	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 Important	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied	Write responses below
30	Volunteering/taking part in fun activities with others	☐	☐	☐	☐	☐	☐	☐	☐	☐	
31	Getting the exercise that is good for me	☐	☐	☐	☐	☐	☐	☐	☐	☐	
32	Having someone to talk to when I'm lonely	☐	☐	☐	☐	☐	☐	☐	☐	☐	
33	A senior center that is close to my home	☐	☐	☐	☐	☐	☐	☐	☐	☐	
34	Being able to attend religious services	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	Health Services										
35	Assistance keeping my home clean	☐	☐	☐	☐	☐	☐	☐	☐	☐	
36	Assistance with personal care or bathing	☐	☐	☐	☐	☐	☐	☐	☐	☐	
37	Assistance with washing and drying my laundry	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	Assistance to pay for medications	☐	☐	☐	☐	☐	☐	☐	☐	☐	
38	Having someone assist me with my prescription medicine	☐	☐	☐	☐	☐	☐	☐	☐	☐	
39	Assistance with controlling pests, such as bed bugs, rats, etc.	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	Housing										
40	Keeping warm or cool as the weather changes	☐	☐	☐	☐	☐	☐	☐	☐	☐	

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 impor	A Little Importan	Not at all Importa	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied	Write responses below
41 Preventing falls and other accidents	☐	☐	☐	☐	☐	☐	☐	☐	☐	
42 Modifications to my home so that I can get around safely	☐	☐	☐	☐	☐	☐	☐	☐	☐	
43 Assistance with repairs and maintenance of my home or yard	☐	☐	☐	☐	☐	☐	☐	☐	☐	
44 Assistance paying rent/mortgage/property tax										
Legal/Advocacy										
45 Assistance making choices about future medical care and end-of-life decisions	☐	☐	☐	☐	☐	☐	☐	☐	☐	
46 Someone to protect my rights, safety, property or dignity	☐	☐	☐	☐	☐	☐	☐	☐	☐	
47 Someone to call when I feel threatened or taken advantage of	☐	☐	☐	☐	☐	☐	☐	☐	☐	
48 Someone to help prepare my will, legal documents	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Civic Participation and Employment										
49 Assistance with job training	☐	☐	☐	☐	☐	☐	☐	☐	☐	
50 Assistance finding jobs	☐	☐	☐	☐	☐	☐	☐	☐	☐	
51 Assistance with voting	☐	☐	☐	☐	☐	☐	☐	☐	☐	

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 Important	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied	Write responses below
Outdoor spaces and buildings										
50 Safe place to live	☐	☐	☐	☐	☐	☐	☐	☐	☐	
51 Safe sidewalks	☐	☐	☐	☐	☐	☐	☐	☐	☐	
52 Safe outdoor areas, such as parks	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Caregivers										
53 Assistance for the people who help you	☐	☐	☐	☐	☐	☐	☐	☐	☐	
54 Information on where to get additional help or support	☐	☐	☐	☐	☐	☐	☐	☐	☐	

55 **Within your organization, what are the major challenges in providing services for seniors in the next 5 years?**

56 **What do you think major barriers will be in addressing these challenges, e.g. money, people with knowledge and skills, regulatory issues,**

57 **What percentage of your organizations funding comes from the DCOA?**

58 **Have you or your organization sought funding elsewhere? If so, was it successful?**

APPENDIX 9: GUIDE FOR INTERVIEW WITH HEALTHCARE PROFESSIONALS

Name:____________________________ Organization ______________________Date________

DCOA TC guide to exploring best practices and opportunities for collaboration
DCOA Mission: *To advocate, plan, implement, and monitor programs in health, education, employment, and social services to promote longevity, independence, dignity, and choice for our senior citizens.*

Introduction: The DC Office on Aging has retained The Center for Aging, Health, and Humanities at GWU School of Nursing to conduct a 2016 Needs Assessment. The purpose of the needs assessment is to answer the question:

- How do we serve more Seniors and/or serve Seniors more effectively, including:
  - Keeping seniors in their homes longer
  - Providing a holistic array of services to optimize quality of life
  - Ensuring that most frail or sick elderly are heard by service providers, including those with chronic progressive illness or disability and those who may be terminally ill, as more able bodied can speak up for themselves to more readily garner more resources

Global questions

- What do you see as the most critical unmet needs of seniors in DC, including the chronically ill and disabled, and those nearing death?
- What are the barriers to meeting these needs?
- If you could do one thing to improve services for seniors in DC, what would that be?
- What barriers are preventing this from happening?

Institution-specific questions

- Does your institution have a senior outreach program or other programs that significantly impact seniors?
- What drives and motivates you to provide senior care?
- What services do you provide, and how has your outreach changed in the past 5 yrs.? Have you adopted any best practices or innovative programs in senior care, or do you know about such programs?
- How do you serve chronically ill/seniors with disabilities or those nearing the end-of-life phase?
- Does any part of your senior outreach funding or support come from DCOA? What portion? What other sources of funding or support do you have for your senior programs?
- DCOA is exploring opportunities for collaboration and partnership to enhance services for senior DC residents. Have you used any of DCOA's services for your senior clients/ patients? Which ones, and how would you rate them?
- What opportunities do you envision for further collaboration with DCOA in initiating best practices in the care of our seniors (both at your institution and with others)?
- What are the more critical problems you have in transitioning senior care across care settings, and what are the barriers to addressing these?

For hospitals

- What are the most common reasons for avoidable hospitalizations/ 30 day readmissions/ frequent ER visits among your clients?
- How could best practices be utilized in concert with DCOA and others to mitigate this problem?
- What are the barriers to implementing these?
- What are the problems you have in trying to discharge medically stable seniors from your institution?
- What could ease the discharge process for seniors with complex medical and psychosocial problems?
- What are the challenges you face in carrying out goals of care or advance directive discussions with patients to ensure treatments are congruent with the patient's values and realistic for the stage of illness?

For Nursing Homes

- What barriers to discharge back to the home setting do you encounter for your clients/ patients (from skilled or custodial care)?
- What could help to overcome these barriers?
- What are common reasons for frequent repeat hospitalization in your patient population?
- Are there any interventions that you can think of that would prevent frequent hospital readmissions among your patients?
- What are the barriers to implementing these interventions?
- What are your challenges in having goals of care/ advance directive discussions with patients and families?
- Does your institution utilize Physician Orders for Life Sustaining Treatment? If so, in what proportion of you residents?

For Physician Practices

- What innovations has your practice initiated to help keep seniors safe at home?
- What additional innovations implemented in concert with DCOA and others might be useful?
- What barriers do you encounter in trying to provide holistic care to your patients?
- What are the barriers to initiating timely goals of care/ advance directive discussions with your patients and families?
- Have you initiated any innovative practices to promote these discussions?

APPENDIX 10: GWU IRB RESEARCH DETERMINATION

Memorandum

To: Beverly Lunsford, PhD

Shari Sliwa

From: The George Washington University Office of Human Research

Date: July 12, 2016

Study Title: DCOA Needs Assessment and Feasibility Study

RE: Not Research Determination

Regarding the IRB application submitted on June 27, 2016 for the project entitled, "DCOA Needs Assessment and Feasibility Study", a determination has been made that this project does not meet the definition of research. That is, a systematic investigation designed to contribute to generalizable knowledge.

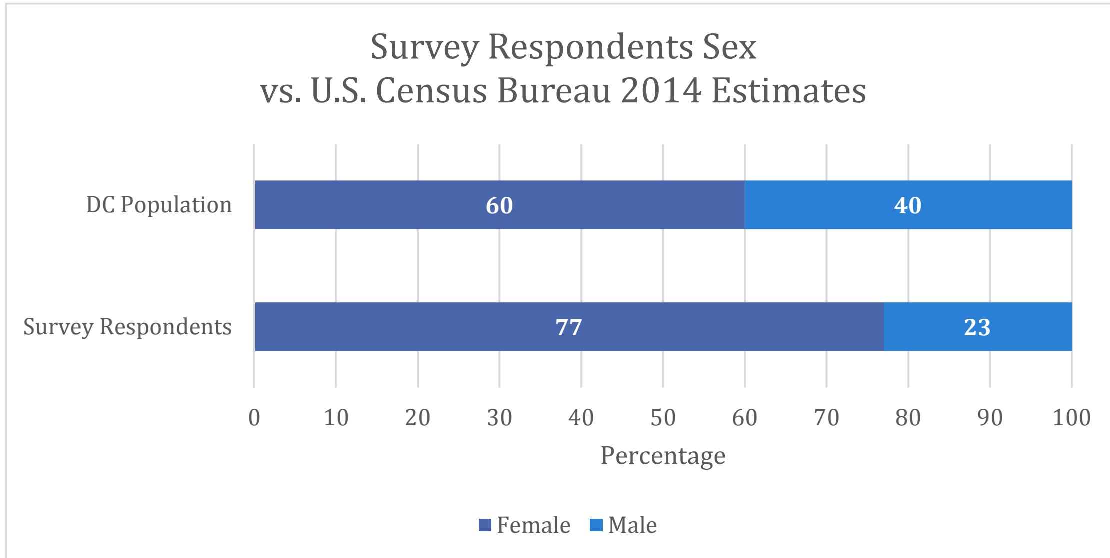
This determination is because the project is being conducted as a Needs Assessment and Feasibility Study for the District of Columbia Office of Aging. It is conducted to address and suggest innovative and best practice strategies to address gaps and to improve the overall agency efficiency. These findings are not considered to be generalizable outside of the immediate research context. Should the data collected be used for research purposes at any time, IRB review and approval is required.

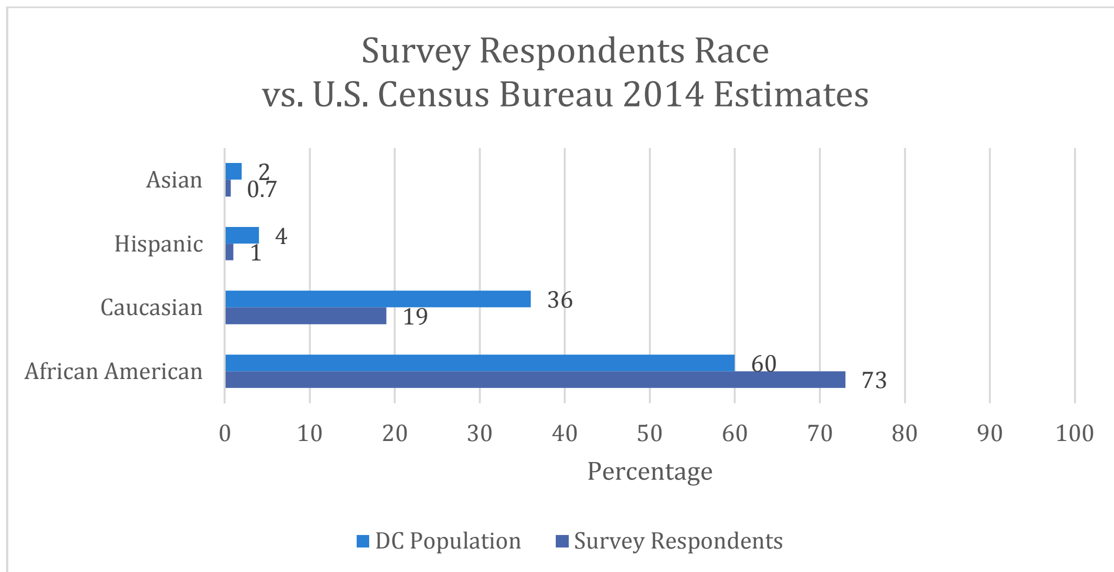
Further review by the GW Institutional Review Board (IRB) is not required.

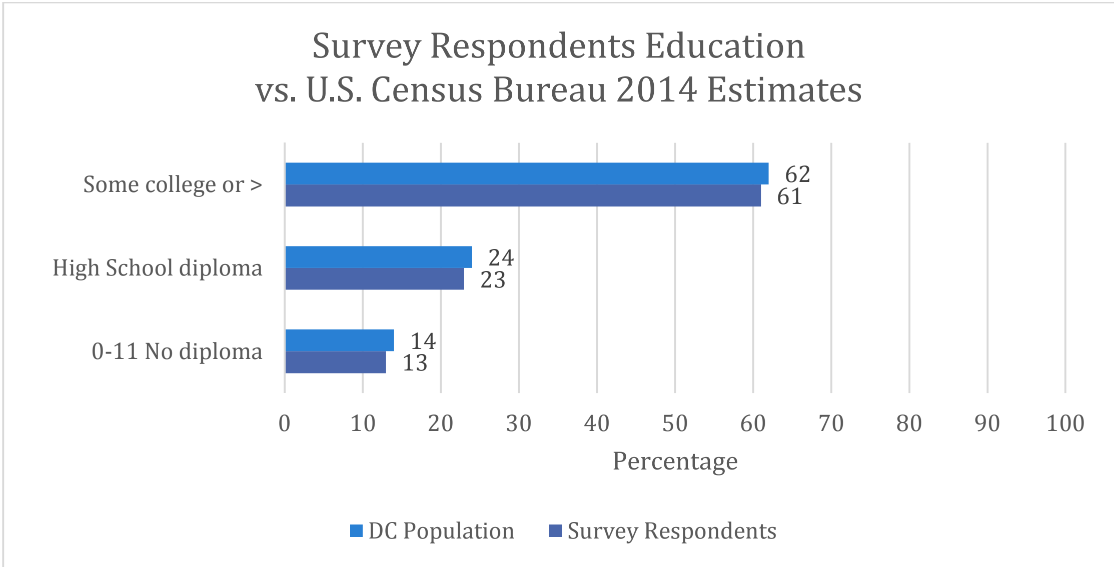
Should your project change in such a way that it does meet the definition of human subjects research, please consult with the Office of Human Research (OHR) before proceeding.

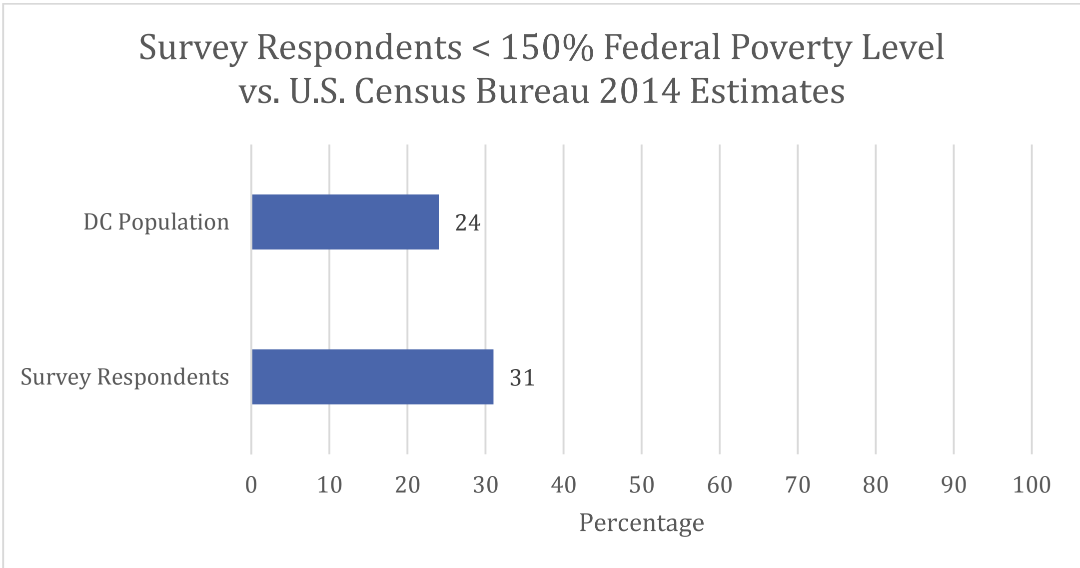
OHR/tao

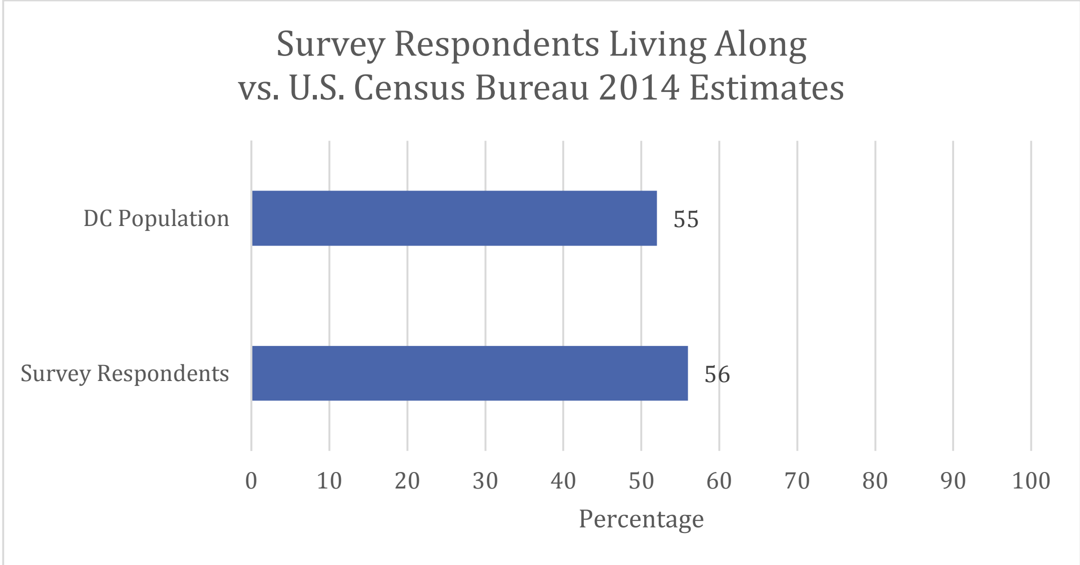
APPENDIX 11: SENIOR SURVEY RESULTS VS. 2014 AMERICAN COMMUNITY SURVEY ESTIMATES

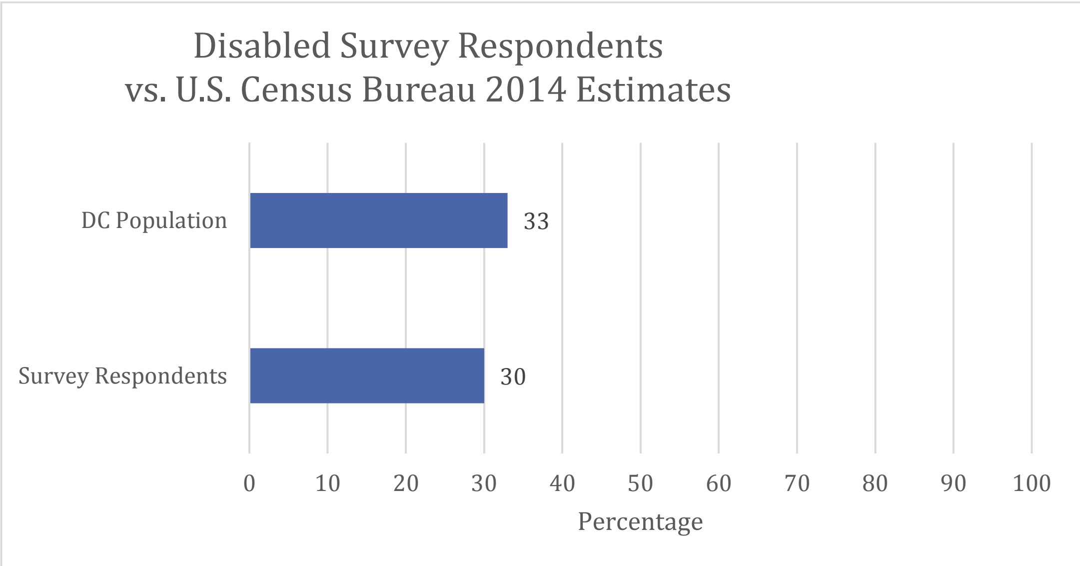


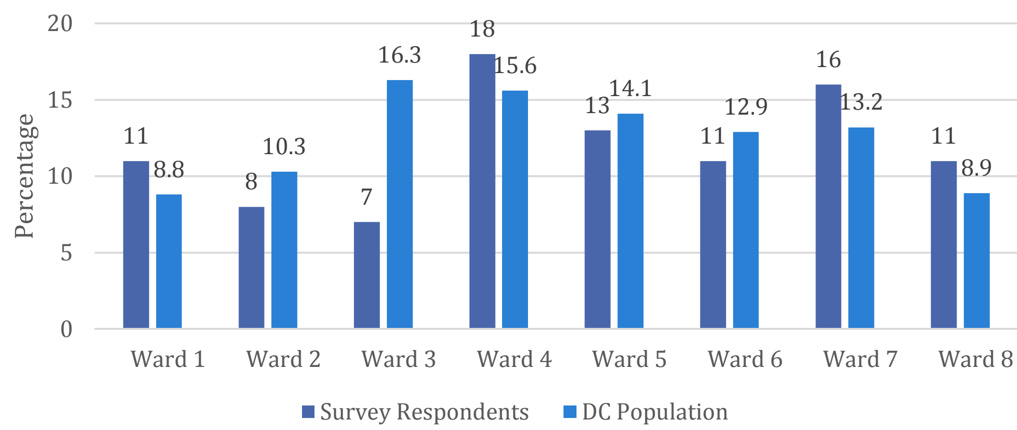



Survey Respondents Education
vs. U.S. Census Bureau 2014 Estimates
Some college or >
High School diploma
0-11 No diploma
62
61
24
23
14
13
0
10
20
30
40
50
60
70
80
90
100
Percentage
DC Population
Survey Respondents


Survey Respondents < 150% Federal Poverty Level
vs. U.S. Census Bureau 2014 Estimates
DC Population
Survey Respondents
24
31
0
10
20
30
40
50
60
70
80
90
100
Percentage


Survey Respondents Living Along
vs. U.S. Census Bureau 2014 Estimates
DC Population
55
Survey Respondents
56
0
10
20
30
40
50
60
70
80
90
100
Percentage


Disabled Survey Respondents
vs. U.S. Census Bureau 2014 Estimates
DC Population
33
Survey Respondents
30
0
10
20
30
40
50
60
70
80
90
100
Percentage


Survey Respondents Ward
vs. U.S. Census 2014 Estimates
Percentage
20
15
10
5
0
11
8.8
8
10.3
7
16.3
18
15.6
13
14.1
11
12.9
16
13.2
11
8.9
Ward 1
Ward 2
Ward 3
Ward 4
Ward 5
Ward 6
Ward 7
Ward 8
Survey Respondents
DC Population

APPENDIX 12: 2016 NEEDS ASSESSMENT RESPONDENT WARD DEMOGRAPHICS

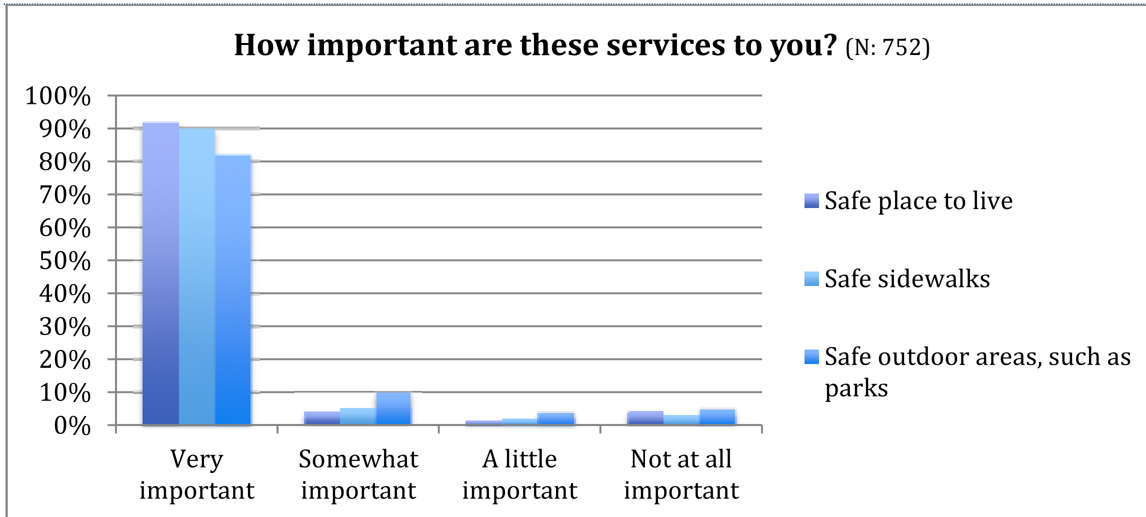
Survey respondents were separated by ward to illustrate differences across wards for age, income, education and sources of information. To highlight major differences in composition among the wards, the cells with greater than 20% are highlighted green.

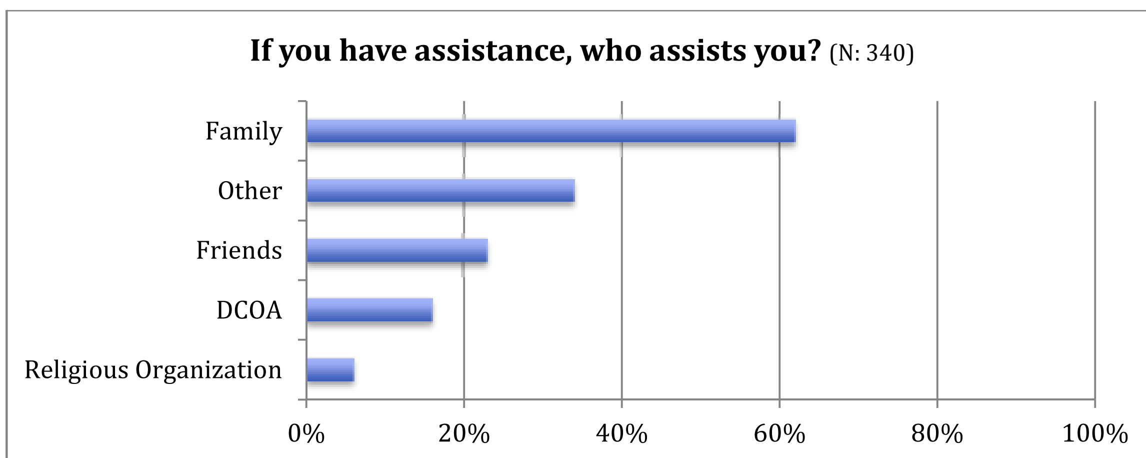
	Respondent Characteristics by DC Ward								TOTALS or AVERAGE
	1	2	3	4	5	6	7	8	
# Survey respondents	93	70	63	159	110	94	137	98	824
	11%	8%	8%	19%	13%	11%	17%	12%	
Sex									
Female	68%	71%	76%	80%	84%	73%	78%	88%	77%
Age (Intra-Ward percentage)									
No Response	1%	0%	0%	0%	1%	1%	0%	0%	0%
18-59	5%	3%	2%	3%	5%	4%	1%	2%	3%
60-64	12%	9%	10%	11%	14%	14%	10%	12%	11%
65-69	26%	27%	16%	17%	23%	29%	27%	26%	24%
70-74	26%	29%	27%	16%	17%	21%	18%	21%	22%
75-79	15%	20%	24%	16%	15%	13%	17%	16%	17%
80-84	8%	6%	11%	16%	8%	10%	12%	16%	11%
85-89	5%	7%	6%	14%	9%	5%	10%	2%	7%
90-94	2%	0%	5%	4%	6%	3%	2%	3%	3%
95+	0%	0%	0%	4%	1%	0%	3%	1%	1%
Race									
No response	3%	1%	3%	6%	2%	2%	4%	4%	3%
Caucasian	35%	80%	84%	5%	1%	10%	1%	0%	27%
Hispanic/ Latino	3%	1%	0%	3%	0%	0%	0%	0%	1%
Black/African American	58%	17%	10%	82%	94%	86%	94%	95%	67%
Native Hawaiian/Pacific Islander	0%	0%	0%	0%	1%	0%	0%	0%	0%
American Indian/Alaskan Native	0%	0%	0%	1%	0%	0%	1%	0%	0%
Asian	0%	0%	3%	1%	0%	1%	0%	1%	1%
No response	6%	10%	13%	14%	13%	16%	18%	9%	12%
< 10,000	14%	10%	5%	13%	22%	23%	21%	28%	17%
10,000-14,999	20%	3%	3%	5%	15%	21%	19%	19%	13%
15,000 - 19,999	8%	3%	3%	10%	8%	4%	14%	9%	7%
20,000-24,999	4%	1%	6%	8%	2%	10%	2%	9%	5%
25,000-29,999	6%	3%	2%	7%	8%	4%	6%	3%	5%
30,000-34,999	8%	4%	2%	8%	4%	1%	3%	7%	4%
35,000-39,999	2%	3%	2%	7%	5%	1%	2%	6%	3%
40,000-44,999	4%	4%	3%	4%	5%	2%	4%	1%	4%
45,000-49,999	1%	1%	5%	2%	3%	2%	1%	2%	2%
50,000- 59,999	6%	4%	10%	6%	5%	0%	2%	2%	4%

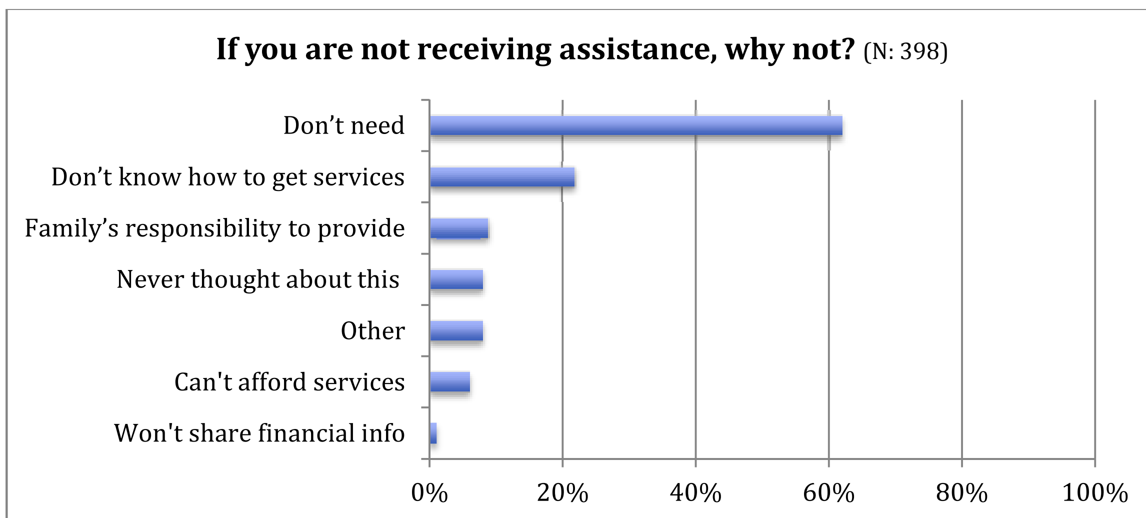
	Respondent Characteristics by DC Ward								TOTALS or AVERAGE
	1	2	3	4	5	6	7	8	
60,000-74,999	4%	6%	10%	5%	4%	6%	2%	2%	5%
>75,000	15%	47%	38%	10%	7%	9%	5%	2%	17%
Self-Description (not exclusive)									
Senior	63%	86%	78%	70%	68%	69%	80%	63%	
Senior with disability	35%	16%	17%	32%	28%	35%	26%	45%	
Non-senior with disability	2%	1%	0%	2%	0%	3%	0%	0%	
Caregiver	1%	6%	11%	12%	15%	3%	4%	6%	
Relative of senior who needs care	2%	1%	13%	8%	6%	2%	3%	3%	
Neighbor of senior who needs care	0%	1%	6%	3%	4%	1%	0%	1%	
Education									
No response	2%	1%	0%	2%	1%	2%	1%	3%	2%
0-11 years, no diploma	12%	1%	3%	9%	13%	3%	21%	16%	10%
High school diploma	26%	7%	3%	18%	23%	2%	32%	38%	19%
Some college	13%	3%	13%	19%	22%	0%	25%	27%	15%
Associate's degree	2%	1%	2%	7%	8%	1%	4%	6%	4%
Bachelor's degree	17%	16%	27%	17%	12%	2%	7%	3%	12%
Graduate/professional degree	28%	70%	52%	28%	22%	0%	9%	7%	27%
Employment Status									
No response	3%	0%	0%	3%	2%	5%	1%	1%	2%
Fully retired	65%	57%	63%	71%	67%	0%	65%	65%	57%
Working full-time	8%	9%	11%	8%	6%	0%	6%	4%	6%
Homemaker	0%	0%	0%	0%	2%	1%	3%	0%	1%
Retired but working part-time	3%	13%	16%	8%	6%	1%	3%	5%	7%
Unemployed, looking for work	1%	3%	2%	4%	5%	0%	4%	3%	3%
Unemployed, not looking for work	4%	0%	2%	2%	1%	2%	3%	1%	2%
Disabled	14%	7%	2%	3%	10%	0%	14%	19%	9%
Other (e.g., work part time or volunteer)	2%	11%	5%	1%	1%	0%	1%	1%	3%
Where do you get info on senior services? (not exclusive)									
Word of mouth	55%	31%	43%	43%	51%	47%	33%	40%	38%
Television	17%	11%	8%	19%	24%	28%	12%	28%	16%
Radio	12%	6%	11%	9%	6%	13%	1%	9%	8%
Senior center	29%	9%	21%	33%	43%	47%	53%	50%	30%
Newspaper/ newsletter	31%	47%	57%	26%	28%	22%	11%	17%	28%
Senior Beacon	26%	7%	11%	27%	26%	14%	20%	20%	18%
Internet	35%	29%	37%	20%	16%	9%	9%	11%	21%
Office on Aging	41%	17%	11%	42%	45%	33%	32%	36%	29%
AARP	34%	49%	37%	38%	45%	34%	33%	45%	36%
Villages	13%	37%	14%	1%	0%	1%	0%	0%	8%

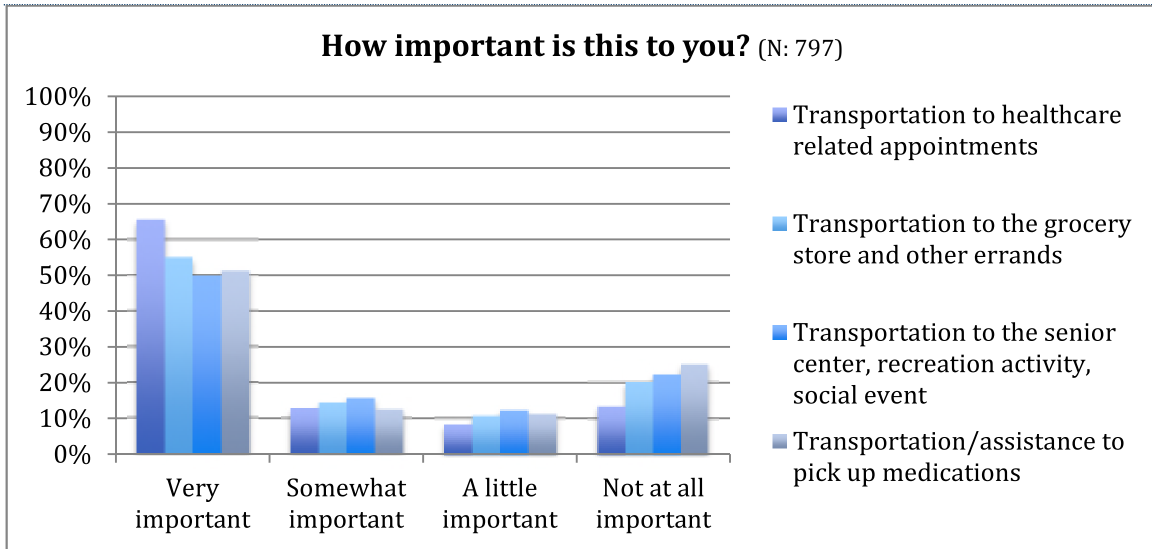
APPENDIX 13: OLDER ADULT SERVICE/ ACTIVITY RESPONSES

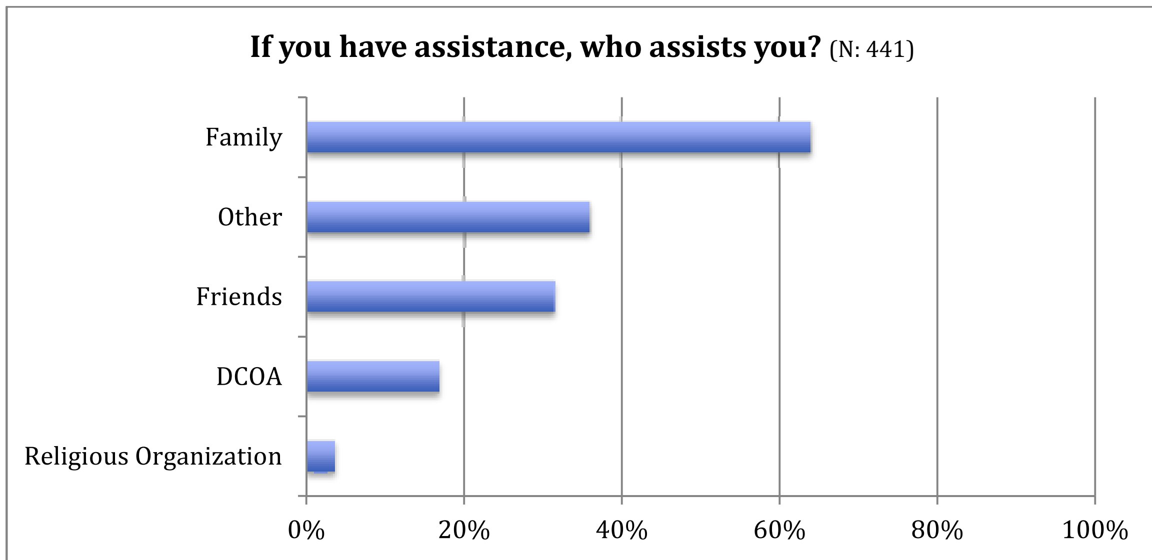
DOMAIN 1: OUTDOOR SPACES AND BUILDING

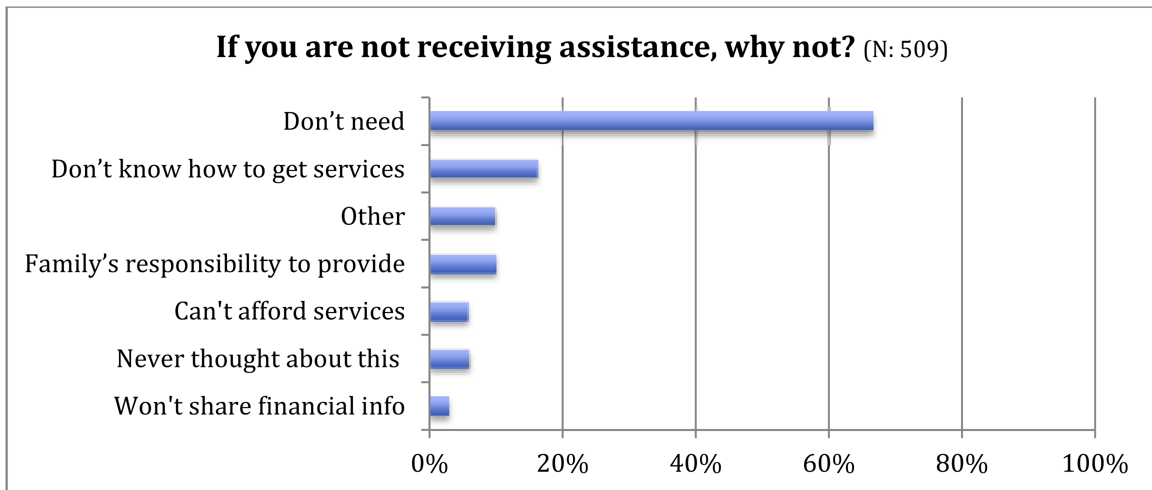


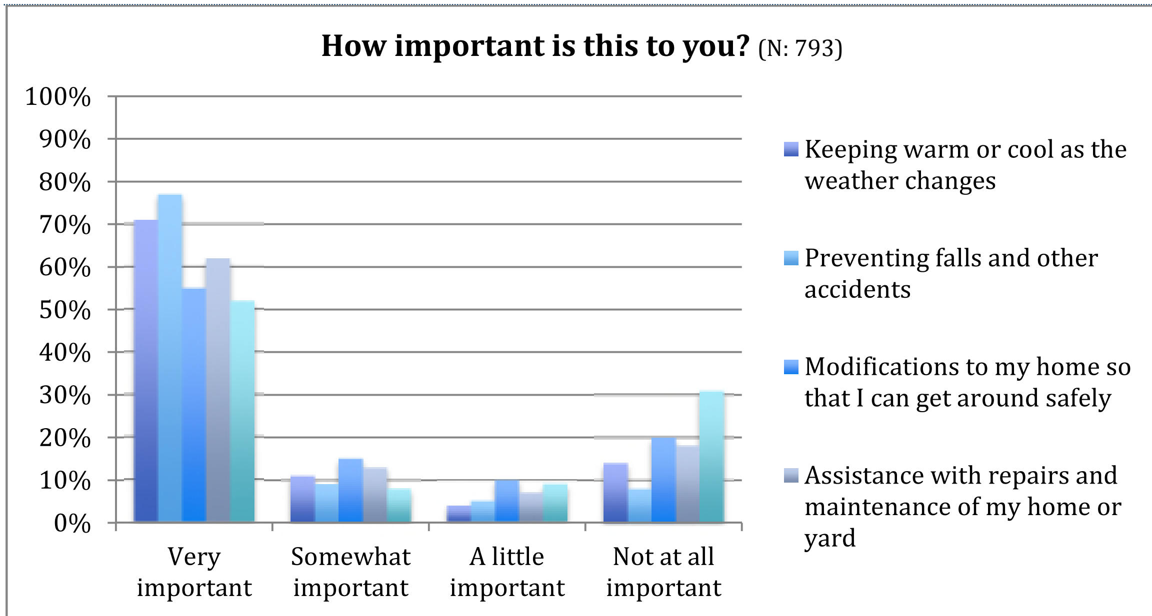


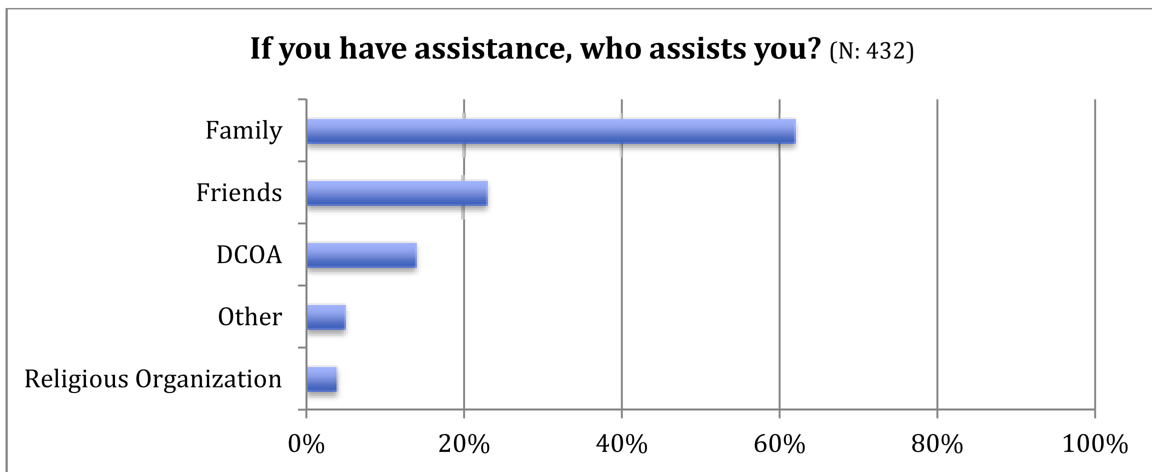


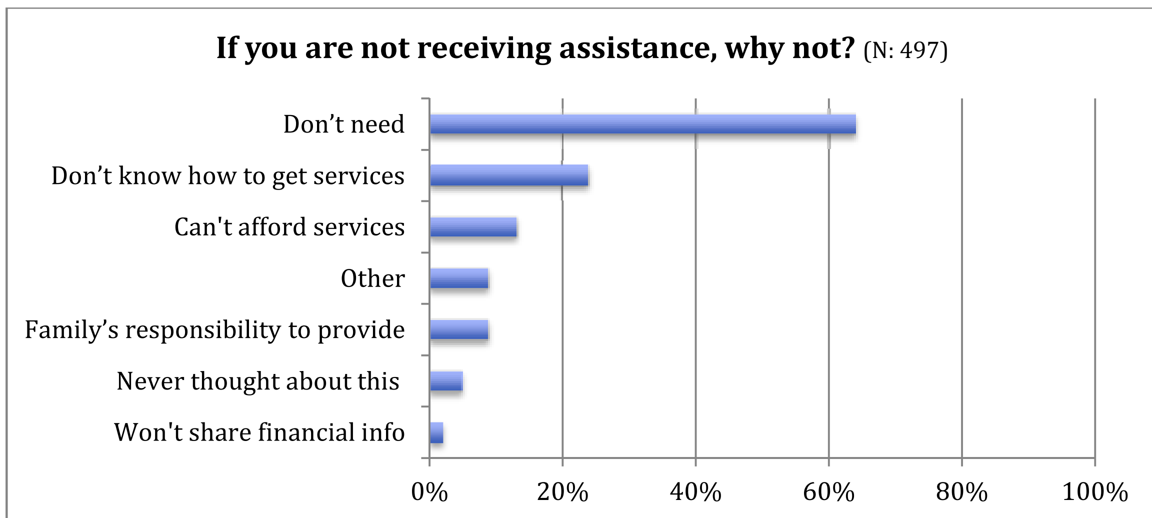

How important is this to you? (N: 797)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Very important
Somewhat important
A little important
Not at all important
Transportation to healthcare related appointments
Transportation to the grocery store and other errands
Transportation to the senior center, recreation activity, social event
Transportation/assistance to pick up medications

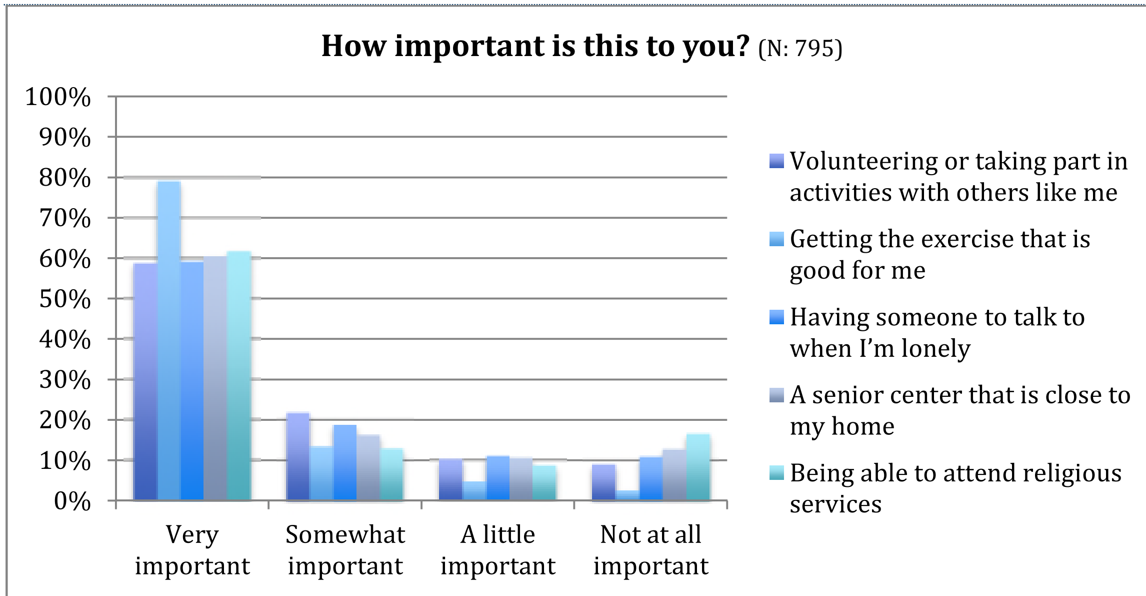

If you have assistance, who assists you? (N: 441)
Family
Other
Friends
DCOA
Religious Organization
0%
20%
40%
60%
80%
100%

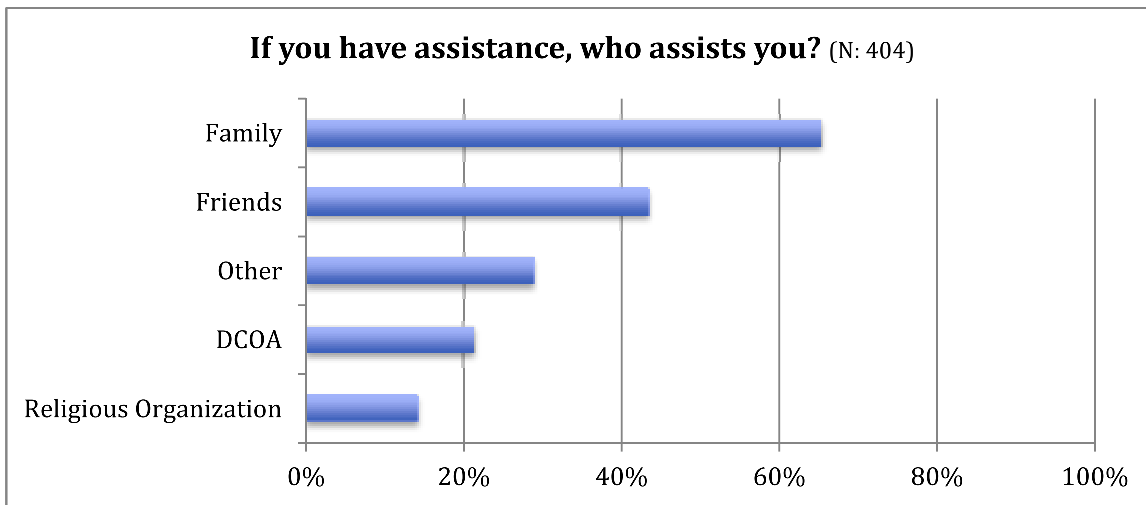

If you are not receiving assistance, why not? (N: 509)
Don't need
Don't know how to get services
Other
Family's responsibility to provide
Can't afford services
Never thought about this
Won't share financial info
0%
20%
40%
60%
80%
100%

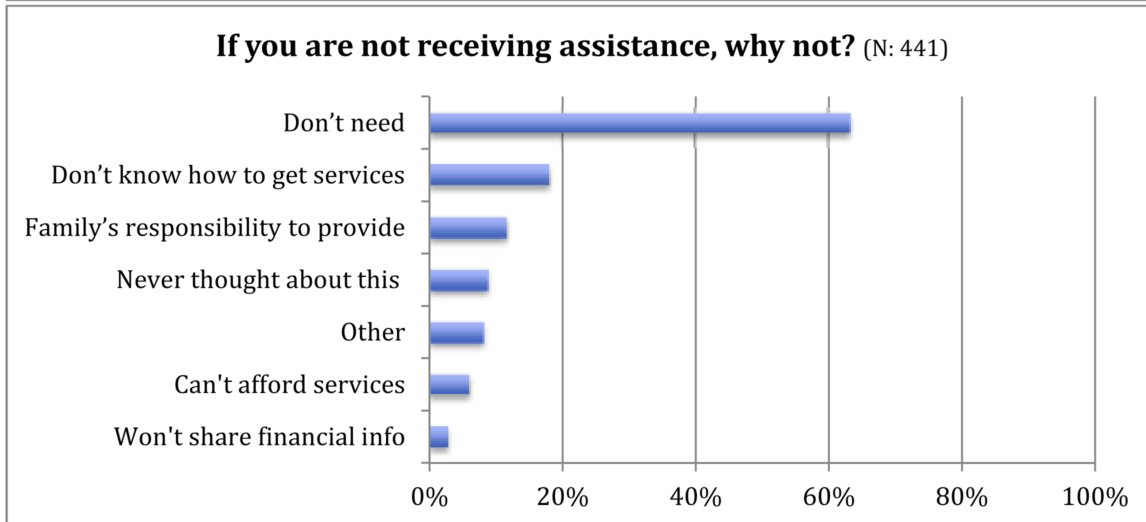

How important is this to you? (N: 793)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Very important
Somewhat important
A little important
Not at all important
Keeping warm or cool as the weather changes
Preventing falls and other accidents
Modifications to my home so that I can get around safely
Assistance with repairs and maintenance of my home or yard

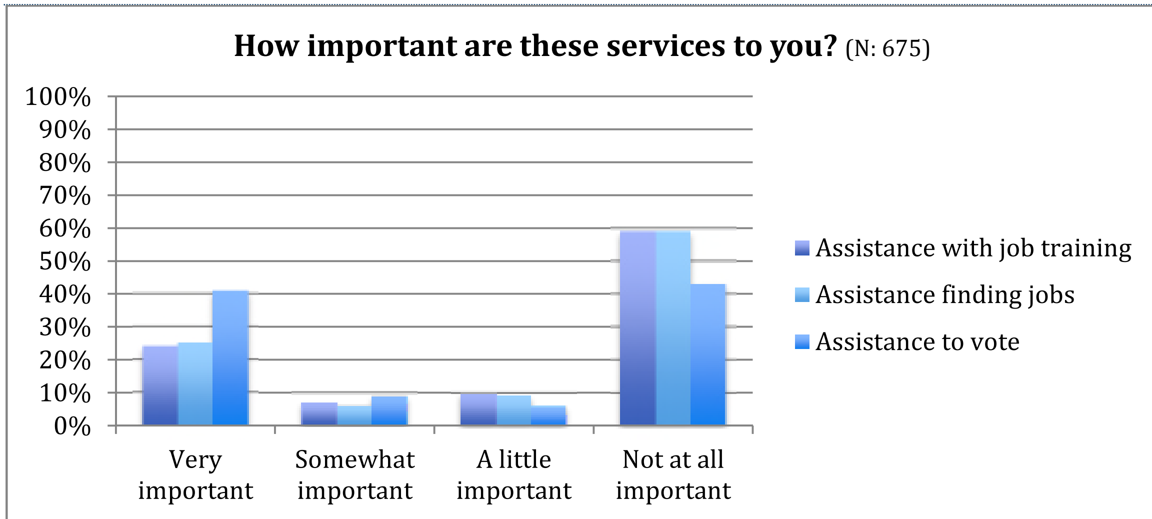

If you have assistance, who assists you? (N: 432)
Family
Friends
DCOA
Other
Religious Organization
0%
20%
40%
60%
80%
100%

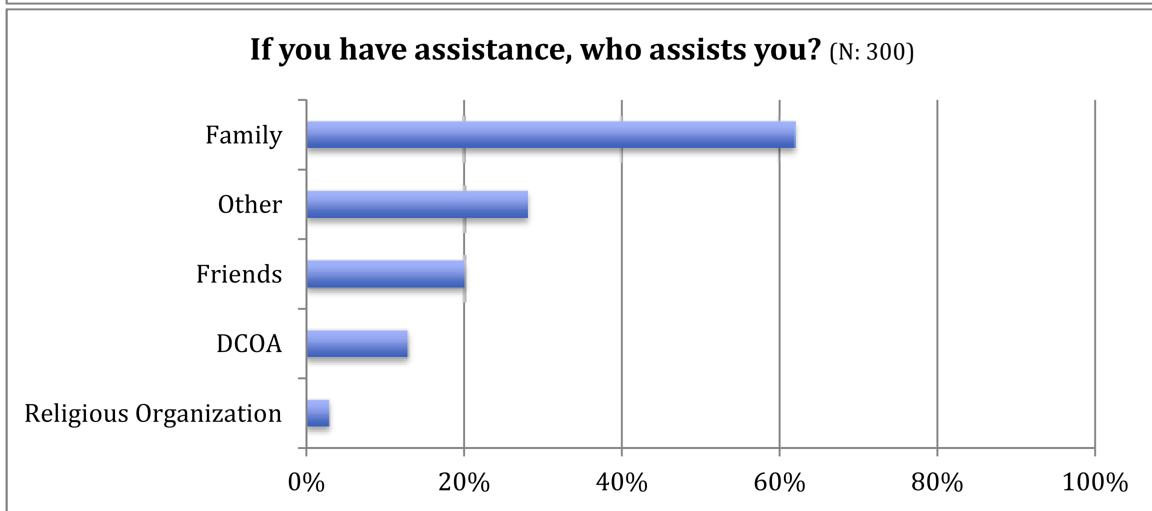

If you are not receiving assistance, why not? (N: 497)
Don't need
Don't know how to get services
Can't afford services
Other
Family's responsibility to provide
Never thought about this
Won't share financial info
0%
20%
40%
60%
80%
100%

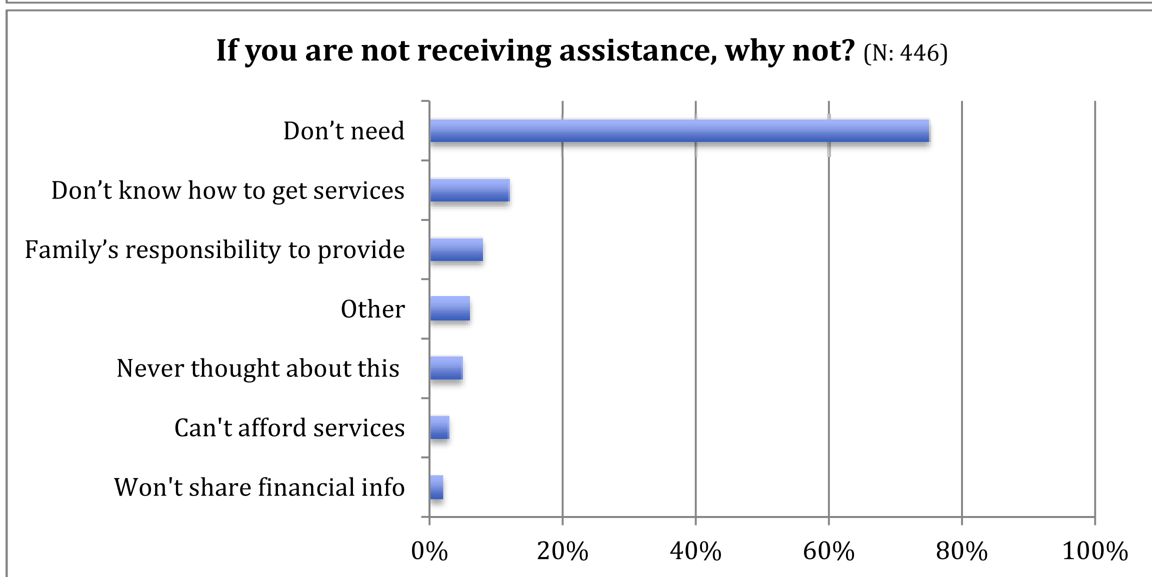

How important is this to you? (N: 795)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Very important
Somewhat important
A little important
Not at all important
Volunteering or taking part in activities with others like me
Getting the exercise that is good for me
Having someone to talk to when I'm lonely
A senior center that is close to my home
Being able to attend religious services

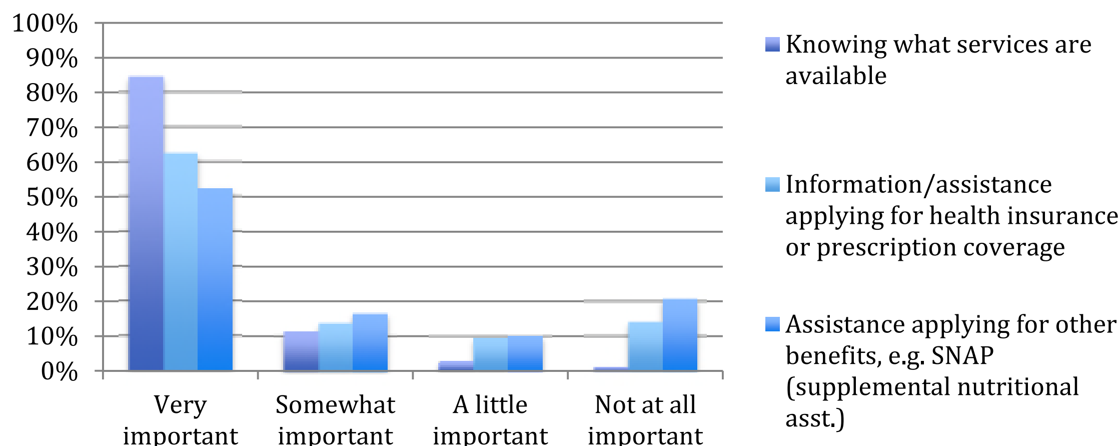

If you have assistance, who assists you? (N: 404)
Family
Friends
Other
DCOA
Religious Organization
0%
20%
40%
60%
80%
100%

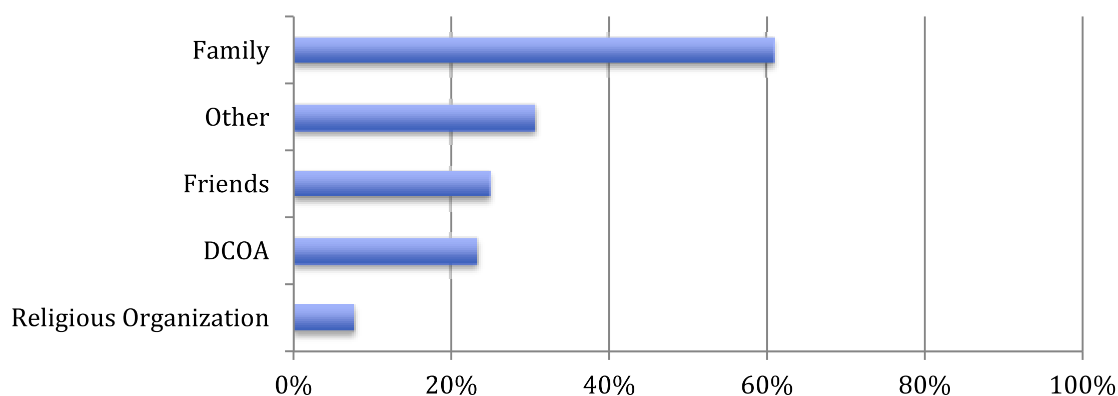

If you are not receiving assistance, why not? (N: 441)
Don't need
Don't know how to get services
Family's responsibility to provide
Never thought about this
Other
Can't afford services
Won't share financial info
0%
20%
40%
60%
80%
100%

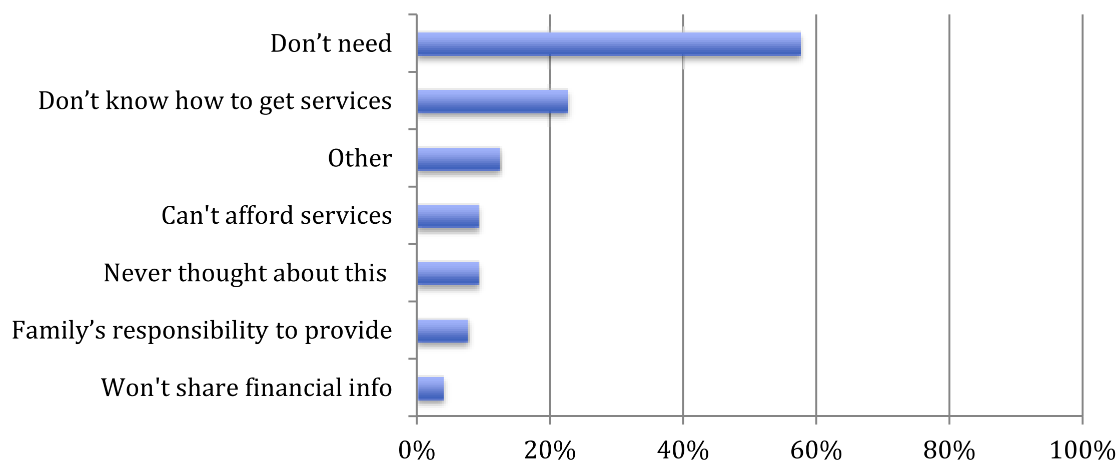

How important are these services to you? (N: 675)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Very important
Somewhat important
A little important
Not at all important
Assistance with job training
Assistance finding jobs
Assistance to vote

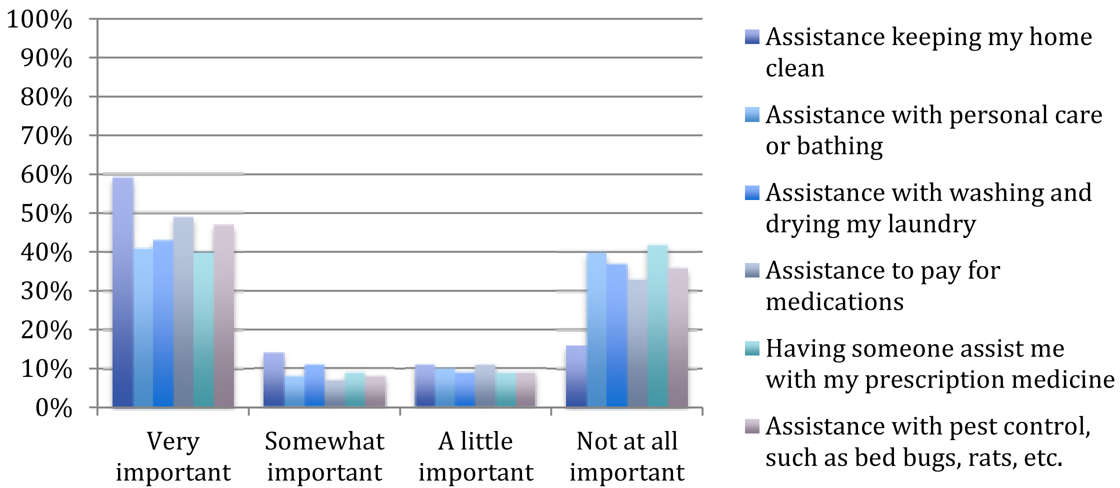

If you have assistance, who assists you? (N: 300)
Family
Other
Friends
DCOA
Religious Organization
0%
20%
40%
60%
80%
100%

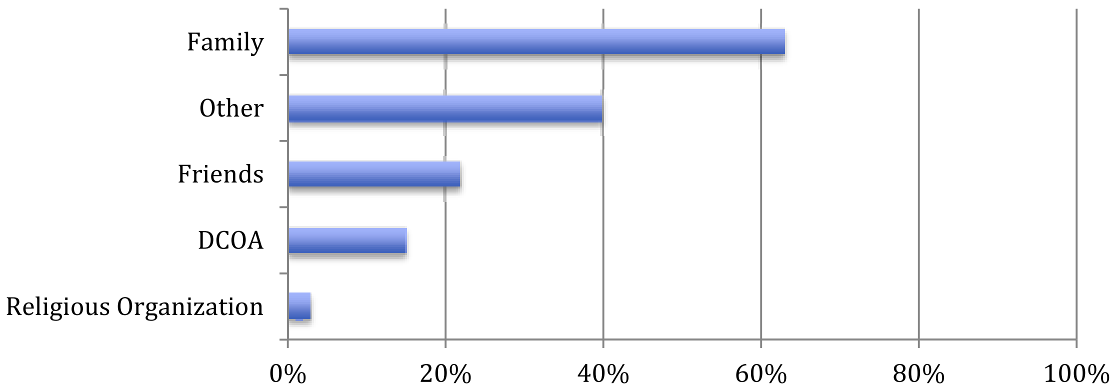

If you are not receiving assistance, why not? (N: 446)
Don't need
Don't know how to get services
Family's responsibility to provide
Other
Never thought about this
Can't afford services
Won't share financial info
0%
20%
40%
60%
80%
100%

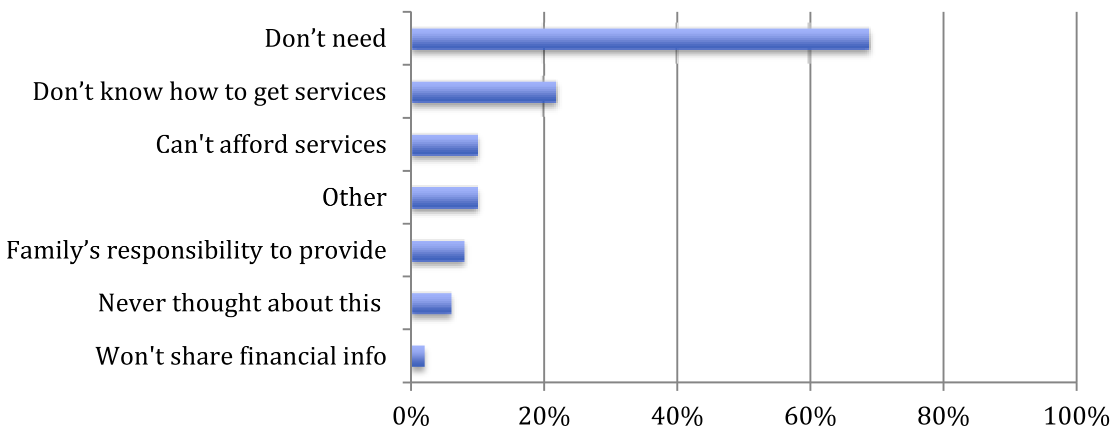

How important are these services to you? (N: 848)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Very important
Somewhat important
A little important
Not at all important
Knowing what services are available
Information/assistance applying for health insurance or prescription coverage
Assistance applying for other benefits, e.g. SNAP (supplemental nutritional asst.)

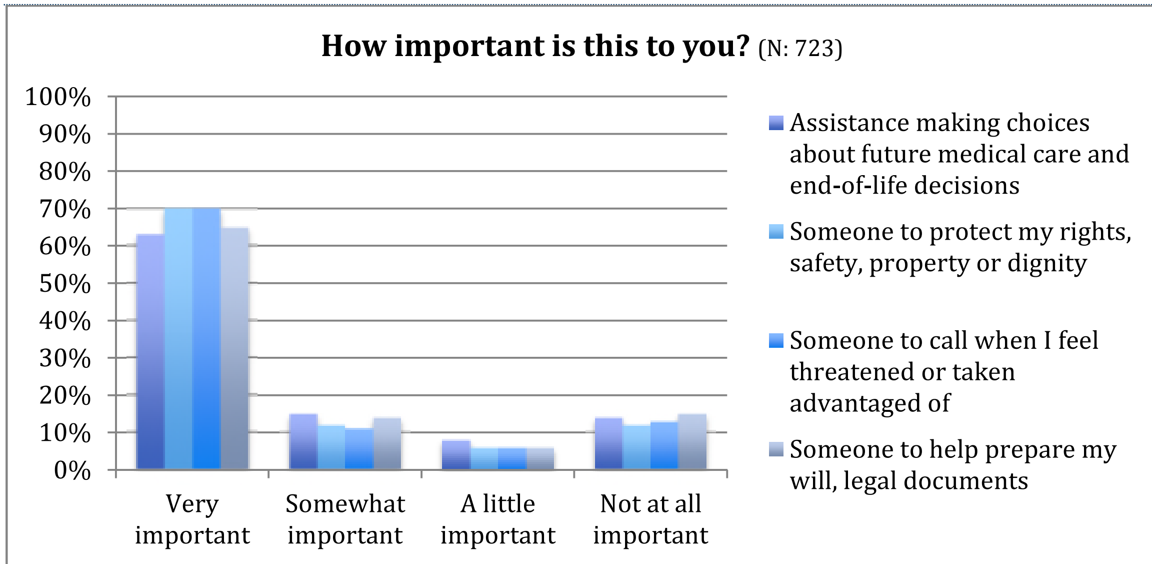

If you have assistance, who assists you? (N: 533)
Family
Other
Friends
DCOA
Religious Organization
0%
20%
40%
60%
80%
100%

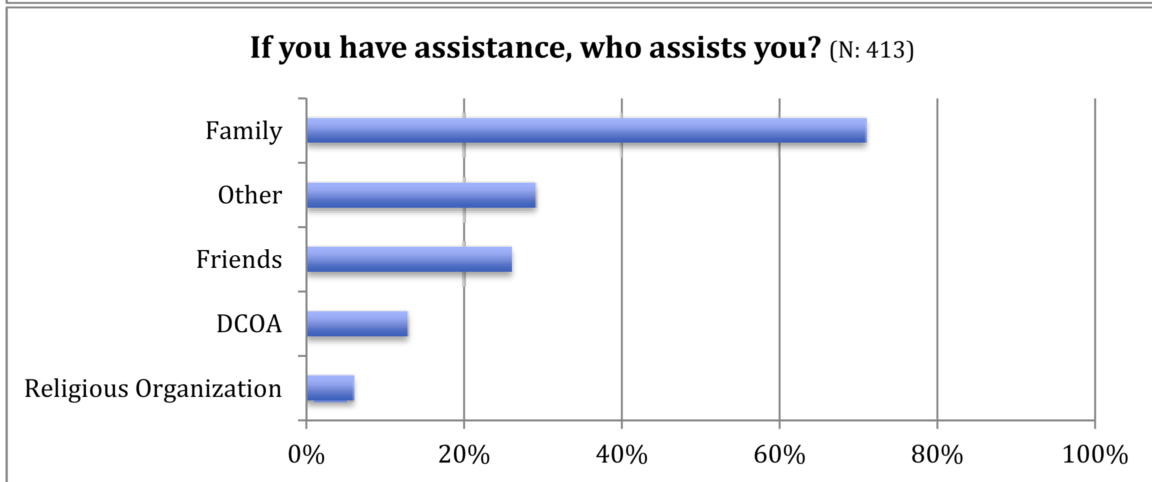

If you are not receiving assistance, why not? (N: 573)
Don't need
Don't know how to get services
Other
Can't afford services
Never thought about this
Family's responsibility to provide
Won't share financial info
0%
20%
40%
60%
80%
100%

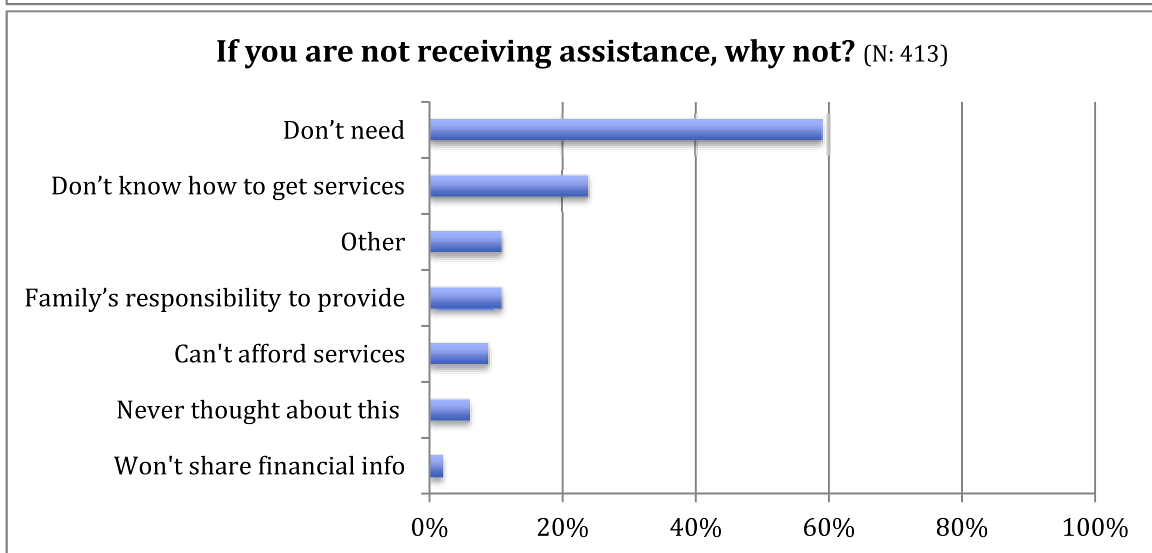

How important is this to you? (N: 787)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Very important
Somewhat important
A little important
Not at all important
Assistance keeping my home clean
Assistance with personal care or bathing
Assistance with washing and drying my laundry
Assistance to pay for medications
Having someone assist me with my prescription medicine
Assistance with pest control, such as bed bugs, rats, etc.

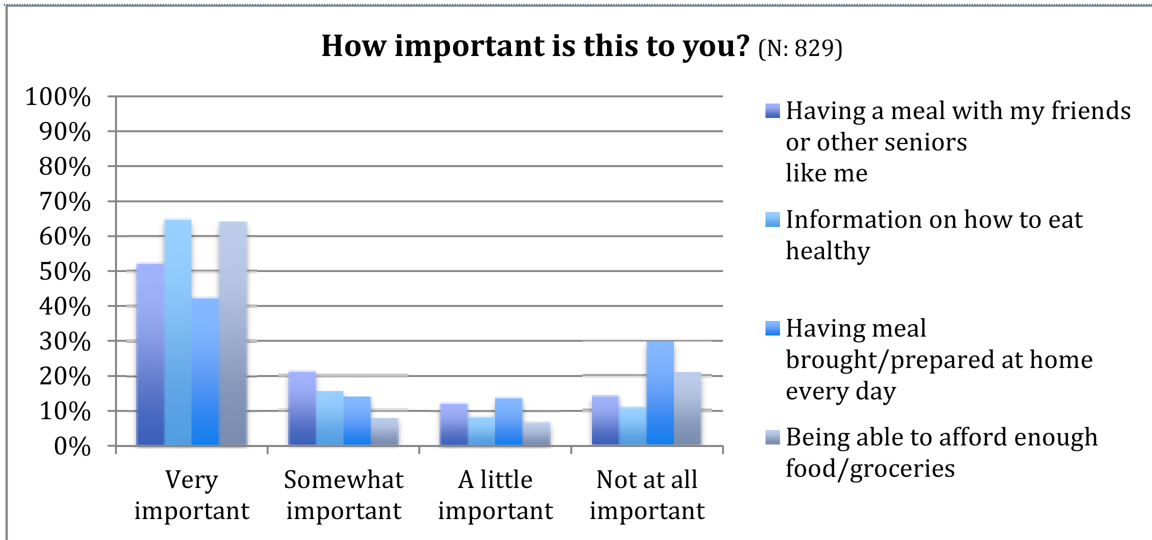

If you have assistance, who assists you? (N: 419)
Family
Other
Friends
DCOA
Religious Organization
0%
20%
40%
60%
80%
100%

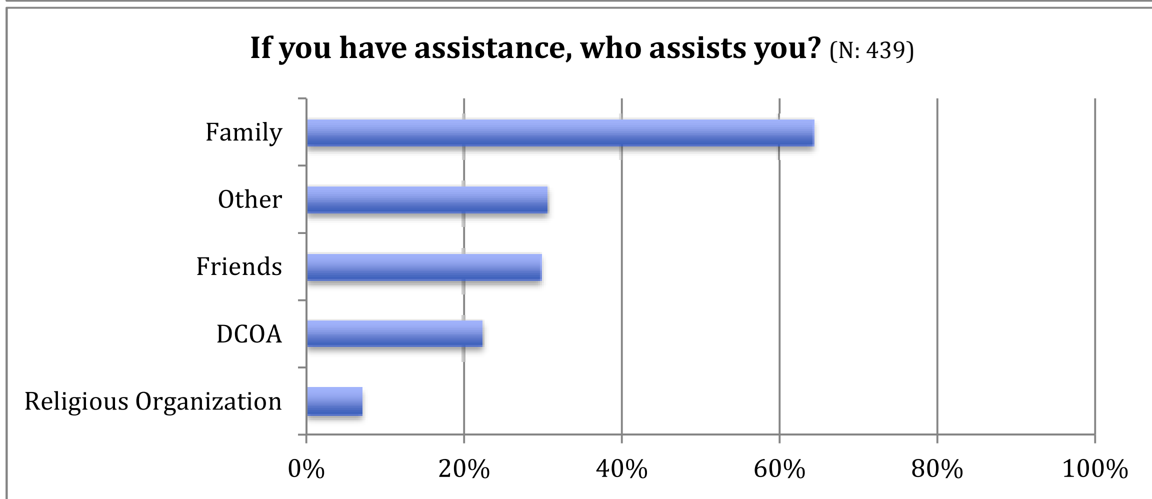

If you are not receiving assistance, why not? (N: 526)
Don't need
Don't know how to get services
Can't afford services
Other
Family's responsibility to provide
Never thought about this
Won't share financial info
0%
20%
40%
60%
80%
100%

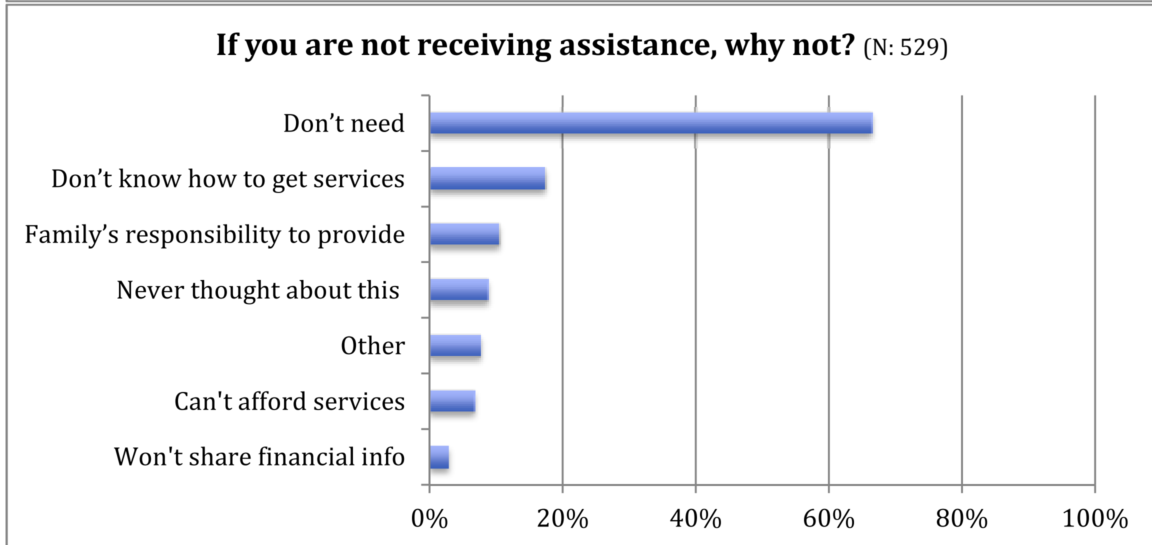

How important is this to you? (N: 723)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Very important
Somewhat important
A little important
Not at all important
Assistance making choices about future medical care and end-of-life decisions
Someone to protect my rights, safety, property or dignity
Someone to call when I feel threatened or taken advantaged of
Someone to help prepare my will, legal documents

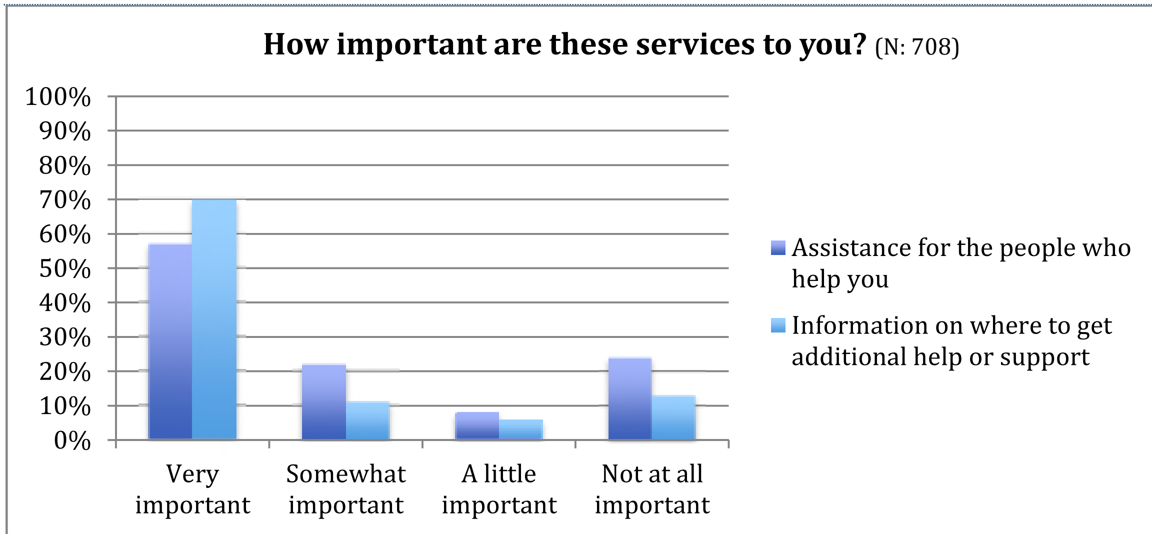

If you have assistance, who assists you? (N: 413)
Family
Other
Friends
DCOA
Religious Organization
0%
20%
40%
60%
80%
100%

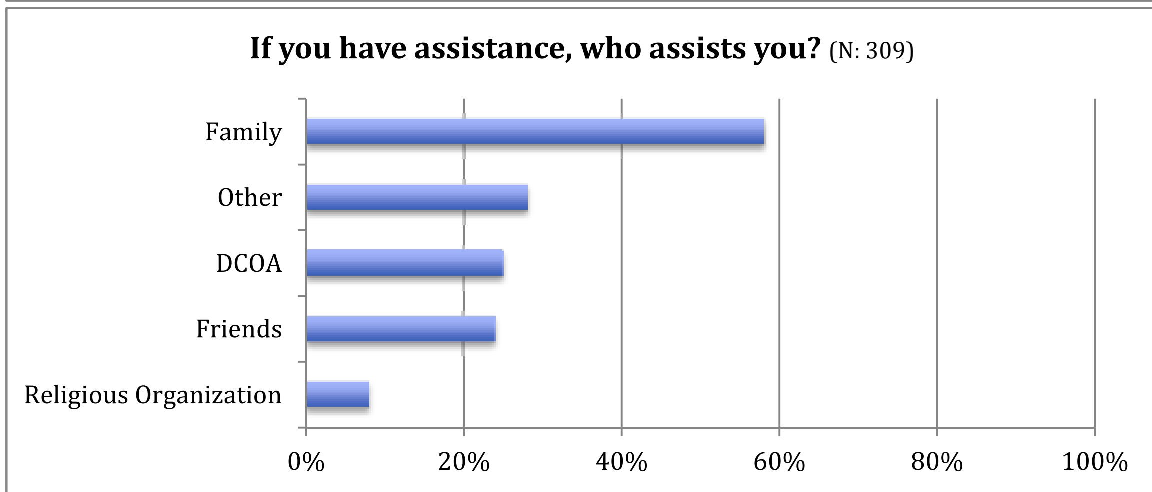

If you are not receiving assistance, why not? (N: 413)
Don't need
Don't know how to get services
Other
Family's responsibility to provide
Can't afford services
Never thought about this
Won't share financial info
0%
20%
40%
60%
80%
100%

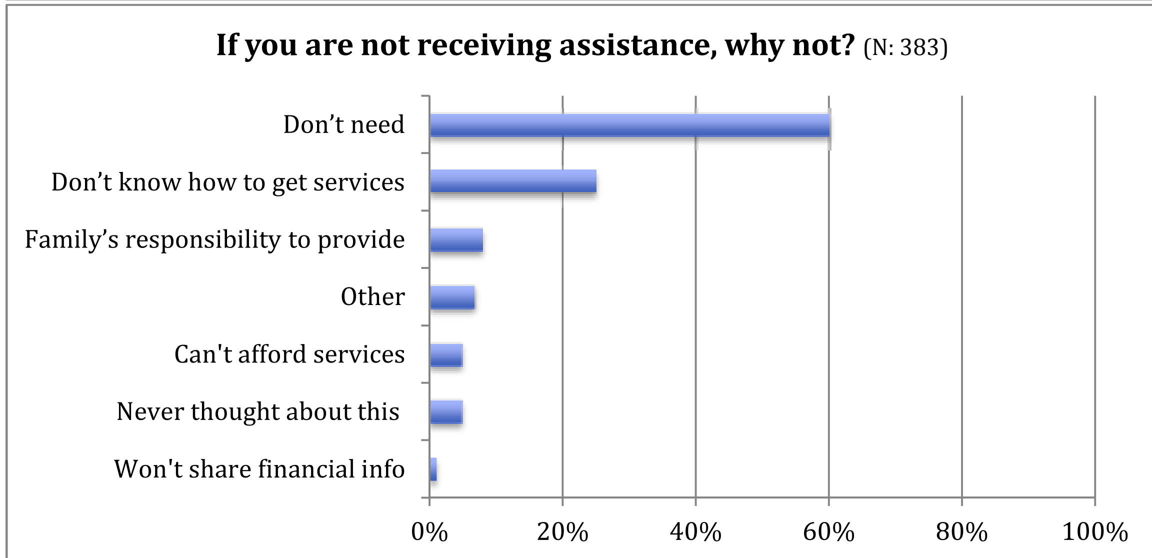

How important is this to you? (N: 829)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Very important
Somewhat important
A little important
Not at all important
Having a meal with my friends or other seniors like me
Information on how to eat healthy
Having meal brought/prepared at home every day
Being able to afford enough food/groceries


If you have assistance, who assists you? (N: 439)
Family
Other
Friends
DCOA
Religious Organization
0%
20%
40%
60%
80%
100%


If you are not receiving assistance, why not? (N: 529)
Don't need
Don't know how to get services
Family's responsibility to provide
Never thought about this
Other
Can't afford services
Won't share financial info
0%
20%
40%
60%
80%
100%


How important are these services to you? (N: 708)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Very important
Somewhat important
A little important
Not at all important
Assistance for the people who help you
Information on where to get additional help or support


If you have assistance, who assists you? (N: 309)
Family
Other
DCOA
Friends
Religious Organization
0%
20%
40%
60%
80%
100%


If you are not receiving assistance, why not? (N: 383)
Don’t need
Don’t know how to get services
Family’s responsibility to provide
Other
Can't afford services
Never thought about this
Won't share financial info
0%
20%
40%
60%
80%
100%

APPENDIX 14: BEST/GOOD PRACTICES

Domain 1: Outdoor Spaces and Building

DC Parks RX

A community health initiative in coordination with local DC pediatricians to write prescriptions to encourage wellness by connecting them to local parks. Parks are recommended based on proximity and accessible resources.
Contact: Unity Health Care Pediatrics Department
Resource: http://aapdc.org/chapter-initiatives/dc-park-rx/

Increase Park Usage- NYC

BeFitNYC is a search engine on the Parks website that helps senior New Yorkers find free and low-cost fitness opportunities offered by the Parks Department and partners.
Senior Swim hours have been designated at 15 public pools citywide, which is double the number of pools in the original pilot program.
Resource: https://www.nycgovparks.org/seniors

Domain 2: Transportation

Accessible Dispatch- NYC

The City's Taxi and Limousine Commission (TLC) launched Accessible Dispatch compensates drivers for their travel to a pickup location, so passengers pay only the metered taxi fare. In addition, TLC was recently authorized to increase the number of medallions for accessible taxicabs by 2000. All drivers of wheelchair accessible taxicabs are required to participate in the Accessible Dispatch program.
Contact: NYC Department for the Aging

Market Ride- NYC

Market Ride uses school buses during off hours to take seniors from senior centers to supermarkets and farmers' markets. School buses are also used to take senior center members to recreational facilities, museums, Broadway shows, and a host of other venues. Buses depart from the centers in the mornings and return to the center just before lunchtime.
Contact: NYC Department for the Aging

Simply Get There

Atlanta Regional Commission- developed an interactive "Trip discovery" tool for public, private, specialized and volunteer transportation services.
Resource: http://www.simplygetthere.org/

Transportation Reimbursement Escort Program

Operated in conjunction with a local non-profit. The senior is responsible for finding their own driver to take them wherever they need to go. They submit a claim, certifies it and sends it to the Senior and Disabled Fund for payment. At the end of each month DAAS reimburses the Senior and Disabled Fund for the total cost of the month's claims. *Contact:* San Bernadino DAAS

Domain 3: Housing

EZ Fix Program

The EZ Fix Program helps seniors and adults with disabilities remain safely in their homes by providing minor home repair, housekeeping, and in-home technology training and services throughout

Contact: Maine Eastern Area Agency on Aging

Free A/C

Due to fluctuations in funding, the number of air conditioners distributed to at-risk residents who meet low-income guidelines and suffer from a documented medical condition.

Contact: NYC Department for the Aging

Living Together Benefits Young People and Old

At a dozen independent living residences that serve older adults, college students are invited to move in and pay discounted rent in exchange for socializing with the building's older residents. Another program helps fill rooms in the houses of older adults with empty nests.

Contact: Lyon, France - from AARP

Making Big Sense of Small Homes

Accessory dwelling units (ADUs) are small, independent housing units created within single-family homes or on their lots. Reduced (or "waived the largest") municipal fees and adjusted the city's zoning codes to make it easier for a homeowner to add an ADU to his or her property. An overriding reason for the change: to help residents age in place. The cost of building ADUs is borne by the property owner.

Contact: Portland, OR

Rent Increase Exemption Program

The Senior Citizen Rent Increase Exemption Program (SCRIE) provides eligible older New Yorkers with an exemption from some or all increases in rent. The City successfully transferred responsibility for administering SCRIE from DFTA to the Department of Finance (DOF). Partnering with DOF, DFTA staffs an on-site walk-in center to assist with applications. Customer service has improved through the walk-in center, improved language access, a dedicated customer service group within the Exemptions division, and the publication of a comprehensive SCRIE guide. The processing time for SCRIE approval or denial has been reduced to 30 days.

Resource: http://www1.nyc.gov/nyc-resources/service/2424/senior-citizen-rent-increase-exemption-scrie

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

Community Breakfast

Breakfast Shoppe is a Monday through Friday 7:00-9:00 a.m. Community Breakfast Program at the Rochester Senior Center run jointly by the FRIENDS of the Rochester Senior Center and Rochester Lions Club. It operates solely with volunteers who do the purchasing, cooking, serving and clean-up. Historically, numerous community folk, namely senior citizens and many of them male, would gather for hours at this site for a bite of breakfast and coffee, but also for the opportunity to socialize and chat or debate about local happenings and state and world news. The COA has tripled its annual unduplicated participation count overall, and it has doubled the number of male attendees within the unduplicated count.

Creative Aging Art Courses

The New York public Library has been offering Creative Aging art courses that include quilt-making, music, drama, creative writing, and portraiture. The NYPL received private grants to increase technology courses and programming for older adults, and the NYPL Tech Connect staff, who focus on computer training, has developed curricula for several computer classes targeting those over 50.
Resource: https://www.nypl.org/blog/2016/09/01/creative-aging-our-communities
Resource: http://www.lifetimearts.org/

Seniors Partnering with Artists Citywide (SPARC)

SPARC places artists in residence at the City's senior centers, where they provide arts programming to older adults. Artists work at various centers in a variety of media, including dance, theater, visual arts, music, photography, and writing.
Resource: http://www.nyc.gov/html/dcla/html/sparc/sparc.shtml

Sicolovia (DC street festivals)

Síclovía is a free street party and health fair hosted in cities nationwide. Along the route, the partners, including the AWLW program, host what are known as reclovías—areas where attendees can stop to watch demonstrations, participate in physical activities, or learn more about their health.

Silver Line Helpline

24-hour call center for older adults seeking to fill a basic need: contact with other people.
Resource: https://www.thesilverline.org.uk/

Telephone Reassurance Program- NYC

117 community-based senior center providers participated in DFTA's telephone reassurance program and made 41,947 calls to homebound older adults in their respective communities.
Contact: NYC Department for the Aging

Domain 6: Civic Participation and Employment

Senior Job Club

The project helps seniors return to the workforce and achieve financial stability by: (1) increasing employment skills through a 6-week job search skills training and one-on-one coaching, (2) increasing education and work skills through computer technology training and (3) increasing employment through on-the-job training.
Contact: Region IV Area Agency on Aging

Success Mentor Initiative

Program that connects mentors to students who are chronically absent in an effort to improve attendance. Each mentor was matched with 15-20 mentees. At the end of the school year, the percentage of chronically absent students declined on average by 50%.
Contact: NYC Department for the Aging

Workforce Academy for Youth

Workforce Academy for Youth (WAY) is a groundbreaking intergenerational program that utilizes the strengths of older volunteers as Life Skills Coaches in mentoring youth ages 17-21 who 'age out' of the foster care system. WAY unites older adults with youth to support the acquisition of work and life skills in a six-month paid internship program that provides employment, training and mentorship. After six sessions, the graduation rate is 89 percent. Of those who graduated, 89 percent were hired to continue working in County departments after graduation and 26 percent of those who were not previously enrolled in school registered for college.
Contact: San Diego Workforce Partnership
Resource: http://workforce.org/youth-programs

Domain 7: Communication and Information

NIH- Older Adult Recommendations for Website Design

By performing usability tests DCOA can discover which online format DC seniors find conducive in obtaining information through the current website, or alternatives that include self-identification filter or a resource filter. By holding focus groups, observing current usage, multiple platform abilities, structured interviews the ability to develop a senior-friendly website that minimizes user discovery time and maximizes the user experience.
Resource: https://www.nia.nih.gov/health/publication/making-your-website-senior-friendly
Example: http://www.nyc.gov/html/dfta/html/home/home.shtml
Example: http://www.area10agency.org/
Example: https://www.marinhhs.org/community-resource-guide

Virtual Senior Center Model, see http://vscm.selfhelp.net/classes. The Virtual Senior Center offers: 1) Simple, senior-friendly, touch screen computer, 2) Technical Support at home, on the phone or remotely, 3) Socialization, education, and recreation in a secure online environment, 4) 25-35 weekly entertaining discussion-based classes where you can see, hear, and talk to each other, 5) Easy access to online resources, games, email, and Skype

Domain 8: Community and Health Services

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. Data on program effectiveness have not yet been collected and analyzed.

Community paramedicine program

Community paramedicine aims to abate the frequency of unnecessary hospitalizations by performing focused patient assessment and providing treatment within the confines of patients' own homes. With the intent of keeping the patient at home and under the care of their primary care providers, risks associated with the catch-all safety net of an emergency department and/or an unnecessary readmission are avoided.
Resource: https://www.naemt.org/MIH-CP/MIH-CP.aspx

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 that the patient answers to their specific health issues. It uses predictive analytics to avert hospitalizations. Alerts of changes in patient status are automatically sent to the Coordination Center, which triages which services are needed by the client (also aided by computer software). The aim is to prevent unwarranted hospitalizations and keep persons living and thriving in the community setting. The program reportedly saved three Maryland hospitals $2,676,259.00 in

avoided hospitalizations between November 2013 and October 2014 (Agency for Healthcare Research and Quality, 2014). [EB Program] [All Domains]

Located in a neighboring jurisdiction to DC, this program might warrant a closer look by DCOA to see what elements of the program might be adopted by DC in order to improve assignment and coordination of services in a pro-active rather than reactive manner, thus lowering overall costs of care by avoiding costly but ineffective interventions.

Eastern Virginia Care Transition Partnership (EVCTP)

EVCTP—comprised of five Area Agencies on Aging, five health systems and 69 skilled nursing facilities—combines medical and long-term home and community supports to reduce hospital readmissions and prolong quality life for patients living in their own homes. In addition to coaching, patients have access to enhanced services including transportation, home-delivered meals, in-home care and housing. EVCTP also helps created a seamless model of patient-centered care through enhanced agreements with hospitals for secure data sharing systems; trainings for governance, management and clinical teams; a single, centralized source for billing, tracking readmissions and other metrics; and integration into health systems' electronic health records and health information exchanges. The Centers for Medicare & Medicaid Services (CMS) have recognized EVCTP as a "top performer," with one of the largest and most successful care transitions intervention (CTI) programs in the nation.
Resource: http://www.evctp.org/

Evidence is in….Healthy Living Programs Catch the eye of Managed Care

Senior Whole Health (SWH), a managed care program for older adults in Massachusetts, recognized that members with multiple chronic conditions could benefit from self-management programs to reduce readmissions and overall medical costs. SWH "bought it rather than built it" by partnering with the Elder Services of the Merrimack Valley's Healthy Living Center of Excellence (HLCE), which has a centralized statewide infrastructure for program delivery. This statewide contract is the first of its kind. SWH reimburses HLCE for every participant who enrolls and completes an evidence-based program such as Chronic Disease Self-Management or Matter of Balance.
Resource: www.esmv.org

Gatekeeper Program

The Gatekeeper model has been applied nationally and internationally to train employees to identify and refer isolated, at-risk older adults residing in their own homes. These are elders who have little or no support system to act in their behalf as they experience serious difficulties that compromise their ability to live independently. Gatekeepers are nontraditional referral sources who come into contact with older adults or adults with disabilities through their everyday work or activities and who are trained. They learn to identify red flags that may indicate

someone is ill or in trouble or struggling and then refer the client's name to the proper place so there can be follow up and evaluation.
Resource: multco.us/ads/gatekeeper-program

Healthy Seniors at Home

The Healthy Seniors at Home project provides frail seniors, who cannot attend site-based classes offered by RIV AAA, access to chronic disease self-management training through an in-home information-sharing model. Volunteers for RIV AAA's Senior Companion Program (SCP) who also have a chronic condition, attend a six-week Personal Action Toward Health (PATH) class and then share what they have learned with homebound seniors through a peer-to-peer information-sharing model. Quarterly in-service trainings and ongoing staff support ensure volunteers maximize program impact. This variation on the evidence-based PATH program developed by Stanford University brings critical support to frail elders each week by teaching them chronic disease self-management skills, while also providing much-needed respite for their caregivers
Resource: www.areaagencyonaging.org

Mediware's Harmony Suite

This program is used by human services agencies and managed care organizations for home- and community-based long-term care. The platform enables collaboration among states, local agencies, managed care organizations, service providers, and volunteer caregivers to more effectively coordinate services. This can enhance quality of care by increasing efficiency, enabling consumer-driven delivery models, and providing critical business intelligence to make the most of available funding sources. The program also ensures compliance with federal funding requirements, such as complex Medicaid waivers. From: https://www.mediware.com/ltss/

Medicare/ Medicaid Independence Project at Home Demonstration. Home-based primary care allows health care providers to spend more time with their patients, perform assessments in a patient's home environment, and assume greater accountability for all aspects of the patient's care. This focus on timely and appropriate care is designed to improve overall quality of care and quality of life for patients served, while lowering health care costs by forestalling the need for care in institutional settings.

The Independence at Home Demonstration builds on these existing benefits by providing chronically ill patients with a complete range of primary care services in the home setting. Medical practices led by physicians or nurse practitioners will provide primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations. See
https://innovation.cms.gov/initiatives/independence-at-home/

Medstar Washington Hospital Center Medical House calls Program

This is an entirely home-based primary geriatric care program with geriatric physicians and advance practice nurses who visit patients in their homes or in the extended care facilities. They have done studies indicating that 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. This demonstration project provides chronically ill patients with a complete range of primary care services in the home setting. Savings to the Medicare/Medicaid Programs are shared with providers. Quality performance measures must be met in order to qualify for shared savings. In the year 2 analysis, Independence at Home Practices saved Medicare $10 million, or $1,010/beneficiary. The Mid-Atlantic Coalition alone saved $866,865 (Centers for Medicare & Medicaid Services, 2016). Two other house calls programs are present in DC, but are not formally a part of the Independence at Home Demonstration Project. [Domain 8]

The current house calls programs practicing within the District each serves an area geographically close to their sponsoring institution (i.e., NOT citywide), but all are willing to expand services citywide, with input of appropriate external resources.

Team San Diego

The program engages physicians, their office staff and community-based health and social service providers in a targeted training program to better coordinate health and social service programs for individuals with complex needs. Multiple providers who often rely on electronic communications learn to work together to coordinate care. By coordinating their communication, patient education and record-keeping methods, providers act as a multidisciplinary team without having to be co-located.
Resource: http://www.sandiegocounty.gov/hhsa/programs/ais/
Contact: San Diego County Aging & Independence Services

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. They have studied the efficacy, and found that 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]

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.

Domain 9: Legal Issues

Faith to Fate

The Faith to Fate (F2F) Advance Care Planning Initiative seeks to assist with end-of-life medical and property-asset legal questions and provide free wills, advance medical directives and powers of attorney to members of African-American congregations and their surrounding communities within the Greater Richmond Virginia Metro region. F2F addresses the lack of advance medical and legal planning among older African-American adults through a partnership between Senior Connections, three institutional partners, several volunteer legal partners and six area churches.

Contact: www.seniorconnections-va.org

Marin County Financial Abuse Specialist Team (FAST)

Collaboration between Marin County Division of Aging and Adult Services (DAAS) and the Elder Financial Protection Network (EFPN), a non-profit. This program assists representative payee clients, partners with staff on financial abuse investigations and provides community education.

Protective Money Management

Run entirely by trained volunteers, this program helps seniors with low income and people with disabilities who are unable to manage their financial affairs. The program is unique in emphasizing full representative payee services, using online banking, Quicken and other technology to help serve residents; and in combining services to both older adults and those with mental disabilities.

Resource: www.rrcsb.org

Wills for Seniors

JABA hosts Wills for Seniors in conjunction with four teams of lawyers, law students and notary republics who volunteer their time to meet privately with seniors to prepare customized legal documents, including a will, a power of attorney and an advance medical directive. Materials on the process, schedule, documents used and more are ready and available for use by other agencies.

Resource: www.jabacares.org

Domain 11: Food Security

Senior Nutrition Program Placement

Senior Nutrition Program placemats are an educational tool to boost awareness of healthy and affordable food options for low-income older adults. The placemats, which are available in English and Spanish and change monthly, aid seniors at congregate meal sites or who receive home-delivered meals by educating them on affordable, healthy food options. The placemats feature a recipe approved by VCAAA's registered dietitian using ingredients purchased at the "99 Cent Store." The back includes the phone number of a registered dietitian seniors can contact with

questions or to set up one-on-one nutritional counseling, as well as tips related to optimal aging, exercise, healthy living, senior scams and community resources.
Contact: Ventura County Area Agency on Aging

Elderly Nutrition Food Box Program

The Elderly Nutrition Food Box addresses the need of elders on a fixed income who struggle to choose between food and medications or other bills each month. The program targets those at risk of malnutrition and who may have transportation difficulties. Each month all Hawkeye Valley older adults in the home-delivered meals program received a fifteen-meal food box. The food bank orders the food and arranges for volunteers to pack the boxes. The food bank delivers the meal boxes to senior centers who in turn find volunteers to distribute them to the home-delivered meal participants.
Resource: www.nei3a.org

CHOICE in Missouri & CHAMPSS: Choosing healthy and appetizing meal plan solutions for seniors in San Francisco

Local restaurants and national restaurant chains, provide healthy meals for older adults. The average contribution is three times what is collected at senior centers. Surveys reveal that as a result participants are more aware of community resources, are using new resources, "living a healthier life" and are socializing more.
Contact: San Francisco Department of Aging and Adults Services or Mid-East Area Agency on Aging (MEAAA)
Resource: https://www.selfhelpelderly.org/our-services/nutrition-services/champss

Heritage Pet Assistance Program

The Heritage 'Tails-a-Waggin' Pet Assistance Program helps older adults care for their companion pets. Because of limited income or a lack of transportation to get to a store, some frail seniors feed their home-delivered meals to their pets, creating nutrition problems for themselves. In addition to pet food, products include cat litter, litter boxes and puppy-training pads, which help seniors maintain a safer and more sanitary home environment.
Resource: www.kirkwood.edu/site/index.php?d=443

Domain 12: Caregivers

Caring for the Caregiver

Provides professional training to volunteers who then mentor family caregivers. "caregiver coaches" play an "enhanced good neighbor role" by helping often overwhelmed family caregivers understand their options and make informed decisions about caring for an older or disabled loved one in their own or their relative's home. The coaches become a stabilizing force and sounding board. a phone-based program.

Caregiver Training Coalition

Local agencies, including the AAA, the Caregiver Resource Center, the Adult Day Health Care Center, Lifespan & Visiting Angels (for-profit home care agencies), Hospice, Meals on Wheels, and the County of Santa Cruz & Cabrillo College collaborated to put together a series of 8 classes for entry-level caregivers and/or family members, providing essential skills to the new caregiver and an introduction to the field for those seeking a career. The program uses regular extension class fees to cover instructor costs.

Caregiving MetroWest

CareGivingMetroWest.org provides family caregivers in 25 MetroWest Boston communities real-time information and interaction, including a clickable map that allows users to view location-specific resource listings, an interactive glossary of caregiving terms, a blog, an assessment tool and a "Wellness Wall" offering tips and advice.

Resource: http://www.caregivingmetrowest.org/

APPENDIX 15:. RESULTS INTEGRATED ACROSS SURVEY, INTERVIEW AND BEST PRACTICES PATHWAYS

https://cahh.gwu.edu/aging-programs-best-practices

Survey Pathway - SENIORS	Survey Pathway - Providers	Interview Pathway – Aging Care Leaders	Example Best Practices See Best/Good Practices in Discussion, Appendix 14 & Website for details/citation
Domain 1: Outdoor Spaces and Building ***(Safe place to live, Safe sidewalks, Safe outdoor spaces)***			
• Most respondents rated these items as "Very Important": ***Safe place to live*** (92%), ***safe sidewalks*** (90%), and ***safe outdoor areas, such as parks*** (82%) • 62% reported ***not needing assistance in this domain***, • 22% reported ***not knowing how to access assistance.***	• Most providers rated these items as "Very Important": ***Safe place to live*** (100%), ***safe sidewalks*** (94%), and ***safe outdoor areas, such as parks*** (75%) • Comments highlighted lack of available affordable, ADA compliant housing in DC	Sidewalks identified as problem in discussion with DC Commission on Aging and question regarding sidewalks added to the survey tool	DC Parks RX Increase Park Usage- NYC
Domain 2: Transportation ***(Transportation to healthcare related appointment, grocery store and other errands, senior center)***			
• More than half of respondents rated as "Very Important" ***transportation to healthcare*** (66%) and ***transportation to obtain groceries and run errands*** (56%) • Most reported not yet needing assistance with transportation • 16% reported ***not knowing how to access help in this area*** • 6% reported ***not being able to afford needed transportation***	Service Providers rated services generally as more important than respondents in Senior Survey, • 98% rated as "Very Important" ***transportation to healthcare*** • 89% rated as "Very Important" ***transportation to pick up groceries*** • These high importance ratings are closer to the importance placed on transportation by Seniors with Disability than by all seniors.	Difficulty with reliable transportation [HCPs]	Market Ride Transportation Reimbursement Escort Program Accessible Dispatch

Even higher proportion of Seniors with Disability rated these "Very Important" - ***transportation to healthcare*** (85%), ***to pick up groceries*** (71%), and ***to pick up medications*** (65%) Comments Q1 re: ***Biggest problem faced by DC Seniors:*** transp. identified most frequently	Challenges identified: insufficient vehicles, unreliable pick-up service, and inflexible scheduling. Creative solutions: using program funds to supply alternative transportation solutions to needy seniors.		
Survey Pathway - SENIORS	**Survey Pathway - Providers**	**Interview Pathway – Aging Care Leaders**	**Example Best Practices**
Domain 3: Housing, ***i.e. 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 or yard***			
Seniors listed as "Very Important" • ***Keeping warm or cool, depending on weather*** (71%) • ***Preventing falls*** (77%) • ***Assistance with repairs/ main-tenance of home, yard*** (62%) • ***Modifications to the home to get around safely*** (Over 50%) Seniors with Disability rated these more highly than all seniors: • ***Prevention of falls and accidents*** (88%) • ***Keeping warm or cool as weather changes*** (79%) • ***Assistance with repairs/maintenance (***75%) • ***Modifications to home for safety*** (69%) Most didn't have current need, but 25% reported ***not knowing how to access*** or ***not being able to afford assistance in this area***	Service Providers rated as "Very Important" more frequently than did Seniors or Seniors with Disability: • ***Preventing falls and accidents*** (94%) • ***Keeping warm or cool as weather changes*** (94%) • ***Modification to the home for safety*** (89%) Challenges identified: long wait lists and times for housing, insufficient rental support, and lack of reliably available services	HC Professionals identified the following issues: • Lack of available, affordable housing • Need for ADA compliant housing options for frail and disabled in DC	DC Safe At Home Initiative EZ Fix Program Rent Increase Exemption program Free A/C Living Together Benefits Young People and Old Making Big Sense of Small Homes

Comments Q1 re: ***Biggest problem faced by DC Seniors:*** Housing issues rated among top 3 items			
Survey Pathway - SENIORS	**Survey Pathway - Providers**	**Interview Pathway – Aging Care Leaders**	**Example Best Practices**
Domain 4: Social Participation and Domain 5: Respect and Social Inclusion ***(Taking part in fun activities (crafts, music, games) with others like me, Getting the exercise that is good for me, Having someone to talk to when I'm lonely, A senior center that is close to my home)***			
• 79% of seniors rated as "Very Important" ***getting exercise that is good for me*** • Over 50% of the time, rated as "Very Important" other activities, such as ***volunteering***, ***having someone to talk with, having a Senior Center close to home,*** and ***being able to attend religious services*** • 20% of seniors reported ***not knowing how to get service***	• 90% of providers 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)	Wellness Centers are out of space [DC Commission on Aging]	SPARC Community Breakfast Creative Aging art courses Siclovia/festivals (presence) Telephone reassurance program
Domain 6: Civic Participation and Employment ***(Assistance with job training/ finding jobs)***			
• None of the items queried in this section were rated "Very Important" at the same level as previous domains • 41% of respondents rated as "Very Important" ***assistance with voting*** • 25% rated as "Very Important" ***assistance with job training*** and ***finding a job*** • 64% reported they were ***fully retired***, and only 7% reported ***working full time***, so not likely to need assistance with job	• Similar to responses in the Senior Survey none of the items queried in this section were rated "Very Important" at the same level as previous domains Challenges mentioned • Lack of job opportunities for non-tech savvy seniors • Need for more access to IT training for seniors	SSN Directors indicated older adults needed more opportunity for computer training	Senior Job Club Success Mentor Initiative Workforce Academy for Youth

Survey Pathway - SENIORS	Survey Pathway - Providers	Interview Pathway – Aging Care Leaders	Example Best Practices
Domain 7: Communication and Information, ***(Knowing what services are available, Where do you get your information, Assistance with applying for benefits)*** ***Who assists Seniors in need of assistance in Domains above***			

• 85% rate as "Very Important": ***Knowing what services are available***
• 23% reported not knowing how to get 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% of Seniors got their information from the Internet
 	
Common "Other" was Villages
 	
NOTE: Consistent across all Domains approximately 20% of Seniors don't know how to access information.
	• 98% of providers 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)
	• Satisfaction with DCOA ~ 25%
	
	Challenges included lack of timely and knowledgeable responses from service providers and difficulty contacting service providers.
		• Health care Professional Interviews: Several participants requested improved access to information about available DCOA services via several possible venues, i.e.
		  ○ Online or print publication in one-stop shop format;
		  ○ Resource person at the DCOA offices to provide one-stop shop problem solving for individual patients;
		  ○ Pamphlet and/or periodic newsletter; on-site (at their practice sites)
		  ○ Presentations and training; [Domain 7]
		• Jointly plan/execute education for healthcare providers and public on various topics, i.e. advance care planning, DCOA services and community programs; [Domain 7 & 8]
		• People receiving services from DCOA Service Network are unaware of funding by DCOA [DC Commission on Aging]
		
		Research: DCOA website is a centralized location for providing information. With numerous DC initiatives, reports, service offerings, and events to market the ability to distill information, as a consumer presents a challenge to older adults.
			Virtual Senior Centers Model,
			
			National Institute of Health
			
			The Coordinating Center Anne Arundel County, MD
			
			Mediware Harmony suite

Survey Pathway - SENIORS	Survey Pathway - Providers	Interview Pathway – Aging Care Leaders	Example Best Practices
Domain 8: Community and Health Services ***i.e., Assistance keeping my home clean, Assistance with personal care or bathing, Assistance with laundry, Assistance with prescription medicines, Assistance with controlling pests, such as bed bugs, rats, etc.***			
• Over 59% rated as "Very Important": ***Assistance keeping my home clean*** • 41% rated as "Very Important": ***Assistance with personal care*** • 48% and 36% respectively rated as "Important": ***assistance with paying for medications*** and ***taking medications***	• Over 80% of Providers 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 • 20-33% indicated a fairly high dissatisfaction with services in this category Challenges included limited availability, long wait times, overly strict requirements for obtaining services, and shortage of competent providers	• Health Care Professional Interviews indicated lack of access to in-home personal care for multiple reasons: o Inability to pay (especially for those "stuck in the middle" who can't afford to private pay but don't qualify for Medicaid or Medicaid Waiver Services o Prolonged time to arrange in-home services (e.g., not available at the time needed) due to prolonged processing and shortage of personnel • Difficulty with placing seniors in nursing homes, especially those without skilled needs or requisite 3-day hospital stay to qualify for Medicare services in a skilled nursing facility • Recommended DCOA work with current in-home primary care geriatric practices to expand services • Need for increased inter-professional/ interdisciplinary provision of services (i.e., not just social workers) • Need for point-of-service electronic information input • Need for more focus on chronic disease management	Medicare/Medicaid Independence at Home Demonstration Mediware's Harmony suite Geriatric Advance Practice Nurse to bridge social, medical service, educ., consultation Sibley 60+ Club TEAM SAN DIEGO Healthy Seniors at Home Eastern Virginia Care Transitions Partnership The Evidence Is In...Healthy Living Program Catch Eye of Managed Care Gatekeeper Program Community Paramedicine Program and Community Palliative Care Program Safe at Home

<table>
<tr><th>Survey Pathway - SENIORS</th><th>Survey Pathway - Providers</th><th>Interview Pathway – Aging Care Leaders</th><th>Example Best Practices</th></tr>
<tr><td colspan="4">Domain 10: Legal Issues
(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 advantage of, Someone to help prepare my will, legal documents)</td></tr>
<tr><td>• Over 60% rated as “Very Important”: Assistance with choices for future medical care, someone to protect my rights, safety, property, or dignity Someone to call when I feel threatened or taken advantage of</td><td>• Over 75% of the time Service Providers rated all items in this domain as “Very Important”.
• This was closer to the range of ratings from 70% to 82.5% for Seniors with Disability

Challenges included insufficient finances, seniors’ unwillingness to report abuse, inadequate access to needed services, and lack of responsiveness from Adult Protective Services</td><td>• Perception by Healthcare providers that APS response capacity is inadequate
• DC MOLST initiative is not funded. Needs to be funded and implemented</td><td>Wills for Seniors

Protective Money Management

Faith to Fate: A Faith-Based Advance Care Planning Initiative for Underserved Communities

Marin County Financial Abuse Specialist Team (FAST)

POLST/ MOLST Initiatives</td></tr>
<tr><td colspan="4">Domain 11: Food Security,
(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)</td></tr>
<tr><td>• 2 items most frequently rated as “Very Important”: Information on how to eat healthy (65%) and Being able to afford food (64%)
• 67% reported not needing assistance in this area
For Seniors with Disability, rated “Very Important” by 80% for Being able to afford enough food and 60% for Having meals brought to or prepared in the home</td><td>• 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</td><td>DC Seniors may lack pots/ pans, stoves, refrigeration, etc.</td><td>Senior Nutrition Program Placemats

Elderly Nutrition Food Box Program

CHAMPSS: Choosing Healthy and Appetizing Meal Plan Solutions for Seniors in San Francisco
/ Choice
Heritage Pet Assistance Program</td></tr>
</table>

Survey Pathway - SENIORS	Survey Pathway - Providers	Interview Pathway – Aging Care Leaders	Example Best Practices
Domain 12: Caregivers ***(Assistance for the people who help you)***			
• 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*** • 25% don't know how to get help • Open-ended comments: o Majority of the suggestions included monetary help to caregivers o Need respite for caregivers o Importance of easy access to one-stop information to guide them in their caregiving activities o Advocated a "no wrong door" for obtaining info. o Caregiving education o Increased pay o Training in English language proficiency o Help with transp. expense o Access to health benefits	• When asked what is the most important service for caregivers of seniors or seniors who are caregivers (free text response), the most frequent response was "respite care" • 72-82% of the time rated as "Very Important" the items related to caregiver support, which closely mirrored the 73-81% range of ratings "Very Important" by Seniors with Disability Challenges included lack of timely response to request for assistance, lack of available services for homebound seniors, caregiver burnout, and lack of available resources.	**SAC Nutrition Subcommittee Recommends:** • Home-delivered meals as part of EPD waiver • Investigate home delivered groceries and CSAs • Develop Nutritional Supplement Bank CAFB • Transition nutrition care when discharging hospital to home	Caring for the Caregiver Caregiver Training Coalition Caregiving MetroWest
Cross-cutting topics			
Who helps you with this? (From Senior Survey) • Over 50% across all domains: Family • Friends: generally around 25% • Others included DCOA, Wellness Centers, DCOA, Contractors, Villages • 10% do not know who they would call if needing assistance across all domains			

Suggestions from providers:

- DCOA convene stakeholders conference to review needs assessment and plan service delivery options [HCP]
- Providers recommended collaboration to pool resources in all domains
- Providers recommended offering education for seniors, caregivers, and care providers across all domains

APPENDIX 15: RESULTS INTEGRATED ACROSS SURVEY, INTERVIEW AND BEST PRACTICES PATHWAYS

The following table 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. This analysis culminated in the recommendations discussed in an earlier section. Details of Best Practices in column 4 are described in Appendix 14 and a comprehensive listing is located at https://cahh.gwu.edu/aging-programs-best-practices

Survey Pathway - SENIORS	Survey Pathway - Providers	Interview Pathway – Aging Care Leaders	Best Practices: Details at Appendix 14 and Website
Domain 1: Outdoor Spaces and Building ***(Safe place to live, Safe sidewalks, Safe outdoor spaces)***			
• Most respondents rated these items as "Very Important": ***Safe place to live*** (92%), ***safe sidewalks*** (90%), ***safe outdoor areas, e.g. parks*** (82%) • 62% reported ***not needing assistance in this domain***, • 22% reported ***not knowing how to access assistance***.	• Most providers rated these items as "Very Important": ***Safe place to live*** (100%), ***safe sidewalks*** (94%), and ***safe outdoor areas, such as parks*** (75%) • Comments highlighted lack of available affordable, ADA compliant housing in DC	Sidewalks identified as problem in discussion with DC Commission on Aging and question regarding sidewalks added to the survey tool	DC Parks RX Increase Park Usage- NYC
Domain 2: Transportation ***(Transportation to healthcare related appointment, grocery store and other errands, senior center)***			
• More than half of respondents rated as "Very Important" ***transp. to healthcare*** (66%) and ***transp. to obtain groceries & run errands*** (56%) • Most reported ***not yet needing assistance with transportation*** • 16% reported ***not knowing how to access help in this area*** • 6% reported ***not being able to afford needed transportation*** Even higher proportion of Seniors with Disability rated "Very Important***" - transp. to healthcare*** (85%), ***to pick up groceries*** (71%), and ***to pick up medications*** (65%) Comments Q1: ***Biggest problem faced by DC Seniors:*** transp.most frequent	Service Providers rated services generally as more important than respondents in Senior Survey, • 98% rated as "Very Important***"*** ***transportation to healthcare*** • 89% rated as "Very Important" ***transportation to pick up groceries*** • These high importance ratings are closer to the importance placed on transportation by Seniors with Disability than by all seniors. Challenges identified: insufficient vehicles, unreliable pick-up service, and inflexible scheduling. Creative solutions: using program funds to supply alternative transportation solutions to needy seniors.	Difficulty with reliable transportation [HCPs]	Market Ride Transportation Reimbursement Escort Program Accessible Dispatch

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<tr><td colspan="4">Domain 3: Housing, i.e. 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 or yard</td></tr>
<tr><td>Seniors listed as “Very Important”
• Keeping warm or cool, depending on the weather (71%)
• Preventing falls (77%)
• Assistance with repairs and maintenance of home and yard (62%)
• Modifications to the home to get around safely (Over 50%)

Seniors with Disability rated these more highly than all seniors:
• Prevention of falls and accidents (88%)
• Keeping warm or cool as weather changes (79%)
• Assistance with repairs/maintenance (75%)
• Modifications to home for safety (69%)
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
Comments from open-ended Q1 re: Biggest problem faced by DC Seniors: Housing issues rated among top 3 items identified</td><td>Service Providers rated as “Very Important” more frequently than did Seniors or Seniors with Disability:
• Preventing falls and accidents (94%)
• Keeping warm or cool as weather changes (94%)
• Modification to the home for safety (89%)
Challenges identified: long wait lists and times for housing, insufficient rental support, and lack of reliably available services</td><td>HC Professionals identified the following issues:
• Lack of available, affordable housing
• Need for ADA compliant housing options for frail and disabled in DC</td><td>DC Safe At Home Initiative

EZ Fix Program

Rent Increase Exemption program

Free A/C

Living Together Benefits Young People and Old

Making Big Sense of Small Homes</td></tr>
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Survey Pathway - SENIORS	Survey Pathway - Providers	Interview Pathway – Aging Care Leaders	Example Best Practices
Domain 4: Social Participation and Domain 5: Respect and Social Inclusion ***(Taking part in fun activities (crafts, music, games) with others like me, Getting the exercise that is good for me, Having someone to talk to when I'm lonely, A senior center that is close to my home)***			
• 79% of seniors rated as "Very Important" ***getting exercise that is good for me*** • Over 50% of the time, rated as "Very Important" other activities, such as ***volunteering***, ***having someone to talk with, having a Senior Center close to home,*** and ***being able to attend religious services*** • 20% of seniors reported ***not knowing how to get service***	• 90% of providers 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)	Wellness Centers are out of space [DC Commission on Aging]	SPARC Community Breakfast Creative Aging art courses Siclovia/festivals (presence) Telephone reassurance program
Domain 6: Civic Participation and Employment ***(Assistance with job training/ finding jobs)***			
• None of the items queried in this section were rated "Very Important" at the same level as previous domains • 41% of respondents rated as "Very Important" ***assistance with voting*** • 25% rated as "Very Important" ***assistance with job training*** and ***finding a job*** • 64% reported they were ***fully retired***, and only 7% reported ***working full time***, so not likely to need assistance with job	• Similar to responses in the Senior Survey none of the items queried in this section were rated "Very Important" at the same level as previous domains Challenges mentioned • Lack of job opportunities for non-tech savvy seniors • Need for more access to IT training for seniors	SSN Directors indicated older adults needed more opportunity for computer training	Senior Job Club Success Mentor Initiative Workforce Academy for Youth

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<tr><td colspan="4">Domain 7: Communication and Information,
(Knowing what services are available, Where do you get your information, Assistance with applying for benefits)
Who assists Seniors in need of assistance in Domains above</td></tr>
<tr><td>• 85% rate as “Very Important”: Knowing what services are available
• 23% reported not knowing how to get 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% of Seniors got their information from the Internet

Common “Other” was Villages

NOTE: Consistent across all Domains approximately 20% of Seniors don’t know how to access information.</td><td>• 98% of providers 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)
• Satisfaction with DCOA ~ 25%

Challenges included lack of timely and knowledgeable responses from service providers and difficulty contacting service providers.</td><td>• Health care Professional Interviews: Several participants requested improved access to information about available DCOA services via several possible venues, i.e.
o Online or print publication in one-stop shop format;
o Resource person at the DCOA offices to provide one-stop shop problem solving for individual patients;
o Pamphlet and/or periodic newsletter; on-site (at their practice sites)
o Presentations and training; [Domain 7]
• Jointly plan/execute educational for healthcare providers and public on various topics, i.e. advance care planning, DCOA services and community programs; [Domain 7 & 8]
• People receiving services from DCOA Service Network are unaware of funding by DCOA [DC Commission on Aging]

Research: DCOA website is a centralized location for providing information. With numerous DC initiatives, reports, service offerings, and events to market the ability to distill information as a consumer presents a challenge to older adults.</td><td>Virtual Senior Centers Model,

National Institute of Health

The Coordinating Center Anne Arundel County, MD

Mediware Harmony suite</td></tr>
</table>

Survey Pathway - SENIORS	Survey Pathway - Providers	Interview Pathway – Aging Care Leaders	Example Best Practices
Domain 8: Community and Health Services *i.e., Assistance keeping my home clean, Assistance with personal care or bathing, Assistance with laundry, Assistance with prescription medicines, Assistance with controlling pests, such as bed bugs, rats, etc.*			

• Over 59% rated as "Very Important": ***Assistance keeping my home clean***
• 41% rated as "Very Important": ***Assistance with personal care***
• 48% and 36% respectively rated as "Important": ***assistance with paying for medications*** and ***taking medications***
	• Over 80% of Providers 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
	• 20-33% indicated a fairly high dissatisfaction with services in this category
	
	Challenges included limited availability, long wait times, overly strict requirements for obtaining services, and shortage of competent providers
		• Health Care Professional Interviews indicated lack of access to in-home personal care for multiple reasons:
		  ○ Inability to pay (especially for those "stuck in the middle" who 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) due to prolonged processing and shortage of personnel
		• Difficulty with placing seniors in nursing homes, especially those without skilled needs or requisite 3-day hospital stay to qualify for Medicare services in a skilled nursing facility
		• Recommended DCOA work with current in-home primary care geriatric practices to expand services.
		• Need for increased inter-professional/ interdisciplinary provision of services (i.e., not just social workers)
		• Need for point-of-service electronic information input
		• Need for more focus on chronic disease management
			Medicare/Medicaid Independence at Home Demonstration
			
			Mediware's Harmony suite
			
			Geriatric Advance Practice Nurse to bridge social, medical service, educ., consultation
			
			Sibley 60+ Club
			
			TEAM SAN DIEGO
			
			Healthy Seniors at Home
			
			Eastern Virginia Care Transitions Partnership
			The Evidence Is In...Healthy Living Program Catch Eye of Managed Care
			Gatekeeper Program
			Community Paramedicine Program and
			Community Palliative Care Program
			Safe at Home

Survey Pathway - SENIORS	Survey Pathway - Providers	Interview Pathway – Aging Care Leaders	Example Best Practices
Domain 10: Legal Issues **(*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 advantage of, Someone to help prepare my will, legal documents)***			
• Over 60% rated as "Very Important": ***Assistance with choices for future medical care, someone to protect my rights, safety, property, or dignity Someone to call when I feel threatened or taken advantage of***	• Over 75% of the time Service Providers rated all items in this domain as "Very Important". • This was closer to the range of ratings from 70% to 82.5% for Seniors with Disability Challenges included insufficient finances, seniors' unwillingness to report abuse, inadequate access to needed services, and lack of responsiveness from Adult Protective Services	• Perception by Healthcare providers that APS response capacity is inadequate • DC MOLST initiative is not funded. Needs to be funded and implemented	Wills for Seniors Protective Money Management Faith to Fate: A Faith-Based Advance Care Planning Initiative for Underserved Communities Marin County Financial Abuse Specialist Team (FAST) POLST/ MOLST Initiatives
Domain 11: Food Security, **(*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)***			
• 2 items most frequently rated as "Very Important": ***Information on how to eat healthy*** (65%) and ***Being able to afford food*** (64%) • 67% reported not needing assistance in this area For Seniors with Disability, rated "Very Important" by 80% for ***Being able to afford enough food*** and 60% for ***Having meals brought to or prepared in the home***	• 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***	DC Seniors may lack pots/ pans, stoves, refrigeration, etc.	Senior Nutrition Program Placemats Elderly Nutrition Food Box Program CHAMPSS: Choosing Healthy and Appetizing Meal Plan Solutions for Seniors in San Francisco / Choice Heritage Pet Assistance Program

Survey Pathway - SENIORS	Survey Pathway - Providers	Interview Pathway – Aging Care Leaders	Example Best Practices
Domain 12: Caregivers ***(Assistance for the people who help you)***			
• 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*** • 25% don't know how to get help • Open-ended comments: o Majority of the suggestions included monetary help to caregivers, increased pay o Need respite for caregivers o Importance of easy access to one-stop info to guide caregiving activities o Advocated a "no wrong door" for obtaining info. o Caregiving education o Training in English language proficiency o Help with transp. expense o Access to health benefits	• When asked what is the most important service for caregivers of seniors or seniors who are caregivers (free text response), the most frequent response was "respite care" • 72-82% of the time rated as "Very Important" the items related to caregiver support, which closely mirrored the 73-81% range of ratings "Very Important" by Seniors with Disability Challenges included lack of timely response to request for assistance, lack of available services for homebound seniors, caregiver burnout, and lack of available resources.	**SAC Nutrition Subcommittee Recommends:** • Home-delivered meals as part of EPD waiver • Investigate home delivered groceries and CSAs • Develop Nutritional Supplement Bank CAFB • Transition nutrition care when discharging hospital to home	Caring for the Caregiver Caregiver Training Coalition Caregiving MetroWest
Cross-cutting topics			
Who helps you with this? (From Senior Survey) • Over 50% across all domains: Family • Friends: generally around 25% • Others included DCOA, Wellness Centers, DCOA, Contractors, Villages • 10% do not know who they would call if needing assistance across all domains			
Suggestions from providers: • DCOA convene stakeholders conference to review needs assessment and plan service delivery options [HCP] • Providers recommended collaboration to pool resources in all domains • Providers recommended offering education for seniors, caregivers, and care providers across all domains			

ATTACHMENT Q23b

DISTRICT OF COLUMBIA

STATE PLAN ON AGING

Fiscal Years 2017 - 2018

I. VERIFICATION OF INTENT

The District of Columbia State Plan on Aging is hereby submitted for the District of Columbia for the period of October 1, 2016 through September 30, 2018. The plan includes all assurances and plans to be conducted by the District of Columbia Office on Aging (DCOA) under provisions of the Older Americans Act of 1965 as amended in 2006 (Public Law 109-365).

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

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

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

____

Laura Newland Date
Executive Director
District of Columbia Office on Aging

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

____

Muriel Bowser Date
Mayor
Government of the District of Columbia

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II. Executive Summary

A. Plan's Purpose

The District of Columbia State Plan on Aging (State Plan) is the blueprint for coordinating and delivering services and supports to be provided through the Office on Aging and covers the next two years (October 1, 2016 to September 30, 2018).

The State Plan on Aging provides a description of the District of Columbia Office on Aging's (DCOA) roles and responsibilities, challenges and focuses. The plan provides a blueprint to improve and expand quality health and social support services to older District residents (age 60 and older), people with disabilities (ages 18 to 59), and their caregivers.

B. Senior Service Delivery System

DCOA administers the provisions of the Older Americans Act (OAA) through a Senior Service Network (SSN) comprised of 20 community-based non-profit organizations through a competitive grant making and procurement process. Specifically, DCOA administers OAA core programs from Title III and Title VII—supportive services, nutrition, health promotion, caregiver support, and elder rights services—through 37 programs in the SSN. Crucial to this network are Lead Agencies that offer a broad range of legal, nutrition, social and health services. The goal of these agencies is to enhance the quality of life for older adults and their families throughout all eight wards of the District of Columbia. The agencies accomplish this goal through service delivery and widespread distribution of information about the variety of services and programs offered to older adults throughout the city.

Additionally, DCOA operates the Aging and Disability Resource Center (ADRC), which provides a coordinated system of information and access for individuals seeking long-term care services and supports. ADRC provides information, counseling, and service access to older adults, people with disabilities, and caregivers. DCOA began to manage and operate the ADRC in 2009 through a Memorandum of Understanding (MOU) with the Department of Health Care Finance (DHCF).

C. Development of the Plan

The development process for the State Plan was initiated in fiscal year 2016, following the guidelines and program instructions issued by the U.S. Administration for Community Living (ACL). Community leaders and other stakeholders look to DCOA for guidance in designing sustainable models of service, collecting data to assess critical needs, and ensuring oversight and accountability of the service delivery system. The process for developing the State Plan included the input from various stakeholders, including the DC Commission on Aging (a mayoral appointed citizen's advisory group), the Senior Service Network, consumers, residents, advocacy groups and organizations, and health and human services providers (see Attachment D which describes the community participation process).

D. DCOA Direction

The State Plan is consistent with Mayor Muriel Bowser's vision to create an Age-Friendly DC—an urban environment that promotes active and healthy aging. This movement is designed to address two significant demographic trends: urbanization and aging. The District is making investments in ten overarching domains: (1) Outdoor Spaces and Buildings, (2) Transportation, (3) Housing, (4) Social Participation, (5) Respect and Social Inclusion, (6) Civic Participation and Employment, (7)

Communication and Information, (8) Community Support and Health Services, (9) Emergency Preparedness and Resilience, and (10) Elder Abuse, Neglect and Fraud.

Additionally, the District's goal is to operate a coordinated, District-wide, No Wrong Door (NWD) system that will support all D.C. residents in need of long-term services and supports (LTSS), regardless of where they enter the system. In October 2014, D.C. received a grant from ACL to develop a three-year plan to transform current LTSS programs and processes in the District. The objectives are to design a NWD system that is: (1) Person and family-centered—connecting people with LTSS based upon what is important to and for them and their families; (2) Culturally and linguistically competent—being responsive to cultural preferences, needs, and the diverse languages spoken by people in the District of Columbia; (3) Respectful and provides excellent customer service; (4) Inclusive and integrated—supporting people to live at home, with the services they prefer and need to be independent and fully included in all aspects of their community life; (5) Community-based—linking people with LTSS through a coordinated and comprehensive network of public and private supports.

E. Federal and State Cohesion

DCOA's State Plan goals and objectives were guided by the strategic goals established by ACL's Strategic Plan for years 2013 to 2018. ACL's goals include:

1. Advocate to ensure the interests of people with disabilities, older adults, and their families are reflected in the design and implementation of public policies and programs.
2. Protect and enhance the rights of, and prevent the abuse, neglect, and exploitation of, older adults and people with disabilities.
3. Work with older adults and people with disabilities as they fully engage and participate in their communities, make informed decisions, and exercise self-determination and control about their independence, well-being, and health.
4. Enable people with disabilities and older adults to live in the community through the availability of and access to high-quality long-term services and supports, including supports for families and caregivers.
5. Implement management and workforce practices that support the integrity and efficient operations of programs serving people with disabilities and older adults and ensure stewardship of taxpayers' dollars.

DCOA and the Senior Service Network continue to work towards promoting aging in place policies that empower older adults, people with disabilities, and caregivers to make informed decisions and remain independent in their neighborhoods and communities for as long as possible. DCOA's State Plan goals and objectives are:

Goal 1: Strengthen core program operations and service coordination.

Objective 1: Evaluate internal agency operations and procedures to ensure effective and efficient program monitoring and support.

Objective 2: Assess community needs and service gaps to improve connectivity to appropriate services and supports.

Objective 3: Identify best practices and implement strategies to expand delivery of and access to services and supports.

Objective 4: Reduce duplication of services with other District Government and community-based providers.

Goal 2: **Promote awareness and access to long-term care services and supports offered in the District.**

Objective 1: Work closely with other District Government health and human service agencies to develop and implement strategies for a "No Wrong Door" (NWD) approach to accessing long-term care services and supports.
Objective 2: Integrate "Alzheimer's Disease Initiative" with core programs.

Goal 3: **Promote aging in place with dignity and respect.**

Objective 1: Partner with District of Columbia's Homeland Security and Emergency Management Agency (HSEMA) to review and update the District Preparedness System (DPS).
Objective 2: Integrate and implement initiatives outlined in the District Olmstead Plan.
Objective 3: Support and promote efforts for the District to become a recognized Age-Friendly City.
Objective 4: Promote the development and sustainability of senior villages in the District.

Goal 4: **Ensure agency is driven by customer experience.**

Objective 1: Develop and implement strategies to expand opportunities to offer input in agency decision-making process.
Objective 2: Implement person-centered practices that match other District Government health and human service agencies in accordance with the No Wrong Door work plan.

F. Challenges

In 2015, the District of Columbia estimated a population of 658,893 residents and projected an approximate net gain of 1,000 new residents per month. The older adult population (age 60 and older) in the District is approximately 16.2 percent of total population, 107,711. With baby boomers retiring and moving into the city and people living longer, the District expects the older adult population to continue to increase. The District is working to provide greater opportunities for people to age in the community, because DC has been ranked as one of the top ten most expensive cities to live in the U.S. when considering housing, transportation, food, entertainment, and healthcare costs.[1] District older adults identified during a survey conducted between April 18, 2016 and May 31, 2016 by DCOA that housing and health services are the top two priorities for aging in the community. Increases in property values also raise home owners' property taxes and increase rent.

[1] "Cost of Living - Washington, DC," NerdWallet, n.d. Web.

III. District of Columbia State Plan on Aging Narrative

A. Mission Statement

The mission of the District of Columbia Office on Aging (DCOA) is to advocate, plan, implement, and monitor programs in health, education, employment, and social services 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.

B. Vision

The District of Columbia Office on Aging (DCOA) is committed to assisting older adults and people with disabilities remain independent and involved in their neighborhoods and communities for as long as possible, commonly known as aging in place. Since 1975, DCOA has been building a network of programs and services that help District older adults age in place with programs including health, wellness, education, employment, and safety. DCOA's vision for the future embraces a strategic direction that incorporates past goals and objectives, new and innovative programs that consider current 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.

C. District of Columbia Office on Aging (DCOA)

DCOA was established by the Mayor in 1975 to plan, develop, and implement programs and services for residents age 60 and older. In 2009, DCOA expanded its scope to include services for people with disabilities between ages 18 and 59.

DCOA acts as both the District's State Unit and Area Agency on Aging and is structured to carry out advocacy, leadership, management, programmatic, and fiscal responsibilities. The agency operates the Aging and Disability Resource Center (ADRC), which provides a coordinated system of information and access for people seeking long-term services and supports. Additionally, the agency funds a Senior Service Network comprised of 20 community-based non-profit and private organizations that operate 37 programs. These programs provide services that are vital and life sustaining and life enhancing for the District's older adults (age 60 and older), people with disabilities (ages 18 to 59), and their caregivers.

DCOA's annual budget is more than $40 million, which is comprised of approximately 82 percent District funds, which 7 percent is from contractual relationships with other District Government agencies, and 18 percent federal funds. In FY 2016, more than 80 percent of DCOA's budget is allocated to the Senior Service Network to provide direct services and supports in the community. The agency has 69 full-time employees who provide direct services and monitor and support DCOA funded programs and services in the community.

In FY 2015, DCOA grantees in the Senior Service Network served 17,610 older adults and the ADRC served 5,859 older adults and people with disabilities. The most requested services by older adults were community dining (formerly known as congregate meals) and home delivered meals, in-home support, case management, transportation, and health and wellness services. By comparison, the most used services were community dining and home delivered meals, wellness programs and transportation.

D. Legislative Authority

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

D.C. Law 1-24, codified as amended at D.C. Official Code §§ 7-501.01 (2001) et seq., states that the District of Columbia government "shall insure a full range of health, education, employment, and social services shall be available to the aged in the District of Columbia, and the planning and operation of such programs will be undertaken as a partnership of older citizens, families, community leaders, private agencies, and the District of Columbia government." D.C. Official Code § 7-501.01 (2001).

The law established the Office on Aging as the "single administrative unit, responsible to the Mayor, to administer the provisions of the Older Americans Act (P.L. 89-73, as amended), and other programs as shall be delegated to it by the Mayor or the Council of the District of Columbia, and to promote the welfare of the aged." DC Official Code § 7-503.01 (2001).

DC Law 1-24 as amended also established the Commission on Aging, a 15 person citizen's advisory group that advises the Executive Director of the Office on Aging, the Mayor, and the Council of the District of Columbia on the needs and concerns of older Washingtonians.

E. Local Statistics and Trends

The District of Columbia has an estimated population of 658,893 residents. From 2010 to 2014, the D.C. Office on Planning estimated, using Census data, that the District's population increased by 53,683 people, of which 7,992 were age 60 years and above. The older adult population (age 60 and older) in the District is 107,117 (16.2 percent of total population), with 20,190 persons 80 years of age and older.

Between 2010 and 2014, the District experienced a high rate of people entering the city for retirement. The number of District residents 60 years and older grew 8.1 percent, which is 1.5 percent more than grade school aged residents (ages 5 to 18 years old). The cohort age 65 to 69 years old (the oldest segment of baby boomers in 2014) was the fifth fastest growing age group. An additional growth factor is that District older adults are living longer. District residents 85 years and older grew by 7.5 percent during this period.

The older adult population is expected to continuing growing in the District and across the United States. By 2030, all surviving baby boomers in the U.S. will be 66 to 84 years old and predicted to represent 20 percent (one in five) of the total population at that time.[2] In 2010, baby boomers made up 23.2 percent of the District population, evidence of a critical need to evaluate aging services necessary to foster the health of this population group. In 2014, baby boomers made up 20.2 percent of the District population. However, each age cohort of baby boomers in 2014 is larger than the same age cohort in 2010. For example, District residents 65 to 69 years old grew 16.9 percent between 2010 and 2014.

[2] "Global Age-friendly Cities: A Guide." World Health Organization (2007). n.d. Web.

DISTRICT OF COLUMBIA

POPULATION 60 YEARS AND OLDER FROM 2010 TO 2014

DEMOCRAPHIC INFO	2010	2014	Growth between 2010 and 2014	Percent of District Pop. 60 years and over
Population 60 to 64 years	30,055	32,363	7.68%	30.2%
Population 65 to 69 years	21,593	25,232	16.85%	23.6%
Population 70 to 74 years	15,553	17,206	10.63%	16.1%
Population 75 to 79 years	11,819	12,126	2.60%	11.3%
Population 80 to 84 years	9,687	8,987	-7.23%	8.4%
Population 85 years and over	10,418	11,203	7.54%	10.5%
Population 60 years and over	99,125	107,117	8.06%	100.0%
Median age of Population 60 years and over	68.9	69.6	1.02%	NA
Population 60 years and over, White	34,996	38,660	10.47%	36.1%
Population 60 years and over, African American	60,384	64,086	6.13%	59.8%
Population 60 years and over, American Indian and Alaska Native	377	445	18.04%	0.4%
Population 60 years and over, Asian	2,124	2,484	16.95%	2.3%
Population 60 years and over, Native Hawaiian and Other Pacific Islander	51	74	45.10%	0.1%
Population 60 years and over, Two or more races	1,193	1,368	14.67%	1.3%
Population 60 years and over, Female	57,737	62,109	7.57%	58.0%
Population 60 years and over, Male	41,388	45,008	8.75%	42.0%
Population 60 years and over, Veteran	16,851	16,389	-2.74%	15.3%
Population 60 years and over, with Disability living at home	29,466	34,851	18.27%	32.5%

EDUCATIONAL ATTAINMENT	2010	2014	Growth between 2010 and 2014	Percent of District Pop 60 years and over
Population 60 years and over, less than high school graduate	19,726	14,996	-23.98%	14.0%
Population 60 years and over, high school graduate, GED, or alternative	24,187	25,494	5.41%	23.8%
Population 60 years and over, some college or associate's degree	17,347	21,852	25.97%	20.4%
Population 60 years and over, bachelor's degree or higher	37,965	44,668	17.66%	41.7%

EMPLOYMENT STATUS	2010	2014	Growth between 2010 and 2014	Percent of District Pop 60 years and over
Population 60 years and over, in labor force - employed	30,630	32,349	5.61%	30.2%
Population 60 years and over, in labor force - unemployed	2,379	2,035	-14.45%	1.9%
Population 60 years and over, not in labor force	66,116	72,732	10.01%	67.9%

Source: U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates and 2010 American Community Survey 1-Year Estimates

POVERTY STATUS IN THE PAST 12 MONTHS	2010	2014	Growth between 2010 and 2014	Percent of District Pop 60 years and over
Population 60 years and over, below 100 percent of the poverty level	14,160	16,486	16.43%	15.8%
Population 60 years and over, 100 to 149 percent of the poverty level	8,105	8,661	6.85%	8.3%
Population 60 years and over, at or above 150 percent of the poverty level	75,387	79,197	5.05%	75.9%

HOUSEHOLDS BY TYPE	2010	2014	Growth between 2010 and 2014	Percent of District Pop 60 years and over
Households of population 60 years and over ("Household")	67,588	71,499	5.79%	
Household, not living alone with family	26,900	29,744	10.57%	41.6%
Household, not living alone with non-family	2,704	2,788	3.14%	3.9%
Household, living alone	37,984	38,967	2.59%	54.5%
Household, owner occupied	40,485	43,757	8.08%	61.2%
Household, renter occupied	27,103	27,742	2.36%	38.8%
Population 60 years and over, living with grandchild(ren)	5,254	5,034	-4.17%	4.7%

HOUSEHOLD INCOME IN THE PAST 12 MONTHS	2010	2014	Growth between 2010 and 2014	Percent of District Pop 60 years and over
Household, with earnings	33,591	35,821	6.64%	50.1%
Household, with Social Security income	41,972	42,756	1.87%	59.8%
Household, with Supplemental Security Income	5,069	6,292	24.12%	8.8%
Household, with cash public assistance income	1,217	2,002	64.56%	2.8%
Household, with retirement income	30,820	31,817	3.23%	44.5%
Household, with Food Stamp/SNAP benefits	7,570	10,582	39.79%	14.8%
Mean Social Security income (dollars)	$14,149.00	$15,588.00	10.17%	
Mean Supplemental Security Income (dollars)	$7,394.00	$7,657.00	3.56%	
Mean cash public assistance income (dollars)	$5,084.00	$3,171.00	-37.63%	
Mean retirement income (dollars)	$37,192.00	$41,845.00	12.51%	

Source: U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates and 2010 American Community Survey 1-Year Estimates

F. Issues and Challenges

1. Abuse, Neglect and Financial Exploitation

The U.S. Department of Justice and U.S. Department of Health and Human Services indicate that the exploitation and abuse of vulnerable adults affects approximately five million Americans each year. However, incidents are widely unreported due to fear, embarrassment, protection of family who are perpetrating the crime and denial. In fact, studies suggest that only 1 in 14 cases of elder abuse are reported or come to the attention of authorities.[3] In the absence of a large-scale, national tracking system, studies of prevalence and incidence of abuse, neglect, and exploitation of older Americans conducted over the past few years by independent investigators have been critical in helping to understand the magnitude of this problem. In Fiscal Year 2014, the District of Columbia Adult Protective Services (APS) reported 831 cases of abuse, neglect, self-neglect and exploitation of vulnerable adults, not including unreported incidents.

2. Aging in Place

Community living offers important health and financial benefits for older adults and people with disabilities, as well as for the entire District community. The opportunity for older adults to maintain meaningful relationships in their neighborhoods and maintain familiar comforts of daily living has emotional, social, and health benefits. According to the U.S. Department of Housing and Urban Development, "civic engagement… can reduce mortality; increase physical function, muscular strength, and levels of self-rated health; reduce symptoms of depression and pain; and increase life expectancy."[4]

Community living for older adults and people with disabilities also benefits the larger District community by reducing the need for unnecessary nursing home placements and the significant expense associated with nursing home care. Genworth Insurance Company's 2016 Cost of Care Survey reported that in the District of Columbia the median annual rate for home health aide services was $54,912 compared to $121,363 for a semi-private room in a nursing home, and trends show the disparity is growing.[5] Over the past five years, the average increase in annual cost of a private nursing home room has far exceeded the rate of inflation, which means high costs for consumers and increased pressure on government entitlement programs.

3. Alzheimer's disease and related dementia

Alzheimer's disease (AD), a progressive, degenerative disease of the brain and the most common dementia, is a difficult disease to manage—for the individual, the family and for governmental and non-governmental agencies and service providers mandated to help alleviate the resulting burdens. According to the Alzheimer's Association, in 2014 approximately 9,200 individuals in the District 65 years and older live with Alzheimer's.[6] People who reach the age of 85 without incidence of dementia have a twenty-fold greater short-term risk for developing dementia than those who reach the age of 65 without dementia. Furthermore, approximately 27,000 individuals care for a person with Alzheimer's disease and related dementia (ADRD) and close to 31 million hours of unpaid care was provided in 2013.[7] Alzheimer's disease was ranked the 7th leading cause of death in the District of Columbia in 2011.

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[3] Richard J Bonnie and Robert B Wallace, "Elder Mistreatment." *National Academies Press (US)* (2003): n. pag. Web.
[4] Measuring the Costs and Savings of Aging in Place. U.S. Department of Housing and Urban Development, n.d. Web.
[5] Long Term Care Costs & Cost of Care in 2016. Genworth Insurance Company, Apr. 2016. Web. 16 June 2016.
[6] "2014 Alzheimer's Disease Facts and Figures." Alzheimer's & Dementia 10.2 (2014). Alzheimer's Association. Web.
[7] Ibid.

4. Caregiver Support

More than 65 million people, 29 percent of the U.S. population, provide care for a chronically ill, disabled or aged family member or friend during any given year and provide an average of 20 hours of care per week. Caregiving families—families in which one member has a disability—have median incomes that are more than 15 percent lower than non-caregiving families. In every state, including the District of Columbia, the poverty rate is higher among families with members with a disability than among families without.

5. Falls Prevention

The D.C. Chief Medical Examiner reported that in 2013, 70 percent of accidental deaths among District residents ages 65 years and older were due to falls, making it the leading cause of older adult deaths for the fourth year in a row. Across the nation, falls among older adults are the leading cause for both fatal and nonfatal injuries. Falls among older adults may lead to severe physical and cognitive health problems that result in extended stays in hospitals and long-term care facilities. An older adult's hospital stay after a fall could last up to 15 days; and in the case of hip fractures, the most common fall related injury, stays may extend to 20 days. Studies indicate that individuals 75 years and older who fall are four to five times more likely to be admitted to a long-term care facility for greater than a year. An article in the American Journal of Epidemiology found that fall-related "injuries are directly related to the loss of independence and may further limit mobility due to fear of falling." Furthermore, the World Health Organization reports that "loss of autonomy, confusion, immobilization and depression" are common in patients experiencing "post-fall syndrome," and leads to further restrictions in daily activities.

6. Housing

Since 1999, there have been over 2,000 public and private subsidized units reserved for older adults. The city now has 50 subsidized apartment developments totaling over 7,000 units. Many older adults are aging in place in these facilities and will require in-home support services. According to the D.C. Department of Housing and Community Development's (DHCD) Five Year Consolidated Action Plan for fiscal years 2011-2015, the goal for special needs housing for elderly, disabled and homeless is 895 units. In addition, over half of elderly homeowners live in homes over 30 years old. Most do not have handicapped features or amenities, and are "house rich but cash poor." In 2012, the DC Fiscal Policy Institute found that nearly 30 percent of District homeowners 60 years and older spend more than half of their income on housing, which is known as a "severe housing cost burden."[8]

7. Hunger

Older adult hunger is an important issue affecting 15.8 percent of older adults or 10.2 million older adults nationally. Older adults are more likely to face hunger if they are low-income, a racial or ethnic minority, living in the South or Southwest United States, a younger senior (ages 60-69), divorced or separated, a grandparent raising a grandchild, or person with disabilities. This is especially significant as older adults who face hunger are significantly more likely to have diabetes, depression, high blood pressure, congestive heart failure, or a heart attack, and more likely to report fair or poor general health, gum disease, asthma, and at least one activity of daily living (ADL) limitation. In the District, one in five older adults reported that they faced the threat of hunger in 2014.[9]

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[8] Reed, Jenny. "Disappearing Act: Affordable Housing in DC Is Vanishing Amid Sharply Rising Housing Costs." (n.d.): n. pag. DC Fiscal Policy Institute, 7 May 2012. Web.

[9] Dr. James P. Ziliak and Dr. Craig G. Gundersen. "State of Senior Hunger in America 2014: An Annual Report." (2016): n. pag. National Foundation to End Senior Hunger. Web.

8. Social Isolation and Underserved Populations
Social Isolation has proven negative impacts on physical and mental health, particularly for older adults. Studies indicate that feelings of loneliness are linked to poor cognitive performance and quicker cognitive decline. Additionally, research suggests that long-term illnesses and issues of mobility are associated with social isolation. According to a 2015 study by Brigham Young University, living alone had a greater impact to a person's health, increasing mortality risk by 32 percent. In the District, the majority of older adults, 54.5 percent, live alone. Social isolation impacts demographic groups differently. LGBTQ older adults are twice as likely to live alone and face isolation. According to a 2011 national health study on LGBTQ older adults, 53 percent of responders indicated they feel isolated from others. The District is estimated to have the largest percentage of LGBTQ residents in the nation, approximately 10 percent. Racial minority older adults have an increased perception of isolation and social disconnectedness.[10] One study indicates that, "Despite… greater residential kinship ties, [African American and Hispanic older adults'] network size, network range and number of friends appear to be much smaller." Barriers to accessing programs include socioeconomic issues, such as transportation options outside of the family, and education.

9. Transportation
To maintain independence, all people, including the elderly, need transportation options. A survey by the American Public Transportation Association determined that 82 percent of respondents 65 years of age or older are very concerned about becoming "stranded" and unable to travel short distances when they can no longer drive. These concerns have been validated by a study which found that seniors age 65 and older who no longer drive make 15 percent fewer trips to the doctor, 59 percent fewer trips to shop or eat out, and 65 percent fewer trips to visit friends and family, than drivers of the same age.[11] According to the 2010 Census, more than one third (37 percent) of District older adults had no personal vehicle at their disposal.

G. Services and Supports

DCOA administers the Older Americans Act (OAA) core services—supportive services, nutrition, health promotion, caregiver support, and elder rights—through the Senior Service Network (SSN), comprised of 20 community-based non-profit and private organizations that operate 37 programs. These programs provide vital and life sustaining services and supports for the District's older adults (age 60 and older), people with disabilities (ages 18 to 59), and their caregivers.

In FY 2016, DCOA commissioned a needs assessment and feasibility study to help identify older adult needs in the District and how the District can best meet those needs. The final report will analyze the District's demographic trends, program services and supports, facility capabilities and opportunities, and national best practices. The needs assessment will help identify service gaps and community demands that will inform the agency's future service provision.

Each of the services and supports are organized in the following three categories. Refer to Attachment G for a complete list of services, and refer to Attachment F for a complete list of providers in the SSN.

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[10] Christina E. Miyawaki "Association of Social Isolation and Health across Different Racial and Ethnic Groups of Older Americans." U.S. National Library of Medicine, Nov. 2015. Web.
[11] Linda Bailey, "Aging Americans: Stranded Without Options." Surface Transportation Policy Project (2004): n. pag. Web.

1. Customer Information, Assistance and Outreach

DCOA provides information, assistance, and outreach for a variety of long-term care needs to older adults, people with disabilities, and caregivers regarding long term care services and supports offered in the District.

a) Advocacy and Elder Rights—provides legal support and advocacy for elder rights 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 older adults (LTC Ombudsman—Title VII Funding).
b) 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, people with disabilities between the ages of 18 and 59, and caregivers.
c) Community Outreach and Special Events—provides socialization, information, and recognition services for District residents age 60 or older, people with disabilities 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 (SHIP Funding).

2. Home and Community-Based Supports

DCOA provides 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 health promotion, case management services, nutrition, homemaker assistance, wellness, counseling, transportation, and recreation activities.

a) Caregivers Support—provides caregiver education and training, respite, stipends, and transportation services to eligible caregivers (Title III E Funding and Alzheimer's Disease Initiative).
b) 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 (Title III B and E Funding).
c) 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 (Title III B Funding).
d) Lead Agencies and Case Management—provides core services and supports, such as case management, counseling services health promotion, and nutrition counseling and education, for District residents age 60 or older, people with disabilities between the ages of 18 and 59, and caregivers (Title III B and E Funding).
e) Senior Wellness Centers/Fitness—provides socialization, physical fitness, and programs that promote healthy behavior and awareness for District residents age 60 or older (Title III D Funding).
f) Supportive Residential Services—provides emergency shelter, supportive housing, and aging-in-place programs.
g) Transportation—provides transportation to life-sustaining medical appointments and group social and recreational activities for District residents age 60 or older (Title III B Funding).

3. Nutrition Services

DCOA provides meals, food, and nutrition assistance to District residents 60 and over to maintain or improve their health and remain independent in the community.

a) 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 (Title III C Funding).
b) Home-delivered Meals—provides District residents age 60 or older who are frail, homebound, or otherwise isolated meals delivered directly to their home (Title III C Funding).
c) Nutrition Supplements—provides nutrition supplements each month for District residents 60 and over who are unable to obtain adequate nutrition from food alone.
d) 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 (CSFP Funding).

H. Efforts to Improve the System

1. Within DCOA and the Senior Service Network

a) Alzheimer’s Disease Initiative

In October 2014, DCOA was awarded a competitive grant by the Administration for Community Living (ACL) to further develop a dementia-capable system of long-term services and supports (LTSS). DCOA's Alzheimer's Disease Initiative was successful in reaching its goal to increase access to home and community-based services and supports for individuals with Alzheimer’s Disease and Related Dementias (ADRD) throughout FY15. Through the Initiative, DCOA launched five pilot programs: 1) A “Cluster Care” model of service for individuals living in high-density residential communities and living alone with ADRD (ended because there was no population to suit this program); 2) Money Management/Rep Payee Program provides money management training and representative payee support to people experiencing ADRD and has enrolled 10 individuals 3) Sibley's Club Memory program—a stigma-free social club for people with early-stage Alzheimer’s disease, mild cognitive impairment or other forms of dementia and their spouses, partners and caregivers—has successfully expanded to Wards 7 and 8, and has enrolled 80 new members; 4) Saturday Respite programs were developed and established in both Wards 7 and 8; and 5) The Behavioral Symptom Management training program was approved to provide professional Continuing Education Credits (CEUs) by the DC Board of Nursing Assistive Personnel to Personal Care Aides and the National Association of Social Work (NASW) for Licensed Social Workers and presented trainings to 180 professionals and family caregivers. After year one of the grant, DCOA worked with ACL to replace the Cluster Care program with a pilot Dementia Navigator program. Dementia Navigators will provide dementia training for family caregivers, cross training for the senior service network and community partners utilizing DCOA’s Behavior Symptom Management Training Program, outreach and awareness, and direct service planning and referral as needed.

b) Case Management Task Force

In FY16, DCOA started a Case Management Task Force to discuss the District's case management offerings through Medicaid's Elderly and Persons with Physical Disabilities (EPD) Waiver and DCOA’s Lead Agencies. The goal of the task force is to identify and address ongoing community concerns, and to reduce duplication of case management services. The task force is composed of DCOA's Senior Service Network and Aging and Disability Resource Center social workers and case managers. DCOA will continue to meet monthly with the task force.

c) ConnectorCard

In FY15, DCOA replaced "Call-N-Ride," a subsidized paper coupon system for low- to moderate-income residents, with a program called the ConnectorCard. The ConnectorCard is a DCOA-subsidized debit card that is loaded with up to $100 per month, with each participant making contributions based on his/her income. The ConnectorCard provides older adults with greater choice and flexibility by opening access to a broader range of transportation options without needing a reservation 24 hours or more in advance. In addition, Seabury Resources for Aging has received additional funding through a grant from the National Capital Region Transportation Planning Board to expand the ConnectorCard program.

d) Needs Assessment

In FY 2016, DCOA commissioned a needs assessment to be completed by September 30, 2016 that was awarded to the Center for Aging, Health and Humanities at the George Washington University School of Nursing (GW). The goal of the needs assessment is to identify high-value areas for improvement, expansion and/or innovation. GW plans to accomplish this by analyzing demographic and economic trends, program services and supports, facility capabilities and opportunities, and national best practices. Furthermore, GW will design and use a survey tool to identify current and future service gaps, and will organize focus groups and interviews with various stakeholders.

e) Nutrition Task Force

In FY15, DCOA established the Nutrition Task Force to bring together stakeholders to address issues related to older adult nutrition and hunger. The Task Force used meal program participation data to develop and implement policy reforms and system changes to decrease food waste, improve systems of tracking, and meet customer needs. DCOA will continue to work with the Task Force to adjust eligibility criteria and programming to ensure nutrition programs reach older adults in greatest need. The group will continue to discuss innovative strategies to improve the current programing to reach working seniors and baby boomers.

f) Options Counseling Integration

Options Counseling is a decision-support process to help people make informed choices in long term care services and supports that reflect their own preferences, strengths and values. Key components of Options Counseling include a personal interview, assistance with identification of choices available, assistance with developing an individual plan, link to desired services, and follow up. A grant from the U.S. Administration for Community Living in 2011 acted as the catalyst for establishing this service within the ADRC. Since its inception, Options Counseling has grown from two staff members providing Options Counseling as a distinct service, to a person-centered approach that all ADRC social work staff is trained on and use daily when working with their community transition, hospital discharge, and social work clients. Through the No Wrong Door initiative, DCOA is engaged with other District Government health and human service agencies in streamlining understanding of and implementation of person-centered practices throughout the District's network of long-term services and supports, including the point of intake, completion of assessments, service delivery, and follow up. DCOA's many years of experience with Options Counseling has provided a strong foundation for our staff to understand new concepts presented in future No Wrong Door/Person-Centered Counseling trainings and implementation.

2. In collaboration with other District Government agencies

a) Adult Protective Services (APS)

In FY 16, key leaders within DCOA's Aging and Disability Resource Center (ADRC) and DC's Department of Human Services' Adult Protective Services (APS) have collaborated to improve communication between agencies and with stakeholders. Starting as a monthly meeting for discussions about complex cases, the DC agency collaboration grew into a comprehensive forum for cross-trainings to ensure a clear understanding of the respective responsibilities of ADRC and APS; creating inter-agency policies and procedures; and developing DCOA/APS trainings and outreach materials for DCOA's grantees, other DC agencies, and the public. The working group expects this partnership to continue to grow into 2018, as both DCOA and DHS programs continue to evolve under the No Wrong Door system. Currently there are several communication plans in place due to the absence of a common case management database that both DCOA and DHS can use to assist with providing streamlined services. As the No Wrong Door initiative works toward integrating case management database systems, it is expected that communication among DC agencies and grantees will continue to become more streamlined and customer service will continue to improve.

b) Community Transitions

In FY15, DCOA's Aging and Disability Resource Center successfully expanded the Community Transition Team that assists older adults and people with disabilities in their transition from long-term care settings back to the community. The program provides significant post-discharge case management services up to one year after the date of discharge to ensure sustained independence and quality of life. In November 2014, the District's Money Follows the Person Demonstration (formerly housed at the Department of Health Care Finance) merged with the DCOA Nursing Home Transition Program to create one unified entity: the Community Transition Team. The convergence of these two teams ensures more effective and streamlined management which has contributed to a higher number of transitions, improved utilization of housing vouchers in comparison to previous years, and improved inter-agency collaboration between DCOA and DHCF. Since November 2014, ADRC managers have focused on merging the teams by working closely with the full Community Transition team to develop new case assignment procedures, offer new trainings, and conduct weekly team meetings to help with team building and professional development. Efforts have been successful. The Money Follows the Person (MFP) Demonstration exceeded the Center for Medicare and Medicaid's (CMS) 2015 calendar year benchmark (35 total transitions), by successfully assisting 36 older adults and people with disabilities to transition from institutional settings back into the community. This is the first time in the history of the Demonstration that the CMS benchmark has been met and exceeded by the District.

c) District Preparedness System (DPS) Enhancement Project

Over the last 3 years, the District of Columbia Homeland Security and Emergency Management Agency (HSEMA) has been collaborating with stakeholders to develop, implement, and socialize the District Preparedness System (DPS). However, preparedness planning approaches and products vary significantly within the District, potentially contributing to duplication of effort and inconsistent outcomes. In order to elevate some of these issues, HSEMA has initiated the DPS Preparedness Planning Enhancement Project. The purpose of this project is to develop key enhancements to the DPS intended to align strategic and operational doctrine to ensure that the suite of plans are fully synchronized and provide a comprehensive planning foundation. DCOA is a critical stakeholder, providing expertise on risks and impacts to the aging and physically disabled communities in the District.

d) Elderly and Persons with Physical Disabilities (EPD) Waiver

DCOA is working in collaboration with other District Government agencies to improve customer service to DC residents by streamlining the Elderly and Persons with Physical Disabilities (EPD) Waiver enrollment process and building understanding of the complex EPD Waiver enrollment process among clients, professionals, caregivers and other stakeholders. Collaborative work includes: participating in weekly meetings with DHCF and the Department of Human Services' Economic Security Administration (ESA) to discuss and improve the enrollment process; coordinating monthly community trainings on the new enrollment process; and hiring and training additional Medicaid Enrollment Specialists, who provide in-person enrollment assistance to EPD Waiver applicants. The Medicaid Enrollment Specialists have fielded more than 1,901 referrals since June 1, 2015, when the new enrollment process began, and submitted more than 579 EPD Waiver applications to ESA. In May 2015, ADRC hired five Medicaid Enrollment Specialists, one Medicaid Lead, and one Clinical Social Work Supervisor to assist with the expanded enrollment responsibilities. In September 2015, DCOA hired three more Medicaid Enrollment Specialists and two more Information and Referral/Assistance (I&R/A) specialists. With the increased number of staff and responsibility, the Medicaid Lead position was converted to a Medicaid Enrollment Supervisor, and an I&R/A Supervisor was hired to help manage the unexpectedly high volume of EPD Waiver intakes.

e) Medicaid-Funded Adult Day Health

Since the summer of 2015, ADRC has worked closely with DHCF to create an Adult Day Health Program (ADHP) enrollment process so DC residents receiving State Plan Medicaid or EPD Waiver who request, and are eligible for ADHP services, are able to enroll in a timely manner. As requested by DHCF, and to ensure ADHP attendees did not lose their ADHP Medicaid funding as of January 1, 2015, ADRC conducted enrollment activities with 100+ ADHP attendees in FY16 including 30+ in-person expedited enrollment visits in December 2015, and obtained all necessary documentation for each of the referrals received. DCOA and DHCF have worked together to conduct community trainings on this new process to ensure professionals, Medicaid beneficiaries, and other stakeholders understand it. DCOA and DHCF meet weekly to discuss process improvements and data collection; and DCOA attends monthly ADHP provider meetings to ensure we are communicating well with the directors of the agencies that provide ADHP services.

f) Olmstead Community Integration Plan

In 2006, the District of Columbia government passed the Disability Rights Protection Act, which created the Office of Disability Rights (ODR). Among other things, ODR was given responsibility for developing and submitting an Olmstead Compliance Plan. ODR published the District's first Olmstead Plan in 2011, and the city has since made numerous revisions based on stakeholder feedback. In 2015, the District created an Olmstead Working Group to make recommendations for revisions to the Olmstead Plan for 2016, and into the future. The Olmstead Working Group was developed with the advice and recommendations of ODR and other agencies serving people with disabilities. The group is comprised of representatives from District Government agencies and community stakeholders, including people with disabilities and advocates for people with disabilities.

g) Safe at Home Program

In FY16, DCOA and the Department of Housing and Community Development (DHCD) partnered to develop and implement a new home adaptation program called Safe at Home. The program promotes aging-in-place for older adults (age 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

complete the recommended adaptations. DCOA plans to serve at least 100 District residents through the Safe at Home Program in FY16.

h) Transportation Collective

In FY16, DCOA began working with other District Government transportation agencies to identify opportunities for greater collaboration and coordination around services for District older adults and people with disabilities. The Transportation Collective is comprised of staff from DCOA, District Department of Transportation (DDOT), Department of Health Care Finance (DHCF), Washington Metro Area Transit Authority (WMATA), Department of Parks and Recreations (DPR), DC Taxi Cab Commission, and Age-Friendly DC. The Transportation Collective will work to align eligibility criteria, provide consistent communication and outreach on transportation options, and identify gaps, if any, in transportation offerings for older adults and people with disabilities. Moreover, the Collective will work to identify strategies to create more reliable and affordable transportation options for older adults.

3. With federal and District-wide stakeholders

a) Age-Friendly DC Initiative

The District completed the Age-Friendly D.C. (AFDC) Strategic Plan and submitted the proposal to the World Health Organization (WHO) and AARP on December 3, 2014. The initial 2012-2014 listening phase of the age-friendly initiative engaged nearly 4,000 residents through community forums, focus groups, surveys, and neighborhood walks. Using opinions, concerns and ideas from District residents and stakeholders as a baseline, the AFDC Task Force incorporated the wisdom of academics, government officials and community leaders to develop a comprehensive and thoughtful series of goals and objectives in each of the ten domains. Since completing the strategic plan, government officials and community leaders have been working together to implement and evaluate progress in each domain. In 2017, the WHO will review DC's progress and results and determine whether to designate DC as an Age-Friendly City.

b) Benefits Check Up

In FY15, DCOA partnered with the National Council on Aging (NCOA) to customize their unique and widely used product, BenefitsCheckUp®, to the District. BenefitsCheckUp® offers a comprehensive, online service to screen older adults and people with disabilities for public benefit eligibility and access to local and federal programs. The tool caters to people with limited income. BenefitsCheckUp® includes more than 2,000 public and private benefits programs from all 50 states and the District of Columbia. DCOA's customized version of the website went live at the end of FY2015 at www.BenefitsCheckUp.org/dcoa. DCOA developed and implemented a plan to inform and connect District residents to the new service.

c) Money Smart for Older Adults

In FY15, DCOA successfully expanded the "Money Smart for Older Adults" pilot program, a training program offered through a formal partnership with the Federal Deposit Insurance Corporation and the Consumer Financial Protection Bureau. DCOA's Elder Abuse Prevention Committee (EAPC) successfully trained more than 1,000 people in the Money Smart for Older Adults program. Training sessions for older adults were conducted at 27 locations across all eight Wards of the District. In addition, the Money Smart for Older Adults training was included as an entire track of workshops at the Senior Symposium sponsored by the DC Office on Aging on May 13, 2015. EAPC members conducted the training and facilitated the sessions throughout the day and more than 195 older adults participated in the workshops. EAPC also hosted two "train the trainer" classes for social workers, case managers, and

other volunteers who expressed interest in taking the class and conducting Money Smart for Older Adults workshops in the District. In FY 16, DCOA's goal is to train an additional 1,000 District older adults and caregivers using the Money Smart program.

d) Senior Villages

In FY15, DCOA partnered with Capital Impact Partners to successfully deliver 20 hours of technical assistance each month to four villages, organize quarterly peer-to-peer knowledge exchanges building local leadership capacity, and produce the District's first "How to Start a Village" guide book entitled "Explore, Discover, Act: How to start a Village in the District of Columbia." DCOA engaged all nine established villages, four villages in development, business partners, and community leaders to strengthen relationships and develop clear lines of communication. In addition to the guide, DCOA is hosting a web-based, interactive map for residents to find a village in their neighborhood. In FY16, DCOA continues to strengthen its relationship with villages by dedicating a full-time staff member of the Community Outreach team to offer technical assistance, organize quarterly peer-to-peer knowledge exchanges, and educate the community of the village model.

I. Results of Objectives for Previous State Plan, 2013-2016

The "District of Columbia State Plan on Aging, FY 2013-2016" focused on enhancing services and activities in the areas of in-home services, public safety, consumer assistance, long-term care, health promotion/disease prevention, hunger prevention, and employment. Of the 147 strategies mapped across 15 objectives, DCOA was able to fully and partially accomplish 84 percent of all strategies. Highlights include:

- Successfully advocated for the enactment of legislation to address abuses in the real property tax sales process that was resulting in the loss of their homes through foreclosure due to relatively small sums of unpaid real property taxes. Based on Legal Counsel for the Elderly's (LCE) analysis of the tax sale lists provided by Office of Tax and Revenue (OTR), the number of tax sales of properties coded as "senior" fell from 26 in 2013 to just 9 in 2014, a reduction of over 70 percent.
- Eliminated the home delivered meals wait list and further expanded this program to weekend services for non-frail customers.
- Consolidated transportation services and acquired a new fleet of 21 vehicles.
- Reduced food waste in the Senior Wellness Centers by nearly 20 percent through the "What a Waste" program.
- In collaboration with DHCF and community stakeholders, developed and implemented a new enrollment process for the Elderly and Persons with Physical Disabilities (EPD) Waiver.

IV. Goals, Objectives, Strategies, and Performance Measures

The development of the State Plan's goal, objectives, strategies and performance measures were developed using guidelines issued by the U.S. Administration for Community Living (ACL), in collaboration with community stakeholders through surveys and public meetings, and the evaluation of strategic priorities outlined by Mayor Muriel Bowser. In each goal and objective, strategies focus on quality management measures by working with community stakeholders and District Government agencies to ensure efficient and effective delivery of Older Americans Act (OAA) core services—supportive services, nutrition, health promotion, caregiver support, and elder rights services (see Attachment G for definitions and listing of DCOA services and supports). DCOA is becoming a more data driven agency through continuous programmatic and financial assessment of ongoing programs, and identifying areas for improvement and innovation.

Goal 1: Strengthen core program operations and service coordination.

Objective 1: Evaluate internal agency operations and procedures to ensure effective and efficient program monitoring and support.

Strategies**:**

a. Work with agencies in similar jurisdictions across the country to review procedures and identify best practices for monitoring Older Americans Act (OAA) core services: supportive services, nutrition, health promotion, caregiver support, and elder rights services.
b. Review and update the DCOA Grants Manual and DCOA Service Standards incorporating federal and local policies, and implement programmatic and fiscal reporting best practices, where appropriate.
c. Organize educational opportunities for grantees in the Senior Service Network to review changes.
d. Work with grantee providing legal and LTC ombudsman services to update laws, regulations, policies and procedures in accordance with Administration for Community Living's new rules, effective July 2016.
e. Review and revise, as needed, programmatic and fiscal monitoring tools for each program.
f. Design and implement regular programmatic and fiscal reporting training programs for grantees in the Senior Service Network.
g. Establish regular meetings that bring together Program Directors providing similar core services.
h. Increase DCOA staff's professional knowledge and skills to monitor grantees through trainings.

Objective 2: Assess community needs and service gaps to improve connectivity to appropriate services and supports.

Strategies:

a. Review findings and implement recommendations, when appropriate, of DCOA's FY 2016 Needs Assessment by George Washington University.

b. Design and implement an annual demographic survey that will allow DCOA to regularly update the Needs Assessment.
c. Establish policies and procedures for Lead Agencies to perform the annual demographic survey.
d. Work with D.C. Office of Planning to identify demographic and geographic trends of District older adults.
e. Analyze service utilization of OAA core services—supportive services, nutrition, health promotion, caregiver support, and elder rights services—and population trends to identify any gaps in services.
f. Ensure grantees in the Senior Service Network are organizing focus groups and community town halls with District older adults to evaluate consumers' needs and demands.
g. Work with other District Government agencies to identify and target services and supports for underserved communities including: LGBTQ, Veterans, and returning citizens in the District.

Objective 3: Identify best practices and implement strategies to expand delivery of and access to services and supports.

Strategies**:**

a. Work with agencies in similar jurisdictions across the nation to review innovative programs and identify best practices for delivering OAA core services: supportive services, nutrition, health promotion, caregiver support, and elder rights services.
b. Evaluate the FY 2016 Restaurant Community Dining Program pilot—a nutrition program that allows participants to attend restaurants around the District as an alternative to traditional community dining settings.
c. Research the elasticity of and legal ability to implement consumer cost-sharing requirements to DCOA's core services.
d. Conduct public outreach campaigns to receive feedback and educate District residents of consumer cost-sharing at DCOA.
e. Work with Transportation Collective and other transportation providers in the District to identify opportunities to streamline existing services and create new services.
f. Continue to monitor and amend procedures used by Medicaid Enrollment Staff (MES) to assist District older adults and people with disabilities through the Medicaid enrollment process.

Objective 4: Reduce duplication of services with other District Government and community-based providers.

Strategies**:**

a. Review older adult related services and supports administered by District Government agencies to identify areas of duplication.
b. Identify Medicaid eligible recipients who receive the same or similar services from multiple District Government agencies.
c. Work with District Government agencies to design and implement procedures that connect older adults to services in the appropriate funding source.
d. Review and amend, where appropriate, program's eligibility requirements to streamline enrollment process with similar programs and reduce overlap.

e. Perform an outreach campaign to educate District older adults of impacts of duplication and plans to improve the system.

Outcomes and Performance Measures:

1. Each Lead Agency captures 10 percent of their Ward's older adult population during the annual demographic survey.
2. Each grantees in the Senior Service Network organizes at least one focus group or community town hall by FY 2018.
3. Increase the accuracy and decrease the time needed to process grantees' monthly invoices.
4. Perform quarterly programmatic or fiscal reporting trainings for grantees in the Senior Service Network.
5. Perform quarterly meetings with Program Directors who provide similar core services.
6. Identify all programs to implement consumer cost-sharing opportunities by FY 2018.
7. Implement consumer cost-sharing procedures for appropriate programs by FY 2019.
8. By FY 2018, draft policies that will reduce occurrences of single service being paid for by multiple agencies.
9. Educate community of action plan by FY 2019.

Goal 2: Promote awareness and access to long-term care services and supports offered in the District.

Objective 1: Work closely with other District Government health and human service agencies to develop and implement strategies for a "No Wrong Door" (NWD) approach to accessing long-term care services and supports.

Strategies**:**

a. Continue to build and strengthen the NWD Leadership Council within District government.
b. Participate in monthly meetings with other agencies: Leadership Council, Person-Centered Practices Workgroup, Stakeholder Engagement Workgroup, IT Integration Workgroup, Marketing and Outreach Workgroups.
c. Develop and implement clear cross-system expectations and competency criteria for all staff involved in Person-Centered Counseling (PCC).
d. Develop and implement statewide cross-agency strategies, including cross training, for educating managers and other key staff from public and community agencies and referral sources about PCC and Person-Centered Practices.
e. Establish clear expectations to ensure the ongoing meaningful involvement of key stakeholders in the development, implementation and ongoing evaluation of the NWD system.
f. Establish performance measures across systems that measure satisfaction with interactions with the LTSS system, time from first contact to services, and collaborations and referrals between systems/referral sources.
g. Develop cross-agency process and work flows that improve coordination and integration of functions while reducing or eliminating duplication of efforts in intake, screening, eligibility determinations, application processes, case management, service authorization, and Continuous Quality Improvement (CQI).

h. Monitor project impact to assess progress, system growth and enhancement, improved experiences for people in need of LTSS and their families, and outcomes achieved over the 3 years of the project.

Objective 2: Integrate "Alzheimer's Disease Initiative" with core programs.

Strategies**:**

a. Develop sustainability model for Alzheimer's Disease Initiative programs to include cross training of DCOA's Senior Service Network and frontline community members.
b. Improve identification of and data tracking protocol for clients with Alzheimer's disease and related dementias (ADRD).
c. Develop a strategic outreach and target marketing plan to improve knowledge of DCOA as an entry point to access ADRD programs and educational resources.
d. Establish policy and grantee requirements that are inclusive of individuals with ADRD and their caregivers.

Outcomes and Performance Measures:

1. Fully implement amendments to Intake & Referral (I&R) process that identify ADRD clients and streamline program delivery by FY 2018.
2. Complete an integration and sustainability action plan for Alzheimer's Disease Initiative by FY 2018
3. Ensure DCOA participation in all NWD focus areas by attending and contributing at all monthly meetings: Leadership Council, Person-Centered Practices Workgroup, Stakeholder Engagement Workgroup, IT Integration Workgroup, Marketing and Outreach Workgroups.
4. Complete review and modification of all DCOA outreach materials to ensure they match NWD materials by FY 2018.
5. Complete development of cross system measures that evaluate client satisfaction with interactions with the LTSS system by FY 2019.

Goal 3: Promote aging in place with dignity and respect.

Objective 1: Partner with District of Columbia's Homeland Security and Emergency Management Agency (HSEMA) to review and update the District Preparedness System (DPS).

Strategies**:**

a. Research and review qualitative and quantitative data to identify critical areas of risk for District older adults and people with disabilities.
b. Work with the District Recovery Steering Committee to review and monitor the goals, objectives and targets identified in Health and Social Services and Housing Recovery Support Functions (RSFs).
c. Participate in District-wide emergency and recover workshops and trainings.
d. Review and amend, where appropriate, DCOA's Continuity of Operations Plan (COOP).
e. Work with HSEMA to educate appropriate grantees in the Senior Service Network of the emergency and recovery plans.

Objective 2: Integrate and implement initiatives outlined in the District Olmstead Plan (refer to Attachment H for copy of plan).

Strategies**:**

a. Determine methodology to evaluate housing needs for individuals who have been referred to the Aging and Disability Resource Center because they want to live in the community.
b. Increase inclusive daytime programming offerings and provide technical assistance and training to improve staff capacity at Adult Day Health providers, Senior Wellness Centers, Senior Centers, public libraries and DPR recreation centers.
c. Assess and align the capacity of transportation providers to support the transportation needs of people with disabilities.
d. Develop a discharge manual to be used by both institutional and community-based professionals.
e. Identify gaps and develop recommendations to improve the discharge process.

Objective 3: Support and promote efforts for the District to become a recognized Age-Friendly City.

Strategies**:**

a. Participate in each of the ten Age-Friendly DC domains: 1) Outdoor Space and Buildings, 2) Transportation, 3) Housing, 4) Social Participation, 5) Respect and Social Inclusion, 6) Civic Participation and Employment, 7) Communication and Information, 8) Community Support and Health Services, 9) Emergency Preparedness and Resilience, and 10) Elder Abuse, Neglect and Fraud.
b. Work with District Government agencies and community stakeholders to implement and monitor initiatives outlined in the Age-Friendly DC Strategic Plan.
c. Assist with outreach and education to inform the community of Age-Friendly DC's progress.
d. Coordinate with District residents ages 60 and above to participate in evaluation and survey opportunities for Age-Friendly DC.

Objective 4: Promote the development and sustainability of senior villages in the District.

Strategies**:**

a. Coordinate learning exchange opportunities with village leaders to share lessons and experiences in organizational development.
b. Offer technical assistance to the network of villages in the District.
c. Organize outreach and educational forums with community leaders to promote the creation of new villages, particularly in underserved communities.

Outcomes and Performance Measures:

1. Ensure DCOA representation at each of the ten Age-Friendly DC Domain Committees.
2. Receive Age-Friendly City recognition by the World Health Organization by FY 2019.
3. Conduct quarterly peer-to-peer learning opportunities for senior villages.

Goal 4: Ensure agency is driven by customer experience.

Objective 1: Develop and implement strategies to expand opportunities to offer input in agency decision-making process.

Strategies**:**

a. Organize the Senior Service Network and other community stakeholders in a Performance Management Taskforce.
b. Identify effective outreach mechanisms and data collection tools for customers to deliver feedback and responses.
c. Identify areas in decision-making process to engage customers.
d. Research and construct a qualitative survey tool for customers of OAA core services: supportive services, nutrition, health promotion, caregiver support, and elder rights services.
e. Develop protocols for delivering and collecting the qualitative survey in a statistically significant way.
f. Update and implement current Aging and Disability Resource Center annual customer satisfaction survey.

Objective 2: Implement person-centered practices that match other District Government health and human service agencies in accordance with the No Wrong Door work plan.

Strategies**:**

a. Create a District-wide Person-Centered Profile for use in all human services for youth and people with disabilities, veterans and elders with common information that can be collected by referral sources or state systems and shared to avoid duplication of effort.
b. Create one or more resource portals through which community and public referral sources, youth and adult state agency program staff, families, people with disabilities, elders and veterans can conduct a comprehensive review and identify private/community resources and informal supports in an up-to-date resource database.
c. Develop cross-system guidelines and protocols to facilitate and ensure informed choice from available options to assist in the development of a Person-Centered Plan.
d. Train trainers to develop capacity across public, private and community systems to provide Person-Centered Counseling.
e. Develop multiple approaches for training and coaching staff to ensure that Person-Centered practices are consistently employed and evaluated, redesigning processes that are not reaching desired outcomes

Outcomes and Performance Measures:

1. Complete trainings on person-centered practices for DCOA and Senior Service Network staff.
2. Complete qualitative survey tool by FY 2018.
3. Train at least four DCOA trainers and at least 35 direct service DCOA staff (Social Workers, Case Managers, Medicaid Enrollment Specialists, and Information and Referral/Assistance Specialists) in the NWD Person-Centered Counseling module by FY 2018.
4. Ensure that trained staff members receive follow-up training and evaluation of skills as prescribed by the NWD Initiative by FY 2019.

DC Office on Aging
Aging and Disability Resource Center (ADRC)
Customer Service Satisfaction Survey
Draft Report

September 30, 2016

I. Executive Summary

The District of Columbia Office on Aging (DCOA) is the designated State and Area Agency on Aging and operates the Aging and Disability Resource Center (ADRC). ADRC provides a coordinated system of information and access for individuals seeking long-term services and supports. This is accomplished through the provision of unbiased, reliable information, counseling, and service access to older adults (60 years and older), individuals with disabilities (18 to 59 years old), and their caregivers. ADRC facilitates the acquisition of services individualized to the unique needs and desires expressed by each person. It funds the Senior Service Network, a network of providers consisting of more than 20 community-based non-profit organizations operating programs that provide a wide range of social and health services throughout the eight wards of the District.

In September 2015, DCOA released the results of its first customer satisfaction survey which gathered input from customers about a wide range of issues that influence customer satisfaction. In September of 2016, ADRC retained Hales Creative Solutions and Isabel Friedenzohn (Contractors) to administer the survey to assess perceived customer satisfaction, and to identify ongoing service gaps. This report uses the previous year's results as a baseline for comparison. The research focused on five of ADRC's direct services:

- Information and Referral/Assistance (I&R/A)
- Community Social Work
- Community Transition
- Elderly and Persons with Physical Disabilities (EPD) Waiver Program Enrollment
- Adult Day Health Program Enrollment

The Contractors conducted 168 telephone interviews in September 2016, to collect data from two groups of people who received assistance from ADRC within the last six months: (1) adults 60 years of age and older, and (2) individuals with disabilities who are 18 years of age and older. Of the 168 participants, 102 (61 percent) were adults 60 years of age and older and 66 (39 percent) were individuals with disabilities, ages 18-59. The research objectives were designed to address the following areas:

- Perceptions of and experiences with key ADRC programs and services
- Experience with ADRC staff
- Reactions to the process that connects individuals to services
- Ease or difficulty in accessing ADRC programs and services
- Perceived gaps in current programs and services

Using telephone interviews allowed people to respond in their own words and encouraged detailed and in-depth answers. A semi-structured interview guide directed the discussion, while allowing for participants to provide more detailed information about their experience. Most of the questions used a five-point scale: agree, strongly agree, disagree, strongly disagree and don't know/can't remember.

The contractors recruited participants from a 2,284-person list provided by ADRC. All respondents had received at least one ADRC service within the last six months. In some cases, individuals chose not to participate.

Summary of Key Findings

This section summarizes responses and identifies key findings and highlights from all participants.

- **Consideration of Opinions.** Eighty-one percent agreed or strongly agreed that ADRC staff considered their preferences before recommending services (67 percent in 2015).

- **Overall Satisfaction with Response Time.** Seventy-five percent of the participants "agreed" or "strongly agreed" that ADRC staff were responsive to their request (73 percent in 2015).

- **Satisfaction with Initial Information Received.** Seventy-eight percent agreed or strongly agreed that ADRC provided the correct information the first time they called (71 percent in 2015)**.** In contrast, only 7 percent either disagreed or strongly disagreed (19 percent in 2015).

- **Staff Knowledge and Interpersonal Skills.** Participants provided the most favorable ratings when describing their communication with staff. In particular, 84 percent (81 in 2015) agreed that ADRC staff was both knowledgeable and helpful. This climbed to 90 percent (89 percent in 2015) when asked if they were treated with respect and courtesy. Seventy-five percent found staff attentive when discussing their needs (compared to 84 percent in 2015).

- **Reasons for Contacting ADRC**. The three most common reasons for contacting ADRC were the need for in-home care (33 percent) and transportation and housing assistance (both 18 percent).

- **Sources of Referrals to ADRC.** When asked about the source of referral to ADRC – including social workers/case managers, family, social service agencies, health care providers, and the media, the most selected response (30 percent) was 'other sources'. Health care providers (17 percent) and media (16 percent) also significantly contributed to referrals. Lastly, social workers/case managers (8 percent), family (8 percent), and social service agencies (9 percent) were the least likely reported groups to provide referrals to ADRC. Participants in the 2015 survey were referred at a higher rate by Social Service Agencies (20 percent) and far less by health care providers (5 percent).

- **Person Requiring Assistance.** The majority of participants (67 percent) contacted ADRC to obtain services for themselves (73 percent in 2015). Twenty-one percent were calling for a family member (8 percent in 2015) closely followed by 6 percent of calls to obtain services for a parent/grandparent (12 percent in 2015), or a family member (8 percent). Only 4 percent contacted ADRC to request services for a child (2 percent in 2015).

In presenting the findings, we've organized this report into three sections following the Executive Summary:

- Statement of the Problem and Study Methodology
- Findings
- Conclusions

II. Statement of the Problem and Study Methodology

In September of 2016, ADRC retained Hales Creative Solutions and Isabel Friedenzohn (Contractors) to administer a customer satisfaction survey used the previous year. The purpose of the survey is to gather input from customers about a wide range of issues that influence customer satisfaction and to determine the perceived gaps in existing services.

Campbell & Company DC (CCDC), a different contractor, developed and administered the 2015 survey tool. In 2016, while DCOA used the 2015 survey tool as a starting point, some revisions were made as a result of programmatic changes in the agency. Questions regarding the Hospital Discharge Planning Program and the Senior Employment Program were removed as DCOA no discontinued the former, and the latter moved to the Department of Employment Services. Two new programs were added to the survey: Elderly and Persons with Physical Disabilities (EPD) Waiver Enrollment, and Adult Day Health Enrollment (ADHP). ADRC worked collaboratively with the Department of Health Care Finance (DHCF) throughout FY16 to develop and implement the two new programs, and the survey provided an opportunity to help measure the success of the implementation.

The research focused on five of ADRC's direct services:

- Information and Referral/Assistance
- Community Social Work
- Community Transition
- Elderly and Persons with Physical Disabilities (EPD) Waiver Program Enrollment
- Adult Day Health Program Enrollment (ADHP)

The Elderly and Persons with Physical Disabilities (EPD) Waiver Program helps seniors and adults with disabilities to live in their own home or community instead of a nursing home by using Medicaid funds to receive home and community based services and supports. The EPD Waiver population that was surveyed was divided between those that were in the process of enrollment in the EPD Waiver, and those that already had been enrolled. The two groups were analyzed separately. The EPD Waiver Group 1 represents those that are in the pre-enrollment phase, and the EPD Waiver Group 2 includes those that are already enrolled in the Waiver.

The contractors conducted 168 telephone interviews in September 2016, to collect data from two groups of people who received assistance from ADRC within the last six months: (1) adults 60 years of age and older, and (2) people with disabilities who are 18 years of age and older. Of the 168 participants, 102 (61 percent) were adults 60 years of age and older and 62 (31 percent) were individuals with disabilities, ages 18-59. The research objectives were designed to address the following areas:

- Perceptions of and experiences with key ADRC programs and services
- Experience with ADRC staff

- Reactions to the process that connects individuals to services
- Ease or difficulty in accessing ADRC programs and services
- Perceived gaps in current programs and services

The results of the 2015 survey created a necessary baseline from which to compare the results of the 2016 survey as well as future customer satisfaction surveys administered by DCOA. Insights garnered from the 2015 survey provided an important opportunity to inform ADRC's programmatic offerings as well as their outreach and communications efforts. Now with results of the 2016 survey, the DCOA can assess how changes implemented based on the 2015 survey have made an impact.

A. Data Collection

Using telephone interviews allowed people to respond in their own words and encouraged detailed and in-depth answers. An interview guide directed the discussion, while allowing for participants to expound on topics. Most of the questions used a five-point scale: agree, strongly agree, disagree, strongly disagree, and don't know/can't remember. The survey also included three open-ended questions that asked how the respondents learned about ADRC; their recommendations for improving services; and whether there are services respondents would like ADRC would provide. To ensure that the five direct services listed above were adequately addressed, the guide included sections dedicated to each topic area. The average interview was between 20 and 30 minutes long.

B. Participant Recruitment

The contractors recruited participants from a 2,284 person list provided by ADRC. In some cases, individuals chose not to participate.

C. Qualitative Research and Sample Size

While this research is qualitative in nature, and does not aim to produce a statistically representative sample or draw statistical inference, it can contribute to an improved understanding of perceptions of and experiences with ADRC's programs and services. DCOA believes that a sample size of 168 participants is adequate to fulfil this purpose.

III. FINDINGS

3.1 Summary of Key Findings and Highlights from All Participants

Interview feedback provided an important foundation for informing ADRC's programmatic offerings as well as their outreach and communications efforts.

The first section summarizes responses and identifies key findings and highlights from all 168 participants.

Overall Satisfaction with ADRC. Compared to 2015, 2016 results indicate a significant improvement in overall satisfaction by clients with 78 percent agreeing that they were satisfied with the services they received through ADRC, compared with 60 percent in 2015. The results were consistent with responses of those seeking services for community social work (77 percent) and as well as those in the EPD Waiver Group 2 (76 percent). The rest of the programs still received fairly high satisfaction rates - Information and Referral (68 percent), Community Transition (64 percent), EPD Waiver Group 1 (63 percent) and Adult Day Health Program enrollment (70 percent). All program-specific satisfaction rates have increased since last year.

Figure 1: Participant satisfaction rates with services received for all programs

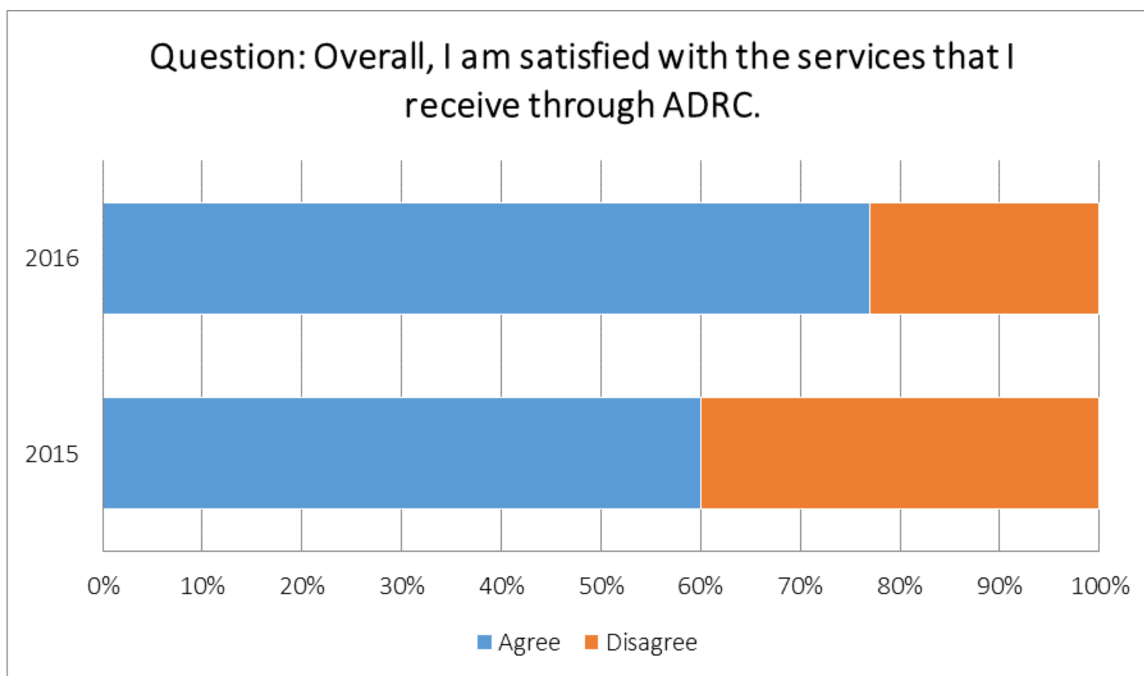
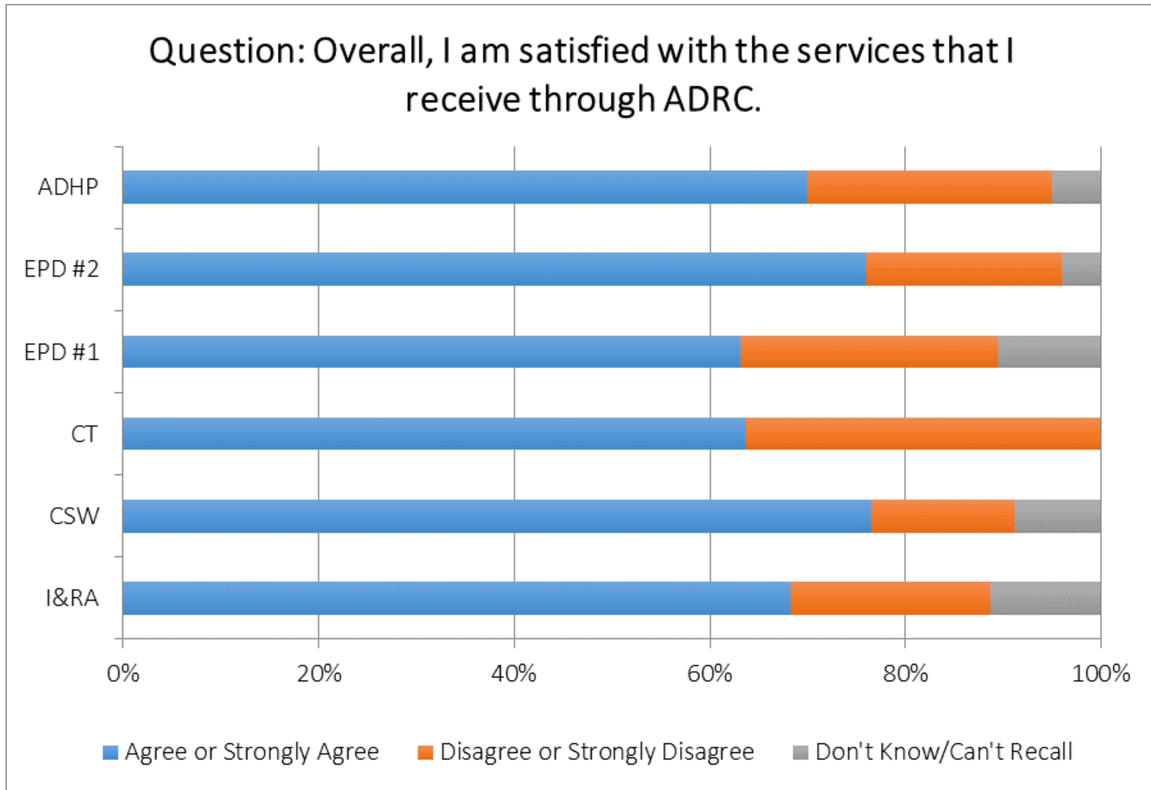


Figure 2: Satisfaction rates by program



Likelihood to Recommend ADRC to Others. The 2016 survey showed that an even larger majority (82 percent) would recommend ADRC compared to 2015 (77 percent). Additionally, when looking at each program specifically, participants receiving services from the Community Social Work and the EPD Waiver Group 2 programs reported the highest likelihood of recommending ADRC (89 percent and 84 percent, respectively). Still, a majority of those who sought services from Information and Referral (76 percent), Community Transition (73 percent), and EDP Waiver Group 1 (77 percent) would recommend ADRC to others. Although, those needing Adult Day Care Enrollment were slightly less likely to recommend (64 percent).

Figure 3: Likelihood of recommending ADRC to others for all participants

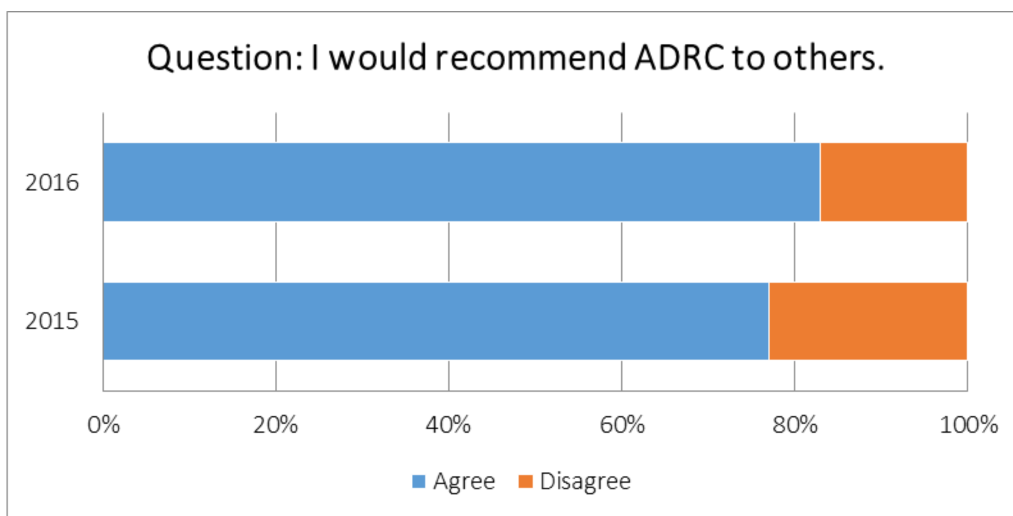
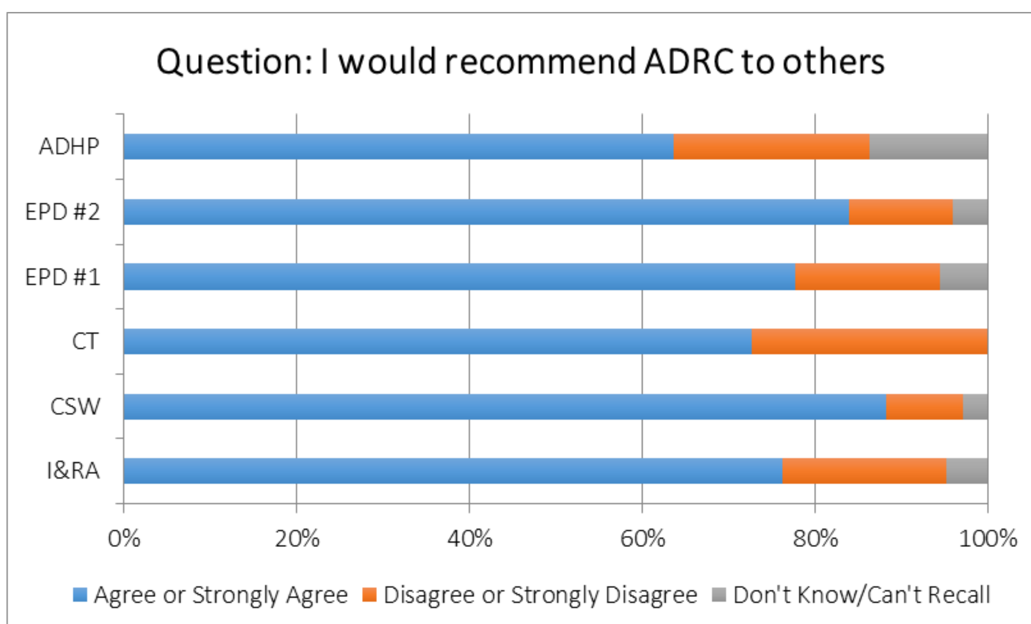
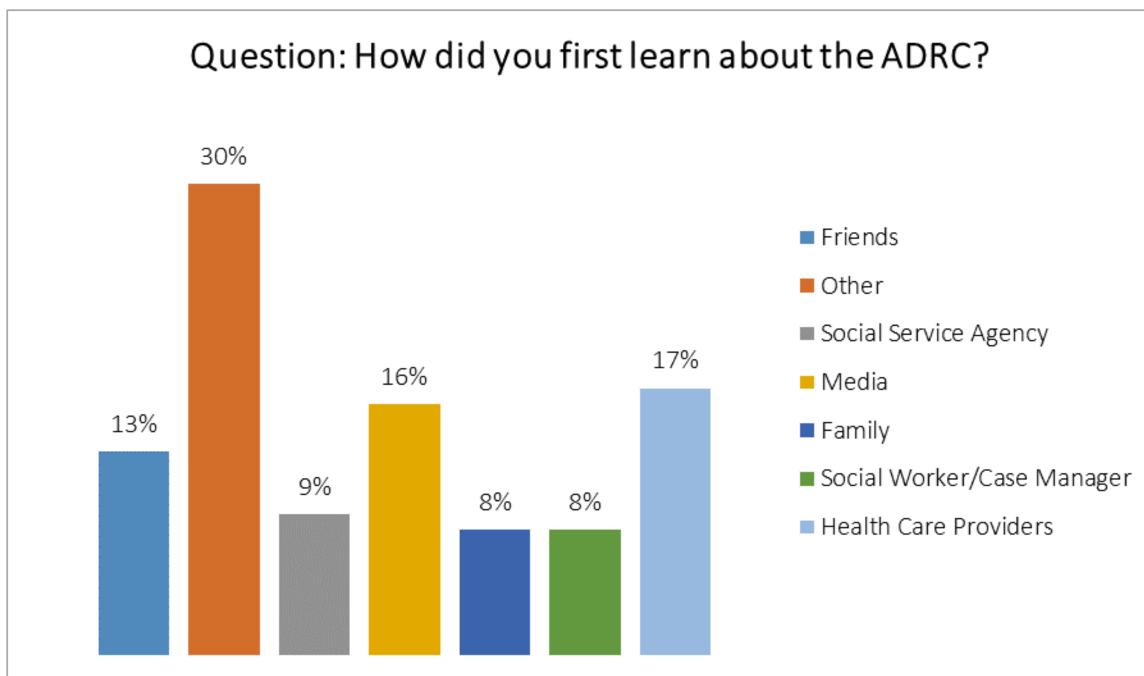


Figure 4: Likelihood of recommending ADRC to others by program



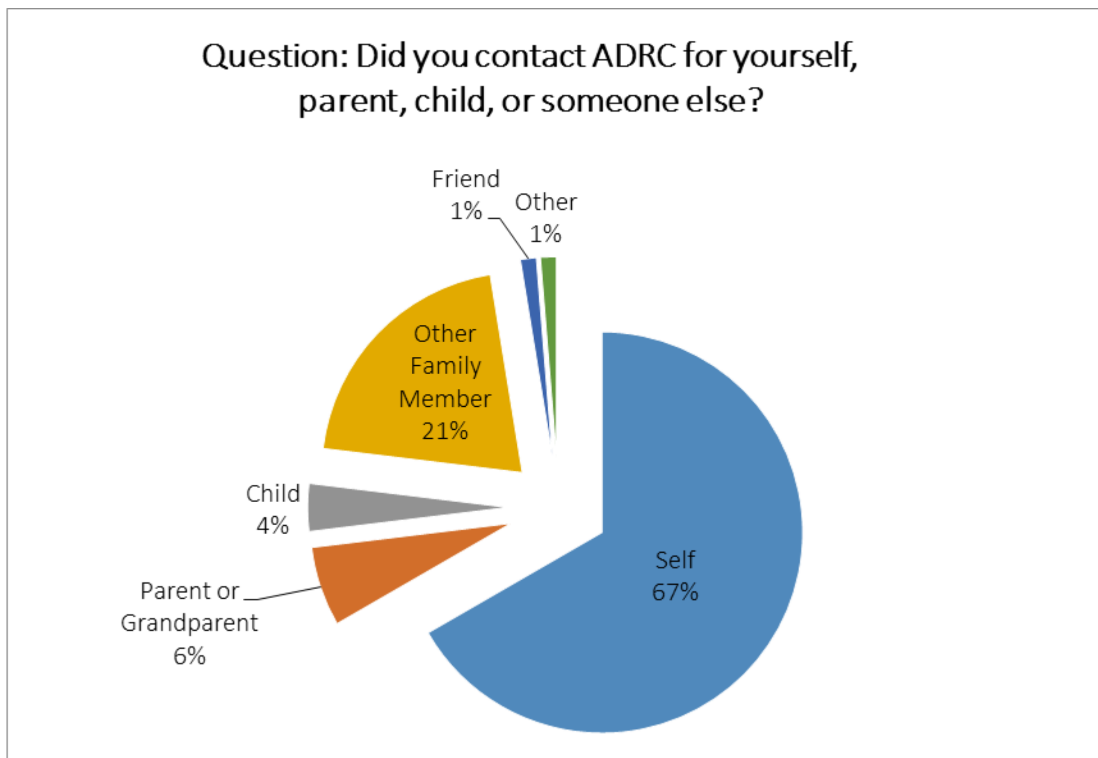
Sources of Referrals to ADRC. When asked regarding the source of referral to ADRC – including social workers/case managers, family, social service agencies, health care providers, and the media, the most selected response (30 percent) was 'other sources'. Health care providers (17 percent) and media (16 percent) also significantly contributed to referrals. Lastly, social workers/case managers, family, and social service agencies were the least likely reported groups to provide referrals to ADRC. The results below show a different picture compared to the 2015 results. Participants in the 2015 survey indicated that Social Service Agencies had referred more frequently (20 percent) and health care providers less frequently (5 percent). This difference may be accounted for by the differences in how participants answered the questions and how information on 'other' was received/perceived.

Figure 5: Initial referral source for ADRC



Person Requiring Assistance. Overall, there was a slight increase from 2015 to 2016 on the proportion of participants who contacted ADRC to obtain services for themselves (73 percent in 2015; 67 percent in 2016). Of note, the percentage of participants that indicated that they were contacting ADRC for a family member that was not a parent, grandparent or child, rose significantly in 2016 (21 percent) compared to 8 percent in 2015. Only 4 percent contacted ADRC to request services for a child in 2016.

Figure 6: Relationship of the person referring, to the person referred



Overall Satisfaction with Response Time. Seventy-five percent of the respondents agreed or strongly agreed that ADRC staff were responsive to their request (compared to 73 percent in 2015). Seventeen percent disagreed or strongly disagreed (compared to 23 percent in 2015). Eight percent didn't know or couldn't recall (compared to 4 percent in 2015).

Figure 7: Satisfaction with response time for all respondents

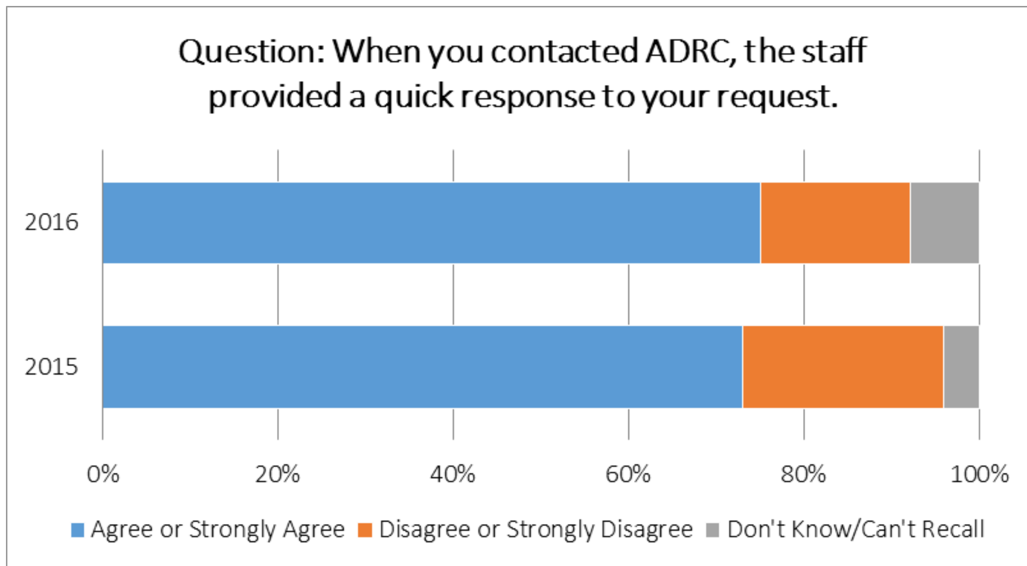
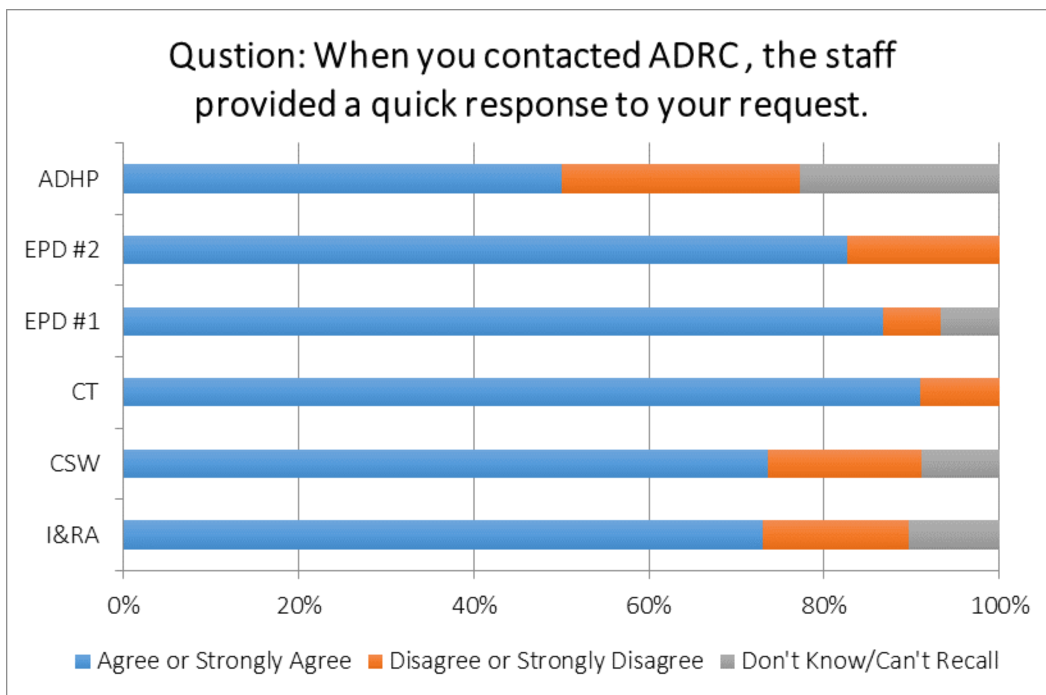


Figure 8: Satisfaction with response time by program



Satisfaction with Initial Information Received. Seventy-eight percent agreed or strongly agreed that ADRC provided the correct information the first time they called (compared to 71 percent in 2015). In contrast, 10 percent either disagreed or strongly disagreed (compared to 19 in 2015).

Figure 9: Satisfaction with information received during initial ADRC contact for all participants

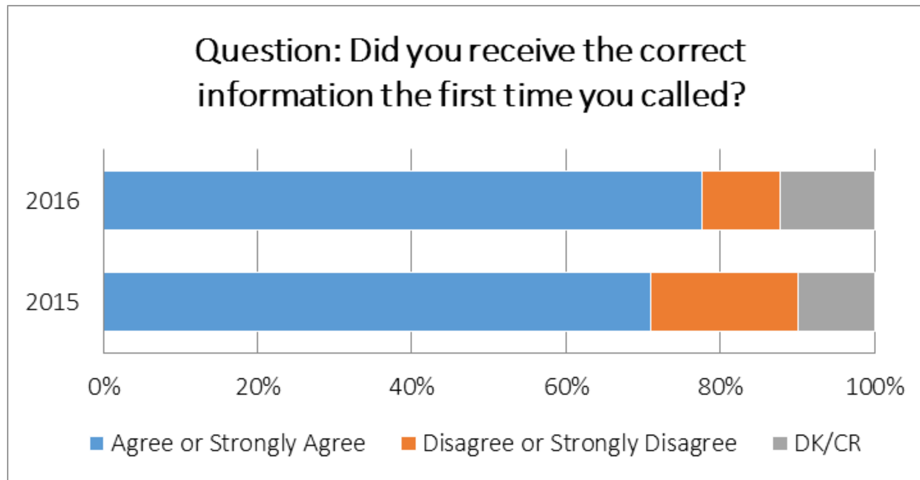


Figure 10: Satisfaction with information received during initial ADRC contact by program

Staff Knowledge and Interpersonal Skills. Over the past two years, survey participants provided very consistent and favorable ratings concerning staff knowledge and communication skills. Eighty-three percent of responses agreed that ADRC staff was both knowledgeable and helpful (compared to 81 percent in 2015). A majority, 91 percent, agreed that they were treated with respect and courtesy (compared to 89 percent in 2015). On the issue of staff attentiveness when discussing their needs, there was a dip in positive responses by 2016 participants with only 75 percent agreeing, compared to 84 percent in 2015.

Figure 11: Staff knowledge and interpersonal skills for all participants

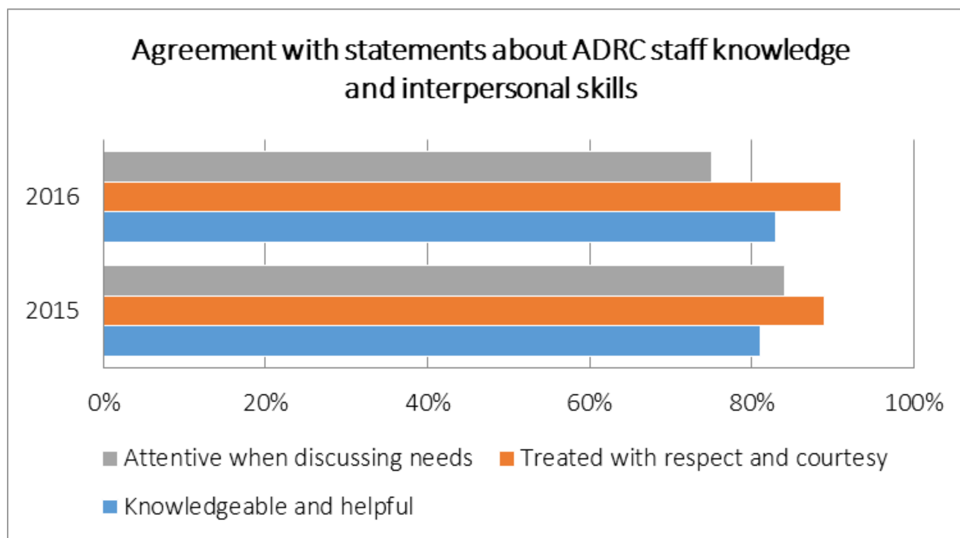
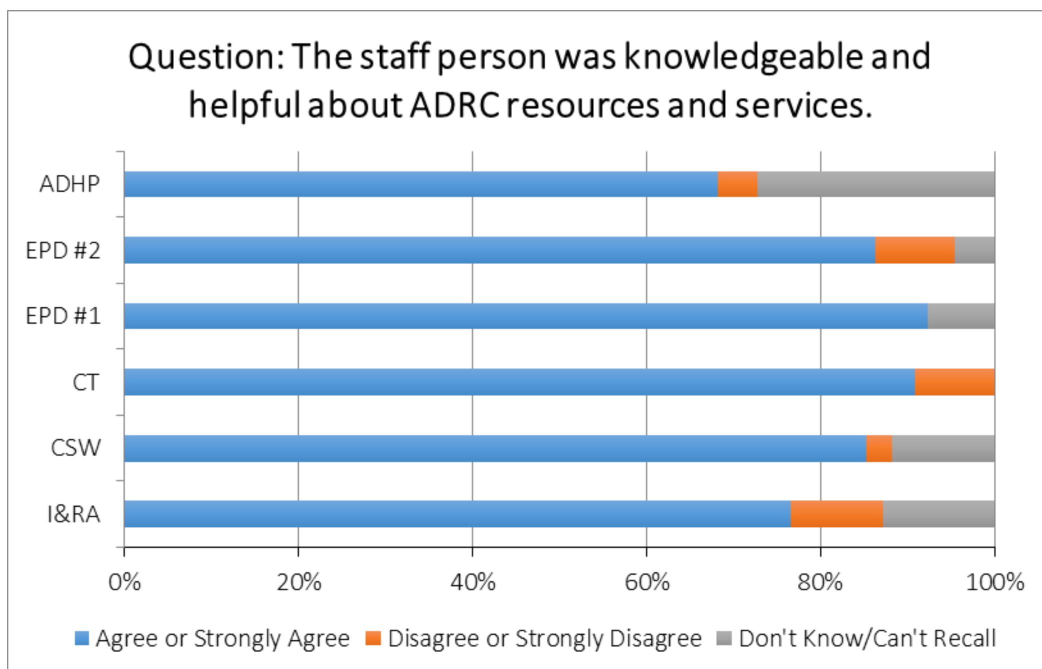


Figure 12: Staff knowledge and helpfulness by program



Consideration of Opinions. The 2016 survey results indicate remarkable improvements in the area of ADRC staff's consideration of clients' opinions. Eighty one percent agreed or strongly agreed that ADRC staff considered their preferences before recommending services (compared to 67 percent in 2015). Six (6) percent disagreed or strongly disagreed (compared to 21 percent in 2015). Individuals in the EPD Waiver Group 1 indicated the lowest level of agreement (60 percent) on the issue of whether their opinions were considered. ADRC expects to investigate the low level of agreement in FY17.

Figure 13: Consideration of opinions, likes, and dislikes for all respondents

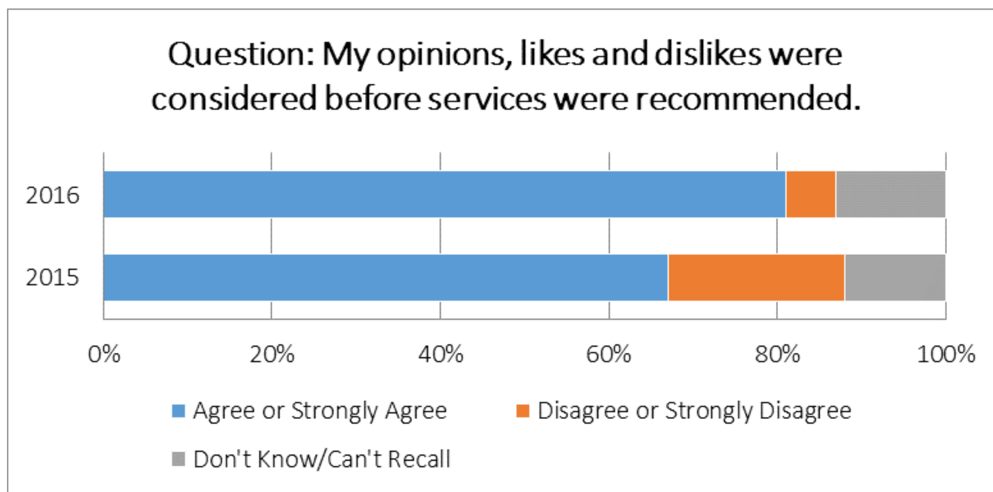
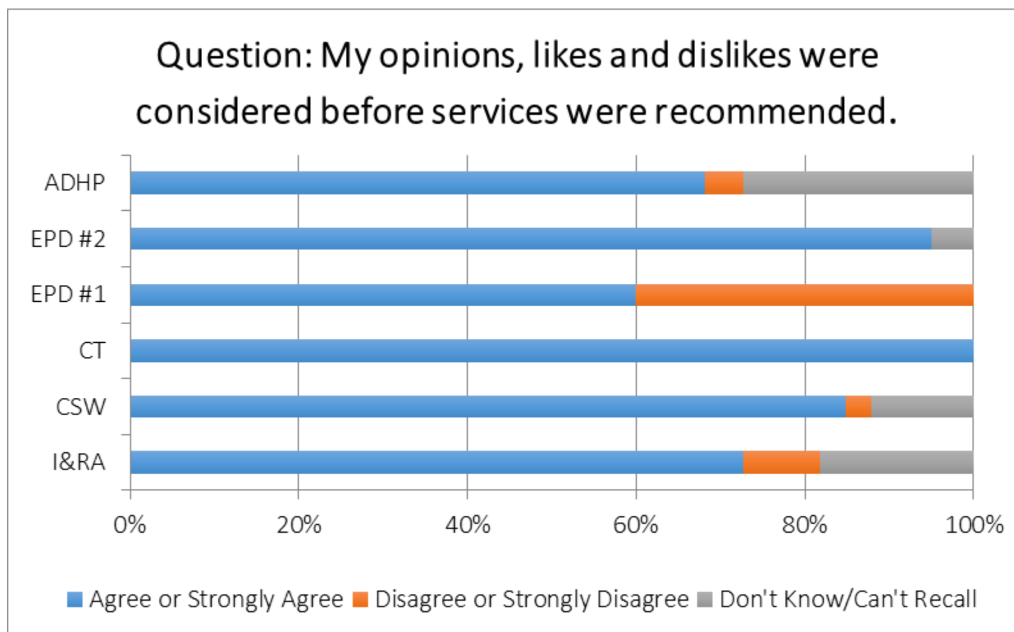
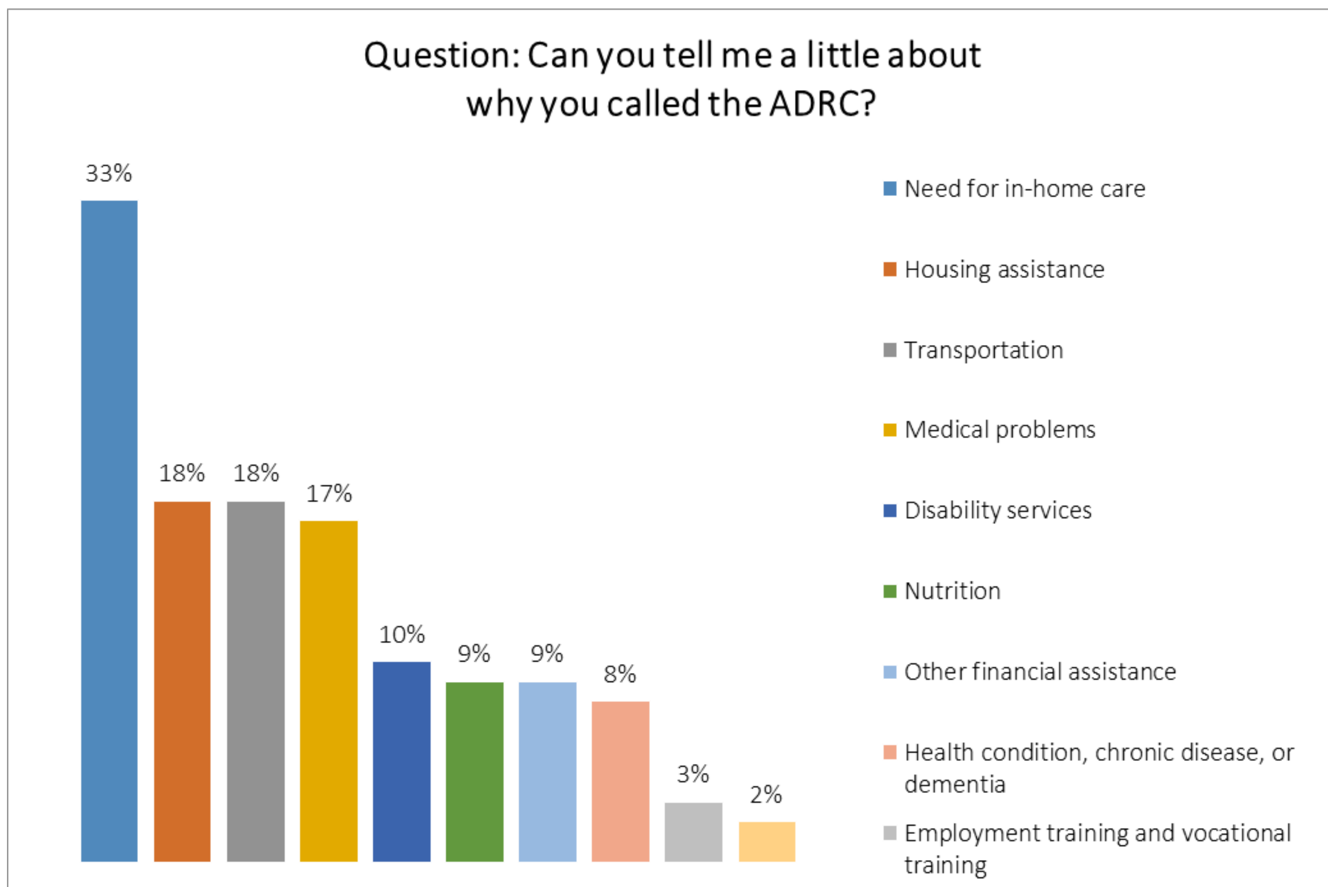


Figure 14: Consideration of opinions, likes, and dislikes by program



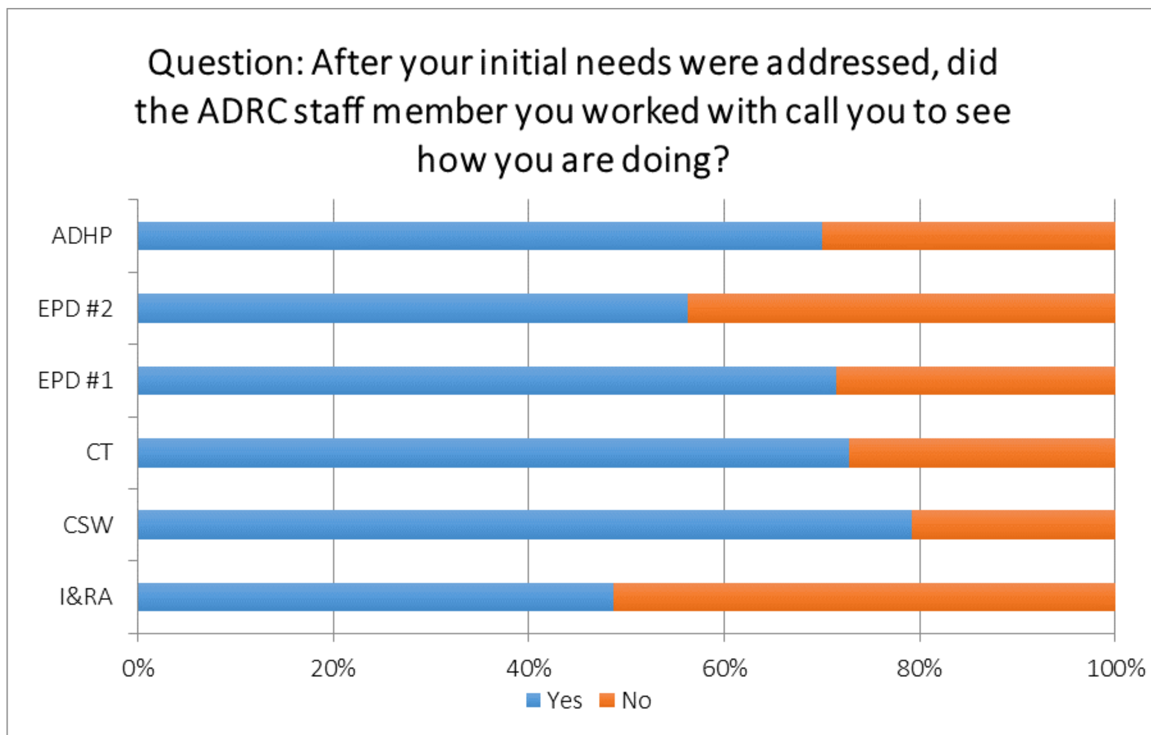
Reasons for Contacting ADRC. In 2016, the question regarding the reason for contacting ADRC was administered differently than the previous year. In 2015, participants could only indicate one reason, while in 2016 participants could indicate several reasons. Consequently, the results are not directly comparable to the previous year. The most common reason for calling ADRC was the need for in-home care (33 percent) followed by both transportation (18 percent) and Housing Assistance (18 percent). Seventeen percent of participants also indicated that Medical problems were a cause for contacting ADRC. Of note, in 2015, 'employment, training, and vocational training' was included as a response option and represented the second highest reason for calling. ADRC's programmatic shift to no longer house Employment Specialists (they moved to Department of Employment Services) partially accounts for the shift to other areas of need.

Figure 15: Reason for Contacting ADRC for all participants



Received a Follow-up call from ADRC. In 2016, ADRC showed a dramatic improvement in their focus on follow-up with their clients. Sixty-three percent of survey participants said they did receive a follow-up call from ADRC after the initial needs were addressed (compared to 37 percent in 2015). Of note, the 2015 results indicated that 86 percent of those seeking employment services and training said they did not receive a follow-up call. A comparison with the 2015 data suggests that removal of employment services from DCOA's service option may account for the overall improvement on follow-up. Despite positive improvements overall, when drilling down to specific programs, individuals in the EPD Waiver (Group 2) and the Information and Referral/Assistance programs reported the lowest follow-up rates (56 percent and 48 percent, respectively). This feedback suggests that more work remains to be done to clarify expectations, and implement procedures regarding follow-up activities.

Figure 16: Follow-up activities by program



3.2 <u>Program-Specific Feedback</u>

A. Information and Referral Assistance

Clients receiving help from the Information and Referral/Assistance program indicated general satisfaction with the services. They agreed or strongly agreed that that ADRC staff took time to listen to their concerns (92 percent). Eighty-one percent felt as though their preferences were discussed and respected. The numbers dipped in relation to whether the staff helped clients understand the options available to them (71 percent) and whether the staff connected clients to the services that they needed (76 percent). Sixty-five percent of the survey participants indicated that staff identified other types of help that they might need. All of those individuals agreed that they had additional needs.

B. Community Social Work

The survey participants that received support from the Community Social Work program also indicated general satisfaction with ADRC staff. Seventy-seven percent agreed or strongly agreed that their preferences were taken in to account. Seventy-six percent agreed or strongly agreed that the staff helped them understand the options that were available to them and that ADRC staff took time to listen to their concerns. Seventy-three percent agreed or strongly agreed that ADRC staff helped them to connect to services needed. Only 63 percent found that it was easy to access services once they were connected. Sixty-two percent indicated that staff identified other types of help that they may need.

C. Community Transition

Clients receiving services through the Community Transition program rated ADRC staff high on interpersonal skills. Taking in to account that this was a small group of 11 individuals, 100 percent found that the staff took time to listen to their concerns. Ninety percent agreed or strongly agreed that their preferences and choices were respected. A majority (80 percent) agreed that the staff helped connect them to the services they needed and 90 percent found it was very easy to access the services. In relation to discharge, 78 percent thought the staff helped them understand the options for getting care after discharge. The same percentage of individuals (78 percent) was satisfied with the follow-up that they received after discharge. Staff identified other types of help that clients might need in 70 percent of those surveyed. All agreed that they did have additional needs.

D. Elderly and Persons with Physical Disabilities (EPD) Waiver Enrollment Program

The Elderly and Persons with Physical Disabilities (EPD) Waiver Program helps seniors and adults with disabilities to live in their own home or community, instead of a nursing home. The EPD Waiver population surveyed was divided between those that were in the process of enrollment and those that already had been enrolled. The EPD Waiver Group 1 represents

those that are still in the pre-enrollment phase, and the EPD Waiver Group 2 includes those that have already been enrolled in the Waiver.

E. EPD Waiver Group 1 (Pre-Enrollment)

The EPD Waiver Group 1 provided high ratings overall regarding ADRC assistance. All respondents in the group found that staff to be very attentive and helpful in terms of understanding the options available to them. Ninety percent agreed that the staff helped them to connect to the services they needed. As has been seen consistently in the responses, there was dip in satisfaction (77 percent) when participants were asked if it was easy to access services.

Only 35 percent of respondents knew who their Medicaid Enrollment Specialist (MES) was (could identify them by name without prompting); however, 100 percent felt as though their questions were answered by the MES. While 59 percent believed it was easy to stay in touch with their MES, 100 percent agreed that the MES explained the steps of the EPD Waiver enrollment process.

Twenty six percent of respondents found that they were contacted by an EPD Waiver case manager in a timely manner.

F. EPD Waiver Group 2 (Enrolled)

The EPD Waiver Group 2 also provided high rankings on their experience with ADRC staff. Ninety two percent of respondents found ADRC staff to be very helpful in understanding the options that were available to them; ninety-six percent agreed that the staff took time to listen to their concerns; and 100% believed that their preferences and choices were discussed and respected. Seventy-six percent of respondents reported that staff helped connect them to the services they needed; and 92 percent indicated that it was easy to access the services once they were connected.

Group 2 had a far higher rate (76 percent) of identifying their MES (could identify them by name without prompting), compared to 35 percent of respondents in EPD Waiver Group 1 (above). Likewise, 96 percent agreed that their answers were answered and 100 percent agreed that the MES explained the steps of the EPD Waiver enrollment process. Eighty -our percent agreed that it was easy to stay in touch with their MES.

Results show declining satisfaction once the process moved to the EPD Waiver case manager. Only 51 percent of respondents agreed that they were contacted by their EPD Waiver case manager in a timely manner and 74 percent felt that their case manager really listened to their needs. Additionally, 53 percent found that they received their assessment for personal care assistance from the Delmarva nurse in a timely manner and 45 percent agreed that they received their personal care assistance services in a timely manner.

Results indicated an increase in satisfaction in relation to respondents ability to contact their case manager (80 percent) when necessary as well as contact their personal care assistance provider when necessary (67 percent).

G. Adult Day Health Program

Respondents that have accessed the Adult Day Health program were generally satisfied with their experience. Eighty percent agreed or strongly agreed that staff helped them to understand the options that were available, that they took time to listen to their concerns, and their preferences were respected. As has been reported in other programs, there were fewer individuals (70 percent) that believed that staff helped to connect them to the services needed. Likewise, only 68 percent of respondents thought that it was easy to access the services. Staff identified other types of help for 60 percent of those surveyed and 83 percent agreed that they did have additional needs.

3.3 Qualitative Feedback from Clients (answers to several open-ended questions)

A. Recommendations for Improving Services

There were a variety of recommendations offered by clients as a way to improve upon ADRC's current services. The most prominent and recurring recommendations related to communication and timeliness. Respondents indicated that there is a need to improve overall communication and follow-up with clients. Likewise, improvements in communication regarding program changes and also transitions with care providers are necessary. Generally, respondents commented that the overall process and response time has to be quicker and streamlined so it is less overwhelming. Respondents noted that there should be broader criteria for people who can receive assistance, particularly with regards to income. Others commented on the need for more ADRC staff – with more experience – to provide assistance. Finally, one participant commented on the need for transportation to and from programs.

B. Additional Community Services and Supports

When asked about whether there were any additional community services and supports that respondents would like ADRC to provide, respondents indicated they needed more help for non-seniors, greater availability of social workers, increase in accessible apartment availability, providing clothing, and providing money for medication.

C. ADRC's Strengths

When respondents were asked about the one thing they think ADRC does very well, the most prominent response was in relation to the availability of programs and outreach. Below are other responses:

- *Everything!*
- *Disseminating information, especially on home visits*
- *Timely response*
- *Overall customer service and treatment*
- *Being connected with the right programs*
- *Home health aides are very good*
- *Social worker is very understanding*
- *Help with housing*
- *Knowledge about programs*
- *Communication*
- *Keeping promises*
- *Persuasive*
- *Sponsors transportation*
- *Ability to call in about services without visiting office*
- *Overall customer service and treatment*
- *Disseminating information, especially on home visits*
- *Home health aides are very good*
- *Great follow-up*
- *Ensure bills are paid on time*
- *Time and patience with explaining process*
- *Provide assistance in every facet of life*
- *Connect to proper organizations*
- *Made process simple*

Several respondents indicated how happy they are with ADRC's support:
The service is the best in the world and I am so very grateful.

My case manager and rep from DCOA are doing a great job of helping.

I really like and appreciate Ms. Butler who is on top of everything and does a very good job.

3.4 Further Analysis of Population Subgroups (response comparison by ward; Older Adults, ages 60 and over; and people with disabilities, ages 18 – 59)

A. Ward-by-Ward Comparisons

One hundred thirteen (113) of the 162 survey participants had their ward information specified. The majority of respondents in all the Wards said they were satisfied overall with services received through ADRC. The results remained consistent in all the Wards whether respondents

would recommend ADRC to others. Ward 2 (n=7) was the only Ward that indicated less satisfaction (34 percent) and less willingness to recommend ADRC to others (50 percent).

Regarding follow up from ADRC staff after initial assistance was provided, survey respondents indicated that many did not receive a follow-up call. All of the survey participants from Ward 2 said there was no follow up; while 75 percent from Ward 1 also did not receive a call. Residents from Ward 4, 6, 7 had the largest proportion of full up calls (73 percent, 88 percent, and 75 percent, respectively). Likewise 67 percent in Ward 3 and 64 percent in Ward 8 received a call back.

Figure 17: Satisfaction with ADRC services by ward

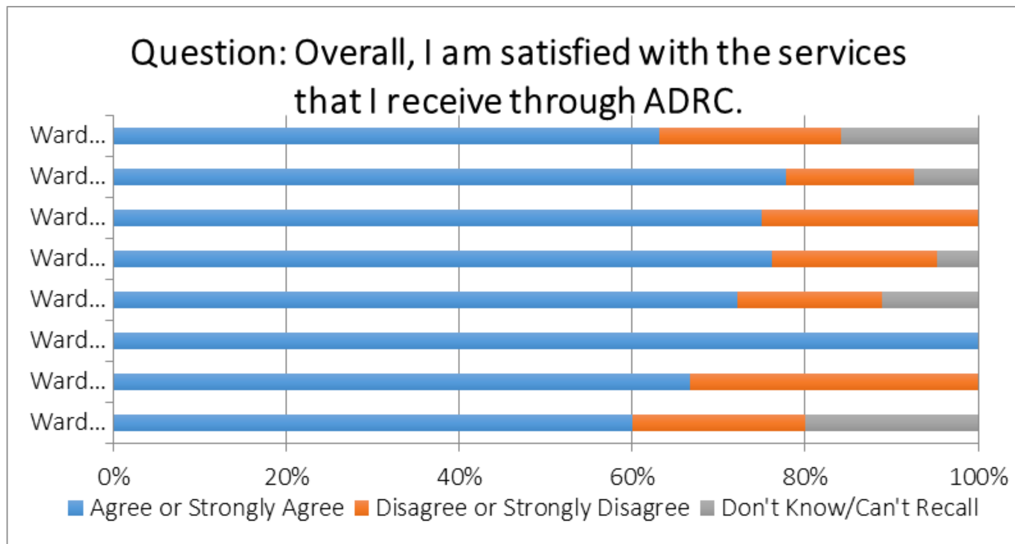


Figure 18: Rate of willingness to recommend ADRC to others by ward

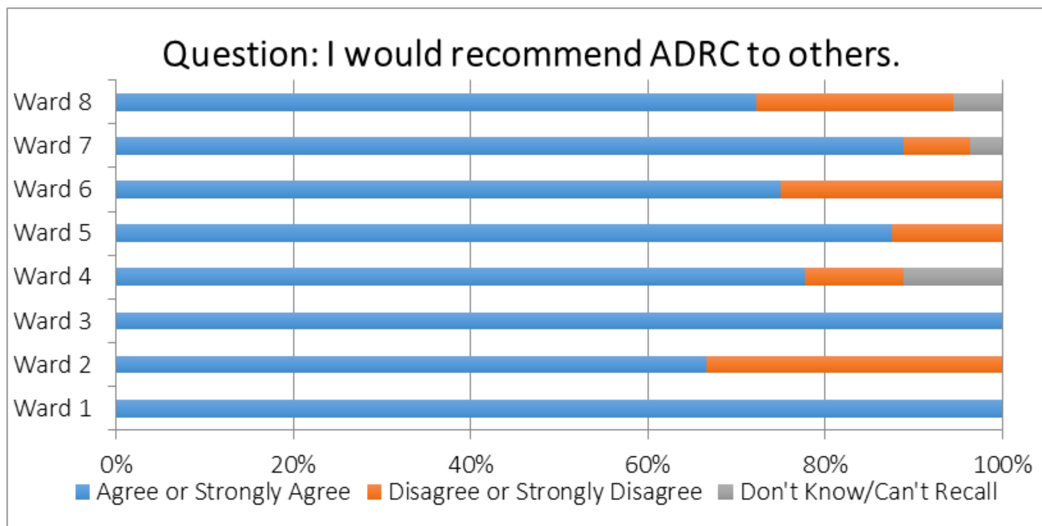


Figure 19: Satisfaction with follow up of ADRC staff by ward

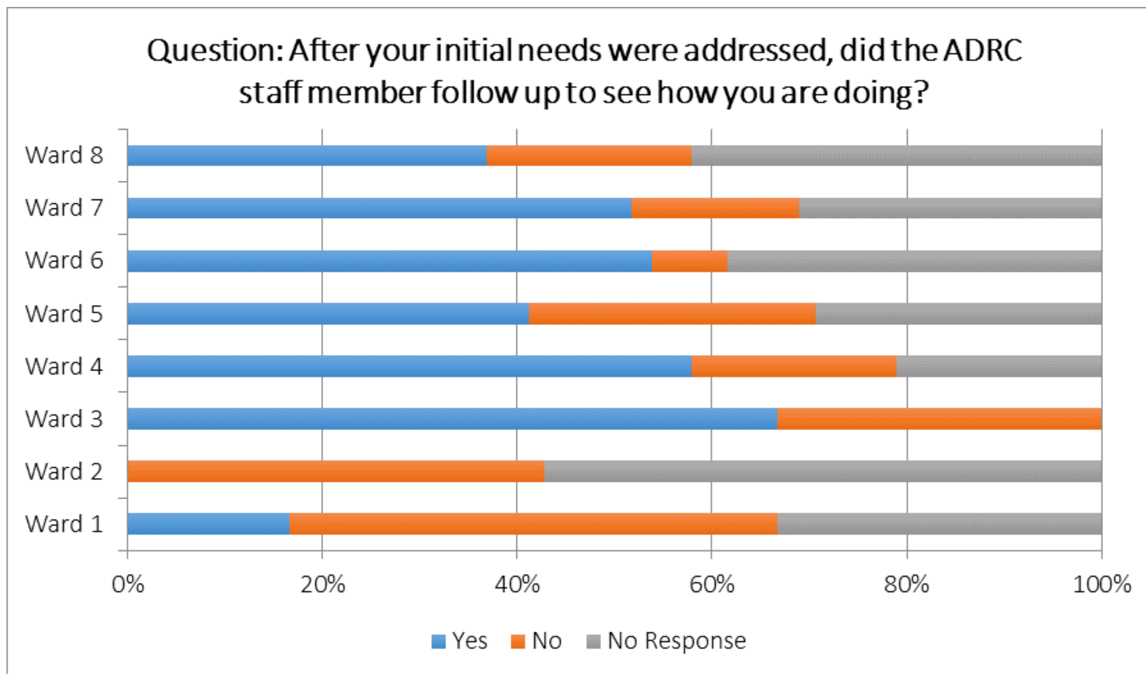
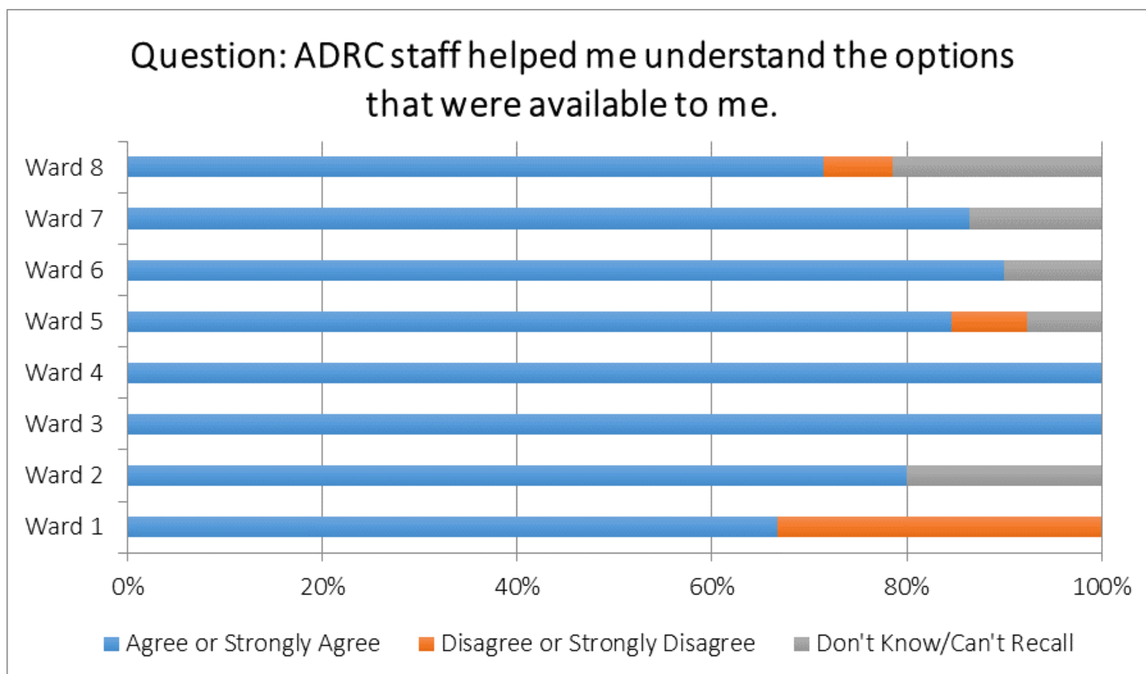


Figure 20: Satisfaction with assistance understanding available options by ward



B. Older Adults

This section reflects the opinions of the older adults, 60 years of age and older, that participated in the survey. Of this cohort, 22 percent were male, 78 percent were female with ages ranging from 60 to 98. The majority of the participants were seeking services that fall under Information and referral/assistance (n=22), community social work (n=20), and EPD Waiver Group 1 (n=20). This was followed by Adult Day Health Enrollment (n=16) and EPD Waiver Group 2 (n=14). The fewest respondents requested services with community transitions (n=10). Within the group of older adults, there was representation across all eight wards.

A. Information and Referral Assistance

Within the population of older adults surveyed, respondents primarily learned about ADRC from word of mouth.

Sixty-Eight percent of respondents who accessed ADRC's Information and Referral/Assistance service requested assistance for themselves, and 21 percent called for a family member. This number shrank to 11 percent when calling on behalf of a parent/grandparent.

When asking participants about their interaction with ADRC staff, 84 percent agreed or strongly agreed that "staff provided a quick response" (compared to 78 percent in 2015). Eighty nine percent of participants also found that ADRC staff provided the correct information during the initial call (compared to 68 percent in 2015).

Participants rated ADRC staff high on interpersonal skills. Seventy eight percent find staff to be knowledgeable and helpful (80 percent in 2015); 94 percent agreed that they were treated with respect and courtesy (86 percent in 2015), and 94 percent said that ADRC staff were attentive (84 percent in 2015). There was a slight drop when respondents were asked if their preferences were considered before services were recommended. In this instance, 75 percent felt that their wishes were considered (74 percent in 2015).

B. Community Social Work

When asked if ADRC staff explained available options, 79 percent (61 percent in 2015) of those seeking help with Community Social Work said yes, agreeing or strongly agreeing. Among this group, 79 percent of participants believe that ADRC staff listened to their concerns (77 percent in 2015).

This year's survey results show a marked improvement in relation to whether ADRC connected participants to needed services. Sixty nine percent of respondents said that ADRC connected them to requested services (40 percent 2015). Likewise, 68 percent agreed that they easily accessed services (28 percent in 2015).

While 74 percent of participants said that the staff did identify other types of help that they may need, there were insufficient responses on whether they agreed that they had additional needs.

C. Community Transition

Older participants in the community transition program overwhelmingly reacted positively when asked if staff paid attention to their concerns (90 percent; compared to86 percent in 2015), connected them to desired services (80 percent; 86 percent in 2015), and 90 percent agreed that their preferences were discussed and respected. Sixty percent of respondents felt that staff clearly explained potential options (29 percent in 2015). And 90 percent agreed or strongly agreed that, once services were identified, they were easy to access (67 percent in 2015). Only 67 percent were satisfied with the follow-up contact from the Community Transition Team (80 percent in 2015).

Staff identified additional needs for 60 percent of the respondents and 100 percent agreed that additional help was needed.

D. EPD Waiver

EPD Waiver Group 1

The EPD Waiver Group 1 represents older adults that are still in the process of enrolling in the EPD Waiver. It is important to take into account that while there were 20 older participants in this category, a significant number of them did not respond to all of the questions. Consequently, results should be evaluated under this context.

Of the participants that received EPD Waiver enrollment assistance services, 100 percent of those that responded felt that ADRC helped them understand the options that were available and helped to connect to the services needed. Eighty percent felt that their preferences and choices were discussed and respected. Eighty four percent felt that it was easy to access services. Only 35 percent indicated that they knew who their Medicaid Enrollment Specialist (MES) was (could identify them by name without being prompted). One hundred percent of respondents agreed or strongly agreed that their questions were answered by the MES. Only 67 percent agreed or strongly agreed that it was easy to stay in touch with the MES. 100 percent of respondents agreed or strongly agreed that the MES explained the steps and walked them through the steps of the EPD Waiver enrollment process.

EPD Waiver Group 2

The EPD Waiver Group 2 represents individuals that have already successfully enrolled in the EPD Waiver program.

The individuals surveyed provided very positive feedback on ADRC's interpersonal skills. Ninety two percent agreed or strongly agreed that ADRC staff helped them to understand the options available to them. One hundred percent agreed or strongly agreed that the staff took time to listen to their concerns, connected them to the services they needed, and that their preferences and choices were discussed and respected. Eighty six percent agreed or strongly agreed that once they were connected, it was easy to access the services.

No responses were given regarding whether staff did or did not identify any other types of help that the participants may need or whether they agreed with them that they had additional needs.

While only 71 percent indicated that they knew who their Medicaid Specialist (MES) was (could identify them by name without being prompted), respondents found the MES to be very helpful. All respondents agreed their Medicaid Enrollment Specialist answered their questions and explained the steps of enrollment, and 93 percent agreed or strongly agreed that it was easy to stay in touch with their MES.

Participants were not as pleased with the case management portion of the process. Only 46 percent of respondents agreed or strongly agreed that after their cased was transferred to the EPD Waiver case management agency, they were contacted by their EPD Waiver case manager in a timely manner. Nonetheless, 75 percent strongly agreed that they are able to make contact with their EPD Waiver case manager when necessary, and 80 percent agreed or strongly agreed that their EPD case manager really listened to their needs. Only 54 percent agreed or strongly agreed that they received their assessment for personal care assistance from the Delmarva nurse in a timely manner. Likewise, only 43 percent agreed or strongly agreed that they received their personal care assistance in a timely manner.

There were insufficient responses, however, to determine if participants were able to make contact with their personal care assistance provider when necessary.

E. Adult Day Health Enrollment (ADHP)

The small group of ADHP participants was referred to ADRC by a mix of word of mouth, friends, the media, and health care providers. Most contacted ADRC for themselves but a small group also called for other family members.

Sixty percent agreed or strongly agreed that the staff provided a quick response to their request. Eighty percent agreed or strongly agreed that they received the correct

information the first time they called, that the staff person was knowledgeable and helpful, treated them with respect and courtesy, and listened carefully to what they had to say, and their preferences were considered before services were recommended.

Respondents reported very favorably overall on the program services. 74 percent agreed that ADRC staff helped them understand the options that were available to them. Sixty four percent agreed that the staff helped connect them to the necessary services, while 73 percent agreed that the staff took time to listen to their concerns, and that their preferences were discussed and respected. Only 64 percent agreed that it was easy to access services once they were connected.

Fifty three percent of respondents indicated that the staff identified other types of help that might be needed and of those individuals, 75 percent agreed that they did have additional needs.

Individuals with Disabilities

Thirty five individuals with a disability, characterized by being under the age of 59, were surveyed. Notably, within this group, 14 received services through the community social work program, 8 through EPD Waiver Group 2, and 6 through the Adult Day Health enrollment. Only 3 responses were inputted for information and referral assistance, and 1 response for community transition.

When asked how they heard about ADRC, the most popular response was through word of mouth. With that said, those who received services through the community social work program or the EPD Waiver program indicated that they also received referrals from their health care providers as well as social workers/case managers.

A. <u>Information and Referral Assistance</u>

Consistent with the general survey group, word of mouth was the prominent source of referral for this group.

This group of respondents had overall positive responses on questions regarding ADRC's response time, knowledge and interpersonal skills. Specifically, 72 percent agreed or strongly agreed that staff members responded quickly to their concerns and provided the correct information the first time.

When asked to recall if staff was knowledgeable and helpful, 67 percent agreed. All the participants provided favorable ratings (100 percent) when asked if they were treated with respect and courtesy, if ADRC staff "listened carefully" to their concerns, and if their "likes and dislikes" were considered before services were recommended.

B. Community Social Work

Responses in this group also indicated a marked improvement in client satisfaction. Seventy eight percent agreed that staff helped them to understand their options (57 percent in 2015). Consistent with 2015, 77 percent provided high ratings on whether ADRC staff listened to their concerns (79 percent).

Similar to 2015's survey results for respondents ages 18-59 with a disability, clients are still struggling to access services. While 78 percent said that staff led them to the needed services, only 51 percent agreed that it was easy to access services. This still represents an improvement from last year when only 64 percent said that staff led them to needed services, and 29 percent agreed that it was easy to access these services.

C. Community Transition

There was only one respondent aged 18-59 who accessed community transition services. This individual strongly agreed that ADRC was helpful, and connected him/her to the services, which were easily accessed. They also were very satisfied with the follow-up they received after being discharged and agreed with the additional help that was identified for him/her.

D. EPD Waiver (Group 1)

While this was also a small group of respondents (n=3) there was overall agreement that ADRC staff was helpful, responsive, provided correct information, listened attentively, and was courteous and respectful. Likewise, the participants responded favorably on whether their preferences and choices were discussed and respected, and that it was easy to access services once they were connected. There were no responses as to whether the staff identified any other types that individuals might need or whether there was agreement with that on having those needs.

Most did not know who their MES was. They did agree that their questions were answered by the MES and that they walked them through the steps of the EPD Waiver enrollment process; however, there was a mixed response with regards to their experience with how easy it was to stay in touch with their MES, whether they were contacted by their EPD Waiver case manager in a timely manner, whether they received their assessment for personal care assistance from the Delmarva nurse in a timely manner, and if they are able to make contact with their case manager when necessary.

E. EPD Waiver (Group 2)

8 individuals were surveyed in this group. One hundred percent of respondents contacted ADRC for themselves. Seventy one percent agreed or strongly agreed that the staff provided a quick response to their request. This group universally agreed (100 percent) that they received the correct information the first time they called, that staff were knowledgeable and helpful, they listened carefully, were respectful and courteous, and that their preferences were considered before services were recommended.

Overall, this group was very happy with their experience with ADRC. Eighty five percent agreed or strongly agreed that the staff helped them connect to the services they needed. All agreed that their preferences and choices were discussed and respected, and 86 percent agreed that once they were connected, it was easy to access services. All individuals for whom staff identified other types of helpful services/supports agreed that they needed the additional supports.

Eight eight percent knew who their MES was, agreed or strongly agreed that their questions were answered by their MES, and agreed or strongly agreed that it was easy to stay in touch with their MES. 100 percent agreed that the MES explained the steps of the EPD Waiver enrollment process.

Seventy five percent agreed or strongly agreed that they were contacted by their EPD Waiver case manager in a timely manner, while 71 percent agreed or strongly agreed that when completing their person centered plan they felt that their EPD Waiver case manager really listened to their needs. Sixty seven percent agreed or strongly agreed that they received their assessment for personal care assistance from the Delmarva nurse in a timely manner, and 83 percent believed that they were able to make contact with their EPD Waiver case manager when necessary. Sixty seven percent of respondents believed that they were able to make contact with their personal care assistance provider when necessary.

F. Adult Day Health Enrollment

Sixty percent of participants with disabilities that accessed Adult Day Health enrollment services had contacted ADRC on their own, and 60 percent also agreed that the staff provided a quick response to the request. Eighty percent believed that they had received the correct information the first time they called, their staff person was knowledgeable and helpful, treated them with respect and courtesy, listened carefully to what they said, and took in to account their preferences before services were recommended.

Respondents indicated very high satisfaction (100 percent agreement) in relation to staff helping them understand the options available, listening to their concerns, and respecting their preferences. Eighty percent agreed that the staff helped connect them

to the services they needed; however, only 60 percent agreed that once they were connected, it was easy to access services. Of those that indicated that ADRC staff identified additional needs for them, all agreed that they did agree with having those additional needs

IV. Conclusions

ADRC received a majority of consistent and favorable customer satisfaction responses. As was highlighted earlier in the report, overall satisfaction rates for all the programs in ADRC (that could be compared) have improved since last year. ADRC staff continues to excel in their knowledge and strong interpersonal skills and has demonstrated to their clients that they consider their opinions and preferences. Furthermore, ADRC has shown a dramatic improvement in the last year in its commitment to follow-up with its clients.

As was noted in 2015, while ADRC clients are generally very satisfied with customer service during the initial part of the process, they find that it is still challenging to access services once they have been connected. This seemed of particular concern in those programs which require connecting with additional individuals outside of ADRC to move the process along (i.e., Medicaid Enrollment Specialist, EPD Waiver care manager). For the purposes of overall quality improvement, ADRC should review processes and assess mechanisms that can improve client's overall experience and accessibility to services to the extent possible.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE ON AGING

Office of the Executive Director

POLICY MEMORANDUM 16-P01

TO: **Senior Service Network**

FROM: **Laura Newland, Acting Executive Director**
D.C. Office on Aging

DATE: **February 12, 2016**

EFFECTIVE DATE: **Immediately**

SUBJECT: **Inclement Weather-Emergency Closure Policy**

This policy replaces the Inclement Weather/Short Term Closure Policy, Memorandum 14-P01. It ensures uniformity among Senior Service Network organizations when either full or partial day closures of programs or a suspension of services occur due to inclement weather, natural disasters, or other incidents causing disruptions to operations. Services to seniors, persons with disabilities, and their caregivers provided by Senior Service Network organizations are crucial, and in many cases, life sustaining. Therefore, care should be taken when deciding to close sites.

Seniors, persons with disabilities, and their caregivers should be instructed to determine Senior Service Network organizations' closing information by contacting its main telephone number. Prior to closing or an early departure, organizations must leave a recorded message advising callers of its operating status and a contact telephone number for emergency referrals. The recorded message must be updated if and when the operating status changes.

Social Services

All Senior Service Network organizations' social services programs must follow the D.C. Public School's guidelines concerning late arrivals, dismissals and closures in the event of inclement weather, natural disasters, or other incidents causing disruptions to operations.

In the event that a meal site host determines its facility must be closed when D.C. Public Schools are open, the Lead Agency must contact the food contractor to cancel meals **before 7:00 a.m.** on the day of closure.

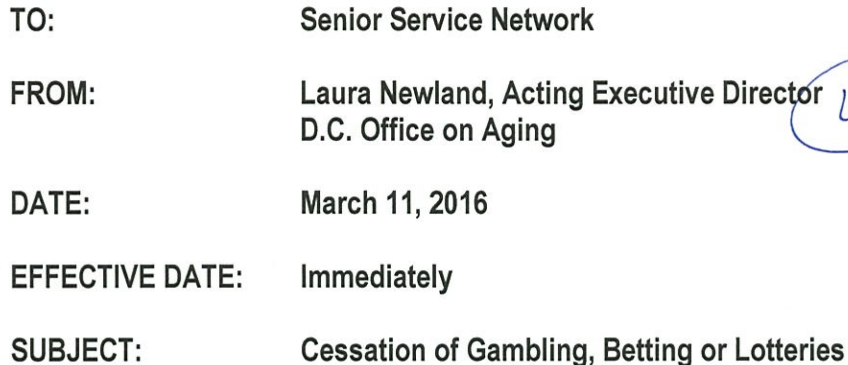
Administrative Services

All Senior Service Network organizations' administrative offices must adhere to the D.C. Government's guidelines concerning late arrivals, dismissals and closures of offices in the event of inclement weather, natural disasters, or other incidents causing disruptions to operations. Closing of sites when D.C. Government is open requires both DCOA approval and notification of your grant monitor.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE ON AGING

Office of the Executive Director

MEMORANDUM



TO: **Senior Service Network**

FROM: **Laura Newland, Acting Executive Director**
D.C. Office on Aging

DATE: **March 11, 2016**

EFFECTIVE DATE: **Immediately**

SUBJECT: **Cessation of Gambling, Betting or Lotteries**

Be advised that if you are currently sponsoring or conducting gambling, betting or lotteries for money or prizes, regardless of monetary value, without a license, you are to cease from doing so immediately. This includes bingo games and any gambling activity for money or property, regardless of monetary value, except for those lawful activities sponsored by the DC Lottery and Charitable Control Board (the "Board").

D.C. law prohibits any person or entity from aiding or abetting bingo games, raffles, or Monte Carlo night parties, except in accordance with a license duly issued and unsuspended or revoked by the Board.[1] Any person convicted of violating the law may be subject to a fine not to exceed $1,000 or imprisonment not to exceed six (6) months, or both.

In addition, for those entities discovered to be in violation of the law, DCOA reserves the right to suspend, discontinue, or terminate funding if it determines that such action is reasonable to protect the interests of the District government.

My staff is currently working with the Board to obtain licenses for those entities in the Senior Service Network that wish to provide bingo as a program activity. Upon doing so, we will contact you. Thank you for your cooperation.

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[1] *See* D.C. Official Code § 3-1332.

ATTACHMENT Q25b

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE ON AGING

Office of the Executive Director

POLICY MEMORANDUM 16-P02[1]

TO:	**Senior Service Network**
FROM:	**Laura Newland, Acting Executive Director** **D.C. Office on Aging**
DATE:	**March 16, 2016**
EFFECTIVE DATE:	**Immediately**
SUBJECT:	**Compliance with the Local Hatch Act**

This policy memorandum is communicated to ensure compliance among Senior Service Network ("Network") employees concerning their engagement in political activities.

The Local Hatch Act establishes limitations and restrictions on the political activities of D.C. government employees and **any individual paid by the D.C. government from a grant or appropriated funds for his or her services**.[2]

The Local Hatch Act defines "political activity" as any activity that is **regulated by the District** and directed toward the success or failure of a political party, candidate for partisan political office, partisan political group, ballot initiative, or referendum.[3]

District Regulated Political Activity

When engaging in political activity that ***is*** regulated by the District, Network employees cannot:[4]

1. Knowingly solicit, accept, or receive a political contribution from any person (except if the employee has filed as a political candidate for office);
2. File as a candidate for election to a partisan political office; or
3. Knowingly direct, or authorize anyone else to direct, that any subordinate employee participate in an election campaign or request a subordinate to make a political contribution.

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[1] This policy memorandum should be placed behind Policy Memorandum 16-P01 (Inclement Weather-Emergency Closure Policy) inside the Grants Policy Manual, Section XII, Tab I, "Selected Policy Memoranda."
[2] *See* D.C. Official Code § 1-1171.01 (3).
[3] *Id.* at § 1-1171.01 (8)(A).
[4] *Id.* at § 1-1171.02.

When engaging in ***any*** political activity, Network employees cannot use their official authority or influence for the purpose of interfering with or affecting the result of an election.

Non-District Regulated Political Activity

When engaging in political activity that is ***not*** regulated by the District:[5]

1. A Network employee who is ***not*** a District resident may file as a candidate to a partisan political office in their local, non-District election without restriction by the Local Hatch Act; and
2. A Network employee engaged in political activity that is ***not*** regulated by the District is permitted to solicit, accept, or receive political contributions from any person.

Fundraising

The Local Hatch Act permits Network employees to take an active part in political management or in political campaigns. As such, Network employees **may**:

a. Work on and manage a District-regulated partisan or non-partisan political campaign of another;
b. Manage and fundraise for your own District regulated non-partisan campaign; and/or
c. Manage and fundraise for a non-District regulated campaign of another or yourself, regardless of whether it is a partisan or non-partisan campaign.

But, Network employees ***cannot*** fundraise for a District-regulated campaign of another, even if it is a non-partisan campaign.

Meet and Greet Events

Organizing a "Meet and Greet" event is a permissible political activity. But Network employees are prohibited from fundraising for the District regulated campaign of another person. Therefore, if the Meet and Greet is for fundraising purposes, Network employees are prohibited from taking an active part in the event (other than attending).

If the Meet and Greet has a cost to attend, Network employees are prohibited from taking an active part in the event (other than attending) because the cost to attend the event (which is being held to promote a candidate) constitutes fundraising.

Non-Partisan Political Office

Network employees who are District residents may file as candidates for non-partisan District office.[6] Network employees who ***are not*** District residents may participate in their local, non-District elections without restriction by the Local Hatch Act.

Prohibited Political Activity for All Network Employees

All Network employees are prohibited from engaging in ***all*** political activity, regardless of whether it is regulated by the District, while:

a. On duty;

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[5] *Id.*
[6] *Id.*

b. In any room or building occupied in the discharge of official duties in the D.C. Government, including any agency or instrumentality thereof;
c. Wearing a uniform or official insignia identifying the office or position of the employee;
d. Using any vehicle owned or leased by the District, including an agency or instrumentality thereof.[7]

In addition, a Network employee may not coerce, explicitly or implicitly, any subordinate employee to engage in political activity;[8] or, use their official authority or influence for the purpose of interfering with or affecting the result of an election.[9]

Questions
If you have questions about the Local Hatch Act, you may contact the Board of Ethics and Government Accountability ("BEGA") office. Inquires may be made by email to bega@dc.gov. Inquiries may also be made by telephone at (202) 481-3411.

[7] *Id.* at § 1-1171.02 (a)(1).
[8] *Id.* at § 1-1171.03 (b).
[9] *Id.* at § 1-1171.02 (a)(1).

ATTACHMENT Q25d

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE ON AGING

Office of the Executive Director

POLICY MEMORANDUM 16-P03[1]

TO: **Senior Wellness Centers**

FROM: **Laura Newland, Executive Director**
D.C. Office on Aging

DATE: **April 13, 2016**

SUBJECT: **Campaigning at Senior Wellness Centers**

Please use the following statement as guidance on handling political candidates' requests to visit senior wellness centers as part of their campaigns for public office.

Pursuant to D.C. Official Code § 1-1163.36, Prohibition on Use of Government Resources for Campaign Related Activities, it is a violation of the law to permit a candidate (or his or her agents) to conduct a campaign event or to campaign at a senior wellness center or any District government owned facility.

However, it is permissible for a wellness center to sponsor political forums, candidate speeches, meet and greets, and/or debates, if all of the candidates running for a particular office are invited to participate and no candidate, either directly or indirectly, receives an endorsement, preference, or support from the wellness center.

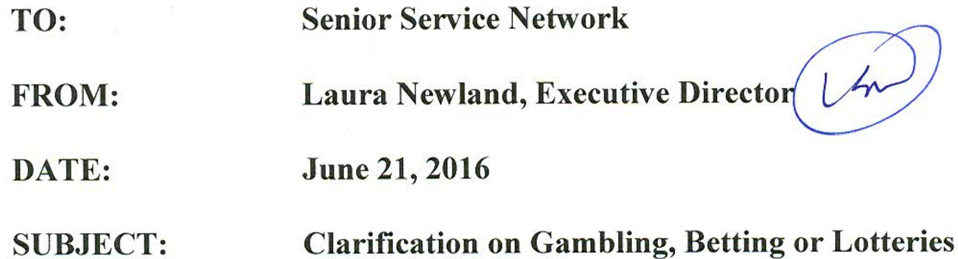
If you have any questions about requests from political candidates to visit senior wellness centers, please contact Jackie Geralnick, Public Health Nutritionist, DCOA. jackie.geralnick@dc.gov or (202) 724-2190.

[1] This policy memorandum should be placed behind Policy Memorandum 16-P02 (Compliance with the Local Hatch Act) inside the Grants Policy Manual, Section XII, Tab I, "Selected Policy Memoranda."

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE ON AGING

Office of the Executive Director

MEMORANDUM



TO: **Senior Service Network**

FROM: **Laura Newland, Executive Director**

DATE: **June 21, 2016**

SUBJECT: **Clarification on Gambling, Betting or Lotteries**

In March 2016, the attached memorandum was forwarded to the Senior Service Network and requested that grantees not sponsor or facilitate gambling, betting or lotteries without the proper license. Specifically, the request was to ensure that if seniors were required to pay monies to participate in bingo games, lotteries, or similar activities, in order to win money or a prize, the sponsoring organization obtained the proper license to conduct such activities.

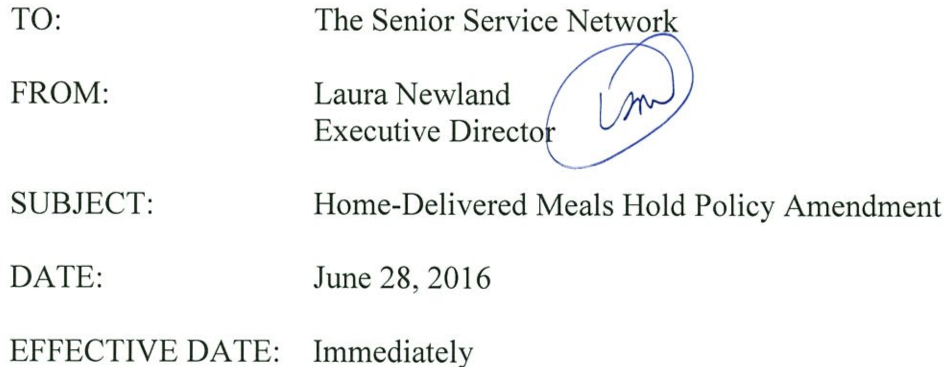
Since then, DCOA has received inquires about whether it is permissible to conduct games, including bingo, that ***do not*** require participants to pay an entry fee or purchase a game board to play. If seniors are ***not*** required to "pay to play" then such an activity would not constitute gambling and, therefore, would not be regulated by DC municipal regulations or require a license. Therefore, it is permissible to award participants prizes for their participation in games, raffles, etc. so long as they are not required to pay to participate.

ATTACHMENT Q25f

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE ON AGING

Policy Memorandum 14-PO2
Home-Delivered Meals Hold Policy

AMENDMENT 1



TO: The Senior Service Network

FROM: Laura Newland
Executive Director

SUBJECT: Home-Delivered Meals Hold Policy Amendment

DATE: June 28, 2016

EFFECTIVE DATE: Immediately

The District of Columbia Office on Aging (DCOA) herby issues the following changes or clarifications to the Home-Delivered Meals Hold Policy. Specific changes to the text within the policy appear in bold type.

Page 2:
If a participant has been on hold for 10 consecutive business days, s/he shall be terminated from the meals program on the 11th day. The Lead Agency must contact the participant to inform of the termination and then report to DCOA's Nutritionist how the participant was informed of the termination (over phone, mailed letter, unable to make contact, etc.). The participant may only begin receiving meals after a reassessment is completed by the Lead Agency.

An exception may be made for participants that are identified within ten business days to have relocated temporarily to a hospital or rehabilitation facility. As these participants are expected to return home and may need to resume services, they may be placed on hold for up to sixty (60) calendar days. After 60 calendar days, the Lead Agencies should change the participant's status to remove him/her from the program.

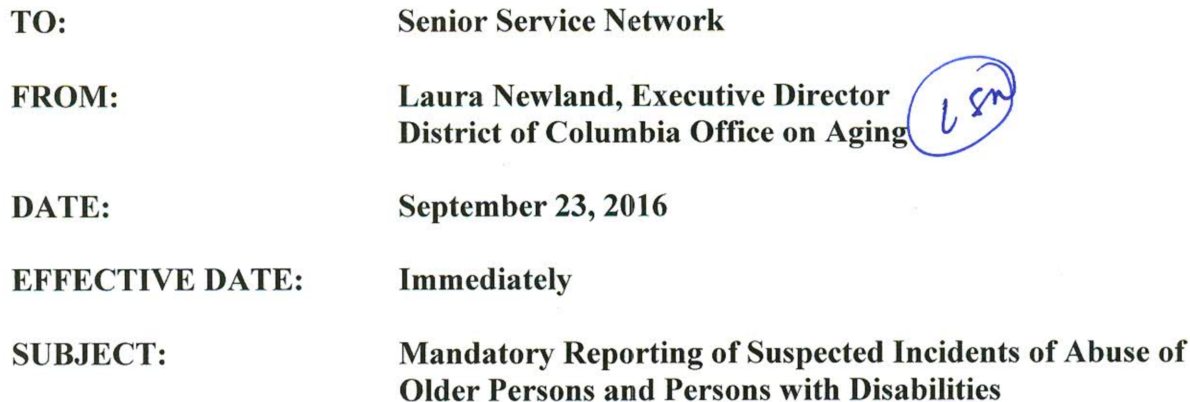
When Lead Agencies are alerted that a participant will return home, they must conduct a reassessment within fourteen (14) calendar days of the participant's return to ensure that the previous meal plan is still appropriate to meet the participant's needs.

ATTACHMENT Q25g

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE ON AGING

Office of the Executive Director

POLICY MEMORANDUM 16-P04[1]



TO: **Senior Service Network**

FROM: **Laura Newland, Executive Director**
District of Columbia Office on Aging

DATE: **September 23, 2016**

EFFECTIVE DATE: **Immediately**

SUBJECT: **Mandatory Reporting of Suspected Incidents of Abuse of Older Persons and Persons with Disabilities**

This Memorandum seeks to ensure compliance by Senior Service Network (Network) employees with the requirements for reporting suspected incidents of abuse, neglect, self-neglect, or exploitation of older persons and persons with disabilities to the District of Columbia Adult Protective Services (APS).

I. Reporting Requirements

Network employees shall make a report if they suspect that an older person or an adult with disabilities has suffered abuse, neglect, self-neglect, or exploitation and, therefore, needs protective services.[2] Afterwards, an incident report shall be forwarded to the Associate Director of the D.C. Office on Aging and Disability Resource Center (ADRC).

A Network employee who is a mandatory reporter must make a report to APS by calling the APS Hotline: (202) 541-3950. By law, licensed health professionals, social workers, police officers, court-appointed guardians, bank managers, and financial managers are mandatory reporters.[3]

A Network employee who is not a licensed health professional or a social worker must make a report to a supervisor. As is appropriate, the supervisor shall make a report to APS. The supervisor shall also track each reported case and forward an incident report to the Associate Director of ADRC.

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[1] This policy memorandum should be placed behind Policy Memorandum 16-P03 inside the Grants Policy Manual, Section XII, Tab I, "Selected Policy Memoranda."

[2] *See* D.C. Code § 7-1903(a)(1). For statutory definitions of *abuse*, *neglect*, *self-neglect*, and *exploitation*, please refer to Section VI of this Memorandum.

[3] *See* D.C. Code § 7-1903(a)(1).

Each report made must include the following information, if known:

- The name, age, physical description, and location of the adult alleged to be in need of protective services
- The name and location of the person(s) allegedly responsible for the abuse, neglect, or exploitation
- The nature and extent of the abuse, neglect, self-neglect, or exploitation
- The basis of the reporter's knowledge
- And any other information the reporter believes might be helpful to an investigation.[4]

II. Training Requirements

Network employees shall participate in an annual training session on the requirements set forth in this Memorandum. Also, Network employees shall participate in any additional periodic training session established by DCOA's Executive Director.

III. Compliance Monitoring

The Associate Director of ADRC shall oversee and monitor compliance with the reporting and training requirements set forth in this Memorandum.

V. Penalty for Noncompliance

Any Network employee who fails to comply with the requirements set forth in this Memorandum will be subject to disciplinary action in accordance with his or her employer's policies. Any Network employee who makes a report in accordance with this Memorandum is immune from civil or criminal liability if he or she acted in good faith.

VI. Definitions

Abuse is defined as follows:

i. The intentional or reckless infliction of serious physical pain or injury;
ii. The use or threatened use of violence to force participation in "sexual conduct";[5]

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[4] D.C. Code § 7-1903 (c).

[5] D.C. Code § 22-3101(5) defines "sexual conduct" as follows:
(A) Actual or simulated sexual intercourse:
(i) Between the penis and the vulva, anus, or mouth;
(ii) Between the mouth and the vulva or anus; or
(iii) Between an artificial sexual organ or other object or instrument used in the manner of an artificial sexual organ and the anus or vulva;
(B) Masturbation;
(C) Sexual bestiality;
(D) Sadomasochistic sexual activity for the purpose of sexual stimulation; or
(E) Lewd exhibition of the genitals.