ATTACHMENT Q1

DISTRICT OF COLUMBIA OFFICE ON AGING
ORGANIZATIONAL CHART

OFFICE OF THE EXECUTIVE DIRECTOR

Laura Newland
Executive Director

Commission on Aging

Sara Tribe Clark, LCSW
Associate Director of ADRC

Gerald Kasunic
Deputy Associate Director of ADRC

Garret King, J.D.
Chief of Staff

Michael Kirkwood
General Counsel

Tanya Reid
Executive Assistant

Brian Footer, MPA
Director of Policy, Planning, & Evaluation

Olamide Ogbara
Resource Allocation Officer

Aurora Delespin-Jones
Program Manager

Karen Dorbin
Director of Communications

AGING & DISABILITY RESOURCE CENTER (ADRC)

Information & Referral Assistance Supervisor
Dominique Vinson

Customer Services Community Specialist
Vadonia Mallory

Customer Service Communications Specialists
Sherri Ellerbe, MA
Luanne Greenaway
Jennifer Witherspoon
Nia Pride
Janeashia Williams
Elicitia Cleveland
Vacant (1)

Medicaid Enrollment Supervisor
Lourdine Jean-Francois, LCPC

Medicaid Enrollment Specialists
Mia Butler
Becky Hazlett
Katrice Jefferson
Shante Trumpet
Charlotte Morgan
Natasha Webb
Maria Ellis
Brittney Dorsey

Supervisory Social Workers
Felicia Cowser, MSW, LICSW
Christian Tamasco, LICSW

Transition Care Specialists
Ramona Butler, LGSW
Melanie Gilliam, LGSW
Vanessa Hicks-Edwards, MSW, LGSW
Rolanda Wray, LGSW
Jasmine Wilson, LGSW
Angela Fields
Joel Lucas
Vacant (1)

Transition Case Managers
Mary McLain
Shameaka Mason

Transition Coordinator
Ekundayo Akinola
Emma Baxter
Vacant (1)

Management Assistant
Elizabeth Njuguna

Program Coordinator
Sakena McWright
Margaret Woods

Housing Coordinator
Plathon Watson

Public Health Analyst
Gwendolyn Noonan-Jones, MSW, LGSW

Social Worker
Mayra Vasquez

Receptionist
Antonette Dozier

Staff Assistants
Mamie Garrett

POLICY, PLANNING, & EVALUATION

Data Quality Assurance Coordinator
Aweke Wudineh

Budget & Finance

Resource Allocation Analysts
Nkwenti Sanga, Ms.M, MA
Regat Hagos, MBA
Charrise Baylor

Financial & Grants Specialist
Vacant (1)

Medicaid Claims Specialist
Vacant (1)

GENERAL SERVICES

Management Liaison Specialist
Jennifer Jenkins

IT Specialist
Yolanda Lyles

Facility Services Specialist
Samuel L. Taylor, Jr.
Nigel A. John

PROGRAMS & BUDGET

Program Analysts
Maxine Crowder
Lynn Khoo
Jennifer Adu

Public Health Nutritionists
Jacqueline Geralnick, MPH, RD
Gargi Parikh, MPH, RD, CDE

Research and Grants Analyst
Vacant (1)

Special Projects Coordinator
Linda Irizarry, LGSW, CIRS-A/D

Program Coordinator
Kay-Anne Spence

Staff Assistant
Mary Thompson

EXTERNAL AFFAIRS/COMMUNICATION

Community Relations Specialist
Krystal Branton, M.Ed., MSW

Community Relations Coordinator
Brittany Donald

Customer & Information Service Specialist
Darlene Nowlin

Community Outreach Specialist (Team Lead)
Alice Thompson

Community Outreach Specialist
Mark Bjorge

MFP Community Outreach Specialist
Vacancy (1)

ATTACHMENT Q2 - SCHEDULE A

Title	Name	Division	Hire Date	Vac Stat	Grade	Step	Series	Salary	Fringe	Job Status
Associate Director, ADRC	Tribe Clark,Sara	Aging and Disability Resource Center	5/19/2014	F	14	0	0101	$ 113,300.00	$ 22,886.60	Reg
Clerical Astt. Receptionist	Dozier,Antonette D	Aging and Disability Resource Center	1/7/2008	F	7	7	0303	$ 47,205.00	$ 9,535.41	Reg
Customer Service Commucat Spec	Ellerbe,Sherri A	Aging and Disability Resource Center	1/26/2015	F	11	2	0301	$ 58,673.00	$ 11,851.95	Term
Medicaid Enrollment Specialist	Hazlett,Becky L	Aging and Disability Resource Center	5/11/2015	F	11	2	0301	$ 58,679.00	$ 11,853.16	Term
Medicaid Enrollment Specialist	Butler,Mia	Aging and Disability Resource Center	5/11/2015	F	11	2	0301	$ 58,743.00	$ 11,866.09	Term
Medicaid Enrollment Specialist	Pride, Nia	Aging and Disability Resource Center	2/22/2016	F	11	2	0301	$ 58,679.00	$ 11,853.16	Term
Medicaid Enrollment Specialist	Trumpet,Shante	Aging and Disability Resource Center	9/8/2015	F	11	2	0301	$ 55,195.00	$ 11,149.39	Term
Medicaid Enrollment Specialist	Jefferson,Katrice L	Aging and Disability Resource Center	5/11/2015	F	11	2	0301	$ 58,679.00	$ 11,853.16	Term
Medicaid Enrollment Specialist	Ellis, Maria	Aging and Disability Resource Center	3/1/2016	F	11	1	0301	$ 56,852.00	$ 11,484.10	Term
Medicaid Enrollment Specialist	Webb, Natasha	Aging and Disability Resource Center	3/7/2016	F	11	1	0301	$ 56,852.00	$ 11,484.10	Term
Medicaid Enrollment Specialist	Dorsey, Brittany	Aging and Disability Resource Center	3/7/2016	F	11	1	0301	$ 56,852.00	$ 11,484.10	Term
Medicaid Enrollment Specialist	Morgan, Charlotte	Aging and Disability Resource Center	10/14/2014	F	11	3	0301	$ 60,506.00	$ 12,222.21	Term
Customer Svcs Commucat Spec		Aging and Disability Resource Center		V					$ -	Term
Customer Svcs Community Spec	Crawford Mallory,Vadonia M	Aging and Disability Resource Center	2/2/1998	F	11	6	0301	$ 65,987.00	$ 13,329.37	Reg
Deputy Associate Director, ADRC	Kasunic,Gerald M	Aging and Disability Resource Center	10/20/2014	F	13	0	0101	$ 90,259.00	$ 18,232.32	Reg
Housing Coordinator	Watson,Plathon	Aging and Disability Resource Center	1/13/2014	F	12	3	1101	$ 74,711.00	$ 15,091.62	Term
Information, Referral and Assi	Vinson,Dominique K.	Aging and Disability Resource Center	9/22/2014	F	13	0	0301	$ 86,660.00	$ 17,505.32	Reg
Medicaid Enrollment Supervisor	Jean-Francois,Lourdine C	Aging and Disability Resource Center	5/20/2013	F	13	0	0301	$ 86,660.00	$ 17,505.32	Term
Program Coordinator	Woods,Margaret L	Aging and Disability Resource Center	4/8/2013	F	13	3	0101	$ 88,841.00	$ 17,945.88	Term
Project Coordinator	McWright,Sakena F	Aging and Disability Resource Center	10/14/2008	F	13	10	0301	$ 104,423.00	$ 21,093.45	Term
Public Health Analyst	Noonan-Jones,Gwendolyn A.	Aging and Disability Resource Center	10/27/2008	F	12	7	0685	$ 83,443.00	$ 16,855.49	Reg
Social Worker	Vasquez, Mayra	Aging and Disability Resource Center	7/14/2014	F	12	5	0185	$ 79,077.00	$ 15,973.55	Term
Customer Service Commucat Spec	Wiliams, Janeashia	Aging and Disability Resource Center	2/6/2017	F	11	1	0301	$ 56,852.00	$ 11,484.10	Term
Customer Service Commucat Spec	Cleveland, Elicita	Aging and Disability Resource Center	2/6/2017	F	11	1	0301	$ 56,852.00	$ 11,484.10	Term
Customer Service Commucat Spec	Witherspoon, Jennifer	Aging and Disability Resource Center	6/27/2016	F	11	1	0301	$ 56,852.00	$ 11,484.10	Term
Staff Assistant	Garrett,Mamie R	Aging and Disability Resource Center	8/26/1985	F	9	8	0301	$ 57,741.00	$ 11,663.68	Reg
Customer SVS Communications	Greenaway,Luanne	Aging and Disability Resource Center	1/13/2014	F	11	1	0301	$ 56,852.00	$ 11,484.10	Term
SUPERVISORY SOCIAL WORKER	Tamasco,Christian A	Aging and Disability Resource Center	9/29/2014	F	13	0	0185	$ 89,057.00	$ 17,989.51	Reg
SUPERVISORY SOCIAL WORKER	Cowser,Felicia V	Aging and Disability Resource Center	5/23/2011	F	13	0	0185	$ 89,057.25	$ 17,989.56	Term
Transition Care Specialist	Gilliam,Melanie	Aging and Disability Resource Center	6/17/2013	F	12	4	0101	$ 76,894.00	$ 15,532.59	Term
Transition Care Specialist	Hicks-Edwards,Vanessa L	Aging and Disability Resource Center	6/25/2012	F	12	5	0101	$ 79,077.00	$ 15,973.55	Term
Transition Care Specialist				V						
Transition Care Specialist	Wilson,Jasmine	Aging and Disability Resource Center	12/2/2013	F	12	4	0101	$ 76,894.00	$ 15,532.59	Term
Transition Care Specialist	Wray,Rolanda	Aging and Disability Resource Center	4/8/2013	F	12	4	0101	$ 76,894.00	$ 15,532.59	Term
Transition Care Specialist	Lucas, Joel	Aging and Disability Resource Center	11/28/2016	F	12	1	0101	$ 70,345.00	$ 14,209.69	Term
Transition Care Specialist	Butler, Ramona	Aging and Disability Resource Center	4/8/2013	F	12	3	0101	$ 76,894.00	$ 15,532.59	Term
Transition Care Specialist	Fields, Angela	Aging and Disability Resource Center	2/22/2016	F	12	1	0101	$ 70,345.00	$ 14,209.69	Term
Transition Case Manager	McLain,Mary	Aging and Disability Resource Center	6/25/2012	F	12	5	0101	$ 79,077.00	$ 15,973.55	Term
Transition Case Manager	Mason, Shameka	Aging and Disability Resource Center	8/8/2016	F	12	1	0101	$ 70,345.00	$ 14,209.69	Term
Transition Coordinator	Akinola,Ekundayo K	Aging and Disability Resource Center	9/9/2013	F	12	6	0101	$ 81,260.00	$ 16,414.52	Term
Transition Coordinator	Baxter,Emma D	Aging and Disability Resource Center	9/8/2014	F	12	7	0101	$ 90,254.00	$ 18,231.31	Term
Transition Coordinator				V			0101		$ -	Term
Management Assistant	Njuguna, Elizabeth	Aging and Disability Resource Center	1/3/2017	F	8	4	0344	$ 48,365.00	$ 9,769.73	Term

Title	Name	Division	Hire Date	Vac Stat	Grade	Step	Series	Salary	Fringe	Job Status
Director of Communications	Dorbin, Karen	External Affairs/Communications	10/11/2016	F	14	2	0301	$ 100,000.00	$ 20,200.00	Term
Community Outreach Specialist	Bjorge,Mark L.	External Affairs/Communications	12/8/2014	F	12	3	0301	$ 74,711.00	$ 15,091.62	Term
Community Outreach Specialist	Thompson,Alice Arcenia	External Affairs/Communications	1/2/2007	F	13	4	0301	$ 91,438.00	$ 18,470.48	Term
Community Relations Specialist	Branton,Krystal C.	External Affairs/Communications	4/8/2013	F	12	3	0301	$ 74,711.00	$ 15,091.62	Term
Customer and Information Servi	Nowlin,Darlene E	External Affairs/Communications	2/29/1988	F	9	10	0301	$ 60,757.00	$ 12,272.91	Reg
Community Relations Coord	Donald, Brittany	External Affairs/Communications	7/11/2016	F	14	0	0301	$ 99,659.00	$ 20,131.12	Term
MFP Community Outreach Spec		External Affairs/Communications		V					$ -	
Facilities Services Specialist	Taylor Jr Jr.,Samuel L L	General Services	5/31/2015	F	12	5	1601	$ 79,077.00	$ 15,973.55	Term
Facilities Services Specialist	John,Nigel A.	General Services	1/20/2015	F	12	5	1601	$ 79,077.00	$ 15,973.55	Term
Management Liaison Specialist	Jenkins, Jennifer	General Services	2/6/2017		12	1	0301	$ 76,100.00	$ 15,372.20	Reg
IT SPEC (DATAMGT/CUSTSPT)	Lyles,Yolanda	General Services	10/9/2007	F	12	8	2210	$ 85,626.00	$ 17,296.45	Reg
Executive Director	Newland,Laura S	Office of the Executive Director	4/28/2014	F	10	0		$ 149,000.00	$ 30,098.00	Reg
Chief of Staff	King,Garret	Office of the Executive Director	3/24/2014	F	14	0	0301	$ 128,750.00	$ 26,007.50	Reg
Executive Assistant	Reid,Tanya	Office of the Executive Director	3/24/2014	F	12	2	0301	$ 70,414.00	$ 14,223.63	Term
General Counsel	Kirkwood,Michael D	Office of the Executive Director	1/6/2016	F	2	0	0905	$ 128,400.00	$ 25,936.80	Reg
Director of Policy, Planning a	Footer,Brian Drew	Policy Planning & Evalution	5/5/2014	F	14	0	0601	$ 113,300.00	$ 22,886.60	Reg
Data Quality Assurance Coordinator	Wudineh, Aweke	Policy Planning & Evalution	10/6/2014	F	12	3	0301	$ 74,711.00	$ 15,091.62	Reg
Program Mangager	Delespin,Aurora L	Programs and Grants	10/8/2000	F	14	5	0301	$ 118,450.00	$ 23,926.90	Reg
Program Analyst	Crowder,Maxine R	Programs and Grants	9/6/1983	F	13	8	0343	$ 101,826.00	$ 20,568.85	Term
Program Analyst	Adu, Jennier	Programs and Grants	1/24/2016	F	12	1	0343	$ 70,345.00	$ 14,209.69	Reg
Program Analyst	Khoo, Lynn	Programs and Grants	1/5/2015	F	13	5	0343	$ 91,438.00	$ 18,470.48	Term
Special Projects Coordinator	Irizarry,Linda	Programs and Grants	6/25/2012	F	12	6	0301	$ 81,260.00	$ 16,414.52	Term
Public Health Nutritonist	Geralnick,Jacqueline A	Programs and Grants	3/10/2014	F	12	3	0630	$ 74,711.00	$ 15,091.62	Term
Staff Assistant	Thompson, Mary	Programs and Grants	1/3/2017		11	7	0301	$ 67,814.00	$ 13,698.43	Term
Research and Grants Analyst		Programs and Grants		V					$ -	
Program Coordinator	Spence, Kay Ann	Programs and Grants	6/27/2016		12	3	0301	$ 70,345.00	$ 14,209.69	Term
Public Health Nutritonist	Parikh,Gargi	Programs & Budget	1/5/2015	F	12	2	0630	$ 58,022.00	$ 11,720.44	Term
Resource Allocation Analyst	Sanga,Nkwenti Patrick	Budget and Finance	5/29/2005	F	13	7	0301	$ 96,632.00	$ 19,519.66	Reg
Resource Allocation Analyst	Baylor, Charisse	Budget and Finance	6/27/2016	F	11	4	0301	$ 62,333.00	$ 12,591.27	Term
Resource Allocation Analyst	Hagos,Regat G.	Budget and Finance	4/21/2014	F	13	2	0301	$ 86,244.00	$ 17,421.29	Reg
Financial and Grants Specialist		Budget and Finance		V					$ -	Term
Medicaid Claims Specialist		Budget and Finance		V					$ -	Term
Resource Allocation Officer	Ogbara,Olamide	Budget and Finance	8/17/2009	F	14	0	0301	$ 122,245.00	$ 24,693.49	Reg

V- Vacancy
F- Filled

ATTACHMENT Q5 - FY17 FTEs

FY17 FTEs		
Title	Division	Vac Stat
Associate Director, ADRC	Aging and Disability Resource Center	F
Clerical Asst. Receptionist	Aging and Disability Resource Center	F
Medicaid Enrollment Specialist	Aging and Disability Resource Center	F
Medicaid Enrollment Specialist	Aging and Disability Resource Center	F
Medicaid Enrollment Specialist	Aging and Disability Resource Center	F
Medicaid Enrollment Specialist	Aging and Disability Resource Center	F
Medicaid Enrollment Specialist	Aging and Disability Resource Center	F
Medicaid Enrollment Specialist	Aging and Disability Resource Center	F
Medicaid Enrollment Specialist	Aging and Disability Resource Center	F
Medicaid Enrollment Specialist	Aging and Disability Resource Center	F
Customer Service Specialist	Aging and Disability Resource Center	F
Customer Services Community Specialist	Aging and Disability Resource Center	F
Deputy Associate Director, ADRC	Aging and Disability Resource Center	F
Housing Coordinator	Aging and Disability Resource Center	F
Information, Referral and Asst. Supervisor	Aging and Disability Resource Center	F
Medicaid Enrollment Supervisor	Aging and Disability Resource Center	F
Program Coordinator	Aging and Disability Resource Center	F
Project Coordinator	Aging and Disability Resource Center	F
Public Health Analyst	Aging and Disability Resource Center	F
Social Worker	Aging and Disability Resource Center	F
Customer Service Communications Specialist	Aging and Disability Resource Center	V
Customer Service Communications Specialist	Aging and Disability Resource Center	F
Customer Service Communications Specialist	Aging and Disability Resource Center	F
Customer Service Communications Specialist	Aging and Disability Resource Center	F
Customer Service Communications Specialist	Aging and Disability Resource Center	F
Customer Service Communications Specialist	Aging and Disability Resource Center	F
Staff Assistant	Aging and Disability Resource Center	F
Clinical Supervisory Social Worker	Aging and Disability Resource Center	F
Clinical Supervisory Social Worker	Aging and Disability Resource Center	F
Transition Care Specialist	Aging and Disability Resource Center	F
Transition Care Specialist	Aging and Disability Resource Center	F
Transition Care Specialist	Aging and Disability Resource Center	V
Transition Care Specialist	Aging and Disability Resource Center	F
Transition Care Specialist	Aging and Disability Resource Center	F
Transition Care Specialist	Aging and Disability Resource Center	F
Transition Care Specialist	Aging and Disability Resource Center	F
Transition Care Specialist	Aging and Disability Resource Center	F
Transition Case Manager	Aging and Disability Resource Center	F
Transition Case Manager	Aging and Disability Resource Center	F
Transition Coordinator	Aging and Disability Resource Center	F
Transition Coordinator	Aging and Disability Resource Center	F
Transition Coordinator	Aging and Disability Resource Center	V
Management Assistant	Aging and Disability Resource Center	F
	ADRC FTE: 43	

Director of Communications	External Affairs/Communications	F
Community Outreach Specialist	External Affairs/Communications	F
Community Outreach Specialist	External Affairs/Communications	F
Community Relations Specialist	External Affairs/Communications	F
Customer and Information Servi	External Affairs/Communications	F
Community Relations Coord	External Affairs/Communications	F
MFP Community Outreach Spec	External Affairs/Communications	V
	COMMS FTE: 7	
Facilities Services Specialist	General Services	F
Facilities Services Specialist	General Services	F
Management Liaison Specialist	General Services	F
IT SPEC (DATAMGT/CUSTSPT)	General Services	F
	General Services FTE: 4	
Executive Director	Office of the Executive Director	F
Chief of Staff	Office of the Executive Director	F
Executive Assistant	Office of the Executive Director	F
General Counsel	Office of the Executive Director	F
	OED FTE: 4	
Director of Policy, Planning and Evaluation	Policy Planning & Evalution	F
Data Quality Assurance Coordinator	Policy Planning & Evalution	F
	PPE FTE: 2	
Program Mangager	Programs and Grants	F
Program Analyst	Programs and Grants	F
Program Analyst	Programs and Grants	F
Program Analyst	Programs and Grants	F
Special Projects Coordinator	Programs and Grants	F
Public Health Nutritonist	Programs and Grants	F
Staff Assistant	Programs and Grants	F
Research and Grants Analyst	Programs and Grants	V
Program Coordinator	Programs and Grants	F
Public Health Nutritonist	Programs and Grants	F
	P&G FTE: 10	
Resource Allocation Analyst	Budget and Finance	F
Resource Allocation Analyst	Budget and Finance	F
Resource Allocation Analyst	Budget and Finance	F
Financial and Grants Specialist	Budget and Finance	V
Medicaid Claims Specialist	Budget and Finance	V
Resource Allocation Officer	Budget and Finance	F
	B&F FTE: 6	

DCOA FY17 FTE Total: 76

F = Filled

V= Vacant

ATTACHMENT Q5i - FY16 and FY17 VACANCIES

Close of FY16 - Vacancies			
Position	Division	Length of Vacancy	Vacancy Status
Management Assistant (MFP)	Aging and Disability Resource Center	9 months	Filled on 1/3/2017
Customer Service Specialist	Aging and Disability Resource Center	3 months	Filled on 10/1/2016
Administrative Officer	General Services	Converted Position	Converted Position to Data Quality Assurance Coord.

Current FY17 Vacancies			
Position	Division	Length of Vacancy	Vacancy Status
Transition Care Specialist	Aging and Disability Resource Center	5 months	Vacant as of 9/2016
Customer Service Comms. Specialist	Aging and Disability Resource Center	2 months	Vacant as of 12/2016
Transition Coordinator	Aging and Disability Resource Center	4 months	Vacant as of 10/2016
Financial and Grants Speciliast	Budget and Finance	3 months	Vacant as of 11/2016
Medicaid Claims Specialist	Budget and Finance	2 months	Vacant as of 12/2016
Research and Grants Analyst	Programs and Grants	2 months	Vacant as of 12/2016
MFP Community Outreach Specialist	External Affairs and Communications	4 months	Vacant as of 10/2016

ATTACHMENT Q11i - INFORMATION TECHNOLOGY EQUIPMENT INVENTORY

Assignment	CellPhone	Laptop	Tablet
Angela Fields	iPhone	yes	
Antonette Dozier	iPhone		
Aurora Delespin-Jones	Samsung	yes	
Aweke Wudineh	iPhone	yes	
Becky Hazlett	iPhone	yes	
Brian Footer	Blackberry	yes	
Brittany Dorsey	iPhone	yes	
Charlotte Morgan	iPhone	yes	
Christian Tamasco	Blackberry		
Darlene Nowlin	iPhone	yes	
Dominique Vinson	iPhone		yes
Ekundayo Akinola	iPhone		
Emma Baxter	iPhone		
Garret King	iPhone	yes	
Gerald Kasunic	iPhone	yes	
Gwendolyn Noonan-Jones	iPhone	yes	
Jackie Geralnick	iPhone	yes	
Jasmine Wilson	iPhone	yes	
Joel Lucas	iPhone	yes	
Karen Dorbin	iPhone	yes	
Katrice Jefferson	iPhone	yes	
Krystal Branton	iPhone	yes	
Laura Newland	iPhone	yes	
Linda Irizarry	iPhone	yes	
Lourdine Jean-Francois	iPhone		yes
Lynn Khoo	no	yes	
Margaret Woods	iPhone		yes
Maria Ellis	iPhone	yes	
Mark Bjorge	iPhone	yes	
Mary McClain	iPhone	yes	
Maxine Crowder	no	yes	
Mayra Vasquez	iPhone		yes
Melanie Gilliam	iPhone	yes	
Mia Butler	iPhone	yes	
Michael Kirkwood	iPhone		yes
Natasha Webb	iPhone	yes	
Nigel John	iPhone		
Olamide Ogbara	Samsung		yes
Patrick Sanga	no		yes
Planton Watson	iPhone		yes
Ramona Butler	iPhone	yes	

Assignment	CellPhone	Laptop	Tablet
Regat Hagos	iPhone		yes
Rolanda Wray	iPhone		yes
Samuel Taylor	iPhone		
Sara Tribe Clark	iPhone	yes	
Shameaka Mason	iPhone		
Shanti Trumpt	iPhone	yes	
Tanya Reid	Samsung	yes	
Tonya Frazier	no	yes	
Vanessa Hicks-Edwards	iPhone		yes
Yolanda Lyles	Blackberry	yes	

ATTACHMENT Q11ii - FY16 and FY17 VEHICLES LIST

WDC114 - Asset Master List

ASSET NUMBER	YEAR	MAKE	MODEL	SERIAL NUMBER	LICENSE	DEPT
040788	2010	FORD	E-450	1FDFE4FS4ADA70067	DC0788	BY0100
040789	2010	FORD	E-450	1FDFE4FS1ADA70057	DC0789	BY0100
040790	2010	FORD	E-450	1FDFE4FS9ADA70064	DC0790	BY0100
40791	2010	FORD	E-450	1FDFE4FS5ADA70045	DC0791	BY0100
40792	2010	FORD	E-450	1FDFE4FS8ADA70055	DC0792	BY0100
040793	2010	FORD	E-450	1FDFE4FS3ADA70030	DC0793	BY0100
0410252 DCOA	2013	HONDA	CIVIC HYBRID	19XFB4F28DE200903	DC10252	BY0100
410542	2014	FORD	E-350SD	1FDFE4FSXEDB19780	DC10542	BY0100
410551	2014	FORD	E-150	1FINS1EW9EDA97587	DC10551	BY0100
410558	2014	FORD	E-150	1 FTNS1 EW5EDA97585	DC10558	BY0100
410559	2014	FORD	E-150	1FTNS1EW7EDA97586	DC10559	BY0100
410560	2014-	FORD	E-150	1 FTNS1 EW3EDA97584	DC10560	BY0100
410597	2014	FORD	E-350SD	1FDEE3FLOEDB10326	DC10597	BY0100
410598	2014	FORD	E-350SD	1FDEE3FL3EDB10353	DC10598	BY0100
410599	2014	FORD	E-3SOSD	1FDEE3FL5EDB10354	DC10599	BY0100
410600	2014	FORD	E-3505D	1FDEE3FL8EDB17749	DC10600	BY0100
410601	2014	FORD	E-350SD	1FDEE3FLXEDB10351	DC10601	BY0100
410602	2014	FORD	E-3505D	1FDEE3FLOEDB17728	DC10602	BY0100
410603	2014	FORD	E-350SD	1FDEE3FL7EDB17726	DC10603	BY0100
410604	2014	FORD	E-350SD	1FDEE3FL1EDB10352	DC10604	BY0100
410605	2014	FORD	E-350SD	1FDEE3FL7EDB10355	DC10605	BY0100
410606	2014	FORD	E-350SD	1FDEE3FL9EDB17727	DC10606	BY0100
410617	2014	FORD	E-150	1FTNS1EW9EDA97590	DC10617	BY0100
410657	2014	FORD	E-350SD	1FDEE3FL2EDB10358	DC10657	BY0100
043879	2005	DODGE	CARAVAN	1D4GP25BX5B256810	DC3879	BY0100
046352	2007	MERCURY	MOUTINEER	4M2EU47EX7UJ08996	DC6352	BY0100
046428	2007	DODGE	CARAVAN	1 D8G P24E876195258	DC6428	BY0100
046553 DCOA	2002	FORD	EXPLORER	1FMZU72E02UA75298	DC6553	BY0100
046554 DCOA	2002	FORD	EXPLORER	1FMZU72E22UA75299	DC6554	BY0100
046578	2007	MERCURY	MOUNTAINEER	4M2EU47E37W11464	DC6578	BY0100
046663 DCOA	2003	MERCURY	MOUNTAINEER	4M2ZU86W33W06827	DC6663	BY0100
047364	2009	CHEVROLET	SILVERADO	1GCEC14C89Z241126	DC7364	BY0100
047365	2009	CHEVROLET	C1500	1GCEC14C39Z240725	DC7365	BY0100
047366	2009	CHEVROLET	SILVERADO	1GCEC14CX9Z243203	DC7366	BY0100
047590	2010	FORD	E-150	1FTNS1EW6ADA84354	DC7590	BY0100
047591	2010	FORD	E-450	1FDFE4FS8ADA70069	DC7591	BY0100
047592	2010	FORD	E-150	1FTNS1EWXADA52863	DC7592	BY0100
047607	2010	FORD	E-450	1FDFE4FS3ADA70075	DC7607	BY0100
047974	2010	FORD	E-350	1FDEE3FS2ADA52933	DC7974	BY0100
048109	2014	DODGE	GRAND CARAVAN	2C7WDGBG1ER380127	DC8109	BY0100
048110	2014	DODGE	GRAND CARAVAN	2C7WDGBG8ER380125	DC8110	BY0100
048111	2014	DODGE	GRAND CARAVAN	2C7WDGBG4ER380106	DC8111	BY0100
048112	2014	DODGE	GRAND CARAVAN	2C7WDGBG9ER380098	DC8112	BY0100
048113	2014	DODGE	GRAND CARAVAN	2C7EDGBG7ER380102	DC8113	BY0100
048114	2014	DODGE	GRAND CARAVAN	2C7WDGBG8ER380108	DC8114	BY0100

ASSET NUMBER	YEAR	MAKE	MODEL	SERIAL NUMBER	LICENSE	DEPT
048115	2014	TOYOTA	SIENNA	5TD3K3DCXES084742	DC8115	BY0100
048116	2014	TOYOTA	SIENNA	5TWK3DC6E5086374	DC8116	BY0100
048117	2014	TOYOTA	SIENNA	5TDIK3DCOES087049	DC8117	BY0100
048118	2014	TOYOTA	SIENNA	5TDIK3DC4ES086650	DC8118	BY0100
048119	2014	TOYOTA.	SIENNA	5TDJK3DC1ES086203	DC8119	BY0100
048160	2010	FORD	E-450	1FIDFE4FSXBDA54828	DC8160	BY0100
048161	2011	FORD	E-150	1FTNS1EW4BDA42864	DC8161	BY0100
048162	2011	FORD	E-450	1FDFE4FS6BDA54826	DC8162	BY0100
048163	2011	FORD	E-450	1FDFE4FS7BDA54835	DC8163	BY0100
048164	2011	FORD	E-450	1FDFE4FSXBDA54831	DC8164	BY0100
048165	2011	FORD	E-450	1FDFE4FS4BDA54825	DC8165	BY0100
048784	2014	TOYOTA	SIENNA	5TDJK3DC3ES088292	DC8784	BY0100
048829	2014	CHEVROLET	SILVERADO	1GCNCPEC1EZ379666	DC8829	BY0100
048830	2014	CHEVROLET	SILVERADO	1GNCNCPEC1EZ377352	DC8830	BY0100
048831	2014	CHEVROLET	SILVERADO	1GCNCPEC3EZ376753	DC8831	BY0100
048834	2014	HONDA	CIVIC LX	19XFB2F50EE238478	DC8834	BY0100
048835	2014	HONDA	CIVIC LX	19XFB2F54EE237429	DC8835	BY0100
048848	2014	FORD	E-150	1FTNS1EWOEDA97588	DC8848	BY0100
048849	2014	FORD	E-150	1FTNS1EW2EDA97589	DC8849	BY0100
048850	2014	FORD	E-150	1FTNS1EWOEDA97591	DC8850	BY0100
049029	2008	CHEVROLET	C4500	1GBE4V1958F401545	DC9029	BY0100
049056 DCOA	2003	FORD	EXPLORER	1FMZU72K53UC53987	DC9056	BY0100
049241	2008	CHEVROLET	C5500	1GBE5V1928F403606	DC9241	BY0100
049454 DCOA Leased	2013	DODGE	CARAVAN	2C4RDGBG9DR643831	DC9454	BY0100
049839	2009	DODGE	CARGO VAN	WDOPF445585325064	DC9839	BY0100
953880	2005	DODGE	CARAVAN	1D4GP258358256809	DC3880	BY0100

Distinct Count of Asset: 71

ATTACHMENT 11iv - FY16 and FY17 TRAVEL EXPENSES

Name	Event	Cost
FY 2017 Out-of-Town Travel		
MARK BJORGE	2016 National Village Gathering	$ 430
DARLENE NOWLIN	2016 Senior America Pageant	$ 661
	TOTAL	**$ 1,091**
FY 2017 Local Travel		
VARIOUS EMPLOYEES	Imprest - General Parking / Metro Fare Card	$ 807
	TOTAL	**$ 807**

Name	Event	Cost
FY 2016 Out-of-Town Travel		
AURORA DELESPIN JONES	ACL Regions II & IV SUA Leadership and Directors Meeting	$ 330
MAXINE CROWDER	ACL Regions II & IV SUA Leadership and Directors Meeting	$ 330
LAURA NEWLAND	ACL Regions II & IV SUA Leadership and Directors Meeting	$ 330
SARA TRIBE	National Association of States United for Aging and Disability (NASUAD)	$ 965
LINDA IRIZARRY	National Association of States United for Aging and Disability (NASUAD) (Federal Grant Funded)	$ 729
LAURA NEWLAND	N4a 41st Annual Conference & Tradeshow	$ 1,171
GARRET KING	N4a 41st Annual Conference & Tradeshow	$ 1,171
BRITTANY KITT	N4a 41st Annual Conference & Tradeshow (Federal Grant Funded)	$ 1,305
AURORA DELESPIN JONES	N4a 41st Annual Conference & Tradeshow	$ 2,168
JACKIE GERALNICK	Farmers Market Nutrition Program Annual Conference (Federal Grant Funded)	$ 1,406
	TOTAL	**$ 9,905**
FY 2016 Local Travel		
VARIOUS EMPLOYEES	Imprest - General Parking / Metro Fare Card	$ 2,567
	TOTAL	**$ 2,567**

D.C. Office on Aging FY2016

ATTACHMENT Q12a - DCOA'S FY16 PERFORMANCE ACCOUNTABILITY REPORT (PAR)

Agency D.C. Office on Aging **Agency Acronym** DCOA **Agency Code** BY0

To edit agency and POC information press your agency name (underlined and in blue above).

Agency Performance POCs Brian (DCOA) Footer **Agency Budget POCs** Brian (DCOA) Footer; Shilonda (OFRM) Wiggins **Fiscal Year** 2016

When you believe you are finished with this phase of your Performance Plan, press edit in the upper right, check this box, and then press save.

2016 Objectives

Strategic Objectives: What we want to do for the District

Division/Department	Objective Number	Objective Description
Agency Management (2 Objectives)		
Agency Management	1	Transform the District of Columbia to an Age-Friendly City, an inclusive and accessible urban environment that encourages active and healthy aging for all residents, particularly seniors.
Agency Management	2	Oversee the implementation of agency-wide priorities.
Customer Information, Assistance and Outreach (2 Objectives)		
Customer Information, Assistance and Outreach	1	Provide robust outreach efforts and disseminate critical information that brings about a greater awareness of aging services and issues in order to increase District residents' access and connectivity to programs, and to attract new and innovative services and campaigns.
Customer Information, Assistance and Outreach	2	Continue to develop active and vibrant neighborhoods that promote and create economic opportunity and support a high quality of life for the District's older adults and persons living with disabilities.
In-Home and Continuing Care/Community-Based Support (2 Objectives)		
In-Home and Continuing Care/Community-Based Support	1	Continue to promote and expand prevention and resilience opportunities for vulnerable District residents in order to avoid premature nursing home placement by providing aging and disability resources in every ward of the city.
In-Home and Continuing Care/Community-Based Support	2	Enhance and maintain programs and services in the senior service network that encourage and sustain community living for seniors and people living with disabilities through the implementation of DCOA's 5-year strategic plan.

2016 Key Performance Indicators

Click the link below for a "Blank KPI spreadsheet." You can use this to directly enter data by selecting Grid Edit. You can also use this create an excel document to collect data. Select More in the upper right and Save as a Spreadsheet for a sharable excel spreadsheet to data. The calculated formulas are currently being tested, which is why you see extra data columns. Please check that they are calcula you would expect.

Blank KPI spreadsheet

Performance Plan Measures (FY16 KPIs) Linked to Specific Objective

Performance Plan Metrics	Division	Frequency of Reporting	Measure	Current Fiscal Year Target	FY 2013	FY 2014	FY 2015	Q1FY2016	Q2FY2016	Q3FY2016	Q4FY2016	FY 2016
1 - Continue to promote and expand prevention and resilience opportunities for vulnerable District residents in order to avoid prema nursing home placement by providing aging and disability resources in every ward of the city. (3 Measures)												
Key Performance Indicator		Quarterly	Number of people transitioned from nursing homes back to the community with the appropriate home and community-based supports and services	45		34	43	17	15	12	11	55
Key Performance Indicator		Quarterly	Number of people discharged from the hospital back to the community with the appropriate home and community-based supports and services	100		152	126	10	0	0	0	10

Key Performance Indicator		Quarterly	Number of people who received options counseling services through the Aging and Disability Resource Center	800		962	915	120	154	115	162	551
1 - Provide robust outreach efforts and disseminate critical information that brings about a greater awareness of aging services and in order to increase District residents' access and connectivity to programs, and to attract new and innovative services and campaig Measure)												
Key Performance Indicator		Quarterly	Number of older adults, 55 years and over, receiving jobs with pay rate above minimum wage	90		68	92	7	23	37	13	80
1 - Transform the District of Columbia to an Age-Friendly City, an inclusive and accessible urban environment that encourages a and healthy aging for all residents, particularly seniors. (3 Measures)												
Key Performance Indicator		Quarterly	Average annual amount DCOA saves an older adult that receives services in the community rather than institutional care	10675			10,980	2,644.6	2,521.7	2700.3	2603.6	$10470.2
Key Performance Indicator		Quarterly	Average annual amount DCOA saves an older adult that regularly participates in services that promote aging in place	5055			5,165	1,646.1	1,381.5	1523.2	1577.5	$6128.3
Key Performance Indicator		Quarterly	Number of seniors, caregivers, and family members attending "Money Smart for Older Adults" training	1000			1,039	201	121	69	342	733
2 - Continue to develop active and vibrant neighborhoods that promote and create economic opportunity and support a high quality for the District's older adults and persons living with disabilities. (1 Measure)												
Key Performance Indicator		Annually	Percent of older adults, 60 years and over, at Senior Wellness Centers self-reporting an increase in awareness and practice of healthy habits	75		86.5	90					84.3%
2 - Enhance and maintain programs and services in the senior service network that encourage and sustain community living for se and people living with disabilities through the implementation of DCOA's 5-year strategic plan. (2 Measures)												

Key Performance Indicator		Quarterly	Number of home delivered meals served on Saturdays	138000		65,915	150,654	32,733	32,510	31448	33952	130643
Key Performance Indicator		Annually	Percent of caregivers self-reporting an increased sense of emotional support through Club Memory	90			80					98.5%

Comments/Footnotes

All KPIs must be linked to a specific Objective. If KPIs are already entered without a link to an objective (appearing below) email the Performance Management with a spreadsheet that shows to which Objectives the KPIs should be linked.

Performance Plan Measures (FY16 KPIs) Not Linked to Specific Objective

Performance Plan Metrics	Division	Frequency of Reporting	Measure	Current Fiscal Year Target	Long-Term Target (if different)	FY 2013	FY 2014	FY 2015	Q1FY2016	Q2FY2016	Q
No measures found											

2016 Workload Measures

Click the link below for a "Blank Workload Measures spreadsheet." You can use this to directly enter data by selecting Grid Edit. You can also use this to create an excel document to collect data. Select More in the upper right and Save as a Spreadsheet for a sharable excel spreadsheet to collect data. The calculated formulas are currently being tested, which is why you see extra data columns. Please check that they are calculating as you would expect.

Blank Workload Measure spreadsheet

Add Workload Measure (NOT KPI)

Performance Plan Metrics	Frequency of Reporting	Measure	Add Data FY16 PP	FY 2013	FY 2014	FY 2015	Q1FY2016	Q2FY2016	Q3FY2016	Q4FY2016	FY2016 Annual Total
Workload Measure (11 Measures)											
Workload Measure	Quarterly	Number of homebound meals served		413,694	542,816	723,249	163,225	150,676	233665	177819	725,385
Workload Measure	Quarterly	Number of congregate meals served		262,041	313,651	356,568	86,254	81,725	86982	93509	348,470
Workload Measure	Annually	Number of unduplicated customers provided trips to and from medical related appointments		2,674	3,211	2,161					2211
Workload Measure	Annually	Number of unduplicated customers provided trips to and from social/recreational activities			9,366	2,189					2830
Workload Measure	Quarterly	Number of individual legal advocacy hours provided to customers (legal advice, estate planning, property taxes, etc.)		8,162	9,983	10,127	2,343	2,402	2911	2699	10,355
Workload Measure	Annually	Number of customers actively attending Senior Wellness Centers		2,764	2,957	3,293					2991
Workload Measure	Quarterly	Number of older adults, 60 years and over, receiving information, referral and assistance through the Aging and Disability Resource Center		4,240	15,140	4,184	606	1,867	3464	3540	9477
Workload Measure	Quarterly	Number of individuals living with disabilities, ages 18-59, receiving information, referral and assistance through the Aging and Disability Resource Center		1,206	5,422	1,375	122	179	250	506	1057
Workload Measure	Quarterly	Number of caregivers receiving information, referral and assistance through the Aging and Disability Resource Center		149	447	217	7	27	15	22	71
Workload Measure	Quarterly	Number of seniors receiving employment and training assistance		1,120	438	522	74	129	72	26	301
Workload Measure	Annually	Percent of family caregivers self-reporting improved ability to provide care		100	100						100

2016 Initiatives

Initiative Number	Initiative Title	Initiative Description	# of Initiative Updates
Agency Management - 1 (2 Initiatives)			

1.2	Educate District residents on identification and prevention of elder abuse and mandatory reporting.	DCOA's Elder Abuse Prevention Committee (EAPC) will continue to administer the "Money Smart for Older Adults" program, a training program offered through a formal partnership with Federal Deposit Insurance Corporation and the Consumer Financial Protection Bureau. The informational sessions at DCOA's senior wellness centers and other senior residential facilities will provide tips on how to prevent common fraud, scams and other financial exploitation. In FY 16, DCOA strives to train 1,000 District seniors and caregivers using the Money Smart program.	3
1.1	Sustain existing senior villages and promote the development of new senior villages in underserved neighborhoods.	In 2015, DCOA partnered with a community based organization to offer technical assistance to new and emerging senior villages in order to strengthen business and organization processes and improve the collection of data. For FY 2016, DCOA will roll out "Explore, Discover, Act: How to start a Village in the District of Columbia," a how-to-guide to start and maintain senior villages, and a web-based, interactive map for residents to find a village in their neighborhood.	3
TOT			6
Agency Management - 2 (1 Initiative)			
2.1	Improve quality assurance mechanisms.	DCOA will improve services and supports for District residents by strategically redefining the mission and purpose of DCOA's ADRC. To meet this objective, we will refine standard operating procedures and trainings; standardize data collection practices and evaluations; and increase community partnerships and targeted outreach. The ultimate goal is to ensure that DCOA's ADRC becomes accredited through the Alliance of Information & Referral Systems, which is the primary quality assurance mechanism for affirming excellence in information and referral services. Additionally, DCOA will organize a Performance Measurement Task Force to ensure continued work towards collecting outcome driven data. In FY 2016, the Task Force will develop and implement a standard annual satisfaction survey based off ACL's Performance Outcome Measurement Project (POMP).	3
TOT			3
Customer Information, Assistance and Outreach - 1 (2 Initiatives)			
1.2	Expand DCOA's partnerships with other District agencies to help expand DCOA services and bring about a greater awareness of senior services offered in the District.	DCOA will continue to partner with the District of Columbia Public Library (DCPL) to coordinate services to residents on DCOA's home delivered meals program. Residents who are on the home delivered programs and have visual impairments will receive braille reading materials, and individuals with hearing impairments will be provided specialized books. DCPL will help to disseminate DCOA's newsletters at their locations, and will provide outreach on their websites and social media sites to increase awareness of existing programs and services provided by DCOA. In FY 2016, DCOA will pilot the program by enrolling 50 home-bound seniors currently receiving home-delivered meals. DCOA will work with Department of Parks and Recreations (DPR) to identify overlapping service areas and opportunities for greater collaboration. DPR facilities across the city offer a wide range of services to seniors, including fitness classes and transportation. Streamlining services and better coordination in delivering those services will increase efficiency and access for the older adult population. By the end of FY 2016, the agencies hope to develop a plan to increase access and efficiency.	3
1.1	Promote intergenerational programming in order to combat social isolation, increase emotional support, and offer learning opportunities.	In FY 2016, DCOA will work with a community-based organization to help recruit and train senior volunteers that will be assigned to selected early childhood programs in District of Columbia Public Schools (DCPS). The non-profit will facilitate training sessions, assign program locations, and provide technical assistance and ongoing support to the volunteers at the selected DCPS sites. Volunteers will serve approximately eight (8) hours per week during the academic school year.	3
TOT			6
Customer Information, Assistance and Outreach - 2 (2 Initiatives)			
2.2	Increase outreach and access to services for the older lesbian, gay, bisexual, transgender and queer (LGBTQ) community.	DCOA will partner with organizations, such as Whitman Walker, to cross-train staff in order to increase knowledge of legal and health programs, knowledge of LGBTQ specific health needs and demands, and cultural sensitivity towards LGBTQ customers. By the end of FY 2016, all direct service staff at DCOA will complete training on effective communication techniques. Additionally, DCOA will improve cultural competency around HIV/AIDS by training service providers within the Senior Service Network and provide service linkages and collaborations for seniors living with HIV through partnerships with the D.C. Department of Health.	3
2.1	Increase support to older adults and persons living with disabilities searching for employment and assistance with career counseling, and resume assistance.	DCOA's Older Workers Employment and Training Program (OWETP) will continue its partnership with the Department of Employment Services (DOES), as well as expand its partnerships to the Court Services and Offender Supervision Agency (CSOSA) to assist and support older adults and persons living with disabilities searching for sustainable employment. The OWETP will partner with its stakeholders to increase OWEPTS outreach and training efforts, as well as generate at least three job fairs targeted to returning citizens, older adults, and adults with disabilities.	3
TOT			6
In-Home and Continuing Care/Community-Based Support - 1 (3 Initiatives)			
1.2	Expand the existing dementia-capable system to enhance access to supportive services for individuals with Alzheimer's disease and related dementia (ADRD) and their caregivers, and individuals with ADRD living alone.	The agency will continue to work with community partners to increase access to home and community-based services and supports for individuals with ADRD living alone through the "Alzheimer's Disease Initiative" (ADI) federal grant awarded to DCOA in October 2014. The agency will continue the roll out and implement the grant's programs in collaboration with community partners. ADI grant programs currently include 1) IONA Senior Service's Money Management Program; 2) the expansion of Sibley Memorial Hospital's "Club Memory" program across the city through senior wellness centers; 3) DCOA's Saturday Respite Program which provides a 4 hour break to caregivers caring for individuals with dementia, and 4) DCOA's Behavioral Symptom Management Training Program which promotes professional and family caregiver understanding of ADRD, how to navigate long-term care options, and managing behavioral issues. Additionally, DCOA will continue its outreach efforts to promote awareness surrounding ADRD and services and supports offered in the District. DCOA will also complete and publish the Dementia Resource Guide, a document to assist professionals and family caregivers with the identification of dementia specific resources, in FY16.	3

1.1	Improve residents' access to long-term care services and supports, home and community-based resources, and options counseling by improving the quality and capacity of the intake and referral system within DCOA's ADRC and increasing coordination with District government sister agencies.	DCOA's ADRC is working toward having one Community Social Worker co-located at each lead agency/ADRC site (one in each of 8 wards). The assigned Community Social Worker will focus on the following: 1) Social Work provision to people with disabilities, ages 18-59 years old (a population not traditionally funded under Older Americans Act funds); 2) Nursing Home Transition Services; 3) Hospital Discharge services; 4) Person-Centered enrollment for State Plan Medicaid-funded Adult Day Health Services. DCOA is working in conjunction with our sister agencies to streamline the Elderly and Persons with Disabilities (EPD) Waiver enrollment process in order to reduce confusion and improve customer service. This includes hiring and training DCOA staff who will be specifically devoted to assisting residents with the EPD Waiver application process by performing in-person meetings in the community. These specialists will have a hands-on approach beginning at the point of referral to assist with the collection of necessary medical and financial information for application processing by Department of Health Care Finance (DHCF) and Department of Human Services' Economic Security Administration (DHS-ESA). They will also carefully explain the entire application and enrollment process to reduce confusion and decrease enrollment wait times in order for residents to have the vital services that they need to age in place.	3
1.3	Promote aging in place by reducing the risk of falls and mobility barriers in the home.	DCOA and the Department of Housing and Community Development (DHCD) will partner in FY16 to develop and implement a new home adaptation program called Safe at Home. The program promotes aging-in-place for older adults (60 years and older) and people with disabilities (18 to 59 years old) by providing up to $10,000 in home accessibility adaptation grants to reduce the risk of falls and reduce barriers that limit mobility. Program participants work with an Occupational Therapist (OT) to identify potential fall risks and mobility barriers in their home and then work with a general contractor to begin installing modifications and equipment to address them. In FY16, DCOA plans to serve 100 District residents through the Safe at Home Program.	3
TOT			9
In-Home and Continuing Care/Community-Based Support - 2 (2 Initiatives)			
2.1	Promote the use of internet-based search tools for locating available services.	DCOA is partnering with National Council on Aging (NCOA) to customize their unique and widely used product, BenefitsCheckUp®, to the District. BenefitsCheckUp offers comprehensive, online service to screen seniors and people with disabilities who have limited income, for benefits eligibility and access to public programs. It includes more than 2,000 public and private benefits programs from all 50 states and the District of Columbia. In FY 2016, DCOA will complete the design of the website and develop and implement roll out plan to inform and connect District residents to the new service.	3
2.2	Reduce misdiagnosis of Alzheimer's disease and related dementias generated by chronic dehydration.	DCOA will establish a hydration campaign targeted for seniors. Chronic dehydration is a frequent cause of hospitalization of older adults and one of the ten most frequent diagnoses responsible for hospitalization in the United-States. It can cause confusion and other symptoms that may resemble Alzheimer's disease and related dementias (ADRD.) In FY 2016, DCOA plans to partner with D.C. Water to design and implement a nutrition and ADRD awareness campaign that promotes consumption of tap water in each of the six Senior Wellness Center. This partnership will not only impact health outcomes, but will improve environmental and economic outcomes as well. Drinking tap water over bottled water decreases waste (only 25% of plastic bottles are recycled) and saves residents money (bottled water costs $1,000 per 1,000 gallons vs. tap water that costs $10 per 1,000 gallons).	3
TOT			6
TOT			**36**

2016 Initiative Updates

Time Period	Division/Department	Initiative Title	Initiative Status Update	Status of Impact	Explanation of Impact	Proposed Completion Date	Confidence in completion by end of fiscal year (9/30)?	% Complete to date	Date Modified
No initiative updates found									

Agency Accomplishments

Accomplishments

What is the accomplishment that your agency wants to highlight?	How did this accomplishment impact residents of DC?	How did this accomplishment impact your agency?
DCOA implemented the Restaurant Community Dining Pilot Program with Denny's from June-August 2016. The partnership provided an alternative location and dining opportunity for seniors in wards 7 and 8.	Throughout the pilot program, DCOA provided 322 meals to 124 seniors in wards 7 and 8 over three months. This alternative to the traditional community dining sites offered seniors more flexibility: they had ability to choose their meal off of a pre-set menu, rather than be served the "meal of the day," and they were able to dine whenever and with whomever they wanted. Participants could dine with friends and spouses, but also with people under 60, such as children and grandchildren. Traditional community dining sites require seniors to make a reservation in advance and meals are only served at noon, but participants of this pilot could choose to attend when their schedule allowed. Fifty-fife percent of participants attended the restaurant outside of traditional meal site hours (before 10am and after 2pm). While the pilot was a success, many participants received vouchers for the program but did not use them. DCOA will continue to engage the community and amend the pilot to meet seniors' needs.	The pilot demonstrated that this model could increase meal program reach, by targeting seniors whocannot attend our current sites. Some participants stated that they did not attend the current meal sites because they work. Other seniors have reported missing days at meal programs due to doctors' appointments or other scheduling conflicts. This program also serves seniors more efficiently. While there were still administrative costs to enroll participants and promote the pilot, there were no site costs for staff or supplies. Finally, unlike the traditional meal sites that order meals in advance, meals were only ordered for seniors in attendance, reducing food waste and food costs.

DHCF and DCOA launched a new EPD Waiver enrollment process to help improve customer service, reduce wait times for the EPD Waiver, and gain a better understanding of the District-wide areas for improvement through careful data collection and analysis.	Improvements in programmatic efficiency have reduced the average time it takes customers to enroll in the EPD Waiver. In Quarter 4 of FY 2016, application processing time took an average of 10 days or fewer, which is 35 days less than the allotted 45 day processing timeline, and a decrease from 50 days reported in Quarter 3. As a result, the number of applications submitted to the Economic Security Administration (ESA) increased from 89 in Quarter 3 to 248 in Quarter 4.	DCOA and DHCF have worked together to envision, develop, and implement multiple Medicaid enrollment processes, including hiring and training a 10 member Medicaid Enrollment Team at DCOA. The team has been able to get through the final high volume of case assignments, case closures, 1728 form follow up, and other administrative tasks associated with eliminating the year-long backlog. DCOA and DHCF streamlined enrollment process has resulted in improved performances in the following areas: number of application submissions to ESA, number of cases transferred to case management agencies, number of home visits completed, average days between initial correspondence and case assignment, and average number of days between case assignment and home visit.
In FY 2016, DCOA partnered with the Department of Housing and Community Development (DHCD) to create Safe at Home, a program that promotes aging in place for older adults (60 years and older) and people with disabilities (between 18 and 59 years old) by offering home accessibility adaptions to reduce the risk of falls and reduce mobility barriers.	By the end of FY 2016—September 30, 2016—Safe at Home contractors began work for 235 clients, of which 223 were completed. The program has 908 clients in the pipeline for FY 2017.	After working with community stakeholders to design the program from October through December, the Safe at Home Program began operating on January 4, 2016. The original budget in the pilot year was $1 million with a projection to serve up to 100 clients. The demand for Safe at Home has been much higher than anticipated. The budget was increased to $1.75 million and 223 clients completed home adaptations with contractors. The average number days between the date of the initial occupational therapist assessment visit and the occupational therapist final review of completed project was approximately 45 days.

2016 Special Mayoral Plans

Initiative Title	Initiative Description	Special Mayoral Plan	Mayoral Plan Domain	Mayoral Plan Goal	Mayoral Plan Action
No links to special mayoral plans found					

2016 Linked Goals

District Priority Goal	Priority Area	Initiative Title
Educate District residents on identification and prevention of elder abuse and mandatory reporting. (1 Initiative/Goal Link)		
	A Safer, Stronger DC	Educate District residents on identification and prevention of elder abuse and mandatory reporting.
Expand DCOA's partnerships with other District agencies to help expand DCOA services and bring about a greater awareness of senior services offered in the District. (1 Initiative/Goal Link)		
	Healthy Living for All Eight Wards	Expand DCOA's partnerships with other District agencies to help expand DCOA services and bring about a greater awareness of senior services offered in the District.
Expand the existing dementia-capable system to enhance access to supportive services for individuals with Alzheimer's disease and related dementia (ADRD) and their caregivers, and individuals with ADRD living alone. (1 Initiative/Goal Link)		
	Healthy Living for All Eight Wards	Expand the existing dementia-capable system to enhance access to supportive services for individuals with Alzheimer's disease and related dementia (ADRD) and their caregivers, and individuals with ADRD living alone.
Improve quality assurance mechanisms. (1 Initiative/Goal Link)		
	Excellence in Government	Improve quality assurance mechanisms.
Improve residents' access to long-term care services and supports, home and community-based resources, and options counseling by improving the quality and capacity of the intake and referral system within DCOA's ADRC and increasing coordination with District government sister agencies. (2 Initiatives)		
	Healthy Living for All Eight Wards	Improve residents' access to long-term care services and supports, home and community-based resources, and options counseling by improving the quality and capacity of the intake and referral system within DCOA's ADRC and increasing coordination with District government sister agencies.
	Healthy Living for All Eight Wards	Improve residents' access to long-term care services and supports, home and community-based resources, and options counseling by improving the quality and capacity of the intake and referral system within DCOA's ADRC and increasing coordination with District government sister agencies.
Increase outreach and access to services for the older lesbian, gay, bisexual, transgender and queer (LGBTQ) community. (3 Initiatives)		
	Healthy Living for All Eight Wards	Increase outreach and access to services for the older lesbian, gay, bisexual, transgender and queer (LGBTQ) community.
	Healthy Living for All Eight Wards	Increase outreach and access to services for the older lesbian, gay, bisexual, transgender and queer (LGBTQ) community.
	Healthy Living for All Eight Wards	Increase outreach and access to services for the older lesbian, gay, bisexual, transgender and queer (LGBTQ) community.

Increase support to older adults and persons living with disabilities searching for employment and assistance with career counseling, and resume assistance. (4 Initiatives)		
	Pathways to the Middle Class	Increase support to older adults and persons living with disabilities searching for employment and assistance with career counseling, and resume assistance.
	Healthy Living for All Eight Wards	Increase support to older adults and persons living with disabilities searching for employment and assistance with career counseling, and resume assistance.
	Pathways to the Middle Class	Increase support to older adults and persons living with disabilities searching for employment and assistance with career counseling, and resume assistance.
	Pathways to the Middle Class	Increase support to older adults and persons living with disabilities searching for employment and assistance with career counseling, and resume assistance.
Promote aging in place by reducing the risk of falls and mobility barriers in the home. (1 Initiative/Goal Link)		
	Healthy Living for All Eight Wards	Promote aging in place by reducing the risk of falls and mobility barriers in the home.
Promote intergenerational programming in order to combat social isolation, increase emotional support, and offer learning opportunities. (1 Initiative/Goal Link)		
	World Class Education for All Eight Wards	Promote intergenerational programming in order to combat social isolation, increase emotional support, and offer learning opportunities.
Promote the use of internet-based search tools for locating available services. (1 Initiative/Goal Link)		
	Excellence in Government	Promote the use of internet-based search tools for locating available services.
Reduce misdiagnosis of Alzheimer's disease and related dementias generated by chronic dehydration. (2 Initiatives)		
	Healthy Living for All Eight Wards	Reduce misdiagnosis of Alzheimer's disease and related dementias generated by chronic dehydration.
	Healthy Living for All Eight Wards	Reduce misdiagnosis of Alzheimer's disease and related dementias generated by chronic dehydration.
Sustain existing senior villages and promote the development of new senior villages in underserved neighborhoods. (1 Initiative/Goal Link)		
	Healthy Living for All Eight Wards	Sustain existing senior villages and promote the development of new senior villages in underserved neighborhoods.

Administrative Information

FY Performance Plan D.C. Office on Aging FY2016 **Record ID#** 146

Created on Sept. 4, 2015 at 1:38 PM (EDT). Last updated by Fowler-Finn, MeghanMarie (OSSE) on April 9, 2016 11:13 AM at 11:13 AM (EDT). Owned by Fowler-Finn, MeghanMarie (OSSE).

V. Grant Administration

A. Monitoring Project Performance

Grantees are responsible for properly carrying out the grant project or program to meet goals and objectives in the approved grant and for all administrative matters related to the grant award. Grantees should monitor the on-going performance of the grant, including all subcontracted work, to ensure that they meet performance goals, objectives, and timetables and comply with applicable federal and DC laws and regulations, DCOA service standards and their own internal policies and directives. For example, a grantee should:

1. Oversee the work of its own employees and ensure that their time is properly documented through accurate timesheets, signed by the employee and approved by their supervisor;
2. Make sure that services are being provided in accordance with approved objectives and service standards and are on target to meet performance goals and outcome measures;
3. Check on the work of contractors, ensuring that the work they perform, whether on or off-site, is actually and adequately being performed and that time and expenses are allowed under the contract, are properly supported and timely submitted; and
4. If it is a lead agency, monitor the nutrition sites it services to ensure that meals are being served properly, the voluntary contribution policy is being followed and not abused, and that the sites are using the UPT or Touch Screen system to record meals and other services properly and transmitting electronic data on a timely basis.

Grantees must maintain accurate documentation for each expenditure and action taken under the grant, including appropriate reviews and approvals according to the grantee's own organizational system. To that end, grantees are encouraged to develop written materials including policies, procedures and position descriptions, and implement practices that clearly identify levels of authority and provide for quality assurance in carrying out the functions of the organization, service provision and grant administration. Grantees are encouraged to communicate regularly with the DCOA program and financial staff who are assigned to their grant on programmatic and financial matters.

DCOA monitors each program, function or activity under the grant to ensure that grantees are complying with applicable Federal and DC requirements and that performance goals are being achieved. DCOA monitors progress through oral and written communications, review of information through regular reports or specific requests, on-site visits, and formal audits.

B. Notifications to DCOA and Requests for Approval

Events or developments may occur during the grant period that have a significant impact, either positive or negative, on the program's or project's implementation. Grantees are required to report **immediately** to DCOA any problems, delays or adverse conditions that materially affect their ability to carry out the terms and conditions of the grant. Significant reportable events include but are not limited to unusual incidents or accidents, major site renovations or closures, external events affecting program operations, and a significant drop in program attendance or revenue. In such instances, grantees must notify DCOA as soon as the conditions are known to the grantee. This disclosure must include the basic facts of the incident or event, the persons involved, the persons notified, a description of the action taken or contemplated, and any assistance needed to resolve the situation.

Significant developments that enable the grantee to meet time schedules and objectives sooner or at less cost than anticipated or that produce more beneficial results than originally planned should also be reported. Grantees should inform DCOA of minor changes in the scope of the project through normal channels of communication, including the CURT.

Grantees who need to make significant changes to the grant must obtain advance written approval from DCOA before making the change. Significant changes include but are not limited to changes in scope or objectives of the grant; facility or location of project site; key personnel; budget; or other factors that affect the ability of the grantee to carry out the grant, such as fulfilling objectives or meeting time schedules or performance outcomes. If any change under this Chapter requires a budget revision, the grantee must submit a budget revision request described in Paragraph V.G, below.

C. Changes in Scope or Objectives

In general, except for extreme circumstances beyond their control, grantees should not request a change in scope or objectives before the completion of the first quarter of the grant year but should try to adjust grant implementation so that the scope or objectives can be met. However, where changed circumstances warrant a change in the scope or objectives of the grant, after notification and discussions with DCOA officials, the grantee should request approval in writing from DCOA at least 30 days before the proposed implementation date, specifying the reason for the change, the proposed revision to the scope or objective, the proposed effective date of the change, the impact the change will have on the services provided and clients served, any personnel implications of the change, and, as appropriate, the budget impact of such change.

In its discretion, DCOA may approve the request, ask for additional information or documentation, approve the proposed revision as modified or with conditions, deny the request, or, if the circumstances are appropriate, terminate the grant or take such other action that it deems necessary. If the request for change in scope or objectives is approved, DCOA will amend the grant by issuing an amended Notification of Grant Award, as appropriate.

D. Changes in Facility or Site

While some DCOA grants provide services to DC seniors city-wide, many are located in and targeted to specific Wards or areas, where a change of location could cause a major disruption in service provision. In most circumstances, a change in facility or site, including a temporary closure for renovation, is a significant event requiring prior written approval. If a grantee wishes to change the site or facility from which it provides services, it should notify the DCOA as soon as the need becomes apparent. When an alternate site is located but before a commitment is made, the grantee should request approval to change the site, including the reason for the change, identification and description of the alternate site selected and others considered but rejected, the timing of the move, the impact the move will have on provision of services to its existing as well as prospective clients, the effects on transportation of clients, any projected drop in attendance anticipated and plans to address it, and any changes to the grant budget arising from the change in facility or site.

E. Changes in Key Personnel

Key Personnel are those people (identified in the B-6 Personnel Budget Schedules of the grant application) who fill positions that are critical to the operation of the program. Key personnel positions vary depending upon the program the grantee operates. They include the Executive Director of the organization where the Executive Director and the Project Director are the same, the Project Director and Assistant Project Director, or persons functioning in these capacities, regardless of title, any professional position, including but not limited to social worker, nurse, case manager, program or volunteer coordinator, or any position for which the incumbent must possess a license or certification, such as site managers and drivers for 16- passenger and larger vehicles.

1. Vacancies

When the grantee anticipates a vacancy in a key position, e.g., through a resignation notice, it must notify DCOA as soon as possible describing what steps it is taking to fill the position and to maintain level of services in the interim.

To request approval of key personnel, the grantee should submit the resume of the applicant selected before hiring, the names and a description of at least two other candidates considered but not selected, the salary and related personnel costs offered, revised budget schedules if the salary costs deviate from the original grant, and the proposed start date. In rare circumstances, if the grantee is unable to advertise for the position, it must state what efforts it took to seek competition, why they were unsuccessful and why the selected candidate is appropriate. Job offers should not be made and key personnel should not be hired until DCOA approval is granted. If not submitted in advance, a revised budget schedule showing the new employee with actual salary must be submitted to DCOA after approval of the candidate.

2. Temporary Absence of Project Director

Grantees must notify DCOA for all scheduled absences greater than one day of the Project Director and specify what arrangements are being made to carry out the project in the interim. If the Project Director will be absent cumulatively more than three months

during the grant year, the grantee must notify DCOA, justify retaining the individual as the project director, and state what arrangements are being made in that person's absence and the impact on grantee's ability to carry out the project and related administrative requirements.

3. Changes in FTE Devoted to the Project

Since grants are approved based on the proposed personnel structure and time devoted to carry out objectives, a significant drop in person-hours spent on the grant or change in the personnel structure may impair the grantee's ability to carry out the grant. A grantee must submit a written request if it plans to reorganize the personnel structure. When plans or conditions are known to the grantee that substantially less time than what was proposed in the personnel budget schedules will be devoted to the grant, it must notify DCOA. Any reduction of 25% of the total FTE or the elimination of any key position is considered "substantially less" than what was approved. However, a lesser reduction may trigger the requirement to request approval of the change from DCOA if it has a significant impact on the grantee's ability to carry out grant objectives. For instance, if a grantee fails to fill a vacant position at all or for a substantial period of time, it may have a significant impact on the program and on the budget and require reporting to DCOA, even though the grantee has not undergone a formal reorganization of personnel. A grantee must explain how it intends to meet the grant objectives with the reduced staff time or revised personnel structure. If the reduction would result in a change in the scope or objectives, the grantee must comply with the requirements in Chapter V.C, above).

F. Changes in Contractors and Consultants

Grantees must obtain advance written approval for changes in contractors or consultants retained under the grant and paid using DCOA funds from those identified in the grant. To obtain approval from DCOA, the grantee must provide the resume of the consultant or description documenting organizational capacity of a company, along with a description of competitors considered but not selected, a clear description of the work to be performed and costs. Financial information for contractors or consultants should include total contract cost, hourly rate, and a breakdown of other expenses being paid. Grantees must comply with Procurement standards in retaining contractors and consultants under OMB Policy Guidance, 2 CFR Part 215 Sections 41-48 and AoA regulations, 45 CFR Sec. 92.36(a).

G. Changes in the Grant Budget

The budget in the Notification of Grant Award (NGA) incorporating approved budget documents in the grant application constitute the financial plan covering DCOA and grantee share of expenses to carry out the grant. However, circumstances may develop where the budget does not reflect an accurate picture of actual and planned expenditures, the grantee may wish to make changes in the grant that trigger a change in budget, or the grantee may not be able to meet its financial obligations under the grant. In these situations, grantees must confer with the DCOA to request a budget revision. Grantees will not be reimbursed for expenses exceeding the total budget or for expenses in a particular cost category that exceed the approved total for that cost category. Grantees should request a budget revision if:

1. a change is proposed to any cost category or the total budget amount;
2. a change is needed to reallocate from one cost category to another, including a reallocation when all funds in one cost category have been expended, but additional unused funds are available in another category or a reallocation between direct and indirect costs;
3. a change in the grantee cost share requirement or the percentage of the grantee share is requested (In general, DCOA will not approve a request to reduce the grantee share below the minimum of 15% of the total grant amount.); and
4. a personnel change is requested.

However, grantees should review their entire budget rather than each separate category to avoid the need for multiple budget revisions.

When a grantee wishes to revise its budget, it must make the request in writing, explain why the budget modification is needed, how the revised budget changes will affect clients served and services provided, include a detailed explanation of the changes by cost category and amount made in the revised budget by grantee share and DCOA share, identify what services or items are being deleted and added, and attach revised budget schedules. The DCOA share in the proposed revised budget cannot exceed the amount awarded in the grantees most current NGA.

Requests for budget changes should be submitted to DCOA at least 21 days before the desired effective date. DCOA will not consider grantee proposals for budget revision in the first quarter of the year or after the tenth month (61 days before the end) of the grant year. Thus, at the end of the third quarter of the grant year, grantees should plan ahead and make their best estimates of their projected year-end expenses

and any need for realignment of costs. Requests for budget changes after the tenth month of the grant year will be considered only in emergency circumstances. Grantees must submit information in Table V-1, below, as part of their request for budget revision. Detailed procedures for making a budget revision request are contained in DCOA Policy Memorandum 07-P01, attached at Exhibit XII.I.
When a request for budget revision is approved, DCOA will issue an amended Notification of Grant Award.

Cost Category	Current Budget		Adjustment +/-	Revised Budget		Narrative Justification
	Local	DCOA		Local	DCOA	
Personnel						
Occupancy						
Communication						
Supplies/equipment						
Indirect/Overhead						
Other Directs						
Total						

Table V-1 – Request for Budget Revision

H. Cost Sharing or Local Share

1. Requirements

As a condition of the grant, DCOA requires all grantees to make cash and/or in-kind contributions toward grant expenses. This cost sharing (interchangeably referred to as matching or local share) requirement constitutes the grantee's share of the grant. DCOA expects grantees to share in the costs of the project reflecting their interest in the grant and their ability to cost share. DCOA establishes a minimum amount for a grantee to meet the cost sharing requirements. The standard minimum grantee cost share required for most DCOA grants is 15% of the grant award. Certain grants may have a higher matching requirement. Regardless of the minimum share required, grantees have the discretion to set and assume responsibility in determining the level of cost sharing in their proposal higher than the minimum amount required.

The grantee's share is its proportion of expenses compared to the total grant costs on the NGA, expressed as a percentage. The respective percentages for the DCOA and local

share are set forth as one of the terms and conditions on the back of the NGA. For example, if the DCOA share is $100,000 and the grantee share is $50,000, the total budget would be $150,000, and the grantee's share is
33 1/3%.

If the grantee expends less than the total grant costs for the grant project, the grantee's and DCOA's shares of the total actual costs are based on their respective percentages set forth in the NGA, rather than the dollar amount of the grant. Thus, in that instance, the grantee would be entitled to less than the total grant award. DCOA may require the grantee to apply the difference as a credit on a subsequent continuation grant, it may seek an offset from a current payment due to the grantee, or it may seek reimbursement if the total award has already been paid to a grantee. By or before the close of the third quarter of the fiscal year, if the grantee anticipates that its total local share will be lower than that stated in the grant, it should notify DCOA as soon as possible to discuss a budget modification, under Chapter V.G, above. If a grantee's match exceeds its matching percentage, the grant is limited by the total award amount.

2. Allowable Matching Costs

OMB Policy Guidance A-110, 2 CFR Part 215, and AOA regulations, 45 CFR Sec. 92.24, govern cash and in-kind contributions that satisfy the DCOA cost-sharing or matching requirements. To meet the grantee's cost sharing or matching requirement, cash or in-kind contributions must meet the following criteria. They:

- **a.** are not paid from any other DC grant or contract funds;
- **b.** are not included as a match to meet any other federally-assisted program or project or other DC grant;
- **c.** are necessary and reasonable to carry out the grant;
- **d.** are allowable under applicable cost principles;
- **e.** are verifiable by adequate record-keeping;
- **f.** are provided for under the approved grant; and
- **g.** conform to other requirements in 2 CFR 215 and 45 CFR 92.

Volunteer services that are an integral and necessary part of the grant project may be used to meet the matching requirements. They must be valued at the rate paid for similar work in the grantee's organization. If such work is not found in the grantee's organization, they must be valued at the fair market rate for that type of labor in the DC metropolitan area. Donated supplies or equipment included to meet matching requirements must be valued at their fair market value at the time of the donation.

3. Cost Sharing Records and Reports

Records that document a grantee's cost sharing expenses, for both cash and in-kind, are considered grant records and are subject to the same verification, storage, record retention, and disclosure requirements as other grant documents. To the extent feasible, grantees should document volunteer hours worked in the same manner that they use for their employees. At a minimum, records must identify the volunteer by name, include date and hours worked, and be approved by signature of an authorized employee of the grantee organization.

Grantees that are reimbursed through the M-1 and P financial reports must include documentation of all cost-sharing, including donated volunteer and in-kind expenses, with those reports. It is not sufficient to record $1/12^{th}$ of the budgeted cost share each month; the grantee share recorded on the M-1 and P reports must be based on *actual* cash and in-kind contributions occurring that month.

Grantees report their share total and share per-unit costs at the end of the fiscal year to DCOA in the required audit schedules. See Chapter VII.F.

I. Reporting Requirements

During the course of the grant, DCOA requires a number of reports and information to 1) ensure that the grantee is properly using grant funds and making progress in carrying out its project or program and 2) meet federal and other data collection and reporting requirements. Project Directors are encouraged to contact the appropriate DCOA program or financial staff at any time to answer questions or discuss implementation of the grant.

1. Project Directors Meetings

DCOA conducts monthly Project Directors meetings at the DCOA offices to share information applicable to all grantees, bring guest speakers, discuss topics of general interest to the Senior Service Network, and provide the grantees an opportunity to share information about their programs and raise shared concerns. Project Directors are ***required*** to attend the monthly Project Directors meetings. If in the rare instances they are unable to do so, they must notify DCOA in advance and send an alternate to the meeting.

2. Incident Reports

Because most DCOA grants involve the provision of direct services to the elderly, many of which affect the health and welfare of vulnerable individuals, grantees must report accidents, unusual incidents, attempts to lobby or conduct political activity at program sites, or other matters of a sensitive nature to the appropriate DCOA official as soon as possible. DCOA does not have a standard incident report form. However, many agencies have their own standard incident report forms which may be used in reporting to DCOA. At a minimum, the incident report to the DCOA should include the date and time of the incident, the basic facts of what occurred, the parties (internal and external) to

whom the incident was reported, how the incident was resolved, and any follow-up that is planned or required.

3. Comprehensive Universal Reporting Tool (CURT)

The DCOA Comprehensive Universal Reporting Tool (CURT) is the principle reporting document that grantees submit to provide information on progress in the grant. Grantees are required to provide descriptive information on the current activities conducted, monthly and year-to-date client or units of service counts for each objective under the grant; a summary of the grant finances showing monthly and year-to-date DCOA and grantee share expenses, with explanations of significant variances; and information on outreach activities and any deviations from the approved personnel roster. A description of each section of the CURT is contained in Policy Memorandum 06-07, included in Exhibit XII.I. The CURT Report form is attached as Exhibit XII.A.

The CURT is due 30 days following the end of each month. While DCOA developed the CURT for its monitoring use, the information gathered should be utilized by the grantee as a management tool for assessing its progress and awareness of significant issues arising in the grant. Information in the CURT may be made available to the general public through the Freedom of Information Act.

4. Client Service Information System Reporting Requirements

DCOA collects and compiles information required by AoA for grantees that receive funds under Titles III and VII of the Older Americans Act. Grantees report this information through the Client Service Information System.

a. Units of Service

Most grantees receiving federal Title III or VII funds must report information regarding client services they have provided based on standard units of service. DCOA reimburses some grantees on a unit cost reimbursement basis, and uses units of service to measure performance progress. AoA requires that DCOA report on the following selected services and service units:

i. Personal Care, Homemaker, Adult Day Care/Adult Day Health, Case Management, Legal Assistance, and Respite Care - 1 hour;
ii. Outreach and Access Assistance - 1 contact;
iii. Home-Delivered Meals and Congregate Meals - 1 meal;
iv. Transportation and Escort and Transportation to Sites and Activities - 1 one-way trip;
v. Nutrition Education - 1 session; and
vi. Counseling, including nutrition counseling - 1 session.

At the end of each fiscal year, grantees receiving Title III and Title VII funds must verify to DCOA by type of service the total number of clients served and the total number of units of service and provide an explanation of any decrease in units of service from the prior fiscal year or failure to meet the total projected

number of units of service in the grant. Detailed descriptions of each type of unit of service are contained in the Service Standards, attached as Exhibit XII.F.

b. Universal Participant Tracking System

In 2004, DCOA implemented the Universal Participant Tracking System (UPT) for units of service counts for its congregate meal and wellness programs. Participants are registered to receive a magnetic identification card, similar to a credit card, which must be swiped through a magnetic terminal before receiving a meal or passed under a scanner, depending on the site. The Congregate Meal site managers are authorized to use a guest UPT card for eligible guests only. In 2006, DCOA began expanding the UPT system to additional sites and services using a Touch Screen and card scanner. DCOA is contracting for technological changes in its tracking system. As new client tracking systems are developed, additional guidance will be forthcoming.

c. Source Documentation

For other units of service, grantees must maintain adequate records in accordance with the grantee's policies and procedures to verify the amount and type of services provided to an eligible senior. Depending on the type of service provided, this source documentation may be client attendance sheets, service records, travel logs, caseworker logs, or employee or volunteer logs. Source documentation should show by some identifier the client served, the date and hours of service, and the hours or units of service provided. When manual client attendance sheets are kept, the client must sign to verify attendance. An authorized employee may sign on behalf of a client who is unable to sign. Grantees provide copies of source documentation to DCOA at the time they submit rosters to the Client Service Information System

5. Financial Reports – *See Chapter VII. D, below*

J. Records Retention and Access

Grant records include but are not limited to grant financial records and related original and supporting documents that substantiate performance of the grant and costs charged to the activity. Records include written or recorded material, regardless of media, including electronic transmissions, CD's, videos, tapes and copies. Grant documents include copies of all grant and subgrant awards, applications, reports and correspondence relating to the grant. Personnel and payroll records include time and attendance reports for all individuals paid under the grant, including records of volunteers whose services are included to meet cost sharing requirements and consultants' time and effort reports. The descriptions in this paragraph are not intended to be comprehensive, and other items not described or listed here may constitute grant records.

Grant records must be retained by grantees for a minimum of three years following the date of the final notice from DCOA formally closing out the grant. For grants that are renewed on an annual or periodic basis, records shall be kept from the date of submission of the annual

audited financial statement covering that grant period. The only exceptions to these limits are:

1. If any litigation, claim or audit is started before the expiration of the 3-year period, records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.
2. Records for real property and equipment acquired wholly or in part with federal funds shall be retained for 3 years after final disposition of the property.

DCOA, the DC Office of Inspector General, the DC Attorney General, the U.S. Department of Health and Human Services/Administration on Aging, Office of Inspector General, and the U.S. Comptroller General and their authorized representatives and contractors shall have access to any pertinent records relating to the grant of the grantee and its subcontractors to conduct audits, examinations, excerpts and transcripts. Records may be maintained at the headquarters of the grantee or place of performance of the grant, as appropriate to use and need, provided there is adequate security to protect privacy and confidentiality based on the type of record involved. However, upon request by DCOA, they must be made available at the headquarters of the grantee.

K. Site Visit and Enforcement

DCOA has the right at all reasonable times to make site visits to review project accomplishments and grantee administration and management of the grant with or without prior notification to grantees. Grantees and their subcontractors shall provide reasonable facilities and assistance for DCOA representatives at any such site visit. Upon request or at such site visits, DCOA shall have access to all records relating to the grant and to any employee or contractor paid under the grant.

DCOA shall issue a site visit report following a formal site visit, making findings and recommendations and requesting corrective action, as necessary. Upon consideration of the grantee's response, or at any time if circumstances warrant it, DCOA may take further action to ensure that the terms of the grant and applicable federal and DC laws and regulations and DCOA policies are carried out and that the interests of the government and the clients served under the grant are protected.

DCOA, through its officials or subcontractors, may conduct periodic audits of a grantee for any grant year for which grant records are required to be retained. DCOA may refer the results of its site visits or audits to the DC Inspector General, DC Attorney General or federal officials for further action if appropriate.

L. Grant Close-out

Grant closeout is the process by which DCOA determines that all applicable administrative actions and all required work of the grant have been completed. Close-out is initiated on the date that all work under the grant is completed or on the last approved budget expiration date.

Within 30 days after the grant project is concluded, the grantee must refund to DCOA any balance of *unobligated* funds advanced or paid to the grantee.

Within 90 days after the date of completion of the grant, grantee must meet all its unpaid grant obligations and submit to DCOA final financial and performance reports. DCOA may extend the 90-day final reporting period if the grantee makes a written request with valid reasons for the extension.

1. The final financial report must include a current accounting of any property or equipment funded with grant funds, identifying any item to which DCOA retains title, a final accounting of all grant funds received, the total final grantee share of approved costs and a zero balance for unliquidated obligations and indicate the exact amount of unobligated funds which are to be deobligated by DCOA from the grant.
2. The final performance report should contain a summary of the project's success in meeting the goals, objectives and performance measures in implementing the grant, final year-to-date client counts and units of service, a description of what steps were taken to transition clients to other programs or service providers, and such other information as DCOA may require.
3. DCOA may require a financial and compliance audit of the grant. If a final audit has not been performed prior to the closeout of the grant, DCOA reserves the right to recover appropriate amounts after fully considering the recommendations on disallowed costs resulting from the final audit.

ATTACHMENT Q13 - FY16 and FY17 BUDGET & EXPENDITURE

FY 17 Budget & Expenditures - As of January 30, 2017					
Funding Source	**Comptroller Source Group Title**	**FY17 Budget Appropriation**	**FY 17 Actual Expenditures**	**Variance**	**Variance Explanation**
0100 - Local	**Total Personnel Services**	**3,132,546.62**	**454,288.62**	**2,678,258.00**	Expected expenditures by 09-30-2017
	Total Non-Personnel Services	**27,130,879.68**	**3,792,500.92**	**23,338,378.76**	Expected expenditures by 09-30-2017
Total		**30,263,426.30**	**4,246,789.54**	**26,016,636.76**	
0200 - Federal Grant	**Total Personnel Services & Non-Personnel Services**	**7,731,644.50**	**149,578.20**	**7,582,066.30**	Expected expenditures by 09-30-2017
Total		**7,731,644.50**	**149,578.20**	**7,582,066.30**	
0250 - Medicaid	**Total Personnel Services & Non-Personnel Services**	**1,037,479.27**	**480,213.87**	**557,265.40**	Expected expenditures by 09-30-2017
Total		**1,037,479.27**	**480,213.87**	**557,265.40**	
0700 - Intra-District	**Total Personnel Services**	**2,427,222.90**	**417,473.35**	**2,009,749.55**	Expected expenditures by 09-30-2017
	Total Non-Personnel Services	**642,651.58**	**410.75**	**642,240.83**	Expected expenditures by 09-30-2017
Total		**3,069,874.48**	**417,884.10**	**2,651,990.38**	
Grand Total		**42,102,424.55**	**5,294,465.71**	**36,250,693.44**	

FY 16 Budget & Expenditures					
Funding Source	**Comptroller Source Group Title**	**FY16 Budget Appropriation**	**FY 16 Actual Expenditures**	**Variance**	**Variance Explanation**
0100 - Local	**Total Personnel Services**	**3,055,637.85**	**2,959,343.79**	**96,294.06**	Nominal vacancy savings due to longer than expected hiring times for vacancies.
	Total Non-Personnel Services	**28,313,427.15**	**28,151,623.72**	**161,803.43**	FY16 actual charges for fleet were lower than initial estimates. Also includes miscellaneous nominal savings in other budget lines which includes IT, contracts and supplies
Total		**31,369,065.00**	**31,110,967.51**	**258,097.49**	
0200 - Federal Grant	**Total Personnel Services & Non-Personnel Services**	**7,814,809.00**	**7,721,342.91**	**93,466.09**	Rollover from a 3 year Alzheimer's grant
Total		**7,814,809.00**	**7,721,342.91**	**93,466.09**	
0450 - Private Grant	**Total Non-Personnel Services**	**1,000.00**	**1,000.00**	**0.00**	N/A
Total		**1,000.00**	**1,000.00**	**0.00**	
0700 - Intra-District	**Total Personnel Services**	**2,959,542.97**	**2,959,517.97**	**25.00**	Miscellaneous nominal savings
	Total Non-Personnel Services	**1,482,913.01**	**1,482,913.00**	**0.01**	Miscellaneous nominal savings
Total		**4,442,455.98**	**4,442,430.97**	**25.01**	
Grand Total		**43,627,329.98**	**43,275,741.39**	**351,588.59**	

ATTACHMENT Q14 - FY16 and FY17 REPROGRAMMING LIST

From/To	Agency Code	FY2016 Amount	FY2017 Amount	Original Intent and Reprogrammed use
Internal Reprogramming				
From Health Promotion and Wellness to the same source	BY0	$ 89,888	N/A	Original intent did not change. Reprogramming was completed to move funds to the correct budget line for the Alzheimer's Disease Initiative Grant.
From Personnel and Community Services to Personnel, In-Home & Continuing Care, and Contractual Services	BY0	$ 380,276	N/A	Original intent was for telephone, local personnel travel, and community services, but additional federal funds were received for community services and less funds were used for telephone and local travel than anticipated. Reprogramming was completed to fund grantees, out-of-town travel, and purchase equipment.
From Personnel, Other Services & Charges, and Contractual Services to Subsidies & Transfer	BY0	$ 750,000	N/A	Original intent was for personnel services, other services and charges, and contractual services. Funds were available largely as a result of contractual surpluses. Reprogramming was completed to provide additional funding for the Safe at Home Program.
From Supplies, Telephone, Travel and Contractual Services to Other Services & Charges, Subsidies & Transfer, and Equipment	BY0	$ 200,451	N/A	Original intent was for supplies, telephone, other services and charges, and contractual services. Funds were available due to cost savings. Reprogramming was completed to procure additional equipment and support services.
From Personnel to Personnel	BY0	$ 167,000	N/A	Original intent did not change. Reprogramming was completed to align personnel activities for term and career service.
From Personnel to Subsidies & Transfer	BY0	$ 103,275	N/A	Original intent did not change. Reprogramming was completed to move funds to the correct budget line for ADRC services in the community.
		$ 1,690,890		

ATTACHMENT Q15 - FY16 and FY17 INTRA-DISTRICT FUNDS

Intra-District Transfers Received by DCOA

FY 2016	FY 2017	Project Descriptions
$ 2,407,342.00	$ 1,432,709.00	ADRC Operations - BYADRC
$ 400,000.00	$ 220,000.00	Money Follow the Person Balancing - BYMFPR
$ 100,000.00	$ 100,000.00	Long-Term Ombudsman Program - DCLTC0
$ 128,958.00	$ 129,008.00	Independent Living Services for the Deaf and Blind Seniors - DDSRSA
$ 700,733.00	$ 779,795.00	Money Follow the Person - MFPDP1
$ 1,750,000.00	$ 1,000,000.00	Single Family Residential Rehabilitation Program - SAHOME*
$ 5,487,033.00	**$ 3,661,512.00**	

*Additional funding is pending for FY17

Intra-District Transfers from DCOA

FY 2016	FY 2017	Project Descriptions
$ 110,000.00	$ 110,000.00	OFRM Financial Services
$ 152,217.00	$ 197,941.00	Fleet Management
$ 148,375.82	$ 104,461.00	Purchase Cards
$ 51,503.00	$ 65,166.00	OUC - Communications
$ 228,355.00	$ -	DCHR
$ 11,441.00	$ 11,441.00	Requests for Telecommunications Services
$ 701,891.82	**$ 489,009.00**	

ATTACHMENT Q17iv - CAPITAL FUNDS

Capital LTD Activity and FY2017 - 2022 Planned Allotments - All Capital Funds (excl Intra-District funds)

(Project/Fund Detail with Lifetime Balances Only)

Source: SOAR/BFA

BY0-OFFICE ON AGING

	Project No	Project Title	Allotments in FY 2015	Expenditures in FY 2015	Allotments in FY 2016	Expenditures in FY 2016	LTD Expenditures	Unspent Allotments	Encumbrances	Pre Encumbrances	ID Advances	LifeTime Balance	Status of Available Allotment Balance
2	EA337C	WASHINGTON CENTER FOR AGING SERVICES REN	(1,120)	179,042	0	3,266	2,597,116	557,929	19,462	513,468	19,982	5,018	In DGS solicitation for construction for HVAC Upgrade.

ATTACHMENT Q19 - FY16 and FY17 CONTRACTS & GRANTS

FY2016 DCOA CONTRACTS AWARDED								
i. Name of Contracting Party	ii. Nature of Contract	iii. Contract Amount/Budget	iii. FY17 Expenditures as of Jan 31st	iv. Term of Contract		v. Competitively bid	vi. Agency Contract Monitor	vii. Funding Source
CATHOLIC CHARITIES (ANCHOR MENTAL)	Elderly-Prep & Delivery of Nutritious Meals	2,353,200.98	2,196,832.08	9/1/2012	9/30/2016	Yes	Jacqueline Geralnick	Local & Grant
MOM'S MEALS	Elderly-Prep & Delivery of Nutritious Meals	2,961,556.65	2,961,556.65	9/1/2012	9/30/2016	Yes	Jacqueline Geralnick	Local & Grant
DUTCHMILL	Elderly-Prep & Delivery of Nutritious Meals	2,738,562.23	2,584,053.48	9/1/2012	9/30/2016	Yes	Jacqueline Geralnick	Local & Grant
GLOBAL VISION TECHNOLOGIES	New Enterprise System	108,856.00	6,450.00	10/1/2015	9/30/2016	Yes	Garret King	Local
AISHA NAKIA BAILEY	Saturday respite program coordinator	7,830.00	7,830.00	10/1/2015	9/30/2016	No	Brittany Kitt	Local
COMCAST CORPORATION	Comcast Cable Television	500.00	165.01	10/1/2015	9/30/2016	No	Yolanda Lyles	Local
DELL COMPUTER CORP	Dell Laptop	35,699.82	35,699.82	10/1/2015	9/30/2016	No	Yolanda Lyles	Intra-District
MEDIWARE INFORMATION SYSTEMS	Harmony Maintenance Support	49,336.60	49,336.60	10/1/2009	9/30/2016	No	Yolanda Lyles	Local
RESCUE ONE TRAINING FOR LIFE	Rescue One-AED Parts and Maintenance	900.00	900.00	10/1/2015	9/30/2016	No	Nigel John	Local
SHAWN PERRY DBA	The Senior Zone- Broadcasting Services	8,642.00	8,642.00	10/1/2015	9/30/2016	No	Darlene Nowlin	Local
THE BEACON NEWSPAPERS INC.	Media Outreach	96,000.00	96,000.00	10/1/2015	9/30/2016	No	Darlene Nowlin	Local
THE CURRENT NEWSPAPERS INC	Media Outreach	24,090.00	24,090.00	10/1/2015	9/30/2016	No	Darlene Nowlin	Local
THE WASHINGTON INFORMER	Media Outreach	24,000.00	20,000.00	10/1/2015	9/30/2016	No	Darlene Nowlin	Local
FLIK INTERNATIONAL CORP	Annual Salute Centenarians	9,339.00	9,339.00	10/1/2015	9/30/2016	No	Darlene Nowlin	Local
XEROX DIRECT	Copy Machine Service and Maintenance	57,469.17	44,180.55	10/1/2015	9/30/2016	No	Yolanda Lyles	Local
INTERNATIONAL BUSINESS MACHINE	Statistical Software	2,530.00	2,530.00	10/1/2015	9/30/2016	No	Yolanda Lyles	Local
OST, INC	Business Consulting	31,858.82	31,858.82	10/1/2015	9/30/2016	No	Yolanda Lyles	Local
APPLE INC.	Apple Laptop	5,328.00	5,328.00	10/1/2015	9/30/2016	No	Yolanda Lyles	Local
ANCHORED PRODUCTIONS	Senior Picnic	22,856.25	22,856.25	10/1/2015	9/30/2016	No	Darlene Nowlin	Local
MVS INC	Data Services	53,742.12	53,742.12	10/1/2015	9/30/2016	No	Yolanda Lyles	Local
HARMONY INFORMATION SYS INC	Database Maintenance	99,625.00	99,625.00	10/1/2015	9/30/2016	No	Yolanda Lyles	Local
ARE INC T/A DENNY'S RESTAURANT	Meals Pilot	5,000.00	3,490.00	10/1/2015	9/30/2016	No	Jacqueline Geralnick	Local
MDM OFFICE SYSTEMS DBA	Office Furniture	9,425.25	9,425.00	10/1/2015	9/30/2016	No	Yolanda Lyles	Local
ENERG WELLNESS SOLUTIONS, LLC	Wellness Center Equipment	5,869.85	5,869.85	10/1/2015	9/30/2016	No	Nigel John	Local
THE RMARTIN GROUP LLC	Symposium Media	5,145.00	5,145.00	10/1/2015	9/30/2016	No	Darlene Nowlin	Local
VTECH SOLUTIONS INC.	Consultants	58,850.00	45,947.88	10/1/2015	9/30/2016	Yes	Yolanda Lyles	Local
HANOVER INDUSTRIES, INC	Consultants	24,000.00	7,104.00	10/1/2015	9/30/2016	Yes	Garret King	Local
DIGI DOCS INC/DOCUMENT MGERS	Temp Employee/Data Conversion	68,908.43	67,281.83	10/1/2015	9/30/2016	Yes	Yolanda Lyles	Local
HALES CREATIVE SOLUTIONS, LLC	Survey Services	18,300.00	18,300.00	10/1/2015	9/30/2016	No	Yolanda Lyles	Local

FY2017 DCOA CONTRACTS AWARDED								
i. Name of Contracting Party	ii. Nature of Contract	iii. Contract Amount/Budget	iii. FY17 Expenditures as of Jan 31st	iv. Term of Contract		v. Competitively bid	vi. Agency Contract Monitor	vii. Funding Source
CATHOLIC CHARITIES (ANCHOR MENTAL)	Elderly-Prep & Delivery of Nutritious Meals	1,648,304.23	190,333.23	9/1/2012	9/30/2017	Yes	Jacqueline Geralnick	Local & Grant
MOM'S MEALS	Elderly-Prep & Delivery of Nutritious Meals	3,054,265.00	759,518.00	9/1/2012	9/30/2017	Yes	Jacqueline Geralnick	Local & Grant
DUTCHMILL	Elderly-Prep & Delivery of Nutritious Meals	1,473,252.00	629,707.16	9/1/2012	9/30/2017	Yes	Jacqueline Geralnick	Local & Grant
THE BEACON NEWSPAPERS INC.	Media Outreach	56,000.00	14,000.00	10/1/2016	9/30/2017	No	Darlene Nowlin	Local
THE CURRENT NEWSPAPERS INC	Media Outreach	24,948.00	6,726.00	10/1/2016	9/30/2017	No	Darlene Nowlin	Local
THE WASHINGTON INFORMER	Media Outreach	24,000.00	6,000.00	10/1/2016	9/30/2017	No	Darlene Nowlin	Local
XEROX DIRECT	Copy Machine service and Maintenance	40,320.10	-	10/1/2016	9/30/2017	No	Yolanda Lyles	Local
A DIGITAL SOLUTIONS, INC.	Temp Employee	7,800.00	-	10/1/2016	9/30/2017	Yes	Yolanda Lyles	Local
SIVIC SOLUTIONS GROUP, LLC	Consulting Services	38,500.00	-	10/1/2016	9/30/2017	No	Garret King	Local
CENTER FOR THE STUDY	Consulting Services	9,625.00	-	10/1/2016	9/30/2017	No	Garret King	Local
HEARTLINE FITNESS PRODUCTS	Equipment Maintenance	10,000.00	-	10/1/2016	9/30/2017	No	Nigel John	Local
F.S. TAYLOR & ASSOCIATES, PC	Auditing Services	40,000.00	-	10/1/2016	9/30/2017	Yes	Garret King	Local
HANOVER INDUSTRIES, INC	Consulting Services	36,900.00	9,532.50	10/1/2016	9/30/2017	Yes	Garret King	Local
DIGI DOCS INC/DOCUMENT MGERS	Temp Employee/Data Conversion	89,642.40	-	10/1/2016	9/30/2017	Yes	Yolanda Lyles	Local
WALTON & GREEN CONSULTANTS	Consulting Services	7,800.00	-	10/1/2016	9/30/2017	Yes	Garret King	Local

FY2016 DCOA GRANTS AWARDED

i. Grantee Name	ii. Description	iii. Budget. Amt as of Jan 31, 2017	iii. Expenditures as of Jan 31, 2017	iv. Term of grants	v. Competitively bid	vi. Monitors	vi. Monitoring Activity	vii. Funding Source
LEAD AGENCIES/ADRC								
Terrific Inc.	Terrific Inc. ADRC Ward 1	$ 945,051.00	$ (945,051.00)	Oct1/2015 to Sep30/2016	Yes / 2013	Adu, Jennifer	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District
Terrific Inc.	Terrific Inc. ADRC Ward 2	$ 1,170,572.39	$ (1,121,587.27)	Oct1/2015 to Sep30/2016	Yes / 2013	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District
IONA Senior Services	IONA Senior Services Ward 3	$ 1,337,088.00	$ (1,337,087.96)	Oct1/2015 to Sep30/2016	Yes / 2013	Adu, Jennifer	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District
Terrific Inc.	Terrific Inc. ADRC Ward 4	$ 891,453.00	$ (891,453.00)	Oct1/2015 to Sep30/2016	Yes / 2013	Adu, Jennifer	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District
Seabury Resources for aging Services	Seabury Resources for Aging Services - ADRC Ward 5	$ 1,280,130.49	$ (1,278,466.49)	Oct1/2015 to Sep30/2016	Yes / 2013	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District
Seabury Resources for aging Services	Seabury Resources for Aging Services - ADRC Ward 6	$ 855,849.00	$ (855,623.81)	Oct1/2015 to Sep30/2016	Yes / 2013	Sanga, Nkwenti	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District
East River Family Strengthening Coll.	East River FSC - ADRC Ward 7	$ 1,293,906.00	$ (1,292,242.00)	Oct1/2015 to Sep30/2016	Yes / 2013	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District
Family Matters of Greater Washington	Family Matters - ADRC Ward 8	$ 851,179.00	$ (851,179.00)	Oct1/2015 to Sep30/2016	Yes / 2013	Sanga, Nkwenti	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District
		$ 8,625,228.88	**$ (8,572,690.53)**					
WELLNESS CENTERS								
Mary's Ctr Maternal Child Care	Bernice Fonteneau Senior Wellness Center-Mary Center Inc.	$ 371,403.51	$ (370,630.69)	Oct1/2015 to Sep30/2016	Yes / 2013	Geralnick, Jackie;	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local

Vida Senior Center	Hattie Holmes Senior Wellness Center - Vida Senior Center	$ 373,680.00	$ (373,680.00)	Oct1/2015 to Sep30/2016	Yes / 2013	Geralnick, Jackie;	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Providence Health Foundation	Model Cities Senior Wellness Center - Providence Health Foundation	$ 433,822.52	$ (422,103.65)	Oct1/2015 to Sep30/2016	Yes / 2013	Parikh, Gargi	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District
Howard University	Howard University- Hayes -Ward 6 Senior Wellness Center	$ 414,543.00	$ (412,478.32)	Oct1/2015 to Sep30/2016	Yes / 2013	Parikh, Gargi	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
East River Family Strengthening Coll.	Washington Senior Wellness Center - ERFSC	$ 361,300.00	$ (361,064.55)	Oct1/2015 to Sep30/2016	Yes / 2013	Geralnick, Jackie;	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Providence Health Foundation	Congress Heights Senior Wellness Center - Providence Health Foundation	$ 380,773.00	$ (380,321.79)	Oct1/2015 to Sep30/2016	Yes / 2013	Parikh, Gargi	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
		$ 2,335,522.03	**$ (2,320,279.00)**					
OTHER SERVICE ORGANIZATIONS								
Seabury Resources for aging Services	Seabury Resources for Aging Services - Seabury Connector*	$ 5,966,281.00	$ (5,922,353.93)	Oct1/2015 to Sep30/2016	Yes / 2013	Delespin-Jones, Aurora	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Seabury Resources for aging Services	Seabury Resources for Aging Services - Residence/Aging in Place	$ 512,272.59	$ (512,272.59)	Oct1/2015 to Sep30/2016	Continuation	Delespin-Jones, Aurora	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
East River Family Strengthening Coll.	East River FSC - Weekend Nutrition	$ 86,120.00	$ (86,120.00)	Oct1/2015 to Sep30/2016	Continuation	Geralnick, Jackie;	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Local
Family Matters of Greater Washington	Family Matters - Senior Works	$ 97,105.54	$ (97,105.54)	Oct1/2015 to Sep30/2016	Continuation	Khoo, Lynn	Closed-out	Grant/Local
Family Matters of Greater Washington	Family Matters - Golden Washingtonian	$ 87,020.55	$ (87,020.55)	Oct1/2015 to Sep30/2016	Continuation	Khoo, Lynn	Closed-out	Grant/Local
First Baptist Church, SW, Inc	First Baptist Senior Center	$ 227,301.00	$ (227,301.00)	Oct1/2015 to Sep30/2016	Continuation	Khoo, Lynn	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local

George Washington University - SHIP	George Washington University - SHIP	$ 75,719.76	$ (75,719.76)	Oct1/2015 to Sep30/2016	Continuation	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant
George Washington University	George Washington University - HICAP	$ 84,790.00	$ (83,154.34)	Oct1/2015 to Sep30/2016	Continuation	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Local
George Washington University - HICAP	George Washington University - HICAP	$ 152,732.00	$ (79,641.24)	Oct1/2015 to Sep30/2016	Continuation	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant
George Washington University	George Washington University - Need Assessment	$ 99,735.00	$ (99,623.86)	Oct1/2015 to Sep30/2016	YES / 2016	Delespin-Jones, Aurora		Local
Home Care Partners	HomeCare, Alcare, Caregiver Institute	$ 3,066,061.00	$ (3,028,759.39)	Oct1/2015 to Sep30/2016	Continuation	Khoo, Lynn	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Home Care Partners	Home Care Partner - Alzheimer's	$ 10,526.00	$ (8,771.27)	Oct1/2015 to Sep30/2016	Continuation	Brittany Kitt	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant
Home Care Partners	Home Care Partner - Safe at Home	$ 1,750,000.00	$ (1,748,828.41)	Oct1/2015 to Sep30/2016	Continuation	Khoo, Lynn	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Intra-District
Home Care Partners	Home Care Partner - CREST	$ 82,200.00	$ (52,655.23)	Oct1/2015 to Sep30/2016	Continuation	Khoo, Lynn	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Home Care Partners	Home Care Partner - Life Span	$ 64,203.92	$ (37,878.02)	Oct1/2015 to Sep30/2016	Continuation	Lynn Khoo	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant
Howard University	Howard University School of Social Work - Network Training	$ 115,000.00	$ (114,737.49)	Oct1/2015 to Sep30/2016	Continuation	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Local
Legal Counsel for the Elderly	Ombudsman, legal developer, advocacy, Legal Assistance	$ 1,308,541.00	$ (1,308,541.00)	Oct1/2015 to Sep30/2016	Continuation	Khoo, Lynn	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District

Some Inc./So Others Might Eat	SOME - Senior Center	$ 130,579.00	$ (129,915.75)	Oct1/2015 to Sep30/2016	Continuation	Sanga, Nkwenti	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Some Inc./So Others Might Eat	SOME - Caregivers	$ 117,474.00	$ (117,474.00)	Oct1/2015 to Sep30/2016	Continuation	Sanga, Nkwenti	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Some Inc./So Others Might Eat	SOME - Dwelling Place Kuehner House	$ 297,318.00	$ (297,318.00)	Oct1/2015 to Sep30/2016	Continuation	Sanga, Nkwenti	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
The Downtown Cluster's	Geriatric Date Care Center	$ 639,192.08	$ (639,174.00)	Oct1/2015 to Sep30/2016	Continuation	Delespin-Jones, Aurora	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
UDC - Office of the CFO	University of DC - Bodywise/Respite/Home Aid - Training	$ 150,000.00	$ (148,810.67)	Oct1/2015 to Sep30/2016	Continuation	Parikh, Gargi	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Local
Vida Senior Center	Vida Senior Center - Counseling, Recreation	$ 388,454.00	$ (388,454.00)	Oct1/2015 to Sep30/2016	Continuation	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Washington DC Jewish	Behrend-Adas Senior Fellowship	$ 57,454.00	$ (57,454.00)	Oct1/2015 to Sep30/2016	Continuation	Geralnick, Jackie;	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Local
Zion Baptist Church	Senior Day Care Center	$ 356,231.00	$ (355,911.81)	Oct1/2015 to Sep30/2016	Continuation	Delespin-Jones, Aurora	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
IONA Senior Services	Alzheimer's	$ 73,268.11	$ (70,755.83)	Oct1/2015 to Sep30/2016	Continuation	Kitt, Brittney	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant
The Downtown Cluster's	Alzheimer's	$ 75,952.00	$ (75,952.00)	Oct1/2015 to Sep30/2016	Continuation	Adu, Jennifer	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant

Seabury Resources for aging Services	Seabury MIPPA	$ 10,673.00	$ (10,673.00)	Oct1/2015 to Sep30/2016	Continuation	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant
East River Family Strengthening Coll.	East River MIPPA	$ 5,642.00	$ (4,047.72)	Oct1/2015 to Sep30/2016	Continuation	Maxine Crowder	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant
George Washington University	George Washington University-MIPPA	$ 8,576.16	$ (3,778.12)	Oct1/2015 to Sep30/2016	Continuation	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant
Capital Area Bood Bank	Commodity Supplemental Food Program	$ 856,305.00	$ (854,292.11)	Oct1/2015 to Sep30/2016	Continuation	Parikh, Gargi	1) monthly program progress reports: monitor if the program objectives are met. 2) Monthly incoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
		$ 16,952,727.71	**$ (16,724,494.63)**					
Grand Total		**$ 27,913,478.62**	**$ (27,617,464.16)**					

FY2017 DCOA GRANTS AWARDED

i. Grantee Name	ii. Description	iii. Budget. Amt as of Jan 31, 2017	iii. Expenditures as of Jan 31, 2017	iv. Term of grants	v. Competitively bid	vi. Monitors	vi. Monitoring Activity	vii. Funding Source
LEAD AGENCIES & CASE MANAGEMENT								
Terrific Inc.	Terrific Inc. ADRC Ward 1	$ 779,309.00	$ (172,594.71)	Oct1/2016 to Sep30/2017	Yes / 2013	Adu, Jennifer	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Terrific Inc.	Terrific Inc. ADRC Ward 2	$ 946,120.00	$ (211,462.14)	Oct1/2016 to Sep30/2017	Yes / 2013	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
IONA Senior Services	IONA Senior Services Ward 3	$ 1,100,978.00	$ (200,079.85)	Oct1/2016 to Sep30/2017	Yes / 2013	Adu, Jennifer	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
IONA Senior Services	IONA Senior Services - Supplements	$ 21,150.00		Oct1/2016 to Sep30/2017	Yes / 2013	Adu, Jennifer	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Terrific Inc.	Terrific Inc. Ward 4	$ 750,330.00	$ (174,463.70)	Oct1/2016 to Sep30/2017	Yes / 2013	Adu, Jennifer	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Seabury Resources for the Aging	Seabury Resources for the Aging - Ward 5	$ 1,075,522.00		Oct1/2016 to Sep30/2017	Yes / 2013	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District
Seabury Resources for the Aging	Seabury Resources for the Aging - Ward 5 (Home First and Age in Place)	$ 437,535.00		Oct1/2016 to Sep30/2017	Yes / 2013	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District

Seabury Resources for the Aging	Seabury Resources for the Aging - Ward 6	$ 708,209.00	$ (105,497.95)	Oct1/2016 to Sep30/2017	Yes / 2013	Sanga, Nkwenti	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
East River Family Strengthening Collaborative	East River Family Strengthening Collaborative-Ward 7	$ 998,137.00	$ (109,493.59)	Oct1/2016 to Sep30/2017	Yes / 2013	Maxine Crowder	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Family Matters	Family Matters - Senior Services Ward 8	$ 600,000.00	$ (197,828.39)	Oct1/2016 to Sep30/2017	Yes / 2013	Khoo, Lynn	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District
		$ 7,417,290.00	**$ (1,171,420.33)**					
SENIOR WELLNESS CENTERS/FITNESS								
Mary Center Inc.	Bernice Fonteneau Senior Wellness Center-Mary Center Inc.	$ 360,358.00	$ (54,305.91)	Oct1/2016 to Sep30/2017	Yes / 2013	Geralnick, Jackie	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Mary Center Inc.	Hattie Holmes Senior Wellness Center - Vida Senior Center	$ 357,305.00	$ (23,308.05)	Oct1/2016 to Sep30/2017	Yes / 2013	Geralnick, Jackie	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Providence Model Cities	Model Cities Senior Wellness Center - Providence Health Foundation	$ 360,319.00	$ (43,326.33)	Oct1/2016 to Sep30/2017	Yes / 2013	Parikh, Gargi	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local/Intra-District
Howard University	Howard University- Hayes - Ward 6 Senior Wellness Center	$ 338,199.00	$ (24,941.06)	Oct1/2016 to Sep30/2017	Yes / 2013	Parikh, Gargi	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
East River Family Strengthening Collaborative	Washington Senior Wellness Center -ERFSC	$ 344,351.00	$ (10,121.99)	Oct1/2016 to Sep30/2017	Yes / 2013	Geralnick, Jackie	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local

East River Family Strengthening Collaborative	Congress Heights Senior Wellness Center - Providence Health Foundation	$ 359,496.00	$ (12,088.12)	Oct1/2016 to Sep30/2017	Yes / 2013	Parikh, Gargi	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
University of the District of Columbia	University of the District of Columbia - Gerontolgy	$ 150,000.00	$ (18,521.11)	Oct1/2016 to Sep30/2017	Continuation	Parikh, Gargi	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Local
		$ 2,270,028.00	**$ (186,612.57)**					
IN-HOME SUPPORT SERVICES								
Home Care Partners	Home Care Partners - Alcare/Homemaker	$ 1,703,599.00	$ (436,220.43)	Oct1/2016 to Sep30/2017	Continuation	Khoo, Lynn	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Home Care Partners	Home Care Partners - Alcare/Homemaker	$ 471,939.06		Oct1/2016 to Sep30/2017	Continuation	Khoo, Lynn	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
SOME (So Others Might Eat) - Senior Center	SOME - Caregivers	$ 112,374.00		Oct1/2016 to Sep30/2017	Continuation	Khoo, Lynn	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Capital Area Food Bank	Commodity Supplemental Food Program	$ 410,000.00		Oct1/2016 to Sep30/2017	Continuation	Parikh, Gargi	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
East River Family Strengthening Collaborative	East River Family Strengthening Collaborative-Weekend Nutrition Program	$ 86,120.00	$ (10,701.58)	Oct1/2016 to Sep30/2017	Continuation	Maxine Crowder	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Local
IONA Senior Services	IONA - Alzheimers	$ 152,774.76	$ (32,988.95)	Oct1/2016 to Sep30/2017	Continuation	Adu, Jennifer	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant

Home Care Partners	Home Care Partners -Safe at Home	$ 915,000.00	$ (485,843.65)	Oct1/2016 to Sep30/2017	Continuation	Spence, Kay-Anne	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Intra-District
		$ 3,851,806.82	**$ (965,754.61)**					
COMMUNITY BASED PROGRAMS AND SUPPORTS								
Legal Counsel for the Elderly	Legal Counsel for the Elderly	$ 1,027,039.24	$ (203,761.90)	Oct1/2016 to Sep30/2017	Continuation	Khoo, Lynn	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
George Washington University	George Washington Health Insurance Counseling Assistance Program	$ 84,790.00	$ (17,117.34)	Oct1/2016 to Sep30/2017	Continuation	Crowder, Maxine	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Local
First Baptist Senior Center	First Baptist Senior Center	$ 196,301.00	$ (29,341.55)	Oct1/2016 to Sep30/2017	Continuation	Khoo, Lynn	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
SOME (So Others Might Eat) - Senior Services	SOME - Senior Center	$ 125,304.00	$ (23,469.26)	Oct1/2016 to Sep30/2017	Continuation	Khoo, Lynn	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
SOME (So Others Might Eat) - Senior Center	SOME - Dwelling Place Kuehner House	$ 297,318.00	$ (100,121.48)	Oct1/2016 to Sep30/2017	Continuation	Khoo, Lynn	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Downtown Clusters - Geriatric Day Care	Downtown Clusters- Geriatric Day Care	$ 523,191.00	$ (93,197.58)	Oct1/2016 to Sep30/2017	Continuation	Jennifer Adu	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
VIDA - Senior Center	Vida Senior Center	$ 357,854.00	$ (26,201.35)	Oct1/2016 to Sep30/2017	Continuation	Maxine Crowder	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local

ZION Baptist Church	ZION Baptist Church-Geriatric Day Care	$ 305,631.00	$ (52,950.70)	Oct1/2016 to Sep30/2017	Continuation	Jennifer Adu	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Washington DC Jewish Community Center	Behrend-Adas Senior Fellowship	$ 57,454.00	$ (6,227.75)	Oct1/2016 to Sep30/2017	Continuation	Geralnick, Jackie	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Local
Seabury Resources for the Aging - Connector	Seabury Resources for the Aging - Connector	$ 4,619,333.00	$ (818,097.93)	Oct1/2016 to Sep30/2017	Yes / 2013	Delespin-Jones, Aurora	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
Seabury Resources for the Aging - Connector	Seabury Resources for the Aging - Connector	$ 718,421.00	$ (718,421.00)	Oct1/2016 to Sep30/2017	Yes / 2013	Delespin-Jones, Aurora	1) monthly program progress reports: monitor if the program objectivess are met. 2) Monthly invoices: Monitor if expenses are reasonable. 3) Quarterly financial report: monitor spending activities. 4) twice a year site reviews and unannounced site review(s): review program operations, site, customer satisfaction, staffing and resolve issues. 5) Frequent phone and email communications for trouble-shooting.	Grant/Local
		$ 8,312,636.24	**$ (2,088,907.84)**					
Grand Total		**$ 21,851,761.06**	**$ (4,412,695.35)**					

*** Senior Village is being competitively bid in FY17**

ATTACHMENT Q23a

DCOA 2016 NEEDS ASSESSMENT

This Report was prepared by the Center for Aging, Health and Humanities at George Washington University with the support of a grant from the D.C. Office on Aging.

School of Nursing
THE GEORGE WASHINGTON UNIVERSITY

CENTER FOR AGING
HEALTH AND HUMANITIES

School of Medicine
& Health Sciences
THE GEORGE WASHINGTON UNIVERSITY

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The Center for Aging, Health & Humanities
GW School of Nursing
1919 Pennsylvania Avenue NW, Suite 500
Washington, DC 20006

September 30, 2016

DC Office on Aging Headquarters
500 K Street, NE,
Washington DC 20002

Dear Executive Director Laura Newland & DCOA Partners,

I would like to thank DCOA for commissioning the 2016 Needs Assessment which aligns with Age-Friendly DC Initiative. Through the Mayor's vision, the District of Columbia Office on Aging (DCOA) and its community-based partners play a key role in making our City a better place for the constituents who live here. The 2016 Needs Assessment provides an opportunity to highlight the needs of our older adults, persons with disabilities, caregivers, and service providers, as well as highlight successful programs.

The report includes primary research with residents and community stakeholders who provide services to older adults. It also provides data to address the present and changing demographics and needs within the wards. This information will prove to be instrumental as DCOA and stakeholders prepare to meet the diverse needs of the more than 107,000 older adults in DC.

The Center for Aging Health and Humanities at George Washington University utilized national and local research, focus groups, surveys, and interviews to assess the District's needs. Additionally, best practices from Age-Friendly networks are presented to provide future recommendations and direction for DCOA operations.

I would like to thank you for taking the time to review the 2016 Needs Assessment of older adults in DC.

Sincerely,

Beverly Lunsford, PhD, RN, FAAN

EXECUTIVE SUMMARY

PURPOSE

The DCOA 2016 Needs Assessment was conducted to:

1. improve overall agency efficiency,
2. identify high-value areas for improvement, expansion or innovation, and
3. implement a sustainable approach for establishing priorities and procedures to meet the needs of individuals 60 years and older in DC.

BACKGROUND

There are currently over 107,000 seniors living in DC, and about 17,500 (16.5%) utilize DCOA services and programs. The other 90,000 older adults who are not touched directly by DCOA services may still benefit from DCOA advocacy and DCOA information widely available to elders and their families. However, the extent to which DCOA advocacy and information impacts these older adults is unknown. Furthermore, the extent to which elders use their own purchasing power to access desired services (such as private case management, assisted living, even gym memberships) has not traditionally been measured nor considered as part of the aging services network. Assessing the adequacy or gaps in private market services has not been seen as within the purview of DCOA. This is also true for many services provided by other DC governmental agencies and for a wide array of health services funded through Medicare, Medicaid, and private insurers. In sum, the traditional view of DCOA's domain has been limited to the services DCOA itself provides or funds and to the clients receiving those services. However, this is only a part of the full scope of services that elders use to maintain and enhance their quality of life.

The DCOA client constituency may be roughly seen as three overlapping groups, each of whom has different needs and resources (see Figure 1). First are the well elderly who are living in the community and are hoping to maintain or enhance their quality of life. About half of the elderly in DC live alone. The needs of the well elderly are for information (i.e. advance care planning information, information about caregiving), support for enhancing quality of life (i.e. socialization, civic participation), preventive services to preserve health and functioning (such as fall prevention), support for staying in the community (i.e. accessible housing), and advocacy to address a variety of impediments to "age friendly" living.

The second group is the frail elderly. These are elders with significant health conditions that may bring them into frequent contact with the health care system. A third of DC elder residents are disabled, although the definition for frail and disabled is not precisely equivalent. Many of the frail elders are home bound or socially isolated. Their needs are for tighter integration of health and social socials, for rapid delivery of services during crisis, and for sustained and coordinated support to keep them in community. Finally, there is the subgroup of elders with limited economic power. Currently, about one quarter of DC elders have incomes less than 150% of the federal poverty level. For these residents, poverty compounds age-associated problems by making it harder to afford basic services such as housing and food. Many of these residents contend with significant economic barriers that

are not primarily about aging issues, but that are exacerbated by – and in turn exacerbate – the challenges of living well and happily as one ages.

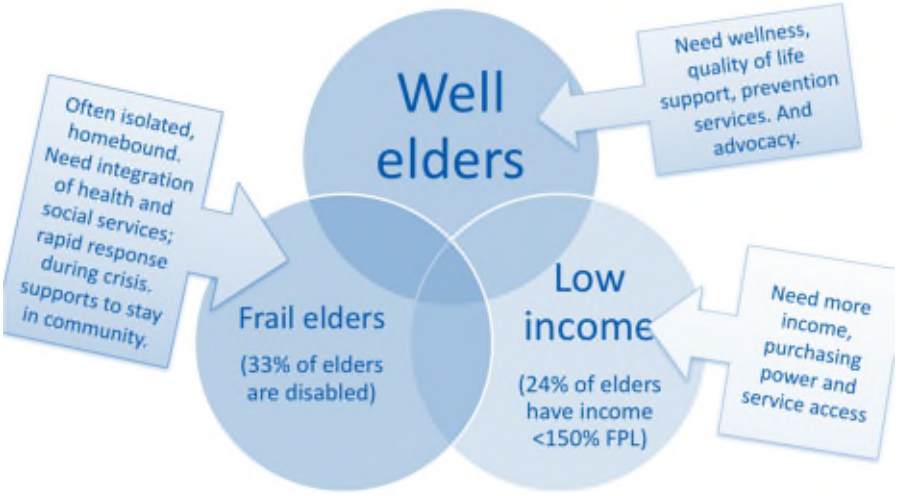


Figure 1. DCOA Client Constituents

Finally, the stark contrast between the rapid increase in the elderly population and the static or declining governmental funding for aging services is well known. Faced with this, the challenge for DCOA is either how to prioritize services within the static pool of available funds, or how to advocate for new funding (including private market funding) that might keep pace with population growth.

FOCAL QUESTION

The focal question the DCOA 2016 Needs Assessment endeavors to answer is:

How do we serve more seniors, and/or serve seniors more effectively, including:

- Keeping seniors in their homes longer,
- Providing holistic array of services to optimize quality of life, and
- Ensuring the most frail and sick people are heard, more able-bodied individuals may be more able to advocate for themselves for resources.

The ***conceptual framework*** of the ten age friendly domains developed as part of DC's participation in the WHO Global Network of Age-Friendly Cities and Community Programs was utilized to address the questions posed by the DCOA 2016 Needs Assessment.

We supplemented these domains with two additional domains: food security and caregivers (Table 1).

TABLE 1. DCOA 2016 NEEDS ASSESSMENT 12 DOMAINS

1	Outdoor spaces
2	Transportation
3	Housing
4	Social participation
5	Respect & social inclusion
6	Civic participation
7	Communication & information
8	Community & health services
9	Emergency preparedness & resilience
10	Legal
11	Food Security
12	Caregivers

Three data pathways (Figure 2.) were used to collect relevant data addressing the focal questions:

- Surveys of seniors in DC, surveys of service providers, and focus groups with vulnerable populations;
- Interviews with key informants and thought leaders; and
- Identification of best practices

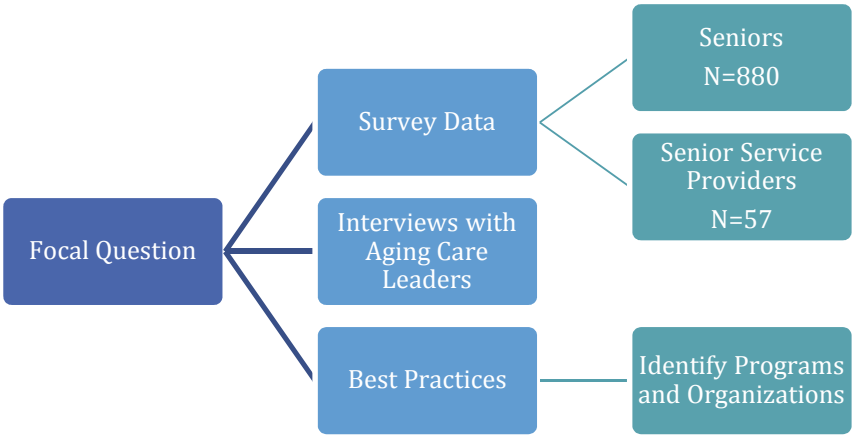


Figure 2. Data Pathways

The **Senior Survey** asked seniors or their caregivers to rate each of 39 services on these dimensions:

- ***How important is this to you?***
  (Rated on a 4-point Likert scale from "Very important" to "Not at all important")
- ***If you have assistance, who assists you?***
  (Choices were family, friend, DCOA, religious organization, other write-in) Rated on a 5-point Likert scale from "Very satisfied" to "Very dissatisfied")
- ***If you are not receiving assistance, why not?***
  (Choices*: "*Don't need", "Don't know how to get services", "Can't afford services", "Don't share financial information", "Never thought about this", "Family's responsibility to provide", "Other" write-in).

This report covers the analysis of 880 resident surveys completed online and in hard copy by September 15, 2016.

The **Service Provider Survey** mirrored the Senior Survey in the items queried. For each of the 39 services and/or activities, service providers were asked:

- ***How important is this to you?***
  (Rated on a 4-point Likert scale from "Very important" to "Not at all important")
- ***How satisfied are you with DCOA and Network Services currently offered?***
  (Rated on a 5-point Likert scale from "Very satisfied" to "Very dissatisfied")
- ***What are the challenges in offering this service/addressing this need?***
  Space was provided for open-ended responses.

The provider survey participants included 57 individuals who self-identified as providing services to older adults in DC.

Interviews with Aging Care Leaders were conducted with 13 key geriatric/gerontology healthcare providers in DC to elicit critical healthcare needs of older adults; to inquire about innovative and evidence-based practices either in use by, or known by, the contacts; to explore opportunities for collaboration with DCOA in caring for Seniors in DC. The interdisciplinary healthcare providers interviewed were practicing in DC hospitals, nursing homes, outpatient clinics, home-based geriatric primary care practices, hospice, front-line DCOA service professionals, and community outreach programs. Providers included physicians, nurse practitioners, social workers, registered nurses, community outreach personnel, and DCOA transitional care coordinators.

Best Practices were identified by reviewing professional literature, websites and organizational information. A search was conducted for best practices in each of the age friendly domains and the practices were evaluated based on the American Public Health Association's (APHA) Health in All Policies framework. These five criteria are: 1) Promoting health and equity, 2) Supporting inter-sectoral collaboration, 3. Creating co-benefits for multiple partners, 4) Engaging stakeholders, and 5) Creating structural or process change. Our final list of identified 165 best practices relevant to the age friendly domains of concern.

Demographics of survey respondents were comparable to all DC older adults:

- more likely to be female (77% survey vs. 60% all DC seniors)
- more likely to be African American (73% survey vs. 60% all DC seniors)
- more likely to have income below 150% of federal poverty level (31% survey vs 24% all DC seniors)
- same level of education with 13% no high school diploma and 61% at least some college
- equally likely to live alone (56% survey vs. 55% all DC seniors)
- equally likely to be disabled (30% survey vs. 33% all DC seniors)

Nearly one quarter of respondents were between 65 and 69, and 20% were between 70 and 74 years. Of seniors responding to the question *What health challenges do you face?*, the most commonly reported conditions were heart disease (including hypertension), hard of hearing, and diabetes mellitus. The distribution of respondents across the Wards in DC varied from 7% in Ward 3 to 18% in Ward 4. All Wards were represented with some over-representation by percent from Wards 1, 4, 7 and 8, some underrepresentation from Wards 2, 3, 5, and 6.

The respondents to the organizational survey mostly worked with private entities: non-profit organizations (51%), and for-profit organizations (21%). The service areas in which they provided services were roughly equally distributed across all DC wards. Over half of respondents reported their provider organizations served DC exclusively, while the balance served the entire Metro area, including Maryland and Virginia suburbs of DC.

A Priority Ranking based on perceived importance and need was developed of each service by combining survey responses about importance (the question "How important is this to you?") with responses that indicated unmet need. The measure of unmet need was the proportion of respondents who said either "don't know how to get services", "can't afford services" or "won't share financial information" in response to the question "If you are not receiving assistance, why not?" Importance and unmet need were combined in equal weights to create a priority ranking score. The importance, unmet need and priority were examined in three sets of respondents: all respondents to the senior survey, only those who were seniors with disabilities, and only those with incomes less than $15,000 per year. The top four responses for all older adult respondents, older adults with low income (<$15,000), older adults who indicate they are disabled are illustrated in Figure 3.

	All Older Adult Respondents	Older adults with Low Income (<$15,000)	Older Adults who Indicate they are Disabled
1	Preventing Falls and other accidents	Knowing what services are available	Knowing what services are available
2	Knowing what services are available	Info/assistance applying for health ins. or Rx coverage	Preventing Falls and other accidents,
3	Keeping warm/cold as weather changes	Assistance applying for other benefits, e.g. SNAP	Info/assistance applying for health ins. or Rx coverage
4	Assistance with repairs and maintenance of my home or yard	Getting exercise that is good for me	Keeping warm/cold as weather changes

Figure 3. Top Four Services By Priority Ranking

MAJOR FINDINGS

More communication and information needed

- 85% of seniors and 98% of providers rated "Knowing what services are available" as *very important,* yet for every domain, 20% or more of seniors report they don't know how to access the service
- For every domain, a high proportion of older adults report "don't know how to get services." This ranges from one in four (24.5%) for the legal advocacy domain to one in eight older adults (12.1%) for the civic participation domain.
- Health care professional interviewees requested many improvements in DCOA service information, ranging from a "one stop shop" resource person at DCOA to more print and on-line information to presentations and training.
- Although almost all (95%) of provider respondents reported knowing about DCOA and its services, almost a quarter (22%) did not know about ADRC services.

No infrastructure for monitoring quality or unmet need

- Although providers reported perception of significant variation in quality between service providers, there is no system-wide data collection to assess either unmet need or quality of service.

Significant unmet need for services in many areas

- 75% of provider respondents said they could not adequately meet the needs of all their clients
- 40% of provider respondents reported maintaining a wait list to provide services, including subsidized handicap accessible housing, case management services, home-bound services, emergency shelters, home modifications, delivery of meals for home-bound clients, housekeeping services, delivery of medical supplies, and adult day care.

- Seniors' reported unmet need was high in all domains. Unmet need ranged from 39% in the housing domain to 36% in the communication/information domain to a low of 17% in the civic participation domain (employment and voting.)

Priorities differ based on senior situation

- *Knowing what services are available* and *preventing falls/accidents* rank among the top 5 priorities for all seniors overall and for the subgroups of seniors with disabilities and seniors with low income.
- Seniors with low income and seniors with disabilities rate *assistance applying for health insurance,* much more highly than do all seniors.
- Seniors with low income rate *assistance applying for other benefits*, and *getting exercise* much more highly than do all seniors or seniors with disabilities.
- Providers, both on the survey and in interviews, place a higher importance on services needed to meet urgent or emergent needs.
- On average, disabled and low-income respondents rate many more services as highly important (at least 3.0 on 4 point scale of importance). For all seniors, 27 out of 39 services were ranked at least 3.0. But seniors with disabilities ranked 35 services and seniors with low income ranked 36 services at least 3.0 in importance.
- On average, need is higher on many more services for seniors with disabilities or seniors with low income than for all seniors.

KEY RECOMMENDATIONS

As a result of our comprehensive review of the state of aging needs and services in DC, the consulting team identified key opportunities that cut across need domains. Faced with a fast-growing gap between the expanding need for services and public funding that is flat, DCOA needs to re-conceptualize its role beyond that of allocating and overseeing public monies to the service providers in each ward. DCOA needs to strengthen its capacity for advocacy and coordination so that it becomes a catalyst for helping a variety of actors, both public and private, foster healthy, fulfilled aging for all DC residents. This will require DCOA to increase its capacity to provide service level improvements, as well as key system-wide components. The five main recommendations are summarized below and are shown conceptually in Figure 4.

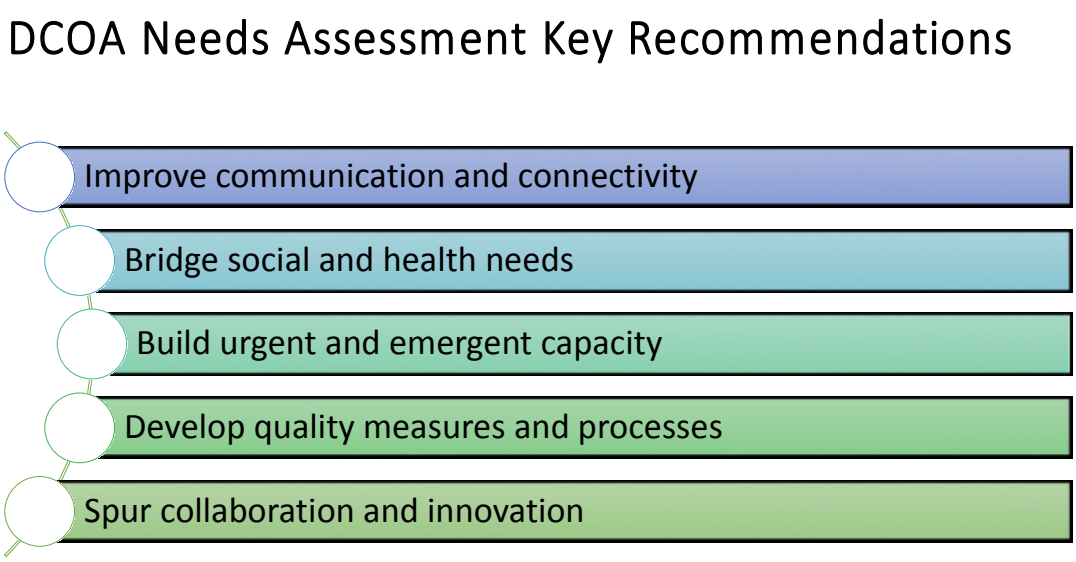


Figure 4. Recommendations from DCOA 2016 Needs Assessment

- ***Improve communication and connectivity*** among services/activities, DCOA, older adults, caregivers, families, and service providers for older adults in DC.
    - Develop a more robust DCOA website with Age-Friendly Navigation.
    - Establish a Virtual Senior Center to provide consistent and city-wide information regarding services offered.
    - Utilize Virtual Senior Center to provide city-wide interactive programming for exercise, socialization, arts activities, education, etc.
    - Extend/Leverage "No Wrong Door" Model to provide portal for comprehensive service access and rapid intake.
    - Extend collaborations with AARP and Villages as local and trusted source of information.

- ***Bridge social and health needs*** to more effectively address the health care needs of older adults and their families/caregivers, including healthcare, housing, food security, transportation and safe environments
    - Establish coalition of DCOA stakeholders and healthcare organizations to collaborate for coordinating and improving care and transitions for older adults, e.g. care management provided by the ADRC's could be coordinated more effectively with hospital programs, programs to reduce hospital readmission could be coordinated with DCOA supports and services.
    - Extend interprofessional DCOA team to include a Geriatric Advanced Practice Nurse to bridge social and broader health services, including chronic disease education and consultation.
    - Recognize importance of addressing chronic illness management in older adults as 4 out of 5 Americans over 50 suffer from at least one chronic condition, more than 50% have more than one and 20% have some form of mental illness (Centers for Medicare and Medicaid Services, 2006), which

precludes addressing social needs in isolation of physical and mental health problems.

- Address service improvements through recognition of the DCOA services as important social determinants of health, which are six domains, i.e. economic stability, neighborhood and physical environment, food, community and social context, and healthcare system. For example, food is a social determinant of health. What about food makes it a social determinant of health? An example is a neighborhood with quality grocery stores and access to three meals a day makes maintaining a healthy diet easier. Hunger and access to healthy options impact an individual's health. Living in a food desert or obtaining one meal a day impacts health outcomes. Collectively the six social determinants of health domains impact the mortality, morbidity, life expectancy, health care expenditures, health status and functional limitations of the District.

- ***Build urgent and emergent capacity*** for critical services
  - Improve ***transportation capacity and quality*** for older adults, especially sick and frail in DC.
    - Develop mechanisms for "urgent care" access to transportation.
    - Develop funding sources beyond DCOA to expand capacity; these may involve public/private partnerships, or collaboration with health care institutions.
    - Collaborate with other agencies/organizations who also provide these services to reduce gaps in transportation
  - Improve ***housing capacity and quality*** for older adults, especially sick and frail in DC.
    - Continue 'Safe at Home" to improve housing for older adults, including reducing fall risk and barriers that limit mobility.
    - Develop funding sources beyond Older Americans Act funding to expand capacity.
    - Expand public/private partnerships and collaboration with health care institutions.
  - Improve capacity to provide ***adequate and healthy foods*** for older adults, especially sick and frail in DC.
    - Ensure comprehensive nutrition services city-wide to provide dedicated expert nutritional providing nutrition information, assessment, and counseling to older adults (geriatrics), their families and caregivers on nutrition and feeding issues education for providers, older adults, families and caregivers, that include: unintentional weight loss or poor appetite; dementia-related feeding issues; dysphagia; diabetes nutrition management; chronic kidney disease nutrition; cardiovascular nutrition issues; weight management; tube feeding or oral calorie & protein nutrition supplements; wound healing; and, general healthy eating for seniors.
    - Utilize city-wide nutrition nutritionist who can write prescriptions for nutrition supplements, secure public and private additional funding and support to maintain an adequate supply of special supplements (nutrition supplement bank at Capital Area Food Bank;

        - advocate for home delivered meals as part of EPD waiver services for FY18, and
        - Establish transitional care nutrition (hospital to home) to reduce compromised health condition and possible readmission.

- ***Develop quality measures and systematic process*** for measurement and evaluation of DCOA service quality, including monitoring unmet needs.
    - Select from available published measures to create a parsimonious panel of structure, process and outcome measures applicable to SSN.
    - Involve SSN in selecting the measures so that they feel the measures are useful in their operations, and not simply reporting for sake of reporting.

- ***Spur collaboration and innovation*** with current Senior Service Network (SSN) and other agencies that serve older adults in DC to increase and expand services.
    - Create an innovation incubator which would provide funding and technical assistance to help SSN agencies test and scale innovations.
    - DCOA would solicit innovations in target areas aligned with strategic plan.

CONCLUSIONS

The results of the DCOA 2016 Needs Assessment point out the significant challenges that DCOA faces as it plans how to stretch finite and constrained resources to meet a large and rapidly growing need. This study did NOT reveal any simple, quick fixes pointing to low priority services that can simply be dropped from the budget. Instead, the study suggests that an array of new approaches is needed to meet the challenges of serving DC's aging citizens. These approaches are not simple and may require investment of substantial time and resources. They may need to be staged, with full completion taking a number of years. We believe such effort will pay off in helping DCOA – and the associated aging services network - pivot from its historic role of serving pieces of the constrained contractual resources of the Older Americans Act pie, into a visionary agency that can marshal public and private energy to make enough pie to meet a larger portion of the need.

The recommendations relating to system infrastructure for communication, quality measurement, and innovation are all multi-year projects. Each could be a major initiative in itself. While there are some "low hanging fruit" within each area (such as having a system to track waiting lists at contractors), fully developing these systemic infrastructure capacities will not be quick. Nevertheless, we recommend beginning the planning for projects in the recommended areas soon, so that the needed system capacity for ongoing measurement of need, quality, and capacity to innovate to meet those needs will be supported.

The recommendations in the area of improving linkage and coordination between the traditional social services of the Senior Services Network (those services funded through Older Americans Act monies) and the health care system (mostly funded through Medicare, Medicaid and private payors) requires a fundamental shift in strategy for DCOA. As long as DCOA continues to see its predominant role as that of steward for the limited stream of DCOA funding and resulting services, it will remain limited in its capacity to fully achieve its

mission of promoting "longevity, independence, dignity, and choice for older District residents, people with disabilities, and their caregivers."

Building on the advocacy role that is encoded both in the Older Americans Act and in DCOA's mission, DCOA can build bridges with healthcare providers so that healthcare and social services are more thoroughly linked from the perspective of both the service recipient and the provider. This approach should build on the evidence that integrated social and health services helps reduce the burden on the health care system (e.g. rapid in-home meal provision after a hospitalization can reduce readmissions). It could also help DCOA leverage its capacity for case management and service delivery in such a way that it could access additional funding from the health service sector. In its advocacy role, DCOA could serve as convener and catalyst to help the health service sector better serve the senior population. Launch of a PACE program is one obvious goal that should be implemented soon. Other possibilities – such as an integrated case management IT system through which both health care providers and social service providers could access up to date and comprehensive information on clients – can only happen with sustained and broad collaboration across the health care and social services sector.

Finally, in the area of prioritizing specific services that should receive more or less funding, we caution that there is tension between the urgent needs of those who are most in need at this moment vs the preventive approach that supports wellness and quality of life in order to prevent, delay, or ameliorate later deterioration of health and wellbeing. The evidence to support cost-effectiveness of widespread wellness and prevention efforts can be hard to come by because the payoff is far into the future compared to the immediate impact of providing urgent or emergent services during crises. But the goal of an age friendly city, which DC has embraced, will require attention to prevention and wellness as well as to capacity to intervene effectively in crisis. Finding the right balance within constrained funds will continue to be a challenge.

ABOUT DCOA

"The ***mission*** of the District of Columbia Office on Aging (DCOA) is to advocate, plan, implement, and monitor programs in health, education, employment, and social services that promote longevity, independence, dignity, and choice for older District residents (age 60 and older), people with disabilities (ages 18 to 59), and their caregivers" (District of Columbia Office on Aging, 2016).

"DCOA's ***vision*** for the future embraces a strategic direction that incorporates past goals and objectives, new and innovative programs that consider trends and baby boomer needs, as well as programs that work harmoniously with existing ones to enhance outreach, advocacy and coordination of services, and meet the special needs of low-income and multicultural populations" (District of Columbia Office on Aging, 2016).

DCOA BACKGROUND

The Older Americans Act (OAA) [Public Law 89-73 (79 Stat. 218)] signed in 1965, creates a system of services and supports that enable older adults to live independently in their community. This act enables the U.S. to support the quality of life by providing OAA services for people 60 years of age and older, people with disabilities 18-59 years of age, and their caregivers with special emphasis on prioritizing services for low socio-economic older adults (42 USC § 3025(a)(2)(E).

DCOA was established October 29, 1975, when the District of Columbia (DC) signed Law 1-24 establishing the DC Office on Aging (DCOA) and a Commission on Aging. Allocated funds from the federal OAA, Medicare program, and DC-Law 1-24 are administered through the State Unit on Agency (SUA)– DCOA. DCOA filed an exemption to serve as both the SUA, as well as the area agency on aging (AAA). Eight states (AK, DE, NV, ND, NH, RI, SD and WY), including DC serve as both the SAA and the AAA and provide local resources and services.

FINANCIAL PROFILE

To provide services and programs for older adults, persons with disabilities and their caregivers, DCOA receives funding from at least three sources: federal grants, local appropriations, and intra-district funds from the DC Department of Health Care Finance. Federal OAA funding has been relatively flat over the past decade, failing to keep up with inflation and demand from a rapidly expanding older population. With the advocacy efforts of the DC Senior Advisory Coalition (SAC) and other members of the community, the District has increased intra-district funding for DCOA and its grantee agencies. Given the fiscal constraints and increasing demands on DCOA for services on DCOA, it is crucial to assess the critical needs of older adults and individuals with disabilities, strategically collaborate and identify respective comparative advantages of each partner, and to share best practices among service providers.

DCOA FOCUS

The DCOA State Plan goals for Fiscal Year 2017-2018 include:

- "Strengthen core program operations and service coordination,
- Promote awareness and access to long-term care services and supports offered in the District,
- Promote aging in place with dignity and respect, and
- Ensure the agency is driven by customer experience" (District of Columbia Office on Aging, 2016).

Challenges

- Growing population of Seniors;
- Growing need for services, e.g., food, transportation, affordable housing;
- Uncertain nature of local and national economy; and
- Federal spending cuts due to federal deficit.

DCOA OPERATIONS

The 2016 Needs Assessment was designed to provide a broad assessment of the DCOA operations to understand the programs, services and overall operations that affect the quality of services for older adults and their caregivers. The DCOA operations includes agency management (administrative support and the required tools to achieve operational and programmatic results) and the following areas.

CONSUMER INFORMATION, ASSISTANCE AND OUTREACH

This program offers three activities to provide information, assistance, and outreach for a variety of long-term care needs to older adults, adults living with disabilities, and caregivers about long-term care services and supports offered in the District.

- **Advocacy and Elder Rights –** provides legal support, advocacy for elder rights, and adult protective service activities for District residents age 60 or older that need assistance with relevant state laws, long-term planning, complaints between residents/families and nursing homes and other community residential facilities for seniors;
- **Assistance and Referral Services –** provides information on, connection to, and assistance with accessing home and community-based services, long-term care options, and public benefits for District residents age 60 or older, residents with a disability between the ages of 18 and 59, and caregivers; and
- **Community Outreach and Special Events –** provides socialization, information, and recognition services for District residents age 60 or older, adults living with a disability between the ages of 18 and 59, and caregivers in order to combat social isolation, increase awareness of services provided, and project a positive image of aging.

HOME AND COMMUNITY-BASED SUPPORT

The home and community-based support program offers seven activities that provide services for District residents who are 60 years of age or older so that they can live as independently as possible in the community including: 1) health promotion, 2) case management services, 3) nutrition, 4) homemaker assistance, 5) wellness, 6) counseling, 7) transportation, and 8) recreation activities.

- **Caregivers Support –** provides caregiver education and training, respite, stipends, and transportation services to eligible caregivers;
- **Day Programs** – provides day programs through adult day health and senior centers, which allow District residents age 60 or older to have socialization and access to core services;
- **In-Home Services –** provides home health and homemaker services for District residents 60 years of age and older to help manage activities of daily living;
- **Lead Agencies and Case Management –** provides core services and supports, such as case management and counseling services, for District residents age 60 or older, residents with a disability between the ages of 18 and 59, and caregivers;
- **Senior Wellness Centers and Fitness –** provides socialization, physical fitness, and programs that promote healthy behavior and awareness for District residents age 60 or older;
- **Supportive Residential Services –** provides emergency shelter, supportive housing, and aging-in-place programs; and
- **Transportation –** provides transportation to life-sustaining medical appointments and group social and recreational activities for District residents age 60 or older.

NUTRITION SERVICES

This program offers four activities including meals, food, and nutrition assistance to District residents 60 and over to maintain or improve their health and remain independent in the community.

- **Community Dining –** provides meals in group settings such as senior wellness centers, senior housing buildings, and recreation centers for District residents age 60 or older;
- **Home-delivered Meals –** provides District residents age 60 or older who are frail, homebound, or otherwise isolated meals delivered directly to their home;
- **Nutrition Supplement –** provides nutrition supplements each month for District residents 60 and over who are unable to obtain adequate nutrition from food alone; and
- **Commodities and Farmers Market –** the Commodity Supplemental Food Program provides a monthly bag of healthy, shelf-stable foods to low-income District residents; the Senior Farmers Market Nutrition Program provides vouchers to participants in the Commodity Supplemental Food Program to purchase fresh produce at local farmers markets.

DEMOGRAPHIC CHARACTERISTICS OF SENIORS IN DC

The DCOA 2016 Needs Assessment was designed to target the population of individuals in DC who are 60 years and older. Demographic characteristics of older adults living in DC are illustrated in Table 2. In addition, there were considerations for reaching older adults who currently use DCOA services and those who are not using DCOA services, older adults who are homebound, and a good representation of older adults across all wards of the city.

DEMOGRAPHICS OF OLDER ADULT POPULATION

TABLE 2. DEMOGRAPHIC CHARACTERISTICS OF OLDER ADULTS IN DC

Female[3]	60%
Male[3]	40%
African American[1]	60%
Caucasian[1]	36%
Hispanic[3]	4%
Asian[1]	2%
Poor (~ below 150% FPL)[1]	24%
Live Alone[1]	55%
Disabled[1]	33%
Education Level[1]	
0-11 No diploma	14%
High School diploma	24%
Some college or >	62%
Ward Distribution[1]	
Ward 1	8.8%
Ward 2	10.3%
Ward 3	16.3%
Ward 4	15.6%
Ward 5	14.1%
Ward 6	12.9%
Ward 7	13.2%
Ward 8	8.9%
Top 3 causes of mortality[2]	Heart disease Cancer Cerebrovascular disease

Sources:
1: U.S. Census Bureau (2015)
2: District of Columbia Department of Health (2014a)
3: DCOA (2008, p. 2)

POPULATION GROWTH FOR SENIORS IN DC 2000 – 2010

The senior population increased in seven of the eight wards (see Table 3), for a total of 9% growth overall from 2000 to 2010.

TABLE 3. WARD COMPOSITION & GROWTH 2000-2014 AMONG ADULTS AGED 60 YEARS +

	WARDS								
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**TOTAL**
2000	7,727	8,346	13,454	16,906	15,021	10,579	13,059	6,788	***91,800***
2010	8,091	9,914	16,146	16,049	15,530	11,095	13,183	8,504	***98,512***
2014 (est.)	9,441	11,058	17,581	16,771	15,204	13,848	14,200	9,589	***107,692***
% of age group	9%	10%	16%	16%	14%	13%	13%	9%	--
Change *(2010-2014 est.)*	17%	12%	9%	4%	-2%	25%	8%	13%	***9%***

Source: U.S. Census Bureau (2015)

The population of older adults in DC is projected to grow to 17.4% by 2030 (District of Columbia Department of Health, 2014). Urban Institute's Interactive Population mapping with age and race trends from 2000-2030 projects increases in 65 and older population, as well as the 50-64 year-olds (Urban Institute, 2016). Additional population projections for individual over the age of 60 indicate increases among all races (white, black, Hispanic, and other races) from 2010- 2030.

ECONOMIC LEVEL AND INCOME INEQUALITY

Older adults are less likely than working-age adults to be poor by the government's traditional poverty measure the federal poverty level (FPL), developed in the 1960s; however, the FPL understates the extent to which older adults live in poverty. The government developed an alternative scale in 2011, known as Supplemental Poverty Measure (SPM), and when used, the rate of poverty among older adults is considerably higher (Altman, 2011). A Kaiser Family Foundation analysis from 2011-2013 reports the percent of DC older adults with incomes below 100% of poverty level using the official measure was 16% and 25% when using the SPM (Cubanski, Casillas, & Damino, 2015). The percent of DC older adults with incomes below 200% of poverty was 37% and 57% using SPM (Cubanski, Casillas, & Damino, 2015).

The Gini index is a measure of income inequality. A Gini index of 0 represents perfect equality, while an index of 1.00 implies perfect inequality. Since 1969, the District of Columbia's Gini index is the highest in the nation, ranging from 0.425 to 0.562 indicating higher inequality.

There are increasing disparities for the DC older adult population in income levels across the wards. The differences are further illustrated by disparities in life expectancy and disease burden. Wards 2 and 3 life expectancy is 85.9 years and 85.1 years, respectively, while ward 8 has the lowest life expectancy at 70.2 years (District of Columbia Department of Health, 2014). Additionally, there are known disparities between race and diseases, such as Alzheimer's and cerebrovascular disease that can be analyzed at the ward level. Additional health disparities exist between races in DC. Examples include:

- *Life expectancy:* Hispanic females is 88.49 years and non-Hispanic black males is 68.6 years;
- *Cerebrovascular diseases:* African Americans are over three times more likely to die from cerebrovascular diseases;
- *Obesity:* African Americans have the highest obesity rates, and are less likely to exercise or consume the recommended serving of fruits and vegetables in the District (District of Columbia Department of Health, 2014).

The data from the Department of Health further substantiates the findings in the 2016 County Health Rankings Key Findings Report that indicates that where one lives "is a fundamental cause of health disparities" (University of Wisconsin Population Health Institute, 2016).

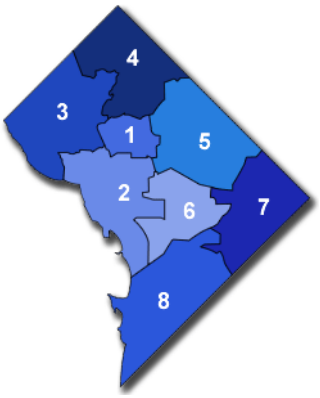
This disparity is most evident in the eight distinct wards that comprise DC. The racial composition, educational attainment and poverty rates in the eight wards can be seen in Table 4.

TABLE 4. WARD-SPECIFIC RACIAL, EDUCATIONAL, INCOME CHARACTERISTICS

	WARDS							
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
African American	31.4%	9%	6%	58.6%	72.8%	36.7%	94.4%	93.7%
Caucasian	54.7%	74.7%	82.2%	26.1%	18.3%	54.1%	2.5%	4.3%
Asian	4%	9.8%	6%	1.9%	1.8%	4.6%	0.2%	0.3%
% in Poverty	12.9%	12.4%	9.9%	13%	20.4%	14.5%	26.3%	37.4%
High school diploma or>	87%	95%	97.3%	87%	85.6%	91.5%	82.8%	82.1%
Bachelor's degree or >	63.7%	82.7%	85.4%	45.3%	36.3%	66.5%	16.1%	13.6%

Source: DC Office of Planning (2016, p. 46-48)

Wards 7 and 8 have the highest rates of poverty and a lower educational attainment level when compared to Wards 2 and 3. The demographic composition of Wards 7 and 8 are primarily African American while Wards 2 and 3 are primarily Caucasian. The social determinants of health such as residential segregation, quality of education, and socioeconomic conditions influence population health outcomes. Older adults residing within the District of Columbia have a diverse set of health and wellness needs that is reflective of the diverse population.



More specific information on the eight wards and their characteristics is in Appendix 2.

DCOA SENIOR SERVICES NETWORK

The 2016 Needs Assessment was targeted to assess the programs and services funded by DCOA, including the Aging and Disability Resource Center (ADRC) and the Senior Service Network (SSN), which together consist of more than 20 community-based nonprofit organizations, operating more than 40 programs for older District residents (age 60 and older), people with disabilities (ages 18 to 59), and their caregivers. See Table 5, which lists the primary Senior Service Network Offerings. The 2016 Needs Assessment focused on individuals 60 years and older.

ADRC

DCOA's Aging and Disability Resource Center (ADRC), provides a coordinated system of information and access for individuals seeking long-term care services and supports. This is accomplished through the provision of information, counseling, and service access to older adults, individuals living with disabilities, and caregivers. The ADRC makes referrals to over 1,500 providers, programs, services, and other community supports including providers within DCOA's Senior Service Network (SSN).

ADRC provides a variety of direct services including:

- Alzheimer's Disease Initiative Grant,
- Caregiver Assistance: Lifespan Respite Care Program,
- Community Social Work,
- Community Transition,
- Housing Coordination,
- Information and Referral/Assistance, and
- Medicaid Waiver Enrollment.

LEAD AGENCIES

DCOA Lead Agencies are grantees within the Senior Service Network that provide core social and health services in each ward. Lead agency staff focus on serving older adults (ages 60 and over) and their caregivers, and ADRC social workers focus on assisting people ages 18-59 with disabilities and their caregivers. Lead agencies provide core supports to older adults in each service area, including:

1. Community Dining and Home Delivered Meals,
2. Caregiver Respite/Supplemental Services,
3. Case Management,
4. Comprehensive Assessment,
5. Counseling,
6. Health Promotion,
7. Nutrition Counseling and Education,
8. Socialization, and
9. Coordinate transportation to sites and activities.

SENIOR WELLNESS CENTERS

There are six Senior Wellness Centers (SWC) that provide programs to promote the health and wellness of residents 60 years and older, and serves a nutritious mid-day meal with a salad bar. SWCs offer health education and exercise classes, such as reflexology, disease management and prevention, nutritious cooking workshops and group Tai Chi. They also have social and recreational programs, such as intergenerational gardening, creative arts, and group trips. Although Wards 2 and 3 do not have physical SWCs within their geographic ward, residents from these wards can use SWC in other wards. During the September 2016 Advisory Neighborhood Commission 3B monthly meeting, proponents for expanding programs for older adults and virtual senior centers discussed advocacy efforts in these wards (Advisory Neighborhood Commission, 2016).

TABLE 5: SENIOR SERVICE NETWORK OFFERINGS

Adult Day Health	In-Home Support
Caregiver Supportive Services	Legal Services
Case Management	Long-Term Care Ombudsman
Community Group Meals	Nursing Homes
Counseling	Nutrition Counseling
Emergency Shelter	Recreation and Socialization
Fitness and Wellness	Respite Aid Services for Caregivers
Health Insurance Counseling	Senior Wellness Centers
Home-delivered Meals	Transportation

See Appendix 3 for a listing of District ADRCs and SWCs.

PROBLEM STATEMENT

Given the increasing percentage of adults in DC over 60 years in DC compared to younger age groups, and the decreasing financial resources in the DCOA budget available for services to older adults, DCOA is faced with the dilemma of how to provide more services with fewer resources. It was important to determine how to allocate the resources most effectively.

The purpose of this study was to:

- improve overall agency efficiency,
- identify high-value areas for improvement, expansion or innovation, and
- implement a sustainable approach for establishing priorities and procedures to meet the needs of individuals 60 years and older in DC.

INITIAL FOCUS GROUPS

The Center for Aging, Health and Humanities is the home of inter-professional faculty from the major universities in DC and community leaders in healthcare of older adults. To lay the groundwork for the study, The Center interviewed key DCOA staff, held roundtables with thought leaders of two interdisciplinary organizations who serve seniors, i.e. the **DC Senior Advisory Coalition** and the **Washington, DC Area Geriatric Education Center Consortium**. In addition, a preliminary review of literature was conducted to determine the primary question(s) to be answered by this study. The roundtables and preliminary review of literature indicated several key themes for the assessment including the need for integrated and holistic programs, including the following domains: education, physical, psychological, community relationship, social, spiritual, housing, social, environment. The DCOA 2016 Needs Assessment should help determine what services are needed to keep older adults in their homes longer.

DCOA staff and other leaders in care of older adults wanted to specifically target not only the older adults currently receiving DCOA services, but also previous service recipients and eligible older adults who have never received services. The focus group participants encouraged consideration of subgroups that included:

- ***People on wait lists*** for services,
- ***Neediest seniors*** who are often the quietest, the most hidden ones,
- ***Frail*** older adults who tend to have very different needs, and
- ***Older persons providing care*** for spouses, parents, children, grandchildren, ***consider*** **caregivers' (formal/informal)** ***needs***, i.e. care for themselves and others, gaps in services

FOCAL QUESTION

As a result of these interviews, conversations, and review of literature, it was determined that the focal question to answer was,

How do we serve more seniors, and/or serve seniors more effectively, including:

- Keeping seniors in their homes longer,
- Providing holistic array of services to optimize quality of life, and
- Ensuring the most frail and sick people are heard, more able-bodied individuals may be more able to advocate for themselves for resources.

FRAMEWORK FOR THE STUDY

AGE FRIENDLY DC

Age Friendly Cities and Communities served to inform the DCOA 2016 Needs Assessment. Since 2012, DC has been incorporating the Age Friendly Cities and Communities to improve the quality of life for seniors in DC by joining the Global Network of Age-Friendly Cities and Community Programs. The DC Council passed a declaration of support entitled World Health Organization's (WHO) Global Network of Age-Friendly Cities and Communities Program Resolution of 2012. WHO developed this program using a bottom-up participatory approach wherein older adults in 33 cities from around the world were asked:

- What are the age-friendly features of the city they live in?
- What problems do they encounter?
- What is missing from the city that would enhance their health, participation and security? (WHO, 2007)

This resulted in the development of eight interconnected Age-Friendly domains. In addition, to the first eight Age-Friendly domains shown in Table 6. DC added domains 9 and 10. Within each domain features are identified that all persons, from toddlers to older adults, need to create an Age-Friendly city. For example, dropped curbs to allow strollers, walkers or wheelchairs to improve accessibility. Over the past four years DC has engaged the DC community, established a strategic plan, and strengthened collaborations to build Age-Friendly DC.

TABLE 6. AGE-FRIENDLY DC 10 DOMAINS

1	Outdoor spaces
2	Transportation
3	Housing
4	Social participation
5	Respect & social inclusion
6	Civic participation
7	Communication & information
8	Community & health services
9	Emergency preparedness & resilience
10	Elder Abuse, Neglect and Fraud

TABLE 7. DCOA 2016 NEEDS ASSESSMENT 12 DOMAINS

1	Outdoor spaces
2	Transportation
3	Housing
4	Social participation
5	Respect & social inclusion
6	Civic participation
7	Communication & information
8	Community & health services
9	Emergency preparedness & resilience
10	Legal
11	Food Security
12	Caregivers

For the DCOA 2016 Needs Assessment, two domains, food security and care-givers were added (Table 7). Other adaptations were made to reduce redundancy in questions. Adaptations included: a) Social participation and respect/social inclusion questions were difficult to distinguish so they were combined; b) Elder abuse, neglect and fraud was expanded to include legal issues, such as advance directives and wills, and renamed as Legal Issues, and c) Emergency preparedness and resilience were not assessed in this Needs Assessment.

METHODOLOGY

Three data pathways were utilized to address the focal question for the DCOA 2016 Needs Assessment and Feasibility Study, "***How do we serve more seniors, and/or serve seniors more effectively***":

- Surveys of seniors in DC, surveys of service providers, and focus groups with vulnerable populations;
- Interviews with key informants and thought leaders; and
- Identification of best practices.

Figure 2 illustrates the 3 pathways and methods for data collection:

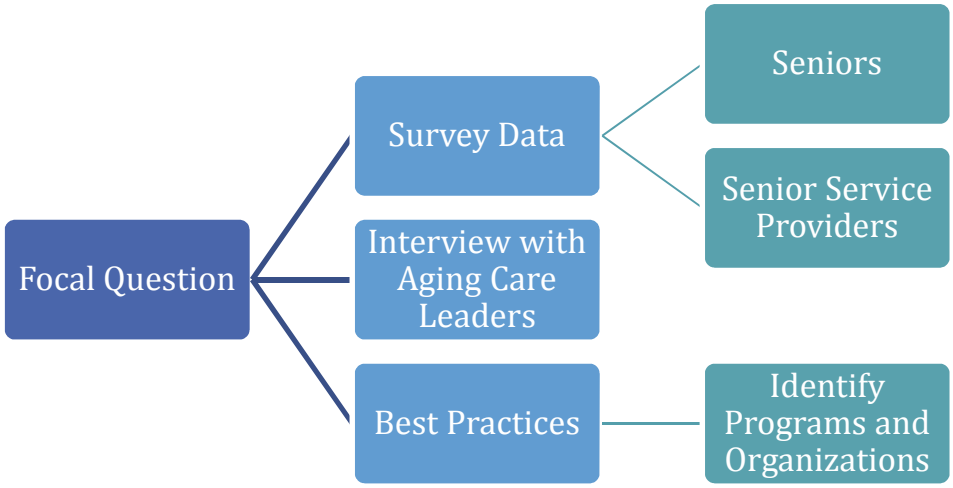
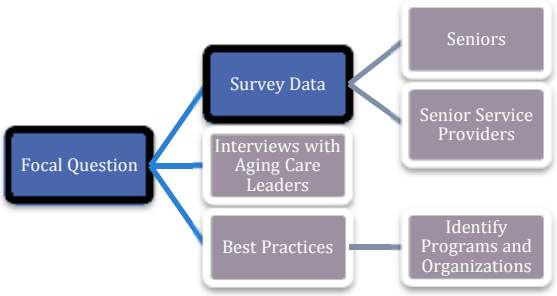


Figure 2: DCOA 2016 Needs Assessment

SURVEY PATHWAY

INSTRUMENT DEVELOPMENT

The first pathway of data collection to answer the focal question was to elicit information from older adults living in DC. Several instruments used by other state Offices on Aging were reviewed. Some tended to count the number of services seniors received and/or services provided by organizations serving older adults in the community. DCOA receives reports from providers on the type and quantity of services provided, so the type and quantity of services can be gleaned from that information. The focal question required a different type of survey. The Fairfield Older Adult Network Survey (FOANS) provided an interesting way to look at individual services and determine how important they were to the senior, as well as how they do/not receive assistance. Additionally, the reading level used in the FOANS was closer to current recommendations for using "plain language" in order to maximize understanding on the part of the general public. This tool structure was modified to accommodate questions relating to Age-Friendly domains.



Based on questions developed from the Age-Friendly Domains, the Senior Survey included 39 selected activity/ service questions for older adults and their caregivers to elicit importance, current help, and considerations about obtaining assistance.

- **How important is this to you?**
  (Rated on a 4-point Likert scale from *very important* to *not at all important*)
- **If you have assistance, who assists you?**
  (Selections of *Family, Friends, DCOA, Religious Organizations,* and *Other*)
- **If you are not receiving assistance, why not?**
  (Selections of Don't need, Don't know how to get services, Can't afford services, Won't share financial information, Never thought about this, Family's responsibility to provide, and Other)

See Appendix 4 and 5 for older adult and caregiver recruitment flier and survey.

TARGET POPULATION

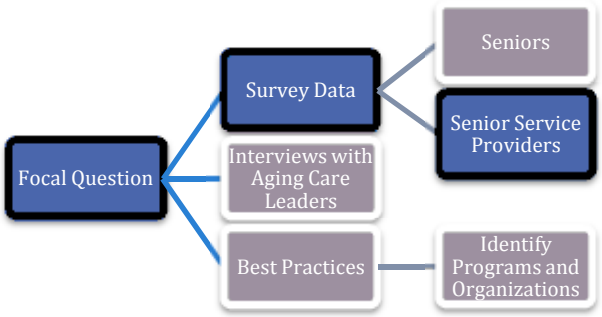
While various internal and external stakeholders exist, this study endeavored to specifically include:

- Older adults and caregivers receiving services,
- Older adults and caregivers not currently receiving services,
- Older adults who are frail and homebound, and
- Older adults who are underserved and disadvantaged.

The Senior Survey was distributed in hard copy with an online version (in Survey Monkey) for people who wanted to complete the survey electronically. The first page of the hard copy also served as an information page and flier for distribution via email and in person. If older adults were unable to fill out the survey themselves, a caregiver was encouraged to fill it out from the older adult's perspective. The survey was translated into six languages including: Spanish, Vietnamese, Korean, Amharic, Mandarin, and French to reach a diverse population.

To reach as many older adults in diverse settings as possible, service users and nonusers, several strategies were used for disseminating the surveys. The first wave of surveys was distributed through the DCOA Senior Service Network, i.e. DCOA Senior Wellness Centers, DCOA Lead Agencies and specifically the homebound meals programs to reach frail and homebound seniors. The second wave of surveys was distributed through the DC Department of Parks and Recreation, DC Public Libraries, Senior Advisory Coalition and the Washington DC Area Geriatric Education Center Consortium (WAGECC) listserv. The next wave for survey distribution was Senior Villages and faith-based organizations in DC. In addition, information about the survey was also made available to attendees of the 2016 Mayor's Symposium, barber shops and nail salons in Wards 7 and 8, and other miscellaneous programs. The survey was also publicized in the Senior Beacon. See Appendix 6 for a comprehensive listing of organizations that aided in survey distribution and collection.

A companion survey was constructed utilizing the Age-Friendly Cities and Communities framework that followed the same 39 services and activities that were listed in the Seniors Survey. The goal of these questions was to get a perception of unmet needs and priorities for service expansion. For the Service Provider Survey, there were 20 initial demographic questions about the service provider. Then questions were asked from the service provider's perspective about the 39 selected activity/ service questions in the Senior Survey to elicit importance, level of satisfaction with DCOA and Network Services currently offered and challenges associated with the service or need. The Service Provider Survey was constructed to query providers within the DCOA SSN and providers working within other organizations or agencies that serve older adults.



For each service and/or activity, service providers were asked:

- **How important is this to you?**
  (Rated on a 4-point Likert scale from *Very important* to *not at all important*)
- **How satisfied are you with DCOA and Network Services currently offered?**
  (Rated on a 5-point Likert scale from *Very satisfied* to *Very dissatisfied*)
- **What are the challenges in offering this service/addressing this need?**
  Space was provided for open-ended responses.

Four additional open-ended questions were included at the end to obtain information about major challenges in providing services for seniors in the past 5 years, major barriers in addressing the challenges, the percentage of funding the Service Provider's organization received from DCOA, and other sources of funding sought by their organization. See Appendix 7 and 8 for Senior Service Provider recruitment flier and Survey.

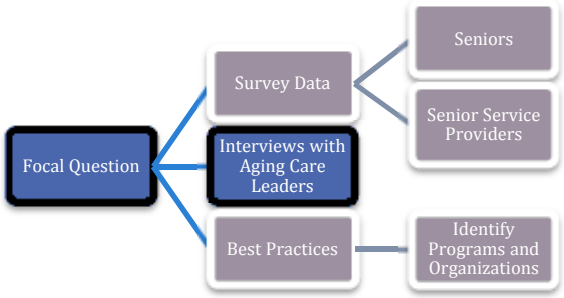
Information about the DCOA 2016 Needs Assessment and instructions for individuals to be able to participate was distributed through the same networks as the Senior Survey, including the DCOA SSN, and other organizations or agencies that provide services to seniors in the community, such as religious organizations, SAC and WAGECC members, and healthcare organizations. Emails were sent to leaders with a link to the survey through Survey Monkey. Service providers were offered the option of calling the research team and receiving a hard copy of the survey if they were unable to participate online, but no one requested that option.

Descriptive statistics were used to describe the survey respondents' characteristics. The remaining 39 questions relating to activity/ services are broken down into 3 questions. Results for seniors are reported as percentages indicating importance, if receiving assistance by whom, and if not receiving assistance, the reason for that. Similarly, results for providers indicate the importance of the activity, satisfaction with how DCOA is doing in providing the service, and challenges from the provider's perspective to providing the service.

There was a high non-response rate by older adults on the questions about who assists the older adult with a specific activity, or if they do not receive the service, why not. The research team interprets this non-response as likely indicating that the senior respondent did not feel they needed that service. The reader should be cognizant that the reported data are only for those respondents who answered any particular question.

INTERVIEWS PATHWAY

Initial focus groups with the Senior Advisory Coalition and the Washington DC Area Geriatric Education Center Consortium, which were conducted to help determine the focal question(s) that need to be answered by the study, provided additional contextual information for the study. Participants were invited to join a WebEx call with the focus group via the established listservs for each of these organizations. These participants were provided with the goals and objectives for the 2016 Needs Assessment that were established by DCOA. Then they were asked, "What do you think the major question(s) are that need to be answered by this study?"



Formal telephone interviews were conducted one-on-one with 13 ***healthcare professionals*** and other experts in care of older adults (including physicians, advanced practice nurses, social workers, nutritionist) using the Guide for Interviews with Healthcare Professionals in Appendix 9. Since a primary concern for stakeholders in this study was how to address the needs of older adults in DC so they can stay in their homes as long as possible (including individuals who are especially frail and vulnerable), it was imperative to gain a better understanding of their needs from healthcare professionals who are working on these issues as well.

The research team met with the ***DC Commission on Aging*** and DC Department of Parks and Recreation to obtain their input on the Senior Survey, dissemination to underserved and diverse populations, local constraints, and other best practices in the community.

BEST/GOOD PRACTICES PATHWAY

Determination of ***best practices*** to address the needs identified by the surveys and interviews was conducted in several ways. First, a review of literature was conducted for best practices in care of older adults, including seniors who suffer from multiple chronic illness and frailty. Then a search was conducted for states, organizations, and other programs trying to develop innovations to address critical needs of older adults. AARP refers to these as ***good practices*** instead of best practices because the replicability of the programs is dependent on the political, economic, social, technological, legal and environmental conditions. Best/Good Practices in neighborhoods must align with the demographics, demand and resources.

STRATEGY FOR IDENTIFYING BEST PRACTICES

Online searches from the following website include World Health Organization (WHO), American Association of Retired Persons (AARP), National Association of Area Agencies on Aging (N4A), National Aging and Disability Transportation Center (NADTC), National Council on Aging (NCOA), California Association of Area Agencies on Aging, and New York City. Best Practices were evaluated using the American Public Health Association's (APHA) five criteria to evaluate policy options in Health in Policies, which include:

- **Promoting health and equity**
  The pursuit of full "physical, mental, and social well-being" without determined disadvantages (i.e., social, demographic, economic, and geographic) Efforts to improve conditions for those who "experienced socioeconomic disadvantage or historical injustice" (Rudolph, L., Caplan, J., Ben-Moshe, K., & Dillon, L., 2013, p. 135)
- **Supporting inter-sectoral collaboration**
  Various partners share the responsibility of decision-making and implementation to improve outcomes, can be formal or ad hoc; focus is on ongoing-collaboration
- **Creating co-benefits for multiple partners**
  Win-win solutions that arise as secondary benefits from policy/ program implementation
- **Engaging stakeholders**
  Inviting, listening, and developing policy/ program with those individuals, groups, or organizations who are impacted by decisions
- **Creating structural or process change**
  Change in how government agencies (and other sectors) interact and make decisions

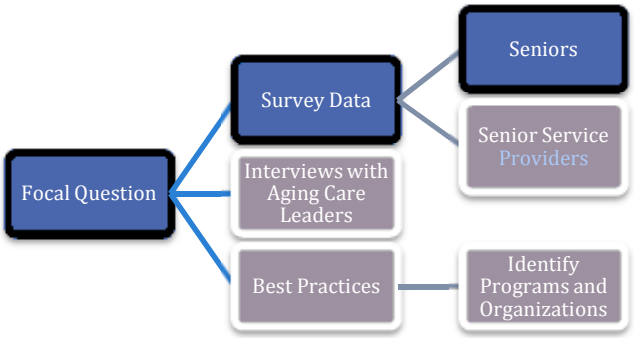
INSTITUTIONAL REVEIEW BOARD REVIEW AND DETERMINATION

This project was reviewed by George Washington University Institutional Review Board and determined to be exempt as the survey was a systematic investigation designed to contribute to generalized knowledge. See Appendix 10 for Memorandum.

LIMITATIONS

The researchers felt that there are a number of limitations to the DCOA 2016 Needs Assessment. First, the survey is approximately sixty questions, participants could experience survey fatigue, which limits the comprehensiveness of each age-friendly domain. Secondly, the Needs Assessment contained several pages of charts that may be difficult for older adults. Thirdly, due to time and funding limitations: additional stakeholder groups were not specifically surveyed: LGBTQ community, homeless, prisoners. Self-selection can be seen with selection bias; the group who responded may intrinsically be different than those who did not respond. Those who responded may have exhibited a social desirability bias to report those things that are more favorable when reporting.

SENIOR SURVEY DEMOGRAPHICS



Demographics of Older Adult Respondents

More than 5,000 hard copies of the questionnaire were distributed, and 880 District individuals completed the 2016 DCOA Needs Assessment Senior Survey, 295 online through SurveyMonkey and 585 by hard copy. It was important to target individuals who are currently using DCOA services, as well as people who do not currently use DCOA services. There were 12% of older adult respondents who indicated they were using DCOA services.

TABLE 8. DEMOGRAPHIC CHARACTERISTICS OF 2016 DCOA SENIOR SURVEY RESPONDENTS

Gender	Female Male No Response	77% 20% 3%
Sexual Preference	Heterosexual Other Gay Lesbian Bisexual Questioning No Response	37% 2% 1% 1% 1% 0% 59%
Marital Status	Widowed Divorced or Separated Married Never Married No Response	29% 24% 23% 21% 4%
Filled out Survey	Self On behalf of someone else No response	87% 10% 3%
Living Situation	Living alone Living with spouse or relative Living with non-relatives No Response	56% 38% 3% 4%
Race	Black/ African-American Caucasian Hispanic/ Latino Asian American Indian/ Alaskan Native Native Hawaiian/ Pacific Islander	73% 19% 1% 0.7% 0.3% 0.1%

	No Response	5.9%
Age-Range of Respondent	18-59 years 60-64 years 65-69 years 70-74 years 75-79 years 80-84 years 85-89 years 90-94 years 95 years and older No Response	3% 12% 23% 20% 16% 11% 8% 3% 1% 2%
Annual Income	< $10,000 $10,000-$14,999 $15,000- $19,999 $20,000- $24,999 $25,000- $29,999 $30,000- $34,999 $35,000- $39,999 $40,000- $44,999 $45,000- $49,999 $50,000- $59,999 $60,000- $74,999 >$75,000 No response	17% 14% 8% 5% 5% 5% 4% 4% 2% 4% 5% 14% 14%
Describes Respondent (multiple choices allowed)	Senior Senior with disability Non-senior with disability Caregiver Relative of senior who needs care Neighbor of senior who needs care	70% 30% 1% 8% 5% 2%
11 Health Challenges	Disabled Diabetes Hard of hearing Heart disease Can't see well Stroke Dementia Arthritis Lung disease Kidney disease Cancer	19% 18% 14% 10% 10% 5% 5% 5% 4% 4% 3%
Education Level	0-11 years, no diploma High school diploma Some college Associate's degree Bachelor's degree Graduate/ professional degree No response	13% 23% 18% 5% 13% 26% 3%
Employment Status	Fully retired Disabled Retired but working part-time Working full-time Unemployed, looking for work Other Unemployed, not looking for work Homemaker	62% 11% 7% 7% 4% 3% 2% 1%
Ward Residence	Ward 1	11%

	Ward 2	8%
	Ward 3	7%
	Ward 4	18%
	Ward 5	13%
	Ward 6	11%
	Ward 7	16%
	Ward 8	11%
Where do you get information about senior services?	Word of mouth	43%
	Senior center	37%
	AARP	38%
	Office on Aging	34%
	Newspaper/ newsletter	27%
	Senior Beacon	20%
	Internet	20%
	Television	19%
	Radio	9%
	Other*	18%
DCOA service utilization	DC seniors using 1+ service	12%

*Within the "Other", 52 respondents wrote in ***Villages***, or their specific Village name.

COMPARISON OF SURVEY PARTICIPANTS TO SENIORS IN DC [1]

Eighty-seven percent of survey respondents were seniors completing the survey on their own behalf. Characteristics of Senior Survey respondents were fairly similar to demographics of older adults in DC (Table 9). Survey participants were predominantly female (77%) compared with 60% female senior population in DC. Most of participants were African American (73%), which compares with 60% of the estimated 2014 senior population in DC. Caucasians, the second largest group of participants comprised 19% of respondents compared with 36% of the senior population of DC. Hispanic and Asian respondents, who comprise 4% and 2%, respectively, of the senior population in DC, were underrepresented in this survey sample at 1% and 0.7%, respectively. Ages represented included 60 through 95+ years, with the highest percent of respondents between 60 and 84 years. Nearly one quarter were between 65 and 69, and 20% were between 70 and 74 years.

The educational level of the respondents was close to that of the DC population educational profile for 2014, with 13% reporting that they did not finish high school (consistent with 14% of the 2014 DC senior population), 23% reporting only a high school diploma (consistent with 24% of the population), and 62% reporting some college or higher (consistent with 62% of the senior population).

The survey does not focus on household income, which requires knowing the income of every person in the home and the number of people that use the residence as primary address. Instead, we asked for the individual's self-reported income. The survey income question referred to only the older adult respondent's income and over half of respondents reported living alone (56%), and 17% of respondents reported an income of less than $10,000. The federal poverty level for 1 person is currently $11,880, and in 2014, 16% of the DC population was estimated to have an income below the federal poverty level Cubanski, Casillas, & Damico (2015). The respondents to the survey who reported an

[1] According to census data provided by DCOA, including estimates from 2014 American Community Survey

income below $15,000 was 31% compared with 2014 data reporting that 24% of seniors fell below 150% of the federal poverty level for income (which in 2016 is $17,820). So survey respondents seem roughly comparable, and a representative sample of economically disadvantaged seniors living in DC.

Thirty percent of respondents self-reported "I am disabled" but 19% checked "Senior with disability" on the question *What health challenges do you face?*, with heart disease (including hypertension), hard of hearing, and diabetes mellitus being the most common diseases reported. In addition, Five percent reported complaints in the musculoskeletal category among the "Other" category, as this was not included as a named choice in the survey. In 2014, 33% of DC senior population was disabled, so the survey sample again seems roughly equivalent to the DC senior population as a whole in this area.

The distribution of respondents across the Wards in DC varied from 7% in Ward 3 to 18% in Ward 4. All Wards were represented with some over-representation by percent from Wards 1, 4, 7 and 8, some underrepresentation from Wards 2, 3, 5, and 6. See Appendix 11 for related graphs.

A subset analysis was done on demographic characteristics of Seniors with Disability compared with Senior respondents as a whole. Seniors with Disability were more likely than Survey respondents as a whole to be female (79%), Black/ African American (86%), individuals earning < $25,000 (71.5%), and individuals without high school diploma (19%). They were more likely to rate assistance for those who help you as "Very Important" (73%) and more likely to rate as "Very Important" information on where to get help (81%). Seniors with Disabilities tended to live in higher percentages in Wards 1 (12%), 4 (23%) and 8 (19%) than the survey sample as a whole.

Considering demographic differences among the 8 wards, survey respondents (n=824) who identified a primary ward were further analyzed. See Appendix 12. The demographic trends noted above are consistent within wards such as race, income, education, and employment status. AARP and word of mouth are 2 popular ways in which seniors in all wards receive information on senior services. However, there is variation among wards for other methods of receiving information. Greater than 20% of individuals in Wards 1-4 report using the Internet, whereas less than 17% of individuals in Wards 5-8 use the Internet. Additionally, many individuals report the Villages in the "Other" category as a way to receive information.

There were 12% of older adult respondents who indicated they were using DCOA services.

TABLE 9. COMPARISON DEMOGRAPHICS SENIOR SURVEY PARTICIPANTS VS. DC POPULATION

	% Survey Respondents	% DC Population
Female	77	60
Male	23	40
African American	73	60
Caucasian	19	36
Hispanic	1	4
Asian	0.7	2
Individuals ~ below 150% FPL	31	24
Live Alone	56	55
Disabled	30	33
Education Level		
0-11 No diploma	13	14
High School diploma	23	24
Some college or >	61	62
Ward Distribution:		
Ward 1	11	8.8
Ward 2	8	10.3
Ward 3	7	16.3
Ward 4	18	15.6
Ward 5	13	14.1
Ward 6	11	12.9
Ward 7	16	13.2
Ward 8	11	8.9

SENIOR SERVICE PROVIDER DEMOGRAPHICS

The Service Provider Survey mirrored the Senior Survey to a large extent in the items queried. Survey participants included 57 individuals who self-identified as providing services to older adults in DC. Most were private entities, with non-profit organizations comprising 51% of survey respondents, and for-profit organizations comprising 21%. The service areas in which they provided services were roughly equally distributed across all Wards. Over half of respondents reported their provider organizations served DC exclusively, while the balance served the entire Metro area, including Maryland and Virginia suburbs of DC. Around half of respondents reported providing direct services to seniors, caregiver support, advocacy, and case management with 21% reporting provision of respite for caregivers. Several providers reported a history of service dating back many years, some for several decades.

When asked "Can you adequately meet the needs of all of your clients?" over 75% answered "No", and 40% reported maintaining a wait list to provide services, including subsidized handicap accessible housing, case management services, home-bound services, emergency shelters, home modifications, delivery of meals for home-bound clients, housekeeping services, delivery of medical supplies, and adult day care. About a quarter (28%) of providers indicated a future willingness to provide services on holidays, during vacations, and on the weekend.

Almost all (90%) were familiar with DCOA and its services. The majority (65%) worked with programs funded by DCOA, and the top 3 services provided were case management (60%), health care in-home support (55%) and transportation (48%). Most (78%) were familiar with ADRC services, but almost a quarter (22%) were not. Most (83%) reported that DCOA has good relationships with the community and stakeholders. When asked about percent of funding received from DCOA, 33 responded 100%, 5 responded "some" with varying amount of support, and 11 responded "none". Alternative sources of funding for programs (when sought) included foundations, government and private grants, individual donors, fundraising activities, donations from congregations (for faith-based programs), service contracts, and fee-for-service reimbursement from insurers and individuals.

SURVEY RESPONSES TO AGE-FRIENDLY DOMAINS

The Senior Survey included 39 selected activity/ service questions for older adults and their caregivers to elicit the level of importance for the older adults, current assistance, and considerations about obtaining assistance.

- **How important is this to you?**
- **If you have assistance, who assists you?**
- **If you are not receiving assistance, why not?**

Findings across domains:

- 85% of seniors and 98% of providers rated "knowing what services are available" as *very important,* yet for every domain, 20% or more of seniors report they don't know how to access the service
- For every domain, a high proportion of seniors report "don't know how to get services." This ranges from one in four seniors (24.5%) for legal advocacy domain to one in eight seniors (12.1%) for civic participation domain.

The domain specific questions and findings are described in the following section. Each set of questions provided space for narrative comments. A select group of actual narrative comments of the survey respondents is included to provide greater dimension for each domain.

This section also includes the rating of the Service Providers for the same domains, so the responses may be compared to the Senior Survey Respondents. The Service Provider Survey included open ended questions in regards to the challenges and opportunities the service provider could offer for each domain. These provide insight into the types of collaborations and partnerships that may be valuable for service improvement.

Domain 1: Outdoor Spaces and Building

Both Seniors and Service Providers rated safe places, sidewalks and outdoor areas as "Very Important" although Service Providers more frequently rated it higher. NOTE: For each section, click on the hotlink of "Seniors Results" to see the actual survey results.

Accessibility to and availability of safe recreational facilities.

- Safe place to live
- Safe sidewalks
- Safe outdoor areas

Senior Results . . .

1. 92%, 91%, and 82% respectively rated ***Safe place to live, Safe Sidewalks, and Safe outdoor areas*** as "Very Important",
2. 62% reported "Don't need" assistance in this domain, 22% reported "Do not know how to get service".

Service Provider Results . . .

- 100% rated as "Very Important" a ***Safe place to live,***
- 94% rates ***Safe sidewalks*** as "Very Important", and
- 75% rated ***Safe outdoor areas*** as "Very Important".
- For satisfaction with DCOA service:
  - 22-29% was the range of respondents who were "Very Satisfied"/"Satisfied" with DCOA services in these categories,
  - Dissatisfaction with services ranged from 10-22%, and
  - Other respondents were "Neutral".

Narrative comments of Seniors . . .

"crucial needs for seniors are safe streets, sidewalks (uneven sidewalks cause huge % of falls for elderly) and livable parks as quality of life services offered by a progressive, caring city."

"I would like to find a place where [there are] no steps to walk up, sometimes they use the side for bikes instead of bike lane, Do not go to parks."

"Sidewalks in our neighborhood are dangerous"

Domain 2: Transportation

Older adults frequently ranked transportation as "Very Important", but an even larger number of Service Providers ranked items in this domain as "Very Important". In addition, in the open-ended question asking, ***Biggest problem faced by DC Seniors,*** transportation was identified most frequently.

Safe and affordable modes of private and public transportation.

- Transportation to healthcare-related appointments
- Transportation to grocery store and other errands
- Transportation to senior center

Senior Results . . .

- More than 50% reported as "Very Important" ***Transportation to healthcare*** (66%) and ***Transportation to obtain groceries and run errands*** (56%),
- Most reported "don't need" assistance with transportation,
- 16% reported "don't know how to get service" in this area, and
- 6% reported "can't afford service".

Service Provider Results . . .

- 98% rated as "Very Important" ***transportation to healthcare,*** and
- 89% rated as "Very Important" ***transportation to pick up groceries.***

These percentages are closer to the subsection analysis of Seniors with Disability, who rated as "Very Important" ***transportation to healthcare*** (85%), ***to pick up groceries*** (71%), and ***to pick up medications*** (65%).

Narrative comments of Seniors . . .

"Income level restraints. Again income should not be the sole criterion for determining eligibility. Need to look at related expenses associated with higher income to determine if assistance needed."

"Sometimes have to get the bus, I don't have any way to get home unless I pay, I need to get into some senior activity, sometimes I have to pay someone $5.00 to do it."

"Live close to services I need. Have a spouse who can help, and am a member of a Village, which is willing to step in when needed."

Service Providers identify:

- Challenges as insufficient vehicles, unreliable pick-up service, and inflexible scheduling.
- Creative responses as use of program funds for alternative transport (i.e., Uber, taxi, staff), or referring clients to alternative sources of transport.

Domain 3: Housing

Several aspects of housing were "Very Important" to Seniors and Service Providers rated it highly with even greater frequency.

Wide range of housing options for older residents, aging in place and other home modification programs.

- Keeping warm or cool as the weather changes
- Preventing falls and other accidents
- Modifications to my home so that I can get around safely
- Assistance with repairs and maintenance of my home/ yard

Senior Results . . .

The following are "Very Important";

- ***Keeping warm or cool, as the weather changes*** (71%),
- ***Preventing falls and other accidents*** (77%),
- ***Assistance with repairs and maintenance of home and yard*** (62%),
- ***Modifications to the home to get around safely*** (55%),
- Most did not have a current need, but nearly 25% reported ***not knowing how to access assistance*** or ***not being able to afford assistance in this area***, and
- For ***Biggest problem faced by DC Seniors,*** Housing issues rated among top 3 items identified.

Service Provider Results . . .

- Rated more frequently as "Very Important"
  - ***Preventing falls and accidents*** (94%),
  - ***Keeping warm or cool as weather changes*** (94%), and
  - ***Modification to the home for safety*** (89%).

These items are also rated more frequently as "Very Important" by the subset Seniors with Disability:

- ***Prevention of falls and accidents*** (88%),
- *K**eeping warm/cool as weather changes*** (79%),
- ***Assistance with repairs/maintenance*** (75%), and
- ***Modifications to home for safety*** (69%).

Narrative comments of Seniors . . .

"Cannot get low -income help with yard & house. Frustrating."

"Where I live they furnish good heat and air, In the process of using in house safe through DC gov., Need section 8 or some other help."

"Need a place without stairs and bathroom with walk in tub, need help to move to a bigger place for my brother and his health problems"

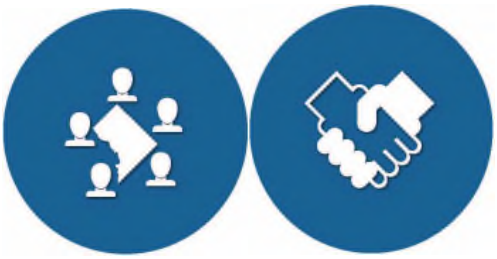
Service Providers identify:

- Challenges as long wait lists and times for housing, insufficient rental support, and lack of reliably available services.
- Creative solutions as sharing information among programs, increasing awareness among seniors of programs available, and referral to appropriate community and volunteer programs.

- Several respondents praised the DC Safe At Home Initiative and emphasized its important role in reduction of fall risk for the frail elderly living at home.

Domain 4 & 5: Social Participation/ Respect and Social Inclusion

For the purpose of this study, items in these domains (4 & 5) tended to overlap, so they were combined. While Seniors rated these items very high for importance, exercise was the most important in this category, while Service Providers rated ***having someone to talk with*** as "Very Important" more often.



Access to leisure and cultural activities and opportunities for older residents to participate in social and civic engagement with their peers and younger people.

- Taking part in fun activities (crafts, music, games) with others
- Getting exercise that is good for me
- Having someone to talk to when I'm lonely
- A senior center close to my home

Senior Results . . .

- 79% rated ***Getting exercise that is good for me*** as "Very Important"
- Over 50% of the time, other activities rated "Very Important," such as ***volunteering, having someone to talk with, having a Senior Center close to home, and being able to attend religious services***
- 20% reported not knowing how to get service

Service Provider Results . . .

- 90% rated as "Very Important" ***having someone to talk to when I'm lonely***. (This is a much higher rating than in the Senior Respondent survey or in the sub-analysis of Seniors with Disability (63% "Very Important").
- Overall satisfaction with services in this domain was low (< 1/3)

Narrative comments of Seniors . . .

"I attend a gym; but could use assistance in winter months to go to senior center"

"Church activities, walk or take public transportation, not cleared medically to attend, church one block away."

"My current family, friends, church & community situations are good!"

Service Providers identify:

- Challenges as difficulty with access to transportation and shortage of personal care assistants.
- Creative solutions as partnering with other organizations to pool resources, using volunteers, providing services where seniors live or participate in other programs, and linking seniors to other resources.

Domain 6: Civic Participation and Employment

None of the items queried in this section were rated "Very Important" at the same level as previous domains by either the Seniors or Service Providers.

Promotion of paid work and volunteer activities for older residents and opportunities to engage in formulation of policies relevant to their lives.

- Assistance with job training
- Assistance finding jobs
- Assistance to vote

Senior Results . . .

- 41% rated ***Assistance with voting*** as "Very Important",
- 25% rated ***Assistance with job training and finding a job*** as "Very Important", and
- 64% reported they were fully retired, and only 7% reported working full time, so not likely to need assistance with job.

Service Provider Results . . .

- None of the items queried in this section were rated "Very Important" at the same level as previous domains

Narrative comments of Seniors . . .

"Village helps with voting information"

"When I was unemployed in 2015, I went to [Department of Employment Services] DOES and the agency did not help me much in getting a job. I finally got a job with a lot of prayer."

"Age discrimination in employment"

"unable to work due to disability"

Service Providers identify

- Challenges as lack of job opportunities for non-tech savvy seniors, and need for more access to IT training for seniors.
- Creative solutions as providing a training site, and information and referrals to seniors.

Domain 7: Communication and Information

Senior respondents were more likely to answer questions in this domain than any other. Service Providers also rated this domain as "Very Important".

Promotion of and access to the use of technology to keep older residents connected to their community and friends and family, both near and far.

- Knowing what services are available
- Information or assistance applying for health insurance or prescription coverage

Senior Results . . .

- 85% rate as "Very Important": ***Knowing what services are available,***
- 23% reported "not knowing how to get this information",
- Most common sources of information: "Word of mouth" (43%), AARP (40%), DCOA and Senior Centers, 34% and 39% respectively, and printed news (32%);
- 25% obtained information from the Internet, and
- For "Other", 52 respondents mentioned the Villages.

Service Provider Results . . .

- 98% indicated **Knowing what services are available** was "Very Important" (close to the 92% of Seniors with Disability who rated this as "Very Important"),
- 85% indicating **information/assistance applying for health insurance etc**. as "Very Important" (A higher rating of importance than responses from both Seniors as a whole and Seniors with Disability), and
- Satisfaction with DCOA ~ 25%

Narrative comments of Seniors . . .

"I have no problem asking for info or help from Capitol Hill Village."

"I need dentures badly but I cannot afford them. Medicaid denied my application. Can Office on Aging assist me in getting dentures."

"I get some services. But there is some I don't know about. Please tell me about all the services for seniors."

Service Providers identify:

- Challenges as lack of timely and knowledgeable responses from service providers and difficulty contacting service providers.
- Creative responses as offering training and education programs for caregivers, hiring and retaining top-notch staff, partnering and coordinating with faith communities and others, offering services at convenient sites, and keeping databases of resources updated.

Domain 8: Community and Health Services

Services and activities in relation to Health Services were rated more frequently as "Very Important by Service Providers than by Seniors. The key findings are listed below.

Access to homecare services, clinics and programs to promote wellness and active aging.

- Assistance keeping my home clean
- Assistance with personal care or bathing
- Assistance with washing and drying my laundry
- Having someone assist me with my prescription medicine
- Assistance with controlling pests, such as bed bugs, rats, etc.

Senior Results . . .

- Over 59% rated as "Very Important" ***Assistance keeping my home clean,***
- 41% rated as "Very Important" ***Assistance with personal care, and***
- 48% and 36% respectively rated as "Important" assistance with ***paying for medications and taking medications.***

Service Provider Results . . .

- Over 80% rated as "Very Important"
  - ***Assistance with paying for medications,***
  - ***Having help with prescriptions,***
  - ***Assistance with controlling pests, and***
  - ***Assistance with personal care***;
- This was a higher rating of importance than either Seniors as a whole, or Seniors with Disability as a subset of survey respondents.

Dissatisfaction with services in this category was fairly high with a range of 20-33% of respondents dissatisfied.

Narrative comments of Seniors . . .

"Generic income limitations without regard to applicable expenses. I pay taxes to help provide services so why can I not use them. Unfair."

"require use of wheelchair for mobility in home and unable to afford paying for a maid to assist with cleaning the home."

"do not like to ask for assistance".

Service Providers identify:

- Challenges as limited availability, long wait times, overly strict requirements for obtaining services, and shortage of competent providers.
- Creative solutions as collaboration across programs, volunteer recruitment and training, and developing education and awareness campaigns.

Domain 10: Legal Issues

The Age Friendly DC Domain, Elder Abuse and Neglect, was expanded for this study to include other potential legal issues in regards to healthcare decision-making. Key findings are listed below.

Prevention and prosecution of financial exploitation, neglect, and physical, sexual and emotional abuse of seniors.

- Assistance making choices about future medical care and end-of-life decisions
- Someone to protect my rights, safety, property or dignity
- Someone to call when I feel threatened or taken advantaged of

Senior Results . . .

- Over 60% rated as "Very Important":
  - ***Assistance with choices for future medical care,***
  - ***Someone to protect my rights, safety, property, or dignity;*** and
  - ***Someone to call when I feel threatened or taken advantage of.***

Service Provider Results . . .

- Over 75% of the time all items in this domain were rated as **"**Very Important".
- This was closer to the range of ratings from 70 to 82.5% for Seniors with Disability.

Narrative comments of Seniors . . .

"I get help from paid professionals and friends."

"Iona and Sibley Hospital have resources to guide me"

"AARP Legal Services for the Elderly - very helpful"

"I have prepared my documents for trusted family member to be responsible/access (will/advance directive)"

Service Providers identify:

- Challenges as insufficient finances, seniors' unwillingness to report abuse, inadequate access to needed services, and lack of quick response from Adult Protective Services.
- Creative solutions included partnering with other organizations to share resources, offering free legal/ financial planning courses, referring to Legal Counsel for the Elderly or other non-profit agencies/ university legal services, and screening elders for abuse and neglect.

Domain 11: Food Security

Due to the concerns of aging care leaders in DC about the lack of food security and DC's rating as 7th in the country for lacking food security, this Domain was added to the Senior and Service Provider surveys.

Ensure access by older adults, in particular the poor and people in vulnerable situations, to safe, nutritious and sufficient food year round.

- Having a meal with my friends or other seniors like me
- Information on how to eat healthy
- Having someone bring a meal to my home every day

Senior Results . . .

- 2 items most frequently rated as "Very Important," ***Information on how to eat healthy*** (65%) and Being able to afford food (64%); and
- 67% reported not needing assistance in this area.

Service Provider Results . . .

- Over 95% rated as "Very Important" ***Being able to afford enough food,***
- 70% rated as "Very Important" ***Having meals brought to or prepared in the home.***

For Seniors with Disability, 80 and 60% respectively rated these items as "Very Important".

Narrative Comments of Seniors . . .

"Had Mom's meals but stopped because I attend the center, need better income/a program like Mom's meals"

"Currently I can prepare my meals and prepare for my mother who I care for at this time"

"Signed up for Produce Plus but very frustrating. Wait in line for over an hour and they run out of vouchers. Rely on Wednesday's farmers market for quality seasonal produce."

Service Providers identify:

Challenges as:

- Difficulty getting face-to-face nutritional assessment to qualify clients for nutrition services/ support,
- Inflexibility of eligibility for home-delivered meals (e.g., seniors who are able to get to a few congregate meals do not qualify service),
- Difficulty obtaining nutritional supplements for clients,
- Lack of follow-up from DCOA,
- Waiting lists for nutrition services, and
- Lack of services for seniors with low income whose income is above federal poverty level, but who still cannot afford adequate nutrition.

Creative solutions offered were:

1. Partnering with other organizations to share resources,
2. Paying for meals for seniors with low income above poverty level from organization budget,
3. Helping to link seniors with community resources (e.g., food banks, soup kitchens), and
4. Gleaning from Farmers Markets to distribute healthy food

Domain 12: Caregivers

The Caregivers Domain was added due to the desire to include the perspectives of older adults who are frail and vulnerable in DC. These individuals are more likely to need and utilize nonfamily caregivers.

Identification and appropriate resources aligned with caregivers to decrease physical, mental, and economic demands.

- Assistance for the people who help you

Senior Results . . .

- 64% rated as "Very Important": ***Caregivers having access to information on where to get additional help and support,***
- 50% indicated it was "Very Important" to have ***assistance for the people who help them,*** and
- 25% don't know how to get help

Service Provider Results . . .

- When asked about the most important service for caregivers of seniors or seniors who are caregivers (free text response), the most frequent response was **respite care;** and
- 72-82% of the time items related to caregiver support were rated as "Very Important", which closely mirrored the 73-81% range of ratings "Very Important" by Seniors with Disability.

Narrative Comments of Seniors . . .

"need a reliable and trustworthy person, no matter what the cost, to manage all the aspects of being an old person without family"

"again, income limitation. I am penalized for life works even though I still have related expenses."

"need a reliable and trustworthy person, no matter what the cost, to manage all the aspects of being an old person without family"

"need a one stop source of help for all the issues of old age"

Service Providers identify:

- Challenges as lack of timely response to request for assistance, lack of available services for homebound seniors, caregiver burnout, and lack of available resources.
- Creative responses included staying abreast of resources accompanied by education and outreach

This prompt seems to have not been well understood, with many commenting in free text that they didn't understand, and many giving free text comments that were clearly not applicable to the question.

- Open-ended comments by Seniors included:
  - A majority offered suggestions for monetary help to caregivers, i.e. family caregivers be paid to provide services for older adults to replace lost income, access to parking passes or reimbursement for parking and travel, discounts on services or goods, or receiving tax breaks;
  - Need for respite for caregivers;
  - Importance of easy access to one-stop information to guide them in their caregiving activities;
  - Advocated a "no wrong door" concept for obtaining needed information;
  - Training and education in caregiving;
  - Increased pay;
  - Training in English language proficiency; and
  - Access to health benefits

Additionally, three open-ended question to older adults and caregivers are used to elicit responses not identified by researchers:

What do you feel is the biggest problem faced by District of Columbia Seniors?

When asked what is the biggest problem you face as an older adult living in the District of Columbia, there are several themes that emerge. Affordable housing, transportation and parking concerns, caregiving, economic security, loneliness & depression, and home repairs.

To illustrate the range and the depths of need, several narratives of older adults are told in the comments below.

"*One of the biggest problems DC seniors face is getting enough food to see them through the month. Another problem is having the help with the other issues that they face such as medical appointments and getting other resources that they need. There are seniors who do not have kin, they may take a particular interest in their well-being thus they are lonely and afraid."*

"My personal challenges are few currently because I am still working and actively engaged in the community. However, I do feel that when I have visited a doctor's office, any health concern[s] I express is immediately judged as "it is because of your age." I have felt "dismissed" by some doctors and would appreciate more sensitivity by medical profession. Perhaps it is the doctors that I have visited. But how do I know which doctors to go to that will be sensitive to needs of older patients. Do we need a "doctors for older patients", only, directory? I am also more concerned about the needs of "sick and shut-in" seniors in my community that have needs but are not eligible for some service because their household income may be a penny or two above the threshold. What can be done to help these that are truly struggling financially?"

"I have worked for 40 plus years and I want to enjoy some me time. I have a son (39) who lives with us who is intellectually disabled & a seizure patient. I want to enjoy some time for myself at almost 69, I still have to work because I owe a lot of DC Taxes. I'm tired all the time and I'm depressed a lot."

"We want to stay in our home as long as possible. Many challenges are involved."

"Transportation and crime are the big issues. I walk most places or use the metro, but during Safe Track and in general have concerns about metro and safety. I am sometimes concerned about walking alone at night. I am always concerned about the state of our sidewalks and especially in winter since I have osteoporosis and could break bones easily if I fall. Our neighbors do not clean the sidewalks and the sidewalks are wildly uneven. I am also concerned about the effects of gentrification in my neighborhood."

Are there other kinds of services you need that we have not mentioned?

Seniors did not identify other services not mentioned, but rather expounded upon themes already covered in the structured questions.

Some of the open-ended responses to this question include the following statements.

> *"I am 60 years old and my husband is 62. His mother (92 years old) lives with us. We need a place she can go so we can have a respite."*
>
> *"Yes. I need dentures. I'm trying to eat with only two teeth, lost/misplaced dentures and partials last year. Replacement cost is $5,600. Can Office on Aging please assist me in getting some dentures."*
>
> *"It would be beneficial if theater, music, and entertainment events were a little cheaper and also easier to access at night. Most are prohibitively expensive. Travel to and from events also is expensive and if you walk or take metro/ bus it feels a bit risky because of the current rash of purse snatches, robberies and assaults in the neighborhood."*
>
> *"No family caregiver. All senior services seem to be based on the idea that there is a younger, abler bodied person around to manage paperwork, technology, negotiate for services. It's the logistics of getting older that bother me."*
>
> *"None, really. We are healthy, and have a car and bicycles to get around. We have Capitol Hill Village to expand our social contacts. We are also active on ANC committees."*
>
> *"Unfortunately, I'm not fully retired! But, I'm blessed that is my 'biggest' problem. Thank God!"*
>
> *"DC needs sufficient options for appropriate affordable not-for-profit housing - We have no major affordable senior housing communities offering various levels of care - from independent living to assisted living to full care, so that a retired teacher could move in with assurance that they would not have to move again as their needs changed. We should not have to seek affordable senior housing outside of our hometown."*
>
> *"We need housing services so we can move on and live comfortable. Right now it too much going on where we live, they hang in the hallways all the time, beer cans all around people selling beers, they kill each other. A bullet came through my apartment."*

Where or who would you call if you needed help obtaining services?

For all domains, the most frequent answer to who assists the senior or who would you call on if you needed assistance was predominantly family (more than 50% of the time), followed by friends (approximately 25% of the time). Other important sources of assistance included DCOA, Wellness Centers, DCOA Contractors, and the Villages throughout DC. Generally, around 10% for each category responded to the "Who would you call if you needed assistance" with "I don't know".

When asked about the most important services and resources to be available to Seniors in DC, which was an open-ended question at the end of the survey, the services most often identified were respite care [18 of 45 comments or 54%] and personal care assistance [5 of 24 or 21%]. Other often repeated themes included education for caregivers (both non-professional and hired) and other supports for caregivers, including direct or indirect financial compensation (e.g., tax breaks), easily accessible information on what services are available, where, and how to access them, telephonic caregiver support, caregiver support groups, and increased availability of in-home services and support for seniors to lighten caregiver loads.

Major challenges each identified as occurring within the next 5 years included an ever-increasing demand due to an increase in senior demographics in the face of dwindling capacity and resources available from government and philanthropy. The burden of legal and regulatory requirements was also mentioned.

One respondent recommended examining the model of networks of AAAs in California which collaborate to offer services to hospitals and medical facilities in order to take advantage of increased federal funding for care transitions.

RESULTS: INTERVIEWS WITH DC HEALTHCARE PROFESSIONALS

Telephone interviews were conducted with healthcare providers who serve older adults in DC between 7/11/16 and 8/5/16 to elicit critical healthcare needs of older adults; to inquire about innovative and evidence-based practices either in use by, or known by, the contacts; to explore opportunities for collaboration with DCOA in caring for Seniors in DC. The interdisciplinary healthcare providers included physicians, nurse practitioners, social workers, registered nurses and DCOA transitional care managers were practicing in DC hospitals, nursing homes, outpatient clinics, home-based geriatric primary care practices, hospice, front-line DCOA service providers, and community outreach programs.

Most critical unmet needs

Some topic areas shared commonalities among several participants:

- Lack of available, affordable, ADA compliant housing options for people who are frail and disabled in DC; [Domain 3]
- Lack of access to in-home personal help for multiple reasons, including inability to afford (especially for those "stuck in the middle" can't afford to private pay but don't qualify for Medicaid or Medicaid Waiver Services); prolonged time to arrange in-home services (e.g., not available at the time needed) d/t prolonged processing and shortage of personnel; [Domain 8 & 12]
- Difficulty with placing seniors in nursing homes, especially those without skilled needs or those without the requisite 3-day hospital stay to qualify for Medicare rehabilitation services in a skilled nursing facility; [Domains 3 & 8] and
- Difficulty with reliable transportation and lack of in-home availability of medical care (including primary geriatric care from physicians or physician extenders). [Domain 2 & 8]

Barriers to improving access to needed services

- Lack of money and resources;
- Lack of personnel to address issues;
- Lack of coordination across care settings; [Domain 8] and
- Lack of knowledge on the part of front-line healthcare providers (except perhaps Social Workers) and patients and families about what services are already available and how to access them. [Domain 7]

Common reasons for hospitalization/ re-hospitalization/ ER visits/ difficulty discharging back to the home setting

- Diminished ability of patients to meet their own needs in the face of lack of caregiver support at home, both professional and family/friends; [Domain 8 & 12]
- Lack of safe, affordable, ADA compliant housing options; [Domain 3]
- Lack of realistic discharge planning on the part of facilities, who fail to recognize challenges faced by ill and impaired patients sent to the home setting; [Domain 8 & 12] and
- Lack of timely follow-up on the part of home care providers to address medical and personal care issues in the home. [Domain 8 & 12]

Opportunities for collaboration with DCOA

- Several conversation participants requested improved access to information about available DCOA services via several possible venues, including online or print publication of available services in a one-stop shop format; availability of a resource person at the DCOA offices who

could also provide one-stop shop help/ problem solving for individual patients; pamphlet and/or periodic newsletter; on-site (at their practice sites) presentations and training; [Domain 7]

- Jointly plan and execute educational offerings for healthcare providers and the public on various topics, including advance care planning, available services from DCOA and community programs; [Domain 7 & 8]
- DCOA serving as data-gatherer and convener for multiple stakeholders in order to plan, prioritize and improve services for seniors in DC, targeting data-identified needs. Recommendations for stakeholders, in addition to healthcare providers (outpatient and home-based medical practices, hospitals, senior communities, nursing facilities, discharge planners from hospital and subacute care, etc.) included apartment managers, the DC Housing Authority, insurers (especially Medicare/ Medicaid), representatives from social programs (including daycare, job training, senior centers, emergency response personnel, transportation providers); [All Domains] and
- Several respondents recommended DCOA work with current in-home primary care geriatric practices to expand services city-wide. [Domain 8]

Innovative and evidence-based programs discussed by participants

Thought leaders willingly shared either innovative or evidence-based practices their programs were personally involved with, or shared innovative or evidence-based practices that they were aware of. Practices thought to be possibly useful for DCOA to explore further are listed below and more detail of each is provided in Appendix 14.

Medstar Washington Hospital Center Medical Housecalls Program
This is an entirely home-based primary geriatric care program with geriatric physicians, advance practice nurses and social workers who visit patients in their homes or in the extended care facilities. This demonstration project provides chronically ill patients with a complete range of primary care services in the home setting. Studies indicate the program has produced shared savings of 1 to 2 times what fee-for-service brings in, and have cut the hospital readmission rate by more than half. They are a Medicare/ Medicaid Independence At Home Demonstration Pilot practice as part of the Mid-Atlantic Consortium. [Domain 8]

The Coordinating Center
Funded by grants and contracts, the Center coordinates services and navigates systems with people who have complex needs so they can live in the community. Located in Anne Arundel County, the Coordinating Center serves all of Maryland. Services include population health, community care coordination, community care transitions, housing and supportive services, managed care case management, and medical legal services & life care planning. Trained health coaches utilize Care at Hand, a tablet-based patient evaluation software program that automatically tailors questions the patient answers to their specific health issues. It uses predictive analytics to avert hospitalizations. [EB Program] [All Domains]

TeleCaring Program
This is a program within the Capital Caring Hospice Program which utilizes twice daily telephonic contact of all patients in the program by specially trained "TeleCaring Specialists" (not necessarily healthcare professionals) to pro-actively anticipate needs and mobilize appropriate resources in a timely fashion. This is a service on top of the traditional hospice interdisciplinary team visitation services. Although specifically developed for a hospice program, this intervention might be modifiable to serve the needs of chronically ill seniors and disabled persons in DC. The intervention has improved patient and family satisfaction

with the program while lowering utilization of clinical services and decreasing clinical miles traveled (Davis, M.S., et al., 2015). [EB program] [Domain 8]

Club Memory
Offered by the Sibley Senior Association, is citywide. It is funded by an Alzheimer's Disease Initiative Grant. The primary purpose is to build community around the person with Alzheimer's disease and their care partners. They provide daytime activities and support groups for both the person with Alzheimer's and their care partner, and also sponsor meals, outings (e.g., Lincoln Cottage, Arboretum), take people to art, music, and equine therapy, and sponsor congregate meals. [Domains 1,2,4,5,7, 8 and 12] Although currently focused on Alzheimer's disease and other dementias, the program may be amenable to adaption for persons with other chronic diseases and their caregivers.

General feedback for DCOA

- Many participants praised the work of specific contractors; [Domains 4,5,7, 8 & 11]
- Many participants cited concern that Adult Protective Services to respond adequately and in a timely manner to referrals from providers; [Domain 9]
- Many participants cited the need for implementation resources for the DC Medical Orders for Life-Sustaining Treatment (MOLST) Initiative that was legislatively passed but remains unfunded. [Domain 7]

ANALYSIS BY SERVICE PRIORITY

ANALYSIS OF SERVICE PRIORITY BASED ON SENOR SURVEY RESPONSES

To better understand which services have the highest priority to be addressed, we looked at senior respondent's perception of both importance and unmet need. Importance was assessed by asking the question "How important is this to you?" for each of 40 different services. Response categories were "very important, somewhat important, a little important, not at all important." For analysis, we assigned numerical scores ranging from 4=very important to 1=not at all important. To assess unmet need, we looked at the percentage of respondents who said either "don't know how to get services" or "can't afford services" or "won't share financial information" in response to the question "If you are not receiving assistance, why not?" (Other answer choices for this questions were "don't need," "never thought about this," "family's responsibility" and "other".) While respondents were asked to rate importance of each specific within a service category, they were only asked to give a reason for unmet need for a general category. For instance, respondents ranked importance of four specific services within the food and nutrition category: "having a meal with my friends", "information on how to eat healthy", "having meal brought/prepared at home every day", and "being able to afford enough food/groceries". However, the question about need, "If you are not receiving assistance, why not" was only asked once applying to the entire category of food/nutrition. For analysis, we applied the single response to the general category (e.g. food/nutrition) to all of the specific services within the category (e.g. having a meal with friends, information on how to eat health, etc.). This is a limitation in our measurement of need. With our method, every service within a category has the same need rating, even though it is possible that respondent perception about need actually varied by service within the category. Also, the order of unmet need is quite sensitive to whether the absolute number of people reporting need or the percent of respondents with need is used.

We conducted this analysis for all respondents to the senior survey, for just those who were seniors with disabilities, and for those whose incomes was less than $15,000 per year. Results for each of those groups is discussed next.

ALL SENIORS

Table 10 displays the importance and need ratings of each service, by order of importance rating, as rated by all respondents to the senior survey. Importance ranged from a high of 3.83 for safe place to live and safe sidewalks to a low of 1.97 for job training. Unmet need ranged from 39.4% in the housing category to low of 17.3% for civic participation and employment. Figure 5 displays a visual comparison for services ranked highly important (more than 3- on a 4-point importance scale) and with high unmet need (at least 27.5% respondents). The higher a service is placed in the upper right hand quadrant the more it is both highly important and with high unmet need.

TABLE 10. SERVICES RANKED BY PERCEIVED IMPORTANCE AND NEED – ALL RESPONDENTS

Questions: How important is this to you?
If you are not receiving assistance, why not?

Answer Options	Average Importance	Unmet Need
Safe place to live	3.83	29.2%
Safe sidewalks	3.83	29.2%
Knowing what services are available	3.79	35.9%
Safe outdoor areas, such as parks	3.69	29.2%
Getting the exercise that is good for me	3.69	26.7%
Preventing falls and other accidents	3.55	39.4%
Someone to protect my rights, safety, property or dignity	3.42	36.3%
Keeping warm or cool as the weather changes	3.39	39.4%
Someone to call when I feel threatened or taken advantaged of	3.39	36.3%
Information on where to get additional help or support	3.37	31.6%
Information on how to eat healthy	3.35	27.0%
Volunteering or taking part in activities with others	3.31	26.7%
Transportation to healthcare related appointments	3.30	25.1%
Someone to help prepare my will, legal documents	3.29	36.3%
Assistance making choices about future medical care and end-of-life decisions	3.28	36.3%
Having someone to talk to when I'm lonely	3.27	26.7%
Information or assistance applying for health insurance or prescription coverage	3.25	35.9%
A senior center that is close to my home	3.24	26.7%
Being able to attend religious services	3.20	26.7%
Assistance with repairs and maintenance of my home or yard	3.19	39.4%
Assistance keeping my home clean	3.17	34.1%
Being able to afford enough food/groceries	3.16	27.0%
Having a meal with my friends or other seniors like me	3.12	27.0%
Modifications to my home so that I can get around safely	3.04	39.4%
Transportation to the grocery store and other errands	3.04	25.1%
Assistance for the people who help you	3.02	31.6%
Assistance applying for other benefits, e.g. SNAP (supplemental nutritional asst.)	3.01	35.9%
Transportation to the senior center, recreation activity, social event	2.93	25.1%
Transportation/assistance to pick up medications	2.90	25.1%
Assistance to pay rent, mortgage or property taxes	2.82	39.4%
Assistance to pay for medications	2.71	34.1%
Having meal brought/prepared at home every day	2.69	27.0%
Assistance with pest control, such as bed bugs, rats, etc.	2.67	34.1%
Assistance with washing and drying my laundry	2.61	34.1%
Assistance with personal care or bathing	2.50	34.1%
Assistance to vote	2.49	17.3%
Having someone assist me with my prescription medicine	2.48	34.1%
Assistance finding jobs	1.98	17.3%
Assistance with job training	1.97	17.3%

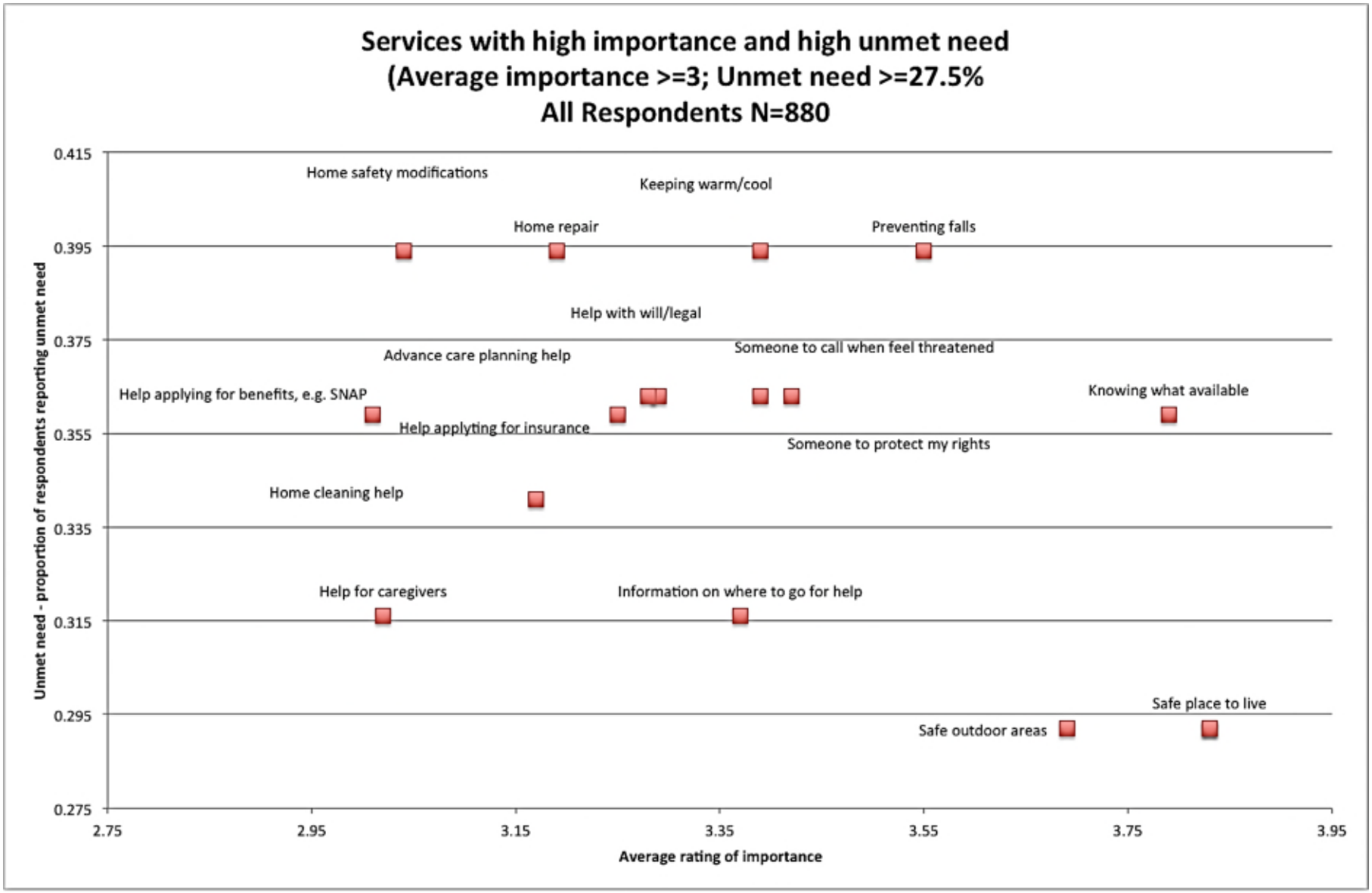


Figure 5: Services with high importance and high unmet need

Table 11 displays services that respondents consider highly important, but where need is lower. These may be success areas where service delivery is fulfilling a need, or it may be areas where need is simply lower. Note that two of the three top most important services (safe place to live and safe outdoor areas) had somewhat lower need than other services. Presumably, this is because people make a great effort to have this most important need (safety in living place and safety in the environment) met. Even so, 116 people (29% of respondents) reported this need was not met.

TABLE 11. IMPORTANT AREAS WITH LOWER UNMET NEED

Answer Options	Average Importance	Unmet Need
Getting the exercise that is good for me	3.69	26.7%
Information on how to eat healthy	3.35	27.0%
Volunteering or taking part in activities with others	3.31	26.7%
Transportation to healthcare related appointments	3.30	25.1%
Having someone to talk to when I'm lonely	3.27	26.7%
A senior center that is close to my home	3.24	26.7%
Being able to attend religious services	3.20	26.7%
Being able to afford enough food/groceries	3.16	27.0%
Having a meal with my friends or other seniors like me	3.12	27.0%
Transportation to the grocery store and other errands	3.04	25.1%

SENIORS WITH DISABILITIES

Compared to all seniors, seniors with disabilities rated many more services as highly important (3 or more). They also reported higher levels of need on many more services. Table 12 reports importance and need of services, in order of importance and Figure 6 displays visually those services with high importance (>3) and high need (>2.75). The two services that stand out as those with the highest combined importance and need are *knowing what* services are available and *preventing falls*.

A subset analysis of Seniors with Disabilities compared with Senior Survey Respondents as a whole revealed that Seniors with Disabilities were much more likely to rate services in all domains (with the exception of Domain 6) as Very Important, to receive needed services from family and DCOA more often, and to rate assistance for the people who help me as Very Important 73% of the time and rating access to information on where to get additional help and support as Very Important 81% of the time.

Seniors with Disabilities were much more likely to report not receiving services due to not knowing how to get the service (ranging from 28% to 40% across domains) and not being able to afford services (9% to 21% across all domains). They were less likely to access information from print, radio, TV, Internet and the AARP and more likely to access information from the Office on Aging.

TABLE 12. SERVICES RANKED BY PERCEIVED IMPORTANCE & NEED–SENIORS WITH DISABILITY

Questions:

How important is this to you?

If you are not receiving assistance, why not?

Answer Options	Average Importance	Unmet Need
Knowing what services are available	3.89	61.3%
Safe place to live	3.88	42.6%
Safe sidewalks	3.83	42.6%
Preventing falls and other accidents	3.80	59.4%
Transportation to healthcare related appointments	3.76	43.3%
Information on where to get additional help or support	3.69	50.4%
Getting the exercise that is good for me	3.68	45.9%
Someone to protect my rights, safety, property or dignity	3.66	50.9%
Safe outdoor areas, such as parks	3.64	42.6%
Someone to call when I feel threatened or taken advantaged of	3.63	50.9%
Being able to afford enough food/groceries	3.60	41.6%
Keeping warm or cool as the weather changes	3.59	59.4%
Information on how to eat healthy	3.58	41.6%
Assistance keeping my home clean	3.57	55.6%
Transportation to the grocery store and other errands	3.50	43.3%
Someone to help prepare my will, legal documents	3.49	50.9%
Assistance for the people who help you	3.48	50.4%
Assistance with repairs and maintenance of my home or yard	3.47	59.4%
Assistance making choices about future medical care and end-of-life decisions	3.47	50.9%
Information or assistance applying for health insurance or prescription coverage	3.41	61.3%
Being able to attend religious services	3.41	45.9%
Modifications to my home so that I can get around safely	3.39	59.4%
Having someone to talk to when I'm lonely	3.39	45.9%
Assistance applying for other benefits, e.g. SNAP (supplemental nutritional asst.)	3.37	61.3%
Transportation/assistance to pick up medications	3.36	43.3%
A senior center that is close to my home	3.32	45.9%
Assistance to pay rent, mortgage or property taxes	3.28	59.4%
Assistance with washing and drying my laundry	3.24	55.6%
Transportation to the senior center, recreation activity, social event	3.24	43.3%
Having meal brought/prepared at home every day	3.20	41.6%
Having a meal with my friends or other seniors like me	3.18	41.6%
Volunteering or taking part in activities with others	3.17	45.9%
Assistance with pest control, such as bed bugs, rats, etc.	3.15	55.6%
Assistance to pay for medications	3.13	55.6%
Assistance with personal care or bathing	3.07	55.6%
Having someone assist me with my prescription medicine	2.96	55.6%
Assistance to vote	2.94	23.5%
Assistance with job training	2.05	23.5%
Assistance finding jobs	2.01	23.5%

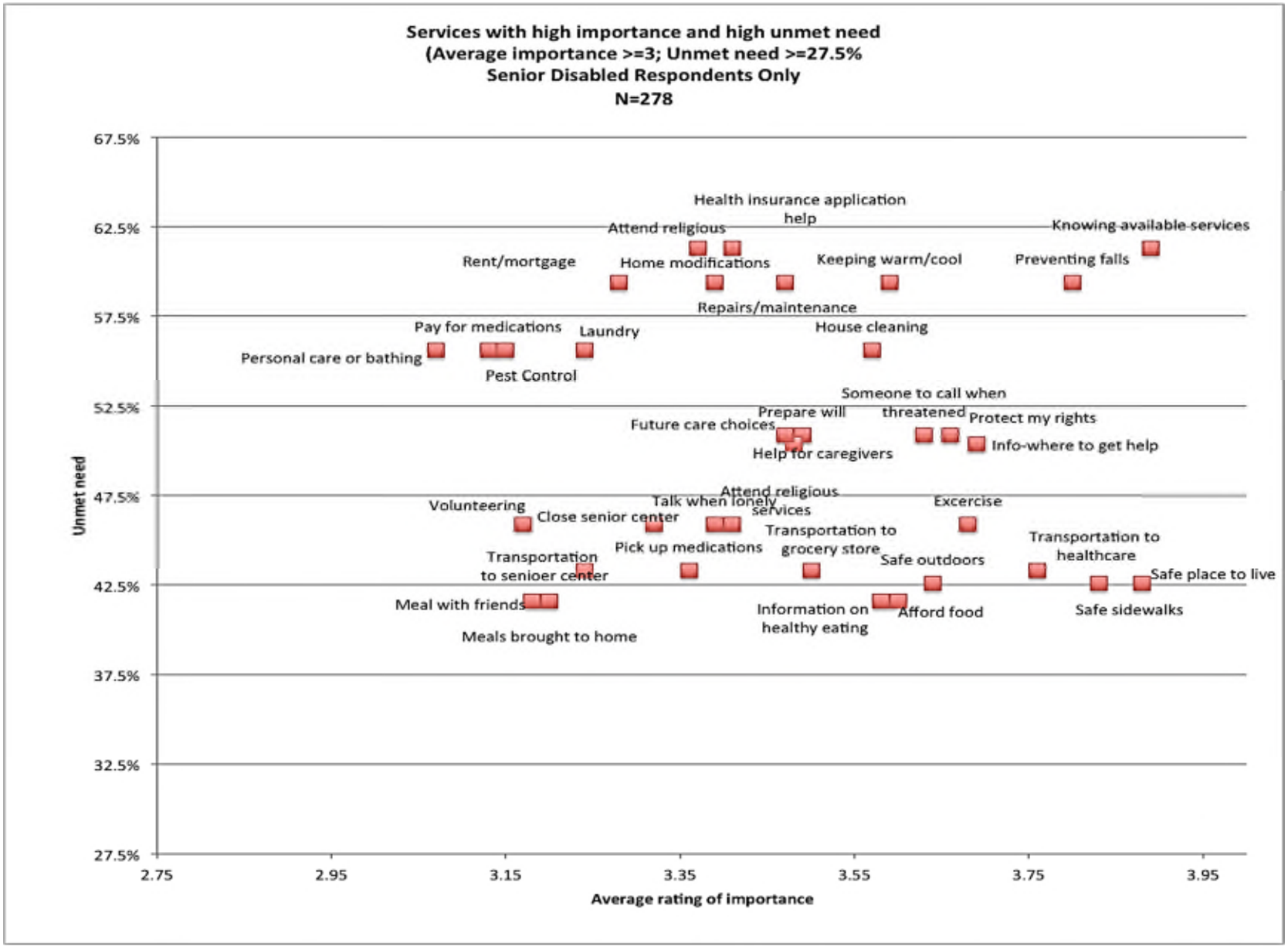


Figure 6. Services with high importance and high unmet need - senior respondents with disabilities

LOW-INCOME RESPONDENTS

Low-income respondents (reporting less than $15,000 in annual income) overlap so a certain extent with seniors with disabilities. The majority of seniors with disabilities (53.1%) reported income less than $15,000 annually. Like seniors with disabilities, low-income respondents report many services as highly important and with high need. See Table 13. The most important service to low-income respondents was a safe place to live, and safe sidewalks. Knowing what services are available – which was the first priority for all seniors and for seniors with disabilities, was the third most important for low-income respondents. Figure 7. Provides an illustration of the relationship of services with high importance and high unmet need for seniors with low-income.

TABLE 13. SERVICES RANKED BY IMPORTANCE AND NEED–RESPONDENTS WITH LOW-INCOME

Answer Options	Average Importance	Unmet need
Safe place to live	3.86	38.5%
Safe sidewalks	3.81	38.5%
Knowing what services are available	3.80	50.0%
Getting the exercise that is good for me	3.70	44.9%
Being able to afford enough food/groceries	3.68	41.8%
Information on how to eat healthy	3.67	41.8%
Safe outdoor areas, such as parks	3.67	38.5%
Transportation to healthcare related appointments	3.66	43.7%
Information on where to get additional help or support	3.64	37.4%
Preventing falls and other accidents	3.63	44.1%
Someone to protect my rights, safety, property or dignity	3.61	38.4%
Someone to call when I feel threatened or taken advantaged of	3.61	38.4%
Information or assistance applying for health insurance or prescription coverage	3.60	50.0%
Keeping warm or cool as the weather changes	3.56	44.1%
Assistance applying for other benefits, e.g. SNAP (supplemental nutritional asst.)	3.47	50.0%
Assistance making choices about future medical care and end-of-life decisions	3.46	38.4%
Being able to attend religious services	3.45	44.9%
Someone to help prepare my will, legal documents	3.44	38.4%
Assistance for the people who help you	3.42	37.4%
A senior center that is close to my home	3.41	44.9%
Assistance to pay rent, mortgage or property taxes	3.39	44.1%
Transportation to the grocery store and other errands	3.39	43.7%
Having someone to talk to when I'm lonely	3.38	44.9%
Having a meal with my friends or other seniors like me	3.36	41.8%
Assistance keeping my home clean	3.34	40.7%
Assistance with repairs and maintenance of my home or yard	3.33	44.1%
Volunteering or taking part in activities with others	3.29	44.9%
Assistance to pay for medications	3.29	40.7%
Transportation/assistance to pick up medications	3.28	43.7%
Modifications to my home so that I can get around safely	3.25	44.1%
Transportation to the senior center, recreation activity, social event	3.24	43.7%
Assistance with pest control, such as bed bugs, rats, etc.	3.22	40.7%
Assistance with washing and drying my laundry	3.11	40.7%
Having meal brought/prepared at home every day	3.09	41.8%
Assistance with personal care or bathing	3.08	40.7%
Having someone assist me with my prescription medicine	3.06	40.7%
Assistance to vote	2.97	21.6%
Assistance with job training	2.37	21.6%
Assistance finding jobs	2.36	21.6%

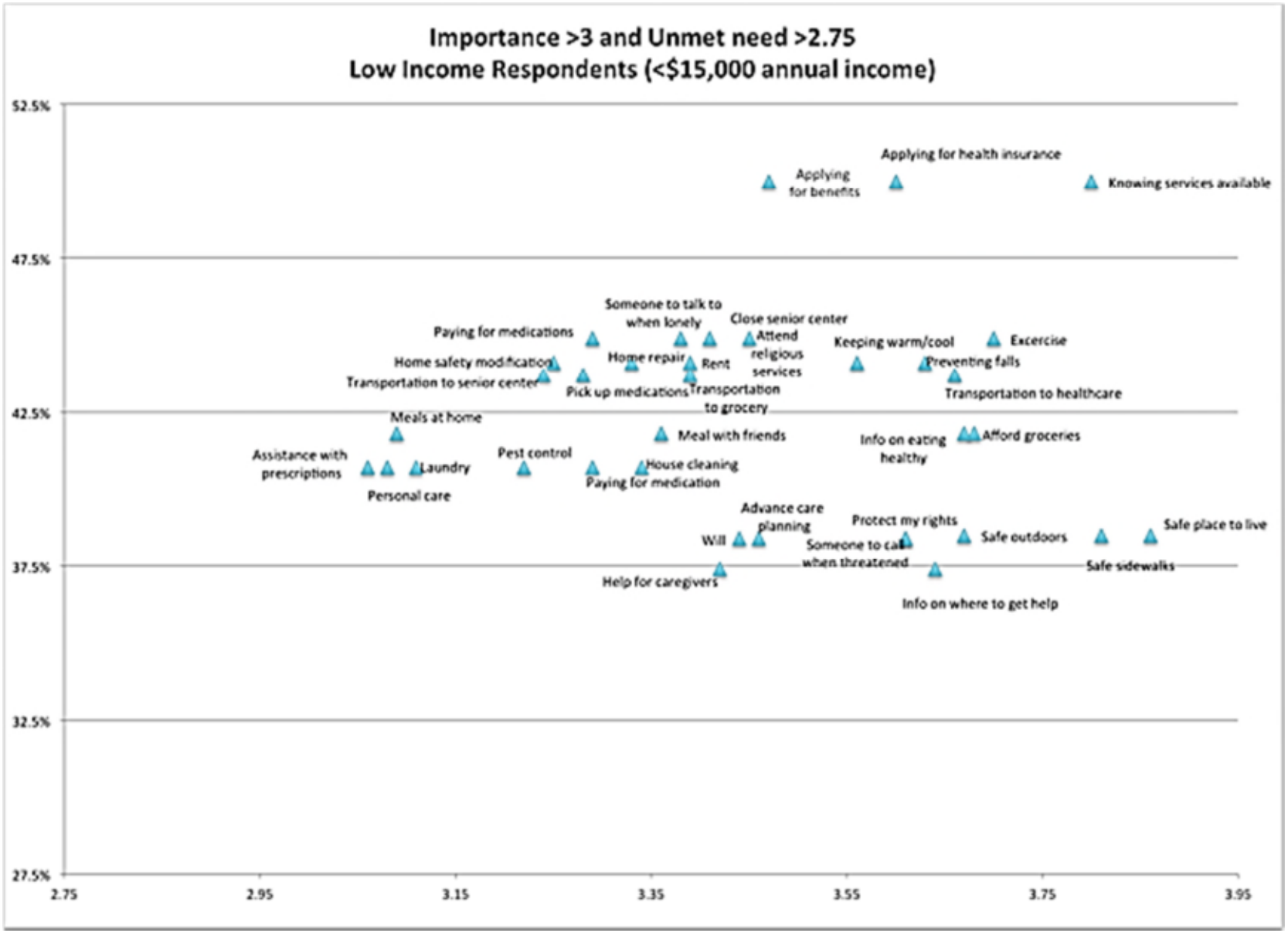


Figure 7. Services with high importance and high unmet need-seniors with low-income

COMPARISON OF PRIORITIES AMONG ALL SENIOR RESPONDENTS, SENIORS WITH DISABILITIES AND SENIORS WHO ARE LOW-INCOME

In order to compare priorities between all seniors, seniors with disabilities and seniors with low-incomes, we created a *composite score* by adding importance and need. To put the importance score and the need score on a similar scale, we multiplied the average importance rating by 10 and converted the need score from a percentage to a number between 1 and 100. Then we added the scaled importance score to the scaled need score. This composite score is shown in Table 14. The top 20 services are shown in the chart, and those ranked within the highest five are color coded so they can be easily found in the other groups. For instance, the highest ranked service for all seniors was preventing falls. This is colored gray and can be seen to move down to the number two ranking among seniors with disabilities, and the number five spot among low-income respondents.

TABLE 14. TOP 20 SERVICES RANKED BY ALL SENIORS, SNEIORS WITH LOW-INCOME, AND SENIORS REPORTING DISABILITIES

	All Senior respondents	Low-Income (<$15,000)	Disabled
1	Preventing falls and other accidents	Knowing what services are available	Knowing what services are available
2	Knowing what services are available	Information or assistance applying for health insurance or prescription coverage	Preventing falls and other accidents
3	Keeping warm or cool as the weather changes	Assistance applying for other benefits, e.g. SNAP (supplemental nutritional asst.)	Information or assistance applying for health insurance or prescription coverage
4	Assistance with repairs and maintenance of my home or yard	Getting the exercise that is good for me	Keeping warm or cool as the weather changes
5	Someone to protect my rights, safety, property or dignity	Preventing falls and other accidents	Assistance applying for other benefits, e.g. SNAP (supplemental nutritional asst.)
6	Someone to call when I feel threatened or taken advantaged of	Transportation to healthcare related appointments	Assistance with repairs and maintenance of my home or yard
7	Modifications to my home so that I can get around safely	Keeping warm or cool as the weather changes	Modifications to my home so that I can get around safely
8	Someone to help prepare my will, legal documents	Being able to attend religious services	Assistance to pay rent, mortgage or property taxes
9	Assistance making choices about future medical care and end-of-life decisions	A senior center that is close to my home	Assistance keeping my home clean
10	Information or assistance applying for health insurance or prescription coverage	Having someone to talk to when I'm lonely	Assistance with washing and drying my laundry
11	Assistance to pay rent, mortgage or property taxes	Being able to afford enough food/groceries	Someone to protect my rights, safety, property or dignity
12	Safe place to live	Information on how to eat healthy	Information on where to get additional help or support
13	Safe sidewalks	Assistance to pay rent, mortgage or property taxes	Someone to call when I feel threatened or taken advantaged of
14	Safe outdoor areas, such as parks	Volunteering or taking part in activities with others	Assistance with pest control, such as bed bugs, rats, etc.
15	Assistance applying for other benefits, e.g. SNAP (supplemental nutritional asst.)	Transportation to the grocery store and other errands	Assistance to pay for medications
16	Assistance keeping my home clean	Assistance with repairs and maintenance of my home or yard	Assistance with personal care or bathing
17	Information on where to get additional help or support	Safe place to live	Someone to help prepare my will, legal documents
18	Getting the exercise that is good for me	Modifications to my home so that I can get around safely	Assistance making choices about future medical care and end-of-life decisions
19	Assistance for the people who help you	Safe sidewalks	Having someone assist me with my prescription medicine
20	Assistance to pay for medications	Transportation/assistance to pick up medications	Assistance for the people who help you

RESULTS: BEST/GOOD PRACTICES

Best/good practices were identified by review of literature and by reviewing websites and organizational information. There were 166 practices identified. One practice was excluded as it was DC's 311 smartphone app that corresponds with its Block-by-Block walk and street improvement program [Domain 1]. 165 practices are evaluated using the American Public Health Association's (APHA) Health in All Policies framework. In response to siloed efforts, increasing demands and challenges, and limited revenues these criteria highlight innovative approaches to improve efficiency and outcomes within and among government agencies (Rudolph, Caplan, Ben-Moshe, & Dillon, 2013). The five criteria to evaluate policy options in Health in All Policies include: 1) Promoting health and equity, 2) Supporting inter-sectoral collaboration, 3. Creating co-benefits for multiple partners, 4) Engaging stakeholders, and 5) Creating structural or process change.

PROGRAMS BY DOMAIN

There is a plethora of Best/Good Practices identified in the DCOA 2016 Needs Assessment that may be useful to address the needs and concerns of older adults and service providers. The numbers of selected practices identified are illustrated in Table 16. How these practices may be used is highly dependent on the intention, resources and skills available for implementation. However, they also illustrate the range of creative and innovative possibilities of addressing each domain. While many domains are not exclusive, many best/good practices programs cross over into other domains and the researchers selected a primary domain.

TABLE 16. BEST/GOOD PRACTICES BY DOMAIN

	Practices
Administrative	4
Domain 1: Outdoor Spaces and Building	5
Domain 2: Transportation	14
Domain 3: Housing	13
Domain 4: Social Participation	10
Domain 5: Respect and Social Inclusion	16
Domain 6: Civic Participation and Employment	11
Domain 7: Communication and Information	19
Domain 8: Community and Health Services	36
Domain 9: Emergency Preparedness and Resilience	2
Domain 10: Legal Issue	13
Domain 11: Food Security	13
Domain 12: Caregivers	10

Detailed descriptions and contact information of the selected Best/Good Practices by domain can be found in Appendix 14. For full results please go online to https://cahh.gwu.edu/aging-programs-best-practices for a complete listing of available best practices.

The limitation of this Best Practices review is that it is not an all-inclusive list of successful age-friendly practices. This is a summary of available, published practices highlighted by age-friendly groups. Note that these Best Practices provide opportunities for DCOA to explore future program options, including partnerships or collaborations that can take various forms.

DISCUSSION

This section will discuss the findings of the DCOA 2016 Needs Assessment in relation to other studies, such as the AARP Livability Index, Age Friendly DC and Health People 2020. In addition, the discussion may highlight developing programs and selected Best Practices that may address the overall findings from each domain. Appendix 15 Integrated Results of Survey, Interviews and Best Practices, which provides an overview that may guide the reader in regards to each domain. It illustrates the common needs and opportunities that were identified across the 3 major pathways of information developed in this study, i.e. surveys, interviews and best practices.

DOMAIN 1: OUTDOOR SPACES AND BUILDING

The first domain illustrates the importance of accessible outdoor spaces and buildings, which allow for individuals of all abilities to increase their independence and social connectedness. The AARP Livability index highlights that in DC walk trips per day are 1.27, which is in the top third of communities in the country. However, older adult survey respondents indicated that items in this domain are “Very Important”. Many narrative comments indicated that sidewalks in DC are particularly problematic. A sidewalk linking a home to a corner grocery store that has cracks, rises, or lacks a curb cut prohibits those using assistive devices (walkers, canes, wheelchairs) from utilizing a pedestrian network. This will limit daily tasks and recreation. According to the AARP livability index, in DC the proximity to destinations, such as grocery stores, farmers’ markets, and parks are in the top third of neighborhoods in the nation. The AlertDC (311) social platform alerts to walkability needs is a success, and it has been highlighted by AARP as an Age-Friendly good practice.

Additionally, DC Healthy People 2020 created an objective to ensure all residents have access to parks and open spaces within half a mile. In 2015, this held true for 97% of District residents. The DC 2020 objective is for 100% of residents to have access to parks and open spaces (District of Columbia Department of Public Health, 2016, p.60). As a recommended strategy, DC Healthy People includes all-age and ability renovations be done for playgrounds and parks (District of Columbia Department of Public Health, 2016, p.60). This is a strategy seen in communities, such as Wichita, Kansas, that have acknowledged the caretaker role many older adults take with grandchildren. This strategy promotes healthy behavior for older adults and models healthy behaviors for young children.

DC Parks Rx is a program to increase activity in children that could be readily adapted for increasing older adult's opportunities for activity. See http://aapdc.org/chapter-initiatives/dc-park-rx/. DC Parks Rx is a Community Health Initiative of health providers, the DC Chapter of the American Academy of Pediatrics, National Park Service, DC Departments of Health and Parks and Recreation, US Health and Human Services, National Environmental Education Foundation, George Washington University, National American Academy of Pediatrics, and National Recreation and Parks Association. Dr. Zarr has created an online database of green spaces in DC, i.e. grassy triangles at road intersections to swaths of Rock Creek Park that includes specific data about access, safety and facilities. This is the first tool of its kind that enables physicians to prescribe a stroll in the park by entering the person's zip code into their records to retrieve specially tailored summaries and maps. While this program was developed to encourage children to engage with nature and be outdoors more, it could be expanded for physicians who care for older adults to encourage outdoor activity. Physicians may need education on how to write effective exercise prescriptions that include recommendations on frequency, intensity, type, time, and progression of exercise that follow disease-specific guidelines. (McDermott, A. & Mernitz, M. 2006).

DOMAIN 2: TRANSPORTATION

The ability to travel to social events, the grocery store, the pharmacy, or to medical appointments was important to respondents in the Senior Survey and it is a vital component of Age-Friendly community. Older adults (16%) indicated they did not know how to get help with transportation services and 6% of respondents indicated they could not afford the service. DC residents are in an urban area, and they have access to a number of different transportation programs. There are 242 buses and train trips per hour in the district, one of the highest rated communities in the country. Transportation is available from automobiles, bus lines, metro, ride-sharing services, shuttle services, and even volunteers in the Villages. However, the distance between a destination and a drop-off location affects the ability of older adults to travel within the District. Additionally, elevator outages in Metro stations, buses without ability to lower stairs, and car services that refuse to service people with assistive devices all impact accessibility.

Service Providers and the subset of Seniors with Disabilities ranked this service as a very important need. DC Metro offers discounted rates for persons 65 years of age and older, and persons who are disabled. But Service Providers indicate there are not enough vehicles, pick-up service is unreliable and scheduling is inflexible. Timeliness, promptness, and quality of services affect the older adult and caregiver's utilization of services. For example, a senior may schedule a follow-up medical appointment at 10am. But if a ride-sharing van service allows for a 4-hour window for pick-up, this impacts the person's ability to get to the appointment if van services starts at 8am.

In DC, alternative transportation for passengers with disabilities who can't ride a bus or subway is funded by the American with Disabilities Act (ADA). Metro Access paratransit

service offers those riders door-to-door service in specially equipped vans. However, this program has at times been suspended or limited due to running out of funds.

Ride-sharing services have expanded to include UberAccess with trained drivers that can help individuals with assistive devices. Additionally, UberWAV connects passengers to wheelchair accessible vehicles. Uber recently partnered with Relatient and MedStar Health to prevent missed appointments and maintain an active plan of care so that patients are not lost to subsequent appointments (Tan, 2016).

It can be difficult determining what services are affordable, available, and accessible for older adults and their caregivers. Other states and cities have responded by providing free rides for seniors on all public transportation through state lottery taxes, developing educational programs, and creating one-call centers to facilitate scheduling on behalf of older adults.

DOMAIN 3: HOUSING

While many people hope to remain in their own home as they age, concerns of accessibility and affordability hinder the ability to age in place. This was evident in the responses from both the Senior Survey and Service Providers survey, as well as interviews with leaders in aging care. Home modifications, keeping warm or cool with weather changes, and preventing falls were of major concerns.

As older adults proactively or reactively respond to the aging process, the most common projects needed for home adaptations include: grab bars, ramps, increasing widths of doorways, lever- handled doorknobs, changing flooring to prevent injuries, adding pullout shelving, widening front entrance, shifting master bedroom to first floor, lowering electrical switches, adding a lift on the stairs, lowering countertops, installing higher electrical outlets, adding a personal alert system (Cusato, 2015). DCOA and Department of Housing and Community Development have partnered to manage the Safe at Home program that allows for $10,000 to go towards home-modifications for eligible residents (DCOA, n.d.x.). Given that only 1.2% of home have this street-level accessibility in the District according to the AARP Livability Index developing solutions to age in place is critical. Certain states such as Portland, Oregon have decreased the cost of building and construction permits for accessory dwelling units and grandmother's quarters.

Beyond home modification that may be necessary to maintain their ability to live at home older adults often report concerns on the rising cost of rent, mortgages, and property taxes. With restricted incomes changes to these can limit their ability to live within the District. It is estimated that the housing cost burden is 17.5% for seniors and the average cost of rent is $1,537 per month, requiring an income of at least $18,444 before utilities, groceries, and health care expenses. Landlords can increase rent annually. The Elderly and Disability Tenant Rent Control Registration Clinic limits the rental increase to the consumer price index up to 5%. To be eligible those who are elderly or disabled must register with the Rent Administrator's Office.

As the population in the District ages and grows, a major concern is the future demand of limited capacity for housing individuals. Estimates that the annual care of an individual in a nursing home costs more than care provided in the home. Many District residents can't afford private care or nursing home care and spend down and turn to Medicaid for long-term care expenses. Innovative solutions within the District include developing age integrated living environments for individuals and families of all ages and the Village model. Integrated living environments can be both building-based and neighborhood-based versions, which can provide core services, including case management, case assistance, information and referral, and health-care-related services.

The Villages program is a national and international program that helps neighborhood communities to develop resources and support services to keep older adults in their homes independently and provide support for the families and caregivers who assist them. In Washington DC, there are approximately fourteen such Villages, which provide a variety of volunteer services, including transportation for groceries and medical appointments, home modifications, yard clean up, computer support, exercise and social activities, and other essential needs. Many of the Villages are in the process of training their volunteers to go to medical appointments with older adults for coaching and note-taking.

Villages utilize community volunteers to provide resources and support services for older adults living at home and their families and caregivers. One Village member who is bed bound was able to age in place and act as a vital member of the Village community. This Village member makes daily calls to other seniors to provide medication reminders and daily wellness checks while other neighbors assist him with meals, home maintenance, and ADLs. The Villages are also a great resource for successful aging-in-place model that uses community services and local professionals, including healthcare, and vendors. The Washington Area Villages Exchange (WAVE) is a local non-profit organization that connects, assists the Villages, and furthers their progress in the Washington, DC metro area. Member Villages are located in DC, Maryland, Virginia, and West Virginia.

DOMAIN 4: SOCIAL PARTICIPATION/DOMAIN 5: & RESPECT AND SOCIAL INCLUSION

Older adult survey respondents indicated it was very important to get exercise, have opportunities for volunteering, be able to talk with others, go to a Senior Center and attend religious services. However, 20% indicated they didn't know how to access these services and activities. Service Providers indicated lack of transportation and personal care assistants may limit the older adult's ability to go out.

According to the AARP Livability Index, DC senior's social involvement, that is the extent to which they share meals with others, call or see relatives and friends, is in the bottom third of communities in the countries. However, their ability to engage with cultural, arts and entertainment institutions is one of the highest with 1.9 institutions per 10,000 people, while the national median is 0.6. While social participation, respect and social inclusion may not seem as critical as falls prevention or adequate food to eat, maintaining relationships and social engagement improve health outcomes and help reduce the three plagues of older adulthood, i.e. loneliness, helplessness, and depression. Loneliness is a

public health issue. Perisonotto, Zenzar & Covinsky (2012) found that those who were over age of 60 and who felt lonely experienced declines in ADL, mobility, upper extremity tasks, and climbing, which results in an increased risk of death. A meta-analysis of studies regarding socialization has found that lack of social relationships is comparable to alcohol misuse, smoking, and obesity (Holt-Lunstad, Smith & Layton, 2010). In response to loneliness, programs such as the Silver Line in the United Kingdom provides a confidential, 24-hour helpline that allows people to chat on the phone (Hafner, 2016).

DCOA has partnered with the Department of Parks and Recreation (DPR) to make exercise classes and activity programs more visible and available to older adults in DC. Recreation Centers provide a community for older adults to come for a specific class or to stay all day for socialization and companionship.

Socio-emotional selectivity theory presents the concept of introducing time horizons to evaluate the motives behind individuals choosing to participate in an activity or not. When an individual views time as finite he/she chooses activities that are deemed meaningful (Carstensen, 2006). The concept of imagining one's own shift of time from infinite to finite is not limited to age. Sheryl Crow, the well-known singer, after being diagnosed with breast cancer began to focus her attention and time on meaningful opportunities (Weller, 2014). Meaningfulness is an often over-looked aspect of well-being (Kauppinen, 2011) and related meaningful activities have the potential to engage residents and decrease boredom and loneliness.

Age Friendly DC is working to combat ageism and stereotypes of seniors, which negatively affect their ability to engage in self-identified meaningful activities. Becca Levy's body of research demonstrates the negative health impacts (physical and mental state decline) of self-perceived stereotypes with older adults. Marshall's discussion (2014, p. 1) notes that, "balance, gait speed, hearing, risk of cardiovascular events and recovery time from such an event" suffer. Additionally, memory performance, self-care and will to live also decline (Marshall, 2014). These have serious implications for potentiating depression, loneliness, boredom, and agitation (Harper Ice, 2002).

DOMAIN 6: CIVIC PARTICIPATION AND EMPLOYMENT

While items in this domain were not rated as important by Seniors or Service Providers, nearly half of the older adults would like assistance voting and 25% would like opportunities for job training and finding a job. Service Providers indicated that older adults need more job opportunities that do not involve IT expertise and/or they need training in the use of computer technologies. There were 64% of respondents who indicated they were retired, but there were also 7% who were still working fulltime.

Older adults are a vital resource to the community. As life expectancy and financial demands increases some older adults find it necessary to push retirement past the age of 65 to make ends meet or to stay engaged. Older adults have a wealth of personal and professional knowledge that does not need to end with retirement or retirement age.

Research has shown that part-time employment and volunteerism can provide a sense of meaningfulness to older adults.

In the District, there are 0.72 jobs per person. (AARP Livability Index) Volunteer work is an economic and social benefit to both the older adult and the organization. Research reflects that depressive symptoms can decrease throughout middle and later life through acts of volunteerism (Li & Ferraro, 2006). Current estimates show that 28.1% of District seniors volunteer for an organization (United Health Foundation, 2016). There are numerous, diverse opportunities available throughout the District since there are approximately 27.1 organizations per 10,000 people (AARP Livability Index). Healthy People 2020 recommended strategy is to increase the number of older adults who volunteer or participate in civic activities (District of Columbia Department of Public Health, 2016, p.60).

Civic participation is important with developing Age-Friendly Cities. The voting rate for all DC residents was 58.7% Of the registered senior voters in DC, 53% voted in 2014 (Mellnik & Lu, 2015).

DOMAIN 7: COMMUNICATION AND INFORMATION

Knowing what services are available was one of the highest ranked needs of older adults, as well as Service Providers. Older adults indicated the most common sources of information were "word of mouth" (43%), followed by AARP (40%), DCOA (34%), Senior Centers (39%) and printed news (32%). In addition, 25% got their information from the Internet. It was also consistent across all domains that approximately 20% of older adults did not know how to access information about services in each domain.

So for effective information transmission for Seniors and Service Providers within the District, it needs be clear and appropriate to the receiver. DCOA website is a centralized location for providing information. With numerous district initiatives, reports, service offerings, and events to market the ability to distill information as a consumer presents a challenge to older adults. The National Institutes of Health provides recommendations to make senior-friendly websites. Websites with concise information allow consumers especially older adults the ability to select, absorb and remember information without the feelings of information overload. Breaking information into short sections makes selections easier. Two AAAs have condensed selections into groups such as I am a senior, I am a caregiver, I am person with disabilities, or I am a community partner. Information must be accessible, translatable, and as needed ("just in time"). It must meet health literacy guidelines, as well as age- and disability-friendly recommendations. Confusion or unawareness of programs within the District is mitigatable through outreach and Internet-friendly sites for seniors. Word-of-mouth marketing is well recognized and trusted source of information, as we evolve to electronic word-of-mouth using short stories and trusted community leaders' experiences can be effective used as effective marketing methods (Bao & Chang, 2014).

About 1/3 of Senior Survey respondents used the online survey to respond to the 2016 Needs Assessment. According to the AARP Livability index, 89.2% of residents have high-speed, low-cost Internet service. Older adults have less access to and daily use of the Internet compared to the adults 18 and over (Zickuhr & Madden, 2012). Identifying the remaining 10% can allow DCOA to communicate programs and service-offerings. DC Healthy People 2020 Older Adult strategy is to increase access to technology at home and in public places for low-income residents (District of Columbia Department of Public Health, 2016, p.60).

In addition to obtaining information about services, an expanded online service could address many other aspects of service provision and data management. Service Providers indicated the need for online platforms that could be used for a variety of needs, such as client check in (which enables service tracking), recording client services and needs, collaborating across agencies, managing data and enabling quality improvement metrics.

DOMAIN 8: COMMUNITY AND HEALTH SERVICES

The older adult respondents indicated it was "very Important" to have assistance in keeping their home clean (59%), assistance with personal care (41%), assistance paying for medications (48%) and for taking medications (36%). Service Providers more frequently rated these needs higher than seniors; they also included assistance with pest control. The interviews with healthcare professionals also indicated a lack of access to in-home personal care due to several reasons, including inability to pay and a prolonged time to actually arrange in-home services. In addition, they noted: 1) difficulty placing older adults in nursing home care when there wasn't a qualifying 3-day hospital stay, 2) lack of adequate geriatric primary care services, particularly in-home, 3) need for point-of service electronic information, and 4) more focus on chronic disease management.

The Community and Health Services within DC could be dissected into primary, secondary and tertiary care. Primary care focuses on prevention of disease, secondary focuses on mitigating the progression of disease burden through disease management and tertiary focuses on acute effects of disease. Primary prevention focuses on population health. In DC Healthy People 2020, three objectives speak to improving population health. The first objective is to improve the overall health of older adults by 50%. The target is for 90% of DC residents 50+ who participate in the survey to rate their health status as good or better. The baseline was set at 73.6% in 2011, and it increased to 76.9% in 2013. The goal is 90% by 2020 (DC Healthy People 2020 Plan). The second objective is to increase the percentage of seniors (50 years old+) who participate in regular physical activity from 76.2% in 2013 to 89.6% in 2020 (District of Columbia Department of Public Health, 2016, p.60). Physical activity builds muscle mass, promotes cardiovascular health, and reduces fall risks. On a similar note, DC Healthy People 2020 third objective in primary prevention is to reduce the rate (per 100,000) of emergency department visits due to falls among older adults (65+). In 2014, there were 2053 falls and in 2015, a total of 2798 falls (District of Columbia Department of Public Health, 2016, p.60). The Robert Wood Johnson Foundation's County Health Ranking and Roadmaps supports data on fall prevention courses as improving health outcomes, decreasing costs, and promoting socialization.

The Senior Wellness Centers, Lead Agencies, Department of Parks and Recreation and many other community centers and programs help to address these needs. However, many of the SWC and DPR programs are full and unable to accommodate the numbers of older adults who want programs. In addition, as previously noted, Wards 2 and 3 do not have a Wellness Center in their geographic area. There are several examples of online Senior Wellness Centers with a full array of programs for socialization, physical activity, health education, chronic disease management, and other topics of interest. Additional best practices are identified in Table 15 that could be utilized to improve population health.

In regards to secondary disease prevention, chronic illness was identified by current providers as a growing need during the past 5 years. The DCOA SSN noted that previously they primarily worked with other social workers, but now they were working more with interdisciplinary healthcare professionals. There are 92% of seniors in the District who have a dedicated healthcare provider compared to 94.3% nationally (United Health Foundation, 2016). There are 23.7% of seniors in DC who are obese compared to 27.5% nationally; and 7.7% of seniors report mental health was not good 14 or more days during the past month compared with 7.3% nationally (United Health Foundation, 2016). Besides noting a shortage of primary care providers for older adults, several older adults commented on the lack of respect and sensitivity to the concerns of aging.

Demand for social services are increasing and waitlists grow with the aging population. Unmet health-related social needs, i.e. food, adequate or stable housing, transportation for medical care, can exacerbate chronic health problems leading to higher disease burden, and increased healthcare utilization and costs (CMS, 2016). There is a need to bridge social services more effectively with health and medical care services. With pushes for shorter hospitalizations individuals are released earlier than ever. As accountable care organizations and health plans pressure providers to provide cost-effective care, the increasing demands of the population require care coordination for community resources and supports to maintain a healthy community. Care coordination assesses individual needs and then connects community resources with the individual and offers re-assessment when necessary. The lack of or ineffective coordination of necessary services post- hospitalization generates subsequent demands on social services and the healthcare system. If needs are not met in the community, individuals are more likely to seek healthcare from emergency departments resulting in readmissions and risk nursing home placement which decreases their desire to age-in place, or die waiting for services.

Effective coordination of community services allows individuals to receive cost-effective services in a timely matter preventing hospitalization or institutionalization. To emphasize the impact this has, Michigan has been pushing to become a no-wait state for older adults. Their efforts have resulted in relaxed wait list rules that previously resulted in long eligibility periods; in addition, they have organized and advocated with the legislature for additional funding to support demands on the social system.

Care coordination may also be improved with the addition of an advanced practice nurse (clinical nurse specialist or nurse practitioner) to collaborate with service providers to increase chronic disease management, care coordination that includes convening

stakeholders, and education/staff development to apply nationally recognized clinical guidelines in population health. This offers a proactive approach to improving disease management and social determinants of health, such as environmental conditions, education, nutrition and social support.

DOMAIN 9: EMERGENCY PREPAREDNESS AND RESILIENCE

Although the DCOA 2016 Needs Assessment does not specifically address emergency preparedness and resilience this is a pertinent topic for those in DC. Located in the mid-Atlantic area, the nation's capital faces threats from severe weather and terrorism. The loss of power and the disruption of systems and services upon which older adults rely, include but are not limited to transportation, communication, health care, elevators, and social supports. Following these events, older adults can be isolated in high-rise buildings and private homes, in need of food, water, warming or cooling, medical attention, and medication.

There is evidence indicating that older adults with strong social networks may be more psychologically resilient in the face of disaster (Wells, 2012). Evidence also suggests that older adults may be more vulnerable in disasters due to a predisposition to one or more of the following factors: mobility and cognitive impairment, chronic health conditions, diminished sensory awareness, social isolation, and financial limitations. These findings are neither mutually exclusive nor contradictory but rather illustrative of a population that is multifaceted, and diverse.

Future questions for a DCOA Needs Assessment should address emergency preparedness and resilience. The Federal Emergency Management Agency and Red Cross encourage older adults to prepare for emergency situations (Federal Emergency Management Agency, 2014; Red Cross, 2009). Three prevention activities for older adults include:

- Maintain an emergency supply kit (water, food, medications, radio, batteries, oxygen, and emergency documents).
- Have a personal support network to help meet your needs in case of an emergency.
- Identify information sources to gain more knowledge about the disaster.

DOMAIN 10: LEGAL ISSUES

DC Healthy People 2020 Objective-5 is to prevent an increase in elder abuse (cases). DC's 2020 target is 892 cases. As part of the recommended OA Strategies-1 is to include screening in preventive care visits related to abuse of elderly adults. With the lack of sensitivity for primary care providers to issues of older adult care, education may be a critical aspect for reaching this goal. Over 60% of respondents rated the services in this domain as "Very Important", i.e. assistance with choices in future medical care (advance care planning), protection for rights, safety, property, or dignity, and someone to call when feeling threatened or taken advantage of.

Documenting one's wishes is crucial before end of life events occur. Approximately 73% of people prefer to die at home (Cable News Network, Roper Center for Public Opinion Research, Time, & Yankelovich Partners, 2000); however, 67% of people die in medical facilities (Teno, Gozalo , Bynum, & et al, 2013). This incongruence suggests a lack of communication between family members and providers. Forty percent of adult in-patients are incapable of making medical decisions (Raymont et al., 2004) and up to 69% of nursing home residents cannot make their own decisions (Kim et al., 2002). This research suggests that advance care planning (ACP) is a crucial determinant to receive the type of care one desires. One aspect of ACP has been developed in DC with an initiative for Medical Orders for Life Sustaining Treatment, but it has not been funded.

ACP educational initiatives occur in localized areas. Dr. Bernard Hammes led local initiatives in LaCrosse, Wisconsin to broach EOL and ACP within the community at churches, schools, and community clubs (Joffe-Walt, 2014). Hammes success in this effort has led to 98% of deceased persons in Wisconsin to have an Advanced Directive; and no one received care that was inconsistent with their wishes (Hammes & Rooney, 1998; Hammes, Rooney, & Gundrum, 2010). As a result, LaCrosse is one of the lowest cost Medicare areas in the country and is in the tenth percentile of Medicare spending per beneficiary (Hammes, Rooney, & Gundrum, 2010; Joffe-Walt, 2014). ACP is now more available to Medicare beneficiaries, as effective January, 2016, Medicare reimburses for voluntary ACP.

Service providers indicated that older adults were frequently unwilling to report abuse, have inadequate access to needed services, and Adult Protective Services could be unresponsive and ineffective.

DOMAIN 11: FOOD SECURITY

Food is a basic need for health. In 2014, Washington DC was ranked 7th for threat of senior hunger (Ziliak, J. & Gundersen, C., 2016. The State of Senior Hunger in America 2014: An Annual Report June 2016, National Foundation to End Senior Hunger). There are three characterizations of food insecurity: 1) the threat of hunger, when a person is defined as marginally food insecure due to having answered affirmatively to one or more questions on the Core Food Security Module in the Current Population Survey (CFSM); 2) the risk of hunger, when a person is food insecure (three or more affirmative responses to questions on the CFSM); and 3) facing hunger, when a person is very low food secure (8 or more affirmative responses to questions in households with children; 6 or more affirmative responses in households without children). Food insecurity increases the risk of malnutrition and poor health outcomes. A randomized control trial, More than a Meal, compared seniors' loneliness in the waitlisted group (control) versus home-delivery group. They reported that those who received daily home deliveries, not only received nutrition support, but they self-reported decreased loneliness (Thomas, Akobundu, & Dosa, 2015). Research has demonstrated that home-delivered meals is a method to maintain low-care older adults out of nursing homes and saved millions in Medicaid funding (Thomas & Mor, 2013). Food delivery programs improve food security as well as the recipients' physical and mental health outcomes. However, home delivered meals are still just one meal daily,

and they do not provide all the nutrition seniors need to survive. Many times this one meal often accounts for about 70% of a senior's total nutritional intake for the day. In addition to basic lack of food, many of the poorest seniors lack pots and pans, spices, working stoves and refrigerators.

In DC, 19% of seniors are at threat of being hungry (Ziliak & Gunderson, 2016, p.6). To address this need, DC has a high Supplemental Nutrition Assistance Program (SNAP) enrollment. In addition to addressing basic food insecurity, older adults with chronic health problems and frailty require special food supplementation. DCOA has a nutrition supplement program for frail older adults to receive liquid nutrition supplements. But this program is underfunded and people have difficulty accessing this service.

Older adult survey respondents also indicated the desire for education on how to eat healthy. They need access to a registered dietitian nutritionist especially to assist the frailest seniors and their caregivers to reverse the devastating effects of senior malnutrition.

The SAC nutrition sub-committee is looking at innovative ways to helping solve senior food and nutrition issues here in DC, including advocating for home delivered meals as part of EPD waiver services for FY18, investigation into home delivered groceries and home CSAs, setting up a nutrition supplement bank at Capital Area Food Bank, and transition care nutrition (hospital to home) (Rose Clifford, Personal Communication, August 9, 2016).

DOMAIN 12: CAREGIVERS

Caregiving is an often-overlooked function many family members assume. With decreasing length-of stays in hospitals and increasing life spans, family caregivers are often asked to perform personal care, care coordination, and complicated medical procedures. While 71% of older adults report not receiving assistance with daily living, 17% of older adults without dementia receive help, 9% with dementia receive help, and 3% of older adults receive care in nursing homes. Approximately, 62% of family caregivers are female, and a third are daughters. 75% of older adults who need help with 2 or more ADLs live at home (Freedman & Spillman, 2014). And nearly 2/3 of those who live home receive all help from unpaid family & friends. Caregiving has emotional, physical, and financial impacts. Higher rates of depression, anxiety, heart disease, and mortality and lower levels of self-care and self-reported health exist among caregivers. Caregivers forego wages and saving for retirement. Future caregiving capacity will be dependent on the capacity and availability of family members.

Older adult respondents indicated several needs for their caregivers, including better monetary compensation, respite care, health insurance, possible tax benefits, and better education, Research indicates that hospital readmission, emergency department visit, and nursing home placements are decreased when systems are family-centered and support caregivers needs through assessment, training, respite (National Academies of Science,

Engineering, and Medicine, 2016). Failure to address caregivers' needs poses an even greater burden on society.

As a result of our comprehensive review of the state of aging needs and services in DC, the consulting team identified key opportunities that cut across need domains. Faced with a fast-growing gap between the expanding need for services and public funding that is flat, DCOA needs to re-conceptualize its role beyond that of allocating and overseeing public monies to the service providers in each ward. DCOA needs to strengthen its capacity for advocacy and coordination so that it becomes a catalyst for helping a variety of actors, both public and private, foster healthy, fulfilled aging for all DC residents. This will require DCOA to increase its capacity to provide service level improvements, as well as key system-wide components. The Recommendations are listed below with additional information and strategies in Table 16.

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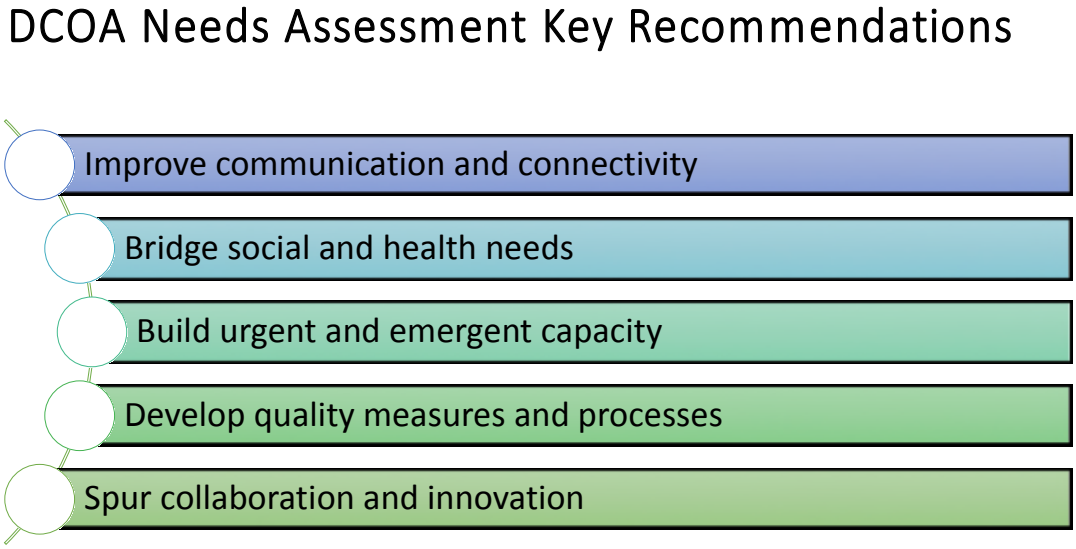

Figure 4. Recommendations from DCOA 2016 Needs Assessment

- ***Improve communication and connectivity*** among services/activities, DCOA, older adults, caregivers, families, and service providers for older adults in DC.
    - Develop a more robust DCOA website with Age-Friendly Navigation.

- Establish a Virtual Senior Center to provide consistent and city-wide information regarding services offered.
- Utilize Virtual Senior Center to provide city-wide interactive programming for exercise, socialization, arts activities, education, etc.
- Extend/Leverage "No Wrong Door" Model to provide portal for comprehensive service access and rapid intake.
- Extend collaborations with AARP and Villages as local and trusted source of information.

- ***Bridge social and health needs*** to more effectively address the health care needs of older adults and their families/caregivers, including healthcare, housing, food security, transportation and safe environments
  - Establish coalition of DCOA stakeholders and healthcare organizations to collaborate for coordinating and improving care and transitions for older adults, e.g. care management provided by the ADRC's could be coordinated more effectively with hospital programs, programs to reduce hospital readmission could be coordinated with DCOA supports and services.
  - Extend interprofessional DCOA team to include a Geriatric Advanced Practice Nurse to bridge social and broader health services, including chronic disease education and consultation.
  - Recognize importance of addressing chronic illness management in older adults as 4 out of 5 Americans over 50 suffer from at least one chronic condition, more than 50% have more than one and 20% have some form of mental illness (Centers for Medicare and Medicaid Services, 2006), which precludes addressing social needs in isolation of physical and mental health problems.
  - Address service improvements through recognition of the DCOA services as important social determinants of health, which are six domains, i.e. economic stability, neighborhood and physical environment, food, community and social context, and healthcare system. For example, food is a social determinant of health. What about food makes it a social determinant of health? An example is a neighborhood with quality grocery stores and access to three meals a day makes maintaining a healthy diet easier. Hunger and access to healthy options impact an individual's health. Living in a food desert or obtaining one meal a day impacts health outcomes. Collectively the six social determinants of health domains impact the mortality, morbidity, life expectancy, health care expenditures, health status and functional limitations of the District.

- ***Build urgent and emergent capacity*** for critical services
  - Improve ***transportation capacity and quality*** for older adults, especially those who are sick and frail in DC.
    - Develop mechanisms for "urgent care" access to transportation.
    - Develop funding sources beyond DCOA to expand capacity; these may involve public/private partnerships, or collaboration with health care institutions.
    - Collaborate with other agencies/organizations who also provide these services to reduce gaps in transportation

- Improve ***housing capacity and quality*** for older adults, especially those who are sick and frail in DC.
  - Continue 'Safe at Home" to improve housing for older adults, including reducing fall risk and barriers that limit mobility.
  - Develop funding sources beyond Older Americans Act funding to expand capacity.
  - Expand public/private partnerships and collaboration with health care institutions.
  -
- Improve capacity to provide ***adequate and healthy foods*** for older adults, especially sick and frail in DC.
  - Ensure comprehensive nutrition services city-wide to provide dedicated expert nutritional providing nutrition information, assessment, and counseling to older adults (geriatrics), their families and caregivers on nutrition and feeding issues education for providers, older adults, families and caregivers, that include: unintentional weight loss or poor appetite; dementia-related feeding issues; dysphagia; diabetes nutrition management; chronic kidney disease nutrition; cardiovascular nutrition issues; weight management; tube feeding or oral calorie & protein nutrition supplements; wound healing; and, general healthy eating for seniors.
  - Utilize city-wide nutritionist who can write prescriptions for nutrition supplements, secure additional public and private funding and support to maintain an adequate supply of special supplements (e.g. nutrition supplement bank at Capital Area Food Bank).
  - Advocate for home delivered meals as part of EPD waiver services for FY18.
  - Establish transitional care nutrition (hospital to home) to reduce compromised health condition and possible readmission.

- ***Develop quality measures and systematic process*** for measurement and evaluation of DCOA service quality, including monitoring unmet needs.
  - Select from available published measures to create a parsimonious panel of structure, process and outcome measures applicable to SSN.
  - Involve SSN in selecting the measures so that they feel the measures are useful in their operations, and not simply reporting for sake of reporting.
  -
- ***Spur collaboration and innovation*** with current Senior Service Network (SSN) and other agencies that serve older adults in DC to increase and expand services.
  - Create an innovation incubator which would provide funding and technical assistance to help SSN agencies test and scale innovations.
  - DCOA would solicit innovations in target areas aligned with strategic plan.

Table 16. Recommendations and Strategies

Recommendation 1: Improve communication and connectivity among services/activities, DCOA, older adults, caregivers, families, and service providers for older adults in DC.	
Service Information Gap. Older adults, caregivers, families, service providers do not know the range of services that are available through DCOA and how to access them. DCOA Website lacks Age-Friendly Navigation **Service Access – Difficulty Accessing Services Provided by Senior Wellness Centers** Homebound Seniors need access to Wellness Centers and activities from their home; Wards 2 & 3 without discreet access to a Senior Wellness Center. ***NOTE: A robust online information system is needed for all subsequent Recommendations*.**	
Strategies	**Best Practice**
Develop a more robust ***DCOA website*** with Age-Friendly Navigation. Establish a ***Virtual Senior Center*** to provide consistent and city-wide information regarding services offered. Utilize Virtual Senior Center to provide city-wide ***interactive programming*** for exercise, socialization, arts activities, education, etc. Extend/Leverage ***"No Wrong Door"*** Model to provide portal for comprehensive service access and rapid intake. ***Extend collaborations*** with AARP and Villages as local and trusted source of information.	• Virtual Senior Center Offerings: http://vscm.selfhelp.net/classes • NIH Senior Friendly Web Guidelines: https://www.nia.nih.gov/health/publication/making-your-website-senior-friendly • AAA Self-Identification Classifications: http://www.area10agency.org/ • http://www.nyc.gov/html/dfta/html/services/centers.shtml • Allow Seniors to search based on need: Marin Health and Human Services Community Resource Guide allows consumers to search based on needs (i.e., food, transit, health care, legal, housing, money) https://www.marinhhs.org/community-resource-guide

Recommendation 2: Bridge social and health needs to address social determinant of health including healthcare, housing, food security, transportation and safe environments

Component: Coordinated and safe transitions needed for frail, vulnerable older adults across settings and agencies, including acute, long-term and home care settings; housing and behavioral health programs, etc.; Increased need for chronic illness management and education for older adults; Service providers dealing with more chronic disease management requiring education to reduce to reduce exacerbations in older adults with chronic illness; and Lag time between need and ability to secure community support services for frail and vulnerable seniors.

Strategies	Best Practice
Establish ***coalition of DCOA stakeholders and healthcare organizations*** to collaborate for coordinating and improving care and transitions for older adults, e.g. care management provided by the ADRC's could be coordinated more effectively with hospital programs, programs to reduce hospital readmission could be coordinated with DCOA supports and services. Extend interprofessional DCOA team to include a ***Geriatric Advanced Practice Nurse*** to bridge social and broader health services, including chronic disease education and consultation. Recognize importance of addressing chronic illness management in older adults as 4 out of 5 Americans over 50 suffer from at least one chronic condition, more than 50% have more than one and 20% have some form of mental illness (Centers for Medicare and Medicaid Services, 2006), which precludes addressing social needs in isolation of physical and mental health problems. Address ***service improvements*** through recognition of the DCOA services as important determinants of health, which are six domains, i.e. economic stability, neighborhood and physical environment, food, community and social context, and healthcare system. For example, food is a social determinant of health. What about food makes it a social determinant of health? An example is a neighborhood with quality grocery stores and access to three meals a day makes maintaining a healthy diet easier. Hunger and access to healthy options impact an individual's health. Living in a food desert or obtaining one meal a day impacts health outcomes. Collectively the six social determinants of health domains impact the mortality, morbidity, life expectancy, health care expenditures, health status and functional limitations of the District. Advocate for PACE program in DC, Create additional mechanisms for coordination across agencies. In particular, hospitals are working to develop transition programs to avoid repeat hospitalizations. Care management provided by the ADRC's could be coordinated with hospital programs.	• Medicare/Medicaid Independence at Home Demonstration • The Coordinating Center, Maryland-wide program located in Anne Arundel County • TEAM SAN DIEGO • Healthy Seniors at Home • Eastern Virginia Care Transitions Partnership ***Local best practices:*** • MedStar HouseCalls Program • Sibley's senior program 60+ club, Club Memory

Recommendation 3: Build urgent and emergent capacity for critical services

Component: **Service Reliability**

- Pick-up service is frequently described as unreliable
- Scheduling characterized as inflexible
- Wide variation in quality exists among contractors

Accessible, Affordable, Safe Housing. Seniors and Providers do not know the range of resources and services available and how to access them: 1) Accessible and affordable housing wait lists, 2) Need safe and ADA compliant housing, 3) Need ability to make safety modifications to existing housing, 4) Need ability to maintain environmental warmth or cooling, and 5) Information on how to access assistance is not readily available

More older adults need meals than can be accommodated. Older adults indicate need for nutrition education

Frail and Sick Older adults need special nutritional assistance, i.e. special supplements such as high protein supplements, supplements for people with diabetes

Strategies	Best Practice
Improve ***transportation capacity and quality*** for older adults, especially sick and frail in DC. • Develop mechanisms for "urgent care" access to transportation. • Develop funding sources beyond DCOA to expand capacity; these may involve public/private partnerships, or collaboration with health care institutions. • Collaborate with other agencies/organizations who also provide these services to reduce gaps in transportation	Uber-MedStar Health Partnership: http://www.hhnmag.com/articles/6916-uber-healthcare-reliable-transportation-patients-medstar-hassle-lyft Transportation Reimbursement Escort Program Accessible Dispatch Creative solution from Service Provider: use program funds to supply alternate transportation to needy seniors
Improve ***housing capacity and quality*** for older adults, especially sick and frail in DC. • Continue 'Safe at Home" to improve housing to prevent falls and reduce barriers in mobility. • Develop funding sources beyond Older Americans Act funding to expand capacity. • Expand public/private partnerships and collaboration with health care institutions.	• DC Safe At Home Initiative ***(http://dcoa.dc.gov/page/safe-home)*** praised by several providers as effective at preventing falls. • EZ Fix Program (similar to $10,000 DC sponsoring) http://www.eaaa.org/index.php?id=518&sub_id=652 • Rent Increase Exemption program • Free A/C • BIG project, Living Together Benefits Young & Old • Making Big Sense of Small Homes Consider modification- to waive municipal fees for redesign)
Improve capacity to ***provide adequate and healthy foods*** for older adults, especially sick and frail in DC. • Expand nutrition coordinator services city-wide to provide dedicated expert nutritional education for providers, older adults, families and caregivers. • Utilize city-wide nutrition coordinator who will securing public and private additional funding and support to maintain an adequate supply of special supplements • Ensure comprehensive nutrition services city-wide to provide dedicated expert nutritional providing nutrition information, assessment, and counseling to older adults (geriatrics), their families and caregivers on nutrition and feeding issues education for	• Senior Nutrition Program Placemats • Elderly Nutrition Food Box Program • CHAMPSS: Choosing Healthy and Appetizing Meal Plan Solutions for Seniors in San Francisco • CHOICE • 21-day Meal Prog. for frail older adults leaving hosp. https://blog.cambro.com/2016/02/29/reducing-hospital-

providers, older adults, families and caregivers, that include: unintentional weight loss or poor appetite; dementia-related feeding issues; dysphagia; diabetes nutrition management; chronic kidney disease nutrition; cardiovascular nutrition issues; weight management; tube feeding or oral calorie & protein nutrition supplements; wound healing; and, general healthy eating for seniors. • Utilize city-wide nutrition nutritionist who can write prescriptions for nutrition supplements, secure public and private additional funding and support to maintain an adequate supply of special supplements (e.g. nutrition supplement bank at Capital Area Food Bank); • Advocate for home delivered meals as part of EPD waiver services for FY18, and • Establish transitional care nutrition (hospital to home) to reduce compromised health condition and possible readmission.	

Recommendation 4: Develop data capacity to monitor and improve quality, including monitoring unmet needs OR Develop quality measures and systematic process for measurement and evaluation of DCOA service quality.

Components: In the previous recommendations for service improvement there isn't a data collection mechanism or process for determining quality and improvement of services.

- Providers: Had strong perception of quality differences among providers (e.g. Iona and Seabury noted as higher quality). Especially notable among the healthcare professionals who serve people from multiple wards and deal with multiple contractors.
- SSN identified lack of quality measures and standards as a problem.
- Consultants' observation: Data on quality of services not available. Consistent metrics not collected across similar contractors.

Information not systematically collected to measure process or outcomes of services; structured comparisons across providers not possible; evaluation of effectiveness based on outcomes not possible

Strategies	Best Practice
• Select from available published measures to create a parsimonious panel of structure, process and outcome measures applicable to SSN. • Involve SSN in selecting the measures so that they feel the measures are useful in their operations, and not simply reporting for sake of reporting.	• Select endorsed measures from the National Quality Forum Quality Positioning System: www.**qualityforum**.org/qps/ • Consider following a consensus process to develop the panel of measures. See Measuring What Matters project for example in field of palliative care. http://aahpm.org/quality/measuring-what-matters

Recommendation 5. Spur innovation with current SSN and other agencies that serve older adults in DC to increase and expand

Service providers and other stakeholders lack resources to develop innovations and improvements in their current services.

<u>Stimulate innovation</u>

Consultants' observation: SSN providers are hungry for help to try new approaches, but many lack staff resources and expertise to go beyond current contracts with DCOA.

Strategies	Best Practice
• Create an innovation incubator to provide funding and technical assistance to help SSN agencies test and scale innovations. DCOA would solicit innovations in target areas aligned with strategic plan.	***Local Best Practices*** • Medstar • Sibley Look to other areas such as arts and technology for examples of innovation incubators.

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SPECIAL ACKNOWLEDGMENTS

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Matthew Brown, MSN, RN

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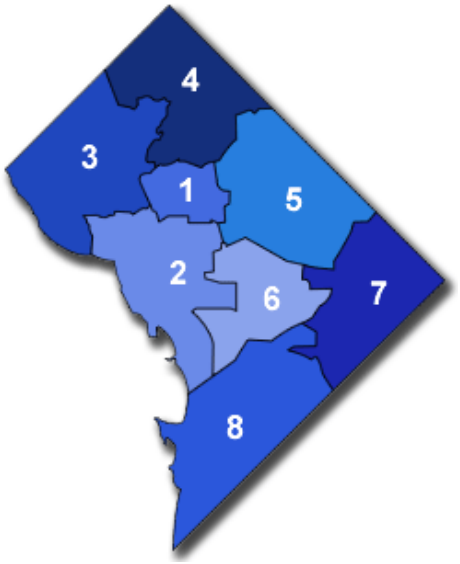
APPENDIX 1: LIST OF ABBREVIATIONS

AAA	Area Agency on Aging
AARP	American Association of Retired Persons
ACL	Administration for Community Living
ACO	Accountable Care Organizations
ACS	American Community Survey
ADL	Activities of daily living
AOA	Administration on Aging
APHA	American Public Health Association
BALC	Business Acumen learning Collaborative
CCTP	Community-based care transition program
DC	District of Columbia
DCOA	District of Columbia Office of Aging
DCPS	District of Columbia Public Schools
DCRA	District of Columbia Regulatory Authority
DHHS	Department of Health and Human Services
DHS	Department of Health Services
DMH	Department of Mental Health
DPR	Department of Parks and Recreation
FMR	Fair market rents
FY	Fiscal year
HCBS	Home and community-based services
HNHC	High-need, high-cost patients
IAH	Independence at H0me
MPD	District of Columbia Metropolitan Police Department
MOLST	Medical orders for Life-Sustaining Treatment
N4A	National Association of Area Agencies on Aging
NCOA	National Council on Aging
OAA	Older Americans Act
OAG	District of Columbia Office of the Attorney General
OP	Office of Planning
PACE	Program of All-inclusive Care for the Elderly
POLST	Physician's Orders for Life-Sustaining Treatment
SAA	State Agency on Aging
SAC	Senior Advisory Council
SWC	Senior wellness center
VSC	Virtual senior center
WAGECC	Washington DC Area Geriatric Education Center Consortium
WAVE	Washington Area Village Exchange
WHO	World Health Organization

APPENDIX 2: WARD DESCRIPTIONS

The Washington District of Columbia is 68 square miles. There are eight distinct electoral divisions. The density distribution of the senior population varies among wards.

WARD 1



Though the smallest ward area-wise, Ward 1 is the most densely populated ward in the District. It is home to some of the best-known residential neighborhoods in DC, including Adams Morgan, Columbia Heights, and parts of Shaw. Howard University is also located in Ward 1, which along with many of the neighborhoods, are culturally and historically significant for the local African-American and Latino populations. Ward 1's population is approximately 20% Hispanic/Latino, and 8% of the Districts older adults live in Ward 1 (DISTRICT OF COLUMBIA COMMUNITY HEALTH NEEDS ASSESSMENT June 2016).

WARD 2

Ward 2 is home to the National Mall, the White House, numerous monuments and museums, as well as the largest population in the District with 86,666 residents. Ward 2 includes the majority of downtown DC, but is also home to some of the oldest residential neighborhoods in the District such as Georgetown, Sheridan Kalorama, and parts of Shaw. In the last decade, Ward 2 has experienced tremendous growth and redevelopment with vacant lots and buildings being filled new retail space, restaurants, entertainment and museums.

WARD 3

Ward 3 is a primarily residential ward in the northwest quadrant of the District, with many of its neighborhoods surrounding commercial centers. Residences range from dense apartment buildings and townhomes to single-family homes. Ward 3 is also home to some of the wealthiest DC residents and home to numerous embassies and ambassadors' residences. Ward 3 is more than 75% White, and together, Wards 3, 4 and 5 are home to almost half (49%) of the District's older adult population.

WARD 4

Ward 4 is a mainly residential area located in the most northern section, bisected by Georgia Avenue. Smaller, local commercial areas include 4th Street, NW in Takoma, Kennedy Street, NW in Brightwood and portions of 14th Street. Like Ward 1, Ward 4 is comprised of approximately 20% Hispanic/Latino, and together, Wards 1 and 4 comprise about 43% of the District's Hispanic/Latino population.

WARD 5

Ward 5 is diverse, ranging from quiet residential neighborhoods, local shopping streets, new high-rise development and industry, as well as open space. Ward 5 is home to Florida Avenue Market, the city's wholesale center, as well as industrial spaces and railroad tracks. The National Arboretum and the U.S. Soldiers' and Airmen's Home, with their greenspace, are also located in this Ward.

WARD 6

Ward 6, due to its location in the heart of the District, has a highly diverse population and neighborhoods. Ward 6 includes parts of downtown DC and is home to office buildings, retail space and restaurants, hotels, museums and other entertainment venues, federal buildings, as well as a growing number of residential buildings. The Southwest Waterfront includes modern apartments and townhomes, and the newly developed Capitol Riverfront neighborhood. The historic Capitol Hill neighborhood and commercial are is located in Ward 6. The new Nationals Stadium is also located in this ward. Ward 6 also has a fairly equal population of White and Black residents (43%).

WARD 7

Ward 7 is also very diverse with its single-family homes, transit stations, and greenspace. Numerous Civil War forts in this ward has been turned into parkland. This ward encompasses several distinct neighborhoods, including riverfront neighborhoods along the Anacostia River. Its population is more than 90% Black, with 25% of its families living below the poverty level.

WARD 8

Ward 8 was historically farmland and the rural character is often reflected in its houses, apartment buildings and institutions. It is also home to the historic Anacostia neighborhood, the oldest in the ward. Major institutions, Federal and otherwise, that take up significant land in Ward 8 include Bolling Air Force Base, Saint Elizabeth's Hospital, the Blue Plains Wastewater Treatment Plant and DC Village. Ward 8 has the lowest population with 77,483 residents. Like Ward 7, its population is more than 90% Black. 23% of Ward 8's families live below the poverty level.

APPENDIX 3: DISTRICT LEAD AGENCIES, SENIOR WELLNES CENTER, & VILLAGES

	Lead Agencies	Senior Wellness Centers	Villages
Ward 1	Terrific, Inc. 910 Westminster Street, NW; Washington, DC 20009 Phone: (202) 387-9000	Bernice Elizabeth Fonteneau Wellness Center	
Ward 2	Terrific, Inc. 1220 L Street, NW, Suite 800; Washington, DC 20036 Phone: (202) 387-9000		Foggy Bottom/West End Village www.fbwevillage.org Georgetown Village www.georgetown-village.org
Ward 3	IONA Senior Services 4125 Albemarle Street, NW; Washington, DC 20016 Phone: (202) 966-1055		Cleveland & Woodley Park Village www.clevelandwoodleyparkvillage.org Northwest Neighborhood Village www.nwnv.org Glover Park Village www.gloverparkvillage.org Palisades Village www.palisadesvillage.org
Ward 4	Terrific, Inc. 418 Missouri Avenue, NW; Washington, DC 20011 Phone: (202) 882-1824	Hattie Holmes Senior Wellness Center	Dupont Circle Village www.dupontcirclevillage.org East Rock Creek Village www.eastrockcreekvillage.com
Ward 5	Seabury Ward 5 Aging Services 2900 Newton Street, NE; Washington, DC 20018 Phone: (202) 529-8701	Model Cities Senior Wellness Center	
Ward 6	Seabury Ward 6 Aging Services 901 A Street, NE, Washington, DC 20002 Phone: (202) 397-1725	Hayes Senior Wellness Center	Capitol Hill Village www.capitolhillvillage.org

Ward 7	East River Family Strengthening Collaborative 3917 Minnesota Avenue, NE; Washington, DC 20019 Phone: (202) 534-4880	Washington Seniors Wellness Center	
Ward 8	Family Matters of Greater Washington 4301 9th Street, SE; Washington, DC 20032 Phone: (202) 562-6860	Congress Heights Senior Wellness Center	

2016 DCOA Senior Needs Assessment Survey

1 Purpose

The GW Center for Aging, Health & Humanities, in collaboration with the District of Columbia Office on Aging (DCOA) is conducting a Needs Assessment for older adults in DC. The purpose of the survey is to ***identify the unmet needs of seniors*** in Washington DC. to enable our team to:

- make recommendations to DCOA and service providers to better meet your needs,
- identify evidence-based, cost-effective practices in other communities, and
- develop creative strategies within the wards.

Senior- those 60 years of age or older. While multiple definitions of senior exist, DCOA offers services to individuals 60 years of age or older.

Caregiver- relatives, friend, neighbors, paid/unpaid providers who regularly provide assistance to older adults who are 60 years old and older

As a senior and a member of the DC community, your input is valuable. The survey is designed to obtain information about services and activities that are important to maintain your health and quality of life. With your participation, together we can create an **Age-Friendly DC**. ***If you need assistance taking the survey, call the research assistant at 202-750-0986.***

If you care for someone over 60 years of age or older who cannot fill out this survey, please fill it out according to your perception of their needs.

2 How to participate in the 2016 Survey

1. ***In-Person:*** Pick up/complete a paper copy of the survey at any of the DCOA Senior Wellness Centers and Lead Agencies. When complete please return it to the same location or mail to the address below.
2. ***Mail:*** You may call **202-994-6726** to have one sent to you. It can be returned by mail or dropped off at a DCOA Senior Wellness Center or Lead Agency by August 30, 2016.
3. ***Electronically:*** You may take the survey online at https://www.surveymonkey.com/r/DCOASeniors.

3 Deadline

Please complete survey by ***AUGUST 30, 2016***

Mailing address: Beverly Lunsford, PhD, RN
GW School of Nursing
1919 Pennsylvania Avenue NW; Suite 500
Washington, DC 20036

4 Questions or Concerns

Call Beverly Lunsford, research coordinator at 202-994-6726.

5. Final Report will be available for review on the DCOA Website late 2016.

CENTER FOR AGING HEALTH AND HUMANITIES

GW School of Nursing and School of Medicine & Health Sciences

APPENDIX 5:SENIOR SURVEY

DCOA Senior Needs Assessment

Section 1: Demographic Information Page

1. Gender	1. a. Sexual Preference	2. Marital Status	3. Are you filling this out on behalf of	4. What is your living situation?	5. Which of the following is your race?
○ Male ○ Female ○ Trans	○ Gay ○ Lesbian ○ Bisexual ○ Heterosexual ○ Queer ○ Other _____	○ Married ○ Widowed ○ Never Married ○ Divorced or Separated	○ Yourself ○ Someone Else	○ Alone ○ With Spouse or Relative ○ With Non-Relatives	○ Caucasian ○ Asian ○ Hispanic/ Latino ○ Black/ African American ○ Native Hawaiian/ Pacific Islander ○ American Indian/ Alaskan Native ○ Other _____

6. What age range do you fall into?	7. What is your annual income?	8. Which best describes you (mark all that apply)?	8a. What health challenges do you face? (Check all that apply)
○ 18-59 years ○ 60-64 years ○ 65- 69 years ○ 70- 74 years ○ 75- 79 years ○ 80- 84 years ○ 85- 89 years ○ 90- 94 years ○ 95 years and older	○ Less than $10,000 ○ $10,000 to $14,999 ○ $15,000 to $19,999 ○ $20,000 to 24,999 ○ $25,000 to $29,999 ○ $30,000 to $34,999 ○ $35,000 to $39,999 ○ $40,000 to $44,999 ○ $45,000 to 49,999 ○ $50,000 to $59,999 ○ $60,000 to $74,999 ○ $75,000 or more	○ Senior ○ Senior w/ Disability ○ Non- Senior w/ Disability ○ Caregiver of senior ○ Caregiver of child/grandchild ○ Relative of senior who needs care ○ Neighbor of senior who needs care ○ Other (please specify) _____	○ I am disabled ○ I am hard of hearing ○ I can't see well ○ I suffer from heart disease ○ I suffer from kidney disease ○ I suffer from lung disease ○ I suffer from diabetes ○ I suffer from cancer ○ I suffer from stroke ○ I suffer from dementia ○ Other _____

9. What best describes your education level?	10. What is your current employment status?	11. Which ward do you live in?	12. Where do you get information about senior services?
○ 0-11 years, no diploma ○ High School diploma ○ Some College ○ Associates degree ○ Bachelor's degree ○ Graduate/ Professional Degree	○ Fully retired ○ Disabled ○ Working full-time ○ Homemaker ○ Retired but working part-time ○ Unemployed, looking for work ○ Unemployed, not looking ○ Other	○ Ward 1 ○ Ward 2 ○ Ward 3 ○ Ward 4 ○ Ward 5 ○ Ward 6 ○ Ward 7 ○ Ward 8	○ Word of mouth ○ Internet ○ Television ○ Office on Aging ○ Radio ○ AARP ○ Senior center ○ Newspaper/ newsletter ○ Senior Beacon ○ Other_____

13. What is the biggest problem you face as an older adult living in the District of Columbia?

Answer the questions to the right for the listed activity/ service	Very important	Somewhat Important	A little important	Not at all important	Family	Friends	DCOA	Religious Organization	*Other*: write-in	Don't need	Don't know how to get services	Can't afford services	Won't share financial information	Never thought about this	Family's responsibility to provide	*Other:* write-in
	How important is this to you				If you have assistance, who assists you?					If you are not receiving assistance, why not?						
14 Knowing what services are available	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15 Information or assistance applying for health insurance or prescription coverage	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16 Assistance applying for other benefits, e.g. SNAP (supplemental nutrition asst.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17 Transportation to healthcare - related appointments	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18 Transportation to the grocery store and other errands	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19 Transportation to senior center, recreation activity, social event	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20 Transportation/ assistance to pick-up medications	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21 Having a meal with my friends or other seniors like me	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Answer the questions to the right for the listed activity/ service	Very important	Somewhat Important	A little important	Not at all important	Family	Friends	DCOA	Religious Organization	*Other*: write-in	Don't need	Don't know how to get services	Can't afford services	Won't share financial information	Never thought about this	Family's responsibility to provide	*Other*: write-in
	How important is this to yo				If you have assistance, who assists you?					If you are not receiving assistance, why not?						
22 Information on how to eat healthy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23 Having meal brought/ prepared at home every day	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24 Being able to afford enough food/ groceries	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25 Volunteering or taking part in activities with others	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26 Getting the exercise that is good for me	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27 Having someone to talk to when I'm lonely	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28 A senior center that is close to my home	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
29 Being able to attend religious services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
30 Assistance keeping my home clean	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Answer the questions to the right for the listed activity/ service	Very important	Somewhat important	A little important	Not at all important	Family	Friends	DCOA	Religious Organization	*Other:* write-in	Don't need	Don't know how to get services	Can't afford services	Won't share financial information	Never thought about this	Family's responsibility to provide	*Other:* write-in
	How important is this to you				If you have assistance, who assists you?					If you are not receiving assistance, why not?						
31 Assistance with personal care or bathing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
32 Assistance with washing & drying my laundry	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
33 Assistance to pay for medications	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
34 Having someone assist me with my prescription medicine	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
35 Assistance with pest control, such as bed bugs, rats, etc.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
36 Keeping warm or cool as the weather changes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
37 Preventing falls & other accidents	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
38 Modifications to my home so that I can get around safely	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
39 Assistance with repairs and maintenance of home or yard	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Answer the questions to the right for the listed activity/ service	How important is this to you? Very important	Somewhat Important	A little important	Not at all important	If you have assistance, who assists you? Family	Friends	DCOA	Religious Organization	Other: write-in	If you are not receiving assistance, why not? Don't need	Don't know how to get services	Can't afford services	Won't share financial information	Never thought about this	Family's responsibility to provide	Other: write-in
48 Safe place to live	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
49 Safe sidewalks	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
50 Safe outdoor areas, such as parks	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
51 Assistance for the people who help you	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
52 Information on where to get additional help or support	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

53 Are you able to leave your home to do the activities you want to do? Yes _____ No _____

54 Are there other kinds of services you need that we have not mentioned? _____

_____

55 Where or who would you call if you needed help obtaining services? _____

_____

56 What services would be helpful for the people who provide personal assistance for you? _____

_____

APPENDIX 6: SENIOR SURVEY DELIVERY LOCATIONS

DCOA Senior Wellness Centers

Ward 1: Bernnice Fontenaeu Senior Wellness Center
Ward 2: Hattie Holmes Senior Wellness Center
Ward 5: Model Cities Senior Wellness Center
Ward 6: Hayes Senior Wellness Center
Ward 7: Washington Seniors Wellness Center
Ward 7: Washington Seniors Wellness Center
Ward 8: Congress Heights Senior Wellness Center

DCOA Lead Agencies

Ward 1: Terrific Inc.
Ward 2: Terrific Inc.
Ward 3: IONA
Ward 4: Terrific Inc.
Ward 5: Seabury Ward 5 Aging Services
Ward 6: Seabury Ward 6 Aging Services
Ward 6: Seabury Ward 6 Aging Services
Ward 7: East River Family Strengthening Collaborative
Ward 8: Family Matters of Greater Washington

Villages

Cleveland and Woodley Park
Foggy Bottom West End
Georgetown Village
Capitol Hill Village
Northwest Neighborhood Village
Mt Pleasant Village

Nutrition

Jackie Geralnick, Nutrition Programs
Homebound Meals Network home-delivered meal coordinators and social workers
Seabury Homebound Meals

Healthcare Providers

VA Clinics
Thomas Circle

Department of Parks and Recreation with Senior Centers

Ward 4: Emory Recreation Center
Ward 4: Fort Stevens Recreation Center
Ward 4: Lamond Recreation Center
Ward 5: Theodore Hagans Cultural Center
Ward 6: William H Rumsey Aquatic Facility
Ward 7: Therapeutic Recreation Aquatic Center
Ward 7: Therapeutic Recreation Center
Ward 8: Fort Stanton Recreation Center

Department of Parks and Recreation (no specific senior centers)

Ward 8: Ferebee Hope Aquatic Facility

Library

MLK Library

Religious Organizations

Audrey Stevenson-Shiloh Baptist
Second Baptist Church
Mt Moriah Baptist Church
Foundry United Methodist Church
Grace Reformed Church
Luther Place Memorial
Metropolitan AME Church
Calvary Baptist Church
National City Church
Hebrew Congregation on Macomb

Barbershops and Hair Salons in Anacostia, Southeast DC

MLK Community Barbershop
Pro Cut Family Barber Shop
JB Barbershop
Like That 2 barbershop
Classic Kutz
Like That Barbershop
Brace's Unisex
Kutt-N-Up
Next Level Cuts
P J's Cut & Style Salon
Jasmine's Hair Gallery
New Creation Hair Salon

Miscellaneous

Howard University School of Social Work
Home Care Partners
Hayes Sr. Wellness
Providence Health Foundation
Mayors Senior Symposium

2016 DCOA Senior Needs Assessment Survey

1 Purpose

The GW Center for Aging, Health & Humanities, in collaboration with the District of Columbia Office on Aging (DCOA) is conducting a Needs Assessment for older adults in DC. The purpose of the survey is to ***identify the unmet needs of seniors*** in Washington DC. to enable our team to:

- make recommendations to DCOA and service providers to better meet your needs,
- identify evidence-based, cost-effective practices in other communities, and
- develop creative strategies within the wards.

Senior- those 60 years of age or older. While multiple definitions of senior exist, DCOA offers services to individuals 60 years of age or older.

As a service provider for older adults in DC, your input is valuable. This survey is designed to obtain information about services/activities that you think are most important for seniors in DC., as well as challenges and barriers in providing these services. With your participation, together we can create an **Age-Friendly DC**.

2 How to participate in the 2016 Service Provider Survey

You may take the survey online at https://www.surveymonkey.com/r/DCOA-NeedsAssess

3 Deadline

Please complete the survey by ***AUGUST 30, 2016***

4 Questions or Concerns

Call Beverly Lunsford, research coordinator at 202-994-6726.

5. Final Report will be available for review on the DCOA Website late 2016.

CENTER FOR AGING HEALTH AND HUMANITIES

GW School of Nursing and School of Medicine & Health Sciences

□ What services does your organization provide? (check all that apply)

□ Adult education
□ Adult day care services
□ Advocacy
□ Case management
□ Emergency group housing
□ Employment and job training
□ Group (congregate) meals
□ Health care in-home support
□ Legal assistance
□ Recreation
□ Transportation
□ Wellness programs
□ Other (please specify)

□ What ward(s) does your organization provide services for?

□ Ward 1
□ Ward 2
□ Ward 3
□ Ward 4
□ Ward 5
□ Ward 6
□ Ward 7
□ Ward 8

□ Does your service area include residents in Maryland or Virginia?

- Yes
- No

□ How long have you been providing services for seniors, in DC or elsewhere (answer in years)?

- ___
-

□ What type of organization are you?

□ Public
□ Private: non-profit
□ Private: for-profit
□ Other (please specify)
_____

- □ Can your organization adequately meet the needs of all of your clients?

□ Yes
□ No

□ If you answered "no", what challenges do you encounter?

_____

□ Do you have a waitlist for services? If yes, what services and how many are currently on?

_____

□ Are you familiar with DCOA?

□ Yes
□ No

□ Do you work with programs funded by DCOA?

□ Yes
□ No

□ If yes, please identify what DCOA programs you work with?

□ Adult education
□ Adult day care services
□ Advocacy
□ Case management
□ Emergency group housing
□ Employment and job training
□ Group (congregate) meals
□ Health care in-home support
□ Legal assistance
□ Recreation
□ Transportation
□ Wellness programs

□ Are you familiar with DCOA's Aging Disability Resource Center (ADRC), the District of Columbia's one-stop resource for public and private information and assistance relate to long-term care services for persons living with disabilities (18 and older) and older adults (60 and older)

□ Yes
□ No

□ Have you utilized the ADRC services?

□ Yes
□ No

□ What ADRC services have you utilized?

□ Care Planning and Outreach
□ Caregivers Support and Services
□ Housing Information and Assistance
□ In-Home Care
□ Long-Term Care Coordination & Guidance
□ Medical Assistance
□ Support Groups
□ I have not utilized ADRC services

□ While DCOA funds a number of service providers in the district if you receive funding from other sources to extend services. Where does the organization look to? For approximately how much?

_____
_____

□ In your view, does DCOA have good relationships with community stakeholders?

□ Yes
□ No

□ Does your organization provide direct services to older adults with any of the following activity of daily living (ADL) and/or instrumental activities of daily living limitations?

□ Personal hygiene and grooming
□ Dressing & undressing
□ Self-feeding
□ Functional transfers (getting from bed to wheelchair, getting onto or off of toilet, etc.)
□ Bowel & bladder management
□ Walking without use of use of an assistive device (walker, cane, or crutches) or using a wheelchair

□ Doing housework
□ Taking medications as prescribed
□ Managing money
□ Shopping for groceries or clothing
□ Use of telephone or other form of communication
□ Using information technology
□ My organization does not provide these services

□ Does your organization provide support services to caregivers?
□ Yes
□ No

□ What type of support services does your organization provide to caregivers?
□ Respite care
□ Advocacy
□ Transportation
□ Financial assistance
□ Home maker
□ Case management
□ My organization does not provide caregiver support services

□ Would your organization be willing to provide free caregiver support services on holidays, vacations and/or weekends?
□ Yes
□ No
□ My organization does not provide caregiver support services

For each service listed below, please answer the questions to the right	From your perspective how important is this service for DC seniors?				How satisfied are you with DCOA & Network Services currently offered					What are the challenges in offering this service/addressing this need
	Very Important	Somewhat important	A Little Important	Not at all Importa	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied	Write responses below
Communication/ Information										
19 Knowing what services are available	☐	☐	☐	☐	☐	☐	☐	☐	☐	
20 Information or assistance applying for health insurance or prescription coverage	☐	☐	☐	☐	☐	☐	☐	☐	☐	
21 Assistance applying for other benefits, e.g. SNAP (supplemental nutrition program)	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Transportation										
22 Transportation to healthcare related appointments	☐	☐	☐	☐	☐	☐	☐	☐	☐	
23 Transportation to the grocery store and other errands	☐	☐	☐	☐	☐	☐	☐	☐	☐	
24 Assistance/transportation to pick-up medications	☐	☐	☐	☐	☐	☐	☐	☐	☐	
25 Transportation to the senior center, recreation activities, social events	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Food										
26 Having a meal with my friends or other seniors	☐	☐	☐	☐	☐	☐	☐	☐	☐	
27 Information on how to eat healthy	☐	☐	☐	☐	☐	☐	☐	☐	☐	
28 Having a meal brought to/prepared at home every day	☐	☐	☐	☐	☐	☐	☐	☐	☐	
29 Being able to afford enough food/groceries	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Community Support, Respect and social inclusion, Social Participation										