreds of community organizations. Each area agency has a "Request for Proposal" process that is utilized annually or biennially so that service delivery procurement is competitive and designed to help assure quality, access, and cost control.

As required by the Older Americans Act, all area agencies have a policy-making board and an advisory council. Area agencies on aging coordinate services among a variety of organizations ranging from senior centers to mental health and long-term care providers. They work to assure that any services provided in the community include provisions for older adults.

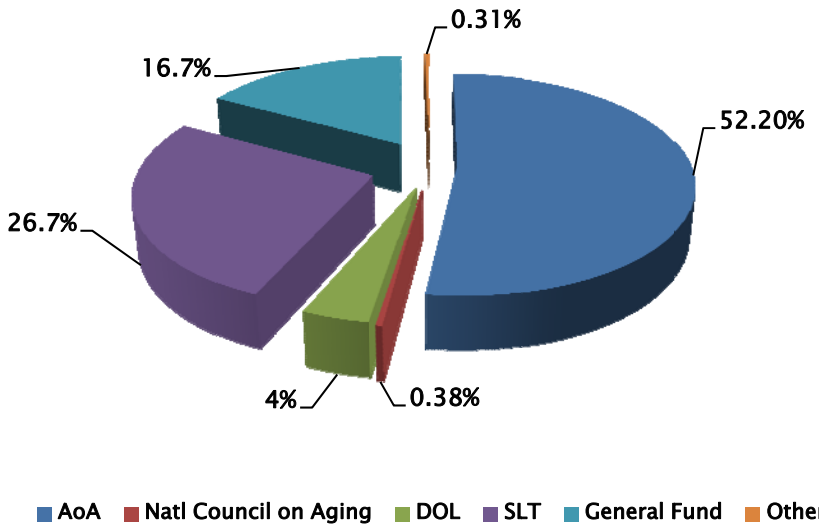
The area agencies on aging strive to meet the needs of the rapidly-growing number of older Iowans through:

- Assessing the current needs of older Iowans;
- Assessing available services, programs, and institutions;
- Developing area plans to help address service gaps;
- Assuring access to services, programs, and institutions;
- Advocating for the needs of older Iowans;
- Financing and administering contracts to providers of services;
- Providing a central leadership role for older Iowans; and
- Providing information and assistance services for older Iowans, their families, and caregivers

A list of Iowa's Area Agencies on Aging and a map of the sixteen Program and Services Areas are located in Appendix I.

Funding for Iowa's aging services through the Department on Aging comes from a variety of State and Federal sources including the Administration on Aging, Iowa Senior Living Trust, General Fund of Iowa, Department of Labor, and National Council on Aging. Total funding is approximately $32 million. A breakout of funding sources is provided in Figure 1.

Figure 1. Funding Breakout of Iowa's Aging Services 2009

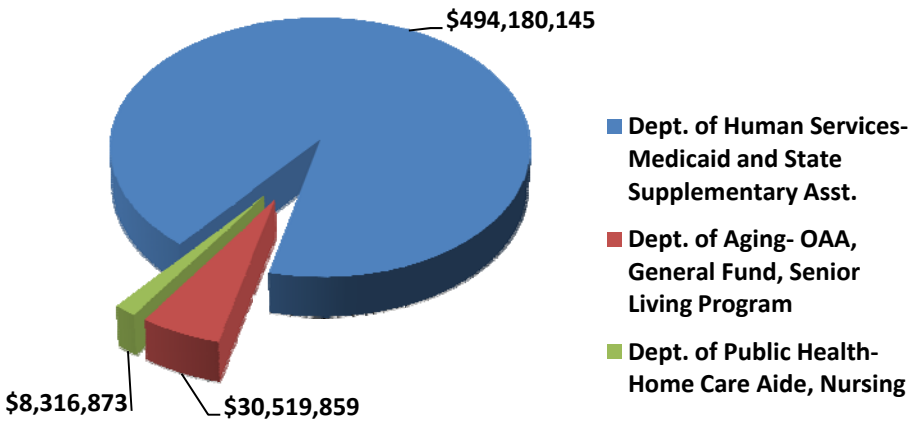


Source: *Budgeted Funding Resource Report*, Iowa Department on Aging, 2009.

In addition to the dollars appropriated to the Department on Aging, the departments of Human Services and Public Health also receive funds to provide services to adults 60+ years of age. Because of this interrelationship, the Department has and continues to actively partner with

these agencies in the development of integrated policies and structures that best support older Iowans. Figure 2 illustrates the public long-term care expenditures for older Iowans.

Figure 2. Public Long-Term Care Expenditures for Iowans Age 60+, SFY 2008



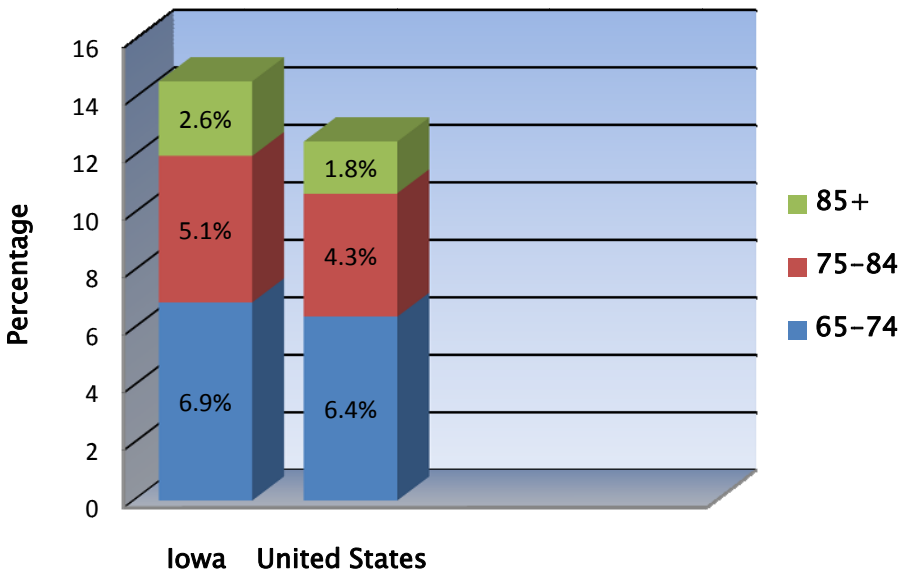
Source: Eiken, S., Iwan, M.J., & Gold, L. (March 31, 2009). Iowa State Profile Tool. *An Assessment of Iowa's Long-Term Support Sytem. Des Moines, Iowa; Iowa Department on Aging.*

Demographics

According to the latest data available from the U.S. Census Bureau, more than one of every seven Iowans was age 65 or older in 2007. (A Profile of Older Iowans Selected Population Characteristics is located in Appendix K.) Iowa also ranks fifth in the country in the percentage of residents age 65 and older. Further, Iowa has a high percentage of people age 85 and older when compared to the national average.

I.E., 2.6% of Iowans are 85 years of age or older compared to 1.8% of the U.S. population. Figure 3 provides a comparison of Iowans 65 to 74 years of age and those 75 to 84 years of age with the U.S. population within those same populations.

Figure 3. Percentage of Population Age 65 or Older, 2007



Source: U.S. Census Bureau, Population Division "Annual Estimate of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May1. 2008. *State Profile Tool.*

Iowans in the 65+ and 85+ cohorts are expected to grow by 1-2% per year through 2030. Should this trend materialize, 22% of Iowans will be age 65 or older, and 3.6% will be age 85 or older by 2030 as illustrated in Figure 4. As a result, there will continue to be pressure to find ways to meet the dramatic and rapidly growing unmet needs of these older and frailer Iowans.

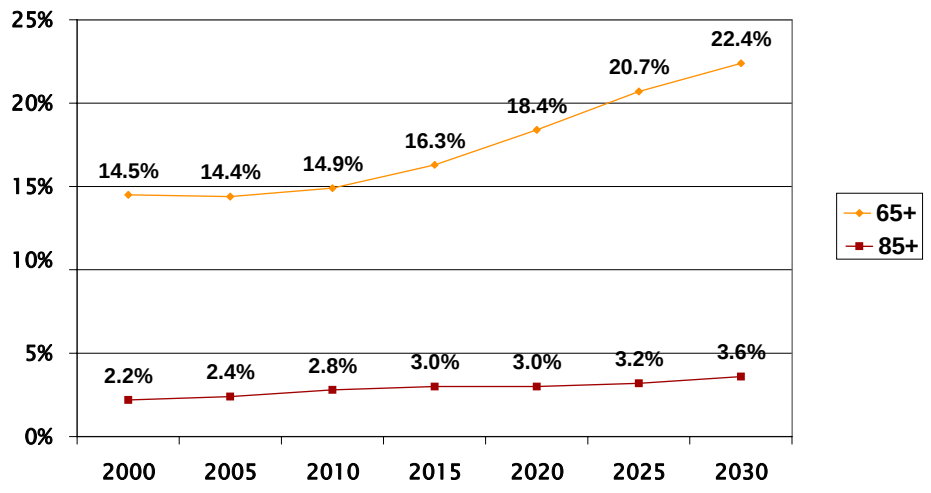


Figure 4. Older Iowans as a Percentage of State Population, 2000 – 2030

Source: Eiken, S., Iwan, M.J., & Gold, L. (March 31, 2009). *Iowa State Profile Tool: An Assessment of Iowa's Long-Term Support System. Des Moines, Iowa: Iowa Department on Aging.*

As the number of aging Iowans increase, so too does the demand for services. In 2008 alone, over 54,000 units of needed services could not be provided to case management clients due to lack of funding or inadequate funding. The total number of funds needed to cover reported unmet services needs in SFY 2008 was almost $1.1 million. (These numbers do not include the additional unmet needs of Iowans receiving services through Senior Living Program funds.)

Table 2 on page 26 details the 2008 unmet service needs of case management clients including the top five unmet service needs of home delivered meals, transportation, home repair, chore, and homemaker. The remaining list of unmet needs included information and assistance, assisted transportation, respite, mental health outreach, medication management and others.

Table 2. Case Management Program for Frail Elders
Unmet Service Needs Due to No Funding or Inadequate Funding, SFY 2008

$1.1 Million

Total additional funds needed to cover reported unmet service needs in SFY 2008 due to No Funding or Inadequate Funding (**Source**: Iowa Department on Aging, December 2008.)

Service Name	Contacts	Units	Needed Dollars	Unit of Measure
Top 5 Unmet Service Needs				
Home Delivered Meals	622	15,545	$131,200	1 meal
Transportation	386	6,872	$44,462	1 one-way trip
Home Repair	227	6,101	$207,911	1 hour
Chore	341	5,668	$120,218	1 hour
Homemaker	244	4,212	$112,671	1 hour
Total for top 5	*1820*	*38,398*	*$616,462*	
Assisted Transportation	358	4,096	$41,370	1 one-way trip
Respite	141	2,760	$45,126	1 hour
Personal Care	135	2,119	$65,583	1 hour
Adult Daycare	129	1,653	$14,414	1 hour
Material Aide	204	919	$125,710	1 client
Caregiver Support	94	763	$81,351	1 hour
Mental Health Outreach	83	653	$13,726	¼ hour
Visiting	36	430	$6,932	1 visit
Legal Assistance	22	365	$16,509	1 hour
Medication Management	43	345	$3,229	1 client
Case Management	207	304	$18,802	1 hour
Emergency Response System	247	247	$7,343	1 client
Congregate Meals	11	220	$1,439	1 meal
Nutrition Counseling	59	220	$6,453	1 session
Reassurance	5	155	$262	1 contact
Training & Education	12	120	$3,053	1 hour
Counseling	15	111	$6,833	1 hour
Grandparent Relative Support	11	72	$9,356	1 client
Nutrition Education	16	47	$125	1 session
Assessment & Intervention	8	26	$2,108	1 hour
Preventive Health Promotion	20	20	$204	1 contact
Placement Service	9	9	$665	1 hour
Advocacy	2	8	$236	1 hour
Protective Payee Service	6	6	$17	1 contact
Health Well Elderly Clinic	4	4	$186	1 hour
Information & Assistance	3	3	$62	1 contact
Employment	2	2	$1,608	1 placement
Total Needs All Services	**3702**	**54,075**	**$1,089,164**	

The data in Table 2 reflects unmet service needs for older Iowans as reported to the Department by the 13 Area Agencies on Aging based on information from the Case Management Program for the Frail Elders in SFY 2008. The number of contacts reported above may reflect clients with multiple needs for different services. The amount of additional funds needed to meet the reported unmet service needs were calculated based on the statewide average expenditures per service unit for these services as reported by the Area Agencies on Aging.

Additional Influences

While many of Iowa's population shifts parallel those of the rest of the country, there are a number of other critical factors that define the dynamics within the State and which in turn, have shaped the department's objectives and strategies contained in the State Plan.

Iowa ranks #2 in the country in adults over age 75 who live alone.[1]

Thirty nine percent (39%) of Iowans over 75 live alone. It has been consistently demonstrated that "living alone" is a key risk factor for premature institutionalization, especially for older adults living in rural communities. The significant numbers of older adults who do not live with a supportive family member or caregiver place greater demands on Iowa's aging network as it strives to help these older adults maintain their independence.

Iowa serves proportionately more adults in nursing facilities than any other state when controlling for state population.[2]

Iowa leads the nation in number of nursing facility beds per adult age 65 and older. The State ranks highest in the nation in the ratio of adults over age 75 living in nursing facilities per 100 adults 75+. Iowa is #2 in the ratio of adults over age 65 living in nursing facilities per 100 adults 65+[3]. This exceptionally high utilization of nursing facilities suggests that too many Iowans may be entering nursing facilities compared to other states and that strengthening the community-based network is essential to balancing the long term care system to better align with what older Iowans say they want.

Data from the *Service Needs of Older Iowans* confirms older Iowans are in search of information about available home and community based services. In particular, the 75 and older cohort reported it is "somewhat likely" they will need services within the next two years that they

[1] Houser, A., Fox-Grage, W. & Gibson, M. Across the States 2009: Profiles of Long-Term Care and Independent Living. (2009, March). Washington, DC: AARP. Retrieved on May 29, 2009, from http://www.aarp.org/research/longtermcare/trends/d19105_2008_ats.html

[2] Ibid

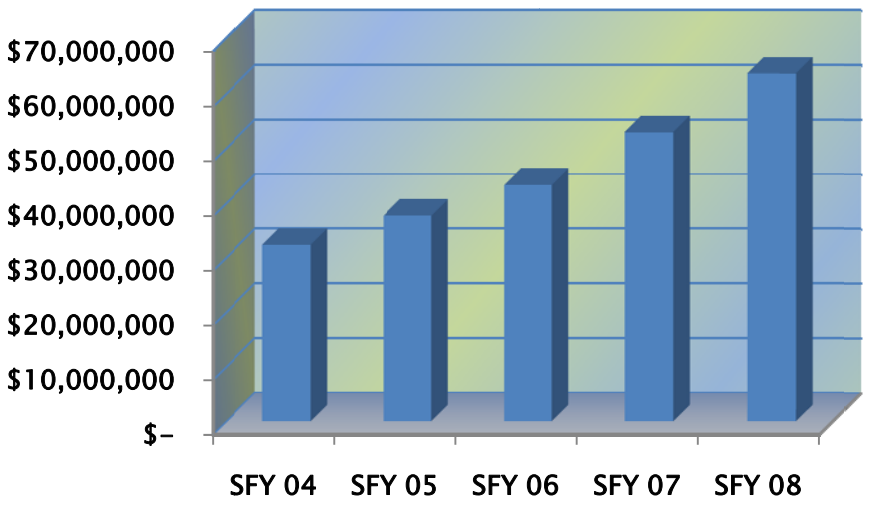
[3] Ibid

currently do not have. A reasonable expectation can be made that this group of older adults will greatly benefit from having information about available programs and services. The survey also reported that 15-21% of older adults across Iowa's 16 Planning and Service Areas are caregivers that need information about financial support for caregivers.

Iowa is second only to Nevada in annual growth of Medicaid elderly waiver expenditures.[4]

Medicaid Elderly Waiver expenditures in Iowa have grown by an average annual rate of 21%, which is the second highest rate of growth when compared to other states that have waivers specifically for older adults. (See Figure 5.) This growth is primarily due to the rise in the number of elderly waiver clients and the increased service utilization per client. It is projected that this level of growth will continue into the foreseeable future which will translate into increased pressure on both the Medicaid program and on services provided through the aging network.

Figure 5. Growth in Medicaid Elderly Waiver Expenditures



Source: Eiken, S., Iwan, M.J., & Gold, L. (March 31, 2009). *Iowa State Profile Tool: An Assessment of Iowa's Long-Term Support System. Des Moines, Iowa: Iowa Department on Aging.*

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[4] Eiken, S & Burwell B. "Medicaid HCBS Waiver Expenditures FY 2002-2007, 10/1/2008.

Key Challenges

Iowans are living longer and healthier lives. This will present opportunities in the areas of health and long-term care, housing, education, employment, and others. This will also present challenges for the State of Iowa and the Iowa's Aging Services Network including but not limited to the following issues:

1) Iowa will continue to experience significant unmet home and community-based service needs for older adults and will be challenged to build needed service capacity.

2) Iowa will continue to be challenged to provide adequate financial resources and alternate models that will address the need for systems change that meet the increasing demand for home and community-based services.

3) A political and systemic bias which provides far greater taxpayer funding to providers of institutional (nursing homes, etc.) over generally lower cost home and community based services, which are in fact preferred by most older Iowans.

Conclusion

There is much work to be done over the next four years. Our plan will serve as a blueprint to guide us. Through the implementation of this plan, the Iowa Department on Aging will seek to engage older Iowans, their families, policy makers and collaborate with other key government and non-government partners to ensure Iowa is ready to respond to the needs of all older Iowans.

The importance of these partnerships is demonstrated in the goals, objectives, strategies and expected outcomes of the State Plan, which will assist us as we strive to balance the array of support and services available to Iowans. We will continue to focus on addressing the documented unmet needs of older Iowans and work to protect the rights and maintain the safety of vulnerable adults.

Most importantly, we will work to ensure older Iowans are empowered to make informed decisions about, and easily access existing health and long-term care options they need to live in independently in the setting of their choice.

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Appendix A
Assurances for State plan on Aging and Area Plan on Aging

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ASSURANCES

Listing of State Plan Assurances and Required Activities

Older American's Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to perform all listed assurances and required activities.

Sec. 305. Organization

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title—

(1) the State shall, in accordance with regulations of the Assistant Secretary, designate a State agency as the sole State agency to—

(A) develop a State plan to be submitted to the Assistant Secretary for approval under section 307;

(B) administer the State plan within such State;

(C) be primarily responsible for the planning, policy development, administration, coordination, priority setting, and evaluation of all State activities related to the objectives of this Act;

(D) serve as an effective and visible advocate for older individuals by reviewing and commenting upon all State plans, budgets, and policies which affect older individuals and providing technical assistance to any agency, organization, association, or individual representing the needs of older individuals; and

(E) divide the State into distinct planning and service areas (or in the case of a State specified in subsection (b)(5)(A), designate the entire State as a single planning and service area), in accordance with guidelines issued by the Assistant Secretary, after considering the geographical distribution of older individuals in the State, the incidence of the need for supportive services, nutrition services, multipurpose senior centers, and legal assistance, the distribution of older individuals who have 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 residing in such areas, the distribution of older individuals who have 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) residing in such areas, the distribution of older individuals who are Indians residing in such areas, the distribution of resources available to provide such services or centers, the boundaries of existing areas within the State which were drawn for the planning

or administration of supportive services programs, the location of units of general purpose local government within the State, and any other relevant factors;

(2) the State agency shall—

(A) except as provided in subsection (b)(5), designate for each such 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;

(B) 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;

(C) in consultation with area agencies, in accordance with guidelines issued by the Assistant Secretary, and using the best available data, develop and publish for review and comment a formula for distribution within the State of funds received under this title that takes into account—

(i) the geographical distribution of older individuals in the State; and

(ii) the distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals;

(D) submit its formula developed under subparagraph (C) to the Assistant Secretary for approval;

(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;

(F) provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16); and

(G)(i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older individuals and older individuals residing in rural areas;

(ii) 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

(iii) provide a description of the efforts described in clause (ii) that will be undertaken by the State agency; and

(3) the State agency shall, consistent with this section, promote the development and implementation of a State system of long-term care that is a comprehensive, coordinated system that enables older individuals to receive long-term care in home and community-based settings, in a manner responsive to the needs and preferences of the older individuals and their family caregivers, by—

(A) collaborating, coordinating, and consulting with other agencies in such State responsible for formulating, implementing, and administering programs, benefits, and services related to providing long-term care;

(B) participating in any State government activities concerning long-term care, including reviewing and commenting on any State rules, regulations, and policies related to long-term care;

(C) conducting analyses and making recommendations with respect to strategies for modifying the State system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(D) implementing (through area agencies on aging, service providers, and such other entities as the State determines to be appropriate) evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(E) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, area agencies on aging, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources.

(b)(1) In carrying out the requirement of subsection (a)(1), the State may designate as a planning and service area any unit of general purpose local government which has a population of 100,000 or more. In any case in which a unit of general purpose local government makes application to the State agency under the preceding sentence to be designated as a planning and service area, the State agency shall, upon request, provide an opportunity for a hearing to such unit of general purpose local government. A State may designate as a planning and service area under subsection (a)(1) any region within the State recognized for purposes of area wide planning which includes one or more such units of general purpose local government when the State determines that the designation of such a regional planning and service area is necessary for, and will enhance, the effective administration of the programs authorized by this title. The State may include in any planning and service area designated under subsection (a)(1) such additional areas adjacent to the unit of general purpose local government or regions so designated as the State determines to be necessary for, and will enhance the effective administration of the programs authorized by this title.

(2) The State is encouraged in carrying out the requirement of subsection (a)(1) to include the area covered by the appropriate economic development district involved

in any planning and service area designated under subsection (a)(1), and to include all portions of an Indian reservation within a single planning and service area, if feasible.

(3) The chief executive officer of each State in which a planning and service area crosses State boundaries, or in which an interstate Indian reservation is located, may apply to the Assistant Secretary to request re-designation as an interstate planning and service area comprising the entire metropolitan area or Indian reservation. If the Assistant Secretary approves such an application, the Assistant Secretary shall adjust the State allotments of the areas within the planning and service area in which the interstate planning and service area is established to reflect the number of older individuals within the area who will be served by an interstate planning and service area not within the State.

(4) Whenever a unit of general purpose local government, a region, a metropolitan area or an Indian reservation is denied designation under the provisions of subsection (a)(1), such unit of general purpose local government, region, metropolitan area, or Indian reservation may appeal the decision of the State agency to the Assistant Secretary. The Assistant Secretary shall afford such unit, region, metropolitan area, or Indian reservation an opportunity for a hearing. In carrying out the provisions of this paragraph, the Assistant Secretary may approve the decision of the State agency, disapprove the decision of the State agency and require the State agency to designate the unit, region, area, or Indian reservation appealing the decision as a planning and service area, or take such other action as the Assistant Secretary deems appropriate.

(5) (A) A State which on or before October 1, 1980, had designated, with the approval of the Assistant Secretary, a single planning and service area covering all of the older individuals in the State, in which the State agency was administering the area plan, may after that date designate one or more additional planning and service areas within the State to be administered by public or private nonprofit agencies or organizations as area agencies on aging, after considering the factors specified in subsection (a)(1)(E). The State agency shall continue to perform the functions of an area agency on aging for any area of the State not included in a planning and service area for which an area agency on aging has been designated.

(B) Whenever a State agency designates a new area agency on aging after the date of enactment of the Older Americans Act Amendments of 1984, the State agency shall give the right to first refusal to a unit of general purpose local government if

(i) such unit can meet the requirements of subsection (c), and

(ii) the boundaries of such a unit and the boundaries of the area are reasonably contiguous.

(C)(i) A State agency shall establish and follow appropriate procedures to provide due process to affected parties, if the State agency initiates an action or proceeding to—

(I) revoke the designation of the area agency on aging under subsection (a);

(II) designate an additional planning and service area in a State;

(III) divide the State into different planning and service areas; or

(IV) otherwise affect the boundaries of the planning and service areas in the State.

(ii) The procedures described in clause (i) shall include procedures for—

(I) providing notice of an action or proceeding described in clause (i);

(II) documenting the need for the action or proceeding;

(III) conducting a public hearing for the action or proceeding;

(IV) involving area agencies on aging, service providers, and older individuals in the action or proceeding; and

(V) allowing an appeal of the decision of the State agency in the action or proceeding to the Assistant Secretary.

(iii) An adversely affected party involved in an action or proceeding described in clause (i) may bring an appeal described in clause (ii)(V) on the basis of—

(I) the facts and merits of the matter that is the subject of the action or proceeding; or

(II) procedural grounds.

(iv) In deciding an appeal described in clause (ii)(V), the Assistant Secretary may affirm or set aside the decision of the State agency. If the Assistant Secretary sets aside the decision, and the State agency has taken an action described in sub-clauses (I) through (III) of clause (i), the State agency shall nullify the action.

(c) An area agency on aging designated under subsection (a) shall be—

(1) an established office of aging which is operating within a planning and service area designated under subsection (a);

(2) any office or agency of a unit of general purpose local government, which is designated to function only for the purpose of serving as an area agency on aging by the chief elected official of such unit;

(3) any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for such purpose;

(4) any public or nonprofit private agency in a planning and service area, or any separate organizational unit within such agency, which is under the supervision or direction for this purpose of the designated State agency and which can and will engage only in the planning or provision of a broad range of supportive services, or nutrition services within such planning and service area; or

(5) in the case of a State specified in subsection (b)(5), the State agency; and 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. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

(d) The publication for review and comment required by paragraph (2)(C) of subsection (a) shall include—

(1) a descriptive statement of the formula's assumptions and goals, and the application of the definitions of greatest economic or social need,

(2) a numerical statement of the actual funding formula to be used,

(3) a listing of the population, economic, and social data to be used for each planning and service area in the State, and

(4) a demonstration of the allocation of funds, pursuant to the funding formula, to each planning and service area in the State.

(42 U.S.C. 3025)

Sec. 306. Area Plans

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, or construction of multipurpose senior centers, within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have 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) residing in such area, the number of older individuals who have 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) residing in such area, the number of older individuals at risk for institutional placement residing in such area, and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community, evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) 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;

(3) (A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(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 sub-clause (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

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(I) identify the number of low-income minority older individuals 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 (i);

(B) provide assurances that the area agency on aging will use outreach efforts that will—

(i) 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

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and

(C) contain an 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) 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) provide that the area agency on aging will—

(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;

(C)(i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that-

(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42 U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) 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;

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that—

(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) 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;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as ''older Native Americans''), including—

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans; and

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) 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;

(C) 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 contract or such relationship;

(D) 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 contract or such relationship; and

(E) 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) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of 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;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care; and

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

(b)(1) An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are 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.

(2) Such assessment may include—

(A) the projected change in the number of older individuals in the planning and service area;

(B) 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;

(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(D) an analysis of how the change in the number of individuals age 85 and older in the planning and service area is expected to affect the need for supportive services.

(3) An area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service

area to meet the needs of older individuals for—

(A) health and human services;

(B) land use;

(C) housing;

(D) transportation;

(E) public safety;

(F) workforce and economic development;

(G) recreation;

(H) education;

(I) civic engagement;

(J) emergency preparedness; and

(K) any other service as determined by such agency.

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

(d) (1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f) (1) If the head of a State agency finds that an area agency on aging has failed to comply with Federal or State laws, including the area plan requirements of this section, regulations, or policies, the State may withhold a portion of the funds to the area agency on aging available under this title.

(2)(A) The head of a State agency shall not make a final determination withholding funds under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the State agency.

(B) At a minimum, such procedures shall include procedures for—

(i) providing notice of an action to withhold funds;

(ii) providing documentation of the need for such action; and

(iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

(3) (A) If a State agency withholds the funds, the State agency may use the funds withheld to directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

Sec. 307. State Plans

(a) Except as provided in the succeeding sentence and section 309(a), each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan for a two-, three-, or four year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a State failed in 2 successive years to comply with the requirements under this title, then the State shall submit to the Assistant Secretary a State plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the State is in compliance with such requirements. Each such plan shall comply with all of the following requirements:

(1) The plan shall—

(A) require 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) be based on such area plans.

(2) The plan shall provide that the State agency will—

(A) evaluate, using uniform procedures described in section 202(a)(29), 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) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; and

(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 section 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2).

(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 intrastate distribution of funds); and

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

(i) provide assurances that the State agency will spend for each fiscal year, 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); and

(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.

(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).

(5) The plan shall provide that the State agency will—

(A) afford an opportunity for a 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) issue guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any 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 plan shall provide that 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.

(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.

(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.

(8)(A) The plan shall provide that no supportive services, nutrition services, or in-home services will be 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.

(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.

(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 assurances 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) The plan shall provide that with respect to legal assistance—

(A) the plan contains 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 (i) 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;

(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;

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

(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; and

(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—

(A) 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—

(i) public education to identify and prevent abuse of older individuals;

(ii) receipt of reports of abuse of older individuals;

(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 where appropriate and consented to by the parties to be referred; and

(iv) referral of complaints to law enforcement or public protective service agencies where appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

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

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

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

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who—

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

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

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

(21) The plan shall—

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

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

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

(23) The plan shall provide assurances that demonstrable efforts will be made—

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

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

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

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

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

(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.

(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.

(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.

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. 316. Waivers.

(a) IN GENERAL.—The Assistant Secretary may waive any of the provisions specified in subsection (b) with respect to a State, upon receiving an application by the State agency containing or accompanied by documentation sufficient to establish, to the satisfaction of the Assistant Secretary, that—

(1) approval of the State legislature has been obtained or is not required with respect to the proposal for which waiver is sought;

(2) the State agency has collaborated with the area agencies on aging in the State and other organizations that would be affected with respect to the proposal for which waiver is sought;

(3) the proposal has been made available for public review and comment, including the opportunity for a public hearing upon request, within the State (and a summary of all of the comments received has been included in the application); and

(4) the State agency has given adequate consideration to the probable positive and negative consequences of approval of the waiver application, and the probable benefits for older individuals can reasonably be expected to outweigh any negative consequences, or particular circumstances in the State otherwise justify the waiver.

(b) REQUIREMENTS SUBJECT TO WAIVER.—The provisions of this title that may be waived under this section are—

(1) any provision of sections 305, 306, and 307 requiring statewide uniformity of programs carried out under this title, to the extent necessary to permit demonstrations, in limited areas of a State, of innovative approaches to assist older individuals;

(2) any area plan requirement described in section 306(a) if granting the waiver will promote innovations or improve service delivery and will not diminish services already provided under this Act;

(3) any State plan requirement described in section 307(a) if granting the waiver will promote innovations or improve service delivery and will not diminish services already provided under this Act;

(4) any restriction under paragraph (5) of section 308(b), on the amount that may be transferred between programs carried out under part B and part C; and

(5) the requirement of section 309(c) that certain amounts of a State allotment be used for the provision of services, with respect to a State that reduces expenditures under the State plan of the State (but only to the extent that the non-Federal share of the expenditures is not reduced below any minimum specified in section 304(d) or any other provision of this title).

(c) DURATION OF WAIVER.—The application by a State agency for a waiver under this section shall include a recommendation as to the duration of the waiver (not to exceed the duration of the State plan of the State). The Assistant Secretary, in granting such a waiver, shall specify the duration of the waiver, which may be the duration recommended by the State agency or such shorter time period as the Assistant Secretary finds to be appropriate.

(d) REPORTS TO SECRETARY.—With respect to each waiver granted under this section, not later than 1 year after the expiration of such waiver, and at any time during the waiver period that the Assistant Secretary may require, the State agency shall prepare and submit to the Assistant Secretary a report evaluating the impact of the waiver on the operation and effectiveness of programs and services provided under this title.

Sec. 705. Additional State Plan Requirements.

(a) ELIGIBILITY.—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

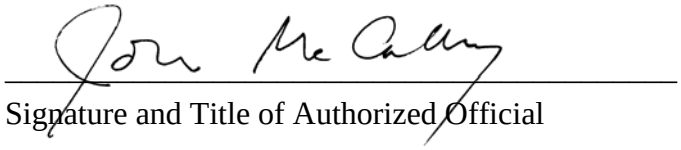
except—

(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; and

(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).



Signature and Title of Authorized Official

July 1, 2009

Date

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Appendix B
Rural and Urban
Area Plans on Aging

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GENERATIONS AREA AGENCY ON AGING

Area IX Services Plan on Aging
State Fiscal Years 2010 – 2013

Submitted April 1, 2009

Policy Board Adopted March 25, 2009

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1.1 VERTIFICATION OF INTENT AND AREA AGENCY SIGNATURES

Verification of Intent

Verification of Intent

Generations Area Agency on Aging accepts full authority and responsibility to develop and administer the Area Plan in accordance with all requirements of the Older Americans Act as amended, 2006, and related Iowa Administrative Code and State policy. By accepting this authority and responsibility, the Area Agency agrees to develop and administer the Area Plan for a comprehensive and coordinated system of service and to serve as the advocate and focal point for all Iowans 60+ years of age in the Area Agency's planning and service area.

The Area Plan is hereby submitted for Fiscal Years 2010-2013 to the Iowa Department of Elder Affairs for approval.

_____ _____

Date Marvin Webb, Director/CEO

Generations Area Agency on Aging
Area Agency on Aging

The Area Agency Advisory Council has reviewed the Area Plan and approves the plan.

_____ _____

Date Chairperson, Advisory Council

Generations Area Agency on Aging
Area Agency on Aging

The governing body of the Area Agency has reviewed the Area Plan and approves the plan.

_____ _____

Date Dennis Mumm, President/ Board of Directors

Generations Area Agency on Aging
Area Agency on Aging

Authorized Signatures
Area Plan / Fiscal years 2010 – 2013

Generations Area Agency on Aging Name of Area Agency	935 E. 53rd Street Street Address
Davenport City	IA 52807 State & Zip
AAA Type of Agency	October 1973 Date of AAA Designation
Signature of Director	Signature of Board Chair

Authorized Signatures for Funding Applications and Contracts

Marvin Webb, Director/CEO — Date Signed

Dennis Mumm, Board of Directors President — Date Signed

Carol Minard, Board of Directors Vice President — Date Signed

Christa Merritt, Assistant Director — Date Signed

Fiscal Reports (Other than Area Agency Director, if applicable)

Danielle Pickering, Fiscal Director — Date Signed

Christa Merritt, Assistant Director — Date Signed

Program Reports (Other than Area Agency Director, if applicable)

Christa Merritt, Assistant Director — Date Signed

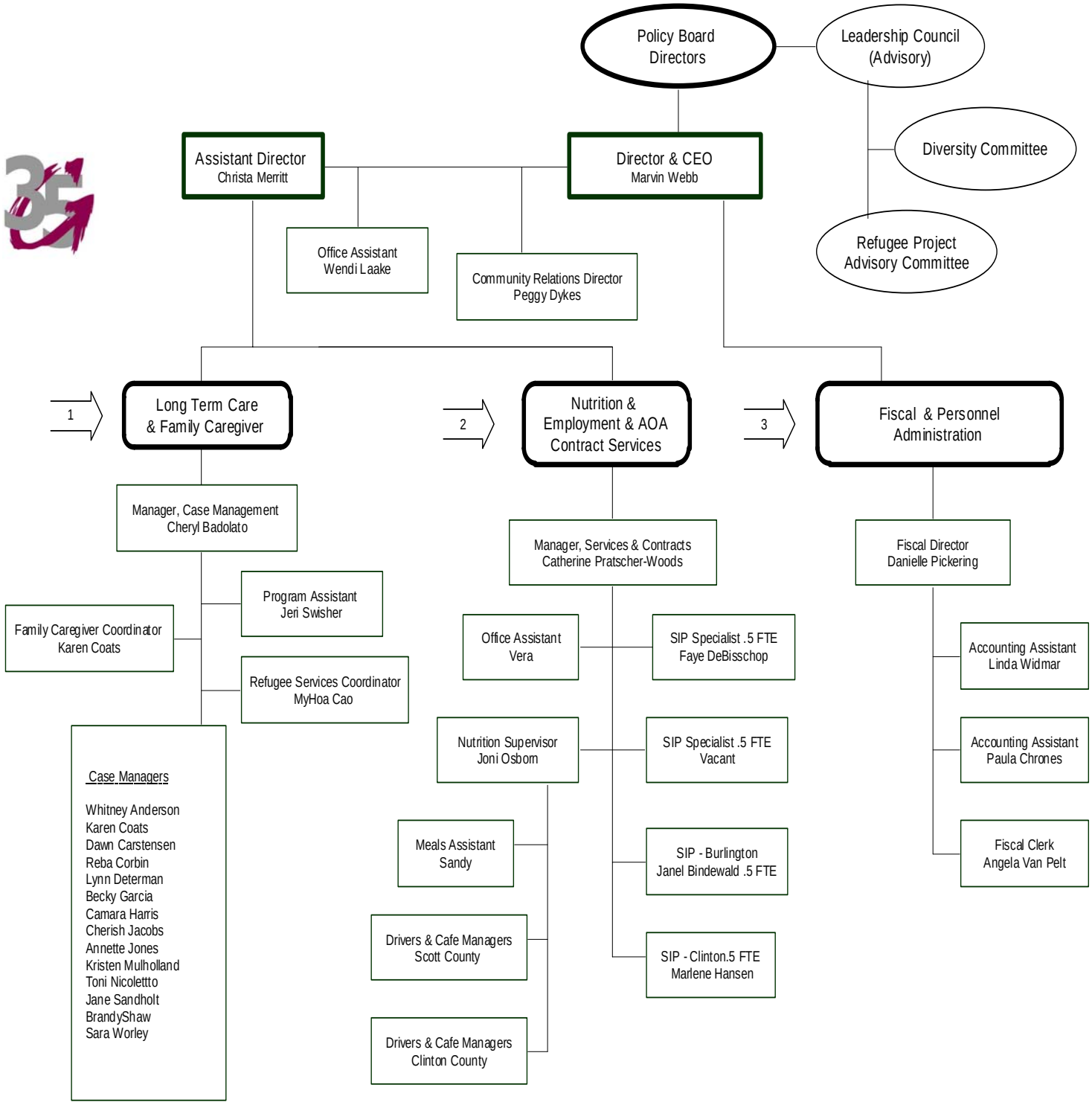
Cheryl Badolato, Case Management Manager — Date Signed

Catherine Pratscher-Woods, Contracts & Services Manager — Date Signed

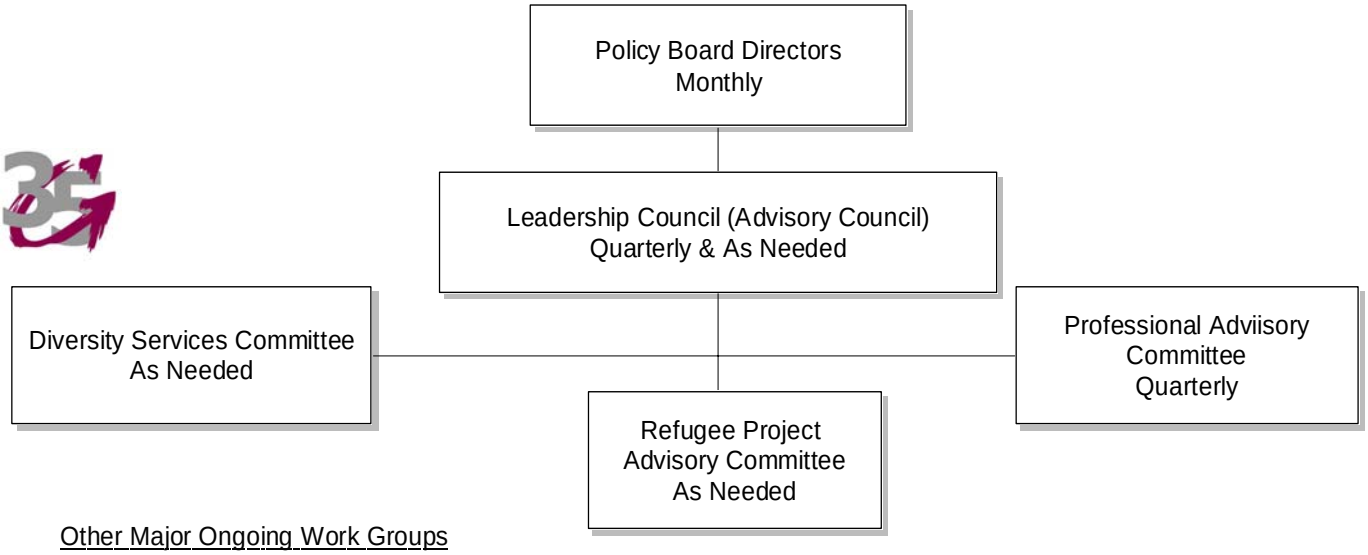
Karen Coats, Family Caregiver Coordinator — Date Signed

1.2 ORGANIZATIONAL STRUCTURE

Organizational Chart



Administrative and Program Workgroups



Other Major Ongoing Work Groups

- ✓ Multi Disciplinary Team - Monthly Dependent Adult Abuse & older adults in an at risk situation (Department of Human Services and local provider organizations)
- ✓ Home Care Providers - Quarterly each county (80 areawide providing home care services)
- ✓ Falls Work Group - Monthly and as needed (Generations, Genesis & Trinity Health Systems)
- ✓ Choices Connection Work Group - As needed (Genereations, Genesis & Trinity Health Systems)

Staff Sharing Opportunities

Monthly - All Staff
Weekly - Management Team
Bi-annual - Nutrition Staff
Quarterly - Older Worker Specialists
First Monday - Budget Review

Area Agency Board Officials and Members

Board Officials of the Generations Area Agency on Aging

Chairperson

Name: Dennis Mumm
Address: 622 12th Avenue
DeWitt, IA 52742
Phone #: (563) 659-5641
E-Mail Address:

Vice-Chairperson

Name: Carol Minard
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Secretary / Treasurer

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Other Board Members

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Other Board Members

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Other Board Members - continued

Other Board Members

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Bettendorf, IA 52722

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Vivian Lane
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(563) 263-5605

Advisory Council Composition

Advisory Council
Committee Composition:

1. *More than 50% older persons, including minority individuals who are participants or who are eligible to participate in programs under this part.*

Generations has representation of 59% of persons over the age of 60 on the Leadership Council.

2. *Representatives of older persons.*

Ten people are over the age of 60, representing 59% of the Council.

3. *Representatives of health care provider organizations, including providers of veterans' health care.*

There are three representatives of health care providers, representing 17% of the Council.

4. *Representatives of supportive services providers organizations.*

There are eight representatives of supportive services organizations, representing 47% of the Council.

5. *Persons with leadership experience in the private and voluntary sectors.*

100% of the members of the Council have leadership experience in the private & voluntary sectors.

6. *Local Elected Officials*

Three people on the council represent local units of government, representing 18% of the Council.

7. *The General Public*

Seven people represent the general public, 41% of the Council.

1.3 PLANNING AND SERVICE AREA OVERVIEW

Mission/Vision Statements and Demographic Data

Mission Statement

Generations is the one resource for connecting seniors and caregivers to services.

Vision Statement

Generations will be the organization for assisting seniors and caregivers to identify and access the services and resources for seniors to remain independent and self-sufficient.

Population(s) Served

Generations serves older adults age 60 and beyond in all programs and those 55 and older in the employment program, which includes five additional counties. Generations serves Clinton, Scott and Muscatine Counties in Iowa with a total three county population of 250,539. Within the three counties there are 42,130 age 60+, 15,710 age 75+ and 4,233 age 85+.

Diversity

The total 60+ population within the three county area is 42,130 and there are 1,524 minorities within that population. There are 830 African Americans, 95 American Indian, 184 Asian, 240 other race and 175 are two or more races.

Rural Communities

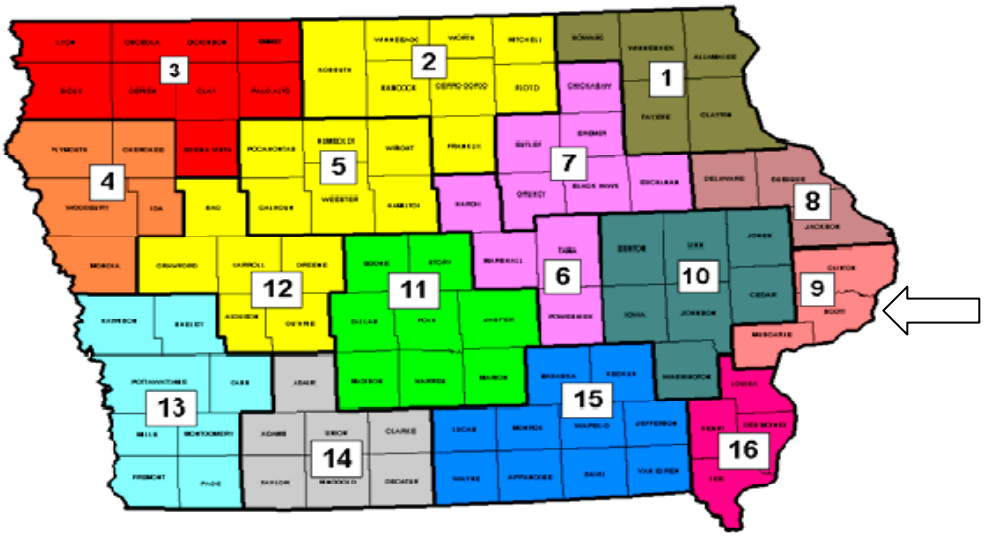
Within Generations 42,130 people over the age of 60, approximately 18.3% of that population lives in rural areas, or 7,725 people. There are 5,465 people over the age of 65 living in rural areas and 2,225 of those people over the age of 75.

Growth of 85+ Population

The projected growth of the 85+ population in the Generations three county areas will be 5,423 people by 2010 in comparison to 4,261 from the year 2000. This number will increase slightly in 2020 to 5,508 people and then increase more significantly in 2030 to 6,531.

Targeting Plan

Generations Area Agency on Aging serves a three county area in Iowa covering Clinton, Muscatine and Scott Counties. Generations is consider as Area 9 in the state and has offices in Davenport, Clinton and Muscatine, Iowa.



The total number of people within the three county area is approximately 250,540 with 42,130 being over the age of 60. This represents 16.8% of the total population in the three counties and 8% of the state's 60+ population. The projected population for Generations Area 9 in 2015 is 263,334 with approximately 48,190 of those people representing the 60+ population.

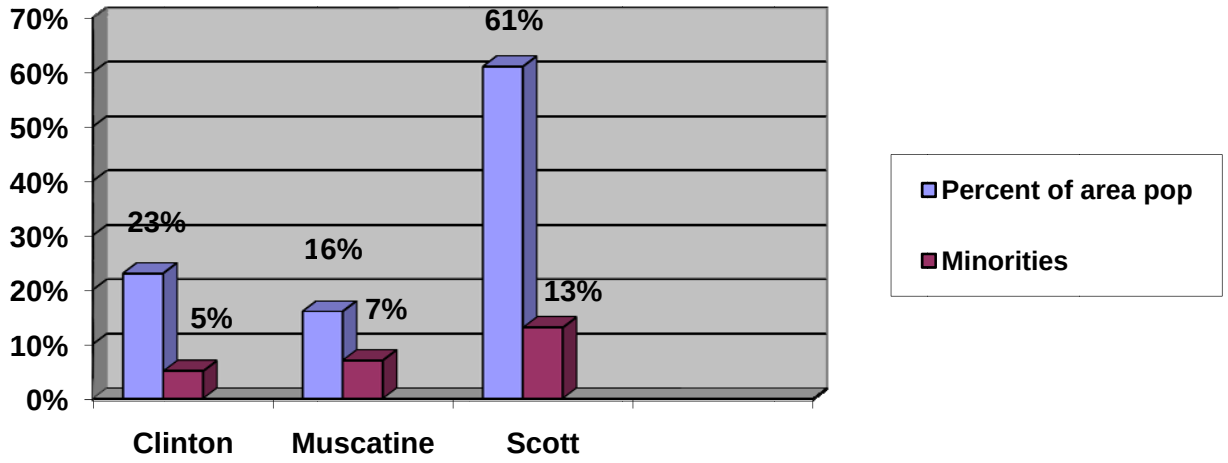
Population Served

- There are 42,130 people age 60+ in Area 9
- Number of 60+ living in rural areas is 7,725 people (18.3%)
- Number of 60+ minorities is 1,524 (3.6%)
- Number of 60+ minorities below poverty level is 344 (22.5% of minority population)
- Number of 60+ African Americans is 830
- Number of 60+ American Indian / Alaska Native is 95
- Number of 60+ Asians is 184
- Number of 60+ Other Race is 240
- Number of 60+ two or more races is 175

Within the counties of Area 9 the total population is 250,540. Scott County has 61% of the total population, Clinton County has 23% and Muscatine County represents 16%. The services provided through Generations also correlate to these percentages within programs. For fiscal year 2008, Generations delivered approximately 337,105 units of service to 5,921 individuals. This shows that on average individuals received 57 units of service for the year.

Based on total populations within each county, Scott County has a 13% minority representation as Muscatine County has 7% and Clinton County has 5%. The three county area has fairly large cities with Davenport, Bettendorf, Clinton and Muscatine which allows for fairly good conditions for choices and selection of services. Transportation is easily accessible in most areas of the counties and RiverBend Transit provides additional transportation services in Clinton and Scott Counties and Muscabus is available in Muscatine. Generations has approximately 29 Genage Cafes throughout the three county area to provide meal sites to people throughout the counties, even those located in smaller towns. All three counties have access to medical care and mental health

counseling options. There are five large hospital systems that provide services and support to residents and clients of Generations.



Expected Growth in Planning & Service Area

PSA or County	Percent Growth Population 60+: Years
Generations Area 9	Projected growth of 15,903 more people age 60+ by 2020

This projection is based on US Census Data that projects the total population over the age of 60 in the State of Iowa will increase by approximately 198,793 people from the year 2000 to the year 2020. Based on this number, Generations has approximately 8% of the older population in Iowa which would indicate an increase of 15,903 more people. The most significant increase will be seen in the age group of 85+ with a projected increase of 26,190 people or about a 40% increase.

TOPIC 2. Diversity

Population of People age 60+ / 2000 Census Projection

Characteristic	Number / PSA	Percent (%) / PSA
Rural	**7,725**	**18.3%**
Urban	**34,405**	**81.7%**
Disabled	**11,858*(65+ population)**	**38.3%* (65+ population)**
Limited English Proficiency		
Minority	**1,524**	**3.75%**
Poverty	**2,869**	**6.8%**

Source: U.S. Census Bureau

TOPIC 3. Rural Communities

The population densities of the three county area show:

- Clinton County 76.7 people per square mile/low
- Muscatine County 97.0 people per square mile/average
- Scott County 355 people per square mile/high

Muscatine and Clinton Counties represent more of the rural population of Area 9. Scott County is more urban with some areas that are rural.

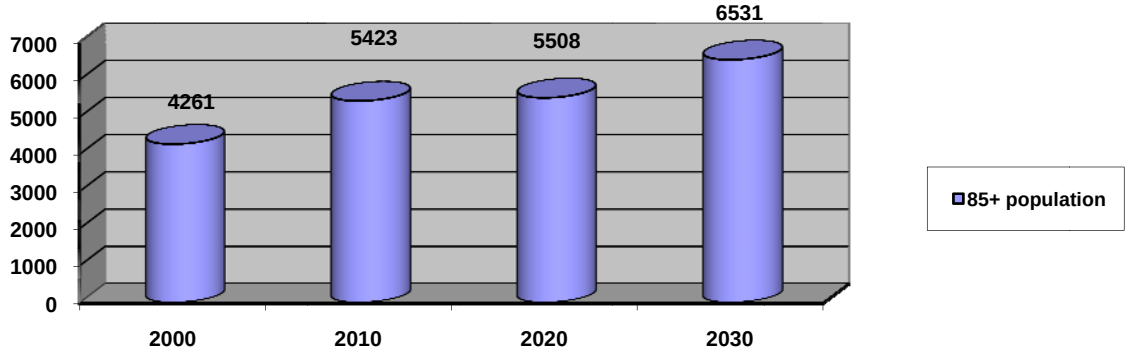
TOPIC 4. Growth of 85+ Population

Generations has a projected increase of the total 85+ population increasing 1162 people from the year 2000 to 2010. There is projected to be another slight increase to 5508 people in the year 2020 with a significant increase to 6531 people in 2030. The numbers from the year 2000 to those projected in the year 2030 shows an increase of 2270 people or a 53.3% increase.

In comparison to the other Area Agencies on Aging, Generations shows a large increase with the increases ranging from 5.5% to 86.2%. Generations shows the 3rd highest increase in this population among Iowa's thirteen AAA's with the 5th highest 85+ population overall.

Based on this information, we could predict that more services will be needed in all areas, especially within the case management unit. The number of people age 60+ will increase with the biggest impact being in the age group of 85+.

Projected increase in the number of persons age 85+ in Generations Area 9
(as provided by Department on Aging):



TOPIC 5. Informal Caregiver System

Generations developed a multidisciplinary team to focus on educating people on how to prevent falls and providing risk assessments to people to see if they are at a higher risk of falling. Generations works in collaboration with the two large hospital systems in the area as well as with Braaten Health, which provides the actual falls assessments to people at the presentations. The group began gathering this data and following up with the participants to see if they had made recommended changes to prevent falls. There were 506 assessments completed last year with 180 of them determined to be "at risk" for falling. This was an increase of 421 assessments completed in the previous year.

Generations purchased an additional 24 Medication machines last year for loan to people within the community. Eighty seven loaner machines were distributed in 2007. Generations sends out donation requests with the machines.

Generations continues to provide Caregiver Support Groups once a month in Clinton and Scott Counties. The group in Clinton county is done in collaboration with Mercy hospital. The hospital provides a location and assistance with speakers for the group. Muscatine County organizes their support groups.

The Caregiver program continues to provide respite and material aid services.

Generations continues to be part of a grant with the University of Iowa. Staff was trained by the University of Iowa, Center for Disability and Development program and have presented the Living Well with Independence class to seniors housed at an assisted living facility in Scott County. Topics include; setting goals, solving problems, health reactions, healthy communication and eating well.

Generations continues to participate in the Senior Medicare Patrol to prevent Medicare/Medicaid waste, fraud and abuse. Information is distributed at local health/senior fairs and there are events scheduled in each county in February, May, August and November of this year.

Choices Connection continues to move forward with Generations is the community partner with the two local, large hospital systems. This is a program to promote the Advanced Care Planning initiative.

Nutrition Initiatives:
Congregate and home delivered meals continue to provide meals in the three counties. There are 29 GenAge Cafe sites, with more sites being requested. Generations continues to focus on meeting the Intake Guidelines and is a part of the Chef Charles program, a state program focusing on wellness and healthy eating. Generations also collaborates with Eastern Iowa Community College as part of the BASICS grant. The college reimburses for food cost for samples done twice a month. There is also a registered dietician offered through the grant to help with information and presentations. Newsletters are provided that give healthy recipes and ideas for promoting healthy eating. Generations promotes the Chef Charles program with events at local assisted living facilities and community venues to provide taste samples of recipes. Those recipes with positive feedback are added to the menu for the congregate meal sites.
Generations has began to offer Nutritional Counseling to those congregate and home delivered meal participants who are determined to be at risk by the Nutritional Risk Outcome Report in NAPIS. Individuals who receive the counseling are provided with information and assistance in improving their scores through a Registered Dietician. Data for this service will be under the taxonomy of Material Aid and available beginning the 4th quarter of FY '09.
The amount of Farmer's Market Checks distributed by Generations increased in 2008. There were a total of 2,245 books given out within the three counties for the Farmer's Markets. This was an increase of 181 books from 2007. Of those books Clinton County received 23% of the books, Muscatine County received 16% of the books and Scott County received 61% of the books. This correlates exactly with the percentage representation of the population served in each county. The age group of 60-69 received 37% of the books, while 35% went to age 70-79, 23% in the age group 80-89, 4% to those 90-99 and there were 14 people or .6% that went to people age 100+.
Generations is continuing to explore the options for expansion of the GenAge Cafes by utilizing local restaurants or grocery stores as a possible alternative on nights or weekends. The focus would be on needs not currently being addressed, low income and underserved areas and neighborhoods. These ideas will be explored and progress will move forward over the next few years with this idea.

Elderly Refugee Project:
Generations continues to participate in the Elderly Refugee Project coordinated by My-Hoa Cao. The overall goals continue to be focused on insuring all older refugees who require services are linked to mainstream aging services within the community and to provide culturally and linguistically appropriate services when they do not already exist and to expand existing services to accommodate increased numbers of older refugees. The program assists in creating opportunities that will enable older refugees to live independently as long as possible and to assist older refugees to access citizenship and naturalization services.
From April 2008 to September 2008 outreach was continued throughout the three county area and during that time provided services to 35 older refugees, all of which are Vietnamese. My-Hoa also continues to assist local law enforcement and hospitals in translating for them when needed. The program advisory committee continues to meet every other month. Generations also continues to provide traditional Vietnamese food at the Vietnamese meal site on the third Saturday of each month.

Senior Employment Program:
Senior Internship Program (SIP) funds are used to provide direct services to eligible Senior Community Services Employment Program (SCSEP) participants who are paid the minimum wage to work 20 hours per week while receiving training and performing valuable services in their local communities at agencies such as homeless shelters, YMCA's, meal sites, Salvation Army Retail shops, museums, senior centers, adult and child daycare locations etc. Eligible participants are unemployed workers 55 and over with income levels at or below 125% of poverty guidelines and with multiple barriers to employment, including low literacy levels, disabilities, homelessness, and being out of the workforce for an extended length of time. The program's benefits are substantial. In the past twelve months approximately 43,156 service hours were provided by the Generations' SIP participants through 33 different community agencies. While providing services in the community, participants are also obtaining skills, experience, and confidence they can use in regular jobs when they leave this training program. Wages earned and spent by participants in the program stimulate local economies, and stave off their increased or sustained dependence on public services. The community organizations where participants work do not have the necessary funds to hire staff, and the services participants perform are valuable to local communities. The SIP program is scheduled to receive approximately 10 slots through the 2009 Stimulus Funds that will enable Generations to provide training to an increased number of older workers and also provide a boost to the local economy.

Generations' program covers the following counties: Jackson, Clinton, Scott, Muscatine, Louisa, Henry, Des Moines and Lee in Eastern Iowa. All older workers age 55 and better can receive assistance in their job search through this program. Those persons who meet the income requirements can be placed into subsidized training positions. In the past 12 months Generations provided the following:

Applicants: 295
Contacts with job seekers and employers: 3,600
Job Placements: 90
Participants in SCSEP: 86

Targeted services provided to

- 19% minority individuals
- 12% persons with less than a high school diploma
- 38% to persons with a disability
- 3% who have limited English proficiency
- 7 % low literacy
- 5% homeless individuals
- 48% who receive other public assistance benefits

NEEDS ASSESSMENT AND IMPLEMENTATION PLAN

Goal 1: Local Objective 1. Enable Older Iowans and Their Families to Make Informed Decisions About, and be Able to Easily Access, Existing Home and Long-Term Care Options.
(Agency-Specific Outcome)

Goal 1. Enable Older Iowans and Their Families to Make Informed Decisions About, and be Able to Easily Access, Existing Home and Long-Term Care Options

Local Objective 1.
Generations will enable older Iowans to easily access Material Aid, Transportation and Minor Home Repair services to provide them with opportunities for good and services and minor home improvements in 2010.

Needs Being Addressed
Generations provides services within this area under Material Aid, Minor Home Repair and Transportation. Material Aid includes aid in the form of goods or services such as food, smoke detectors, eyeglasses and security devices. Home Repair includes minor improvements to the residence or appliances.

Local Strategies / Action Steps

- Provide Material Aid services.
- Home Repair and Transportation services are registered services giving more accurate unduplicated client count and service units.
- Promote the Medication Management program by providing medication dispensing machines. We will expand inventory and refine the criteria for utilization of the machines.

Major Accomplishment(s) past and present regarding this goal.

- Generations now documents Home Repair and Transportation services as registered services through NAPIS (National Aging Program Information System).

Future Challenges

- Limited funding for Home and Community Based services.
- Addressing unmet needs in services with the increase in the overall 60+ population.

FY 2010 / Agency-Specific Outcome
Generations will increase the number of clients receiving Home and Community Based Services by 10% from 317 registered clients in ’08 to 349 registered clients in ’10.

Goal 1: Local Objective 1. Agency-Specific Outcome Measure

Agency-Specific Outcome Measure

NAME OF OUTCOME, PROJECT, SERVICE OR ACTIVITY TO BE MEASURED: Home and Community Based Services

OUTCOME MEASURE FORMAT TO USE: Generations will track the number of registered clients in the Home and Community Based Services within NAPIS.

COST & FUNDING SOURCE: Total budgeted FY '10 amount is $54,258 with $13,508 in Home Repair, $7,000 in Material Aid and $33,750 in Transportation.

Funding Sources are:

Home Repair: Elderly Services, SLP, IIIB

Material Aid: SLP, IIIE

Transportation: SLP

Measure	FY'07 Baseline Data (NAPIS registered clients)	FY'08 Actual (NAPIS registered clients)	FY'09 Year-to-Date 7/1/08-12/31/08 (NAPIS registered clients)	FY'2010 Projection (NAPIS registered clients)
NAPIS HCBS	N/A	317	299	349

GOAL: Generations will increase the number of registered clients within NAPIS under the Home and Community Based Services by 10%.

RATIONALE: Generations documents Home and Community Based Services within NAPIS. Transportation and Home Repair are now registered within the NAPIS program. The projection of 349 registered clients is based on an increase of 10% and with the number of current fiscal year clients registered. The variety of funding sources within this area led to the registering of services that were not registered in previous years.

Goal 1: Local Objective 2. Enable Older Iowans and Their Families to Make Informed Decisions About, and be Able to Easily Access, Existing Home and Long-Term Care Options.
(Agency-Specific Outcome)

Goal 1. Enable Older Iowans and Their Families to Make Informed Decisions About, and be Able to Easily Access, Existing Home and Long-Term Care Options

Local Objective 2.
Generations will enable older Iowans to easily access information through Outreach and Education programs to assist them in having the information needed to make decisions about home and long term care options in 2010.

Needs Being Addressed
Needs addressed within this area include Outreach and Education programs.

Local Strategies / Action Steps

- Formalize a Central Intake System for information and assistance among the three counties by updating the phone system to have one centralized location and training staff on the system.
- Publicize the organizations' website to include more information and clarity on programming for older adults and caregivers.
- Continue membership in 7 Chambers of Commerce in 3 counties.
- Newsletters to all GenAge Cafes for information on the most current information related to seniors.
- Have brochures and other information on all home care providers available to the public.
- Continue to be actively involved with the SMP program (Senior Medicare Patrol) that discusses Medicare Fraud, scams and encourages seniors to report fraud. Quarterly events in all three counties in collaboration with law enforcement and other organizations.
- Advanced Care Planning continues in collaboration with Generations and the two local hospital systems, Genesis and Trinity. This program promotes Advanced Care Directives and the discussion of the need for medical power of attorney. Generations plans to expand this service into Clinton County.
- Development of a Regional Diversity Committee as a part of the Leadership Council to recommend actions that assure services information is accessible to all area residents during the preventative years after age 60 and during any time of services need while older residents continue to live in their own home.
- Continue to work with RSVP (Retired Senior Volunteer Program) within Scott and Clinton Counties and with the Muscatine County Volunteer Center.

Major Accomplishment(s) past and present regarding this goal.

- Generations reports information in these areas and registers clients that would not have been registered in the past.
- SMP events occurring quarterly in all three counties.
- Outreach services with Latino seniors are addressed through a contract with the Diversity Services Center of Iowa in Muscatine.

Future Challenges

- Anticipation of an increase in number of contacts from family members.

FY 2010 / Agency-Specific Outcome
Generations will increase the number of older Iowans and their families receiving services through Outreach and Education programs to 550 registered clients in FY '10.

Goal 1: Local Objective 2. Agency-Specific Outcome Measure

Agency-Specific Outcome Measure

NAME OF OUTCOME, PROJECT, SERVICE OR ACTIVITY TO BE MEASURED: Outreach and Education activities.

OUTCOME MEASURE FORMAT TO USE: Registered clients under these areas within NAPIS.

COST & FUNDING SOURCE: Total budgeted amount for FY '10 is $55,303.

$54,058 is in Outreach with $1,245 in Education

Funding Sources:

Outreach: Elderly Services, SLP

Education: IIIE

Measure	FY'07 Baseline Data	FY'08 Actual	FY'09 Year-to-Date Registered NAPIS clients 7/1/08-12/31/08	FY'2010 Projection Registered NAPIS clients
Name of Measure, Project or Activity	**N/A**	**N/A**	**227**	**550**

GOAL: Increase the number of older Iowans and their families receiving services through Outreach and Education programs.

RATIONALE:
Generations is collecting data within this area and monitoring the information that is registered through NAPIS. Contractors are also providing registered client information via the NAPIS registration forms. The data that was collected in FY '07 and FY '08 were not applicable to the data being collected for FY '09 and beyond.

The projection of 550 registered NAPIS clients is based on FY '09 data of 227 through 12/31/08.

Goal 2: Local Objective 1. Enable Seniors to Remain in Their Own Homes (Case Management Outcome Measure)

Goal 2. Enable Seniors to Remain in Their own Homes with High Quality of Life for as Long as Possible Through the Provision of Home and Community-Based Services, Including Supports for Family Caregivers.

Local Objective 1.
Generations will provide easy access to older Iowans to remain in their own homes by providing support and services to them and family caregivers in 2010.

Needs Being Addressed
Case Management provides assistance to older adults in their homes by connecting them with services to assist in their daily living to maintain their well being in their own homes.

Local Strategies / Action Steps

- Maintain caseloads at no more than 80 each to allow for maintaining a high level of service to all clients by allowing for more availability to attend to the needs of clients in the Case Management program.
- Increase awareness of service options through the Case Management program.
- Continue to target specialized programming to the minority older adults such as the Refugee program for Vietnamese older adults, Spanish speaking staff, outreach services and meal site as well as African American meal sites.

Major Accomplishment(s) past and present regarding this goal.

- Provide Case Management services directly and has 15 Case Managers serving Scott, Clinton and Muscatine Counties.
- Staffing of two bilingual Case Managers speaking fluently in Spanish and Vietnamese.
- Maintaining caseloads at no more than 80 allowed for Case Managers to devote time and effort to their clients has added to the extended length of stay in the program.
- The program continues to expand and grow with new referrals each month and the increased number of older adults maintaining their independent living status within the program.
- Generations increased the average length of stay within the program by an average of 6 months within the first year.

Future Challenges
- Funding continues to be a challenge with the Case Management unit with a $70 cap within the program.
- The public demand for Case Management will increase with the increase in the total number of older adults and their need for assistance with activities of daily living.

FY 2010 Outcome Measure / CASE MANAGEMENT (CMPFE)
Increase the average number of month's a client's independent living status is maintained via CMPFE from 18 months to 20 months.

Goal 2: Local Objective 1 / Outcome Measure / Case Management (CMPFE)

Outcome Measure / Case Management (CMPFE)

Section 306(a) (8) of the Older Americans Act, as amended 2006, requires an Area Agency on Aging to include Case Management in the Area Plan.

OUTCOME MEASURE DEFINITION FOR CASE MANAGEMENT (CMPFE) – 20 months

OUTCOME MEASURE FORMAT TO USE: The average number of months that a client's independent living status is maintained within the program.

Outcome Measure	FY'07 Baseline Data (# of Months)	FY'08 Actual (# of Months)	FY'09 Year-to-Date (# of Months)	FY'2010 Projection (# of Months)
CMPFE	**12**	**18**	**20**	**20**

GOAL FOR AREA PLAN: The FY 2010 projection is for the average number of months that a client's independent living status is maintained to be at 20 months.

RATIONALE:

Generations saw a dramatic increase in the average length of stay within the Case Management program within the first year. This number continues to increase as fiscal year '09 continues. With the projected increase in older adults and the increase in awareness of services we foresee an increase in the need for Case Management services and an increase in the average length of stay in the program. The goal of the Case Management program is to focus on older adults remaining in their own homes.

Goal 2: Local Objective 2. Enable Seniors to Remain in Their Own Homes (Caregiver Outcome Measure)

Goal 2. Enable Seniors to Remain in Their own Homes with High Quality of Life for as Long as Possible Through the Provision of Home and Community-Based Services, Including Supports for Family Caregivers.

Local Objective 2.
Generations will enable older Iowans to easily access services and support through the Family Caregiver Program in 2010.

Needs Being Addressed
Generations provides support to older adults and their caregivers with the program as well as support groups for caregivers and for grandparents raising grandchildren.

Local Strategies / Action Steps

- Collaboration with the five area hospitals in the three county area for support group topics and speakers.
- Increase involvement with the parish nurses on specific projects within the three county area, such as providing support to the needs of clients and assisting with information to staff on health related topics.
- Continue to increase the number of registered clients within the Family Caregiver program through NAPIS.
- Monthly support groups held in Clinton, Muscatine and Scott Counties for caregivers.
- Continue RAPP (Relatives as Parents Program) for support groups for relatives/grandparents caring for children in collaboration with Palmer College and Big Brothers Big Sisters. Generations will explore start up possibilities in Clinton County (DeWitt).
- Maintain ESP (Enhanced Services Program) at current data entry updates of at least 90%.
- Certify three more staff in AIRS.

Major Accomplishment(s) past and present regarding this goal.

- Increase of 15 registered clients from 110 in FY ’07 to 125 in FY ’08.
- For the first quarter of ’09, there were 45 registered clients within the program. This shows a projection of 180 for FY ’09 totals.
- One AIRS Certified Staff

Future Challenges

- Funding continues to be a challenge within this area. A full time position within the unit was cut to one half time, this will free up funds to be used for collaboration with hospitals.
- High levels of match are required within this program making collaboration with outside organizations a must to maintain the program and a challenge to use all the funds.

FY 2010 Outcome Measure / CAREGIVER

Increase the number of registered clients receiving assistance from the National Family Caregiver Support Program from 125 to 180.

Goal 2: Local Objective 2 / Outcome Measure / Caregiver

Outcome Measure / Caregiver

Section 306(a) (7) of the Older Americans Act, as amended 2006, requires an Area Agency on Aging to include Caregiver as an Outcome Measure in the Area Plan.

OUTCOME MEASURE DEFINITION FOR CAREGIVER: Increase the number of registered clients receiving assistance from the National Family Caregiver Support Program.

OUTCOME MEASURE FORMAT TO USE: 125 clients received assistance through the program in '08, the goal is to increase this number by 55 to a total of 180 registered clients.

Measure	FY'07 Baseline Data (# registered clients)	FY'08 Actual (# registered clients)	FY'09 Year-to-Date (7/1/08-9/30/08) (# registered clients)	FY'2010 Projection (# registered clients)
Caregiver	**110**	**125**	**45**	**180**

GOAL FOR AREA PLAN: Generations will increase the number of registered clients within the Family Caregiver Program to 180 clients for FY "10.

RATIONALE:
Generations has seen a dramatic increase in the number of registered clients within the Family Caregiver Program. This is due to an increase in the number of clients that are registering with the NAPIS system as well as improved reporting measures.

Goal 3: Local Objective 1. Empower Older Iowans to Stay Active and Healthy (Nutrition Risk Outcome Measure)

Goal 3. Empower Older Iowans to Stay Active and Healthy Through Older Americans Act Services Including Evidenced-Based Disease Prevention Programs.

Local Objective 1.
Generations will easily enable older Iowans to access services to stay active and healthy by providing education, support groups and nutritional counseling in 2010.

Needs Being Addressed
Generations has made special efforts to improve the Nutritional Risk Scores of persons who receive GenAge Cafe or Home Delivered Meals through improved the monitoring of the nutritional value of our meals, surveying the likes and dislikes of seniors and participation with the Chef Charles and BASICS healthy eating and wellness programs.

Local Strategies / Action Steps

- Chef Charles and the BASICS programs with Eastern Iowa Community Colleges, continue to promote and educate people on the need for healthy eating as a part of living and aging well.
- Continue to promote and increase the number of Farmer's Market checks distributed.
- Promote support groups with a focus on wellness, disease prevention and overall health.
- Community education on health and wellness topics such as Falls Risk Assessments and Prevention.
- Continue to encourage and educate on the state Food Assistance Program (food stamps).
- Provided other local funds for additional food for local food pantries and data collection on senior utilization of the food pantries.
- Continue to distribute information on the Angel Food Ministries nationwide food program which provides low cost groceries to the public.
- Continue to focus on nutritional risk information in the monthly nutrition education information.
- Increase options for nutritional counseling for those with high risk assessments.
- Work with counseling department at Western Illinois on staff training in working with seniors on receiving assistance in improving health.

Major Accomplishment(s) past and present regarding this goal.

- Generations continues to see an increase in the number of Farmer's Market checks distributed.
- Support group at a local assisted living facility was organized to focus on the Food Assistance Program.
- Continued improvement in the quality and taste of frozen meals used for home delivery.
- Continued success and increase in numbers for people receiving holiday meals.

Future Challenges

- Resistance among older adults to receive counseling to improve nutritional risk scores.
- Stigma surrounding the meals such as a low income requirement or that it is a form of public assistance.

FY 2010 Outcome Measure / NUTRITIONAL RISK
Enter Text
Increase the percentage of persons maintaining or improving their Nutritional Risk Score on their NAPIS Registration Nutritional Assessment from 86% to 87%.

Goal 3: Local Objective 1. Outcome Measure / Nutrition Risk

Outcome Measure / Nutritional Risk

Section 306(a) (1) of the Older Americans Act, as amended 2006, requires an Area Agency on Aging to include Nutritional Services in the Area Plan.

OUTCOME MEASURE DEFINITION FOR NUTRITIONAL RISK: Maintain or improve the percent of clients determined to be at high nutritional risk who receive congregate meals, home delivered meals and nutrition counseling and maintain or improve their Nutrition risk scores.

OUTCOME MEASURE FORMAT TO USE: 86% of the clients filling out the nutritional risk forms maintained or improved their scores. This percentage is an increase of 2% from the previous year.

Outcome Measure	FY'07 Baseline Data (% of Clients)	FY'08 Actual (% of Clients)	FY'09 Year-to-Date (% of Clients) 7/1/08-9/30/08	FY'2010 Projection (% of Clients)
Nutrition Risk	**84%**	**86%**	**79%**	**87%**

GOAL FOR AREA PLAN: The goal is to improve the percentage of older adults that score high on their nutritional risk assessment by 1% from FY '08.

RATIONALE: Although the percentage of the first quarter of the fiscal year '09 show 79%, this is contributed to the increase in the number of people filling out the forms, which increases the number. This increase is a positive increase that will continue to trend over the next four years. Therefore, our number of clients maintaining or improving their scores may be an overall higher number, but not as high of an overall percentage.

Goal 3: Local Objective 2. Empower Older Iowans to Stay Active and Healthy (Agency-Specific Outcome)

Goal 3. Empower Older Iowans to Stay Active and Healthy Through Older Americans Act Services Including Evidenced-Based Disease Prevention Programs.

Local Objective 2. Generations will enable older Iowans to stay active and Healthy through the Falls Prevention program by education and awareness in 2010.

Needs Being Addressed: To improve the overall health and independence of seniors by increasing awareness on Falls Prevention and Falls Risk assessments.

Local Strategies / Action Steps

- Increase awareness of Falls Prevention by promoting the topic at events and routinely providing public presentations on the topic and collaborating with the medical profession. The Falls Committee is made up of representatives from Braaten Health, Genesis, Trinity, Scott County Health Department and Generations.
- Continue to move ahead with expansion of the Falls Prevention Committee.
- Involve the medical profession within the committee and at events for Falls Prevention.

Major Accomplishment(s) past and present regarding this goal.

- 506 assessments were completed last year with the Falls Risk Assessment tool provided by Braaten Health/ QC Occupational Health. 180 of those were determined to be “at risk” for falls.
- Follow up on some of the “at risk” patients begun in collaboration with the Falls Committee
- Financial assistance provided through the Scott County Health Department.

Future Challenges

- Involvement of the medical profession and education on the topic.
- Those determined “at risk” having a willingness to receive follow up care or report the information to their doctor.

FY 2010 / Agency-Specific Outcome

Generations, in collaboration with the Falls Prevention Committee, will increase the number of older adults receiving Falls Prevention assessment by 10%, which represents an increase in the number of older adults who receive assessments from 506 to 556.

Agency-Specific Outcome Measure

NAME OF OUTCOME, PROJECT, SERVICE OR ACTIVITY TO BE MEASURED: Falls prevention and risk assessments.

OUTCOME MEASURE FORMAT TO USE: A collaborative partner on the Falls Prevention Committee has an actual Falls Risk assessment balance screening tool that is used to measure whether a person is at risk or not. The number of people receiving this assessment through the program was 506 last year. The projected outcome is to increase this by 10%.

COST & FUNDING SOURCE: Cost for project is funded with IIIE and by reimbursement from the Scott County Health Department.

Measure	FY'07 Baseline Data (Measurement)	FY'08 Actual (Measurement)	FY'09 Year-to-Date (Measurement)	FY'2010 Projection (Measurement)
Number of Falls Risk Assessments completed	N/A	506	N/A	556

GOAL: Generations, in collaboration with the Falls Prevention Committee, will increase the number of older adults receiving Falls Prevention assessments by 10%.

RATIONALE: The number of assessments completed last year was 506, we are projecting an increase of 10% in assessments done this year based on increased public awareness and involvement with the medical community.

Goal 4: Local Objective 1. Ensure the Rights of Older Iowans and Prevent Their Abuse, Neglect, and Exploitation. (Agency-Specific Outcome)

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

Local Objective 1.
Generations will ensure the rights of older Iowans by providing support and education on Dependent Adult Abuse within the community in 2010.

Needs Being Addressed
Generations will provide staff members and the community education and training in regards to Dependent Adult Abuse.

Local Strategies / Action Steps

- Maintain staff trainers to provide trainings.
- Educate the community regarding the need for training and the opportunity to receive training.

Major Accomplishment(s) past and present regarding this goal.

- Three staff members trained and certified and able to provide Dependent Adult Abuse training.

Future Challenges

- Funding for the project

FY 2010 / Agency-Specific Outcome
Enter Text

Generations will provide 2 or more trainings per year on Dependent Adult Abuse for staff and community members.

Agency-Specific Outcome Measure

NAME OF OUTCOME, PROJECT, SERVICE OR ACTIVITY TO BE MEASURED: Trainings on Dependent Adult Abuse.

OUTCOME MEASURE FORMAT TO USE: Generations will track the number of trainings provided each year and how many participants are involved in training.

COST & FUNDING SOURCE: Trainings cost $10 per person for the project.

Measure	FY'07 Baseline Data	FY'08 Actual	FY'09 Year-to-Date (# of trainings)	FY'2010 Projection (# of trainings
Dependent Adult Abuse Training Sessions	N/A	N/A	1	2

GOAL: Generations will provide training and education on the topic of Dependent Adult Abuse to staff and community.

RATIONALE: This measure has not been tracked in previous years. Generations will track the number of trainings and participants in future trainings.

Goal 4: Local Objective 2. Ensure the Rights of Older Iowans and Prevent Their Abuse, Neglect, and Exploitation. (Agency-Specific Outcome)

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

Local Objective 2.
Generations will ensure the rights of older Iowans by providing education and resources within the community to prevent abuse, neglect and exploitation in 2010.

Needs Being Addressed
Generations will assist in the education on scams and Medicare fraud for older adults within the community.

Local Strategies / Action Steps

- Continue relationship with Chambers of Commerce, including information sharing.
- Continue collaboration with TRIAD (Scott County), It represents a group of three, or the three sectors of a community that partner to keep seniors safe from crime: public safety, criminal justice, and the senior community.
- Continue to collaborate with Seniors vs. Crime, a part of the Clinton County Sheriff's Department, on the Clean Out Your Medicine Cabinet project and other initiatives.
- Continue to be a part of Multi-Disciplinary Team (MDT) meetings.
- Continue communication with area law enforcement on scams and Dependent Adult Abuse issues.

Major Accomplishment(s) past and present regarding this goal.

- Quarterly SMP events scheduled for current calendar year.
- Collaborated with the first Clean Out Your Medicine Cabinet (COYMC) project in Clinton County.

Future Challenges

- With an increase in the number of seniors there is likely to be an increase in the number of scams targeting seniors.

FY 2010 / Agency-Specific Outcome

Generations will collaborate with community organizations and provide one quarterly SMP event in each county per year on topics related to scams, Medicare fraud and prescription drugs.

Goal 4: Local Objective 2. Agency-Specific Outcome Measure

Agency-Specific Outcome Measure

NAME OF OUTCOME, PROJECT, SERVICE OR ACTIVITY TO BE MEASURED: SMP activities in the three counties.

OUTCOME MEASURE FORMAT TO USE: The total number of SMP events held, quarterly events in each county (4 times x 3 counties=12).

COST & FUNDING SOURCE: SMP grant, $4000

Measure	FY'07 Baseline Data (total # of events)	FY'08 Actual (total # of events)	FY'09 Year-to-Date (total # of events)	FY'2010 Projection (total # of events)
SMP events	N/A	N/A	3	12

GOAL : Generations will collaborate with community organizations and provide one quarterly SMP event in each county per year on topics related to scams, Medicare fraud and prescription drugs.

RATIONALE: Generations has had one SMP event this calendar year in each county, giving the count of 3 events in FY '09 to date. Projections are to have 4 events in each county giving a total of 12 events.

1.5 EMERGENCY PREPAREDNESS PLAN

Emergency Preparedness Plan

Generations Emergency Preparedness Plan :

(1) Key partners

Generations is an active participant in the local VOAD (Volunteer Organizations Active in Disasters) group which includes; Red Cross, Western Illinois University-Quad Cities, Scott County Health Department, World Relief, Edgerton Women's Health, AmeriCorps VISTA, Salvation Army, Retired & Seniors Volunteer Program, Iowa State University Extension, Western Illinois Area Agency on Aging, Blackhawk College, MetroLink, Illinois Baptist State Association Disaster Relief, Family Resources, Salvation Army, St. Ambrose University, City of Davenport, Iowa Department of Human Services, Girl Scouts, Project NOW, Diocese of Davenport, Southern Baptist Men, HELP Legal Aid, Churches United, CVASI, Community Health Center, Friendly House, Humility of Mary, Arsenal, United Way, Rock Island County Health Dept., Animal Welfare center, Vera French Mental Health Center, TRIAD, River Bend Transit, Emergency Management

(2) Types of emergencies covered under the plan

a. Nuclear emergencies
b. Fires / Explosions
c. Hazardous Materials Release
d. Extended Power or Utility Outages
e. Floods, Earthquakes, Tornado, Evacuation
f. Mass Casualty Events
g. Flu Pandemic

(3) Process used to develop long-range emergency plans with local and state emergency response agencies, relief organizations, local and state governments and other institutions with responsibility for disaster relief service delivery

VOAD is the resource for coordination of emergency response in an emergency. Generations has developed a plan that provides direction to Generations' employees for a large or small scale disaster.

Generations plan is reviewed on a regular basis and updated as needed. Each spring, the staff will be trained and updated on procedures and practices in an emergency. Generations has provided updated disaster information for staff and clients in response to previous disasters.

Generations has an agreement with River Bend transit for the use of their offices to serve as a temporary operating site for Generations' employees in the event of an emergency which would render the Generations' offices unusable. Generations' offices would also be available to River Bend Transit with the addition of their temporary dispatching capabilities.

(4) How activities are coordinated with local county disaster coordinators and others when an emergency strikes

VOAD assists in the area of coordinating local county disaster. The Emergency Management Coordinators for each county are listed within the plan. The Director/CEO and the Assistant Director will coordinate involvement with these agencies as determined to be necessary. Generations will follow the guidelines from Emergency Responders and the Department of Elder Affairs for guidance in a long term emergency.

1.6 AREA PLAN BUDGET REPORT

Submitted with IAFRS report

1.7 COMPLIANCE AND ASSURANCE DOCUMENTS

Compliance with Assurances and General Provisions

Compliance with Assurances and General Provisions

The Area Agency on Aging hereby assures compliance, on behalf of itself and any subcontractors, with all applicable provisions of the following statutes, regulations and requirements for the Area Plan period **July 1, 2009 through June 30, 2013**, and assures that services will be provided in accordance with any and all applicable federal or state laws, regulations, rules and procedures.

- Older Americans Act, as Amended, 2006
- Fair Labor Standards Act of 1938
- Americans with Disabilities Act of 1990
- Senior Living Program**,** IAC 321, Chapter 28
- IAC 321 – 6.9(231) Emergency Situations
- Code of Iowa, Chapter 8F, Contractor Certification and Reporting
- Emergency Preparedness Planning
- Minority Impact Statement
- Assurance of Compliance with the State of Iowa Laptop/Tablet Data Protection Standard (Associated with CMPFE)

The Area Agency on Aging will cooperate fully with the Iowa Department of Elder Affairs to assure compliance with provisions required by legislative action taken by the Congress of the United States, and the Iowa General Assembly, and with Iowa Aging Program Instructions during fiscal years 2010-2013 of the Area Plan.

Further Assurance is Given That:

1. The Area Agency on Aging will provide access to and the right to examine all record books, papers or documents related to the Area Plan.

The Compliance with Assurances and General Provisions is hereby submitted for the Area Plan period July 1, 2009 through June 30, 2013 to the Iowa Department of Elder Affairs for approval.

_____ _____

Date Marvin Webb, Director/CEO

_____

Generations Area Agency on Aging

Older Americans Act, as Amended 2006
38 Sec. 306 OLDER AMERICANS ACT OF 1965

Assurances
Sec. 306, AREA PLANS

306(a)(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-

306(a)(2)(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);

306(a)(2)(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

306(a)(2)(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.

306(a)(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);

306(a)(4)(A) (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

306(a)(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).

306(a)(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 A-3 organic brain dysfunction (and the caretakers of such individuals); and (VII) older individuals at risk for institutional placement; and

306(a)(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.

306(a)(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.

306(a)(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;

306(a)(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.

306(a)(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-

306(a)(11)(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

306(a)(11)(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

306(a)(11)(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.

306(a)(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.

306(a)(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—

306(a)(13)(B)(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

306(a)(13)(B)(ii) the nature of such contract or such relationship.

306(a)(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.

306(a)(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.

306(a)(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.

306(a)(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.

306(a)(15) provide assurances that funds received under this title will be used-

306(a)(15)(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

306(a)(15)(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

The governing body of the area agency has reviewed and approved these Assurances.

Signature of Authorized Official of the Grantee (Marvin Webb, Director/CEO)

_____

Dated: _____

Signature of Other Designee (Dennis Mumm, Board President)

_____

Dated: _____

Assurance of Compliance with the Department of Health and Human Services Regulations Regarding Title VI of the Civil Rights Act of 1964, as Amended

Generations Area Agency on Aging

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives federal financial assistance from the Department; and hereby gives assurance that it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Applicant for the period during which the federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Applicant.

Generations Area Agency on Aging
Applicant Date

By
Authorized official of the grantee, Marvin Webb, Director/CEO

Applicant's Mailing Address (Area Agency on Aging):

Generations Area Agency on Aging

935 E. 53rd Street, Davenport, IA 52807

Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, as Amended

The undersigned (hereinafter called the "recipient") HEREBY AGREES THAT it will comply with Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HHS regulation (45 CFR Part 84), and all guidelines and interpretations issued pursuant thereto.

Pursuant to subsection 84.5(a) of the regulation (45 CFR84.5(a)**,** the recipient gives this Assurance in consideration of and for the purpose of obtaining any and all federal grants, loans, contracts (except procurement contracts of insurance or guaranty), property, discounts, or other federal financial assistance extended by the Department of Health and Human Services after the date of this Assurance including payments or other assistance made after such date on applications for federal financial assistance that were approved before such date. The recipient recognizes and agrees that such Federal financial assistance will be extended in reliance on the representation and agreements made in this Assurance and that the United States will have the right to enforce this Assurance through lawful means. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

This Assurance obligates the recipient for the period during which federal financial assistance is extended to it by the Department of Health and Human Services or, where the assistance is in the form of real or personal property, for the period provided for in subsection 84.5(b) of the regulation (45 CFR84.5 (b)**.**

The recipient: (Check (a) or (b)

a.( ) employs fewer than fifteen persons

b.(X) employs fifteen or more persons and, pursuant to subsection 84.7(a) of the regulation (45 CFR 84.7(a), has designated the following person(s) to coordinate its efforts to comply with the HHS regulations:

Marvin Webb, Director/CEO
Name of Designee

Generations Area Agency on Aging
Name of Recipient (Area Agency on Aging)

935 E. 53rd Street
Street Address or P.O. Box

Davenport IA 52807
City State Zip

I certify that the above information is complete and correct to the best of my knowledge.

Authorized Official of the Grantee, Marvin Webb, Director/CEO Date

Assurance of Compliance with the Minority Impact Statement

Pursuant to Section 8.11, Code of Iowa, all grant applications submitted to the State of Iowa which are due beginning January 1, 2009 shall include a Minority Impact Statement. This is the state's mechanism to require grant applicants to consider the potential impact of the grant project's proposed programs or policies on minority groups.

Please choose the statement(s) that pertains to this grant application. Complete all the information requested for the chosen statement(s).

☒ The proposed grant project programs or policies could have a disproportionate or unique **positive** impact on minority persons.

Describe the positive impact expected from this project

Generations will build and expand on programming that is currently in place. There will be a continued focus on persons with disabilities and the minority population. The Regional Diversity Committee will focus on the minority populations and how to better serve them within the community. Generations continues to promote assistance with the limited English speaking Vietnamese population with the refugee project.

Indicate which group is impacted:

__x_ Women
__x_ Persons with a Disability
__x_ Blacks
__x_ Latinos
__x_ Asians
____ Pacific Islanders
____ American Indians
____ Alaskan Native Americans
____ Other

☐ The proposed grant project programs or policies could have a disproportionate or unique **negative** impact on minority persons.

Describe the negative impact expected from this project.

Present the rationale for the existence of the proposed program or policy.

Provide evidence of consultation of representatives of the minority groups impacted.

Indicate which group is impacted:

___ Women
___ Persons with a Disability
___ Blacks
___ Latinos
___ Asians
___ Pacific Islanders
___ American Indians
___ Alaskan Native Americans
___ Other

☐ The proposed grant project programs or policies are not expected to have a disproportionate or unique impact on minority persons.

Present the rationale for determining no impact.

I hereby certify that the information on this form is complete and accurate, to the best of my knowledge:

_____
Marvin Webb, Director/CEO

Area Agency on Aging:

Generations Area Agency on Aging

_____
Date

Definitions

"Minority Persons", as defined in Iowa Code Section 8.11, mean individuals who are women, persons with a disability, Blacks, Latinos, Asians or Pacific Islanders, American Indians, and Alaskan Native Americans.

"Disability", as defined in Iowa Code Section 15.102, subsection 5, paragraph "b", subparagraph (1):
b. As used in this subsection:
(1) *"Disability"* means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of the individual, a record of physical or mental impairment that substantially limits one or more of the major life activities of the individual, or being regarded as an individual with a physical or mental impairment that substantially limits one or more of the major life activities of the individual.
"Disability" does not include any of the following:
(a) Homosexuality or bisexuality.
(b) Transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments or other sexual behavior disorders.
(c) Compulsive gambling, kleptomania, or pyromania.
(d) Psychoactive substance abuse disorders resulting from current illegal use of drugs.

"State Agency", as defined in Iowa Code Section 8.11, means a department, board, bureau, commission, or other agency or authority of the State of Iowa.

Assurance of Compliance with the State of Iowa Laptop/Tablet Data Protection Standard (Associated with CMPFE)

_____Generations Area Agency on Aging_____

Area Agency on Aging

The Area Agency on Aging assures that laptop and/or tablet computers used to access the Seamless Database System associated with the Case Management Program for Frail Elders (CMPFE) meet all requirements of the State of Iowa Laptop/Tablet Data Protection Standard.

The area agency director and/or governing body has reviewed and approved this assurance.

_____

Marvin Webb, Director/CEO

_____

Date

Request for a Direct Service Waiver

Request for a Direct Service Waiver

_____Generations Area Agency on Aging_____ hereby requests a waiver of the
(Area Agency on Aging)

requirement to award sub-grants of contracts to service providers for the services identified in this request.

1. Identify the service(s) to be delivered by the Area Agency.

   Congregate Meals

2. Identify criteria for which the waiver is warranted.

   [X] a. Provision of the service(s) by the Area Agency on Aging is necessary to assure an adequate supply of such service.

   [X] b. The service(s) is directly related to the Area Agency on Aging's administrative functions.

   [X] c. The service(s) can be provided more economically, and with comparable quality, by the Area Agency on Aging.

3. Describe the rationale for the identified criteria (this must be completed for each service):
   See attached summary

_____ _____
Marvin Webb, Director/CEO Generations Area Agency on Aging Date

Request for a Direct Service Waiver

Request for a Direct Service Waiver

Generations Area Agency on Aging hereby requests a waiver of the
(Area Agency on Aging)

requirement to award sub-grants of contracts to service providers for the services identified in this request.

4. Identify the service(s) to be delivered by the Area Agency.

   Home Delivered Meals

5. Identify criteria for which the waiver is warranted.

   [X] a. Provision of the service(s) by the Area Agency on Aging is necessary to assure an adequate supply of such service.

   [X] b. The service(s) is directly related to the Area Agency on Aging's administrative functions.

   [X] c. The service(s) can be provided more economically, and with comparable quality, by the Area Agency on Aging.

6. Describe the rationale for the identified criteria (this must be completed for each service):
   See attached summary

Marvin Webb, Director/CEO Generations Area Agency on Aging

Date

Narrative for Nutrition Program Congregate Meals Direct Service

Description of Service

Generations coordinates the congregate meals program Clinton and Scott Counties. There are 5 GenAge Cafes (congregate sites) in Clinton County and 17 GenAge Cafes (congregate sites) in Scott County. The Cafes are open from 1 day per month (Vietnamese) to 5 days per week. Staff consists of 1 Area wide Program Coordinator, 1 Nutrition Supervisor (both full time), 5 drivers delivering bulk food from a central food provider located in Scott County to 22 Cafes (part-time 3 – 5.5 hours/day), 16 paid Café managers (2.5 – 4 hours/day), 3 managers paid by Café locations, and 3 volunteer managers. Approximately 102 volunteers assist the Café managers. Café managers contact the Nutrition Supervisor every day their Café is open. Meal order reservations are taken and orders are coordinated on a daily basis by the Nutrition Supervisor with the food provider.

Generations has a toll free number for managers and participants to call. Staff information and training meetings are held bi-annually. The nutrition supervisor performs assessments on every Café annually and both the Coordinator and the supervisor visit the Cafes frequently for special events. Generations is the largest Chef Charles participant statewide with our congregate meals program. Generations also participates in a special BASICS grant with Eastern Iowa Community College to provide wellness activities as well as healthy fruit, vegetable and calcium recipe samples at the Cafes twice each month. The total projected congregate meals for the current fiscal year for Clinton County are 10,872 and for Scott County it is 47,616.

Services of comparable quality can be provided more economically by Generations

Generations assumed the management of the Clinton County Nutrition program in May 1996 when the local service provider, Clinton County Senior Citizens Services closed their doors. Generations assumed management of the Scott County nutrition program in October 1999 when the Center for Active Seniors, Inc. experienced financial difficulties with the program and decided to focus their energies on different services. There were no other service providers interested in managing this program in either county. This remains true today as not other organization has expressed interest in or demonstrated the capability of providing this service.

Both programs are now operating in a more cost effective manner due to economy of scale and there was no disruption of service to seniors. Most of the seniors did not notice any difference as most of the former food drivers and GenAge Café managers transferred over to Generations for employment so there was no loss of service.

Evaluation of service:

Generations GenAge Café participants have reacted very positively to any satisfaction surveys administered in recent years. Food preferences, likes and dislikes are reviewed on-going to keep the menu energized. The current menu and management system is much more consumer driven as seniors express their interest opinions about their program.

Narrative for Nutrition Program Home Meals Direct Service

Description of Service
Generations coordinates the Home delivered meals program Clinton and Scott Counties. Home meals are delivered from 2 GenAge Cafes (congregate sites) in Clinton County and 11 GenAge Cafes (congregate sites) in Scott County. Home meal recipients can receive hot meals from 3 – 5 days per week depending on location and frozen meals are available on the weekend. Special holiday meals are available on Thanksgiving, Christmas and New Years in Scott County. Staff consists of 1 Area wide Program Coordinator, 1 Nutrition Supervisor (both full time), 5 drivers delivering bulk food from a central food provider located in Scott County to 13 Cafes that provide home delivered meals. Most home meal recipients request meal delivery from 5 to 7 days per week. Meal order reservations and cancellations are taken and orders are coordinated on a daily basis by the Nutrition Supervisor with the food provider.

Scott County has four rural drivers and one sub volunteer driver. One driver delivers a few home meals as well as delivering bulk food to 2 rural GenAge Cafes (Walcott & Buffalo). Generations has another driver who delivers bulk food to the Cafes at LeClaire & Eldridge. This route has had individual home meals in the past. The remaining 3 rural drivers are also Cafe managers who deliver meals before or after the cafe is open as part of their normal work hours. There are three rural drivers in Clinton County. One driver does home delivered meals in the DeWitt area. One driver delivers bulk food to the Wheatland Cafe and covers a large amount of very rural Clinton County, encompassing over 100 miles each day. The third driver is also a Cafe manager who delivers to rural participants living near her rural city encompassing about 20 miles per day.

The total projected home delivered meals for the current fiscal year for Clinton County are 22,812 and for Scott County 6,108.

Services of comparable quality can be provided more economically by Generations

Generations assumed the management of the Clinton County Nutrition program in May 1996 when the local service provider, Clinton County Senior Citizens Services closed their doors. Generations assumed management of the Scott County nutrition program in October 1999 when the Center for Active Seniors, Inc. experienced financial difficulties with the program and decided to focus their energies on different services. There were no other service providers interested in managing this OAA program in either county. . This remains true today as not other organization has expressed interest in or demonstrated the capability of providing this service.

There is a separate non-profit organization in each of the counties that provide an in town “meals on wheels” program using volunteer drivers. Generation’s works well with both of these programs and does not duplicate services. Generations picks up all rural deliveries that they are unable to accommodate.

Both the Clinton and Scott County home delivered meal programs are now operating in a more cost effective manner due to economy of scale and there was no disruption of service to seniors. Most of the seniors did not notice any difference as most of the former food drivers and GenAge Café managers transferred over to Generations for employment so there was no loss of service.

Evaluation of service:

Generations’ home meal participants have reacted very positively to any satisfaction surveys administered in recent years. Food preferences, likes and dislikes are reviewed on-going to keep the menu energized. The current menu and management system is much more consumer driven as seniors express their interest opinions about their program.

Equipment and Real Property Acquisitions

Equipment and Real Property Acquisitions

EQUIPMENT AND REAL PROPERTY ACQUISITIONS

TAX #	SERVICE SUPPORT OR DELIVERY CATEGORY	DESCRIPTION	SOURCE	AMOUNT
	Congregate Meals	Dishwasher	IIC(1)	$5000
	Congregate & Home Delivered Meals	Van	IIIC(1) & IIIC(2) & Foundation Grant	$35,000
	Administrative	Computers	Multiple Funding Sources	$7000
	Administrative	Phone System	Local Funds	$40,000
		TOTAL		$87,000

Note: Indicate N/A if there are no equipment and/or real property acquisitions.

List of Contracts with For-Profit Organizations & Contract Notice

An Area Agency on Aging may not contract with a provider that has been denied Medicare/Medicaid Payment.

- To confirm the Medicare/Medicaid Payment status of a provider, check the *Excluded Parties List System* at the following web site: https://www.epls.gov/

Name & Address For-Profit Service Provider	**Provider ✓ for Medicare/Medicaid Payment Denial***	**Service to be Provided**	Unit of Service to be provided	**Cost/Unit of Service**
Sodexo Campus Services St. Ambrose University West Locust Street Davenport, Iowa 52804	X	Prepare Congregate & Home delivered meals for Clinton & Scott Counties	1 meal	$3.61/congregate $3.68/home A raw food cost based on CPI of past 12 months up to a maximum of 3% will be added to this cost on 7/1/2009 (same provider, contract extension increased meal cost)

Note: Indicate N/A if there are no contracts with For-Profit organizations.

AREA XIV AGENCY ON AGING

AREA AGENCY ON AGING
Creston, Iowa

Area Plan on Aging
Fiscal Years 2010 – 2013

April 1, 2009

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Verification of Intent

Area XIV Agency on Aging (AAA) accepts full authority and responsibility to develop and administer the Area Plan in accordance with all requirements of the Older Americans Act as amended, 2006, and related Iowa Administrative Code and State policy. By accepting this authority and responsibility, the Area Agency agrees to develop and administer the Area Plan for a comprehensive and coordinated system of service and to serve as the advocate and focal point for all Iowans 60+ years of age in the Area Agency's planning and service area.

The Area Plan is hereby submitted for Fiscal Years 2010-2013 to the Iowa Department of Aging for approval.

March 31, 2009 _____
Date

_____
Director, Area Agency on Aging
Steve Bolie
Area XIV Agency on Aging

The Area Agency Advisory Council has reviewed the Area Plan and approves the plan.

March 31, 2009 _____
Date

_____
Chairperson, Advisory Council
Joy Eden
Area XIV Agency on Aging

The governing body of the Area Agency has reviewed the Area Plan and approves the plan.

March 31, 2009 _____
Date

_____
Chairperson, Board of Directors
Carl Miller
Area XIV Agency on Aging

Authorized Signatures
Area Plan / Fiscal years 2010 – 2013

Area XIV Agency on Aging Name of Area Agency	215 East Montgomery Street Address
Creston City	Iowa 50801 State & Zip
Non-profit Corporation Type of Agency	August 1973 Date of AAA Designation
_____ Signature of Director	March 31, 2009 Signature of Board Chair

Authorized Signatures for Funding Applications and Contracts

_____ Signature of Director	March 31, 2009 Date Signed
_____ Signature of Board Chair	March 31, 2009 Date Signed

Fiscal Reports (Other than Area Agency Director, if applicable)

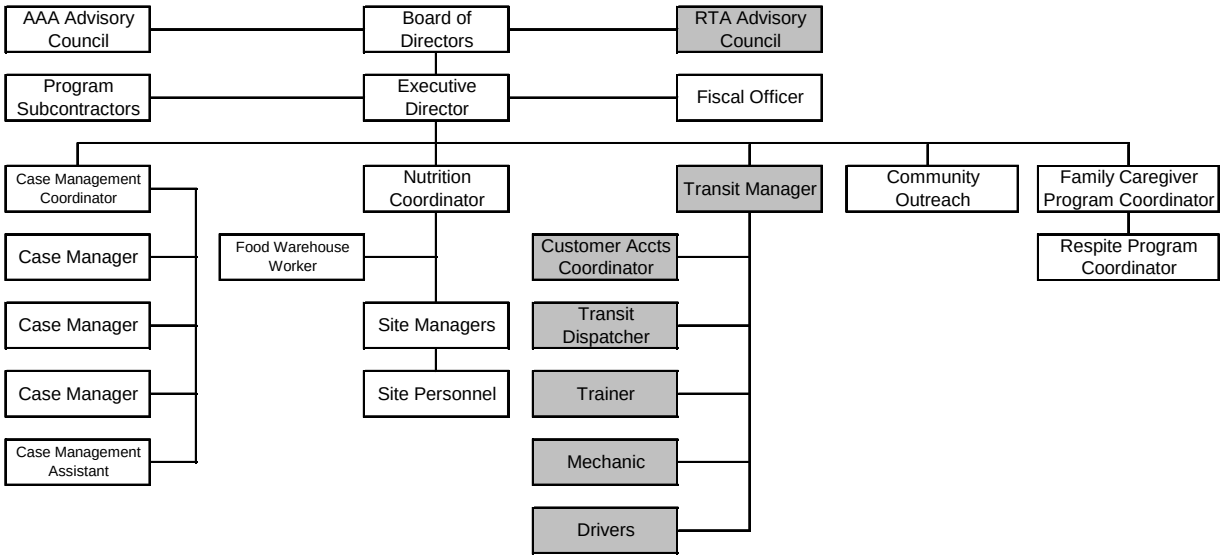
_____ Signature & Title	March 31, 2009 Date Signed

Program Reports (Other than Area Agency Director, if applicable)

_____ Signature of Program Coordinator	March 31, 2009 Date Signed

1.2 ORGANIZATIONAL STRUCTURE

AREA XIV AGENCY ON AGING
(including Regional Transit Agency)
(as of 3/12/09)



NOTE: Shaded boxes are related to the Regional Transit Agency which operates as a department of Area XIV Agency on Aging but functions as if it were a contractor of the area agency on aging.

Area XIV is organized as a free-standing non-for-profit organization under 501c3 of the Internal Revenue Code. It has long-standing destination as both an area agency on aging under the Older Americans act and the regional transit agency. It is funded by and accountable to the Iowa Department on Aging and the Iowa Department of Transportation for its respective roles.

The Board of Directors is the governing body empowered to conduct the business of and set policy for the organization. Each county in the service area is represented by one member of the county's Board of Supervisors and a senior citizen elected by his or her peers in the county. A fifteenth member is an at-large senior elected by all of the seniors in the area.

The Advisory Council advises the staff and Board of Directors on all matters pertaining to the Agency. Two members are elected by their peers in each county. The Council's responsibilities include:

- Be advocates for the elderly in their planning and service area by keeping informed of activities and proposals concerning the elderly.
- Review and make recommendations upon the content, formulation, and administration of the area plan and participate in the public hearings on the area plan.
- Serve as an information link between the Area Agency on Aging and providers of services to the elderly in the area.
- Review and make recommendations upon program priorities for the area.
- Review and comment on community policies, programs and actions that affect older persons.

The Area XIV Agency on Aging office is located in Creston in Union County. Other counties in the PSA are Adair, Adams, Clarke, Decatur, Ringgold, and Taylor

Area Agency Board Officials and Members

Board Officials of the Area XIV Agency on Aging

Area XIV Agency on Aging Board of Directors

2009

Adair County

John Twombly (county)	505 NW 2nd Street, Greenfield, IA 50849	641-743-6282
CHAIR Carl Miller	208 SE Linn Street, Greenfield, IA 50849	641-743-6368

Adams County

VICE CHAIR Karl McCarty	2860 190th Street, Prescott, IA 50859	641-335-2329
Colleen Bickford	2011 11th Street, Corning, IA 50841-1209	641-322-4896

Clarke County

Jack Cooley (county)	1610 240th Ave., Osceola, IA 50213	641-342-3641
Mary Linderman	700 Sherman Street, Woodburn, IA 50275	641-342-7288

Decatur County

J.R. Cornett (county)	486 Park Avenue, Davis City, IA 50065	641-442-3433
Doug Price	312 NW 13th Drive, Leon, IA 50144	641-446-7890

Ringgold County

Larry Ford (county)	307 N. Main Street, Tingley, IA 50863	641-772-4513
Robert (Hap) Richards	605 Cindy Drive, Mt. Ayr, IA 50854-1211	

Taylor County

SECRETARY Bonnie Godden (county)	405 Jefferson, Bedford, IA 50833	712-523-2060
Dennis Cooper	2018 250th Street, Bedford, IA 50833	712-523-3487

Union County

Mike King (county)	1361 Briarwood Lane, Creston, IA 50801	cell 641-202-2121
Breta Kinkade	302 N. Vine, Creston, IA 50801	641-782-5435

At-Large

Deloris Carns-Robertson	Box 42, Diagonal, IA 50845	641-734-5386

Advisory Council Members

Council Members of Area XIV Agency on Aging

Area XIV Agency on Aging Advisory Council
2009

Criteria Represented	Name	Address	Phone
Adair County			
1,2,4,7	Joy Eden **CHAIR**	1584 Fontanelle Road, Casey, IA 50048	641-746-2749
1,2,7	Ken Blazek	1945 330th Street, Orient, IA 50858	641-345-2896
Adams County			
1,2,7	Gerald Queck	1018 9th Street, Corning, IA 50841	641-322-4779
1,2,7	Rosena Fife	1209 Quincy Street, Corning, IA 50841	641-332-5169
Clarke County			
1,2,7	Zola McKnight	310 N. Main, Spt. 123, Osceola, IA 50213	641-342-3008
1,2,7	James Horton	1953 Idaho Street, Osceola, IA 50213	641-342-9013
Decatur County			
1,2,7	Wendell Tuttle	700 N.E. Q, Leon, IA 50144	641-446-6448
2,6,7	Jim Hammer	291 S. Willow, Lamoni, IA 50140	641-784-6894
Ringgold County			
1,2,7	Irma Johnston	1524 330th Avenue, Beaconsfield, IA 50074	641-783-2194
1,2,7	Wanda McGahuey	1201 E. Columbus, Mount Ayr, IA 50858	641-345-2896
Taylor County			
1,2,7	Vivian Keith	408 Jefferson, Apt. 1, Bedford, IA 50833	712-523-3181
1,2,3,7	Pat Rhoades	810 E. Ohio, Lenox, IA 50851	
Union County			
1,2,4,7	Leonard Feld	1277 Creamery Road, Afton, IA 50830	641-347-5369
1,2,7	Max Pool	1715 W. Prairie Street, Apt. 118, Creston IA 50801	641-782-2429

1. More than 50 percent older persons, including minority individuals who are participants or who are eligible to participate in programs under this part;
2. Representatives of older persons;
3. Representatives of health care provider organizations, including providers of veterans' health care (if appropriate);
4. Representatives of supportive services providers organizations;
5. Persons with leadership experience in the private and voluntary sectors;
6. Local elected officials;
7. The general public.

1.3 PLANNING AND SERVICE AREA OVERVIEW

Mission Statement
The mission of Area XIV Agency on Aging is to advocate for, plan and coordinate services to, and support caregivers so that older adults in southern Iowa remain independent, healthy, and productive in their homes and communities.

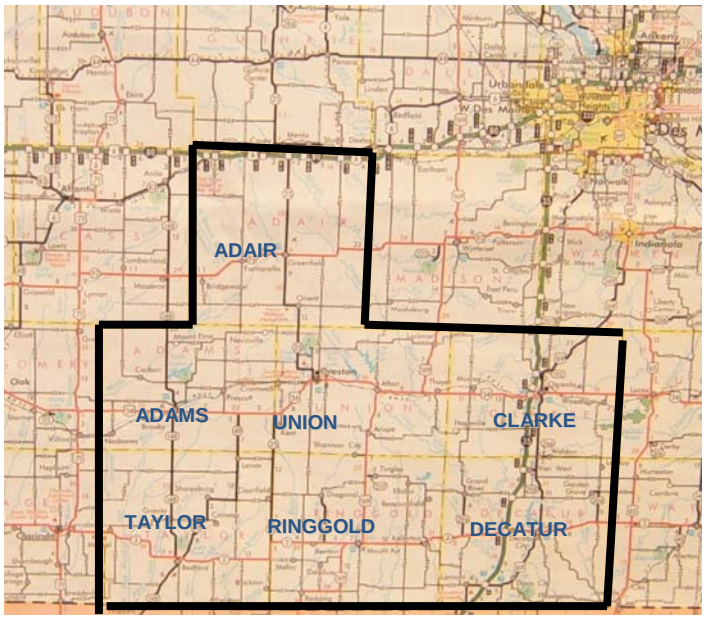
Vision Statement
We envision the time when all older adults in southern Iowa are able to remain independent, healthy, and productive in their homes and communities avoiding premature institutionalization.

Introductory Statement
The Area XIV Agency on Aging office is located in Creston in Union County. Other counties in the PSA are Adair, Adams, Clarke, Decatur, Ringgold, and Taylor. The major towns in the PSA tend to be the county seats, shown in the table below.

Adair	Greenfield
Adams	Corning
Clarke	Osceola
Decatur	Leon
Ringgold	Mount Ayr
Taylor	Bedford
Union	Creston

Other major towns are Adair (Adair County), Lamoni (Decatur), and Lenox (Taylor).

The following map shows the service area and the location of the towns mentioned above.



The population age 60 and older of the PSA at the beginning of the area plan (July 1, 2009) is projected to be 13,278 representing 24.8% of the total population. Over the four years of the area plan the population is expected to decrease by just .18% to 13,254.

The table below shows the projected changes in the 60+ population by county. Clarke and Adair Counties are the only counties projected to have net growth but even that growth is 4.66% and 1.03% respectively. All other counties have a projected net loss of population with Adams, already the smallest of the seven having the greatest percent loss.

Projected Total and Age 60+ Population by County in Area XIV

	Total Population				Projected Age 60+			
Area	2010	2015	Change	% Change	2010	2015	Change	% Change
Adair	7,776	7,855	79	1.02%	1,928	1,948	20	1.04%
Adams	4,081	3,945	-136	-3.33%	1,012	978	(34)	-3.36%
Clarke	9,510	9,950	440	4.63%	2,358	2,468	110	4.66%
Decatur	8,627	8,592	-35	-0.41%	2,139	2,131	(8)	-0.37%
Ringgold	5,281	5,271	-10	-0.19%	1,310	1,307	(3)	-0.23%
Taylor	6,387	6,201	-186	-2.91%	1,584	1,538	(46)	-2.90%
Union	11,884	11,628	-256	-2.15%	2,947	2,884	(63)	-2.14%
	53,546	53,442	-104	-0.19%	13,278	13,254	(24)	-0.18%

Note: Total population data 2000-2005, are from the U.S. Dept. of Commerce.
All data 2010-2030 are projected by Woods & Poole; residential population as of July 1.

Population(s) Served – Social-demographic and economic factors in the PSA

Locations of socially isolated elders – Transportation is the key element causing social isolation for elders. When health issues cause a person to lose the ability to drive isolation can occur. Public transportation helps in the communities where it is available. However, smaller communities lack the consumer base to justify the cost of transportation services that are available in the larger communities like Creston, Osceola and the other county seat towns.

Diversity

Characteristic	Number / PSA	Percent (%) / PSA
Rural	10,210	79.46%
Urban (see note below)	2,605	20.54%
Disabled		
Limited English Proficiency		
Minority	85	.66%
Poverty	1,424	10.39%

Source: Administration on Aging Web site: http://www.aoa.gov/prof/Statistics/Tab/aoacensus2000.html

Racial Diversity: Only 45 (.34%) of those age 60 and older were identified as minority broken down as follows:

Black alone	4
Asian alone	14
Other race	24
Hispanic	39

The PSA has very little racial diversity with the white population comprising approximately 98% of the population (a low of 96.46% in Decatur County to a high of 99.07% in Ringgold County. Decatur's African-American population of .98% is highest in the area and the highest Asian population at .63%. These populations are probably due to the presence of Graceland University so would not constitute a significant ethnic senior population. Clarke County has 4.04% Hispanic or Latino of any race.

Rural Communities

Though there are no urban areas in the PSA, only 79.5% of the population identified themselves as rural. This may reflect a category of non-farm rural population who live in towns that do not qualify as urban for census purposes. For AAA planning and reporting purposes the entire PSA is treated as rural.

Growth of 85+ Population

The number of persons 85+ in the PSA is and will continue to be the lowest in the state. The number is projected to stay relatively static at about 2,200 or 4% of the population.

Table D.1 – 85+ Population Projection Numbers by AAA

85+ Total Population Projections

	Area Agency	2000	2010	2020	2030
14	Area XIV	1,850	2,259	2,104	2,250

(Source: Woods & Poole Economics, Inc., 2007. Provided by the State Library of Iowa, State Data Center Program. http://www.iowadatacenter.org)

Targeting Plan

Low income minority individuals: As detailed above, the 2000 census counted 85 minority persons age 60 and over or .66% of the population. Of this group, only four (in Ringgold county) were recorded as having income below the poverty level. They were in the 85+ age, "some other race or two or more races" group. In telephone survey of city clerks or mayors in early 2008, no minor elders were identified. This illustrates that the main problem in targeting minorities is identification. Targeting objectives: Efforts to identify low income minority individuals will continue throughout the year. Site managers, city leaders, and others will be polled as to such individuals in their towns/areas. Non-discrimination training for site managers will be conducted each year in conjunction with the Farmers' Market program. Whenever minority individuals are identified they will be contacted and informed about the availability of services. When barriers to service are identified efforts will be made to remove them.

Goal 1. Enable Older Iowans and Their Families to Make Informed Decisions About, and be Able to Easily Access, Existing Home and Long-Term Care Options

Local Objective 1 – Information and Referral.
Information and Assistance: Formalize and increase information and assistance services so that by the end of FY2010 the number of persons receiving such services will be 25 per month. (NOTE: This goal concerns new I&A services in the main office in addition to those provided historically in the meal sites.)

Needs Being Addressed
Two areas of need for information and referral services are government health programs and nursing homes. The needs assessment conducted in 2008 found that 42% of the population or 5,449 persons anticipated a need for advice or help with government health programs while 30%or 3,857 anticipated a need for information about nursing homes in the next two years. This is an indication of significant need for all types of information, assistance, and referral that Area XIV will attempt to meet in an increasing way over the next four years.

Local Strategies / Action Steps
The hiring of a Family Caregiver Program Coordinator (FCPC) in February, 2009 provided a base for the development of the information and referral service. In addition, a decision by the Iowa Association of Area Agencies on Aging (a FCP contractor) to switch to the AIRS taxonomy and enhance the ESP data system promised tools for growing the service. Further steps to be taken in FY10 include:

- Starting July 1, 2009, publicize I&A numbers throughout the area on a regular basis through twelve newspaper advertisements and twelve press releases as well as signs in local meal sites and other locations.
- By July 1, 2009, contract with the Family Caregiver Program of the Iowa Association of Area Agencies on Aging for statewide I&A services.
- Prepare the FCPC for AIRS-A certification as soon as the qualifications are met while developing needed skills in the interim.
- By September 1, 2009, train other staff in I&A protocols and the use of ESP so consistent service can be provided throughout the working day even when the FCPC is absent from the office or otherwise occupied (see case management objective for related information).
- By October 1, 2009, fully implement use of the ESP software for both a source for referral and client information.

Major Accomplishment(s) past and present regarding this goal.
Hired a part-time Family Caregiver Program Coordinator in February, 2009. In the past program coordination was one function of another staff person. Now it will be the sole responsibility.

Worked with i4a to explore I&A software alternatives. Settled on retaining ESP with a crossover to the AIRS taxonomy.

Future Challenges
Enhancing the visibility and recognition of the agency as a source of information and assistance.

FY 2010 / Agency-Specific Outcome
In FY2010, Area XIV Agency on Aging will respond to at least 900 information and assistance contacts including 200 contacts through an improved provision and record-keeping system in the agency office.

Agency-Specific Outcome Measure

NAME OF OUTCOME, PROJECT, SERVICE OR ACTIVITY TO BE MEASURED: Information and Referral

OUTCOME MEASURE FORMAT TO USE: Measurement: contacts. Data will be collected from records maintained by the Family Caregiver Coordinator using ESP software to the fullest extent possible.

COST & FUNDING SOURCE: The approximate cost of this goal will be $18,567 and will be supported with IIIB and IIIE funds.

Measure	FY'07 Baseline Data (Contacts)	FY'08 Actual (Contacts)	FY'09 Year-to-Date (Contacts)	FY'2010 Projection (Contacts)
Information and Assistance Contacts	**446 contacts**	**630 contacts**	**384 contacts**	**900 contacts**

GOAL
In FY2010, Area XIV Agency on Aging will respond to at least 900 information and assistance contacts.

RATIONALE:

(1) If the previous outcome measure was met, describe the agency's activities that contributed to the success.

- Not applicable – new goal.

(2) If the previous outcome measure was not met, what were the barriers or outside influences that impacted the agency's ability to achieve the measure?

- Not applicable – new goal.

(3) Explain why the agency plans to maintain, increase or decrease the measure.

- Not applicable – new goal.

Goal 1. Enable Older Iowans and Their Families to Make Informed Decisions About, and be Able to Easily Access, Existing Home and Long-Term Care Options

Local Objective 2 - Transportation.
Transportation: Provide seniors access to congregate meals, medical services, and retail services in the communities where they live during FY2010.

Needs Being Addressed
Ten percent of the respondents to the Elder Affairs Needs Assessment said that they either do not drive now or would be "not likely at all" to be driving in the next two years. While many of these persons will find transportation with family and friends, many will need and be able to use the public transportation services of the Southern Iowa Trolley.

Local Strategies / Action Steps
Area XIV Agency on Aging is the Regional Transit Authority for the area. Under the trade name of Southern Iowa Trolley it operates 35 light-duty buses and mini-vans to provide public transportation in the seven counties. Aging funds are used to subsidize transit fares so that seniors' make a voluntary contribution (suggested: $1.25) to the $2.50 cost of each trip. The Southern Iowa Trolley does the screening of customers for eligibility, collection program income, and reports rides and contributions for reporting through INAPIS, IAFRS, and agency financial reports.

Beginning July 1, 2009, promote the availability of transit services via advertisements, press releases, and presentations in senior centers, meal sites, and other locations.
Beginning July 1, 2009, offer reduced price rides (e.g. 50 cent Wednesdays) and free rides when occasions justify (e.g. Christmas season).
Beginning September 1, 2009, reinstitute regular public transit service from area communities to Des Moines at least once per month.
In January, 2009, evaluate progress to date and modify promotion activities and service as appropriate.

Major Accomplishment(s) past and present regarding this goal.
In the first eight months of FY2009, 17,983 rides have been provided to seniors. (In the comparable time in FY2009, 18,597 rides were provided.)

Future Challenges
As costs (especially wages and fuel) continue to increase and both transit and aging funding stays static or decreases it is increasingly difficult to maintain this service at current levels and prices/contribution.

FY 2010 / Agency-Specific Outcome
In FY2010, Area XIV Agency on Aging will provide funding for 33,100 senior rides on the Southern Iowa Trolley.

Agency-Specific Outcome Measure

NAME OF OUTCOME, PROJECT, SERVICE OR ACTIVITY TO BE MEASURED:
Transportation

OUTCOME MEASURE FORMAT TO USE: One way trip. Data is collected from reports provided by the Southern Iowa Trolley based on information summarized from trip logs maintained by bus drivers.

COST & FUNDING SOURCE: The projected cost of this service is $131,098. It will be supported with Senior Living Program and IIIB funds, county government funds, and program income.

Measure	FY'07 Baseline Data (Measurement)	FY'08 Actual (Measurement)	FY'09 Year-to-Date (Measurement)	FY'2010 Projection (Measurement)
One Way Trip	**New goal**	**New goal**	**New goal**	**33,100**

GOAL
In FY2010, Area XIV Agency on Aging will provide funding for 25,000 senior rides on the Southern Iowa Trolley.

RATIONALE:

(1) If the previous outcome measure was met, describe the agency's activities that contributed to the success.

- Not applicable – new goal.

(2) If the previous outcome measure was not met, what were the barriers or outside influences that impacted the agency's ability to achieve the measure?

- Not applicable – new goal.

(3) Explain why the agency plans to maintain, increase or decrease the measure.

- Not applicable – new goal.

Goal 2. Enable Seniors to Remain in Their own Homes with High Quality of Life for as Long as Possible Through the Provision of Home and Community-Based Services, Including Supports for Family Caregivers.

Local Objective 1 – Case Management.
Maintain and expand the Case Management Program for the Frail Elderly so that more consumers each year are able to live independently for more months as indicated by the average number of months consumers stay in the program.

Needs Being Addressed
The need for case management is demonstrated by the number of individuals who already are in case management. Through eight months of FY09, 364 persons have received case management services. This reflects and increase from FY08. The need increases as persons age and are lower income.

Local Strategies / Action Steps
By July 31, develop an intake questionnaire (using FASE, SEAMLESS preadmission and other questions) which can be used by any staff person to determine a caller's need for service.
By September 30, provide training to all appropriate staff in the use of the intake questionnaire.
In November, team with the Family Caregiver Program to host a workshop on supports for informal caregivers and seniors themselves including case management.
By November 30, work with other community resources will help with linking clients to supports resulting in maintaining their independent living status longer.
By June 30, 2010, provide continuing learning experiences (conferences, webinars, etc.) to case management staff to maintain and develop skills and increase familiarity with services, clients, and the case management process.
By June 30, 2010, increase the number of non-waiver clients in the case management program by targeting existing and new funding to make services available which are unaffordable without the support of the Elderly Waiver.

Major Accomplishment(s) past and present regarding this goal.
Case management program helps nearly 300 family and elders coordinate services and provide resources that are needed by elders and their families to navigate the healthcare system.
Case managers meet with families, assess the consumer need, and develop a comprehensive plan with input from caregivers, service providers, and other professionals.
Locating and coordinating community and government services for consumers and family caregivers for easing difficulty and frustration.

Future Challenges
Case management and I&A disparate services in that case management is very structured and regulated. I&A is more flexible. Coordinating the two into a seamless and complimentary process will be a challenge.

FY 2010 Outcome Measure / CASE MANAGEMENT (CMPFE)
The average number of months a client's independent living status is maintained because of CMPFE before being discharged due to institutionalization or death will be 22 months.

Outcome Measure / Case Management (CMPFE)

Section 306(a) (8) of the Older Americans Act, as amended 2006, requires an Area Agency on Aging to include Case Management in the Area Plan.

OUTCOME MEASURE DEFINITION FOR CASE MANAGEMENT (CMPFE) – The average number of months a client's independent living status is maintained because of CMPFE before being discharged due to institutionalization or death will be 22 months.

OUTCOME MEASURE: the average number of months a client's independent living status is maintained.

Outcome Measure	FY'07 Baseline Data (# of Months)	FY'08 Actual (# of Months)	FY'09 Year-to-Date (# of Months)	FY'2010 Projection (# of Months)
CMPFE	**11**	**21**	**17**	**22**

GOAL FOR AREA PLAN:
Our FY10 goal is to increase the clients' independent living status from an average of 21 months in FY08 to an average of 22 months as measured for FY2010 through the time of preparation of the area plan.

RATIONALE:

(1) If the previous outcome measure was met, describe the agency's activities that contributed to the success.

The projected increase is due to better understanding of the aging process, improvements in technology and service methods, and the familiarity of Area XIV case managers with their clients and the CMPFE process. Few non-waiver clients have chosen to take advantage of case management services. Area XIV has continued to maintain a successful and cost-effective case management system in compliance with CMPFE and Medicaid Waiver

(2) If the previous outcome measure was not met, what were the barriers or outside influences that impacted the agency's ability to achieve the measure?

- Not applicable – new goal.

(3) The agency plans to increase the measure in FY10:

a. Develop and expand, in FY2010, a seamless method of initial intake of persons who contact the agency which integrates CMPFE, information and referral, and the family caregiver program better understanding of the aging process
b. Increasing awareness so technologies and service options.
c. Reaching non-waiver clients who would benefit from case management.
d. Identifying more unmet needs with both existing and new CMPFE clients.
e. Continuing support of the case management staff will help retention and the resulting familiarity with services, clients, and the case management process.
f. Working with other community resources will help with linking clients to supports resulting in maintaining their independent living status longer.

Goal 2. Enable Seniors to Remain in Their own Homes with High Quality of Life for as Long as Possible Through the Provision of Home and Community-Based Services, Including Supports for Family Caregivers.

Local Objective 2 – Family Caregiver Program.
Increase the number of registered clients receiving assistance from the National Family Caregiver Support Program to at least 100 persons plus 350 via the newsletter.

Needs Being Addressed
According to the *Service Needs of Older Iowans* 18% of persons age 60 and over provided informal caregiver services in the past year. Of that group 49% cared for a spouse and 22% for a parent. The number of caregivers can be expected to increase with 37% anticipating such a role in the next two years.

Local Strategies / Action Steps
Publish a quarterly newsletter focusing on family caregiver support and services available.
Increasing our public presence as a source of caregiver support.
Tables will be staffed at any health fairs and other display opportunities in FY2009. Caregivers who visit the table will be invited to provide name and addresses so that information can be provided and follow-up contacts made.
Agency staff will attend monthly interagency meetings whenever we are aware of them.
A database of caregivers will be started compiling names and addresses that become known through the workshops, advertisements, promotions and other methods. By June 30, 2010 there will be at least 350 caregivers identified. Consideration will be given to utilizing the ESP software supported by i4a to maintain the family caregiver database.

Major Accomplishment(s) past and present regarding this goal.
A Family Caregiver Program Coordinator has been hired and began work in February, 2009.

Future Challenges
Identifying caregivers.
Reaching caregivers with needed supports.

FY 2010 Outcome Measure / CASE MANAGEMENT (CMPFE)
Increase the number of registered clients receiving assistance from the National Family Caregiver Support Program to at least 100 persons.

Outcome Measure / Caregiver

Section 306(a) (7) of the Older Americans Act, as amended 2006, requires an Area Agency on Aging to include Caregiver as an Outcome Measure in the Area Plan.

OUTCOME MEASURE DEFINITION FOR CAREGIVER: Increase the number of registered clients receiving assistance from the National Family Caregiver Support Program to at least 100 persons plus 350 via the newsletter.

OUTCOME MEASURE FORMAT: The number of registered clients receiving assistance.

Measure	FY'07 Baseline Data (# Registered Clients)	FY'08 Actual (# Registered Clients)	FY'09 Year-to-Date (# Registered Clients)	FY'2010 Projection (# Registered Clients)
Caregiver	***13***	***83***	***3***	***100***

GOAL FOR AREA PLAN:

Increase the number of registered clients receiving assistance from the National Family Caregiver Support Program to at least 100 persons.

RATIONALE:

More effective informational programs to identify and reach family caregivers as well as better registration of family caregivers will allow Area XIV to reach and support more family caregivers.

A Family Caregiver Program Coordinator without other job assignments will be able to concentrate on reaching and supporting efforts and raise visibility of the program both with in the agency and in the seven counties.

Goal 3. Empower Older Iowans to Stay Active and Healthy Through Older Americans Act Services Including Evidenced-Based Disease Prevention Programs.

Local Objective 1 – Nutrition Risk Reduction
Improve nutrition risk scores in 2010 through education, counseling, monitoring, providing meals and in conjunction with care coordination and other services,

Needs Being Addressed
According to the *Service Needs of Older Iowans*

Local Strategies / Action Steps
July 1, 2009, begin the new round of current clients completing the nutrition risk assessment.
July 1, 2009, begin nutrition education sessions in each meal sites and
February 1, 2010, begin reassessment of all nutrition clients so that there is nutrition risk data to compare.

Major Accomplishment(s) past and present regarding this goal.
During FY09, a plan was developed to refer non-Elderly Waiver home-delivered meal recipients to case management for assessment. One result was better assessment of needs. Another result was the identification of several clients who were eligible for the Elderly Waiver.

Future Challenges
Providing nutritious meals, education, and counseling does not necessarily mean that the clients will improve their nutrition habits.

FY 2010 / Agency-Specific Outcome
The percent of clients who maintain or reduce their nutrition risk score on the nutiriton risk assessment will be 90%.

Outcome Measure / Nutritional Risk

Section 306(a) (1) of the Older Americans Act, as amended 2006, requires an Area Agency on Aging to include Nutritional Services in the Area Plan.

OUTCOME MEASURE DEFINITION FOR NUTRITIONAL RISK: Reduce the percent of clients determined to be at high nutritional risk who receive congregate meals, home delivered meals and nutrition counseling and maintain or improve their Nutrition risk scores.

OUTCOME MEASURE FORMAT TO USE: A combined 90% percent of clients 60+ years of age with high Nutrition risk scores that maintain or improve their High Nutrition Risk scores.

COST & FUNDING SOURCE: The approximate cost of this goal will be $7,832 and will be supported with IIIC and IIID funds as well as non-cash contributions.

Outcome Measure	FY'07 Baseline Data (% of Clients)	FY'08 Actual (% of Clients)	FY'09 Year-to-Date (% of Clients)	FY'2010 Projection (% of Clients)
Nutrition Risk	**50%**	**86%**	**100%**	**90%**

GOAL FOR AREA PLAN:

The percent of clients who maintain or reduce their nutrition risk score on the nutiriton risk assessment will be 90%.

RATIONALE:
The percent of clients who maintain or reduce their risk score was improved from 50% since data was first maintained FY07. Maintainance of score is part of the goal because there some of the factors are outside of the control of the AAA so there is a limit as to how much scores can improve. We are aim to have better data through more effective assessment.

Goal 3. Empower Older Iowans to Stay Active and Healthy Through Older Americans Act Services Including Evidenced-Based Disease Prevention Programs.

Local Objective 2 – Improving the Aging Experience.
Help Iowans better prepare for aging through education about the aging experience by June 30, 2010 using evidence-based presentations at senior centers and other locations.

Needs Being Addressed
Aging can be a solitary process marked by isolation caused by declining health, loss of spouse and friends, and reduced mobility. Information about retaining independence and quality of life is not always readily available. According to the *Service Needs of Older Iowans* 27% of persons in the PSA live alone. As many as 50% need information about some part of the aging process and available support.

Local Strategies / Action Steps

- Explore the availability of video resources on disease prevention available through the Department on Aging.
- Explore the availability of evidence-based wellness programs on the internet and elsewhere.
- Schedule a presentation in each meal site and to other groups using proven information and techniques.

Major Accomplishment(s) past and present regarding this goal.
This will be the first year of this effort.

Future Challenges
Having time in the limited timeframe of meal sites to present meaningful information that will make a difference in the lives of the seniors.

FY 2010 / Agency-Specific Outcome
In FY10, thirty presentations to a total of 600 seniors will be made to groups of seniors in meal sites, senior centers, and other places.

Agency-Specific Outcome Measure

NAME OF OUTCOME, PROJECT, SERVICE OR ACTIVITY TO BE MEASURED: Improving the Aging Experience.

OUTCOME MEASURE FORMAT TO USE: Number of presentations and number of persons present. Data will be collected using sign-in sheets and/or attendance rosters and reported under the Public Information (F03) taxonomy..

COST & FUNDING SOURCE: This goal will cost approximately $5,000 and will be supported with IIIB and IIIE funds.

Measure	FY'07 Baseline Data (Measurement)	FY'08 Actual (Measurement)	FY'09 Year-to-Date (Measurement)	FY'2010 Projection (Measurement)
Improving the Aging Experience Presentations	Not available	Not available	Not available	30 presentations/ 600 persons

GOAL
In FY10, thirty presentations to a total of 600 seniors will be made to groups of seniors in meal sites, senior centers, and other places.

RATIONALE:

(1) If the previous outcome measure was met, describe the agency's activities that contributed to the success.

- Not applicable – new goal.

(2) If the previous outcome measure was not met, what were the barriers or outside influences that impacted the agency's ability to achieve the measure?

- Not applicable – new goal.

(3) Explain why the agency plans to maintain, increase or decrease the measure.

- Not applicable – new goal.

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

Local Objective 1 – Legal Services. in the area
Contract with Iowa Legal Aid in FY2010 for legal services for seniors and outreach on legal issues.

Needs Being Addressed
In FY08, 202 hours of legal services were provided by Iowa Legal Aid to 90 unduplicated clients. Services so far in FY09 follow a similar pattern. This would indicate an ongoing need. Further, Area XIV is served in a lower proportion to the rest of the state indicating a lack of knowledge about the available services.

Local Strategies / Action Steps
By July 1, 2009, finalize a contract with Iowa Legal Aid for services.
By July 15, 2009, obtain a schedule from ILA of outreach and service plans in the area and arrange appropriate publicity.
By July 31, 2009, evaluate services provided in FY09 for adequacy in relation to funding and proportion to the rest of the state and identify awareness and outreach opportunities that may increase use of Iowa Legal Aid by persons in the area.
By October 31, 2009, evaluate the services provided in the previous quarter to make sure that the area is being proportionally served and identify awareness and outreach opportunities that may increase use of Iowa Legal Aid by persons in the area.
By January 31, 2010, evaluate the services provided in the previous quarter to make sure that the area is being proportionally served and identify awareness and outreach opportunities that may increase use of Iowa Legal Aid by persons in the area.
By April 30, 2010, evaluate the services provided in the previous quarter to make sure that the area is being proportionally served and identify awareness and outreach opportunities that may increase use of Iowa Legal Aid by persons in the area.

Major Accomplishment(s) past and present regarding this goal.
For several years, Area XIV has contracted with Iowa Legal Aid for legal outreach and consultation services. This has generally been a cost-effective arrangement. Area XIV supported the ICN broadcasts with staff support and distribution of publicity materials.

Future Challenges
There are no known attorneys in the area who specialize in elder law making Iowa Legal Aid the only alternative for such services. Development of elder law attorneys would both provide contracting alternatives and would provide a local alternative for seniors.

Getting the word out about education and consultation alternatives with Iowa Legal Aid has been and will continue to be a challenge. Some staff resources will need to be dedicated to this effort which will reduce the funds available for actual services.

FY 2010 / Agency-Specific Outcome
During FY2010, 100 hours of legal services will be provided as well outreach on legal matters.

Agency-Specific Outcome Measure

NAME OF OUTCOME, PROJECT, SERVICE OR ACTIVITY TO BE MEASURED: Legal Services

OUTCOME MEASURE FORMAT TO USE: Measurement: hours

COST & FUNDING SOURCE: The approximate cost of this goal will be $4,300 and will be supported with IIIB funds and non-cash match.

Measure	FY'07 Baseline Data (Hours of legal service)	FY'08 Actual (Hours of legal service)	FY'09 Year-to-Date (Hours of legal service)	FY'2010 Projection (Hours of legal service)
Legal Service (hours)	**Not available**	**173**	**105**	**100**

GOAL
During FY2010, 100 hours of legal services will be provided as well outreach on legal matters.

RATIONALE:

Due to the need for IIIB Supportive Service funding in other services, funding for legal services will be reduced in FY10 to nearer the mandated minimum funding.

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

Local Objective 2 - Advocacy.
Increase and enhance the public awareness in FY2010 of Area XIV Agency on Aging and the role it plays in home and community based services through increased outreach efforts,

Needs Being Addressed
The weather emergencies in 2008, though relatively limited in this area, pointed out the need for better advocacy on behalf of seniors. Older residents of the area need to be a stronger legislative and political presence and better represented in advocating for needed services. For example, funding for elder rights and efforts to prevent abuse, neglect, and exploitation have yet to begin in the area.

Local Strategies / Action Steps

Plans to achieve the outcome measure in FY10:

a. At least twelve press releases will be issued highlighting the variety of the needs and giftedness of seniors and the services available.
b. Better record-keeping of persons served will result in a more accurate, and higher, picture of the advocacy services provided by Area XIV.
c. Information/assistance and outreach services will be improved by the assignment of this role to one person in the agency and working toward CIRS-A certification for one or more staff including the Executive Director.
d. Advocate on behalf of seniors on legislation that would impact seniors. Efforts will include:
   - Support of the Older Iowans Legislature by the AAA and recruitment of at least one OIL member/delegate from each county in the service area.
   - Regular reports to the Advisory Council and other venues of advocacy opportunities and efforts as well as the results of those efforts.
   - Increased participation of the Executive Director in advocacy efforts in the state legislature and Congress via letters and personal visits.
   - Publicity in presentations and media of the area agency's role in advocating for the needs and rights of seniors in the area.

Major Accomplishment(s) past and present regarding this goal.

- Frequent press releases and good coverage in area newspapers.
- Monthly appearance by one or more staff on local radio.
- Two seniors from the area were O.I.L. delegates.
- Eight from the area attended the i4a legislative day in February.
- Helped nominate a potential Commission on Aging member from the area.

Future Challenges
Area XIV Agency on Aging struggles to be "at the table" with other human service agencies when senior issues are discussed. For example, emergency planning largely bypasses the agency.

FY 2010 / Agency-Specific Outcome
Our FY10 goal is to maintain the number of persons served with advocacy services at 409/1000.

Agency-Specific Outcome Measure

NAME OF OUTCOME, PROJECT, SERVICE OR ACTIVITY TO BE MEASURED: Advocacy

OUTCOME MEASURE FORMAT TO USE: Measurement: contacts.

COST & FUNDING SOURCE: The approximate of this goal will be $8,000 and will be supported with IIIB and IIIE funds and related match.

Measure	FY'07 Baseline Data (Iowans 60+ years of age)	FY'08 Actual (Iowans 60+ years of age)	FY'09 Year-to-Date (Iowans 60+ years of age)	FY'2010 Projection (Iowans 60+ years of age)
Advocacy Services	409/1000	Projection	Projection	409/1000

GOAL

Our FY10 goal is to maintain the number of persons served with advocacy services at 409/1000.

RATIONALE:

Why the agency plans to maintain the measure. The FY10 goal will be met in the following ways:

Frequent press releases were sent, via email, to local media and have resulted in frequent mention in the agency and its services in weekly newspapers in the area.

The outreach and public information functions was enhanced by hiring a part-time staff person to handle this and related function.

Elderly waiver funding of case management and the change to an internal model has allowed us to identify and advocate for persons with needs.

Monthly appearance by one or more staff on local radio.

Two seniors from the area were O.I.L. delegates.

Eight from the area attended the i4a legislative day in February.

Helped nominate a potential Commission on Aging member from the area.

1.5 EMERGENCY PREPAREDNESS PLAN

In cooperation with other local agencies and state/federal agencies as appropriate, Area XIV Agency on Aging will plan in anticipation of emergency and disasters that may occur in the area so that the needs of elders are recognized and met during and after the emergency.

(1) Key partners: agency aging staff, agency transit staff, emergency planners in each county, case managers (CMPFE), FEMA, Homeland Security, Department of Aging, and a variety of community groups, both volunteer and professional.

(2) Types of emergencies covered under the plan: In developing the Area XIV Disaster/Emergency Plan we are attempting to plan for the common elements in all emergency situations. Emergencies considered in the planning process include: blizzard, ice storm, prolonged heat wave, drought, hazardous material spill on railroad, anhydrous discharge or spill, fire, property destruction, medical emergencies, workplace violence, food contamination, flu pandemic, economic downturn or disaster, fire in elderly housing location, large scale electrical and/or communication shutdown, terrorism-WMD, terrorism.

(3) Process used to develop long-range emergency plans with local and state emergency response agencies, relief organizations, local and state governments and other institutions with responsibility for disaster relief service delivery

Process used to develop your plan.

a. Regular meetings of a staff committee representing nutrition, transit, administration
b. Training of two staff in emergency preparedness
c. Identification of potential partners, potential emergencies and affected populations
d. Meetings with county emergency planners (seven) and other service providers

(4) How activities are coordinated with local county disaster coordinators and others when an emergency strikes

We have named Pam Stow, Transit Manager, as the Emergency Coordinating Officer (ECO). In this role she would be the initial contact for the organization should an emergency or disaster occur anywhere in our seven county area.

We have also surveyed the staff as to their own availability during an emergency giving them notice that this could mean leaving families so they need to have family emergency plan. A telephone tree will be developed using the results of the survey.

We are distributing emergency preparedness (READY program) materials from the Department of Homeland Security to seniors throughout the area starting with the congregate meal sites and instructing them on the preparation of emergency kits for their personal use.

Agency staff (ECO and Transit Operations Manager) attend the monthly meetings of the emergency planning group in Union County.

1.6 AREA PLAN BUDGET REPORT

Documents in this section are electronically submitted through the IAFRS System.
Refer to the Instructions Section for specific document names, completion and submission details.

The following budget related pages are appended

Form 3A – Units of Service	pages 1-3
Summary View Pages	4 pages
Service Totals Pages	pages 1-9

1.7 COMPLIANCE AND ASSURANCE DOCUMENTS

Compliance with Assurances and General Provisions

The Area Agency on Aging hereby assures compliance, on behalf of itself and any subcontractors, with all applicable provisions of the following statutes, regulations and requirements for the Area Plan period **July 1, 2009 through June 30, 2013**, and assures that services will be provided in accordance with any and all applicable federal or state laws, regulations, rules and procedures.

- Older Americans Act, as Amended, 2006
- Fair Labor Standards Act of 1938
- Americans with Disabilities Act of 1990
- Senior Living Program**,** IAC 321, Chapter 28
- IAC 321 – 6.9(231) Emergency Situations
- Code of Iowa, Chapter 8F, Contractor Certification and Reporting
- Emergency Preparedness Planning
- Minority Impact Statement
- Assurance of Compliance with the State of Iowa Laptop/Tablet Data Protection Standard (Associated with CMPFE)

The Area Agency on Aging will cooperate fully with the Iowa Department of Aging to assure compliance with provisions required by legislative action taken by the Congress of the United States, and the Iowa General Assembly, and with Iowa Aging Program Instructions during fiscal years 2010-2013 of the Area Plan.

Further Assurance is Given That:

1. The Area Agency on Aging will provide access to and the right to examine all record books, papers or documents related to the Area Plan.

The Compliance with Assurances and General Provisions is hereby submitted for the Area Plan period July 1, 2009 through June 30, 2013 to the Iowa Department of Aging for approval.

March 31. 2009 _____

Date Director, Area XIV Agency on Aging

Older Americans Act, as Amended 2006
38 Sec. 306 OLDER AMERICANS ACT OF 1965

Assurances
Sec. 306, AREA PLANS

306(a)(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-

306(a)(2)(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);

306(a)(2)(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

306(a)(2)(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.

306(a)(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);

306(a)(4)(A) (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

306(a)(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).

306(a)(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 A-3 organic brain dysfunction (and the caretakers of such individuals); and (VII) older individuals at risk for institutional placement; and

306(a)(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.

306(a)(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.

306(a)(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;

306(a)(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.
306(a)(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-
306(a)(11)(A)	information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
306(a)(11)(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
306(a)(11)(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.
306(a)(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.
306(a)(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—
306(a)(13)(B)(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
306(a)(13)(B)(ii)	the nature of such contract or such relationship.
306(a)(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.
306(a)(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.
306(a)(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.
306(a)(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.
306(a)(15)	provide assurances that funds received under this title will be used-
306(a)(15)(A)	to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
306(a)(15)(B)	in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

The governing body of the area agency has reviewed and approved these Assurances.

Signature of Authorized Official of the Grantee (Director, Area Agency on Aging)

_____ Dated: March 31. 2009

Signature of Other Designee

_____ Dated: March 31. 2009

Assurance of Compliance with the Department of Health and Human Services Regulations Regarding Title VI of the Civil Rights Act of 1964, as Amended

Area XIV Agency on Aging (hereinafter called the "Applicant")
Name of Applicant (Area Agency on Aging)

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives federal financial assistance from the Department; and hereby gives assurance that it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Applicant for the period during which the federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Applicant.

Area XIV Agency on Aging — March 31, 2009
Applicant (Area Agency on Aging) — Date

By_____
Authorized official of the grantee (Director, Area Agency on Aging)

Applicant's Mailing Address (Area Agency on Aging):
215 East Montgomery Street, Creston, IA 50801

ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973, AS AMENDED

The undersigned (hereinafter called the "recipient") HEREBY AGREES THAT it will comply with Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HHS regulation (45 CFR Part 84), and all guidelines and interpretations issued pursuant thereto.

Pursuant to subsection 84.5(a) of the regulation (45 CFR84.5(a)**,** the recipient gives this Assurance in consideration of and for the purpose of obtaining any and all federal grants, loans, contracts (except procurement contracts of insurance or guaranty), property, discounts, or other federal financial assistance extended by the Department of Health and Human Services after the date of this Assurance including payments or other assistance made after such date on applications for federal financial assistance that were approved before such date. The recipient recognizes and agrees that such Federal financial assistance will be extended in reliance on the representation and agreements made in this Assurance and that the United States will have the right to enforce this Assurance through lawful means. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

This Assurance obligates the recipient for the period during which federal financial assistance is extended to it by the Department of Health and Human Services or, where the assistance is in the form of real or personal property, for the period provided for in subsection 84.5(b) of the regulation (45 CFR84.5 (b)**.**

The recipient: (Check (a) or (b)

a.( ) employs fewer than fifteen persons

b.(X) employs fifteen or more persons and, pursuant to subsection 84.7(a) of the regulation (45 CFR 84.7(a), has designated the following person(s) to coordinate its efforts to comply with the HHS regulations:

Steve Bolie -
Name of Designee(s) (type or print) (Director, Area Agency on Aging)

Area XIV Agency on Aging -
Name of Recipient (type or print) (Area Agency on Aging)

215 East Montgomery Street, Creston, IA 50801
Street Address, City, State, Zip

I certify that the above information is complete and correct to the best of my knowledge.

March 31, 2009
Authorized Official of the Grantee Date

Assurance of Compliance with the Minority Impact Statement

Pursuant to Section 8.11, Code of Iowa, all grant applications submitted to the State of Iowa which are due beginning January 1, 2009 shall include a Minority Impact Statement. This is the state's mechanism to require grant applicants to consider the potential impact of the grant project's proposed programs or policies on minority groups.

Please choose the statement(s) that pertains to this grant application. Complete all the information requested for the chosen statement(s).

☐ The proposed grant project programs or policies could have a disproportionate or unique **positive** impact on minority persons.

Describe the positive impact expected from this project

Indicate which group is impacted:

___ Women
___ Persons with a Disability
___ Blacks
___ Latinos
___ Asians
___ Pacific Islanders
___ American Indians
___ Alaskan Native Americans
___ Other

☐ The proposed grant project programs or policies could have a disproportionate or unique **negative** impact on minority persons.

Describe the negative impact expected from this project.

Present the rationale for the existence of the proposed program or policy.

Provide evidence of consultation of representatives of the minority groups impacted.

Indicate which group is impacted:

___ Women
___ Persons with a Disability
___ Blacks
___ Latinos
___ Asians
___ Pacific Islanders
___ American Indians
___ Alaskan Native Americans
___ Other

☒ The proposed grant project programs or policies are not expected to have a disproportionate or unique impact on minority persons.

Present the rationale for determining no impact.

While we will be seeking to have a positive impact, with only 85 minority individuals in the seven counties it will be difficult to have an significant impact, either positive or negative.

I hereby certify that the information on this form is complete and accurate, to the best of my knowledge:

_____
Agency on Aging Director

Not applicable
Director

Area XIV Agency on Aging:

March 31, 2009
Date

Definitions

"Minority Persons", as defined in Iowa Code Section 8.11, mean individuals who are women, persons with a disability, Blacks, Latinos, Asians or Pacific Islanders, American Indians, and Alaskan Native Americans.

"Disability", as defined in Iowa Code Section 15.102, subsection 5, paragraph "b", subparagraph (1):
b. As used in this subsection:
(1) "Disability" means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of the individual, a record of physical or mental impairment that substantially limits one or more of the major life activities of the individual, or being regarded as an individual with a physical or mental impairment that substantially limits one or more of the major life activities of the individual.
"Disability" does not include any of the following:
(a) Homosexuality or bisexuality.
(b) Transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments or other sexual behavior disorders.
(c) Compulsive gambling, kleptomania, or pyromania.
(d) Psychoactive substance abuse disorders resulting from current illegal use of drugs.

"State Agency", as defined in Iowa Code Section 8.11, means a department, board, bureau, commission, or other agency or authority of the State of Iowa.

Assurance of Compliance with the
State of Iowa Laptop/Tablet Data Protection Standard
(Associated with CMPFE)

Area XIV Agency on Aging

The Area Agency on Aging assures that laptop and/or tablet computers used to access the Seamless Database System associated with the Case Management Program for Frail Elders (CMPFE) meet all requirements of the State of Iowa Laptop/Tablet Data Protection Standard.

The area agency director and/or governing body has reviewed and approved this assurance.

_____

Director, Area Agency on Aging

March 31. 2009

Date

Request for a Direct Service Waiver

Area XIV Agency on Aging hereby requests a waiver of the requirement to award sub-grants of contracts to service providers for the services identified in this request.

1. Identify the service(s) to be delivered by the Area Agency.

   Nutrition – Congregate Meals

2. Identify criteria for which the waiver is warranted.

   [x] a. Provision of the service(s) by the Area Agency on Aging is necessary to assure an adequate supply of such service.

   [ ] b. The service(s) is directly related to the Area Agency on Aging's administrative functions.

   [ ] c. The service(s) can be provided more economically, and with comparable quality, by the Area Agency on Aging.

3. Describe the rationale for the identified criteria (this must be completed for each service):

The Area XIV Agency on Aging is the service provider for nutrition for all seven counties in the area. The Agency employs 7 full time and 25 part-time staff to deliver the service through a network of 14 nutrition sites located in multi-purpose senior centers throughout the seven counties. A Nutrition Manager, employed by the agency, manages the program. The food is prepared on-site in 11 of the centers. Four of the sites serve one meal a day five days a week, seven serve one meal a day, three days a week, one serves two days per week and the other two serve one day per week. During any month, over 200 volunteers assist with the delivery of the service.

Supportive services are integrated with the nutrition program throughout Area XIV. Each nutrition site manager also provides information and referral and outreach.

The nutrition program is offered in each of the seven county seat towns (population centers) as well as seven other smaller centrally located communities. This makes access to the service reasonably convenient to the majority of older persons within the area. Transportation via the Southern Iowa Trolley is available in most communities.

To the best of our knowledge, no older person needing the service within Area XIV has been denied congregate nutrition service. No waiting list for the service exists.

On occasions when an independent provider was needed (e.g. when a meal site was closed for a time) there has been no alternative provider available that could meet the nutritional and price requirements.

Executive Director — March 31. 2009

Signature and Title of Director, Area Agency on Aging — Date

Request for a Direct Service Waiver

Area XIV Agency on Aging hereby requests a waiver of the requirement to award sub-grants of contracts to service providers for the services identified in this request.

1. Identify the service(s) to be delivered by the Area Agency.

   Nutrition – Home-delivered Meals

2. Identify criteria for which the waiver is warranted.

   [x] a. Provision of the service(s) by the Area Agency on Aging is necessary to assure an adequate supply of such service.

   [ ] b. The service(s) is directly related to the Area Agency on Aging's administrative functions.

   [ ] c. The service(s) can be provided more economically, and with comparable quality, by the Area Agency on Aging.

3. Describe the rationale for the identified criteria (this must be completed for each service):

Area XIV Agency on Aging provides the home-delivered meal service in all seven counties in area on the same days that congregate nutrition sites serve. Meals are prepared by the agency's staff at the congregate sites and packed in insulated carriers for delivery to homebound older persons. Volunteers or employees deliver the meals. Volunteers also assist with food preparation and packaging in the site kitchens. The Nutrition Manager, employed by the agency, supervises the home-delivered meals program. The service is reasonably accessible to elders within Area XIV.

When requested, home health aids will pick up and deliver a meal to an isolated homebound person if they are going in to the home to provide service. Family members or friends may pick up a meal for an eligible older person who is not located on a regular delivery route. The Area Agency staff carefully screen applicants to receive home-delivered meals to determine that meals are provided only to eligible homebound persons.

There are no waiting lists of persons wanting to receive this service.

Executive Director — March 31. 2009

Signature and Title of Director, Area Agency on Aging — Date

Request for a Direct Service Waiver

Area XIV Agency on Aging hereby requests a waiver of the requirement to award sub-grants of contracts to service providers for the services identified in this request.

1. Identify the service(s) to be delivered by the Area Agency.

   Nutrition Counseling

2. Identify criteria for which the waiver is warranted.

   [X] a. Provision of the service(s) by the Area Agency on Aging is necessary to assure an adequate supply of such service.

   [ ] b. The service(s) is directly related to the Area Agency on Aging's administrative functions.

   [ ] c. The service(s) can be provided more economically, and with comparable quality, by the Area Agency on Aging.

3. Describe the rationale for the identified criteria (this must be completed for each service):

The area agency contracts with a Registered Dietician to provide nutrition counseling. The service is available at each of the fourteen congregate nutrition sites. Counseling sessions may be scheduled during semiannual visits by the Dietician or by special appointment. The Nutrition Manager for the area agency supervises the nutrition education program.

Executive Director — March 31. 2009

Signature and Title of Director, Area Agency on Aging — Date

Request for a Direct Service Waiver

Area XIV Agency on Aging hereby requests a waiver of the requirement to award sub-grants of contracts to service providers for the services identified in this request.

1. Identify the service(s) to be delivered by the Area Agency.

   Nutrition Education

2. Identify criteria for which the waiver is warranted.

   [x] a. Provision of the service(s) by the Area Agency on Aging is necessary to assure an adequate supply of such service.

   [ ] b. The service(s) is directly related to the Area Agency on Aging's administrative functions.

   [ ] c. The service(s) can be provided more economically, and with comparable quality, by the Area Agency on Aging.

3. Describe the rationale for the identified criteria (this must be completed for each service):

Site managers at each meal site provide nutrition education from materials provided by a registered, licensed dietitian and/or the Nutrition Manager. The service is provided at least monthly at the fourteen congregate nutrition sites. The nutrition education materials are also provided to the home-delivered meal recipients. The Nutrition Manager for the area agency supervises the nutrition education program.

Executive Director — March 31. 2009

Signature and Title of Director, Area Agency on Aging — Date

Request for a Direct Service Waiver

Area XIV Agency on Aging hereby requests a waiver of the requirement to award sub-grants of contracts to service providers for the services identified in this request.

1. Identify the service(s) to be delivered by the Area Agency.

   Transportation

2. Identify criteria for which the waiver is warranted.

   [X] a. Provision of the service(s) by the Area Agency on Aging is necessary to assure an adequate supply of such service.

   [ ] b. The service(s) is directly related to the Area Agency on Aging's administrative functions.

   [ ] c. The service(s) can be provided more economically, and with comparable quality, by the Area Agency on Aging.

3. Describe the rationale for the identified criteria (this must be completed for each service):

Area XIV Agency on Aging is the Regional Transit Authority (RTA) designated by the local county governing bodies, the Agency Board of Directors, and the Iowa Department of Transportation. As the RTA the Agency operates the Regional Transit System known as the Southern Iowa Trolley. (SIT)

SIT delivers door-to-door, demand-responsive service to the elders and general public. Regularly scheduled service currently operates Monday thru Friday in all seven counties. SIT operates a fleet of 35 vehicles that includes 31 ADA minivans and light duty buses, 4 non-ADA minivans, and 1 non-ADA light duty bus. Passengers age 60 years and over are encouraged to contribute to the cost of their trip. The suggested contriution is $1.25 per ride.

SIT is managed by a Transit Manager who oversees 35 office staff and drivers. All transit personnel are employees of the Agency. The Transit Advisory Committee consisting of representatives from the various passenger groups assists the Transit Manger, Executive Director and Board of Directors in determining overall system .

Executive Director — March 31. 2009

Signature and Title of Director, Area Agency on Aging — Date

Equipment and Real Property Acquisitions

EQUIPMENT AND REAL PROPERTY ACQUISITIONS

TAX #	SERVICE SUPPORT OR DELIVERY CATEGORY	DESCRIPTION	SOURCE	AMOUNT
				$

No equipment purchases anticipated in FY 10

Note: Indicate N/A if there are no equipment and/or real property acquisitions.

List of Contracts with For-Profit Organizations & Contract Notice

An Area Agency on Aging may not contract with a provider that has been denied Medicare/Medicaid Payment.

- To confirm the Medicare/Medicaid Payment status of a provider, check the Excluded Parties List System at the following web site: https://www.epls.gov/

Name & Address For-Profit Service Provider	Provider ✓ for Medicare/Medicaid Payment Denial*	Service to be Provided		Cost/Unit of Service

No contracts with for-profit organization are anticipated in FY10-13

Note: Indicate N/A if there are no contracts with For-Profit organization

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Appendix C
Executive Summary:
Service Needs of Older Iowans

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Service Needs of Older Iowans: Executive Summary

Prepared by: Center for Social and Behavioral Research, University of Northern Iowa
Sponsored by: Iowa Department of Elder Affairs
December 2008

Background. The Iowa Department of Elder Affairs (DEA) commissioned the Center for Social and Behavioral Research (CSBR) at the University of Northern Iowa (UNI) to conduct a needs assessment among adult Iowans age 60 and older. The purpose of this project was to provide information about each of the DEA's 16 Planning Service Areas (PSAs) regarding the use of various services within the past 12 months, current service needs, and future needs of Iowans age 60 and older living in private residences.

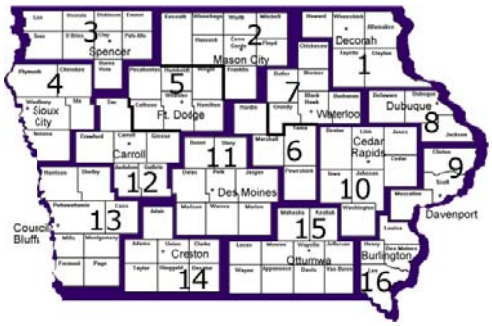


Figure ES-1. DEA's Planning Service Areas in Iowa

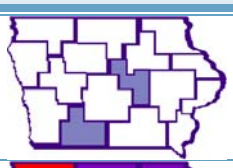
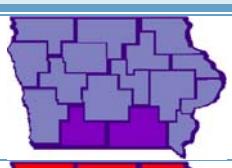
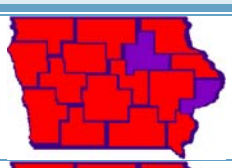
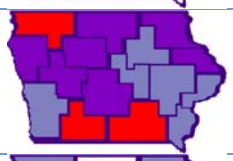
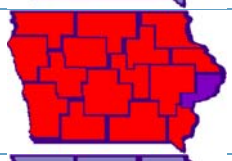
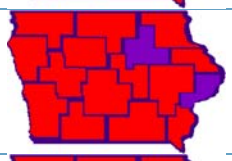
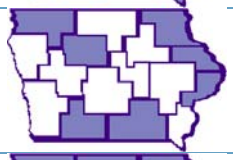
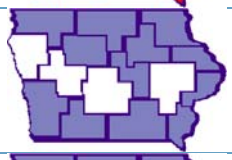
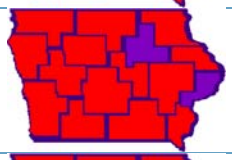
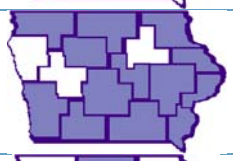
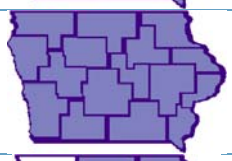
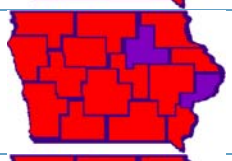
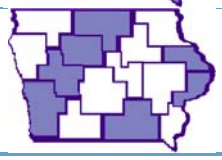
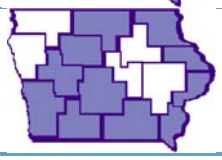
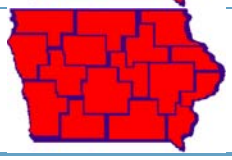
Methodology. A total of 8,476 telephone interviews (at least 500 per PSA) were completed between May 12, 2008, and August 7, 2008. The data were collected via Computer Assisted Telephone Interviewing (CATI) at the Center for Social and Behavioral Research at the University of Northern Iowa. Within each PSA, telephone numbers with a high probability of being associated with a household having at least one person 60 years or older living at the residence were randomly selected and dialed. If two or more people at a given telephone number were eligible for the interview, one respondent was randomly selected to be interviewed. Case weights were used when conducting data analysis to account for differential probabilities of selection and sample representativeness by gender and age group.

Demographic Characteristics. Social Security was the main source of income for older Iowans, but about 1 in 4 of all older adults (21% to 33% across the PSAs) were employed for wages. Household incomes less than $35,000 were reported by 31% to 50% (across the PSAs) of older Iowans who provided their income information (about one-third did not give their income information when asked). The vast majority of older adults had some form of health care coverage with about 3 in 4 receiving Medicare benefits. About 1 in 5 older adults (18% to 27% across PSAs) rated their physical health as *fair* or *poor* and about 1 in 10 older adults (6% to 12% across PSAs) rated their emotional health as *fair* or *poor.*

Transportation. The overwhelming majority of older adults drive themselves (about 9 in 10) or receive rides with someone else (about 1 in 10) when they need to go places. Yet, about 1 in 5 older adults (18% to 24% across PSAs) said there were times they were unable to get to places they needed to go. Approximately 1 in 10 older adults said they *do not drive now* or were *not at all likely* to be driving themselves within the next 2 years.

Service Needs. Older Iowans were asked about a variety of services, help, or assistance they may have received during the past 12 months, needed during the past 12 months, or anticipate needing within the next 2 years. Within the context of this study, the percent who "needed" a service during the past 12 months refers only to their need for a service regardless of whether or not they received the service. Therefore, the percent of older adults who "needed" a service is conceptually distinct from the percent of older adults who had an "unmet need" for a service.

Table ES-1
SERVICES OLDER ADULTS RECEIVED, NEEDED, OR ANTICIPATE NEEDING

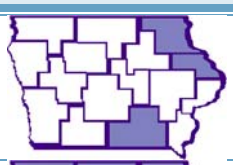
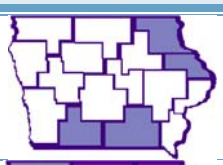
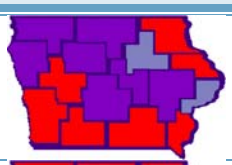
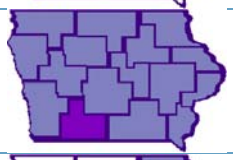
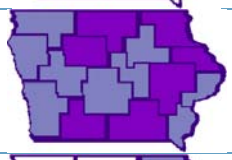
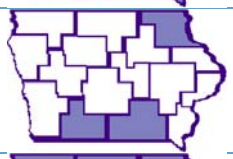
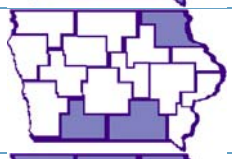
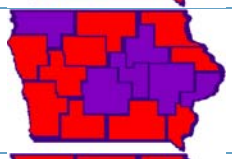
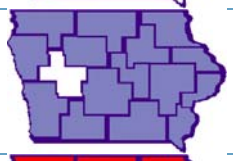
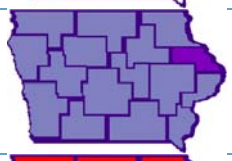
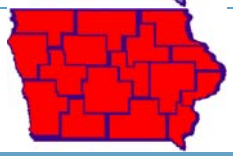
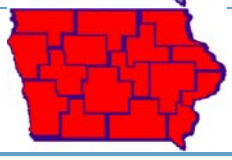
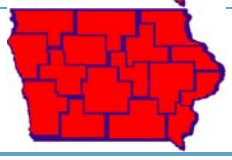
Type of Service	Received During Past 12 Months	Needed During Past 12 Months	At Least Somewhat Likely to Need Within Next 2 Years
Home-Delivered Meals			
Group Meals at Senior or Community Centers			
Nursing Care at Home			
Help Taking Medication			
Managing Day-to-Day Finances			

Notes. Respondents were classified as having "**received**" the service if someone helped them at least once during the past 12 months. Respondents were classified as having "**needed**" the service if (a) they received it *or* (b) they did not receive it for any other reason than the service was not needed. Respondents were classified as "**at least somewhat likely to need within next 2 years**" if they said it was *very likely* or *somewhat likely* they would need this type of help within the next 2 years. Findings for adult day services are not shown in this table (see the *Author's Note* in the main report for an explanation).

Legend

	0-5%
	6-10%
	11-15%
	16% or more

Table ES-2
HELP OLDER ADULTS RECEIVED, NEEDED, OR ANTICIPATE NEEDING RELATED TO DAILY LIVING

Type of Help	Received During Past 12 Months	Needed During Past 12 Months	At Least Somewhat Likely to Need Within Next 2 Years
Getting Dressed, Bathing, or Using the Bathroom			
Laundry or Light Housework			
Cooking or Preparing Meals			
Shopping for Groceries or Household Goods			
Outside Chores			

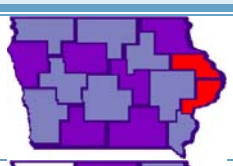
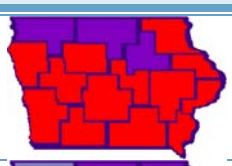
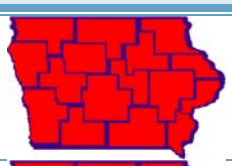
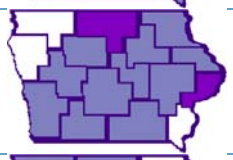
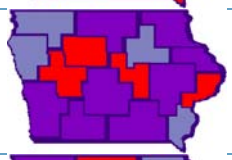
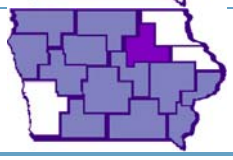
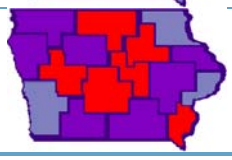
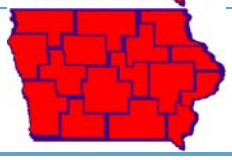
Notes. Respondents were classified as having "**received**" the service if someone helped them *every time* or *most times* they had a need during the past 12 months. "**Needed**" was based on an affirmative response to a question about needing help with an activity during the past 12 months. Respondents were classified as "**at least somewhat likely to need within next 2 years**" if they said it was *very likely* or *somewhat likely* they would need this type of help within the next 2 years.

Legend

	0-5%
	6-10%
	11-15%
	16% or more

Older Iowans as Caregivers. The percent of older adults who were primary caregivers during the past 12 months ranged from 15% to 21% across the PSAs. Caregivers were asked follow-up questions about services (Column 1) they may have needed. The maps in Table ES-3 show the percentages of *caregivers* who received (Column 2) or needed (Column 3) particular services (i.e., the denominator is caregivers and not all older Iowans). The maps in Column 4 of Table ES-3 show the percentages who said it was *very likely* or *somewhat likely* they would need particular services within the next 2 years among the combined group of current caregivers and those who said it was *very likely* they would be caregivers within the next 2 years (i.e., the denominator is current caregivers plus likely future caregivers rather than a denominator of all older Iowans as in Tables ES-1, ES-2, & ES-4).

Table ES-3
SERVICE NEEDS OF CAREGIVERS
(Denominator is caregivers not all older Iowans)

Type of Service	Received During Past 12 Months	Needed During Past 12 Months	At Least Somewhat Likely to Need Within Next 2 Years
Respite Care			
Training and Support			
Information about Financial Support			

Notes. Respondents were classified as having "**received**" the service if they received respite care even once or they received *all* of the training or information they needed during the past 12 months. Respondents were classified as having "**needed**" the service if (a) they received it *or* (b) they did not receive it for any other reason than the service was not needed. Respondents were classified as "**at least somewhat likely to need within next 2 years**" if they said it was *very likely* or *somewhat likely* they would need this type of help within the next 2 years. Anticipated need is based on the combined group of current caregivers and those who said it was *very likely* they would be caregivers within the next 2 years.

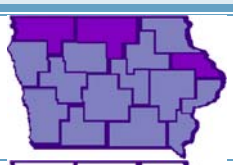
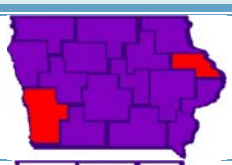
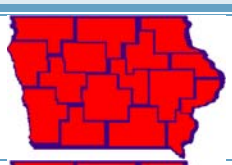
Legend

	0-5%
	6-10%
	11-15%
	16% or more

Correction Notice: Prior to February 6, 2009, the note for Table ES-3 read "if someone helped them *every time* or *most times* they had a need."

Need for Advice or Information. Older Iowans were asked whether they needed advice, help, or information about government health programs and nursing homes, how much of this help or information they received, and how likely it is they might need such advice, help, or information within the next 2 years.

Table ES-4
INFORMATION NEEDS

Type of Service	Received During Past 12 Months	Needed During Past 12 Months	At Least Somewhat Likely to Need Within Next 2 Years
Advice or Help with Government Health Programs			
Information about Nursing Homes for Themselves or Loved Ones			

Notes. Respondents were classified as having "**received**" if they received *all* of the advice, help, or information they needed during the past 12 months. "**Needed**" was based on an affirmative response to a question about needing advice, help, or information during the past 12 months. Respondents were classified as "**at least somewhat likely to need within next 2 years**" if they said it was *very likely* or *somewhat likely* they would need this type of advice, help, or information within the next 2 years.

Legend

	0-5%
	6-10%
	11-15%
	16% or more

Services Not Receiving. Near the end of the telephone interview, older Iowans were asked an open-ended question about whether there were one or two services they needed but were not currently receiving. Approximately 1 in 10 mentioned at least one service. The most commonly mentioned services older adults said they needed but were not receiving were transportation, help with household chores or indoor cleaning, general financial assistance, home-delivered meals, assistance or advice with health insurance, and help with outdoor chores.

Area Agencies on Aging (AAA) Program and Services. Although assessing the sufficiency or quality of services provided by the AAAs was not the focus of this survey, older Iowans were asked a question about their awareness of AAA programming and services in their communities. The majority (63% to 74% across the PSAs) of older Iowans said they were aware of at least one Area Agency on Aging program within their communities.

Conclusions. During the past 12 months, many older Iowans had received a variety of services and assistance provided by government agencies, non-profit organizations, and private groups and individuals. Despite these efforts, there were Iowans age 60 and older who did not receive services they needed or did not receive all of the assistance they needed. Looking ahead, an even larger percent of older Iowans said it was at least *somewhat likely* they would be in need of a variety of services within the next 2 years.

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Download report at:
http://www.state.ia.us/elderaffairs/Documents/Reports/Needs%20Assessment%202008/FINAL%20REPORT_Needs_of_Older_Iowans_2008.pdf

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Download report at:
http://www.uni.edu/csbr/findings.html

Appendix D
Executive Summary:
Iowa State Profile Tool, 2009

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HEALTHCARE

Iowa State Profile Tool: An Assessment of Iowa's Long-Term Support System

Submitted March 31, 2009

To John McCalley
Iowa Department of Elder Affairs
Des Moines, Iowa

By Steve Eiken
Mary Jo Iwan
Lisa Gold

Healthcare
Thomson Reuters

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Iowa State Profile Tool: Executive Summary

The Iowa State Profile Tool is a comprehensive, high-level assessment of Iowa's progress toward a balanced long-term care[1] system – a system that relies less on institutional services and provides greater opportunities for the in-home and community-based services that most people prefer. This report includes long-term support for people of all ages and disability types and is based on a variety of state and federal data sources and interviews with public and private leaders in Iowa's long-term care system.[2] The Iowa State Profile Tool describes all publicly funded long-term care programs and presents data regarding:

- Estimated demand for long-term care (i.e., age and disability rates)
- Expenditures and number of people served in public programs
- Number of people using privately funded long-term support, where available

It also describes the degree to which Iowa's system has eight system components found in states that have reformed their long-term care systems:

- **Consolidated state agencies** – a single agency for both institutional and community services that coordinates policies and budgets to promote community options;
- **Single access points** – a clearly identifiable organization managing access to a wide variety of community supports, ensuring people understand the full range of available options before receiving more restrictive services;
- **Institution supply controls** – mechanisms such as Certificate of Need requirements that enable states to limit or reduce institutional beds;
- **Transition from institutions** – outreach to identify residents who want to move and assistance with their transition to the community;
- **A continuum of residential options** – availability of support services in a range of options from mainstream single-family homes and apartments to integrated group settings for people who need 24-hour supervision or support;
- **HCBS infrastructure development** – recruitment and training to develop a sufficient supply of providers with the necessary skills and knowledge to encourage consumer independence;
- **Participant direction** – people who receive HCBS having primary decision-making authority over their direct support workers and/or their budget for supports;
- **Quality management** – an effective system that: a) measures whether the system achieves desired outcomes and meets program requirements and b) identifies strategies for improvement.

This executive summary presents trends that emerged from spending and utilization data and briefly describes the state's status for all populations regarding the eight system components.

Data Trends

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[1] We use the phrases "long-term care" and "long-term support" interchangeably and use a definition developed by the Georgetown University Long-Term Care Financing Project: "Assistance with essential, routine tasks of life – such as bathing, getting around the house, and preparing meals – provided to people who need this assistance because of physical or mental conditions or disability." This assistance can include therapies or equipment to improve a person's functional capacity. (Rogers, Susan and Komisar, Harriet "Who Needs Long-Term Care?" Georgetown University Long-Term Care Financing Project: May 2003)

[2] See the Bibliography and Appendix A for a list of data sources and individuals interviewed for this report.

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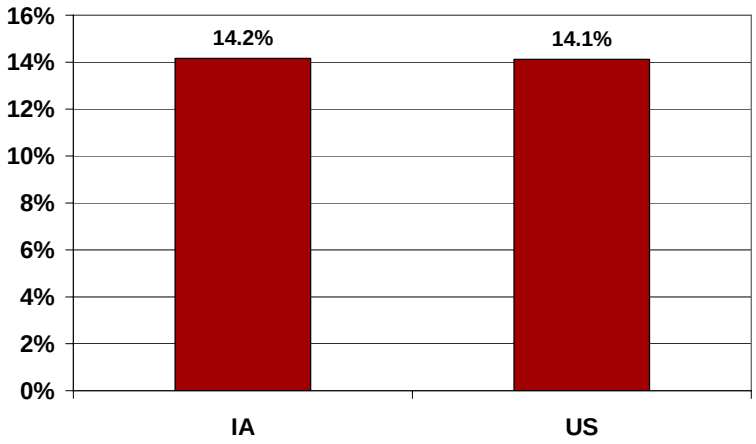
When both age and disability rates are considered, Iowans are about as likely to need long-term care as other Americans, as shown Chart ES.1 below. One of every seven Iowans (14.2%) has a disability.[3] This conclusion may be a surprise because Iowa has a high proportion of people age 65 and older, and older adults are more likely to need long-term care than younger individuals. However, Iowa's seniors have a low disability rate, which largely offsets the high percentage of older adults.

Chart ES.1: Percentage of Total State Population with Disabilities, 2007



Sources:
U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008 for population
U.S. Census Bureau, American Community Survey, 2007 "Table B18002. Sex by Age by Disability Status for Civilian Noninstitutionalized Population 5 Years and Over" September 23, 2008 for community disability data
U.S. Centers for Medicare & Medicaid Services *Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2007* Undated for nursing facility data

Iowa serves more people with disabilities and older adults in large facilities than almost any other state, when controlling for state population (See Table ES.1). Iowa is second to North Dakota in the number of nursing facility residents per 1,000 people age 65 or older. On a single day in 2008, approximately 9,700 individuals would not be in a nursing facility if Iowa's utilization was the same as the national average.[4] Iowa is third to Mississippi and Arkansas in the number of people with developmental disabilities served in residential facilities of 16 or more

[3] U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008 for population; U.S. Census Bureau, American Community Survey, 2007 "Table B18002. Sex by Age by Disability Status for Civilian Noninstitutionalized Population 5 Years and Over" September 23, 2008 for community disability data; and U.S. Centers for Medicare & Medicaid Services *Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2007* Undated for nursing facility data

[4] U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008 for population age 65 or older; and U.S. Centers for Medicare & Medicaid Services *Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2007* Undated for nursing facility data

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individuals.[5] In contrast, Iowa has a relatively low rate of state mental health hospital utilization.[6]

Table ES.1: Residents of Institutional Long-Term Care Facilities per 100,000 State Residents

	Nursing Facilities	Facilities with 16 or more residents with developmental disabilities	State Mental Health Hospitals*
Date for Most Recent Data	**June 30, 2008**	**June 30, 2007**	**June 30, 2006**
Iowa	853	55.1	7.4
United States	457	20.7	15.6

* For state mental health hospitals, United States data are based on 43 states that reported data.

Sources:
U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008 for population age 65 or older. Population data for 2007 were used because they were the latest available.
U.S. Centers for Medicare & Medicaid Services *Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2008* Undated for nursing facility data
Prouty, Robert W.; Alba, Kathryn; Lakin, K. Charlie (eds.) *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007* University of Minnesota Institute for Community Integration: August 2008
National Association of State Mental Health Program Directors Research Institute, Inc. "State Mental Health Agency Profiling System: System: 2007" October 2008

The high institutional utilization affects people with disabilities of all ages. Children in Iowa are more likely to live in nursing facilities and intermediate care facilities for people with mental retardation (ICF/MR) than children in other states (See Table ES.2).[7] In addition, the use of institutions for children with serious emotional disturbances has increased in recent years.[8]

Federal, state, and local governments dedicated approximately $2.2 billion in State Fiscal Year (SFY) 2008 to provide supports and services to Iowans with disabilities and older Iowans.[9] The $2.2 billion estimate does not include county expenditures for community mental health services outside the Medicaid program, because the authors were not able to develop an estimate for

[5] Prouty, Robert W.; Alba, Kathryn; Lakin, K. Charlie (eds.) *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007* University of Minnesota Institute for Community Integration: August 2008

[6] National Association of State Mental Health Program Directors Research Institute, Inc. "State Mental Health Agency Profiling System: System: 2007" October 2008.

[7] Prouty, Robert; Smith, Gary; Lakin, K. Charlie (eds.) *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2006* University of Minnesota: August 2007; U.S. Centers for Medicare & Medicaid Services, *Medicaid Statistical Information System (MSIS) State Summary Datamart*, data obtained December 2008; and U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008

[8] Data provided November 2008 by Iowa Medicaid Enterprise

[9] Most data were provided upon request by the Department of Education, the Department of Elder Affairs, the Department of Human Services, the Iowa Department of Public Health, and Iowa Vocational Rehabilitation Services. Data for some programs were obtained from Iowa Department of Management *Iowa Fiscal Year 2010 Report* January 28, 2009.

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these expenditures. An estimate was available for county-based, non-Medicaid spending for people with developmental disabilities.[10]

Table ES.2: Children under age 21 in Institutions for which National Comparison Data are Available, per 100,000 Population under 21

	State Developmental Disabilities Institutions, Residents on June 30, 2006	Nursing Facilities, Medicaid beneficiaries, Oct. 2005 – Sept. 2006
Iowa	**9.8**	**9.0**
United States	1.7	5.8

Sources:
Prouty, Robert; Smith, Gary; Lakin, K. Charlie (eds.) *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2006* University of Minnesota: August 2007 for developmental disabilities institution data
Thomson Reuters analysis of data from the U.S. Centers for Medicare & Medicaid Services, Medicaid Statistical Information System (MSIS) State Summary Datamart, data obtained December 2008, for nursing facility data
U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008 for population data

Table ES.3 shows the amount of spending in SFY 2008 for five population groups defined by either age or type of disability. Many public long-term care programs are targeted to one or two of these population groups. This report is organized according to these five groups.

As in most states, Medicaid is the major long-term care funding source, with 64% of total spending. Special Education is also a significant funding source (See Chart ES.2). While it is not typically considered part of long-term care, the education system provides significant assistance to children with disabilities. Long-term care spending has increased by approximately 4.1% per year from SFY 2006 through SFY 2008.[11] Real per capita spending, controlling for inflation and population growth, increased by 0.4% per year from $735 to $740 per state resident.[12]

[10] Braddock, David; Hemp, Richard; Rizzolo, Mary C. *The State of the States in Developmental Disabilities: 2008* Preliminary Report from University of Colorado, Department of Psychiatry and Coleman Institute for Cognitive Disabilities: 2008

[11] Most data were provided upon request by the Department of Education, the Department of Elder Affairs, the Department of Human Services, the Iowa Department of Public Health, and Iowa Vocational Rehabilitation Services. Data for some programs were obtained from Iowa Department of Management *Iowa Fiscal Year 2010 Report* January 28, 2009 and Iowa Department of Management *Iowa Fiscal Year 2008 Report* January 30, 2007.

[12] Thomson Reuters analysis based on data from Table ES.2; U.S. Department Of Labor, Bureau of Labor Statistics "Consumer Price Index for All Urban Consumers (CPI-U), Midwest Region" January 26, 2009; and U.S. Census Bureau, Population Division "Annual Population Estimates, Estimated Components of Population Change, and Rates of the Components of Population Change for the United States, States, and Puerto Rico: April 1, 2000 to July 1, 2008" December 22, 2008

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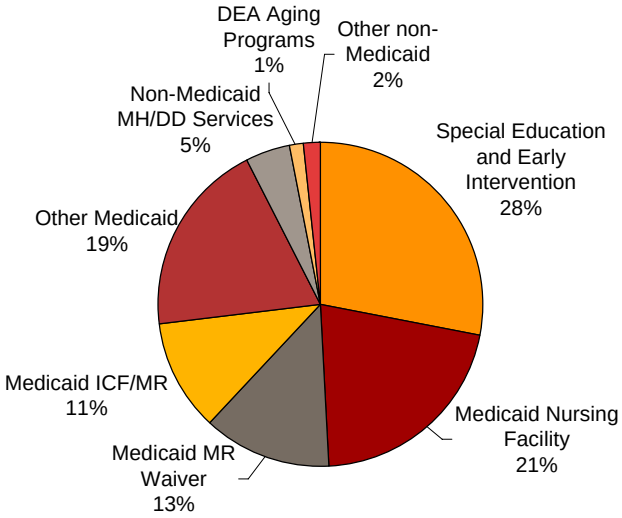
Table ES.3: Public Long-Term Care Spending in Iowa by Target Population in millions, SFY 2008

	2008
Children with Disabilities*	$839
Adults with Mental Retardation	$558
Older Adults**	$533
Adults with Mental Illness***	$160
Adults with Physical Disabilities	$133
Total	$2,223

Sources:
See Tables 4.1, 5.1, 6.1, 7.1, and 8.1 for a complete list of sources.

* Children were defined as people age 18 or younger, except for special education and home health. All special education expenditures were counted as spending for children. For home health, children were defined as under age 21 because service limits change significantly at that age.
** Older Adults were defined as people age 60 or older.
*** Data for adults with mental illness do not include non-Medicaid mental health services provided through counties.

Chart ES.2: Iowa Expenditures for Long-Term Care and Support, SFY 2008



Sources:
See Tables 4.1, 5.1, 6.1, 7.1 and 8.1 for a complete list of sources

Compared to other states, Iowa spends a higher proportion of Medicaid long-term care dollars on institutional services. A little less than two-fifths of Medicaid long-term care spending was for home and community-based services in FFY 2007 (See Table ES.4).[13]

[13] Data provided by the Department of Human Services, Iowa Medicaid Enterprise and Burwell, Brian; Sredl, Katherine; and Eiken, Steve *Medicaid Long-Term Care Expenditures in FFY 2007* Thomson Reuters September 28, 2008.

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Table ES.4: Percentage of Medicaid Long-Term Care Expenditures Used for Community Services, FFY 2007

	Total	Services for Older Adults and People with Physical Disabilities	Services for People with Developmental Disabilities
United States	42%	31%	63%
Iowa	**38%**	**26%**	**50%**

Source: Thomson Reuters analysis of data provided by the Department of Human Services, Iowa Medicaid Enterprise and Burwell, Brian; Sredl, Katherine; and Eiken, Steve *Medicaid Long-Term Care Expenditures in FFY 2007* Thomson Reuters September 28, 2008. Iowa expenditures do not include an assessment that Intermediate Care Facilities for people with Mental Retardation (ICF/MR) are required to pay to the state.

However, Iowa has increased utilization of Medicaid community services and decreased institutional utilization since 2004 (See Table ES.5).[14]

Table ES.5: Change in Utilization of Iowa Medicaid Long-Term Care Services with the Largest Number of Participants, SFY 2004 and SFY 2008

	2004	2008	Average Annual Percentage Change
Institutional Services			
Nursing Facility Participants	20,792	21,023	0.3%
Nursing Facility Days	5,091,688	4,636,441	-2.3%
ICF/MR Participants	2,346	2,154	-2.1%
ICF/MR Days	786,981	711,343	-2.5%
Home and Community-Based Services (all data are number of participants)			
Home Health Nursing	17,073	20,670	4.9%
Elderly Waiver	8,035	11,826	10.1%
Home Health Aide	6,134	6,622	1.9%
Mental Retardation Waiver	7,618	10,695	8.9%
Ill & Handicapped Waiver	2,123	2,695	6.1%

Source: Data provided by the Department of Human Services, Iowa Medicaid Enterprise

Eight System Components

Consolidated State Agency

The Iowa state agencies that fund long-term supports tend to be organized around funding sources rather than common services, so multiple agencies pay for similar services using different methods. On a positive note, Iowa's organizational structure is not based on diagnosis, providing a structure within a funding source (such as Medicaid) to coordinate services for all individuals with long-term support needs. Many states that have reformed their long-term care system (e.g., Oregon, Minnesota, Washington and Vermont) established a single agency

[14] Data provided by the Department of Human Services, Iowa Medicaid Enterprise

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responsible for planning and delivery of services.[15] Some of these states have taken the additional step of creating a single organization for the full range of disabilities, to align services with individuals' functional needs regardless of diagnosis.[16]

Single Access Point

For most populations, the person's initial contact for services varies based on funding source and service. An exception is for adults with developmental disabilities, for whom the county Central Point of Coordination (CPC) is a single access point for all publicly funded services. In addition, there is no standard process to help people navigate the system and no independent assessment to ensure people know about all options before choosing services. Iowa has started several initiatives to improve information and assistance, such as LifeLongLinks, Iowa COMPASS, 2-1-1, and the Iowa Family Caregiver Hotline. However, funding for sustainability of these initiatives is uncertain.

Institutional Supply Controls

Iowa has a Certificate of Need requirement for institutional long-term care services, including nursing facilities and intermediate care facilities for people with mental retardation (ICF/MR). New beds must be reviewed by the State Health Facilities Council, whose members are appointed by the Governor. In addition, between SFY 2001 and SFY 2005, Iowa awarded grants to nursing facilities that agreed to reduce bed capacity and to provide home and community-based services such as respite, assisted living, and adult day care.[17]

Since SFY 2004, nursing facility capacity has declined by almost 1,200 beds while ICF/MR and psychiatric medical institutions for children (PMIC) capacity changed by only a few beds.[18] Market forces and individual provider decisions have contributed to these trends, in addition to the state policies described above. For mental health services, stakeholders expressed concern about a lack of inpatient psychiatric beds and post-acute beds to help people in crisis.

Transition from Institutions

Iowa's most significant effort to help long-term institutional residents move to community settings is the Money Follows the Person Demonstration, which is targeted to people moving from ICF/MR.[19] While there is no specific initiative for other populations, stakeholders indicated nursing facilities have increased the number of short-term admissions by providing more Medicare-funded rehabilitative services and ensuring people return home after rehabilitation is complete.

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[15] Eiken, Steve *Promising Practices in Long Term Care Systems Reform: Common Factors of Systems Change* Medstat: November 9, 2004 and Kane, Rosalie A.; Kane, Robert L.; Priester, Reinhard; Homyak, Patricia *Research and State Management Practices for the Rebalancing of State Long-Term Care Systems: Final Report* University of Minnesota: June 2008

[16] Kane, Rosalie A.; Kane, Robert L.; Priester, Reinhard; Homyak, Patricia *Research and State Management Practices for the Rebalancing of State Long-Term Care Systems: Final Report* University of Minnesota: June 2008

[17] House File 655, chapter 64, section 249H.6, subs. 5, 79th General Assembly (2001)

[18] Data provided by the Iowa Department of Inspections and Appeals, November 2008

[19] Iowa Department of Human Services, Iowa Medicaid Enterprise "Partnership for Community Integration & Money Follows the Person" Application submitted November 2006

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Iowa State Profile Tool: Executive Summary

Continuum of Residential Options

States that have reduced their reliance on institutional services have provided a variety of alternative options for housing and supports, including group residential settings and single-family homes and apartments. The availability of one residential option, assisted living, has increased significantly in recent years. By 2008, Iowa's supply of assisted living beds – controlling for the older adult population – was greater than the national average in 2007, the latest data available. Iowa had 36 beds per 1,000 people age 65 or older, compared to a national average of 26.[20] In contrast, several stakeholders said there was an inadequate supply of residential options that combined long-term housing and supports for people with mental illness and for people with challenging behaviors related to dementia or brain injury.

To improve access to homes and apartments, the Iowa Finance Authority and several service agencies have worked together to address housing issues. Initiatives include:

- A 30% set-aside in the Qualified Allocation Plan for Low Income Housing Tax Credits[21]
- An online Housing Registry that identifies accessible, affordable housing; describes the properties; and provides links to information and referral services
- Training to agencies so they can help people with disabilities can access available housing resources.[22]

HCBS Infrastructure

Iowa's efforts to increase the supply of home and community-based services vary across populations and services, reflecting different service gaps. The Department of Human Services, Mental Health and Disability Services division has worked on:

- Crisis services to provide alternatives to emergency room and inpatient care; [23]
- Implementation of evidence-based practices and
- Improved recruitment and retention of psychologists and psychiatrists, which are in especially low supply in Iowa.

For long-term care services for older adults, the Iowa Finance Authority operates an Affordable Assisted Living program to expand access to assisted living and an HCBS Revolving Fund Loan that assists providers that will provide adult day services, respite, and other services.[24] For people with mental retardation, the Department of Human Services, Iowa Medicaid Enterprise Iowa plans to provide incentives for community providers to expand services and for ICF/MR providers to diversify their services as part of the Money Follows the Person Demonstration.[25]

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[20] Thomson Reuters analysis of data provided by Iowa Department of Inspections and Appeals November 2008; Mollica, Robert; Sims-Kastelein, Kristin; and O'Keeffe, Janet *Residential Care and Assisted Living Compendium: 2007* November 30, 2007; and U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008

[21] Iowa Department of Human Services, Iowa Medicaid Enterprise "Systems Readiness Assessment" part of application for the Federal Systems Transformation Grant Revised September 29, 2005

[22] Iowa Department of Human Services, Iowa Medicaid Enterprise "MFP Housing Inventory Report" September 4, 2007

[23] *Ibid.*

[24] Iowa Finance Authority "IFA Programs" Undated

[25] Iowa Department of Human Services, Iowa Medicaid Enterprise *Operational Protocol for Iowa's Money Follows the Person Grant* (Revised February 26, 2008)

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One issue that affects all populations is the challenge of recruiting and training health and long-term care workers and reducing turnover among these workers. Iowa has pursued multiple strategies on a cross-disability basis to increase recruitment and retention as described in Section 3: Workforce.

Participant Direction

The Department of Human Services, Iowa Medicaid Enterprise has implemented participant-direction in all Medicaid home and community-based services waivers serving adults. Waiver participants who choose to direct their services are given a budget based on a determination of their needs and then can use their budget to obtain necessary, cost-effective services that are not specified in the waiver. Participants can also directly employ their direct support workers, rather than use an agency. In addition, Iowa started a pilot for participant-directed mental health services using a Community Reinvestment Fund established as part of the Iowa Plan, the managed behavioral health program.[26]

Quality Assurance

This report did not evaluate the quality of Iowa's long-term support services, but summarized plans for monitoring or ensuring quality. States that reformed their long-term support systems have had comprehensive quality management plans, but the content of those plans varied significantly among the states.

Two types of quality assurance efforts were summarized in this report:

- Licensure or other requirements that certain long-term care providers must meet in order to operate, regardless of who pays for their services
- Quality management by state agencies that manage particular funding streams such as Medicaid home and community-based services waivers, special education, and Older Americans Act funding.

The Department of Human Services, Iowa Medicaid Enterprise and the Department of Elder Affairs both took steps to improve their quality management in 2008.

[26] Koyanagi, Chris; Alfano, E; and Carty, L. *In the Driver's Seat: A Guide to Self-Directed Mental Health Care* Bazelon Center for Mental Health Law and UPENN Collaborative on Consumer Integration: February 2008

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Appendix E
Alzheimer's Disease
Task Force Report, 2008

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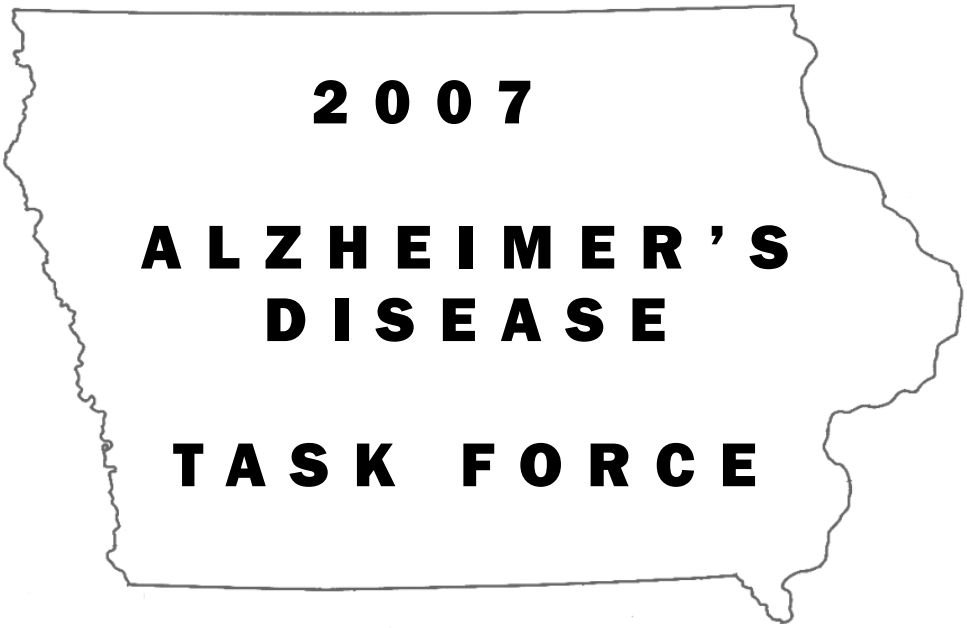

2007

ALZHEIMER'S DISEASE

TASK FORCE

Presented to
Chet Culver, Governor
and the
Iowa General Assembly
January 2008

Pursuant to SF 489
82nd General Assembly

Prepared by the
Department of Elder Affairs

John McCalley-Director

Final Report

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Executive Summary

To many, the words "Alzheimer's disease" trigger a sense of fear and foreboding but little understanding of the reality of the disease. To those who attended the meetings of the Alzheimer's Disease Task Force, the transformative power of the disease became palpable and sobering. The urgency surrounding the need for Iowa to mobilize a state response to this public health crisis was consistently reinforced through the testimony of presenters, the direct experiences shared by task force members, and most profoundly, by Iowans whose lives were shaped by Alzheimer's disease.

The recommendations included herein are in response not solely to the legislative directives in Senate File 489, but also to the concerns and appeals voiced by those who participated in this public process. The scope of the task force's work was enormous. Fully exploring every facet of the issues related to or impacted by Alzheimer's disease was not possible within the timeframe of the task force's deliberations. It was the personal and professional expertise that task force members brought to the table combined with the information provided through presenter testimony and written materials that formed the basis of this report to the Governor and the General Assembly.

The task force recommends that the following strategies (in no particular order) be undertaken within the next 1-2 years (Tier 1):

1. Establish an office for Alzheimer's disease or related disorders within state government. This office would not replace or duplicate any services currently offered by the Area Agencies on Aging, the Alzheimer's Association, or other agencies, but would act as a referral source to local services.

2. Increase and enhance training and education requirements about Alzheimer's disease or related disorders for all direct care employees including, but not limited to, long-term care settings, assisted living, elder group homes, residential care, adult day facilities and home health care.

3. Broaden the spectrum of people who are required to receive training specific to Alzheimer's disease or related disorders to those who work in direct contact with people diagnosed with Alzheimer's disease including but not limited to administrators, directors, dietary staff, administrative and management staff, hospital direct care staff, state employees with responsibility for long term care oversight/monitoring, and ombudsmen.

4. Ensure that all recommendations coalesce with other initiatives and programs within the state, such as the Direct Care Worker Task Force Recommendations, Alzheimer's Association, Area Agencies on Aging, the Hartford Center Grant, Iowa Respite and Crisis Care Coalition and the UI Center on Aging and Geriatric Education Center.

5. Support and assist the rapidly increasing numbers of Iowans with Alzheimer's disease or related disorder by providing a wide array of home and community based services such as adult day services, respite care, and affordable transportation as well as Assisted Living, occupational therapy, speech therapy, social work services, dieticians, and others as these may delay premature nursing facility placement.

6. Fund public awareness efforts and educational efforts for providers, caregivers, and state oversight and monitoring personnel.

7. Implement a statewide campaign to educate healthcare providers regarding early detection instruments, such as AD8 and Mini-Cog, as early detection could prepare patients and families for what to expect.

8. Make Medicaid Waivers a significant factor in helping address the many needs of Iowans dealing with problems associated with Alzheimer's disease or related disorder, such as adult day services, assisted living, respite care, occupational therapy, speech therapy, social work services, dieticians, and affordable transportation as a means to delay premature institutionalization.

9. Given that the Medicaid Waiver is a long process, undertake a three step approach to address the needs of persons with Alzheimer's disease or related dementia:

   Step 1: Allow individuals with a diagnosis of early on-set Alzheimer's disease or related disorders to be served in excess of the current maximum number of clients under the Ill and Handicapped Waiver.

   Step 2: Increase the expenditure limits under the Elderly Waiver to give parity with other waivers including but not limited to the Ill and Handicapped Waiver, the Brain Injury Waiver and the Mental Retardation Waiver for persons with a diagnosis of Alzheimer's disease or related disorder. (This recommendation affects patients older than 65.)

   Step 3: Establish an Alzheimer's disease or related disorder specific waiver to place greater importance on the issue and needs comparable to the Brain Injury Waiver and the HIV/Aids waiver and without regard to the age of the person with Alzheimer's disease or related disorder.

10. Compile an analysis of Iowa's population by county and age to determine current utilization and future service needs of caregivers and persons with Alzheimer's disease or related disorder to support development of programs and services.

11. Review current trends and the impact in the Long Term Care rebalancing efforts affecting persons with Alzheimer's disease or related disorder.

12. Modify existing community needs assessment process to include questions that would identify and quantify at-risk people with Alzheimer's disease or related disorder.

13. Enhance capacity of services to meet the needs of persons with Alzheimer's disease or related disorder

14. Establish Quality Care measures with system benchmarks for facility and community based care for persons with Alzheimer's disease or related disorder.

15. Address the preparedness of the workforce to provide care and services in support of persons with Alzheimer's disease or related disorder and their caregivers.

16. Establish Alzheimer's disease or related disorder Diagnostic Centers of Excellence strategically throughout the state that would serve as multi-disciplinary centers to serve patients with Alzheimer's disease or related disorder and their caregivers.

17. Convene a workgroup on a regular basis to address psychogeriatric needs of persons with Alzheimer's disease or related disorders in Iowa.

18. To keep Iowans healthier and reduce the risk for developing Alzheimer's disease or related disorders:
    a. Provide physical and mental activity programs using evidence-based programs designed for older adults such as Enhance Fitness, Eat Better & Move More, and Healthy Aging.
    b. Provide chronic disease self management programs using evidence-based health promotion programs such as Stanford Chronic Disease Self Management.
    c. Promote dietary quality for older Iowans through provision of nutrition education programs such as Eat Better & Move More.
    d. Provide nutrition counseling by registered dietitians to older adults determined to be at high nutrition risk.
    e. Provide brain health education programs to help Iowans reduce their risk of Alzheimer's disease or related disorders.

The task force recommends the following strategies (in no particular order) be undertaken within the next 3-5 years (Tier 2):

19. Create an optional specialized certification for health and human services professionals to provide quality care and improve the quality of life for people with Alzheimer's disease or related disorders.

20. Increase the spectrum of educational resources available by using on-line courses and community colleges, and make subsidized educational opportunities available for those wishing to specialize in this field.

21. Determine implication of funding and policy on niche populations such as Down's syndrome and young onset Alzheimer's disease or related disorder.

The task force recommends the following strategy be undertaken within the next 6-10 years (Tier 3):

22. Correlate stages of Alzheimer's disease or related disorder with interventions to assist caregivers and service providers to make care decisions and to navigate the delivery system through the:
    a) Identification of intervention
    b) Identification of service needs
    c) Identification of safety needs (including home environments)
    d) Identification of caregiver needs

About This Report

Following an overview of the history of the task force and background information on Alzheimer's disease, the report is divided into four sections. These sections correspond to the delineation of four subcommittees into which task force members were divided.

It should be noted that the term "Alzheimer's Disease" is used to encompass not only Alzheimer's disease but also additional brain disorders such as vascular dementia, mixed dementia, mild cognitive impairment, dementia with Lewy bodies, and other types of dementia.

Interspersed throughout the report are verbatim comments received from Iowans who responded to on-line surveys about how Alzheimer's disease has affected their lives. Their words poignantly give voice to the emotions, frustrations, and hopes of Iowans who are personally experiencing the impact of Alzheimer's disease. A copy of the Department of Elder Affairs survey can be found in Appendix A.

Task Force History and Process

The task force was established with the passage of Senate File 489, a copy of which is attached as Appendix B. Signed by Governor Culver on April 27, 2007, the legislation called for a task force to "assess the current and future impact of Alzheimer's disease and related disorders on the residents of the state; examine the existing industries, services, and resources addressing the needs of persons with Alzheimer's disease or related disorders, their families, and their caregivers; and develop a strategy to mobilize a state response to this public health crisis."

The legislation defined the types of entities and individuals that would comprise the task force. Membership was made up of ten representatives of private sector industries, advocacy agencies, and individuals directly affected by Alzheimer's disease or related dementia, four legislators, and four state agency directors or designees. For a list of taskforce members, see Appendix C.

The formal work of the task force began on September 24 at which time the task force reviewed the group's charge, established operational protocols, and heard testimony from advocacy groups and individuals. Time was allocated for public comment during each meeting of the task force. At the November 19th session, four subcommittees were formed – Education and Training, Funding and Reimbursement, Services and Housing, and Wellness and Disease Management. The subcommittees continued their discussions at the December 10 meeting which culminated in a set of draft recommendations for consideration by the full task force. In a conference call meeting on December 20, task force members refined then finalized the language of the recommendations that follow.

Alzheimer's Disease Background Information

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM – IV – TR) Alzheimer's disease is a form of dementia that is characterized by memory impairment and one other cognitive disorder such as aphasia (inability to produce and understand speech), apraxia (the inability to perform complex movements), agnosia (the total or partial loss of the ability to recognize familiar people or objects) or disruption in executive functioning to such a degree as to cause impairment in work and or social functioning. The 2007, Alzheimer's Disease Facts and Figures defines dementia as a "group of disorders" that cause decline in at least two of the following cognitive functions: memory; ability to generate understandable speech or

comprehend the spoken word or written language; ability to plan and carry out complex tasks, and distortion of visual processes.

There are nine specific types of dementia that have a range of impact on daily functioning from mild to severe:

1. Mild cognitive impairment (MCI) symptoms include memory loss, difficulty with language or other cognitive functions serious enough to be noticeable, but not severe enough to interfere with daily activities.
2. Normal pressure hydocephalus is brain damage caused from the buildup of fluid on the brain.
3. Creutzfeldt-Jakob disease is a rapidly fatal disorder that not only includes memory dysfunction but involves coordination and behavioral changes.
4. Frontotemporal dementia is characterized by two patterns of symptoms involving changes in personality and behavior as well as considerable language problems.
5. Lewy bodies is similar in pattern to Alzheimer's disease (difficulty with memory, confusion and poor judgment) however, alertness and severity of symptoms change from day to day.
6. Parkinson's disease may result in dementia in later stages of the disease with similar characteristic as Lewy body dementia.
7. Mixed dementia is a mix of Alzheimer's disease and vascular dementia.
8. Vascular dementia is also known as multi-infarct dementia caused by reduced blood flow to the brain due to emboli blocking small arteries.
9. Alzheimer's disease is the most common form of dementia. Fifty to 75% of dementia diagnoses are Alzheimer's disease. Initially, the most common symptom is difficulty learning new information. As the brain damage occurs, there is a progression of symptoms from confusion, poor judgment, and language difficulties to the final stage of total loss of function, inability to care for self and ultimately death.

Prevalence

National

The Alzheimer's Association released a statistical report of the United States data on Alzheimer's disease and other dementias in 2007. In summary, the report identifies that Alzheimer's disease is the most common type of dementia. The estimated 5.1 million Americans with this disease by age group revealed the following breakdown:

- Age 65-74 - 2% or 300,000 people
- Age 75-84 - 19% or 2,400,000 people
- Over Age 85 - 42% or 2,200,000 people

According to the report, every 72 seconds someone in America develops the disease and by mid-century, someone will develop Alzheimer's disease every 33 seconds. By 2050, with the advent of the baby boomer generation the number of individuals with Alzheimer's disease could range from 11 million to 16 million.

The Alzheimer's Association report further identifies that 29% of Medicare beneficiaries age 65+ with Alzheimer's disease or other dementias also receive Medicaid benefits. About half live in the nursing home and half in the community. Of the community-based people with Alzheimer's disease, 84% who were at high risk of nursing home placement had assets that would pay for less than a year's stay in a facility. "When baby boomers with severe disabilities or disease like Alzheimer's disease begin to reach the median age for admission to a nursing home in 2025, Medicaid long-term care spending will skyrocket. Medicaid costs for nursing home care alone will climb from $21 billion in 2005 to $38 billion in 2025." (Alzheimer's Disease Facts and Figures, 2007)

Iowa

In Iowa in 2000, there were nearly 65,000 people with a diagnosis of Alzheimer's disease and a potential 6% increase by 2010 resulting in an estimated 69,000 people. The State Library of Iowa, State Data Center revealed that in 2007 the number of Iowans 85 and older was 2.5% of Iowa's population. This is significant as the 85-and-over population has the highest disability rate of any age group. An AARP study revealed that the

preference of nearly all older Iowans (95%) is to remain in their own home (AARP, Iowa Home and Community-Based Long-Term Care: An AARP Survey, 2002.)

Iowa's long-term care financing and delivery system is biased toward institutional care. In State Fiscal Year 2006, only 1.6% of the 2.5 billion Medicaid expenditures in Iowa for people age 65 and older went to Iowa's 1915c Elderly Waiver program which is a home and community based service delivery system designed to support older Iowan's (age 65+) who are at the nursing home level of care and who want to remain in their own home.

Caregiving

Caregivers provide enormous amounts of unpaid time in their caregiving role. If paid, it is estimated that the amount of time spent providing care nationwide would be worth close to $83 billion in 2005 (Alzheimer's Disease Fact and Figures, 2007.) In fact, the report indicates that close to 10 million Americans care for a person with Alzheimer's disease. Furthermore, 29% of caregivers 60+ years and older not only care for someone with a dementia, but also have one or more serious medical conditions themselves. Iowa's estimates for 2005 were 93,556 caregivers of people with Alzheimer's disease or related dementia who provided 80,757,917 hours of unpaid care per year at a value of $789,812,426.

The report, "Families Care: Alzheimer's Caregiving in the United States, 2004," reports that the typical individual caring for someone with Alzheimer's is a woman, age 48, married, employed, has some college education and no children in the home. Half of the Alzheimer's caregivers work full-time. Most often, the caregiver is a relative and the most common relationship between caregiver and care-receiver is child and parent. The typical Alzheimer's care recipient is a 78 year old, widowed female. However, a third of Alzheimer's care recipients are 85 years old and older.

Time spent in care giving produces high incidents of stress, poor health and increased depression. Twenty-five percent of caregivers of people with Alzheimer's report their care giving is stressful, but only fifteen percent of caregivers of non-dementia people report stress. Two-thirds of working caregivers of people with Alzheimer's disease or related disorders missed work because of care giving duties; eight percent turn down promotions

and seven percent lost job benefits. (Alzheimer's Disease Facts and Figures, 2007) The caregiver of someone with ADRD provides assistance with activities of daily living (ADLs) and more likely to help with the most difficult ADLs, i.e. incontinence, bathing and feeding. Twenty-three percent of Alzheimer's caregivers provided care for 20 or more hours per week, 71% have cared for the recipient for more than a year and 32% have made a commitment of five years or more ("Families Care: Alzheimer's Caregiving in the United States, 2004.") Furthermore, there are personal sacrifices of time for family, friends, hobbies, social activities and exercise for the caregiver.

In the September 2006 report, "Caregivers in Decline", a study conducted by Evercare for the National Alliance for Caregiving demonstrated the tremendous impact caregiving has on the physical and mental health of the caregiver. Caregivers in general, reported that their physical health declined because of providing care and the rating of their health was only fair to poor. Of the caregivers surveyed, half are assisting in three or more activities of daily living. The caregiver who spends 40 or more hours weekly attending to their care-recipient reported their health became a "lot worse" as a result of caregiving than the caregiver who spent 20 hours per week or less providing care. Three-quarters of the caregivers in poor health felt they did not have a choice whether or not to provide care. As reported by the survey, the following are the most common aspects of health deterioration: loss of energy and sleep, stress and/or panic attacks, pain, aching, depression, headaches, and weight loss/gain. Depression was reported by 91% of the caregivers in decline; 90% report feelings of increased stress; 51% take medications as a result of providing care; 10% report abusing alcohol or prescription drugs; 82% report inadequate sleep, 63% poor eating habits; 58% report decreased exercise. In addition, 52% of caregivers do less preventative health care than they did prior to caregiving.

In January 2007, the Urban Institute, for the U.S. Department of Health and Human Services released a report that indicated that the physical strain from caregiving was the most important predictor of high stress followed by disturbed sleep and care receiver problem behaviors which lead to admission into a nursing home. A conclusion drawn from this report is that strategies for reducing caregiver stress should include respite, caregiver training and more information about assistive technology and how to access such devices as well as managing care recipient behaviors that are disruptive.

Rural caregiving has unique challenges. In the Easter Seals/National Alliance for Caregiving report "Caregiving in Rural America," people in rural areas have limited health and social services, in-home support services, public transportation options and business opportunities. This report cites that about 11% of rural caregivers have annual incomes

under $15,000, 17% between $15,000 and $29,000; 34% between $30,000 and $49,000; 18% between $50,000 and $74,000; 8% between $75,000 and $100,000; and 11% over $100,000 annually. Rural caregivers are less likely to use formal services that might ease their caregiver work. Twenty-two percent of rural caregivers use an aide or nurse through an agency, and only 8% of rural caregivers use other types of paid help. Twenty-nine percent of rural caregivers utilize transportation services (if transportation services are available to them.)

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Analysis of Department of Elder Affairs Alzheimer's Disease Survey

In November, 2007, the Department of Elder Affairs contracted with the Department of Administrative Services (DAS) to develop a web-based survey that would collect information from Iowans about how Alzheimer's disease had directly affected their lives. The survey tool was designed to collect primarily qualitative information, thereby allowing respondents the maximum amount of latitude to express their thoughts and ideas. Quantitative information was gathered in the form of a ranking of the most pressing areas of need in Iowa as scored by those who completed the survey.

Within just a few days of the survey's release, over 100 Iowans had responded. Their often emotional words poignantly expressed the realities of coping with the impact of Alzheimer's disease, and did so in a way more powerful than numbers or statistics. The survey will continue to be posted on the department's webpage, http://www.state.ia.us/elderaffairs/#survey through May 2008 to serve as an on-going avenue for Iowans to share their experiences and recommendations.

The Department of Elder Affairs contracted with Department of Administrative Services to conduct an analysis of the data received. The following is a synopsis of the DAS analysis.

Review of Findings

In summary, the results of the analysis of survey responses indicated that the experiences and recommendations as conveyed by respondents were consistent with the discussions and findings of the Alzheimer's Task Force. There were no significant departures. When respondents ranked the most pressing area of need that should be addressed in Iowa, the scoring of the seven areas was statistically very close. *Access to Services* received the largest tally at 17.06% of total weighted voting. *Information about the Types of Services Available* was ranked at a very close second with a score of 16.9%. The remaining differences in ranking were negligible.

Service	**Ranking**
Access to services	17.06%
Information about the types of services available and how to use them	16.9%
Affordability of services	15.89%
Education and training	15.89%
Quality of services	15.24%
Support for families and caregivers	15.2%
Other	3.84%

The following table details the weighted ranking used for the analysis. The first table shows a count, or how many times each ranking was chosen for each of the areas by individual participants.

	Access	Information	Affordability	Ed./ Training	Quality	Family Support	Other Needs
7	21	13	15	11	15	12	7
6	18	19	11	18	12	11	1
5	13	19	17	13	14	14	0
4	9	9	18	11	18	25	2
3	17	12	13	20	12	11	3
2	6	22	11	19	10	10	1
1	3	2	4	1	2	3	21

Based on the above table, a weighted score was calculated by multiplying the count of each ranking chosen by the appropriate rank. Each need was then summed to provide a numeric score and percentage ratio as seen in the table below.

Rank	Access	Information	Affordability	Ed./ Training	Quality	Family Support	Other Needs
7	147	91	105	77	105	84	49
6	108	114	66	108	72	66	6
5	65	95	85	65	70	70	0
4	36	36	72	44	72	100	8
3	51	36	39	60	36	33	9
2	12	44	22	38	20	20	2
1	3	2	4	1	2	3	21
Totals	422	418	393	393	377	376	95
%	17.06%	16.90%	15.89%	15.89%	15.24%	15.20%	3.84%

When looking solely at those items that received the highest ranking of 6 or 7, *Access to Services* did rank higher at 21.29%. *Information about the Types of Services Available* remained the second most pressing area with 17.11%. *Education and Training* was third with 15.44% due in part to the large number of people who ranked it with a "6" (the second most pressing area of need.)

Access to Services was seen by respondents as the most pressing need overall. Health care professionals and those in public service consistently identified *Access to Services* as the most pressing need. A sampling of the qualitative responses follows.

Comments by	Comment
Health care provider	• As a healthcare provider who has worked in the DSM metro and now in rural Iowa, I have noticed a lack of services available for rural community members.
	• I am a health care provider and I have repeatedly seen families/ spouses resort to nursing home placement when they are exhausted and/or unable to manage the care of their loved one. There is very, very little in-between care in rural Iowa (e.g., in-home support, specialized outreach). The services simply don't seem to exist or they are not connecting with families in need.
	• I have presented to many community groups on the topic of Alzheimer's and find a shortage of adult day, respite and quality long term care services in most counties throughout Iowa. Few home care agencies provide their home care staff with dementia care training.
Public employee	• It seems that the only services available in local areas are the nursing homes. There are no support groups locally in the small rural areas.
Family member	• It is very difficult to find facilities that are able to care for Alzheimer residents due to their wandering or their behaviors. More and more facilities are choosing to close their Alzheimer units due to survey issues.
	• Access for service is available if you know where to look. The local Alzheimer's chapter is the best place, but this information needs to be communicated better through the media and through medical professionals.

Of the comments made, many focused on the *Availability of Services* and *Access to Services* in rural communities. People discussed the need to travel in order to receive service and care. At the same time, many of the comments regarding *Access to Services* as well as recommendations to address access revolved around information available. The following table highlights individual recommendations that focus on *Access to Services.* These comments reflect the relationship between access and information pertaining to services.

Comments by	Comment
Health care provider	• When physicians diagnose this type of condition they need to immediately make a referral to a clinical manager who provides them with information that puts all of the information into one place, then they can start the thought process for later on down the line.
	• More info about how/where to find a support group & assistance. Radio, TV or news paper adds. Something that comes into the home.
	• An 800 number to help locate local services for all areas in Iowa.
	• Physicians need to be educated about what is available and how to access services and then educate their patients and families. They should begin the education as to what services are available and what might be needed when the patient is in the office or hospital room.
Public employee	• Perhaps localized conferences where family members can get updated information. Can funding be given to nursing homes to provide for more support services?
Family member	• Publicity and public information.....We need to de-mystify this in the mind of the public. We still have some mentality that only weak persons are "mentally ill". Services needed include KNOWLEDGE OF WHAT IS AVAILABLE and WHERE, respite care, financial management for the patient's business, be aware that the patient is just ripe for financial exploitation by outsiders or, worse yet, family members.
	• There needs to be more emphasis on rural areas, esp. with diagnosing, ongoing care and respite. Can you work with existing agencies, such as Area Agencies on Aging, parish nurses, the Alzheimer's Association to first go into a community and lay groundwork about the disease, then come in with a mobile clinic that would make monthly visits, etc?

Based on the results and comments between *Access to Service* and *Information about the Types of Services Available*, there appears to be a relationship between the two. Individuals cannot get to services about which they know nothing. Families rated information as a higher need than access to services. The weighted score of public employees and health care providers pushed *Access to Services* just above *Information about the Types of Services Available* in ranking. Selected comments regarding the need for information follow.

Comments by	Comment
Family member	• There just isn't a lot unless you want to spend hours on the internet. There needs to be more printed material sent out. The only thing I ever get is a please donate.
	• I need an advocate to keep me informed on types of services that are available and affordable for us. I am still quite ignorant of all that is out there. Everything seems so segmented. I feel so uninformed about services that would be helpful to us. I need someone or an agency to give me advice on how to plan for the future and how to deal with the progression of the disease.
	• I am not as familiar anymore with the services offered specifically for Alzheimer's but that is why we have agencies to point us in the right directions such as the Alzheimer's Association, Area Agencies on Aging, Hospice, Adult Day Centers, Assisted Livings, Nursing Homes, Etc. So a person doesn't necessarily need to know the exact types of services available just someone/ someplace to call to get information.
Family member	• Make brochures and materials in simple easy to understand terms. Also maybe have some testimonies from families as to the care of their loved one. With this disease everyone reacts differently so just easy to understand steps of what to do.
Health care provider	• More materials in waiting rooms and for physicians
	• Make sure that information is in public areas i.e. – Drs' office waiting areas. Make sure it is there and getting refreshed and put out ASAP.
	• Again, I have not found any one place to start asking for services in my local area.
	• Not much information available

Demographic Information

Demographic information was requested as a portion of the survey. The four key demographic areas collected include the following:

- Identity of the respondent

- Age range of the respondent
- Rural/Urban location of the respondent (based on county)[1]
- Sex of respondent

Analysis of the demographic data was not considered predictive due to the percentage of respondents who did not answer the demographic questions in the survey. *Identity* was the only survey question that had 100% participation.

The survey asked respondents to identify their role or relationship to persons with Alzheimer's disease or dementia. Options included a person with Alzheimer's disease or dementia, a spouse or partner of a person with Alzheimer's disease or dementia, an immediate family member, a non-family caregiver, a healthcare provider, or a public employee. The options of spouse and family member were combined for the analysis of the survey as were non-family caregiver and health care provider due to the low participation by particular identification groups. The weighted rating of each identification group is seen in the table below.

	Family	Provider	Public Employee	Other	Grand Total
Rating of Access	171	211	43	4	429
Rating of Information	190	189	34	5	418
Rating of Affordability	172	176	38	7	393
Rating of Education	162	195	34	2	393
Rating of Quality	173	176	31	3	383
Rating of Family Support	156	190	29	1	376
Rating of Other Needs	39	30	20	6	95
Count of Respondents	**44**	**47**	**12**	**1**	**104**
% of Respondents	42.31%	45.19%	11.54%	0.96%	100%

[1] Rural/urban county determination is according to the State Data Center of Iowa. http://www.iowadatacenter.org/aboutdata/statisticalareas/

The survey requested an age range be chosen by each respondent. The majority of respondents opted not to answer the question. Nevertheless the weighted rating of each age group is provided in the table below.

	No Answer	Under 35	35-49	50-64	Over 65	Grand Total
Rating of Access	172	27	77	125	21	422
Rating of Information	178	45	61	118	16	418
Rating of Affordability	146	29	56	139	23	393
Rating of Education	150	51	57	116	19	393
Rating of Quality	165	24	67	104	17	377
Rating of Family Support	149	34	62	116	15	376
Rating of Other Needs	31	10	12	38	4	95
Count of Respondents	**41**	**9**	**16**	**32**	**5**	**103**
% of Respondents	39.81%	8.74%	15.53%	31.07%	4.85%	100%

The survey requested the respondents' county as a demographic identifier. Based on the county entered, it was determined whether they were considered in a metropolitan area or rural area as seen by the State Data Center of Iowa. While the State Data Center of Iowa may identify a county as metropolitan, it does not take into account those individuals who still live in a rural area of a metropolitan county. As with other demographic questions, the majority of respondents did not provide county information. The weighted rating of each group is provided in the table below for informational purposes only.

	No Answer	Urban	Rural	Grand Total
Rating of Access	178	147	97	422
Rating of Information	185	162	71	418
Rating of Affordability	165	154	74	393
Rating of Education	155	140	98	393
Rating of Quality	176	121	80	377
Rating of Family Support	157	143	76	376
Rating of Other Needs	38	44	13	95
Count of Respondents	**46**	**38**	**20**	**104**
% of Respondents	44.23%	36.54%	19.23%	100%

The survey also asked the gender of respondents. Again, a high number of participants did not choose to answer this question. For reference, the weighted rating is provided below.

	No Answer	Female	Male	Grand Total
Rating of Access	97	178	147	422
Rating of Information	71	185	162	418
Rating of Affordability	74	165	154	393
Rating of Education	98	155	140	393
Rating of Quality	80	176	121	377
Rating of Family Support	76	157	143	376
Rating of Other Needs	13	38	44	95
Count of Respondents	**41**	**51**	**11**	**103**
% of Respondents	39.81%	49.51%	10.68%	100%

SECTION 1: Education and training

"There seems to be a stigma attached to the disease in the small communities. Somehow there needs to be some dialogue out there that breaks the stigma so you don't have to feel like your loved one wants to hide in a shell."

"I do not think health care providers, direct care providers, or even family members are receiving adequate information on the care and treatment for their loved ones or patients. There are a lot of myths and misconceptions about persons with dementia. It will take a paradigm shift to change the perception that persons with dementia can not live purposeful and meaningful lives."

The need for both public and professional education was repeated over and over again as the task force looked at existing services, resources, and the capacity of Iowa's health care delivery systems to assist persons with Alzheimer's disease and their caregivers. Presentations from providers and trade associations aligned with those of consumers and advocacy groups on the issue of the importance of education and training. The consistent message was that the unique care needs of persons with Alzheimer's or dementia can only be met when caregivers (both professional and less formal) possess the requisite skills and expertise.

The task force's examination of the type, cost, and availability of dementia services, the availability of home and community-based resources for persons with Alzheimer's disease, respite care for families, and similar topics reinforced the need for consistent, expansive education and training. Specific recommendations from the Education and Training subcommittee are as follows:

- Establish an office for Alzheimer's disease or related disorders within state government. This office would not replace or duplicate any services currently offered by the Area Agencies on Aging, the Alzheimer's Association, or other agencies, but would act as a referral source to local services. (Tier 1)

This office would:

a) Increase public awareness for services currently available at the local or state level.
b) Collaborate with various stakeholders including serving as a point of contact for people diagnosed with the disease, caregivers, professionals and consumers for information, education, training and referrals.
c) Create a senior alert program for local, regional or statewide notification of missing senior adults.

d) Coordinate efforts to continue the work of this task force and research the work of experts in both national and international settings.
e) Create an advocacy system for people not currently living in long-term care facilities who have been diagnosed with Alzheimer's disease or related disorder and their families.
f) Be guided by a multi-disciplinary commission (board) to continue the work of this task force.

- Increase and enhance training and education requirements about Alzheimer's disease or related disorders for all direct care employees including, but not limited to, long-term care settings, assisted living, elder group homes, residential care, adult day service facilities and home health care. (Tier 1)

  a) Establish or broaden the number of hours for training for direct care staff to a minimum of 8 hours classroom instruction and a minimum of 8 hours of supervised interactive experience.
  b) Establish or broaden the number of continuing education/in-service hours for direct care workers on the topic of Alzheimer's disease or related disorders to a minimum of 8 hours annually.
  c) Add a competency component following Alzheimer's disease or related disorders training.
  d) Establish a standard curriculum model that will include, but not be limited to: the diagnostic process, the progression of the disease, communication skills (including the person with the diagnosis, family, friends and caregivers), family stress and challenges, nutrition and dining information, activities, daily life skills, caregiver stress, the importance of building relationships and understanding the personal history, expected challenging behaviors and non-pharmacologic interventions, and medication management.
  e) Establish a certification process for trainers and educators of the standard curriculum model.

- Broaden the spectrum of people who are required to receive training specific to Alzheimer's disease or related disorders to those who work in direct contact with people diagnosed with Alzheimer's disease including but not limited to administrators, directors, dietary staff, administrative and management staff, hospital direct care staff, state employees with responsibility for long term care oversight/monitoring, and ombudsmen. (Tier 1)

- Create an optional specialized certification for health and human services professionals to provide quality care and improve the quality of life for people with Alzheimer's disease or related disorders. (Tier 2)

- Increase the spectrum of educational resources available by using on-line courses, community colleges and make subsidized educational opportunities available for those wishing to specialize in this field. (Tier 2)

- Ensure that all task force recommendations coalesce with other initiatives and programs within the state, such as the Direct Care Worker Task Force Recommendations, Alzheimer's Association, Area Agencies on Aging, the Hartford Center Grant, Iowa Respite and Crisis Care Coalition and the UI Center on Aging and Geriatric Education Center. (Tier 1)

SECTION 2: Funding and Reimbursement

"As long as you have the right type of health care coverage, you are okay. If you don't, expect your family to go broke, especially if you are relatively young and in good health otherwise."

"I was forced to retire to care for my husband in our home. We are on a fixed income and I fear the expense of everything and being able to stay above board with expenses. Affordability for this middle-class family is a daily worry for me."

As articulated in the two survey responses above and others, the cost of caring for a person with Alzheimer's disease is beyond what most families can afford and more than a single state program could provide. Funding and reimbursement related in some way to many of the presentations to the task force. The members looked at topics such as projected trends in the state's population of persons with Alzheimer's disease, the unique challenges of Iowans with early-stage and early onset of Alzheimer's disease or related disorders, and efforts to define quality care. The Funding and Reimbursement subcommittee developed the following recommendations:

- Support and assist the rapidly increasing numbers of Iowans with Alzheimer's disease or related disorder by providing a wide array of home and community based services such adult day services, respite care, and affordable transportation as well as assisted living, occupational therapy, speech therapy, social work services, dieticians, and others as these may delay premature nursing facility placement. (Tier 1)

- Fund public awareness efforts and educational efforts for providers, caregivers, and state oversight and monitoring personnel. (Tier 1)

- Implement a statewide campaign to educate health and human services professionals regarding early detection instruments, such as AD8 and Mini-Cog, as early detection could prepare patients and families for what to expect. (Tier 1)

- Make Medicaid Waivers a significant factor in helping address the many needs of Iowans dealing with problems associated with Alzheimer's disease or related disorder, such as adult day services, assisted living, respite care, occupational therapy, speech therapy, social work services, dieticians, and affordable transportation as a means to delay premature institutionalization. (Tier 1)

- Given that the Medicaid Waiver is a long process, undertake a three-step approach to address the needs of persons with Alzheimer's disease or related dementia:

  Step 1: Allow individuals with a diagnosis of early on-set Alzheimer's disease or related disorders to be served in excess of the current maximum number of clients under the Ill and Handicap Waiver.

  Step 2: Increase the expenditure limits under the Elderly Waiver to give parity with other waivers including but not limited to the Ill and Handicapped Waiver, the Brain Injury Waiver, and the Mental Retardation Waiver for persons with a diagnosis of Alzheimer's disease or related disorder. (This recommendation affects patients older than 65)

  Step 3: Establish an Alzheimer's disease or related disorder specific waiver to place greater importance on the issue and needs comparable to the Brain Injury Waiver and the HIV/Aids waiver and without regard to the age of the person with Alzheimer's disease or related disorder. (Tier 1)

- Determine the implications of funding and policy on niche populations including Down's syndrome and Young onset Alzheimer's disease or related disorder. (Tier 2)

SECTION 3: Services and Housing

"We are all too tired, and mom carries the biggest burden…We need help and don't know where to turn, sometimes church members sit in, and we're thankful for the relief, but our batteries don't feel recharged for very long."

"I am a health care provider and I have repeatedly seen families/spouses resort to nursing home placement when they are exhausted and/or unable to manage the care of their loved one. There is very, very little in-between care in rural Iowa (e.g., in-home support, specialized outreach). The services simply don't seem to exist or they are not connecting with families in need."

The members of the task force repeatedly heard about the immediate need to expand support for persons and families living with Alzheimer's disease. Discussions and presentations covered the full spectrum of the components of service delivery such as assisted living options for persons with dementia, availability of geriatric-psychiatric units for persons with behavior disorders associated with Alzheimer's disease, and the distribution of long-term care institutional services across the state.

An analysis of the data received through the Department of Elder Affairs website survey showed that "access to services" and "information about the types of services available" were ranked by respondents as the most pressing areas of need in Iowa. To begin to address service needs and gaps across the state, the Services and Housing subcommittee developed the following recommendations:

- Compile an analysis of Iowa's population by county and age to determine current utilization and future service needs of caregivers and persons with Alzheimer's disease or related disorder to support development of programs and services. (Tier 1)
- Review current trends and the impact in the Long Term Care rebalancing efforts affecting persons with Alzheimer's disease or related disorder. (Tier 1)
  a) Bed occupancy, length of stay in a nursing facility, increase number in elderly waiver, acuity level of nursing facility residents, growth of assisted living programs.
  b) Determine impact of Direct Care Worker shortages on availability and access to services.
  c) Availability of adult day services.
  d) Senior Living Coordinating Unit (SLCU) long-range plan (need to ensure strategies to include those to support service for persons with Alzheimer's disease or related disorder and their caregivers).
- Modify the existing community needs assessment process to include questions that would identify and quantify at-risk people with Alzheimer's disease or related disorder. This would include local public health community needs assessment, Area Agency on Aging area planning process, and other agencies that receive federal and state funding for services to Iowa's aging population. (Tier 1)
- Enhance the capacity of services to meet the needs of persons with Alzheimer's disease or related disorder (Tier 1).
  a) Examine current administrative rules for nursing facilities, CCDI, assisted living, adult day services, home and community-based services, and Medicaid elderly waiver case management programs (administered by the departments of Human Services, Elder Affairs and Public Health).
  b) Develop recommendations which reflect Alzheimer's disease or related disorder capable and friendly practices.
  c) Provide technical assistance to current service providers to enable the diversification of their service base.

d) Examine the caps on waiver funding.
e) Review current re-imbursement rates across all state programs.
f) Ensure the availability of trained workers for facility and community based services.
g) Task the Senior Living Coordinating Unit (SLCU) to formally examine the findings of the University of Iowa's Adult Day Services study (Sanders and Saunders), make recommendations, and track implementation progress across the Unit agencies.

- Establish Quality Care measures with system benchmarks for facility and community based care for persons with Alzheimer's disease or related disorder. (Tier 1)
- Correlate stages of Alzheimer's disease or related disorder with interventions to assist caregivers and service providers to make care decisions and to navigate the delivery system through the: (Tier 3)
  a) Identification of intervention
  b) Identification of service needs
  c) Identification of safety needs (including home environments)
  d) Identification of caregiver needs
- Determine the implications of funding and policy on niche populations such as Down's syndrome and young onset Alzheimer's disease or related disorder. (Tier 2)
- Address the preparedness of the workforce to provide care and services in support of persons with Alzheimer's disease or related disorder and their caregivers. (Tier 1)
  a) Recruit and retain workers across care settings.
  b) Train caregivers across disciplines to meet the unique needs of persons with Alzheimer's disease or related disorder.
  c) Maximize the utilization of information technology to expand the access and availability of health professionals.
  d) Promote the interdisciplinary team approach for planning and care delivery.
  e) Integrate strategies for planned environmental interventions to aid staff, caregiver and person with Alzheimer's disease or related disorder.

SECTION 4 – Wellness and Disease Management

"Our family got no support from anyone. We were just left to try to accept Mom's disease as another dynamic we had to deal with. We had to provide support to each other."

"We had a horrible experience with my Father's dementia. He turned into a Jekyll & Hyde character and there was nowhere we could turn for help…I will never forget the hell we went through and the helpless feeling as there was nobody that would listen or help us in our small town." (AARP survey)

Developing a strategy to mobilize a state response to the growth in the number of Iowans with Alzheimer's disease calls for both short-term and long-term interventions. The task force recognized the role prevention and disease management can play in reducing the long-term incidence of Alzheimer's disease. The existing need for specialized expertise was also evident during task force discussions about the almost insurmountable difficulties that can be encountered in Iowa when trying to help individuals with Alzheimer's disease who are facing a mental health crisis. As an outgrowth of these deliberations, the Wellness and Disease Management subcommittee outlined the recommendations that follow.

- Establish Alzheimer's disease and related disorder Diagnostic Centers of Excellence strategically throughout the state that would serve as multi-disciplinary centers to serve patients with Alzheimer's disease or related disorder and their caregivers. The public could initially access information about the Centers through an 800-number manned by a non-profit entity (such as the Alzheimer's Association). The ideal center would have physician services, social services, nursing, and special interest in the care of persons with Alzheimer's disease or related disorder.

  The state would provide funding to support establishment of new centers. Various organizations focused on patient needs in this area could join forces to ensure efficiency and effectiveness. For example, existing memory centers could joint venture with the Alzheimer's Association and mental health advocate organizations to establish multiple centers across the state that would provide easy access to comprehensive services. These services would include history, physical, lab, x-ray, social support, and treatment. (Tier 1)
- Convene a workgroup on a regular basis to address psychogeriatric needs of persons with Alzheimer's disease in Iowa. The workgroup would be tasked with identifying mechanisms for funding of in-patient mental health services, expanding the statewide availability of services, establishing education pathways for providers, and enhancing the availability of emergency crisis intervention. (Tier 1)
- To keep Iowans healthier and reduce the risk for developing Alzheimer's disease or related disorder.
  a) Provide physical and mental activity programs using evidence-based programs designed for older adults such as EnhanceFitness, Eat Better & Move More, and Healthy Aging.
  b) Provide chronic disease self management programs using evidence-based health promotion programs such as Stanford Chronic Disease Self Management.
  c) Promote dietary quality for older Iowans through provision of nutrition education programs such as Eat Better & Move More.
  d) Provide nutrition counseling by registered dietitians to older adults determined to be at high nutrition risk.
  e) Provide brain health education programs to help Iowans reduce their risk of Alzheimer's disease or related disorders. (Tier 1)

Appendices

Appendix A: Department of Elder Affairs On-line Survey Tool

For over 65,000 Iowans, Alzheimer's disease is a daily personal reality. For each individual with the disease, there are countless family members, friends, or other caregivers who are personally or professionally committed to providing needed support and compassion.

If your life has been touched by Alzheimer's disease or related dementias, the Alzheimer's disease Task Force would like to hear from you. The Iowa Legislature established the Task Force to "assess the current and future impact of Alzheimer's disease and related disorders on the residents of the state; examine the existing industries, services, and resources addressing the needs of persons with Alzheimer's disease or related disorders, their families, and their caregivers; and develop a strategy to mobilize a state response to this public health crisis."

The most critical direction for the Task Force will come from the personal stories of Iowans who have witnessed first-hand the impact of Alzheimer's disease or dementia on their lives. Please take a few minutes to share your experience and any suggestions you have about how to improve the services and resources in Iowa that are available to support persons with Alzheimer's disease or related dementias. The survey will first ask you to describe your personal experiences relating to services and support for persons with Alzheimer's disease. You will then be asked for your specific recommendations for improving Alzheimer's or dementia care in Iowa. Through your responses, you can become part of shaping the future course of dementia care in Iowa. Thank you!

Please enter the following information about yourself for assistance in data gathering:

1) Iowa county in which you live:
2) Gender
3) Age
4) Ethnicity
5) Is English your second language? If yes, what is your native language?
6) I would like to be contacted with more information directly: First name, last name, telephone number, E-mail address.

7) Please describe yourself (drop down options: a) Person with Alzheimer's Disease or dementia, b) spouse or partner of person with Alzheimer's Disease or dementia, c) son, daughter, or other family member of a person with Alzheimer's Disease or dementia, d) non-family caregiver of a person with Alzheimer's Disease or dementia, e) health care provider, f) public employee or official, g) Other.

8) For persons impacted by Alzheimer's disease or other dementia, what do you believe is the most pressing area of need in Iowa? (drop down options: a) Information about the types of services available and how to use them, b) access to services, c) quality of services, d) affordability of services, e) support for families and caregivers, f) education and training, g) other

For those items you ranked as most pressing on the previous page, please respond to the following:

9) In your own words, describe your experience regarding *access to services* for Iowans with Alzheimer's disease or dementia. (Open text field)
10) In your own words, describe your experience regarding *quality of services* for Iowans with Alzheimer's disease or dementia. (Open text field)
11) In your own words, describe your experience regarding *affordability of services* for Iowans with Alzheimer's disease or dementia. (Open text field)
12) In your own words, describe your experience regarding *support for families and caregivers of Iowans* with Alzheimer's disease or dementia. (Open text field)
13) In your own words, describe your experience regarding *education and training* about Alzheimer's disease or dementia. (Open text field)
14) In your own words, describe your experience regarding *information about the types of services available and how to use them* as related to Alzheimer's disease or dementia. (Open text field)
15) In your own words, describe any *other personal experiences* with receiving or providing assistance or services. (Open text field)

For those items you ranked as most pressing on page two, please respond to the following questions:

16) What specific recommendations do you have about how to better address *access to services* for Iowans with Alzheimer's disease or dementia? Please be as specific as possible about what you would like to see happen. (Open text field)
17) What specific recommendations do you have about how to better address *quality of service* for Iowans with Alzheimer's disease or dementia? Please be as specific as possible about what you would like to see happen. (Open text field)
18) What specific recommendations do you have about how to better address *affordability of services* for Iowans with Alzheimer's disease or dementia? Please be as specific as possible about what you would like to see happen. (Open text field)
19) What specific recommendations do you have about how to better address *support for families and caregivers* of Iowans with Alzheimer's disease or dementia? Please be as specific as possible about what you would like to see happen. (Open text field)
20) What specific recommendations do you have about how to better address *education and training* for Iowans with Alzheimer's disease or dementia? Please be as specific as possible about what you would like to see happen. (Open text field)
21) What specific recommendations do you have about how to better address *information about the types of services available and how to use them* in regard to Alzheimer's disease or dementia? Please be as specific as possible about what you would like to see happen. (Open text field)
22) What specific recommendations do you have about how to better address *any other issues* with Alzheimer's disease or dementia? Please be as specific as possible about what you would like to see happen. (Open text field)

Appendix B: Senate File 489

Section 1. ALZHEIMER'S DISEASE TASK FORCE.
1. The Alzheimer's disease task force is established. The task force shall consist of the following members:

a. The joint chairpersons of the legislative health and human services appropriations subcommittee and the chairs of the human resources standing committees of the senate and the house of representatives.

b. The following members appointed by the governor:

(1) One person with Alzheimer's disease.
(2) One caregiver of a person with Alzheimer's disease.
(3) A representative of the nursing facility industry.
(4) A representative of the assisted living industry.
(5) A representative of the adult day services industry.
(6) A representative of the health care provider community.
(7) A person who conducts Alzheimer's disease research.
(8) A representative of the Alzheimer's association.
(9) A representative of Iowa AARP.
(10) A licensed health care provider specializing in the practice of gerontology.

c. The director, or the director's designee, of each of the following agencies:

(1) The department of elder affairs.
(2) The department of human services.
(3) The department of public health.
(4) The department of workforce development.
(5) The department of inspections and appeals.

2. The department of elder affairs shall convene the taskforce and provide necessary administrative support for the task force.

3. The task force shall assess the current and future impact of Alzheimer's disease and related disorders on the residents of the state; examine the existing industries, services, and resources addressing the needs of persons with Alzheimer's disease or related disorders, their families, and their caregivers; and develop a strategy to mobilize a state response to this public health crisis.

4. The task force shall include an examination of the following in its assessment and recommendations:

a. Trends in the state's population of persons with Alzheimer's disease or related disorders and the needs of such persons including but not limited to:

1) The state role in long-term care, family caregiver support, and assistance to persons with early-stage and early onset of Alzheimer's disease or related disorders.
2) State policy regarding persons with Alzheimer's disease or related disorders.

b. Existing services, resources, and capacity including but not limited to:

1) The type, cost, and availability of dementia services.
2) Dementia-specific training requirements for long-term care staff.
3) Quality care measures for residential care facilities.
4) The capacity of public safety and law enforcement agencies to respond to persons with Alzheimer's disease or related disorders.
5) The availability of home and community-based resources for persons with Alzheimer's disease or related disorders and respite care to assist families.
6) An inventory of long-term care dementia care units.
7) The adequacy and appropriateness of geriatric=psychiatric units for persons with behavior disorders associated with Alzheimer's disease and related dementia.

8) Assisted living residential options for persons with dementia.
9) State support of research of Alzheimer's disease and related disorders through the state's institutions of higher education and other resources.

c. Needed state policies or responses including but not limited to directions for the provision of clear and coordinated services and support to persons and families living with Alzheimer's disease or related disorders, and strategies to address any identified gaps in services.

5. All meetings of the task force shall comply with chapter 21 and the task force shall utilize technological means, such as web casts, to gather feedback on its discussions and recommendations from persons and families affected by Alzheimer's disease and related disorders and from the general public.

6. The task force shall submit a report of its findings and date-specific recommendations to the general assembly and the governor in the form of a state Alzheimer's disease and related disorders plan by January 1, 2008. The task force shall be dissolved upon the submission of the plan.

Appendix C: Task Force Members

Category defined in SF 489	Name	Position
Joint chairpersons of the legislative health and human services appropriations sub-committee	Rep. Ro Foege (D) Senator Jack Hatch (D)	
Chair of Senate Human Resources Committee	Senator Amanda Ragan (D)	
Chair of House Human Resources Committee	Rep. Mark Smith (D)	
Person with Alzheimer's disease	Barbara Barker	Consumer
Caregiver of a person with Alzheimer's disease	Linda Linderbaum	Retired teacher, Solon
Representative of the nursing facility industry	Don Chensvold	Health Care of Iowa, Inc – Cedar Rapids
Representative of the assisted living industry	Linda Larkin	Agemark Corporation - Ft. Madison
Representative of the adult day services industry	Renee Grummer-Miller, MSW, LISW	Aging Service – Cedar Rapids
Representative of the health care provider community	Joann Simpson, ARNP	Alzheimer's support group facilitator. Alegent Health Mercy Hospital, Corning
A person who conducts Alzheimer's research	Dr. Mehrdad Razavi	Neurologist, lead physician at the Memory Clinic, McFarland Clinic, PC - Marshalltown
Representative of the Alzheimer's Association	Pat Gill	Board member with Big Sioux Chapter, former state legislator
Representative of AARP	Becky Groff	AARP Associate State Director Community Outreach

Licensed health care provider specializing in the practice of gerontology	Robert L. Bender II, M.D.	Medical Director, The Johnny & Romie Orr Center for Healthy Aging and Memory Loss
Representatives of Iowa Dept. of Elder Affairs	John McCalley	
Iowa Dept of Human Services	Jennifer Steenblock	
Iowa Dept of Public Health	Carol Peterson	
Workforce Development	Tony Dietsch	
Iowa Dept of Inspections and Appeals	Kathy Sutton	

Appendix D — List of websites for more information about Alzheimer's disease and caregiver issues.

Alzheimer's Association

www.alz.org

The Alzheimer's Association is the leading voluntary health organization in Alzheimer care, support and research. Its mission is to eliminate Alzheimer's disease through the advancement of research; to provide and enhance care an support for all affected; and to reduce the risk of dementia through the promotion of brain health. This website includes links to local chapter who provide a variety of programs and services for people impacted by Alzheimer's disease.

Alzheimer's Foundation of America

www.alzfdn.org

The mission of the Alzheimer's Foundation of America is "to provide optimal care and services to individuals confronting dementia, and to their caregivers and families through member organizations dedicated to improving quality of life." The AFA's toll-free hotline provides information, counseling by licensed social workers and referrals to community resources across the nation.

Alzheimer's Disease Centers (ADCs) Directory. National institutes of Health

http://www.nia.nih.gov/Alzheimers/Researchinformation/ResearchCenters/

Alzheimer's Disease Centers offer diagnosis and medical management; clinical research and drug trials; and information abut the disease, services and resources.

ADEAR.Alzheimer's Disease Education and Referral Center

http://www.nia.nih.gov/alzheimers

ADEAR maintains information on Alzheimer's disease research, diagnosis, treatment, clinical trials and federal government programs and resources. AD Lib, ADEAR's literature database, has nearly 8,500 materials related to Alzheimer's disease that includes fact sheets, textbook chapters, journal articles, brochures, teaching manuals, directories, videos and other media, bibliographies, program descriptions, monographs, newsletters and reports.

Alzheimer's Disease International (ADI)

http://www/alz.co.uk

ADI is an international membership group of Alzheimer associations. The ADI site links to member association sites throughout the world. It also provides information in several languages, statistics on the number of people with dementia worldwide, and the implications for the distribution of research funding, especially in developing countries.

Alzheimer Research Forum

http://www.alzforum.org

This website reports on the latest scientific findings, from basic research to clinical trials; creates and maintains public databases of essential research data and reagents; and produces discussion forums to promote debate, speed the dissemination of new ideas, and break down barriers across the numerous disciplines that can contribute to the global effort to cure Alzheimer's disease.

Alzheimer Society of Canada

www.alzheimer.ca

The Alzheimer Society of Canada is a nationwide, not-for-profit health organization dedicated to helping people affected by Alzheimer's disease. The Society develops and provides support and educational programs for people with the disease, their families and their caregivers.

Fisher Center for Alzheimer's Research

http://www.alzinfo.org

Fisher's site is a comprehensive portal for caregivers, family members, people living with Alzheimer's, and the general public.

Mayo Clinic Alzheimer's Disease Center

http://www.mayoclinic.com

The Mayo Clinic Alzheimer's Disease Center has easy to understand, practical in-depth information on Alzheimer's and caregiving.

MedicineNet

http://www.medicinenet.com/alzheimers_disease/article.htm

MedicineNet.com is an online, healthcare media publishing company. It provides easy-to-read, in-depth, authoritative medical information for consumers via its robust, user-friendly, interactive web site.

MedlinePlus

http://www.nlm.nih.gov/medlineplus/alzheimersdisease.html

MedlinePlus will direct you to information to help answer health questions. MedlinePlus brings together authoritative information from the National Library of Medicine, the National Institutes of Health, and other government agencies and health-related organizations. MedlinePlus also has extensive information about drugs, an illustrated medical encyclopedia, interactive patient tutorials, and latest health news.

Wem MD.com Alzheimer's Health Center

http://www.webmd.com/alzheimers/default.htm

This site has a broad range of information, with an emphasis on information for individuals who are concerned about memory problems or have Alzheimer's disease.

Iowa Department of Elder Affairs

http://www.state.ia.us/elderaffairs

Family and informal caregivers are the backbone of our long-term care system. The vast majority of long-term care in Iowa and the nation is provided informally and privately at no public cost. Often at great sacrifice, families keep a loved one at home, avoiding more costly institutional care. Most caregivers are reluctant to use formal help. They often provide care with little support, experience adverse consequences to their own physical and emotional well-being, and use formal services only when faced with a crisis. But, even the most self-sufficient people may need information and direct services to best meet the needs of both aging family members and themselves. This Family Caregiver section will provide links to information and resources that can help individuals and caregivers.

LifeLongLinks

www.lifelonglinks.org

The LifeLong Links Web site provides a place to start for consumers and providers who are thinking about and planning for long-term living. LifeLong Links also connects informed consumers and providers with a coordinated entry point to Iowa's information and referral resources: Iowa COMPASS, the Iowa Association of Area Agencies on Aging, Iowa Family Caregiver Support Program, and Iowa 2-1-1.

Iowa Family Caregiver

http://www.iowafamilycaregiver.org

A collaborative effort of the area agencies on aging, the Iowa Family Caregiver Support Program puts people in touch with essential services to help them in their caregiving role and to meet the needs of the older loved one. Information specialists, experienced and knowledgeable in the field of aging, will listen to requests or concerns and explain sources of help based on individual circumstances.

Family Caregiver Alliance, National Center on Caregiving

http://www.caregiver.org

Family Caregiver Alliance (FCA), founded 30 years ago in 1977, serves as a public voice for these caregivers, illuminating the daily challenges they face, offering them the assistance they so desperately need and deserve, and championing their cause through education, services, research and advocacy.

National Alliance for Caregiving

http://www.caregiving.org

Established in 1996, The National Alliance for Caregiving is a non-profit coalition of national organizations focusing on issues of family caregiving. Alliance members include grassroots organizations, professional associations, service organizations, disease-specific organizations, a government agency, and corporations.

National Family Caregivers Association

http://www.nfcacares.org

NFCA offers a virtual library of information and educational materials ranging from national educational campaigns to tips and guides for family caregivers, information on agencies and organizations which provide caregiver support, to communicating effectively workshops.

Family Care America

http://www.familycareamerica.com

The *National Caregivers Library* is one of the most extensive online libraries for caregivers that exist today. It consists of hundreds of articles, forms, checklists and links to topic-specific external resources. The library is organized into the eighteen Caregivers Resources categories, which appear to the immediate left on the screen. Clicking on any category will lead to a list of sub-categories which in turn, lead to lists of articles and other resources.

ElderCare Locator

http://www.eldercare.gov

Eldercare Locator is a public service of the U.S. Administration on Aging. The Eldercare Locator is the first step to finding resources for older adults in any U.S. community. Just one phone call or Website visit provides an instant connection to resources that enable older persons to live independently in their communities. The service links those who need assistance with state and local area agencies on aging and community-based organizations that serve older adults and their caregivers.

AARP

http://www.aarp.org/families/caregiving

This website provides a Guide to Caring which contains information and links on such topic areas as "Planning Ahead," "Providing Care at Home," and "Information and Resources for Caregivers."

Senior Health Insurance Information Program

http://www.shiip.state.ia.us

Senior Health Insurance Information Program can help people find answers to the important questions about Medicare, Medicare supplement insurance, long term care insurance, and other health insurance issues. Created in 1990 by the State of Iowa Insurance Division, SHIIP has helped thousands of people on Medicare sort through confusing health insurance information.

Family Caregiving – It's Not All Up to You

www.familycaregiving101.org

This site is designed to provide caregivers with the basic tools, skills and information they need to protect their own physical and mental health while they provide high quality care for their loved one. It is also a place for family caregivers to return again and again as new levels of caregiving are reached. Advertising

messages, crafted with the assistance of family caregivers themselves, assure caregivers across America that they are not alone, and encourage caregivers to take better care of themselves and their loved one by visiting the site and asking for help.

Note: The Iowa Department of Elder Affairs does not control or guarantee the accuracy, timeliness or completeness of this information.

Appendix F
Single Point of Entry Long-Term Living Resource System Team Report

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Single Point of Entry Long-Term Living Resource System Team Report

Iowa
Dept. of Elder Affairs

Final Report

December 2008

Single Point of Entry Long-Term Living Resource System Team

Dept. of Elder Affairs

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Resource Team Activities

House File 451 (**Appendix B**) charged the Iowa Department of Elder Affairs (DEA) with convening and staffing the Single Point of Entry Resource Team to make recommendations about the structure and means for providing a single point of entry to long-term care or long-term living resources in Iowa. Daniel Ernst, DEA Commission Chair, served as Chair. During the first Team meeting in Council Bluffs, on December 17, 2007, representatives from the U.S. Administration on Aging, AARP, and the Lewin Group presented an overview of single entry point systems in other states – their successes, challenges, and lessons learned. During the next meeting in Des Moines, on February 22, 2008, the Team further refined operational procedures and constructed a mission statement - *"To recommend the best single point of entry system for all Iowans who need or will need long-term care."* Key issue areas identified through the course of the discussion were Access, Coordination, Marketing-Education Awareness, Accountability, Cost, and Culture/Societal Change.

The April 11, 2008, meeting in Oskaloosa focused on the trends and structures of Aging and Disability Resource Centers (ADRCs) across the nation using "Fully Functio

Awareness and Information
Assistance
Access
Target Populations
Critical Pathways to Long-Term Support
Partnerships and Stakeholder Involvement
IT/Management Information Systems
Evaluation Activities
Staffing and Resources

A chart providing more explanation of each category can be found in **Appendix C**.

During the 2008 Legislative Session, clarification was provided by members of the General Assembly that the target population for the Team's efforts should be persons age 60 and older and that the Team was to develop proposals for an enhanced and coordinated method of accessing existing services rather than creating new structures. A form was identified for Team members to use to submit suggestions for recommendations to be considered for possible inclusion in the final report.

At the July 14, 2008, meeting in Des Moines, information was shared about the single entry point systems in seven selected states followed by a presentation covering the Lewin Group's assessment of Iowa's progress towards a "Fully Functioning Single Entry Point Process/ADRC." Proposed recommendations (**Appendix A**) received prior to the meeting were distributed to Team members. Discussion began on the recommendations and continued through the next meeting, on August 18, 2008, in Des Moines.

Some of the themes made during Team member discussions were:

- <u>There is no right or wrong single entry point model</u>. Each state's configuration is reflective of the history and strengths within that state.
- <u>A single point of entry process is not constructed overnight</u>. Other states have found that making incremental change over time yielded a system that is more sustainable than one that is imposed or executed quickly.
- <u>Creating a single point of entry system is an on-going process</u>. There is no definitive point

where the system is complete. It is continually evolving.

Why a Single Point of Entry?

- *2007 US Dept of Health and Human Services report found 7 out of 10 nursing home residents say they are there in part because they didn't know there were options.*

Sources: US AoA, The Lewin Group

Section One: Why a Single Point of Entry

This report details the activities of the Single Point of Entry Resource Team. Section two describes a fully functioning Single Point of Entry/Age and Disability Resource Center and outlines the progress Iowa has already made in this area. Section three outlines the team's recommendations about how to move forward in the development of an informational single point of entry process in Iowa. The appendices provide background information used by the Team to develop recommendations.

As the comments below from Iowans confirm, making Iowa's long-term care system work to meet consumer needs is a challenge. The network of services, agencies, and programs has been described by some as fragmented, confusing, insensitive, and unyielding. For Iowans most in need, the challenge can be too daunting.

> *"You have to be a detective to negotiate the maze of (long-term care) services out there."*
>
> *"Families do not know where to turn to for support. They often feel like they are going it alone."*
>
> *"You have to be very savvy, willing to do a lot of research on your own, and just hope you happen on good information."*
>
> *"It is all very time consuming and you often feel overwhelmed. Nothing is simple or easy."*

Legislative and Executive Branch policymakers recognized that access to information regarding all components of the long-term living resource system is necessary to empower consumers in planning, evaluating, and making decisions to appropriately meet individual long-term living needs. (See **Acknowledgments** for a list of workgroup members.)

Section Two: Background on Fully Functioning Single Entry Point/Age and Disability Resource Center

The Aging and Disability Resource Center (ADRC) Technical Assistance Exchange identifies nine key elements of a fully functioning Single Entry Point (SPE)/ADRC. The criteria are recommended measures intended to be applicable across different types of ADRC models.

Fully functioning Single Point of Entry System — Key Elements:

1. Public Education

2. Assistance

3. Access

4. Target Populations

5. Critical Pathways

6. Partnerships & Stakeholders

7. IT/MIS

8. Evaluation

9. Staffing & Resources

Depending on the model of ADRC a state is implementing, the term SEP/ADRC may be interpreted to represent a) one operating organization in each community at the local level, b) a network of organizations serving as operating partners in each community at the local level, or, c) a combination of state and local level organizations operating in partnership. The key elements include:

1. **Public education**

A) ADRCs serve as highly visible and trusted places where people can turn for the full range of long-term support options.

B) Actively promote public awareness of both public and private long-term support options, as well as awareness of the ADRC, especially among underserved and hard-to-reach populations.

2. **Assistance**

A) ADRCs provide information and counseling to help people assess the potential need and eligibility for all available long-term support options, both public and private.

B) ADRCs link consumers with needed support through appropriate referrals to other programs and benefits and may track client intake, needs assessment, and care plans.

C) ADRCs establish collaborative relationships with programs that provide home and community-based services, including the Senior Health Insurance Information Program, National Family Caregiver Support Program, Alzheimer's' Disease services, health promotion and disease prevention programs, transportation, employment, housing, adult education, and others.

D) ADRCs consistently conduct follow-up when needed to determine outcome of options counseling.

E) ADRCs enable people to make informed, cost-effective decisions about long-term care.

F) ADRCs ensure people are connected to appropriate crisis intervention services.

G) ADRCs assist individuals to plan for future long-term care needs.

3. **Access**

A) Eligibility screening; assistance in gaining access to private-pay long-term support services; comprehensive assessment; programmatic eligibility determination; Medicaid financial eligibility determination that is integrated or closely coordinated with Resource Center services; one-stop access to all public programs for community and institutional long-term support services.

B) ADRCs serve as the entry point to publicly funded long-term care.

C) ADRCs have necessary protocols and procedures to facilitate access (intake, eligibility, assessment) to public programs that are integrated or closely coordinated the process is seamless for consumers.

D) ADRCs support help to reduce the cost of long-term care by delaying or preventing the need for more expensive public long-term care services.

Nearly all 370,000 Iowa AARP members say it is important to remain in their own homes as long as possible if they need long-term care services.

- AARP 2002 survey.

4. **Target Populations**

A) ADRCs serve older adults and at least one target population of people with disabilities (e.g. physical; developmental/mental retardation; mental illness). ADRC projects should move toward the goal of serving persons with disabilities of all ages and types.

5. **Critical Pathway to Long Term Supports**

A) ADRCs create formal linkages between and among the critical pathways to long-term support.

6. **Partnerships & Stakeholder Involvement**

A) ADRCs have documented support and active participation of the State Unit on Aging, the State Medicaid Agency, and the State Agency(s) serving the target populations of people with disabilities.

B) ADRCs establish strong partnerships with the State Health Insurance Information Program (SHIIP) and other programs instrumental to ADRC activities. Examples of other programs include Alzheimer's disease programs, Area Agencies on Aging, Centers for Independent Living, Developmental Disabilities Councils, Information and Referral/2-1-1 programs, Long-Term Care Ombudsman programs, housing agencies, transportation authorities, State Mental Health Planning Councils, One-Stop Employment Centers, and other community-based organizations.

C) ADRCs meaningfully involve stakeholders, including consumers, in planning, implementing, and evaluation activities.

7. **Information Technology/Management Information Systems**

A) The ADRCs have a management information system that supports the functions of the program, including tracking client intake, needs assessment, care plans, utilization and costs.

8. **Evaluation Activities**

A) At a minimum, ADRCs must have performance goals and indicators related to visibility, trust, ease of access, responsiveness, efficiency, and effectiveness.

9. **Staffing and Resources**

A) ADRCs have adequate capacity to assist consumers in a timely manner with long-term supports requests and referrals.

B) ADRCs have an individual assigned to be the overall leader of all SEP/ADRC operations. It is particularly important to have an overall leader with sufficient authority to maintain quality processes when functions occur in more than one location or agency.

C) ADRCs have conducted an assessment of potential funding sources such as Medicaid Federal Financial Participation, foundations, and community organizations.

Section Three: Iowa's Progress on Single Entry Point/Age and Disability Resource Center

Iowa's progress toward a fully-functioning SEP/ADRC

- *Collaboration across aging and disabilities communities*
- *Statewide database*
- *State leadership and legislative supporting SEP development*

In March 2008, The Lewin Group, which serves as the Administration on Aging (AoA) ADRC technical assistance contractor, presented its assessment of the progress that Iowa has made toward realizing the AoA/CMS vision of a fully functioning ADRC. Major areas of strength include collaboration across aging and disabilities communities, a statewide database, and state leadership and legislation supporting SEP development. Major areas for growth include coordinating ADRC activities with a state plan for a SEP system, streamlining access at the local level, and piloting options counseling and streamlined processes at the local level. The full report can be found in **Appendix D**.

The Single Point of Entry Resource Team recognized that Iowa is already has a base to assemble a more expansive single entry point process. The goal was to build on the existing foundation using best practices and protocols utilized in other states and to provide logical and tactical next steps. The existence of awareness efforts, partnerships among state agencies, linked database resources, LifeLongLings.org, options counseling pilot projects and strong community presence by an array of providers linked by area agencies on aging and centers for independent living give the state a leg-up on others that may be starting from scratch.

Other States

Representatives from the Administration on Aging (AoA), The Lewin Group, and AARP presented information to the Team about facets of single entry point processes in other states. In total, components of 14 other state systems were reviewed.

Presentations from AoA and The Lewin Group served as an informational starting point for the Team by explaining the history and current status of Aging and Disability Resource Centers across the nation. Presenters described what a coherent long-term care system would look like and how other states have moved forward in streamlining consumer access to services and supports. An important overarching concept that ran throughout the presentations was that "Single Point of Entry is not about replacing existing organizations and networks. It is about building a better, more coordinated network."

Where Iowans turn for help with navigating long-term care choices:

Religious Support	*.2%*
AAA	*2.9%*
Self	*5.6%*
Other	*8.6%*
Relative or Friend	*11.4%*
Medical Support	*30.4%*
Don't Know	***37.5%***

Source: Iowa 2000 Behavioral Risk Factor Surveillance System.

AARP Iowa reported the results of in-depth telephone surveys conducted with policymakers in seven selected states – Illinois, Maryland, Minnesota, Nebraska, New Jersey, Nevada, and Oregon. Survey questions covered key topics such as funding, partnerships, operational components, challenges, processes, evaluation/QA, marketing/public education, and electronic health records.

Common themes emerged from this "snapshot" of the seven states surveyed. Many states said that they had not developed their system as far as they had hoped up to this point. Most states report that developing single entry point systems is a process that is ongoing, evolves, and takes continued commitment. All states surveyed said that adequate and ongoing funding is the critical factor to successful development of fully functioning SEP/ADRCs. The full report can be found in **Appendix E**.

Section Four: Recommendations

The Resource Teams' recommendations are organized around key components of the "Fully Functioning Single Point System/ADRC Criteria," specifically Awareness & Information, Assistance, Access, Evaluation Activities, and Staff and Resources. The criteria were developed by The Lewin Group to assist states in measuring and assessing their progress towards a fully functioning system.

Awareness and Information which incorporates activities that provide public education and information about long-term support options such as an outreach and marketing plan, a comprehensive resource database, consistent and uniform information, and service to private pay consumers in addition to those who utilize public assistance.

> **Recommendation #1:** Seek an increase in funding provided to the Department of Elder Affairs during the 2009 Legislative Session in the Health Care Reform Act to expand the initiative to promote general awareness regarding long-term living needs and resources through community partners, posters, brochures, handouts, and television and radio spots. Also, educate and link all appropriate associations, including, but not limited to medical providers, pharmacy association, advanced funeral planning, death, dying, and bereavement, homecare, Alzheimer's disease, and mental health to [*the*] LifeLongLinks [*website*].

The Resource Team believes that this will mean that more Iowans will become aware of the tools available to help them navigate the maze of long-term care choices. As a result, more Iowans will access services in the setting of their choice and avoid more expensive and more restrictive long-term care environments.

Assistance such as long-term support options counseling, benefits counseling, employment options counseling, referral to other programs and benefits, crisis intervention, and helping people to plan for their future long-term care needs.

> **Recommendation #2:** Enhance the Iowa Family Caregiver hotline service so that consumers who need additional information on Medicare and Medicaid services and long-term care insurance may be transferred to information specialists, including but not limited to the Senior Health Insurance Information Program (SHIIP) and vice-versa. Also, expand pilot projects of Local Options Counselors, link applications and forms to assistance programs to the Life Long Links web site.

The Resource Team believes that this will provide seamless access to critical pathways for Iowa consumers searching for a variety of types of services and supports. As a result, more Iowans will more easily obtain information that helps them become informed consumers as they purchase desired services or plan for their future long-term care needs.

Access including eligibility screening, assistance in gaining access to private-pay long-term support services, comprehensive assessment, programmatic eligibility determination, Medicaid financial eligibility determination that is integrated or closely coordinated with the Aging and Disability Resource Center services, one-stop access to all public programs for community and institutional long-term support services.

Recommendation #3: Seek adequate funding to allow for the integration of Life Long Links, the Family Caregiver hotline, COMPASS, and 2-1-1 databases. Also, include funding for brick and mortar ADRC sites, utilize the no wrong door approach, and build upon existing infrastructure.

The Resource Team believes that this will provide an integrated IT/MIS infrastructure that provides consumers with the type of information about supportive services no matter what website or toll-free telephone service they use. This will minimize confusion for consumers and expedite their access to supportive services provided in the setting they choose.

The concept of integration is important to the Team because it acknowledges the importance to consumers of finding desired information about – and access to – multiple home and community-based services, employment assistance, transportation, crisis/emergency service, residential and housing without researching and contacting an endless series of entities on a trial and error basis. As such, integration ensures that multiple systems are connected, coordinated and working together so that consumers end up with their needs met with minimal effort and anxiety.

Recommendation #4: Explore and identify federal, state, and market-based methods that may include, but are not limited to presumptive eligibility, fast track pilot projects under Medicaid, a standardized comprehensive assessment tool, and the use of electronic health records with the goal of expediting service system delivery.

The Resource Team believes that analyzing methods of access, eligibility, and delivery models that ease access to and expedite the delivery of long-term care services will lead to continuous improvements in the overall delivery of long-term care. As a result, Iowa's long-term care system will benefit from the knowledge of existing or emerging innovations and can then determine whether they make sense to adopt in this state.

Evaluation Activities consisting of, at a minimum, performance goals and indicators related to visibility, trust, ease of access, responsiveness, efficiency, and effectiveness.

Recommendation #5: Utilize the Senior Living Coordinating Unit (SLCU) as the structure to ensure long-term coordination and accountability including an evaluation component of the single point of entry system.

The Resource Team believes that this will ensure that limited resources are maximized so that consumers receive high quality service and have recourse to protect their rights. It will ensure that tracking mechanisms are in place that support consumer confidence and captures data that demonstrates accountability of the system to the people it serves and the State. This will lead to higher consumer satisfaction and continual quality improvements in the single entry point system as it develops and evolves with shifting consumer demand.

Staffing and Resources which relate to efforts to pursue private and public funding opportunities to create sustainable programs and ensure that adequate capacity exists to assist consumers in a timely manner with long-term support requests and referrals.

Recommendation #6: Explore all options for sustainable funding for a Single Point of Entry System.

The Resource Team knows the Iowa ADRC was made possible through a federal grant from the U.S. Administration on Aging, which concluded in September 2008 for FY 2009, the General Assembly provided funding to sustain the program and implement two pilot projects at the county level utilizing Option Counselors. Additional and redirected state and federal resources will be needed to craft the Single Entry Point. The Resource Team strongly believes that all other sources of private and public funding should be pursued to supplement limited state and federal funding.

Section Five: Observations and Concluding Remarks

Due to the fragmentation in public programs and information deficit, many Iowans currently lack access to quality information on community-based long-term care services. This long-standing condition is a significant factor in over-utilization of institutional care.

Through the use of a single entry point system, such as the Aging and Disability Resource Centers (ADRCs) developed by the Administration on Aging and the Centers for Medicare and Medicaid Services (CMS), the aging service network can provide individuals and their families with streamlined, comprehensive, and reliable information that will help consumers make informed decisions about long-term care.

ADRCs integrate outreach, information, and options counseling for home and community-based long-term care. This component builds on the current statewide network of the Department of Elder Affairs and the Area Agencies on Aging, as well as complementary programs. Iowa is fortunate to have been among 43 states to receive federal grants to start an ADRC, but it is clear from this report that much work remains in order to develop a fully functioning single point of entry system.

ADRCs/SEPs initiatives do not create new entitlement programs, but rather seek to serve more people in the community while helping to alleviate fiscal pressures on Medicaid. The goal of a single point of entry information system is to reach out to all consumers and caregivers who have the need for information on long-term care before they make irreversible decisions, ideally including younger adults who need to prepare in advance for their future long-term care needs.

Federal agencies expect states to develop ADRCs that will provide information, options counseling, and referrals to individuals who can and will finance their own care, as well as those who may be eligible for support through the full array of programs available in the community. If targeted and managed properly, the ADRC/SEP will cost less overall than if the aging services community maintains the current patchwork approach to services.*

The Department of Elder Affairs has circulated this report among the many stakeholders in Iowa's fragmented long-term care system. In consultation with the Commission on Elder Affairs, it will

work in collaboration with public and private funding partners to develop and implement the Resource Team's recommendations.

* According to an analysis by the Lewin Group conducted for the National Association of State Units on Aging and the National Association of Area Agencies on Aging.

Appendices

Appendix A

Proposed Recommendations as Submitted

The following matrix reflects all the suggested recommendations that were submitted and considered by stakeholders in the development of the six final recommendations.

Single Point of Entry Resource Team Proposed Recommendations

Seek an increase in funding provided to the DEA during the 2008 Legislative Session in the healthcare reform legislation to expand the initiative to promote general awareness regarding aging services through community partners, posters, brochures, handouts, and television and radio spots.		DEA
Provider Awareness / Marketing of SPE to professionals.	Berdette Ogden	DPH
Public Awareness / Marketing of SPE.	Berdette Ogden	DPH
Work with a representative of the Iowa Pharmacy Association to provide a link on the Life Long Links web site to an informational piece on services available by pharmacists to home bound or long-term care residents.	Nichole Schultz	IA. Pharmacy Assn.
Support current efforts to establish high quality information concerning LTC that is available electronically. Pay particular attention to the provision of information and resources that address needs of older Iowans with mental health problems who have long-term care needs	Kitty Buckwalter	IA. Coalition on Mental Health and Aging
That information regarding the planning of one's funeral in advance, with the additional option of possibly funding, be included in the Single Point of Entry Resource Team's information.	Scott Eriksen	Hamilton's Funeral Home
To include information and resources on death, dying, grief and bereavement for residents of Assisted Living facilities.	Trudy Holman	Hamilton's Funeral Home
Iowa's SEP system should use the existing Iowa Information and Referral Network.	Robert Bacon	CDD
IAHC will provide Awareness and Information.	Mark Wheeler/Kim Anderson	IA. Alliance in Home Care

Funding for the existing Information and Referral (I&R) network needs to be adequate and sustainable to support basic operations (i.e. sufficient staff, marketing, database entry and updates).	Robert Bacon	CDD
Improve Accessibility of LifeLongLinks/SPE through phone line and off-line personal component, in conjunction with educational component to both the public and providers.	Anthony Carroll	AARP
The Alzheimer's Association chapters in Iowa should be contracted with to provide training and technical assistance to single point of entry providers on Alzheimer's disease, recognizing symptoms and warning signs and other topics as needed.	Carol Sipfle	Alz. Assn.
IAHC will provide Partnerships and stakeholder involvement.	Mark Wheeler/Kim Anderson	IA. Alliance in Home Care
IAHC will provide a web site that will link all Iowans to home care services which is a part of the long-term solution achieving a seamless entry system.	Mark Wheeler/Kim Anderson	IA. Alliance in Home Care
Enhance the Family Caregiver Hotline service so that consumers who need additional information on Medicare and Medicaid services and long-term care insurance may be transferred to information specialists with the Senior Health Insurance Information Program (SHIIP) and vice versa.		DEA
Expand the local Options Counselor pilot project statewide by using a phased-in approach over a six-year period. Beginning in FY 2010, add three Options Counselors at a cost of $255,000 each year through FY 2015 for a total estimated cost of $1.5 million.		DEA
Make available on Life Long Links, linkages to actual applications/forms needed for the various assistance programs.	Barb Morrison	SW 8 Senior Services
Seek adequate funding to allow for the integration of the Life Long Links, Family Caregiver, COMPASS, and 2-1-1 databases.		DEA
Explore the feasibility of, and funding necessary to, merge the elder and disability databases into the software used by COMPASS to create a single database using the AIRS taxonomy codes that is searchable via the internet by staff from both I & R systems.	Robert Bacon	CDD
That Iowa's single point of entry utilizes a telephone system that is based on a simple easy telephone number, whether this be 211 or 311 or something like 800-555-2372 (LLL-ADRC).	Bob Welsh	SLCU Consumer Member
Determine which existing provider organizations could be utilized to serve as actual "brick and mortar" ADRC service centers for consumers.		DEA

That Iowa's single point of entry do everything it can to expedite the delivery of service. This might include encouraging the co-location of those who assess need, determine eligibility, and authorize expenditure, to help expedite the process. This also might include developing a method of presumptive eligibility that does not put the state at risk financial.	Bob Welsh	SLCU Consumer Member
That Iowa use LifeLongLinks as "the management information system that links the resources available in order to provide a single electronic point of entry to the long-term living resource system…	Bob Welsh	SLCU Consumer Member
That Iowa use the "no wrong door" approach and establish an ADRC within 30 miles of every Iowan by 2011, coordinated by the Senior Living Coordinating Unit.	Bob Welsh	SLCU Consumer Member
That the single point of entry in Iowa be designed to serve all persons who need long-term care.	Bob Welsh	SLCU Consumer Member
Ultimate goal must best service to the customer for the $ available. Utilize the in-place resources of the user friendly LifeLongLinks ADRC as a stepping stone for SPE in Iowa – merging the resources of other avenues with LLL as appropriate, establishing linkages and improving the accessibility of service with phone line and off-line (options counselor/ADRC personnel). Marketing will also be important.	Eve Casserly	Older Iowans Legislature
Utilize the existing Information and Assistance services offered through each area agency on aging through trained and certified AIRS (Association of Information and Referral Services) counselors to offer face-to-face options counselors and specialized aging information services.	Donna Harvey	Iowa Assn. of Area Agencies on Aging
Any recommendations on developing a single point on entry system should include Iowa's current single point of entry system into the long term care system for older adults that are implemented via the Area Agency on Aging (i4a) network and the Iowa Department of Elder Affairs.	Liz Silk	Heritage AAA
Utilize the already existing Lifelong Links (Aging and Disability Resource Center) concept administered through DEA in collaboration with DHS to identify Lifelong Links as the 'single point of entry' in Iowa. Using Lifelong Links as a base and using the resources offered through the nationwide network of Aging and Disability Resource Centers and the Lewin Group, the base for the single point of entry is in place and now is ready for expansion.	Donna Harvey	Iowa Assn. of Area Agencies on Aging
Propose federal policy changes that permit states to receive federal reimbursement for services delivered to aging applicants during the period their Medicaid eligibility is being decided.		DEA

Propose legislation that allows for presumptive eligibility for individuals who are being discharged from a hospital to a Medicaid home and community-based waiver program.		DEA
Propose legislation that allows for the implementation of a "fast track" pilot project that will include expediting the Medicaid financial application and determination of disability.		DEA
That Iowa utilize a standardized, comprehensive, independent assessment to be done prior to entry into a long-term care facility.	Bob Welsh	SLCU Consumer Member
As one-stop shops are being formed throughout Iowa's single point of entry/aging and disability resource center, we would recommend that a single comprehensive assessment be developed and required for all access points -- telephone, web, or face-to-face.	Donna Harvey	Iowa Assn. of Area Agencies on Aging
SPE/IDEA/IDPH/DHS oversee the establishment of a standardized, comprehensive, independent assessment to be given an individual prior to out of home placement in order to determine what level services (including placement) is needed.	Eve Casserly	Older Iowans Legislature
Specific questions about memory loss and other symptoms related to dementia should be added to assessment tools to more quickly identify individuals with Alzheimer's and related dementia and refer them to appropriate services.	Carol Sipfle	Alz. Assn.
Move beyond information and referral into determining financial and programmatic eligibility and authorizing of services.	Anthony Carroll	AARP
That Iowa encourage the use of electronic health records and the electronic collection of all information so that the transfer of information can be expedited and Iowans can be better served. The information needed for statistical data collection and evaluation is therefore readily accessible.	Bob Welsh	SLCU Consumer Member
That Iowa work to help change the institutional bias in Medicaid. Iowa should seek to influence national policies and make such changes as it can to help eliminate the institutional bias.	Bob Welsh	SLCU Consumer Member
Create a structure to ensure long-term coordination and accountability of the Single Point of Entry system.	Anthony Carroll	AARP
Sustain ADRC/SPE funding.	Anthony Carroll	AARP
Infrastructure with regards to staffing, system maintenance.	Berdette Ogden	Dept. of Public Health

That Iowa's single point of entry utilize "global budgeting" as is done in states such as Ohio, New Jersey, Oregon, Vermont and Washington.	Bob Welsh	SLCU Consumer Member
Seek protection of funding for SPE and other needed community-based senior services by collectively asking that the Senior Living Trust fund be restored to its original level, that it be made constitutionally protected and that the interest of this be used exclusively for home and community-based services. (While this proposal is not directly related to SPE, this relates to the funding for same and for the services needed by the client community.)	Eve Casserly	Older Iowans Legislature

Appendix B

House File 451 - Enrolled

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  1  1                                          HOUSE FILE 451
  1  2
  1  3                              AN ACT
  1  4 RELATING TO A SINGLE POINT OF ENTRY LONG=TERM LIVING RESOURCES
  1  5    SYSTEM.
  1  6
  1  7 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
  1  8
  1  9    Section 1.  LEGISLATIVE FINDINGS == SINGLE POINT OF ENTRY
  1 10 LONG=TERM LIVING RESOURCES SYSTEM.
  1 11    1.  The general assembly finds that access to information
  1 12 regarding all components of the long=term living resources
  1 13 system is necessary to empower consumers in planning,
  1 14 evaluating, and making decisions to appropriately meet their
  1 15 individual long=term living needs.  This access should be
  1 16 provided through a single point of entry into an integrated,
  1 17 seamless system that facilitates navigation of the variety of
  1 18 private and public resources available, minimizes service
  1 19 fragmentation, reduces duplication of administrative paperwork
  1 20 and procedures, enhances individual choice, supports informed
  1 21 decision making, and increases the cost=effectiveness of long=
  1 22 term living services and support systems.
  1 23    2.  a.  A single point of entry long=term living resources
  1 24 system team is created, consisting of the following members:
  1 25    (1)  The director of the department of elder affairs, or
  1 26 the director's designee.
  1 27    (2)  The director of the department of human services, or
  1 28 the director's designee.
  1 29    (3)  The director of public health, or the director's
  1 30 designee.
  1 31    (4)  The director of the department of inspections and
  1 32 appeals, or the director's designee.
  1 33    (5)  The commissioner of insurance, or the commissioner's
  1 34 designee.
  1 35    (6)  The executive director of the Iowa finance authority,
  2  1 or the executive director's designee.
  2  2    (7)  The director of the department of veterans affairs, or
  2  3 the director's designee.
  2  4    (8)  The director of the department of workforce
  2  5 development, or the director's designee.
  2  6    (9)  A representative of the office of the governor.
  2  7    (10)  The director of an area agency on aging or the
  2  8 director's designee and a consumer member selected by the
  2  9 director.
  2 10    (11)  The state director of the AARP Iowa chapter or the
  2 11 state director's designee and a consumer member selected by
  2 12 the state director.
  2 13    (12)  The chairperson of the older Iowans legislature or
  2 14 the chairperson's designee and a consumer member selected by
  2 15 the chairperson.
  2 16    (13)  A consumer member of the senior living coordinating
  2 17 unit created in section 231.58 selected by the senior living
  2 18 coordinating unit.
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2 19 (14) A representative of the Iowa hospital association.
2 20 (15) A representative of the Iowa pharmacy association.
2 21 (16) A representative of the Iowa health care association.
2 22 (17) A representative of the Iowa association of community
2 23 providers.
2 24 (18) A representative of the Iowa association of homes and
2 25 services for the aging.
2 26 (19) A representative of the Iowa association of home
2 27 care.
2 28 (20) The director of the university of Iowa center on
2 29 aging, or the director's designee.
2 30 (21) Two members of the senate and two members of the
2 31 house of representatives, with not more than one member from
2 32 each chamber being from the same political party.
2 33 b. The legislative members of the team shall serve in an
2 34 ex officio, nonvoting capacity. The two senators shall be
2 35 appointed by the president of the senate, after consultation
3 1 with the leaders of the senate, and the two representatives
3 2 shall be appointed by the speaker of the house, after
3 3 consultation with the majority leader and the minority leader
3 4 of the house of representatives.
3 5 c. Public members shall receive actual expenses incurred
3 6 while serving in their official capacity and may also be
3 7 eligible to receive compensation as provided in section 7E.6.
3 8 d. The team shall do all of the following:
3 9 (1) Hold at least four public meetings in at least four
3 10 geographically balanced venues around the state to receive
3 11 input regarding access to the long=term living resources
3 12 system and recommendations for improved access. The team
3 13 shall also receive input regarding the benefits of the use of
3 14 electronic health records.
3 15 (2) Make recommendations regarding the structure of and
3 16 best means of providing a single point of entry to the long=
3 17 term living resources system. The team shall also make
3 18 recommendations regarding the use of electronic health
3 19 records.
3 20 (3) Submit a report of the team's findings from the
3 21 meetings described in subparagraph (1) and the team's
3 22 recommendations for establishing a single point of entry to
3 23 the long=term living resources system to the general assembly
3 24 on or before December 1, 2008. The recommendations may
3 25 provide for multiple access sites that are standardized and
3 26 coordinated to provide for access to the single point of
3 27 entry, a management information system that links the
3 28 resources available in order to provide a single electronic
3 29 point of entry to the long=term living resources system, a
3 30 telephonic single point of entry, or suggestions for
3 31 colocation or integration of long=term living resources system
3 32 administration and services. The report shall also include
3 33 recommendations for funding the single point of entry to the
3 34 long=term living resources system through available grants or
3 35 other sources. The report shall also include recommendations
4 1 regarding the use of electronic health records.
4 2
4 3
4 4
4 5 PATRICK J. MURPHY
4 6 Speaker of the House
4 7
4 8

4 9
4 10 JOHN P. KIBBIE
4 11 President of the Senate
4 12
4 13 I hereby certify that this bill originated in the House and
4 14 is known as House File 451, Eighty=second General Assembly.
4 15
4 16
4 17
4 18 MARK BRANDSGARD
4 19 Chief Clerk of the House
4 20 Approved _____, 2007
4 21
4 22
4 23
4 24 CHESTER J. CULVER
4 25 Governor

http://www.iowa.gov/elderaffairs/services/SinglePointOfEntry.html

Appendix C

Aging & Disability ResourceCenter
An Initiative of the U.S. Department of Health and Human Services
TECHNICAL ASSISTANCE EXCHANGE

Fully Functioning Single Entry Point System/ADRC

These criteria were developed to assist states measure and assess their progress toward developing fully functioning Single Entry Point Systems/ADRCs. These criteria and recommended metrics are intended to be applicable across different types of ADRC models. Depending on the model of ADRC a state is implementing, the term "SEP/ADRC" may be interpreted to represent one operating organization in each community at the local level, a network of organizations serving as operating partners in each community at the local level, or a combination of state level and local level organizations operating in partnership. Metrics that should be interpreted or applied differently to systems with a "single entry point" than to systems where there are "multiple entry points" are noted.

Program Component	Criteria / Description	Recommended Metrics
Awareness and Information	*Public education; information on long-term support options.* • ADRCs serve as highly visible and trusted places where people can turn for the full range of long-term support options. • Actively promote public awareness of both public and private long-term support options, as well as awareness of the ADRC, especially among underserved and hard-to-reach populations.	• The SEP/ADRC has a proven **outreach and marketing plan** in place that takes into consideration: (a) culturally diverse, underserved and unserved populations, their family caregivers, and the professionals who serve them through focused outreach and community education; (b) the identification of unique needs of the different populations being served; (c) a strategy to assess the effectiveness of the outreach and marketing activities; and (d) a feedback loop to modify activities as needed. • The SEP/ADRC has a **comprehensive resource database** which includes information about the range of long term support options in the SEP/ADRC service area. Information regarding providers, programs, and services available in the SEP/ADRC service area (including for private-payment) is collected into a central database. - Resources included in the database conform to established Inclusion/Exclusion policies. - A system is in place for updating and ensuring the accuracy of the information provided. - The database is accessible to the public via a comprehensive website and is user friendly, searchable and accessible to persons with disabilities. - Statewide coverage for the database is preferable. • The SEP/ADRC may have a single or multiple entry points within the service area. All agencies operating entry points (operating partners) have access to the same comprehensive resource database and provide **consistent and uniform information.** • The SEP/ADRC actively markets to and serves **private pay** consumers in addition to those that require public assistance.

Program Component	Criteria / Description	Recommended Metrics
Assistance	*Long-term support options counseling; benefits counseling; employment options counseling; referral to other programs and benefits; crisis intervention; helping people to plan for their future long-term support needs.* • The ADRC will provide information and counseling to help people assess their potential need and eligibility for all available long-term support options, both public and private. • ADRC has the capacity to link consumers with needed support through appropriate referrals to other programs and benefits and has the ability to track client intake, needs assessment, and care plans. • ADRC has established collaborative relationships with programs that provide home and community-based services including SHIP, NFCSP, Alzheimer's Disease services, health promotion and disease prevention programs, transportation, employment, housing, adult education and others. • ADRC consistently conducts follow-up when needed to determine outcome of options counseling. • ADRC enables people to make informed, cost-effective decisions about long term care. • ADRC has process to ensure that people are connected to the appropriate crisis intervention services. • ADRC assists individuals to plan for future long-term care needs.	<u>Options Counseling</u> • SEP/ADRC has the capability, either through a single operating organization or through close coordination among operating partners, to provide accurate and comprehensive long term support options counseling to any consumer who requests it. • All SEP/ADRC entry point agencies use standard intake and screening instruments. • Protocols are in place to identify consumers who will be offered options counseling. At a minimum, this will include consumer that have gone through a comprehensive assessment process. • Options counseling sessions: (a) entail individualized assistance; (b) are provided in a uniform manner to all SEP/ADRC consumers with the use of protocols or standard operating procedures; and (c) are conducted by staff qualified to provide objective assistance to consumers in the process of making informed decisions, as evidenced by certification requirements and/or training/cross-training practices. • SEP/ADRC can demonstrate evidence that options counseling provided enables people to make informed, cost-effective decisions about long-term care services. • SEP/ADRC uses systematic processes across all entry points to provide information, referral and access to services. These services include, at a minimum: - Public benefits (OAA, Medicaid, Medicare including new Medicare Modernization Act benefits, state revenue programs and others) - Employment - Health promotion/disease prevention - Transportation - Crisis/Emergency services - Services for family caregivers - Residential care including assisted living <u>Referrals and Follow Up</u> • SEP/ADRC has the ability to track referrals made. • SEP/ADRC consistently conducts follow-up to determine outcome of options counseling. <u>Crisis Intervention</u> • SEP/ADRC responds to situations requiring short-term assistance to support an individual until a plan for long-term support services is in place. • Short-term case management is available as needed for all target populations and provided directly by SEP/ADRC (by at least one operating partner in multiple entry point systems), or is contracted out. <u>Future Long Term Support Needs Planning</u> • Evidence of one of the following: (1) SEP/ADRC is involved with Own Your Own Future Campaign; (2) SEP/ADRC is a pilot Home Equity Conversion Mortgage counseling site; or (3) SEP/ADRC provides futures planning directly or contractually by staff who possess specific skills related to LTC needs planning and financial counseling.
Access	*Eligibility screening; assistance in*	• SEP/ADRC has a single, standardized entry process for accessing

http://www.iowa.gov/elderaffairs/services/SinglePointOfEntry.html

Program Component	Criteria / Description	Recommended Metrics
	gaining access to private-pay long-term support services; comprehensive assessment; programmatic eligibility determination; Medicaid financial eligibility determination that is integrated or closely coordinated with the Resource Center services; one-stop access to all public programs for community and institutional long-term support services. • ADRC serves as the entry point to publicly funded long term care. • The ADRC has in place necessary protocols and procedures to facilitate access (intake, eligibility, assessment) to public programs that is integrated or so closely coordinated that the process is seamless for consumers. • ADRC support helps to reduce the cost of long term care by delaying or preventing the need for more expensive public long term care services.	public and private services. In multiple entry point systems, the entry process is coordinated and standardized so that consumers experience the same process wherever they enter the system. • For SEP/ADRCs with multiple entry points, the entry processes are overseen by a coordinating entity. • Financial and functional eligibility determination processes are highly coordinated. • SEP/ADRC uses uniform criteria across sites to assess risk of institutional placement in order to target support to individuals at high-risk. • SEP/ADRC staff conduct level of care assessments that are used for determining functional eligibility, or SEP/ADRC has a formal process in place for seamlessly referring consumers to the agency that conducts level of care assessments. • ADRC/SEP staff assist consumers as needed with initial processing functions (e.g., taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews. 42 CFR 435.904). • Staff located on-site within the ADRC/SEP can determine financial eligibility (staff co-located from or delegated by the Single State Medicaid Agency), or ADRC/SEP staff can submit completed applications to the agency authorized to determine financial eligibility directly on behalf of consumers. • SEP/ADRC is able to track individual consumers' eligibility status throughout the process of eligibility determination and redetermination. • In localities where waiting lists for public LTC programs or services exist, there is a process by which the SEP/ADRC is informed of consumers who are on the waiting list and the SEP/ADRC conducts follow-up with those individuals. • There is a process by which the SEP/ADRC is informed of consumers who are determined ineligible for public LTC programs or services and the SEP/ADRC conducts follow-up with those individuals. • SEP/ADRC has a plan for reducing the average time from first contact to eligibility determination and the average time is below current time requirement. • There is a reduction in the rate of institutional placement in the SEP/ADRC service area. • SEP/ADRC tracks diversions and transitions (i.e., # nursing home diversions attempted and # of successful diversions; # nursing home relocations to community completed). • SEP/ADRC can report the proportion of consumers requesting services that actually receive them. • SEP/ADRC has a plan for streamlining access to long-term care signed by the State Medicaid Agency, State Unit on Aging and the State agency(s) representing target population(s) of people with disabilities. (Streamlining Access Plan).

Program Component	Criteria / Description	Recommended Metrics
Target Populations	*ADRCs must serve the elderly and at least one **target population** of people with disabilities (e.g. physical; developmental/mental retardation; mental illness). ADRC projects should move towards the goal of serving persons with disabilities of all ages and types.*	• The SEP/ADRC tracks the number of actual individuals served against the resident population estimate, by target population. • SEP/ADRC demonstrates competencies relating to serving all of its target populations. • SEP/ADRC is accessible to all of the populations it serves. • There is evidence that the SEP/ADRC is moving towards the goal of serving all persons with disabilities, either through a single operating organization or through close coordination among operating partners.
Critical Pathways to Long Term Support	*ADRCs will create formal linkages between and among the **critical pathways to long-term support.***	• SEP/ADRC has "formal linkages" that involve all three of the following components that are updated on an ongoing basis: (1) providing training and education about the SEP/ADRC to critical pathway providers (CPPs); (2) involving CPPs in advisory board representation; and (3) establishing protocols for referrals, particularly with hospitals and LTC facilities.
Partnerships & Stakeholder Involvement	*ADRCs must have the documented support and active participation of the Single State Agency on Aging, the Single State Medicaid Agency and the State Agency(s) serving the target populations(s) of people with disabilities.* *ADRCs must establish strong partnerships with the **State Health Insurance Assistance Program (SHIP**) and other programs instrumental to ADRC activities. Examples of other programs include Alzheimer's disease programs, Area Agencies on Aging, Centers for Independent Living, Developmental Disabilities Councils, Information and Referral/2-1-1 programs, Long-Term Care Ombudsman programs, housing agencies, transportation authorities, State Mental Health Planning Councils, One-Stop Employment Centers and other community-based organizations.* *ADRCs must **meaningfully involve stakeholders, including consumers**, in planning, implementation and evaluation activities.*	<u>Medicaid</u> • SEP/ADRC has an agreement with Medicaid agency to ensure that access to Medicaid benefits is as streamlined as possible for consumers; MOU describes explicit role of each agency and information sharing policies. <u>Aging or Disability Partners</u> • There is evidence of collaboration, including formal agreements, at the state and pilot level between aging and disability partners. • SEP/ADRC has protocols for information sharing and cross-training across entry point operating partners and with other critical aging and disability services partners in the community. <u>Stakeholders</u> • If the SEP/ADRC and SHIP are operated by separate entities, there is a MOU or Interagency Agreement establishing, at a minimum, a protocol for mutual referrals. • There is evidence of strong collaboration with programs and services instrumental to SEP/ADRC activities including home and community-based service providers, residential care alternatives including assisted living, institutional care providers, hospitals and other critical pathways and others. <u>Consumers</u> • Formal mechanisms for consumer involvement have been established, including consumer representation on the state/local SEP/ADRC advisory board or governing committee and there is evidence that consumers have been involved in planning, implementation and evaluation activities.

Program Component	Criteria / Description	Recommended Metrics
IT/MIS	*The ADRC program must have a **management information system** that supports the functions of the program including tracking client intake, needs assessment, care plans, utilization and costs.*	• SEP/ADRC uses a management information system that can support the program functions. • SEP/ADRC can submit evidence of reports on the following: - # of unduplicated consumers YTD - Referrals for current month, referring agency/entity, # referrals under age 60; # referrals age 60 and older. o Types of assistance provided o Timing of eligibility determinations o Information regarding level of impairment and preferred support need o Disposition/placements (e.g., waiver, institution) • SEP/ADRC has established an efficient process for sharing information electronically with external entities, as needed, from intake to service delivery. In multiple entry point systems, all entry points use MIS that allows for electronic exchange of resource and client data across entry points and with other partners, as appropriate.
Evaluation Activities	*At a minimum, ADRCs must have **performance goals and indicators** related to visibility, trust, ease of access, responsiveness, efficiency and effectiveness.*	• SEP/ADRC is measuring performance related to the established indicators. • SEP/ADRC can demonstrate ability to develop reports summarizing issues and making recommendations for corrective action or quality improvement based on performance indicators. • SEP/ADRC has used information obtained from consumer satisfaction evaluations to improve performance. • SEP/ADRC can demonstrate ability to document the impact on nursing home use • SEP/ADRC can demonstrate the ability to document the impact on the use of home and community based services. • SEP/ADRC can demonstrate a reduction in the average time from first contact to eligibility determination for publicly funded home and community-based services. • SEP/ADRC informs consumers of complaint and grievance policies and has the ability to track and address complaints and grievances. • SEP/ADRC has a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered.
Staffing and Resources	• Capacity • Quality • Any conflicts of interest have been addressed • Specialized training/gaps identified • Private and public funding opportunities are pursued to create sustainable programs	• SEP/ADRC has adequate capacity to assist consumers in a timely manner with long term support requests and referrals, including referrals from critical pathway providers. • SEP/ADRC has an individual assigned to be the overall director/manager/coordinator of all SEP/ADRC operations. It is particularly important to have an overall coordinator or manager with sufficient authority to maintain quality processes when SEP/ADRC functions occur in more than one location or agency. • SEP/ADRC has conducted an assessment of potential funding sources such as Medicaid Federal Financial Participation, foundations and community organizations.

Appendix D

Iowa: Progress towards a Fully Functioning Single Entry Point System/ADRC

March 2008

This document presents The Lewin Group's assessment of the progress that Iowa has made toward realizing the AoA/CMS vision of a fully functioning ADRC. In the first three columns, the ADRC program components, their descriptions, and recommended metrics describe the fully functional ADRC vision. The description of ADRC Grantee Progress in the fourth column identifies grantee strengths as well as areas for future growth. In the last column are suggested Technical Assistance Resources that relate to the different Program Components and/or were discussed on the Fully Functioning call that AoA and The Lewin Group held with Iowa on March 3, 2008.

Major ADRC strengths – 1) Collaboration across aging, PD and DD communities; 2) statewide resource databases; and 3) state leadership and SEP legislation

Most important areas for growth – 1) coordinating ADRC activities with state plan for SEP system; 2) streamlining access at local levels; and 3) piloting options counseling and streamlined processes at local level

"At a Glance" Rating System:

● = Meets Criteria ◐ = Partially Meets Criteria/ Making Progress ○ = Important Area for Growth

Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
Awareness & Information	*Public education; information on long-term support options.* • ADRCs serve as highly visible and trusted places where people can turn for the full range of long-term support options • Actively promote public awareness of both public and private long-term support options, as well as awareness of the ADRC, especially among underserved and hard-to-reach populations.	• The SEP/ADRC has a proven **outreach and marketing plan** in place that takes into consideration: (a) culturally diverse, underserved and unserved populations, their family caregivers, and the professionals who serve them through focused outreach and community education; (b) the identification of unique needs of the different populations being served; (c) a strategy to assess the effectiveness of the outreach and marketing activities; and (d) a feedback loop to modify activities as needed. • The SEP/ADRC has a **comprehensive resource database** which includes information about the range of long term support options in the SEP/ADRC service area. Information regarding providers, programs, and services available in the SEP/ADRC service area (including for private-payment) is collected into a central database.	**Outreach and Marketing** ◐ Iowa has implemented a statewide marketing plan for LifeLongLinks (LLL). The new pilot sites will have an opportunity to do more public education locally about community based options for LTC. **Resource Database** ● Iowa has three comprehensive statewide resource databases connected through LifeLongLinks website. Each database uses inclusion/exclusion criteria and are routinely updated and maintained. They think that LifeLongLinks is becoming more known. The SEP Resource Committee is interested in LLL being the key tool for information and awareness in the new SEP system. They would like to see more development similar to Network of Care or Minnesota's site, so that it is more interactive. Iowa and Nebraska AIRS are now collaborating on I&R for all ages and populations, which is a	ADRC-TAE Issue Brief - Marketing to External Audiences: http://www.adrc-tae.org/tiki-download_file.php?fileId=2833 ADRC-TAE Training Handout - Social Marketing Topic Overview: http://www.adrc-tae.org/tiki-download_file.php?fileId=26863 ADRC-TAE Issue Brief - Private Industry Lessons: Branding and Marketing: http://www.adrc-tae.org/tiki-download_file.php?fileId=26301

http://www.iowa.gov/elderaffairs/services/SinglePointOfEntry.html

● = Meets Criteria ◐ = Partially Meets Criteria/ Making Progress ○ = Important Area for Growth

Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
		- Resources included in the database conform to established Inclusion/Exclusion policies. - A system is in place for updating and ensuring the accuracy of the information provided. - The database is accessible to the public via a comprehensive website and is user friendly, searchable and accessible to persons with disabilities. - Statewide coverage for the database is preferable. • The SEP/ADRC may have a single or multiple entry points within the service area. All agencies operating entry points (operating partners) have access to the same comprehensive resource database and provide **consistent and uniform information.** • The SEP/ADRC actively markets to and serves **private pay** consumers in addition to those that require public assistance.	success and a sign of progress. They are talking about referral protocols and developing a common taxonomy. **Private Pay** ◐ There is some content on LifeLongLinks targeted toward private paying families and related to futures planning. The task force has not really talked about this or focused on this area yet, but they will need to. **Suggestion**: State should consider increasing its focus and helping ADRCs increase focus on actively reaching out to private pay consumers. Raising visibility and awareness about LTC options among private paying populations is a key element of the ADRC initiative, and it is also an important way to build a broader base of public support for the initiative.	The Community Toolbox (University of Kansas): Successful Marketing and Institutionalization of the Initiative: http://ctb.ku.edu/en/tablecontents/chapter_1045.htm Minnesota's Approach to Data Maintenance Presentation: http://www.adrc-tae.org/tiki-download_file.php?fileId=27032 Setting Inclusion/Exclusion Criteria: Determining the Scope of a Resource File: http://www.nasua.org/informationandreferral/pdf/inclusion_exclusion.pdf ADRC-TAE Training Handout - Marketing to and Serving Private Paying Populations: http://www.adrc-tae.org/tiki-download_file.php?fileId=27297
Assistance	*Long-term support options counseling; benefits counseling; employment options counseling; referral to other programs and benefits; crisis intervention; helping people to plan for their future long-term support needs.* • The ADRC will provide information and counseling to help people assess their potential need and eligibility for	Options Counseling • SEP/ADRC has the capability, either through a single operating organization or through close coordination among operating partners, to provide accurate and comprehensive long term support options counseling to any consumer who requests it. • All SEP/ADRC entry point agencies use standard intake and screening instruments.	**General Comments:** Most of the services in this section have not yet been offered in-person or by telephone through the ADRC in Iowa, except to the extent that the partnering networks already provide these services to their own target populations at the local level. Iowa will fund two local pilot programs in spring/early summer to design and implement options counseling as well as standard intake and referral procedures.	ADRC-TAE Issue Brief - Long Term Support Options Counseling: Decision Support in ADRCs: http://www.adrc-tae.org/tiki-download_file.php?fileId=26557

● = Meets Criteria ◍ = Partially Meets Criteria/ Making Progress ○ = Important Area for Growth

Program Component	Criteria / Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
	all available long-term support options, both public and private. • ADRC has the capacity to link consumers with needed support through appropriate referrals to other programs and benefits and has the ability to track client intake, needs assessment, and care plans. • ADRC has established collaborative relationships with programs that provide home and community-based services including SHIP, NFCSP, Alzheimer's Disease services, health promotion and disease prevention programs, transportation, employment, housing, adult education and others. • ADRC consistently conducts follow-up when needed to determine outcome of options counseling. • ADRC enables people to make informed, cost-effective decisions about long term care. • ADRC has process to ensure that people are connected to the appropriate crisis intervention services. • ADRC assists individuals to plan for future long-term care needs.	• Protocols are in place to identify consumers who will be offered options counseling. At a minimum, this will include consumers who have gone through a comprehensive assessment process. • Options counseling sessions: (a) entail individualized assistance; (b) are provided in a uniform manner to all SEP/ADRC consumers with the use of protocols or standard operating procedures; and (c) are conducted by staff qualified to provide objective assistance to consumers in the process of making informed decisions, as evidenced by certification requirements and/or training/cross-training practices. • SEP/ADRC can demonstrate evidence that options counseling provided enables people to make informed, cost-effective decisions about long-term care services. Information and Referral • SEP/ADRC uses systematic processes across all entry points to provide information, referral and access to services. These services include, at a minimum: - Public benefits (OAA, Medicaid, Medicare including new Medicare Modernization Act benefits, state revenue programs and others) - Employment - Health promotion/disease prevention - Transportation - Crisis/Emergency services - Services for family caregivers - Residential care including assisted living	○ **Options Counseling** Iowa will begin piloting options counseling services through local level pilot sites. They expect that a system, standards and protocols for options counseling will be designed and implemented by the local level networks of organizations chosen as pilot sites. ◍ **Information and Referral** In terms of I&R, Iowa has information and resources on all types of resources listed and includes them in LLL at the state level. The extent to which they will be able to provide comprehensive I&R in all areas listed at the local level will depend on pilot sites that are selected and partnerships developed. ○ **Referrals and Follow Up** Iowa's new pilots will need to examine and adjust their existing referral protocols between and among partners as well as identify a way to follow up with consumers on a routine basis. **Suggestion**: Following up with consumers to make sure they connect with needed services is a key function of the ADRC. Consider testing a standard under which staff follow-up by telephone with a set percentage of callers (perhaps 30% at first) to track the appropriateness of services and ensure that consumers are able to make the necessary connections. The data collected during follow-up can be used to identify service gaps in the community. Staff can share follow-up results with one another as a way of improving ADRC service delivery. ◍ **Crisis Intervention** Iowa's Department of Elderly Affairs administers the Elder Abuse program through AAAs, which will be involved in new pilot sites. **Suggestion**: Involve community partners in discussion of how to provide and coordinate short term case management to consumers entering the system in different areas.	ADRC-TAE Training Handout - Options Counseling Overview: http://www.adrc-tae.org/tiki-download_file.php?fileId=26845 Wisconsin's Options Counseling Toolkit: http://www.adrc-tae.org/tiki-index.php?page=LTCOptionsToolkit Indiana Standard Operating Procedures Manual http://www.adrc-tae.org/tiki-download_file.php?fileId=27255 ADRC-TAE Tool - Measuring Options Counseling: Goals and Objectives Grid: http://www.adrc-tae.org/tiki-index.php?page=PreviousEvaluationPeerWorkGroupCalls Intake and screening tools from Ohio and North Carolina as well as other ADRCs: http://www.adrc-tae.org/tiki-index.php?page=p_Intake New Jersey Automated Screen for Community Services http://www.adrc-tae.org/tiki-download_file.php?fileId=2604

http://www.iowa.gov/elderaffairs/services/SinglePointOfEntry.html

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
		Referrals and Follow Up • SEP/ADRC has the ability to track referrals made. • SEP/ADRC consistently conducts follow-up to determine outcome of options counseling. Crisis Intervention • SEP/ADRC responds to situations requiring short-term assistance to support an individual until a plan for long-term support services is in place. • Short-term case management is available as needed for all target populations and provided directly by SEP/ADRC (by at least one operating partner in multiple entry point systems), or is contracted out. Future Long Term Support Needs Planning • Evidence of one of the following: (1) SEP/ADRC is involved with Own Your Future Campaign; (2) SEP/ADRC is a pilot Home Equity Conversion Mortgage counseling site; or (3) SEP/ADRC provides futures planning directly or contractually by staff who possess specific skills related to LTC needs planning and financial counseling.	○ **Future Long Term Support Needs Planning** Assisting consumers to plan for their future long term care needs will be part of options counseling in the new pilots. **Suggestion**: The state should support and encourage sites to build expertise and resources in this area. This might involve training some staff at each site to become counselors, identifying community partners who can routinely provide this service for ADRC consumers, and/or developing off-the-shelf informational materials and tools such as Wisconsin's resource called House in Order. The state may be able to reach more private paying consumers by adding an informational section about planning for long term care needs into the LifeLongLinks website.	NASUA Vision 2010: Toward a Comprehensive Aging Information Resource System for the 21st Century: http://www.nashp.org/Files/NASUA_Vision.pdf NCOA Use Your Home to Stay at Home Program: http://www.ncoa.org/content.cfm?sectionid=250 A House in Order: How Planning for Your Aging Brings Peace of Mind: http://www.adrc-tae.org/tiki-download_file.php?fileId=26901 American Institute of Certified Public Accountants (AICPA) http://www.feedthepig.org/AboutUs.aspx Own Your Future Campaign Information http://www.aoa.gov/LTC/404/404_message.htm
Access	*Eligibility screening; assistance in gaining access to private-pay long-term support services; comprehensive assessment; programmatic eligibility determination; Medicaid financial eligibility determination that is integrated or closely coordinated with the Resource Center services; one-stop access to all public programs for community and institutional long-term support services.*	• SEP/ADRC has a single, standardized entry process for accessing public and private services. In multiple entry point systems, the entry process is coordinated and standardized so that consumers experience the same process wherever they enter the system. • For SEP/ADRCs with multiple entry points, the entry processes are overseen by a coordinating entity. • Financial and functional eligibility determination processes are highly coordinated.	○ **General Comments:** Iowa's ADRC project has not yet focused on streamlining the eligibility processes for Medicaid and other public programs. They have focused on building partnerships with Medicaid, Aging and Disability agencies, which should put them in a strong position once their local pilot sites begin operations. ADRC staff are also staffing the SEP Resource Committee that will make recommendations to legislature about developing a SEP system. When recommendations are made, big changes could follow quickly. ADRC staff should work to ensure pilot sites are positioned to implement these changes.	ADRC-TAE Issue Brief - Engaging Medicaid Agencies About ADRCs: http://www.adrc-tae.org/tiki-download_file.php?fileId=26974 ADRC-TAE Tool - Streamlining Access Self-Assessment and Workbook with State Examples – Hoops: http://www.adrc-tae.org/tiki-download_file.php?fileId=27057

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Program Component	Criteria / Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
	• ADRC serves as the entry point to publicly funded long term care. • The ADRC has in place necessary protocols and procedures to facilitate access (intake, eligibility, assessment) to public programs that is integrated or so closely coordinated that the process is seamless for consumers. • ADRC support helps to reduce the cost of long term care by delaying or preventing the need for more expensive public long term care services	• SEP/ADRC uses uniform criteria across sites to assess risk of institutional placement in order to target support to individuals at high-risk. • SEP/ADRC staff conduct level of care assessments that are used for determining functional eligibility, or SEP/ADRC has a formal process in place for seamlessly referring consumers to the agency that conducts level of care assessments. • ADRC/SEP staff assist consumers as needed with initial processing functions (e.g., taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews. 42 CFR 435.904). • Staff located on-site within the ADRC/SEP can determine financial eligibility (staff co-located from or delegated by the Single State Medicaid Agency), or ADRC/SEP staff can submit completed applications to the agency authorized to determine financial eligibility directly on behalf of consumers. • SEP/ADRC is able to track individual consumers' eligibility status throughout the process of eligibility determination and redetermination. • In localities where waiting lists for public LTC programs or services exist, there is a process by which the SEP/ADRC is informed of consumers who are on the waiting list and the SEP/ADRC conducts follow-up with those individuals. • There is a process by which the SEP/ADRC is informed of consumers who are determined ineligible for	ADRC should also advocate for system changes to include disability service systems as well as aging. **Suggestion**: In implementing pilots, ADRC staff should keep in mind the importance of tracking diversions, transitions and placement as a way to demonstrate impact of options counseling and SEP system.	ADRC-TAE Issue Brief - Options for Assessing the Impact of ADRCs on Long Term Care Costs: http://www.adrc-tae.org/tiki-download_file.php?fileId=26986 ADRC-TAE Issue Brief - ADRC Roles in Diversion: http://www.adrc-tae.org/tiki-download_file.php?fileId=2805

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
		public LTC programs or services and the SEP/ADRC conducts follow-up with those individuals. • SEP/ADRC has a plan for reducing the average time from first contact to eligibility determination and the average time is below current time requirement. • There is a reduction in the rate of institutional placement in the SEP/ADRC service area. • SEP/ADRC tracks diversions and transitions (i.e., # nursing home diversions attempted and # of successful diversions; # nursing home relocations to community completed). • SEP/ADRC can report the proportion of consumers requesting services that actually receive them. • SEP/ADRC has a plan for streamlining access to long-term care signed by the State Medicaid Agency, State Unit on Aging and the State agency(s) representing target population(s) of people with disabilities. (Streamlining Access Plan).		
Target Populations	*Resource Center grantees must serve the elderly and at least one **target population** of people with disabilities (e.g. physical; developmental/mental retardation; mental illness). ADRC projects should move towards the goal of serving persons with disabilities of all ages and types.*	• The SEP/ADRC tracks the number of actual individuals served against the resident population estimate, by target population. • SEP/ADRC demonstrates competencies relating to serving all of its target populations. • SEP/ADRC is accessible to all of the populations it serves. • There is evidence that the SEP/ADRC is moving towards the goal of serving all persons with disabilities, either through a single operating organization or through close coordination among operating partners.	● At the state level, ADRC partners represent full range of disability populations and are committed to serving all disability types. The state advisory board should be able to guide and monitor the pilot sites' activities to ensure pilot sites are competent and accessible to all populations. ◐ The original SEP legislation calling for the SEP Resource Committee did not specifically include all disability populations, and it seems the legislative intent was for it to focus primarily on streamlining aging services. Disability advocates have been attending the meetings and they do have one advocate for including them in the SEP system on the legislatively appointed Resource Committee. **Suggestion**: Iowa should draw on the expertise of its ADRC advisory board, as well	ADRC-TAE Issue Brief - Supporting Adults with Physical Disabilities: http://www.adrc-tae.org/tiki-download_file.php?fileId=2823 ADRC-TAE Issue Brief - Long Term Support for Individuals with Mental Retardation/Developmental Disabilities: http://www.adrc-tae.org/tiki-download_file.php?fileId=2827

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Program Component	Criteria / Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
			as the experience of other states, to advise the SEP Resource Committee about including all populations in SEP planning process – even if initially they will focus on streamlining aging services and incorporate other systems later. Aging and disability system integration and/or coordination is a major national trend. The experience of other states highlights the importance of involving all groups in the planning and discussion up front and early. This is important as a way for building broad-based support for the initiative, as well as to make sure the SEP design will be compatible with other service systems when they are eventually integrated.	Resource in development: ADRC-TAE Issue Brief - Serving Individuals with Mental Illness
Critical Pathways to Long Term Support	*Resource Centers will create formal linkages between and among the* ***critical pathways to long-term support.***	• SEP/ADRC has "formal linkages" that involve all three of the following components that are updated on an ongoing basis: (1) providing training and education about the SEP/ADRC to critical pathway providers (CPPs); (2) involving CPPs in advisory board representation; and (3) establishing protocols for referrals, particularly with hospitals and LTC facilities.	◐ At state level, ADRC has worked to reach out to different associations. With their continuation funding, they are adding to LLL website more information for and a special section for hospital discharge planners. They tried to get a good group of critical pathway providers for the local advisory groups. They did not mandate which ones should be involved. They think it will be an on-going conversation. **Suggestion**: Reaching out to and actively intervening in critical pathways can be a key streamlining access strategy. On average across states, CPPs account for more than 50% of all referrals to ADRCs. Consider how ADRCs can more formally intervene in critical pathways, through some kind of state mandate or partnership. For example, Arkansas recently passed legislation requiring anyone entering a nursing home to receive ADRC options counseling. Other states have developed less formal linkages through partnerships and referral protocols.	ADRC-TAE Issue Brief - Hospital-Based Nursing Facility Diversion Initiatives: http://www.adrc-tae.org/tiki-download_file.php?fileId=27079 New Hampshire protocols for discharge planners referring to ADRC: http://www.adrc-tae.org/tiki-searchresults.php?words=nh+protocols+for+discharge+planners&where=pages An Act to Create the Arkansas Options Counseling for Long Term Care Program: http://www.arkleg.state.ar.us/ftproot/bills/2007/public/HB1132.pdf

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Program Component	Criteria / Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
Partnerships & Stakeholder Involvement	*ADRC's must have the documented support and active participation of the Single State Agency on Aging, the Single State Medicaid Agency and the State Agency(s) serving the target populations(s) of people with disabilities.* *Resource Centers must establish strong partnerships with the* ***State Health Insurance Assistance Program (SHIP****) and other programs instrumental to ADRC activities. Examples of other programs include Alzheimer's disease programs, Area Agencies on Aging, Centers for Independent Living, Developmental Disabilities Councils, Information and Referral/2-1-1 programs, Long-Term Care Ombudsman programs, housing agencies, transportation authorities, State Mental Health Planning Councils, One-Stop Employment Centers and other community-based organizations.* *Resource Center programs must* ***meaningfully involve stakeholders, including consumers****, in planning, implementation and evaluation activities.*	Medicaid • SEP/ADRC has an agreement with Medicaid agency to ensure that access to Medicaid benefits is as streamlined as possible for consumers; MOU describes explicit role of each agency and information sharing policies. Aging and Disability Partners • There is evidence of collaboration, including formal agreements, at the state and pilot level between aging and disability partners. • SEP/ADRC has protocols for information sharing and cross-training across entry point operating partners and with other critical aging and disability services partners in the community. Stakeholders • If the SEP/ADRC and SHIP are operated by separate entities, there is a MOU or Interagency Agreement establishing, at a minimum, a protocol for mutual referrals. • There is evidence of strong collaboration with programs and services instrumental to SEP/ADRC activities including home and community-based service providers, residential care alternatives including assisted living, institutional care providers, hospitals and other critical pathways and others. Consumers • Formal mechanisms for consumer involvement have been established, including consumer representation on the state/local SEP/ADRC advisory board or governing committee and there is evidence that consumers have been involved in planning, implementation and evaluation activities.	Medicaid ◍ Medicaid staff have been active and consistent participants in ADRC at state level, assisted in developing RFP for new ADRC pilot sites, and just completed a MOU. However, they will need to increase the level of engagement with Medicaid as they move forward with the pilot sites and SEP development. **Suggestion**: Use the pilot sites as an opportunity to renew interest in the ADRC within Medicaid. Identify additional staff/point people within Medicaid to ensure more consistent involvement. Make the case that streamlining changes that are piloted through the new ADRC sites may be part of SEP Resource Committee's recommendations to legislature, so Medicaid should be involved in the pilot site's streamlining plans. Aging and Disability Partner ● Strong partnerships at state level. RFP for new pilot sites put heavy emphasis on partnerships at local level. Stakeholders and Consumers ◍ SHIP is in Dept of Insurance and representative from this department serves on Advisory Board. In the aging network, they do have a good connection with SHIP, but not as sure about disability community. **Suggestion**: Disability partners may be able to help spread the word to consumers about SHIP services being available to people under 60 with disabilities. ● Consumers participate on advisory board at state level and will do so on local levels. ADRC has administered consumer satisfaction surveys statewide.	ADRC-TAE Issue Brief - Engaging Medicaid Agencies About ADRCs: http://www.adrc-tae.org/tiki-download_file.php?fileId=26974 ADRC-TAE Issue Brief - Strategies for Building Collaboration http://www.adrc-tae.org/tiki-download_file.php?fileId=2821 ADRC-TAE Issue Brief - Public and Private Partnerships: http://www.adrc-tae.org/tiki-download_file.php?fileId=2813 ADRC-TAE Issue Brief - Facilitating a Productive Advisory Committee: http://www.adrc-tae.org/tiki-download_file.php?fileId=2825

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
IT/MIS	*The ADRC program will have a **management information system** that supports the functions of the program including tracking client intake, needs assessment, care plans, utilization and costs.*	• SEP/ADRC uses a management information system that can support the program functions. • SEP/ADRC can submit evidence of reports on the following: - # of unduplicated consumers YTD - Referrals for current month, referring agency/entity, # referrals under age 60; # referrals age 60 and older. o Types of assistance provided o Timing of eligibility determinations o Information regarding level of impairment and preferred support need o Disposition/placements (ex. waiver, institution) • SEP/ADRC has established an efficient process for sharing information electronically with external entities, as needed, from intake to service delivery. In multiple entry point systems, all entry points use MIS that allows for electronic exchange of resource and client data across entry points and with other partners, as appropriate.	◍ AAAs all use ESP for I&R and client tracking; other potential partnering organizations use other client tracking systems. MIS is under discussion right now in the aging network. The AAAs may move to software that it would be easier to use AIRS taxonomy. **Suggestion**: State should encourage aging network to plan for and build capacity to share data with organizations outside the network, as this will be a requirement for ADRCs and is a significant trend in IT. State should also work with new pilot sites to facilitate data sharing and ensure consistent and standardized data collection and reporting.	Moving Forward: Opportunities for IT Advances in the Aging Network: http://www.adrc-tae.org/tiki-download_file.php?fileId=26984 Improving HCBS Delivery Systems for Older Adults and Individuals with Disabilities: Redesigning Information Technology and Business Processes to Support Participant Control, Quality, and Cost Effectiveness: http://www.adrc-tae.org/tiki-download_file.php?fileId=27215 Review of IT Systems for Single Point of Entry: http://www.adrc-tae.org/tiki-download_file.php?fileId=1700 ADRC-TAE Tool - ADRC MIS Requirements Development Tool: http://www.adrc-tae.org/tiki-download_file.php?fileId=396
Evaluation Activities	*At a minimum, ADRCs must have **performance goals and indicators** related to visibility, trust, ease of access, responsiveness, efficiency and effectiveness.*	• SEP/ADRC is measuring performance related to the established indicators. • SEP/ADRC can demonstrate ability to develop reports summarizing issues and making recommendations for corrective action or quality improvement based on performance indicators. • SEP/ADRC has used	● ADRC has benefited from strong evaluation team and it will continue through pilot. The new sites will have to cooperate with IA State evaluators, which they hope will mean full access to staff, data and budget information. The IA State evaluators will continue to handle the survey work. **Suggestion**: Partnering organizations may have different levels of capacity or quality assurance. Use consumer satisfaction survey process as a way to help pilot sites build capacity for ongoing data	ADRC State Project Evaluation Guidelines for Assessing ADRC Project Progress and Accomplishments: http://www.adrc-tae.org/tiki-download_file.php?fileId=1671

http://www.iowa.gov/elderaffairs/services/SinglePointOfEntry.html

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
		information obtained from consumer satisfaction evaluations to improve performance. • SEP/ADRC can demonstrate ability to document the impact on nursing home use • SEP/ADRC can demonstrate the ability to document the impact on the use of home and community based services. • SEP/ADRC can demonstrate a reduction in the average time from first contact to eligibility determination for publicly funded home and community-based services. • SEP/ADRC informs consumers of complaint and grievance policies and has the ability to track and address complaints and grievances. • SEP/ADRC has a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered.	collection and quality assurance activities. ◐ In implementing pilots, ADRC should keep in mind the importance of quality assurance across all partners – which can be particularly difficult in decentralized models – as well as measuring outcomes of options counseling, tracking diversions, transitions and placement. **Suggestion**: Put evaluation and data collection issues on agenda to discuss with Medicaid. It may spark some interest if they see the potential for cost-savings and will also provide an opening to talk more about data sharing and looping the ADRC into the eligibility determination process.	ADRC-TAE Tool - Selected Measures of Streamlining Access: http://www.adrc-tae.org/tiki-download_file.php?fileId=2493 ADRC-TAE Issue Brief – Excellent Customer Service in an ADRC: http://www.adrc-tae.org/tiki-download_file.php?fileId=2839 Wisconsin ADRC Quality Site Review Process: http://www.nashp.org/Files/WI_ADRC_Site_Quality_Review.doc ADRC-TAE Issue Brief - Options for Assessing the Impact of ADRCs on Long Term Care Costs: http://www.adrc-tae.org/tiki-download_file.php?fileId=26986
Staffing and Resources	• Capacity • Quality • Any conflicts of interest have been addressed • Specialized training/gaps identified • Private and public funding opportunities are pursued to create sustainable programs.	• SEP/ADRC has adequate capacity to assist consumers in a timely manner with long term support requests and referrals, including referrals from critical pathway providers. • SEP/ADRC has an individual assigned to be the overall director/manager/coordinator of all SEP/ADRC operations. It is particularly important to have an overall coordinator or manager with sufficient authority to maintain quality processes when SEP/ADRC functions occur in more than one location or agency.	○ Adequacy of staffing and resources at local level will be determined when pilot sites are selected. ● State leadership of ADRC is strong, has a clear vision for ADRC growth and development, and is working closely with SEP Resource Committee on its vision for statewide SEP system. ◐ SUA recently began claiming for case management services. There may be opportunity for legislative funding, depending on recommendations of SEP Resource Committee. Current House and Senate study bills discuss ADRC (continuing funding) and they are part of LTC legislation. One legislative author is on the SEP Resource Committee. Suggestion: Explore FL and MT strategies for	ADRC-TAE Training Handout - Sustainability Topic Overview: http://www.adrc-tae.org/tiki-download_file.php?fileId=26841 ADRC Profiles in Sustainability: http://www.adrc-tae.org/tiki-download_file.php?fileId=26355 ADRC Business Plan Template http://www.adrc-tae.org/tiki-download_file.php?fileId=2846

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Program Component	Criteria/ Description	Recommended Metrics	ADRC grantee progress	Suggested TA Resources
		• SEP/ADRC has conducted an assessment of potential funding sources such as Medicaid Federal Financial Participation, foundations and community organizations.	claiming FFP. FL is claiming for employees who are 100% dedicated to Medicaid and they are also testing Wisconsin's 100% time reporting form in their AAAs to see how cumbersome this process would be for them. If IA wants to pursue the cost/benefit of potential claiming, ADRC-TAE is available for consult.	Information on Medicaid funding is available at: http://www.adrc-tae.org/tiki-index.php?page=MedicaidFunding Resources from Montana, Florida, Wisconsin and other states on working with Medicaid on FFP http://www.adrc-tae.org/tiki-index.php?page=Medicaid

Appendix D

SPERT "Other States" Report

SPERT "Other States" Report

(As Compiled by Anthony Carroll, AARP Iowa ASD Advocacy)

Oregon, Nevada, Nebraska, Illinois, Maryland, New Jersey & Minnesota

July 14, 2008

1

Caveats

- Quick and Dirty Snapshots of States, not comprehensive analysis (except where otherwise attached or referenced)
- Remember these are subjective, impressions. Survey often called for opinions. Even when multiple sources consulted, still opinions.
- Not meant to be authoritative, comprehensive.

2

Common Themes

- Humbleness about what these states have done, and what they have yet do.
  - Many: "Well I'm not sure we've gone as far as everyone hoped." OR "Wish we had more to report."
  - Balanced with not wanting to be overly critical.
- Common theme that this is ongoing, takes continuing commitment, and evolving
- **FUNDING!!!!!!!**

3

Overview of Process

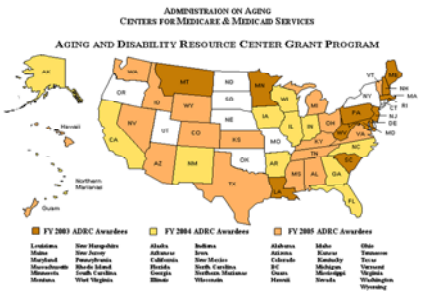
- Started with AARP state offices. In most cases several people consulted.
- State agencies were used either as sources for information, and in some cases have their own survey results
- Questions were answered in different ways, and to varying degrees of depth

4

Overview of States

5

ADRC Awardees



6

Oregon (Background stats)

- Oregon has had one of the lowest % institutionalization for some time, and has consistently had THE highest % of the LTC spending on HCBS (70+%).
- Their state budget is set up to allow them to shift Medicaid NF $ from NF to HCBS (have a received a waiver to do so).

7

Oregon Background

- *Oregon started looking at access to LTC and state spending on HCBS in 1970's. In 1979, Don's district was part of a demonstration project evaluated and used in the 1981 legislation. His AAA was one picked because they were already starting in that direction.*
- *In 1981, legislature passed law. Experiment in seeing if Oregon could: better serve people in community v. nursing facilities.*
- *Gave local AAA's the option to stay focus on traditional AAA duties or take on this role of being the entry points for LTC. The key here: **optional**, **local points** of entry. Don estimates about ??80% of population served this way, but some rural AAA's have not opted to participate.*
- OR really does not have a viable SPE system as you would define. OR did NOT receive AoA $ for ADRCs and is playing catch up

8

Oregon Partners

- *Labor & senior activists, AAA's advocating for some time. Worked with nursing facilities too from beginning*

9

Oregon Funding

- *No ADRC grant, and still none.*
- What funding sources were used to support implementation of the SPE?
  - *State General Funds and Older Americans funds, and funds raised locally from AAA's, no additional funds from the beginning. State took attitude "we don't care how, just don't ask us for more money"*
- What funding sources are used to support the ongoing operations of the SPE?
  - *It always comes down to State's ability to match federal $$.*

10

Oregon Process

- Did your state start with one target population and then roll out the SPE system to other targeted populations (for example: disabled, youth) – What were your state's lessons and insights? In hindsight, what could be done differently?
  - *Disabilities community originally part of it. Later, in the 80's disability advocates said wait, they like concept, but didn't want to be a part of program mainly for seniors, and "by the way, also some younger people with disabilities". So then it became optional for local offices to set up entry system to include disability population, or not include them. A Separate advisory council has been set up for disability community*
- Did your state test the SPE by setting up a demonstration site?
  - *Yes, used Demonstration counties, including Don's in 1979*
- If your state utilizes the 211 systems, caregiver support system, etc., how did those systems work together? What worked, what didn't?
  - *Not currently statewide*

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Oregon Process cont.

- What role did federal level agencies, such as CMS or AoA, play in the establishment and ongoing operations of the SPE?
  - *CMS had to approve some waivers, and Older American Act $$$ have been part of the mix from the beginning 1981*
- If your state has an ADRC grant, how were ADRC activities integrated into SPE processes?
  - *Still no ADRC grant*

12

Oregon Operation

- Does your state have a standardized tool to assess consumers utilizing the SPE? How and by whom was the tool developed?
  - *Yes, universal**, IF** putting them onto any LTC portion (but not everywhere, ie. ADL for nutritional services)*
- What types of information and assistance does your SPE provide, i.e. Options Counselors?
  - *No Option Counselors currently in most (some more sophisticated local agencies do). This is a possibility if move to ADRC*
- What are the hours of operation of the SPE?
  - *AAA hours 8-5 (some do have 24 help line)*

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Oregon Challenges

- What challenges or difficulties did your state encounter in your SPE process?
  - Biggest: State has de-invested, thus contracted services, for PURELY budget implemented considerations: ie. Oregon no sales tax; senior programs 1st in line for cuts. State has been great on Medicaid, but more resources needed into non-Medicaid portion.
- How did you tackle the challenges of streamlining the SPE system?
  - *Movement underfoot to get ADRC and make more sophisticated and statewide*
- What advice would you give to a group pursuing this?
  - *"When it works it is a win, win."*
  - *Note Oregon has decreased (not held even) nursing home population every year for last 20 years. For Oregon, key has been to continue to reinvest.*
  - *Central to success is good case management, always tougher, takes more time, ongoing, problems like turnover*
- Was there resistance to the SPE idea/process?
  - *Original concern about putting Medicaid dollars into SPE, that it would increase demand on state budgets because too many people would demand service, but that has not been the case. Saved money.*
  - *AAA fear would lose focus, become more about LTC, but this was overcome because first of all it was optional, and the more and more came on as they saw this was not the case.*

14

Oregon Education/Marketing

- *Literature, talked with hospitals, met with; word of mouth, media, including national*

15

Oregon Record System for SPE

- Not used for SPE
- Did the state create an information database to identify what services were being delivered to seniors (or target population group) and/or what services seniors (or target population group) need?
  - *Do have a common data-base, but with movement toward state system, more central screening system 800# could be possibly added, not currently there.*

16

Oregon Next Steps (from AARP office)

- ***The current ADRC plan has been drafted by AAA and Statue Unit on Aging (SUA) staff. Presented to key stakeholders (AARP, SEIU and LTC industry) in May.***
- ***SUA and one AAA just wrote a grant proposal to CMS which would secure $ for a SPE/ADRC in one county as effort to pilot for future expansion.***
  - ***Grant includes pilot on discharge planning and follow through with county's hospitals, too.***
- **Using OAA $, state signed up to use the Network of Care web site and had all AAAs have resource info placed on site.**

17

Nevada Background from AARP office

- Set up by 2003 legislation, primarily through 211 system.
- The new ADRC's integral part of endeavor.
- Has continued to switch gears as new things come up. It was a phone line and website concept originally – with a brochure, became the 211 system (with dreams of an integrated info and referral system for one form to apply for everything with shared info – which has not exactly been realized)…
  - and then now the 211 combined with ADRC. Part of it is the reality of where the money is at the time. The grants for the ADRC's became available and seemed a good fit.
- Funding (lack of) is a major issue

18

Nevada Survey Info.

- Filled out by Mary Liveratti
  - Deputy Director of Nevada Dept of Health and Human Services
- Mary is the 211 person that has become part of the focus of SPE.

19

Nevada Partners

- Who were the identified partners in design of the SPE (both formal and informal)?
  - For the 2-1-1 system: *State govt. (Health and Human Services, Information Technology/Telecommunications), county govt, United Ways, telephone association, telephone providers, NV. Eldercare/Caregiver support, Aging Services, Crisis Call Center, HELP of So. NV, NV Public Health Foundation, Family advocates, NV Disability Advocacy & Law Center.*
- Who were the identified partners in implementation of the SPE (both formal and informal)?
  - *Same as above and, governor's office, legislators, social service providers, AARP, disability and senior groups/advocates.*
- Who were your partners in the ongoing process of SPE?
  - *Same as above, with additional agencies, such as Health Division,(and Health Preparedness), State Business and Industry*
- What internal process did you use to complete the work of establishing a single point of entry?
  - *2-1-1 grew out of the NV Commission on Aging's public hearings on establishing a single point of entry. By partnering with the United Ways, the focus changed to 2-1-1. The Legislature passed a resolution to establish a work group on 2-1-1 and single point of entry with DHHS providing leadership with the United Ways. Since Aging Services was part of the coalition, when Nevada received the ADRC grant, it folded into the on-going efforts.*

20

Nevada Funding

- What were the funding sources identified to support the SPE design and implementation?
  - *Tobacco settlement dollars, state general funds, United Way funds, local funds, Originally we hoped to receive telephone surcharge funding (1 cent would have generated about $500,000) but this was killed by the phone companies.*
- What entities are helping with funding?
  - *State Government, United Ways, Health Preparedness funds. We also received some "one shot" funds through the Casey Family Foundation and a United Health Care settlement.*
- Were there funding "champions"? *(I.e. Governor, legislator, etc.)*
  - *Yes, we have several legislators who have fought for funding. DHHS also put a line item in our budget last session for 2-1-1.*
- If state dollars were used, what strategies were used to inform the state legislature?
  - *Coalition members were able to work with several legislators to propose legislation concerning 2-1-1.*

21

Nevada Funding cont.

- What funding sources were used to support implementation of the SPE?
  - *Tobacco dollars, UW and state general funds.*
- What requirements do identified funding sources have? What have been the outcomes, negative and positive?
  - *One shot money is easy to get, the on-going funding was difficult at first. As people have seen the benefit, including legislators, we have received more stable funding through the state. We have not had a statewide manager for the system, but United Way has given us a grant to hire one for the next two years. We also need a data coordinator.*
- After implementation of the SPE, was there an increase in the number of clients who needed to access home and community-based services?
  - We have not done an analysis of this. in the first two years, we have struggled with just implementing the service and maintaining it.
- Was any cost analysis completed regarding how much the State saved by having a SPE system in terms of delaying clients' needs for more costly institutional care options? *NO*

22

Nevada Enacting Legisation

- Two bills were considered during the 2003 legislative session. SB 239 did not pass. We negotiated for the SCR 11 to pass, because SB 239 required us to establish the system, but did not appropriate any funding to do it.
- Set up the coalition in 2003 and had the governor appoint the 211 partnership by executive order several years later.
- System actually started in February 2006. We have had additional bills, for example one in our 2007 session to appropriate funding.

23

Nevada Process

- Did your state start with one target population and then roll out the SPE system to other targeted populations (for example: disabled, youth)
  - *NO we rolled the system out to the whole state at one time*
- Did your state test the SPE by setting up a demonstration site? noWere existing systems used?
  - *Yes, the two call centers were experienced as helplines: Crisis Call Center in the north and HELP of So. NV in the south.*
- If your state utilizes the 211 systems, caregiver support system, etc., how did those systems work together? What worked, what didn't?
  - We*'ve been lucky to have a good working relationship. The fact that DHHS was involved helped these systems to work together (sister agencies).*
- What role did federal level agencies, such as CMS or AoA, play in the establishment and ongoing operations of the SPE?
  - *Very little*
- If your state has an ADRC grant, how were ADRC activities integrated into SPE processes?
  - *Both are part of the coalition for 2-1-1. good working relationship.*

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http://www.iowa.gov/elderaffairs/services/SinglePointOfEntry.html

Nevada Operation

- What programs are included in the SPE program eligibility determination, for example, Medicaid state plan services, Medicaid HCBS wavier services, nursing facility, Older Americans Act programs/services, state-funded programs/services, and other?
  - *This is being developed by the ADRC.*
- Does your state have a standardized tool to assess consumers utilizing the SPE?
  - *Yes*
- How and by whom was the tool developed?
  - *Coalition members*
- What types of information and assistance does your SPE provide, i.e. Options Counselors?
  - *2-1-1 is basic information and referral (more screening activities and connecting to resources); the ADRC provides more eligibility assessment and assistance.*
- What are the hours of operation of the SPE?
  - *2-1-1 is available M thru F, 8 am. To midnight, sat and sun 8 to 4. we plan to go 24 hours, 7 days a week this year.*

25

Nevada Challenges

- Was there resistance to the SPE idea/process?
  - *Biggest resistance was from some service providers who were concerned that it would compete with them for limited program dollars.*
- How were issues resolved?
  - *Communication and trying to find ways to help providers. Many providers use the system for information themselves.*
- What were the outcomes?
  - I B*elieve problem has been resolved, as people have seen the benefit of the system. We had a harder time prior to implementation*

26

Nevada Challenges cont.

- What challenges or difficulties did your state encounter in your SPE process?
  - ******Funding****** *was the biggest challenge. On going, the challenge is policy development, i.e. inclusion/exclusion policy, data policy, oversight of the system.*
- How did you tackle the challenges of streamlining the SPE system?
  - *I don't know that we've tackled that yet. We are in the process of developing a strategic plan for the system.*
- What advice would you give to a group pursuing this? learn from other states.
  - *We talked to others who had successfully implemented the system. We also belong to AIRS and got help from them. Partnerships are vital –both public and private.*

27

Nevada Evaluation

- What does your state's SPE look like now? How is it different from the SPE vision the state may have started with?
  - *Pretty similar. It would be wonderful to link to case management services, which is what we hope will happen with the ADRCs.*
- Has access improved for the population identified/targeted?
  - *We expected about 24,000 calls the first year, but received double that amount (50,000)*
- Has empirical data been collected to verify outcomes?
  - *Data has been collected, but no formal evaluation has been conducted.*
- Has duplication of services been reduced?
  - *Unknown at this time*
- Was access streamlined for all populations?
  - *We have not done a formal evaluation, but believe it to be so based on the numbers calling.*
- Was access streamlined for individual populations?
  - *Appears to be for seniors and people with disabilities.*

28

Nevada Education/Marketing

- Who are the primary referral sources to the SPE and how did the state approach and educate the primary referral sources and targeted individuals about the SPE?
  - *(Physicians, faith communities, family, friends, neighbors, discharge planners, etc?) agency referrals, family/friends, TV PSAs. All grantees of the DHHS are required to be listed with 2-1-1, that helped their awareness. We also built off the United Way I and R system.*
- How did the state approach and educate the target population groups about SPE?
  - *Print articles, TV and radio PSAs.*
- Did the state specifically direct marketing efforts to consumers who were financially secure and/or consumers receiving public assistance?
  - *Only direct marketing efforts have been direct mailing to foster care parents (through the Casey funding) and booths at senior health fairs.*

29

Nevada Records

- Does the state utilize electronic health records in its SPE?
  - *Not at this time*
- Did the state create an information database to identify what services were being delivered to seniors (or target population group) and/or what services seniors (or target population group) need?
  - *Yes we do track what referrals are made and what services are needed, but may not be available.*

30

Maryland Partners

- Who were the identified partners in design of the SPE (both formal and informal)?
  - *State Dept of Disabilities, Advocates (MD Disabilities Law Center, MD Disabilities Council (AARP Exec Council Member was co- chair)*
- Who were the identified partners in implementation of the SPE (both formal and informal)?
  - *Dept of Aging, local heath dept in Worcester County and Howard County Office of Disabilities*
- Who were your partners in the ongoing process of SPE?
  - *Same*
- How did you coordinate information from other executive branch agencies?
  - *MAP Advisory Council*

31

Maryland Funding

- What were the funding sources identified to support the SPE design and implementation? Are hospitals and/or other entities that use these SPE resources for greater efficiency, deferring work to other entities and saving money helping fund the implementation or the ongoing operations? If so, what entities are helping with funding?
  - *Federal and local counties (Worcester and Howard) Baltimore City and Prince Georges Counties will be next. After that, plan for next target is the Lower E. Shore where 7 hospitals will be participating.*
- Were there funding "champions"? (I.e. Governor, legislator, etc.)
  - *Stuart Rosenthal (currently Chair of the State Commission on Aging was a representative of the Commission to the MAP Advisory Council and a strong advocate for SPE. He is also publisher of a newspaper called the Beacon, which is targeted to the senior community.*
- If state dollars were used, what strategies were used to inform the state legislature?
  - *The Dept of Aging made budget presentations to the House and Senate budget Committees.*
- What funding sources were used to support implementation of the SPE?
  - *Combo of Federal, state and local. Fed is expected to be phased out. State and local governments are expected to continue.*

32

Maryland Process

- Did your state start with one target population and then roll out the SPE system to other targeted populations (for example: disabled, youth) – What were your state's lessons and insights? In hindsight, what could be done differently?
  - *Adults w disabilities, including elderly.*
  - *The programs vary with each County. In one jurisdiction it is run by the health dept, in another by the disabilities agency. Baltimore City will be run through the Center for Independent Living. It is designed for maximum flexibility. The website will hopefully provide info on a County by County basis.*
- To what extent was legislation necessary to establish the SPE system in your state (could we have a copy of the legislation?)
  - *MAP is not in statute yet, but expected to be in the future. Senior Information and Assistance Program was adopted through legislation in 1982.*
- If your state has an ADRC grant, how were ADRC activities integrated into SPE processes?
  - *MD has an ADRC grant. MD uses the "No Wrong Door" system. Eventually they will be the same.*

33

Maryland Operation

- What programs are included in the SPE program eligibility determination, for example, Medicaid state plan services, Medicaid HCBS wavier services, nursing facility, Older Americans Act programs/services, state-funded programs/services, and other?
  - *Goal is to include all of these on the website.*
- Does your state have a standardized tool to assess consumers utilizing the SPE? How and by whom was the tool developed?
  - Yes, by Dept. of Aging, chief of housing, Stephanie Hull
- What types of information and assistance does your SPE provide, i.e. Options Counselors?
  - *Options Counseling and direct service where eligible.*

34

Maryland Records

- Does the state utilize electronic health records in its SPE?
  - *No. Plan is to have it by county on the State website so that a case worker can access records from the secured website*
- Did the state create an information database to identify what services were being delivered to seniors (or target population group) and/or what services seniors (or target population group) need?
  - *The Dept of Aging is creating County based databases.*

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Maryland further info.

- *For further information: best contact is Stephanie Hull, currently chief of housing for the Dept of Aging for Maryland. She ran the SPE program, and knows the logistics of its day to day operation.*

36

New Jersey background from AARP

- The State has issued two reports that give an overview of our new LTC law. Many answers to questions can be found in these reports. You can find the most recent report online at http://www.state.nj.us/health/senior/documents/idc_report_108.pdf
- The report paints a rosy picture and does a good job explaining the positives. Answers in questionnaire reflect some of our concerns and points out the negatives

37

New Jersey background cont

- There are two types of SPEA. The old NJEASE and the new ADRC
- NJEASE
  - This program has been up and running in each county in NJ since the mid-90's. It was implemented by the State with and through the Divisions on Aging in each county and it is done well in some counties and poorly in others. In general though, it has been a disappointment since too few people use it, probably because many do not know about it, and/or staff is limited.
  - The NJ EASE Counselors help link callers to Medicaid state plan services, Medicaid HCBS wavier services, nursing facility, Older Americans Act programs/services, state-funded programs/services, and other local services.
- ADRC is the new model being rolled out in about 8 counties. It has been up and running in two pilot counties for two years but there has been no formal assessment done.

38

New Jersey Process

- Did your state test the SPE by setting up a demonstration site? Were existing systems used?
  - There were two pilot counties. These counties were already doing much of what the state envisioned. There has been no formal assessment of the success of these counties.
- If your state utilizes the 211 systems, caregiver support system, etc., how did those systems work together? What worked, what didn't?
- To what extent was legislation necessary to establish the SPE system in your state (could we have a copy of the legislation?)
- What role did federal level agencies, such as CMS or AoA, play in the establishment and ongoing operations of the SPE?
- If your state has an ADRC grant, how were ADRC activities integrated into SPE processes?
  - Many of these answers are in the annual report.

39

New Jersey Funding

- There are no separate state figures assessing the use of these services. The state monitors by looking at federal expenditures on Medicaid dollars.

40

New Jersey Fast Track Eligibility Evaluation (from Auerbach memo)

- *(from page 3)* "Although there has been an evaluation of the ADRC model under the AoA grant, there is no evaluation reported on the cost-effectiveness of either fast-track eligibility, the new client assessment instrument or the client-tracking system. Only fast-track is being implemented statewide at this time."
- *(page 6: #3)* "The Fast-Track eligibility system appears to be approving very few people. The 1/1/08 report states that 625 people were referred for financial screening using Medicare Part D Low-Income Subsidy data and 45 were approved, 82 were already on Medicaid and were referred for further clinical eligibility. In the 10/07 report, it states that clinical eligibility was done first before the names were screened by the Part D data. Was this a change over a few months and, if so, why wasn't it noted? "

41

New Jersey Operation

- Does your state have a standardized tool to assess consumers utilizing the SPE? How and by whom was the tool developed?
  - The state is rolling out the implementation of a SAMS technology system which is intended to track individuals in a uniform manner. The system is only in place in some areas of the state and no data has been issued from the technology to date.

42

New Jersey Challenges

- What challenges or difficulties did your state encounter in your SPE process?
  - Swift and full implementation.
- What advice would you give to a group pursuing this?
  - Require specific timelines for the roll out. Have diligence in monitoring the progress the state is making. Establish measurement tools to evaluate success.
- Was there resistance to the SPE idea/process? If so who or what group resisted? How were issues resolved? What were the outcomes?
  - The issue has not been resolved. We continue to put pressure on the Commissioner of Health and Senior Services to make the roll out in all 21 counties a priority.

43

New Jersey Evaluation

- There have been no state studies of the success/failure of the pilot counties.
  - This is a significant problem in evaluating the success of the state's LTC plan.
- The state expects the new SAMS database system that is being rolled out gradually will begin to answer some of these questions.
  - However, it is not clear that the database can be manipulated in ways to address these questions.

44

New Jersey Education

- How did the state approach and educate the target population groups about SPE?
  - There has been virtually no $$**spending**$$ on outreach and education.
- Did the state specifically direct marketing efforts to consumers who were financially secure and/or consumers receiving public assistance?
  - No.

45

New Jersey Records

- Does the state utilize electronic health records in its SPE?
  - No.
- Are there recommendations about software, computer systems?
  - A commission has been established by a law that will review the use of e-HIT in New Jersey. To date, I do not think members have been appointed to this Commission.

46

Illinois background

- Illinois has not yet adopted a model for Single Point of Entry however there are three ADRC's running in the State and a number of other efforts around Illinois to improve access and awareness by having a coordinated entry point where people can find the services they need.
- There are three ADRC's running in Illinois, two are operated by an Area Agency on Aging and one is operated by a case management organization (CCU) for the HCBS Waiver program.
  - Currently the case management groups and AAAs both have members that feel they should be the single point of entry.
    - This disagreement is a big obstacle in moving forward on SPE at a state wide level.
  - Interestingly the other obstacle is that a number of organizations have made branding efforts in the past and going forward at a statewide level may feel like reinventing the wheel for those that have done some branding already.
- Outside of the ADRC's there are a number of other efforts that are related to SPE that may also help in this discussion

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Illinois background cont.

- The first is the City of Chicago's 311 senior services phone number that has been throroughly branded in Chicago and is identifiable by most seniors in the area. Since most older adults that need services in Chicago know that number, it acts as a single point of entry for the city.
- The West Central Illinois Area Agency on Aging in Quincy, Illinois led an effort to house most senior services in one building.
  - This is an excellent example of a physical site single point of entry. Within this one building they have the area agency on aging, adult day services, home care providers, a senior center, nutrition services, case management for waiver services and more.

48

Illinois Partners

- Who were the identified partners in design of the SPE (both formal and informal)?
- Who were the identified partners in implementation of the SPE (both formal and informal)?
- Who were your partners in the ongoing process of SPE?
  - *The AAAs and the CCUs have been involved. Of course, the Illinois Department on Aging as the ADRC grant recipient has been involved. Finally a few years back AARP and other groups put together and Older Adult Services Advisory Committee that advises agencies that provide services to older adults. One of the sub-committees that meets every other month is the Coordinated Point of Entry group that is composed of many different organizations many of them are from either a AAA or CCU but advocacy groups (including AARP), and academic groups participate in this subcommittee as well.*
- How did you coordinate information from other executive branch agencies?
  - *The advisory committee has been critical for this.*
- What internal process did you use to complete the work of establishing a single point of entry?
  - *It is not yet complete.*

49

Illinois Funding

- What were the funding sources identified to support the SPE design and implementation? Are hospitals and/or other entities that use these SPE resources for greater efficiency, deferring work to other entities and saving money helping fund the implementation or the ongoing operations? If so, what entities are helping with funding?
  - *This varies depending on where the individual effort is. Area Agencies on Aging have used many sources of funding to pursue single point of entry relate goals.*
- Were there funding "champions"? (I.e. Governor, legislator, etc.)
  - *Not at a state wide level individual projects may have some. For the ADRC sites the grant funds have been critical.*
- If state dollars were used, what strategies were used to inform the state legislature?
  - *Significant state funds were not specifically appropriated for these efforts.*
- What funding sources were used to support implementation of the SPE?
  - *ADRC grant funds and funds that local efforts were able to pull together from various sources.*
- What funding sources are used to support the ongoing operations of the SPE?
  - *It depends on the model. In most cases the operations fit for Information and Assistance Funding through the Older Americans Act or case management from the waiver program.*

50

Illinois Funding cont.

- What requirements do identified funding sources have? What have been the outcomes, negative and positive?
  - *If operating funds are mostly for operating information and assistance or case management, there is no financial incentive for branding and other site development efforts.*
- After implementation of the SPE, was there an increase in the number of clients who needed to access home and community-based services: If so, did the increase require additional funding to provide these services?
  - *We have not completed implementation statewide. There is not much information on this from individual sites.*
- Was any cost analysis completed regarding how much the State saved by having a SPE system in terms of delaying clients' needs for more costly institutional care options?
  - *No*

51

Illinois Process

- Did your state start with one target population and then roll out the SPE system to other targeted populations (for example: disabled, youth) – What were your state's lessons and insights? In hindsight, what could be done differently?
  - *Each ADRC site was different, they all served older adults but they chose different populations as a second group. One of them did developmental disbilities but I am not aware of rolling out to other populations. There are multiple state agencies that would be involved in serving mixed populations and the Department on Aging has been the only one to really buy into Single point of entry.*
- Did your state test the SPE by setting up a demonstration site? Were existing systems used?
  - *Yes we still have those demonstrations operating. The systems used are mentioned above.*

52

Illinois Process cont.

- *The Older Adult Services Act (included) was the act that established some direction on this and set up the advisory committee.*
- What role did federal level agencies, such as CMS or AoA, play in the establishment and ongoing operations of the SPE?
  - *With the ADRC sites they have provided a lot of guidance and the funding was important as well.*
- If your state has an ADRC grant, how were ADRC activities integrated into SPE processes?
  - *So far they have been well structured demonstrations and they have provided great examples of how to move forward.*

53

Illinois Operation

- What programs are included in the SPE program eligibility determination, for example, Medicaid state plan services, Medicaid HCBS wavier services, nursing facility, Older Americans Act programs/services, state-funded programs/services, and other?
  - *This depends on the site. The AAA sites have approached ADRC mostly as information as referral to the proper services and have not done much eligibility determination. They may have done some of the OAA services but there is not much that needs to be collected for eligibility determination.*
  - *The CCUs do eligibility determination for state HCBS waiver services and assisting other Medicaid services by assisting with Medicaid applications.*
- Does your state have a standardized tool to assess consumers utilizing the SPE? How and by whom was the tool developed?
  - *The subcommittee on Coordinated point of entry has discussed and worked on this but has not gotten anything concrete yet.*
  - *The CCUs have recently adopted a comprehensive assessment tool that is intended to determine eligibility for a wide range of services beyond just the waiver services. This is a sizable tool and it may not make sense to use this on every person that goes to the SPE*
- What are the hours of operation of the SPE?
  - *Depends on the site. I believe that most are standard business hours.*

54

Illinois Challenges

- What challenges or difficulties did your state encounter in your SPE process?
  - *Other than previously listed, the biggest challenges, in my opinion, are joining branding efforts and determining the organization that will be the SPE.*
- How did you tackle the challenges of streamlining the SPE system?
  - *Yet to be determined.*
- What advice would you give to a group pursuing this?
  - On a local level get the groups involved together on this early. If those groups develop a branding strategy it may be difficult to ask them to allow a unified brand to supercede the one they have already developed.
- Was there resistance to the SPE idea/process?
  - *Not the idea but there are still some issues with the process as mentioned above.*
- If so who or what group resisted? How were issues resolved? What were the outcomes?
  - *There have not been statewide resolutions but most of the individual demonstrations have not had too much trouble finding ways to work through those issues in their community.*

55

Illinois Evaluation

- Has access improved for the population identified/targeted?
  - *The individual sites have improved access.*
- Has empirical data been collected to verify outcomes?
  - *The ADRCs sites are collecting data but have not been released.*

56

Illinois Education/Marketing

- Who are the primary referral sources to the SPE and how did the state approach and educate the primary referral sources and targeted individuals about the SPE? (Physicians, faith communities, family, friends, neighbors, discharge planners, etc?)
  - *Varies by region.*
- How did the state approach and educate the target population groups about SPE?
  - *There has not been a single approach from the state level. This is mostly left to regional entities. The state has made some effort to brand a single point of entry but it has not yet succeeded.*
- Did the state specifically direct marketing efforts to consumers who were financially secure and/or consumers receiving public assistance?
  - *They have not done much but the emphasis has been mostly lower income consumers.*

57

Illinois Records

- Does the state utilize electronic health records in its SPE?
  - *No, but AARP is working on getting electronic health records within health care. Their use in HCBS services have only been discussed on a theoretical level.*
- Are there recommendations about software, computer systems?
  - *Not yet*
- Did the state create an information database to identify what services were being delivered to seniors (or target population group) and/or what services seniors (or target population group) need?
  - *Not yet. This has been another challenge. Some of the stakeholders have been using benefits checkup but there are data bases that the State has pursued. The outputs from the data bases they are pursuing are not yet clear.*

58

Nebraska background

- No real SPE, and no ADRC grant
- The Care Management Program (CMP) is probably as close as we have to a single point of entry program.
  - The program does not authorize funding for services. It assesses need, works with clients to develop a plan of care and then helps mobilize resources to implement that plan of care using formal and informal resources in the community.

59

Nebraska CMP background

- The program was initiated by area agencies on aging. The key to the enactment of legislation in 1987 was the election of an AAA staff member to the Unicameral. That person became the champion of the concept in the Legislature.
- The program started 1989. The administration was not particularly supportive of the program and didn't make implementation a priority.

60

Nebraska CMP background cont.

- The program struggled along, but was successful due to the efforts of the AAAs.
- Not much support for the program outside the aging network.
- Coordination with other program was facilitated when area agencies on aging were given the responsibility for providing the case management for the HCBS Waiver program in 2000.
  - Getting that step in place was done over the objections of the Medicaid agency which had been doing the case management.
  - Moving that function to the AAAs allowed for HCBS Waiver growth and provided some relief on Care Management caseloads.

61

Nebraska CMP funding

- CMP is primarily state-funded.
  - Neither Older Americans Act nor Medicaid funds are used (and no ADRC grant)
  - AAAs supplement program funding with discretionary state and local funding.
  - State funding provides optimal flexibility to serve everyone who needs to be served regardless of income level.

62

Nebraska CMP Process

- The CMP authorizing statutes say that it is for persons who need long-term care.
- Practically, since it is administered by area agencies on aging it is for older people who are not Medicaid eligible, but have low incomes.
  - Recently, the median age of a CMP client was 80.
  - 80% had incomes below 150% of poverty, but few are currently eligible for Medicaid. However, if admitted to a nursing facility, they would be eligible almost immediately.
  - A CMP demonstration was implemented prior to enactment of state legislation. When pre-admission screening was implemented, the enabling legislation called for two demonstration projects.
  - Nebraska has a fairly strong caregiver support network. There is a state-funded respite program. Those programs vary in the degree of integration with CMP.
  - There is a 211 system in the state which, in my opinion, has failed to make a significant impact.

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Nebraska CMP Operation: Care Managers & Standardized Tool

- Care managers will attempt to utilize any resource to develop and implement a plan of care. Since they cannot authorize services, they must be creative and often use informal services in the care plans.
  - If formal programs are used the client must go through the eligibility process for that program. In some instances (SSBG for example) the program has established a cooperative eligibility screening process with the CMP.
- The Care Management Program operates during normal business hours.
- There is a standardized tool that is used.
  - Original tool developed by the University of Kansas Medical Center.
  - In 1990s, the tool was revised by the Department on Aging in consultation with care managers to better elicit the information they needed to develop effective care plans.

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Nebraska CMP Operation cont

- One of the outgrowths of the CMP was legislation to require pre-admission screening for Medicaid-eligible applicants for nursing facility care.
  - Hospitals (specifically hospital social workers) were the primary opposition to PAS.
    - The work of the social worker is to discharge patients in a timely manner. A pre-admission screening process was viewed as an impediment to fulfilling that work.
    - PAS has staff on call on weekend

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Nebraska CMP Operation cont.

- CMP referrals come primarily through the aging network.
  - Plans early in the program's development to engage in an extensive publicity campaign, but the referrals started coming in and quickly tapped the capacity of the program.
  - I have concerns right now that the program is overextended. Some CM workers are following more than 100 individuals who need long-term care.
- CMP has a sliding fee scale reimbursement system.
  - Clients with income over 150% of poverty must pay a portion of the cost of the program. Those with incomes above 300% of poverty pay full cost.
  - Care management generally costs about $50 per hour. This statutory provision has resulted in the vast majority of the clients having incomes below 150% of poverty

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Nebraska CMP Evaluation

- In the early years of the program, as it was found that the program was having a positive effect in reducing nursing home overutilization, the Department on Aging prepared annual reports for the program that showed that counties where care management was used more extensively were experiencing a reduction in nursing facility utilization rates. While those where it was not being used were experiencing increased rates.

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Nebraska CMP Eval. cont.

- The CMP did increase demands for some services. Emergency response systems saw an increase in demand, along with the need for in-home supports. Most of the increased demand was in the IADL type of service.
- Cost analysis from Medicaid expenditure data:
  - Medicaid spending for long-term care for the 65+ population is $20 million less than what we would have expected it to be in FY-07 if spending had grown at the rate of inflation using FY-00 as a base year.
  - Medicaid spending for people over 65 grew 27.2% in FY-91 and an additional 20.2% in FY-92. That growth was driven by nursing home spending.
    - By gearing up the CMP, we began to turn the utilization of nursing homes down. Average annual growth in Medicaid spending for people over 65 from FY-85 to FY-96 was 12.0%. From FY-96 to FY-07 the average annual growth rate was 3.6%.

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Nebraska CMP Eval. cont.

- Access has been enhanced and independent living has been supported. Nebraska's nursing home population peaked in 1993 at 17,769. By 2006, the nursing home population had fallen to 13,804.
- The age group that has seen the steepest decline in utilization has been the 85+ age group. The under 65 utilization rate has actually increased, so there is a need to better address the needs of younger adults with disabilities.
- Streamlined access is difficult to measure. At various points in the development process we have looked at methods of addressing the most challenging access issues.
  - It is difficult for community-based long-term care providers who have to mobilize a variety of service providers to compete for the affection of hospital discharge planners, with nursing homes which provide a single point of contact and an immediate yes or no answer.
- One of the challenges is developing a supply of high quality independent contractors who can provide in-home IADL and ADL support. We have had legislation in the past two sessions to create a long-term care worker registry. The registry would provide a better means of identifying, recruiting, deploying, training and compensating in-home service workers, particularly in rural areas. I see that as the next step in the evolution of our system.

69

Nebraska Records

- A database was developed within the aging network to comply with AoA NAPIS reporting requirements.
  - The system was built out to try to provide management and planning information. It was a difficult build. (Unsure of its current status)

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Minnesota background

- See website: www.Minnesotahelp.info
- The Senior Linkage Line is very popular and well known to folks in Minnesota and to the extent that the Linkage Line refers people to this site, it will be well used for referrals to home and community based services for example.
- It appears as though the SPE has expanded beyond senior services, such as youth services, military services, etc. so it has the look and feel of being a true one-stop shop for services for folks if they are looking.

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Minnesota background cont.

- The challenge of course is to get people aware of the site and to get them looking at it. It still a challenge to increasingly make it a widely publicized resource. It has also gone through some renovations since its inception a couple of years ago, so I expect some of that will continue to shake out to make the website useful and popular to use.
- Minnesota has a very strong home and community based services structure and people become aware of the availability of these services in a number of ways. I believe at this time it is likely the county, or the folks who have immediate impact during crisis time that refer people to services. It is my impression that DHS is working toward getting people (county case workers, families, discharge planners, law/policy makers, etc) familiar with this site so it can be a truly one-stop shop, but it is also my impression that work needs to be done to get there in Minnesota.

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Minnesota Process

- Site was rolled out to seniors and recently expanded to include others.
- To my recollection there was a demonstration site.
- Minnesota does have a 211 system
- Minnesota receives funding from ADRC

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Minnesota Operation Senior LinkAge Line (info. from ’05 article)

- “As a senior or caregiver uses the online tool, he or she builds a self-care plan, which includes caregiver, community and home-based resources.
- The self-care-plan developer includes six questionnaires about memory loss, medicine, health insurance, housing and housekeeping, safety and security, and estate planning.
- Each area uses in-depth assessment questions that provide information to the community resource plan.”

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Minnesota Operation Senior LinkAge cont. (info. from ‘05 article)

- Minnesota… “is planning to work with hospital discharge planners and other health-care organizations.”
  - “With this information, it is hoped that the tool will be used to review care options, including home- and community-based types of services.”

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Minnesota Education/Marketing (info. from ’05 article)

- Senior Surf Days and similar programs
  - Community education to learn about the decision support tool as it is integrated in the overall curriculum for computer training.

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Minnesota ADRC project link w/ LTC Transparency

- Quality and Cost of LTC
- See included slide show

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Appendix G

Iowa's Roadmap to
Emergency Preparedness

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Roadmap to
Emergency Preparedness

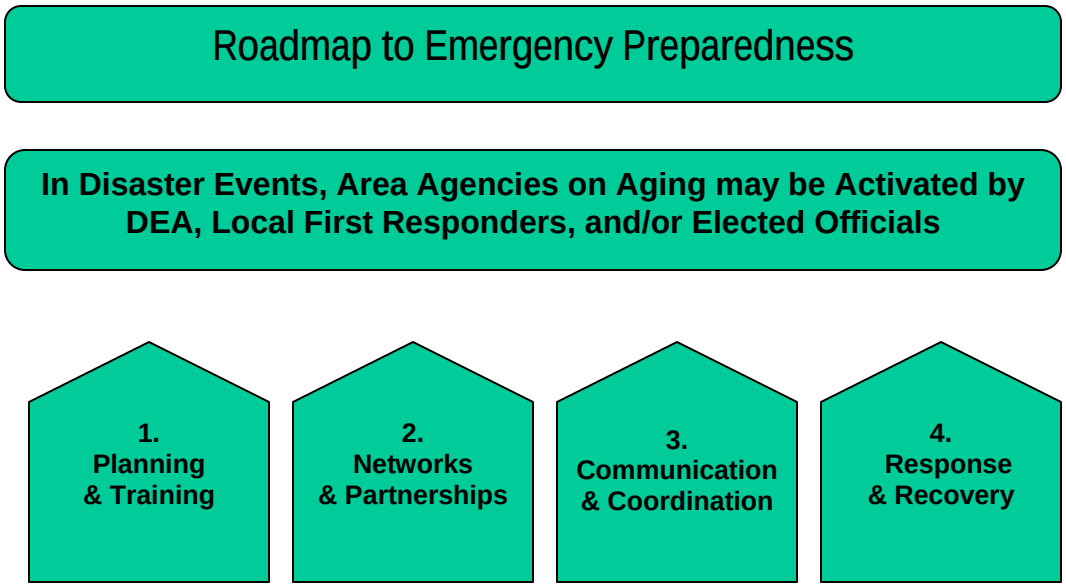
A Collaboration between
Iowa's Area Agencies on Aging and the
Department of Elder Affairs
February, 2009

Introduction All Iowans hope that we never have to go through disasters of the magnitude Iowa experienced in 2008. But if we do, we want to make sure we have documented a system that is useful to us and allows for the sharing of collective experience and knowledge with our strategic partners

The Roadmap to Emergency Preparedness is a collaborative effort by Iowa's Area Agencies on Aging (AAAs) and the Department of Elder Affairs (DEA) to strengthen collaboration and coordination in emergency preparedness, and response and recovery between nonprofits, businesses and government. It is based upon the four critical key component areas of (1) Planning and Training, (2) Networks and Partnerships, (3) Communication and Coordination, and (4) Response and Recovery.

Because one size does not fit all when it comes to emergency preparedness, the Roadmap provides a functional Check List for each of the four key component areas. This allows each AAA and DEA to utilize the action steps specific to its role in response to and recovery from disaster events.

Chronology of Response



Planning & Training The purpose of Planning & Training is to ensure that plans are developed, trained, and exercised to strengthen nonprofit emergency preparedness, and to engage similarly focused nonprofit and government partners.

It is important to gather some basic information before you write or revise a Continuity of Operations Plan (COOP). This may include, among other issues, the following information.

1. What is our role in Planning and Training?
2. Have regional Volunteer Organizations Active in Disaster (VOADS) agreed to principles of shared coordination? For example, have VOADS shared their member directories with AAAs or capacity matrix that shows each of their member organizations preparedness?
3. Are there county volunteer centers in our planning and service areas and how well did we work together during the most recent disasters to mobilize volunteers?
4. Do we annually update & test our Continuity of Operations Plan (COOP) to look for what works well and/or opportunities for improvement?
5. Do we make sure clients, consumers and partners are aware of our disaster services and resources?

Planning

Note: Refer to the Check List at the end of this section to select the planning elements useful to your AAA during a disaster event.

Cornerstone: A Continuity of Operations Plan (COOP)

1. Update existing COOP plan
    - Human Element
        - ✓ Clarify AAA chain of command
        - ✓ Select AAA Disaster POC
        - ✓ Update communication protocols
        - ✓ Educate staff (and family) on COOP
        - ✓ Evaluation and shelter-in place plan
        - ✓ Develop volunteer assistance plan
    - AAA Building Facilities & Alternate Facilities
        - ✓ Identify alternate operations facility
        - ✓ Identify mission critical services & programs
        - ✓ Organize service delivery plans
        - ✓ Secure IT systems
        - ✓ Secure client files, records & data base
        - ✓ Secure financial systems

Disaster Services

1. Identify and address gaps in services
   (Remember VOADS may have cataloged this information. Is it available to AAA?)
    - Identify areas of unmet needs before disaster strikes
        - ✓ Special Needs Shelters
        - ✓ Mental Health Needs, etc.
    - Identify the depth/breadth of potential service areas and resources
    - Identify AAA's current capacity to meet needs
    - Design a mechanism to get data and/or resources to emergency managers

Training The purpose of emergency training is to prepare AAA staff, local, and state emergency personnel, community volunteers, and leaders to respond in a comprehensive, coordinated effort to an emergency, to promote safety and the well being of citizens in the affected community, to establish and strengthen relationships among responders, and to ensure a safe and sustainable community.

Activities:

- Train AAA staff
- Participate in local, regional and/or state training exercises
- Test COOP
- Promote training among partners

PLANNING & TRAINING CHECK LIST

PLANNING

Update Existing COOP				
	Yes	**No**	**Complete**	**Comments**
Clarify AAA chain of command				
Select AAA disaster POC				
Update communication protocols				
Educate staff (& family) on COOP				
Evaluation & shelter-in-place plan				
Develop volunteer assistance plan				
Other				
Building Facilities & Alternate Facilities				
	Yes	**No**	**Complete**	**Comments**
Identify alternate operations facility				
Identify mission critical services				
Organize service delivery plans				
Secure IT Systems				
Secure client files, records, data base				
Secure financial systems				
Other				
Gaps in Services / Products **Have VOADS cataloged this information? Is it available to AAA**				
	Yes	**No**	**Complete**	**Comments**
Identify unmet needs before disaster strikes (special needs shelters; mental health)				
Identify Service Areas & Resources				
Identify Current Capacity/ Meet Needs				
Design Mechanism to get Resources to emergency managers				
Other				

TRAINING

	Yes	**No**	**Complete**	**Comments**
Train AAA staff				
Participate in training exercises				
Test COOP				

Promote regionally sponsored training among partners				
Other				

Networks & Partnerships The purpose of Networking and Partnerships is to encourage and strengthen collaborative planning among local and regional partners including business and industry, government and private sector partners to enable outreach for disaster events and to ensure the provision of goods and services.

Consider the following questions as Networks and Partnerships form:

1. What is our role in Networks and Partnerships?
2. Are government partners educated about our capacity and commitment to provide leadership and resources to older Iowans during a disaster?
2. Are local emergency managers aware of our capacity to help?
3. Have we considered creating or increasing the scope and scale of cooperative agreements (MOA/MOU), with government and private sector partners for emergency planning, response and recovery?

NETWORKS AND PARTNERSHIPS

Note: Refer to the Check List at the end of this section to select the planning elements useful to your AAA during a disaster event.

1. Define existing nonprofit service networks and relationships.

2. Record key contact for each partner.

3. Identify each partner's resources and tools to be utilized during disasters.
    - Acknowledge the resulting gaps in products and services.
    - Create a plan with partners about how gaps will be addressed.
    - Identify AAA's current capacity to meet needs.

4. Agree upon mechanism for information sharing among partners.

5. Agreements (as appropriate)
    - Inventory, strengthen or create existing agreements for coordination and support between core groups of nonprofit service providers.

NETWORKS & PARTNERSHIPS CHECK LIST

NETWORKS & PARTNERSHIPS

Identify existing local service networks				
	Yes	**No**	**Complete**	**Comments**
SEOC				
County EMAs, First Responders				
Local Law Enforcement				
Councils of Government				
Local Service Providers				
Churches, Food Pantries, Soup Kitchens				
Nursing Homes, Asst. Living Facilities				
Long Term Recovery Committee				

Identify existing regional networks				
	Yes	**No**	**Complete**	**Comments**
State Government				
National Guard / Military				
Other				

Identify existing national networks				
	Yes	**No**	**Complete**	**Comments**
Red Cross				
VOADS				
Federal Agencies				
Other				

PARTNERSHIPS

	Yes	**No**	**Complete**	**Comments**
Cooperative Agreements with partners Before federal declaration.				
Cooperative Agreements with partners after federal declaration. Examples: Provision of meals to responders, translator services.				
Capabilities / communications in place				
Other				

Communications & Coordination The purpose of Communications & Coordination is to provide an orderly flow of information before, during and after a disaster. The plan should facilitate necessary interactions and minimize unnecessary contacts during and after a disaster through careful planning, training and drilling. Backups and redundancies (both human and technological) are essential.

Consider the following questions as Communications & Coordination plans are developed:

1. What is our role in Communications & Coordination?
2. How can we maintain current contact information (both primary and backup) for all key individuals necessary to implement the disaster plan, both inside and outside our agency?
3. What information system will assure that contact information is available to those who need it at all times?
4. How do we establish contact with our consumer group during and after a disaster?
5. Are there clear expectations of what communications (internal and external) need to take place, when, how and by whom?

Note: Refer to the Check List at the end of this section to select the planning elements useful to your AAA during a disaster event.

Two arenas of AAA operations need a communication plan:

- **COOP** – Continuity of Operations Plan
  Purpose: To maintain essential services and restore all services as quickly and cost-effectively as possible.

- **Disaster Services** – expanded services to AAA consumer group
  Purpose: To help identify and resolve unmet needs in our consumer group.

Start with the question "What happens first?" Issues to consider in plan development include (both internal and external):

- Triggers and sequences of activities and contingency plans for breakdowns
- Roles & responsibilities and how they fit together
- Authorities & reporting

Designate appropriate communications technologies for preferred and back-up information sharing, such as:

- Telephone (land line or cell)
- Internet (email, website, IM, blogs, chat rooms)
- Mail ("snail mail")
- Message centers (physical locations)
- Personal contact (door-to-door)

A communications strategy covers interactions within the AAA's, as well as between the AAA and its vendors, partners, consumers and the DEA. The "Before Disaster" communications build our ability to react to disasters. "Response" communications enhance our effectiveness immediately before and after (and perhaps during) a disaster. "Recovery" communications enable us to assume an appropriate role in the long-term process of rebuilding our community. A comprehensive plan includes all of these areas.

COMMUNICATIONS & COORDINATION CHECK LIST

Before Disaster				
	Yes	No	Complete	Comments
Within AAA				
COOP				
Expanded disaster roles				
Training				
Distribution of Information				
With DEA				
Contacts & backup information				
Disaster plans				
Identification of resources				
With Consumers				
Special needs assessment				
Contact mechanism				
Strategy to distribute information				
With Partners				
Contact points with backups				
Hand-off & interaction plans				
Known gaps assessment				
Roles & capabilities				
Information sharing				
With Vendors				
Alternate contacts				
Contingency plans				
Backup suppliers				

Response to Disaster				
	Yes	No	Complete	Comments
Within AAA				
Backup contact information				
Roles, responsibilities & backups				
With DEA				
Access to advice & resources				
Authority issues				
Reporting requirements				
With Consumers				
Establishing contact				
Needs assessment				
Connect with resources				
With Partners				
Hand-offs				
Information sharing				
Advocacy				

With Vendors				
Assess capabilities				
Transmit needs				
Recovery from Disaster				
	Yes	**No**	**Complete**	**Comments**
Within Agency				
Roles & responsibilities				
Debriefing				
Reporting				
With DEA				
Advice & resources				
Authority				
Reporting				
With Consumers				
Follow-up contacts				
Needs reassessment				
Resource connections & hand-offs				
With Partners				
Hand-offs				
Information sharing				
Advocacy				
With Vendors				
Status updates				

Response The purpose of Response is to ensure that plans are implemented effectively to react to the community need as appropriate in relation to older adults and to take action within the scope and role of the AAA.

If you can answer the following questions, you are well on the way to developing a Response Plan:

1. What is our role in Response?
2. What can we expect from our key partners in the event of a disaster?
3. What expectations do we have of our staff and volunteers in the event of a disaster?
4. What is our agency capable of doing during a disaster?
5. What is our role in the region?
6. What assessment tools do we have in place and what resources do we have available to utilize?

Note: Refer to the Check List at the end of this section to select the planning elements useful to your AAA during a disaster event.

Key Components

1. Staff, volunteer and client safety is of first concern.

2. Initiate Communication Plan – internal & external.

3. Initiate internal COOP – such as determine Lead Staff Person with back up. Establish mobile office or at-home office scenario as needed.

4. Activate the key partners' emergency plans. Confirm actions are being taken.

5. Assessment of immediate needs for older adults – met and unmet.
    - Numbers and general location of senior citizens.
    - What needs are currently being met and by whom? What needs are not being met?
    - Availability and accessibility of services: Are roads clear? Traffic permitted? Is it safe to use private cars of volunteers? Are LIFTS, SEATS and/or other public transportation in operation?
    - Geographic scope of disaster.

6. Determine AAA role in the situation and assign resources accordingly.
    - Does the AAA have any available funds?
    - What urgent needs are not being met?
    - What needs can AAA and subcontractors address immediately?
    - Do resources need to be redirected?
    - What barriers exist and how can they be removed to get services to seniors as soon as possible?

7. Maintenance of Response
    a. Maintain communication with key partners on actions being taken by AAA, other key partners and assessment of needs.

b. Assessment of need should continue throughout response and into the recovery phase.

RESPONSE CHECK LIST				
Safe to Initiate Response Activity				
	Yes	**No**	**Complete**	**Comments**
Staff				
Volunteers				
Key Partners				
Operational Location (s)				
Activation of Plan Components				
	Yes	**No**	**Complete**	**Comments**
Internal COOP				
Communications				
Key Partners				
Assessment of Need				
	Yes	**No**	**Complete**	**Comments**
Identify Needs being met by other resources				
Identify Unmet Needs				
Determine Role				
	Yes	**No**	**Complete**	**Comments**
Allocation of Resources				
Maintenance of Response				
	Yes	**No**	**Complete**	**Comments**
Communication				
Assessment of Need & Available Resources				

Recovery The purpose of Recovery is to assure that needed services are identified, funding for the services is obtained, and service is provided. This means that the range of activities will vary from advocacy to the direct provision of services.

Questions important to consider:
1. What is our role in Recovery?
2. What needs are not being met?
3. What needs can we address immediately versus long term?
4. Do our resources need to be redirected?
5. What barriers exist and how can they be removed to get services to seniors?

RECOVERY

Note: Refer to the Check List at the end of this section to select the planning elements useful to your AAA during a disaster event.

1. Identify vulnerable elders that require special needs (mental health, shelters for disabled, etc.)
    - Collaborate with
        - ✓ IDEA
        - ✓ County EMA
        - ✓ FEMA
        - ✓ Long Term Recovery Committee
        - ✓ VOAD
        - ✓ Develop volunteer assistance plan
    - Assist in coordination of recovery efforts
    - Help identify potential funds, volunteer services, etc.
    - Determine available AAA resources
    - Actively advocate for affected elders
    - Provide information and referral service
    - Collaborate with partners to identify services and resources in gaps
    - Identify commonly needed services
    - Collaborate with partners (to avoid duplication of services)

2. Participate in review panel to determine who provides what services.

3. Participate in case management committee with partners (to identify unmet needs)..

4. Involve case managers as appropriate.

5. Post review of AAA actions after disaster event.

6. Conduct an ongoing assessment of need.

RECOVERY CHECK LIST

Recovery

Update Existing COOP				
	Yes	**No**	**Complete**	**Comments**
Clarify AAA chain of command				
Select AAA recovery POC				
Update communication protocols				
Educate staff (& family) on COOP				
Develop volunteer assistance plan				
Other				

Building Facilities & Alternate Facilities				
	Yes	**No**	**Complete**	**Comments**
Re-establish alternate operations facility				
Re-establish mission critical services				
Re-establish service delivery plans				
Re-establish IT Systems				
Re-establish client files, records, data base				
Re-establish financial systems				
Other				

Client Unmet Needs (immediate versus long term)				
	Yes	**No**	**Complete**	**Comments**
Chore services				
Legal services (insurance settlements, appeals)				
Transportation services				
Handyman services				
Meal programs				
Miscellaneous programs/assistance				
Other				

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Appendix H
Iowa Department on Aging
Commission Membership List

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Iowa Department on Aging Commission Membership List
2009

Name	Address		Telephone	E-mail	Term End
Dava James	104 Southwoods Dr	Nevada, IA 50201	641-752-7106 X207	dava.james@iavalley.edu	2011
Gloria Reber	104 Mildred Ave	Iowa Falls, IA 50126	641-648-6649	gloreber@aol.com	2012
Linda Larkin	1304 Avenue B	Fort Madison, IA 52627	319-372-8764	llarkin@agemark.com	2012
Nancy Nichols	6200 EP True Parkway #505	West Des Moines, IA 50266	515-221-3212	narnichols@yahoo.com	2011
Daniel Ernst	899 Mount Carmel	Dubuque, IA 52003	563-586-3721	ernstdan@mchsi.com	2013
Kenneth Petersen	242 Warren St	Council Bluffs, IA 51503	712-322-4846	kpetersen@aea13.org	2013
Frank Leu	1016 7th Street	Sibley, IA 51249	712-754-3935	fsleu@nethtc.net	2013
Sen Bill Heckroth (D)	1010 Ridgewood Blvd NW	Waverly, IA 50677	319-352-5149	Bill.heckroth@legis.state.ia.us	2011
Sen David Johnson (R)	P O Box 279 (877 Main St)	Ocheyedan, IA 51354	712-758-3280	David.johnson@legis.state.ia.us	2011
Rep Phyllis Thede (D)	2343 Hawthorne Court	Bettendorf, IA 52722	563-441-0630	Phyllis.thede@legis.state.ia.us	2011
Rep Dawn Pettengill (R)	P.O. Box 76 (303 East St)	Mount Auburn, IA 52313	319-610-3412	Dawn.pettengill@legis.state.ia.us	2011

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Appendix I
Area Agencies on Aging
List and Map of
Planning and Service Areas

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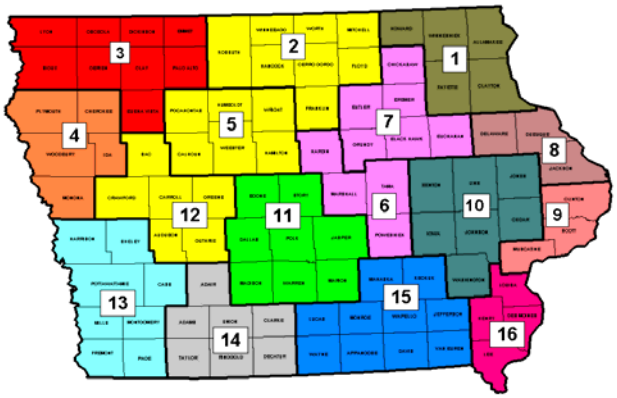
Appendix X

Iowa's Area Agencies on Aging



Area 1

Northland Agency on Aging
(private non-profit organization)
Bruce Butters, Director
808 River Street
Decorah, IA 52101
(563) 382-2941 or (800) 233-4603
Fax (563) 382-6248
mail@northlandaging.com

Area 2, 5 & 12

Elderbridge Agency on Aging
(private non-profit organization)
Lahoma Counts, Director
22 N Georgia, Suite 216
Mason City, IA 50401
(641) 424-0678 or (800) 243-0678
Fax (641) 424-2927
Fort Dodge (515) 955-5244 or
(800) 543-3280
Carroll (712) 792-3512 or (800) 543-3265
elderbridge@elderbridge.org

Area 3

Northwest Aging Association
(private non-profit organization)
Cynthia Beauman, Director
714 10th Ave. East
Spencer, IA 51301
(712) 262-1775 or (800) 242-5033
Fax (712) 262-7520
naa@nwaging.org

Area 4

Siouxland Aging Services, Inc.
(private non-profit organization)
Kim Keleher, Director
2301 Pierce Street
Sioux City, IA 51104
(712) 279-6900 or (800) 798-6916
Fax (712) 233-3415
siouxlandaging@siouxlandaging.org

Area 6 & 7

Hawkeye Valley Area Agency on Aging
(private non-profit organization)
Donna Harvey, Director
2101 Kimball Avenue, Suite 320
Waterloo, IA 50704
(319) 272-2244 or (800) 779-8707
Fax (319) 272-2455
hvaaa@hvaaa.org

Area 8

Scenic Valley Area Agency on Aging
(private non-profit organization)
Linda McDonald, Director
3505 Stoneman Road, Suite 4
Dubuque, IA 52002
(563) 588-3970, Fax (563) 588-1952
scenicaaa@aol.com

Area 9

Generations Area Agency on Aging
(private non-profit organization)
Marvin Webb, Director
935 E. 53rd
Davenport, IA 52807
(563) 324-9085, Fax (563) 324-9384
mwebb@genage.org

Area 10

Heritage Area Agency on Aging
(separate organizational unit)
Liz Selk, Director
6301 Kirkwood Blvd SW
PO Box 2068
Cedar Rapids, IA 52406
(319) 398-5559 or (800) 332-5934
Fax (319) 398-5533
elizabeth.selk@kirkwood.edu

Area 11

Aging Resources of Central Iowa
(private non-profit organization)
Joel Olah, Director
5835 Grand Avenue, Suite 106
Des Moines, IA 50312
(515) 255-1310 or (800) 747-5352
Fax (515) 255-9442
agingres@aol.com

Area 13

Southwest 8 Senior Services, Inc.
(private non-profit organization)
Barbara Morrison, Director
300 W. Broadway, Ste 240
Council Bluffs, IA 51501
(712) 328-2540 or (800) 432-9209
Fax (712) 328-6899
bmorrison@southwest8.org

Area 14

Area XIV Agency on Aging
(private non-profit organization)
Steve Bolie, Director
215 E. Montgomery
Creston, IA 50801
(641) 782-4040, Fax (641) 782-4519
areaxiv@iowatelecom.net

Area 15

Seneca Area Agency on Aging
(private non-profit organization)
Connie Holland, Director
117 North Cooper Street, Suite 2
Ottumwa, IA 52501
(641) 682-2270 or (800) 642-6522
Fax (641) 682-2445
senecaaaa@seneca-aaa.org

Area 16

Southeast Iowa Area Agency on Aging, Inc
(private non-profit organization)
Dennis Zegarac, Director
509 Jefferson Street
Burlington, IA 52601-5427
(319) 752-5433 or (800) 292-1268
Fax (319) 754-7030
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Appendix J
Organizational Chart
for Iowa Department on Aging

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IOWA DEPARTMENT OF ELDER AFFAIRS
TABLE OF ORGANIZATION (March 2009)

John McCalley
Director

Commission
Iowa Department of Elder Affairs

Greg Anliker
Policy & Administration
Division Administrator-PSE 3

- **Jeff Batz** — Accountant-Acct3
- **Mark Fetter** — Acct Tech-AT3
- **Sandra Hockett** — Acct Tech-AT2
- **Dixie Daniels** — Acct Tech-AT1
- **Janet Eisenbarth** — Secretary-Sec2
- **Dick Harmon** — Statistical Analyst-SRA3
- **Minnie Mallard** — Program Eval-EO2
- **Debi Meyers** — Case Mgmt Research-MA3
- **Stephen Johnson** — Info Tech Specialist-IT2
- **Sue Olson** — Program Evaluation-PP3
- **Judy White** — Case Mgmt-PP3

Joel Wulf
Elder Programs & Advocacy
Division Administrator-PSE 3

- **Mary Anderson** — Resource Ctr Project-EO2
- **Terry Hornbuckle** — Employment-EO2
- **Vacant** — Comm Services Coord-EO2
- **Carlene Russell** — Nutrition Program Mgr-EO2
- **Kay Corriere** — Comm Health Consultant
- **Nicki Stajcar** — Consumer Protect/Edu-EO1
- **Linda Hildreth** — Elder Abuse/Prev-EO1
- **Carolyn Danielson** — Events Coordinator-AA2
- **Deanna Clingan-Fischer** — Legal Services-EO2
- **Kimberly Murphy** — Sub Decision Maker-Atty1
- **Sherri Pollard** — Sub Decision Maker-Paralegal

Jeanne Yordi
Long Term Care Ombudsman
Ombudsman-PSE 2

- **Tonya Amos** — Ombudsman-LTCO
- **Kim Cooper** — Ombudsman-LTCO
- **Carol DeBoom** — Ombudsman-LTCO
- **Vacant** — Ombudsman-LTCO
- **Vacant** — Ombudsman-LTCO
- **Julie Pollock** — Ombudsman-LTCO
- **Pam Railsback** — Ombudsman-LTCO
- **Kim Weaver** — Ombudsman-LTCO
- **Katie Mulford** — Ombudsman Asst-AA2
- **Shirley Taylor** — Secretary-Sec1

Danika Welsch
Executive Secretary

- **Machelle Shaffer** — Communication PIO-EO2
- **Lisa Burk** — Legislative Liaison-EO2
- **Nancy Exline-Downing** — Rules Writer-EO2
- **Vivone Abdel-Razeq** — Human Resources-HRA

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Appendix K
Profile of Older Iowans,
Selected Population Characteristics

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Profile of Older Iowans
Selected Population Characteristics

	Number	Percent
Age (2008 est.)		
60-64	151556	5.0%
65-74	213,534	7.1%
75-84	152,321	5.1%
85 and over	78,699	2.6%
Total 65+	444,554	14.8%
Ethnicity, Age 65+*		
White	432,106	97.20%
Black	4,446	1%
Hispanic	4,001	0.90%
Asian/Pacific Islander	2,667	0.60%
Other	1,334	0.30%
Adults 65+ At or Below the Federal Poverty Level*	34,231	7.70%
Median Household Income	$29,228	
Adults 65+ Living Alone *	144,035	32.4%
Disability Status, Non-institutionalized Adults Age 65+ (2007 est.)		
One of more types of disabilities	146,398	33%
No disabilities	298,156	67%
Marital Status, Adults 65+ *		
Married	255,174	57.40%
Widowed	136,478	30.70%
Other	52,902	11.90%
Adults 65+ in the Labor Force in 2007	74,299	17%
Adults 65+ who were born in Iowa and still living in Iowa in 2006	336,972	75.80%
Adults 60+ Raising Grandchildren*	4,173	0.70%

Sources: Houser, A., Fox-Grage, W. & Gibson, M. *Across the States 2009: Profiles of Long-Term Care and Independent Living*. (2009, March). Washington, DC: AARP. State Data Center of Iowa and the Iowa Department of Elder Affairs. (2008). *Older Iowans: 2008*. Retrieved May 29, 2009, from http://www.state.ia.us/elderaffairs/Documents/OlderAmericansMonth2008.pdf.

* 2007estimated percent updated utilizing 2008 65+ or 60+ base.

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Appendix L
Profile of Iowans Served through Title III Programs, State Fiscal Year 2008

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Profile of Iowans Served Through Title III Programs
State Fiscal Year 2008

	Number of Unduplicated Clients	Percent
Total Clients who received one or more services (Unduplicated)	80,908	
The number of clients and calculated percentages below represent only those registered clients who reported the applicable demographic data.		
Age		
Under 60	1,841	3%
60-65	4,130	7%
65-74	15,762	26%
75-84	23,508	38%
85+	15,958	26%
Ethnicity		
White	55,332	97%
Black/African-American	1,070	1.7%
Hispanic	413	0.7%
Asian	351	0.6%
Other	31	0.1%
Clients Below the Federal Poverty Level	17,922	30%
Clients Living Alone	32,231	55%
Clients Living in Rural Areas	38,539	65%
Clients With Impairment in Activities of Daily Living (ADL)		
One ADL	803	1%
Two ADLs	947	2%
Three ADLs	23,473	41%
No assistance needed	32,372	56%

Impairment in Activities of Daily Living (ADL) is defined as the inability to perform one or more of the following six activities of daily living without personal assistance, stand-by assistance, supervision or cues: eating, dressing, bathing, toileting, walking, and transferring in and out of bed/chair.

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Appendix M
Intrastate Funding Formula
and Resource Allocation Plan

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Iowa Department on Aging
Intrastate Funding Formula and Resource Allocation Plan

Funding Formulas: State Elderly Services and Older Americans Act Allocations. Available state general fund dollars and federal Older Americans Act Title III funds are allocated to the Department and passed on to Area Agencies on Aging on the basis of the number of persons 60 and older, number of 60+ minorities, and double-weighted for persons 60+ at or below the poverty level in each planning and service area.

Senior Living Program Allocations. Available resources from the Senior Living Program are allocated to each Area Agency on Aging utilizing through a formula that triple weights individuals a) 75 years of age and older, b) 60 and older who are members of a racial minority, c) 60 years of age and older who reside in rural areas, d) 60 years of age and older who have incomes at or below the official poverty guideline as defined each year by the federal Office of Management and Budget and adjusted by the Secretary of the U.S. Department of Health and Human Services, and single weights individuals 60 years of age and older.

NSIP Allotments. Area Agencies on Aging will receive a portion of the NSIP allotment to the state based on the proportion that an area's eligible meals bear to the total of NSIP eligible meals for all area agencies.

Rural Cost: Iowa is a rural state and its rural status is addressed in Iowa's Intrastate funding formula. There are only 10 counties of Iowa's 99 that are considered to be a Statistical Metropolitan Area. The Senior Living program, established in October of 2000, addresses the needs of persons living in rural areas with low or moderate income.

Home and Community Based Service Unmet Needs Funding Distribution. The initial disbursement of the Home and Community Based Service Unmet Service funds shall be based on official unmet needs data reported for active Case Management consumers due to inadequate funding or no funding as of June 30, 2009 and statewide weighted average unit costs for those services

based on the official financial data for the 2008 fiscal year. Each Area Agency on Aging will receive a proportionate share of the funding represented by their unmet service needs multiplied by the statewide average unit cost across all Home and Community Based Service services.

The Funding Allocation Formula appears in Table 3 on the page below as well as Tables for the following information:

Table 4 Title III Allotments to Area Agencies on Aging for State Fiscal Year 2010

Table 5 FY 2010 AAA Federal Title III Funding Allotment Planning Projections

Table 6 Total Title III Administration & Program Funding

Table 7 FY 2010 AAA Federal NSIP Funding Allotments

Table 8 FY 2010 Area Agency State Appropriations Allotment Planning Projections

Table 3. Funding Allocation Formulas		
Intrastate Funding Formula	**Factor**	**Weight**
Title IIIB, C(1), C(2), E and State Elderly Svcs.	Persons aged 60 & older	1
	Minority persons aged 60 & older	1
	Persons aged 60 & older living at or below the poverty level of income	2
*Title III Admin incl. in Alloc.	AAA Block [greater of $24K/AAA or .25% of Total Title III Alloc./AAA] AAA Block [greater of $4K/County or .04% of Total Title III Alloc./County]	
Title IIID	Persons aged 60 & older living at or below the poverty level of income	1
	Medically underserved persons aged 60 & older	1
Nutrition Service Incentive Program	**Factor**	**Weight**
NSIP	Meals Served	1
State Senior Living Program Funding Formula	**Factor**	**Weight**
Senior Living	Persons aged 60 & older	1
	Rural persons aged 60 & older	3
	Persons aged 60 & older living below the poverty level of income	3
	Minority persons aged 60 & older	3
	Persons aged 75 & older	3
State Case Management Program for the Frail Elderly	**Factor**	**Weight**
CMPFE	Persons aged 60 & older	1
	AAA Block [$45,000]	
State Unmet Needs	**Factor**	**Weight**
HCBS	Identified unmet needs for home & community based service units	1

Table 4. Title III Allotments to Area Agencies on Aging For State Fiscal Year 2010

-	TITLE IIIB	TITLE IIIC-1	TITLE IIIC-2	TITLE IIID	TITLE IIID Med Mgmt	TITLE IIIE	TOTAL ALL
ACTUAL FFY 2009 FEDERAL ALLOCATION	4,271,207	5,142,483	2,263,072	169,176	60,753	1,753,607	13,660,298
STATE ADMINISTRATION (5.00% OF FED ALLOC)	213,560	257,124	113,154	11,496	0	87,680	683,014
OMBUDSMAN	107,209						107,209
ACTUAL SFY 2010 AAA PLAN ALLOTMENTS TO AAAs	3,950,438	4,885,359	2,149,918	157,680	60,753	1,665,927	12,870,075

Table 5. FY 2010 AAA Federal Title III Funding Allotment Planning & Projections

Area Agency		Title III Administration Funding				
	Total Title III	Total Admin	Title III B	Title III C(1)	Title III C(2)	Title III E
Northland	$499,552	$ 70,953	$ 22,155	$ 27,398	$ 12,057	$ 9,343
Elderbridge	1,742,166	183,003	57,142	70,666	31,098	24,097
Northwest Aging	747,451	98,661	30,807	38,097	16,766	12,991
Siouxland Aging	710,339	77,592	24,228	29,962	13,185	10,217
Hawkeye Valley	1,449,723	124,790	38,965	48,187	21,206	16,432
Scenic Valley	600,688	64,085	20,010	24,746	10,890	8,439
Generations	957,489	75,164	23,470	29,024	12,773	9,897
Heritage	1,369,816	107,827	33,669	41,637	18,323	14,198
Aging Resources	2,180,712	137,593	42,963	53,131	23,381	18,118
Southwest 8	871,136	97,367	30,402	37,598	16,546	12,821
Area XIV	393,259	77,468	24,189	29,914	13,164	10,201
Seneca	794,410	104,878	32,748	40,498	17,822	13,810
Southeast Iowa	553,334	67,626	21,116	26,113	11,492	8,905
Total Allocation	$12,870,075	$ 1,287,007	$ 401,864	$ 496,971	$ 218,703	$ 169,469

Table 6. Total Title III Administration & Funding Program

	Title III B		Title III C(1)		Title III C(2)		Title III D	=	Title III D	+	Title III D Med Mgmt		Title III E
Northland	150,996	$	186,731	$	82,175	$	15,974	$	11,531	$	4,443	$	63,676
Elderbridge	530,196		655,674		288,545		44,164		31,881		12,283		223,587
Northwest Aging	229,976		284,402		125,158		10,933		7,892		3,041		96,982
Siouxland Aging	218,691		270,447		119,016		9,962		7,191		2,771		92,223
Hawkeye Valley	445,482		550,912		242,442		23,024		16,620		6,404		187,863
Scenic Valley	182,734		225,980		99,448		15,465		11,164		4,301		77,061
Generations	295,679		365,655		160,915		10,550		7,616		2,934		124,690
Heritage	425,179		525,803		231,392		8,141		5,877		2,264		179,301
Aging Resources	677,754		838,153		368,849		10,142		7,321		2,821		285,814
Southwest 8	267,654		330,998		145,664		13,948		10,069		3,879		112,872
Area XIV	115,675		143,051		62,953		22,799		16,458		6,341		48,781
Seneca	242,471		299,855		131,958		17,874		12,903		4,971		102,252
Southeast Iowa	167,951		207,698		91,403		15,457		11,157		4,300		70,825
Total Allocation	3,950,438	$	4,885,359	$	2,149,918	$	218,433	$	157,680	$	60,753	$	1,665,927

Table 7. FY 2010 AAA Federal NSIP Funding Allotments

Area Agency	FFY'08 Proportion		FFY'09 Total NSIP		FY 2010 Commodity Election		FY 2010 Cash
Northland	3.8368%	$	74,133	$		$	74,133
Elderbridge	18.3220%		354,009				354,009
Northwest Aging	5.7142%		110,407				110,407
Siouxland Aging	5.3632%		103,626				103,626
Hawkeye Valley	6.6560%		128,604				128,604
Scenic Valley	3.8274%		73,951				73,951
Generations	3.7201%		71,878				71,878
Heritage	15.9821%		308,799				308,799
Aging Resources	19.6179%		379,049				379,049
Southwest 8	4.0990%		79,198				79,198
Area XIV	4.0358%		77,977				77,977
Seneca	6.9193%		133,692				133,692
Southeast Iowa	1.9063%		36,832				36,832
Total Allocation	100.0000%	$	1,932,155	$	0	$	1,932,155

Table 8. FY 2010 Area Agency State Appropriations Allotment Planning Projections

Area Agency	Total Elderly Services	=	Elderly Services: AAA Case Mgt.	+	AAA Eld Svcs General	=	AAA Other Svc (Block)	+	AAA Other Svc (Formula)
Northland	$ 92,307		$ 74,182		$ 18,125		$ 8,500		$ 9,625
Elderbridge	199,687		155,849		43,838		8,500		35,338
Northwest Aging	115,126		91,748		23,378		8,500		14,878
Siouxland Aging	113,057		90,030		23,027		8,500		14,527
Hawkeye Valley	176,707		137,840		38,867		8,500		30,367
Scenic Valley	102,411		81,755		20,656		8,500		12,156
Generations	135,973		107,139		28,834		8,500		20,334
Heritage	175,431		137,685		37,746		8,500		29,246
Aging Resources	247,300		191,380		55,920		8,500		47,420
Southwest 8	126,496		100,273		26,223		8,500		17,723
Area XIV	80,548		65,214		15,334		8,500		6,834
Seneca	115,731		91,564		24,167		8,500		15,667
Southeast Iowa	98,017		78,549		19,468		8,500		10,968
Total Allocation	$ 1,778,791		$ 1,403,208		$ 375,583		$ 110,500		$ 265,083

	Total Senior Living Program & Admin	=	Senior Living Base: Program & Admin	Senior Living Base: Admin	+	Senior Living Supplemental Program	+	Senior Living Case Mgmt Minimum Support: Program & Admin	Senior Living Case Mgmt Minimum Support: Admin
Northland	$ 245,565		$ 185,159	$ 12,961		$ 7,805		$ 52,601	$ 3,682
Elderbridge	868,387		642,082	44,946		43,899		182,406	12,768
Northwest Aging	390,630		296,217	20,735		10,262		84,151	5,891
Siouxland Aging	304,433		212,842	14,899		31,126		60,465	4,233
Hawkeye Valley	644,675		468,309	32,782		43,326		133,040	9,313
Scenic Valley	240,585		170,674	11,947		21,425		48,486	3,394
Generations	356,570		232,555	16,279		57,950		66,065	4,625
Heritage	592,787		419,363	29,355		54,289		119,135	8,339
Aging Resources	928,205		667,579	46,731		70,977		189,649	13,275
Southwest 8	401,555		295,414	20,679		22,218		83,923	5,875
Area XIV	174,866		131,065	9,175		6,567		37,234	2,606
Seneca	363,945		271,187	18,983		15,718		77,040	5,393
Southeast Iowa	252,969		185,759	13,003		14,438		52,772	3,694
Total Allocation	$ 5,765,172		$ 4,178,205	$ 292,475		$ 400,000		$ 1,186,967	$ 83,088

Appendix N
Public Hearing Documents

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Iowa Department of Elder Affairs

NOTICE OF PUBLIC HEARING

Public Hearing on the State Plan on Aging

Tuesday, June 16, 2009

Holiday Inn Downtown at Mercy Campus, North View Room

Des Moines

2:45PM- 3:15PM

A public hearing will be held on Tuesday, June 16, 2009 at the Holiday Inn Downtown/Mercy Campus, North View Room, located at 1050 6th Avenue, Des Moines. The hearing is to discuss the State Plan on Aging - a required document of the U.S. Administration on Aging (AoA.)

Those wishing to attend the meeting and speak to the State Plan on Aging will have an opportunity to do so during this public hearing. The public hearing will be held from 2:45PM – 3:15PM. The hearing is being held in conjunction with the regularly scheduled Elder Affairs Commission meeting.

###

IOWA DEPARTMENT OF ELDER AFFAIRS
Jessie Parker Building
510 East 12th Street, Suite 2
Des Moines, IA 50319-9025

PUBLIC HEARING

State Plan on Aging - FFY 2010-2013
Holiday Inn Downtown Mercy Campus
1050 6th Avenue, Des Moines, IA

June 16, 2009

Agenda

Welcome	John McCalley
Record of Attendance	
Purpose of Public Hearing	
State Plan on Aging FFY 2010-2013	
Public Input	
Adjournment	

IOWA DEPARTMENT OF ELDER AFFAIRS
Jessie Parker Building
510 East 12th Street, Suite 2
Des Moines, IA 50319-9025

PUBLIC HEARING
State Plan on Aging – FFY 2010-2013
Holiday Inn Downtown Mercy Campus
1050 6th Avenue, Des Moines, IA
June 16, 2009

PLEASE SIGN IN

NAME	ADDRESS	CITY/STATE/ZIP
Greg Anlikin	6715 Elmcrest	Windsor Heights 50324
Jeanine Yordi	1520 Birch St	Norwalk IA 50211
[illegible]	2301 Pierce St	Sioux City, IA 51104
Sue Norem	1730 28th ST, ~~WDM, IA 50266~~	WDM, IA 50266
Cynthia Beaumont	1102 St Luke Dr #204	Spencer IA 51301
Joe WOLF	510 E 12th St, DM IA 50319	
Danika Welch	510 E 12th St, DM IA 50319	
Lisa Burk	510 E 12th St, DM, IA 50319	
John McCalley		
Dawn Pettengill		
Dana James		
Nancy Nichols		
Dan Ernst		
Gloria Reben		
Ken Petersen		
Linda Larkin		
Frank Ley		
Phyllis Thede		

IOWA DEPARTMENT OF ELDER AFFAIRS
Jessie Parker Building
510 East 12th Street, Suite 2
Des Moines, IA 50319-9025

PUBLIC HEARING SUMMARY
State Plan on Aging - FFY 2010-2013
Holiday Inn Downtown Mercy Campus
1050 6th Avenue, Des Moines, IA

June 16, 2009

The Public Hearing for the Iowa Department on Aging's State Plan on Aging for FFY 2010-2013 was held June 16, 2009. A record of attendance is attached to the State Plan.

Sue Olson provided an overall of the Plan including a discussion about the Administration on Aging's Program Instruction that informs the development of the Plan as well as the Code of Iowa, which directs the submission of the Plan.

John McCalley gave a detailed look at the Plan's Focus Areas, which included Elder Rights Protection Activities, Disaster Preparedness, Health Care System Coordination and Project 2020.

Commission Chair Dan Ernst invited comments from the public. Being none, he asked for a motion to accept the State Plan on Aging for FFY 2010-2013. Commission members seconded the motion, and the State Plan on Aging was accepted and approved by the Commission.

Iowa Department on Aging Director John McCalley and Iowa Commission on Aging Chair Dan Ernst signed and dated the Verification of Intent.

Iowa
State Plan on Aging
FFY 2010 to 2013
Balancing Long-Term Care for Aging Iowans

510 E 12th St, Ste. 2
Des Moines, IA 50319

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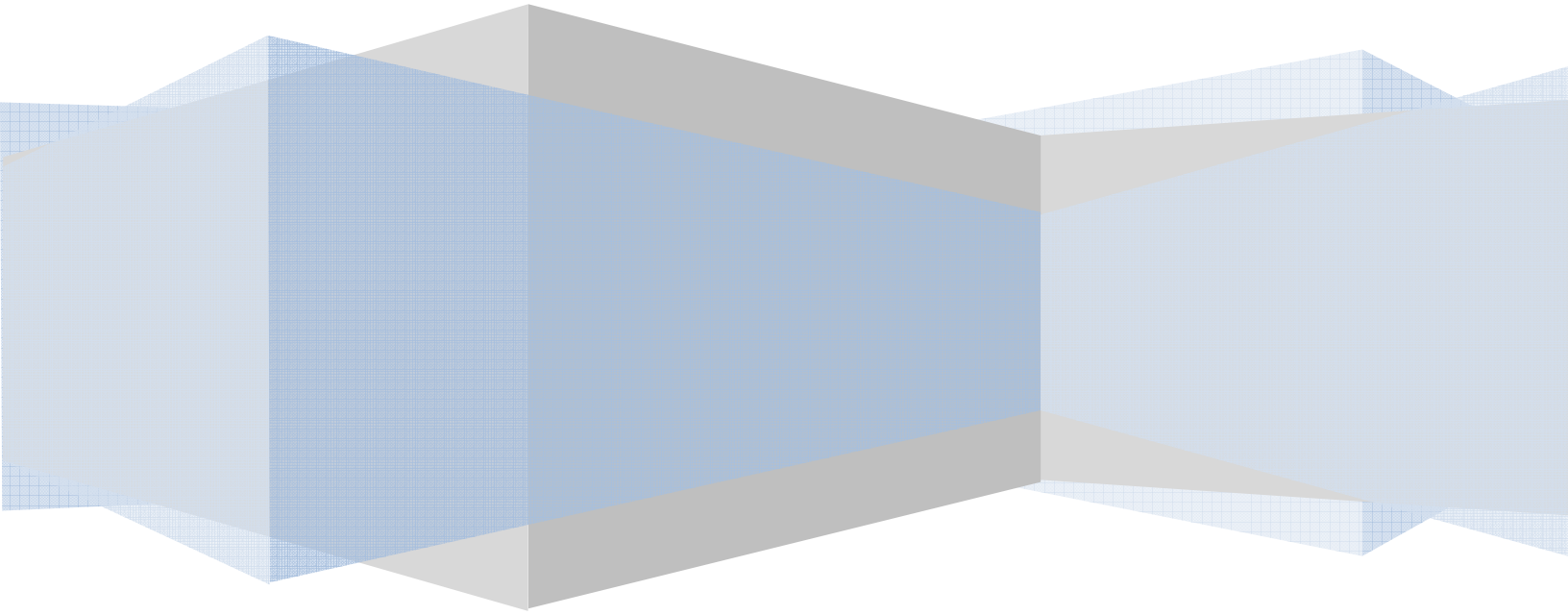
E-mail: John.mccalley@iowa.gov

For additional information on the Iowa Department on Aging visit the Web site at: http://www.iowa.gov/elderaffairs/