

## Goals and Objectives

The Department has aligned the Area Plan goals and objectives with those of the Administration on Aging, which are indicated by this symbol: ▲. Additional goals and objectives particular to each AAA may be added.

**GOAL 1:** Empower seniors, individuals with disabilities, their families, and other consumers to choose and easily access options for existing mental and physical health and long-term care

**OBJECTIVE 1.1: ▲ Provide streamlined access to health and long-term care options through the Aging and Disability Resource Centers (ADRCs)**

**EXPLANATION:** The primary intent of this objective is to address ways you link people to information and services.

**STRATEGIES/ACTION STEPS:**

The AAAPP will continue to serve as an Aging and Disability Resource Center (ADRC), providing access to the long-term care arena of services for seniors, caregivers, and adults with disabilities.

The Helpline I&R/A will continue to serve as the entry point for the ADRC.

- The ADRC Helpline's Information and Referral/Assistance Specialists will continue to serve clients from 8 AM to 5 PM five days a week, providing information and referral of clients to the most appropriate entity to address their need. Resources provided will include those funded through DOE (CCE, ADI, HCE, OAA, SMMCLTCP, SHINE, VOCA, PACE) as well as non-profit organizations and private-for-profit businesses in the community. For calls outside the 8 AM - 5 PM hours, the Helpline's voice mail will continue to provide callers with the 9-1-1 number for police, fire and medical emergencies and with the 2-1-1 number for after-hours assistance with other human service needs. The Helpline and 2-1-1 communicate and work as partners to serve the community.
- Resource data is available online via the agency website at any time.
- The Helpline will link individuals with 701S screening for funded programs to determine priority ranking for services. The Helpline also connects callers with staff providing other Medicaid functions, including long-term care education, grievance/complaint, and assistance with lost Medicaid.

- The Helpline will continue to use an automatic call distribution (ACD) system to receive and respond to calls. Callers may choose to speak with staff in Spanish or English. Callers are allowed to leave a voice message at any time to avoid holding. Due to call volume, many callers are served by return outbound calls in response to voice mails. Management will continue to review the phone system data that is available and will work to address any performance measures that DOEA includes in contract. The AAAPP will make every effort to increase efficiency while still maintaining high quality customer service. Historically, the customer satisfaction surveys show high levels of satisfaction with I&R/A service provided.
- The Helpline will continue to utilize standardized fax sheets submitted by social workers and hospitals to request that the Helpline contact a client. The form requires client signature to confirm that they are aware of the referral.
- In addition, the Helpline will continue to publish a Helpline email address on the agency website and to receive inquiries from both consumers and professionals seeking guidance, information, and access to programs.

#### Outreach

- Individuals with the greatest need may not be aware of community resources. To address this need, the AAAPP Director of Outreach and other staff will take steps to increase the amount of outreach to targeted populations and to adults with disabilities utilizing our “Outreach Plan” coinciding with the most current DOEA Elder Index data sets.
- Increased knowledge of the ADRC and the Helpline can be achieved through community partnerships. This is one focus and benefit of the Local Coalition Workgroup in PSA 5. (See Goal 2.3)
- Outreach will include efforts to promote the Diapers for Dignity Program: An Adult Incontinence Supply Bank started by the Area Agency on Aging in CY2018.
- Falling under the Dementia Care and Cure Initiative (DCCI), the AAAPP, the local Morton Plant Memory Disorder Clinic and a multitude of partners will shed information on Alzheimer’s Disease and related Dementia Disorders (ADRD) resources throughout Pasco and Pinellas Counties.

#### Integration of ADRC services with the local DOEA CARES Unit and the local Department of Children and Families Economic Self-Sufficiency (ESS) Unit

- The AAAPP will continue valuable partnerships with both the DOEA CARES Unit and DCF and will continue to be virtually co-located.
- The AAAPP will continue communication with the CARES Unit via email and telephone to address eligibility issues and questions.
- Both the CARES Unit and the AAAPP will continue to use common email boxes to streamline and enhance communication.
- AAAPP Directors and supervisors will continue to communicate with DCF management and ADRC staff will continue to communicate with DCF workers regarding individual clients.
- DCF will continue to use the AAAPP’s Intake email box for referrals of clients under age 60 and APS staff will use it to communicate Under 60 clients who are on the CCDA/HCDA waitlist and also need to be added to the SMMC LTCP waitlist. DCF APS also uses the email box for APS Intermediate and Low Risk referrals and for APS to ALF High Risk cases for SMMCLTCP.

- PSA 5 will continue to host a quarterly meeting with DCF, PSA 6, PSA 8, and the CARES Unit Regional Director to enhance our regional relationships, share best practices and develop efficiencies.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 1.2: ▲ Encourage individuals, including people under 60, to plan for future long-term care needs by providing access to information**

**EXPLANATION:** The primary intent of this objective is to get the message to people who are not yet 60 that planning for long-term care (LTC) is needed.

**STRATEGIES/ACTION STEPS:**

Helpline and ADRC staff educate individuals about available LTC options, and can provide information on eligibility and elder law resources for LTC and Medicaid planning.

Offer training to SHINE/SMP volunteers on long-term care options (when available from DOEA) and provide approved tools for counseling on long term options with clients, caregivers and others. Conduct SHINE/SMP educational presentations to increase knowledge of health insurance for Long Term Care planning and detection and prevention of Medicare fraud, abuse and error.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 1.3: Ensure that complete and accurate information about resources is available and accessible**

**EXPLANATION:** The intention of this objective is to keep ReferNET current and to continue to enhance how people can connect to the information.

**STRATEGIES/ACTION STEPS:**

The AAAPP will continue to use ReferNet from RTM which is the statewide I&A/R database.

- The database will make resources accessible to Helplines statewide and to the public online via the 11 AAA websites.
- The AAAPP will participate in regular F4A Refer Workgroup conference calls along with the other 11 AAAs to manage the statewide database.
- The AAAPP will maintain resources in the Refer statewide online database. PSA 5 will update local resources in the statewide database at least once a year and will also annually update state and national resources assigned to PSA 5 in cooperation with the other ten Area Agencies in Florida.
- The AAAPP will use the Refer database to record Helpline data and create reports for DOEA including the number of callers by race/ethnicity/gender, the units of information and referral, data on SHINE calls, the number of calls by subject area of the request, and the unmet needs in PSA 5.
- The database will include resources for those seeking long-term care.

The ADRC staff will use the Refer data base to record client related contacts and to collect data on Intake/Screening and the contracted Medicaid functions for SMMCLTCP. PSA 5 will use the Refer database to document and report on work done for the SMMCLTCP statewide as directed by F4A and DOEA.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 1.4: Ensure that elders have access to free, unbiased, and comprehensive health insurance counseling**

**EXPLANATION:** The primary intent of this objective is to show how the AAA is supporting the SHINE Program. Ways to show the support might be through establishing additional counseling sites.

**STRATEGIES/ACTION STEPS:**

Provide consumers with accurate and current information on Medicare and Medicaid programs.

Recruit SHINE/SMP volunteers and provide on-going education and mentoring for counselors. Work to retain quality SHINE/SMP volunteers including those who are bi-lingual.

Conduct on-site training periodically for all SHINE/SMP and veteran counselors to assure provision of quality counseling.

Utilize a broad array of communication systems including websites, e-mail, mail, press releases, media stories, television and radio to offer counseling services, educate the community and recruit volunteers.

Conduct educational programs and outreach in the community to increase knowledge of health insurance and access to the SHINE/SMP program, particularly in underserved, low-income, minority and rural areas.

Strive to increase outreach/counseling sites, and partners, with a goal to reach clients who are low-income, rural, minority, dually eligible for Medicare and Medicaid or underserved.

**OUTCOMES**

**OUTPUTS:**

**OBJECTIVE 1.5: Increase public awareness of existing mental and physical health and long-term care options**

**EXPLANATION:** The primary intent of this objective is to help people become aware that they might benefit from mental and physical health services and that the services are available in the community.

**STRATEGIES/ACTION STEPS:**

The AAAPP will contract for mental health and gerontological counseling services in Pasco and Pinellas counties and will encourage the provision of services in the home and community.

Inform the public of available long-term services through the AAAPP website, as well as the agency's social media channels.

Formalize relationships with hospitals, first responders, and higher learning institutions to increase public awareness of existing long-term care options and possibly gain resources from these entities.

Continue education and outreach in the community through health fairs, public training and other community forums.

Increase awareness of long-term care options during ADRC Workgroup, Board of Director and Advisory Council meetings.

Educate SHINE/SMP volunteers to facilitate appropriate referrals to the Helpline to assure appropriate information about mental health community services is offered.

As an ADRC, the AAA will continue to maintain and promote awareness of the community and long-term care resources for older adults and persons age 18 and older with a disability.

- ADRC staff meets with community partners (such as DCF and APS), with the Local Coalition Workgroup, and with professionals at networking meetings and will share that the ADRC can provide information on resources for adults age 18 and over with a disability.
- The AAAPP website and the Helpline flier that is distributed at all community outreach events promotes the Helpline as a trusted source of information on community resources for mental and physical health services and LTC options.
- Mental and physical health resources in the Refer database are available through I&R/A staff and in the online database on the AAAPP website.
- AAAPP social media efforts include promoting awareness of long-term care options.
- Increased outreach efforts to targeted groups and adults with a disability will focus on promoting awareness of community and LTC resources.

**OUTCOMES:**

## **OUTPUTS:**

### **OBJECTIVE 1.6: Identify and serve target populations in need of information and referral services**

**EXPLANATION:** The primary intent of this objective is for the AAA to detail how it plans to reach populations in need of information and referral (I&R) services that might require more challenging outreach efforts.

#### **STRATEGIES/ACTION STEPS:**

The AAAPP will participate in outreach events for targeted populations, including but not limited to limited English proficiency; low-literacy, low-income, individuals residing in rural populations; persons with disabilities under age 65; grandparents caring for grandchildren; and dual eligible; to provide information and referral and/or encourage contact with the Helpline for information and referral.

The AAAPP will continue existing partnerships in order to outreach individuals with disabilities and in order to promote effective access to long-term care options planning.

Build capacity to facilitate increased outreach efforts, dependent on funding, to populations needing resources/information including new partnerships to address rurality, hunger, and Alzheimer's Disease and related dementias.

Educate partners, Board of Directors, Advisory Council and other community stakeholders on the AAAPP in order for information to be disseminated throughout the community regarding information and referral services.

Providers will develop and implement targeting plans with an emphasis on identification of underserved populations with a focus on those individuals targeted by the Older Americans Act in order for underserved populations to access information and referral services.

During annual programmatic monitoring visits, AAAPP staff will review the functions of the ADRC including I&R services to ensure those individuals being targeted by the Older Americans Act providers are aware of the availability of I&R services.

SHINE/SMP will develop partnerships and outreach sites in areas and with organizations to improve access for hard to reach populations, including low-income and disabled persons, or those with low-literacy or limited English proficiency and persons dually eligible for Medicare and Medicaid.

The AAAPP will continue to promote I&R services to target populations.

- Utilizing and “Outreach Plan” coinciding with the most current DOEA Elder Needs Index data set, the AAAPP will participate in community events for targeted populations, including adults with a disability, to encourage contact with the Helpline for information and referral.
- An effort will be made to target increased outreach to hard-to-identify consumers, including low-income.
- ADRC staff can serve clients with limited English proficiency in Spanish or can use a translator to assist in hundreds of languages.
- The AAAPP television show provides information and education and is accessible to adults and caregivers who are limited in their ability to leave home. This population is unable to attend community events and may be isolated, making outreach difficult.
- The AAAPP website and social media will be used to reach consumers who use computers and mobile devices but may not be familiar with the ADRC and the Helpline.
- The Helpline database includes community resources for food and meals. The Helpline provides information on where to get assistance with nutrition, including where to get help with SNAP applications.
- The Helpline will seek additional resources to include in the database as a way to expand potential sources of assistance to callers of all ages.

Utilizing the recently completed “Community Assessment Survey of Older Adults” (CASOA), the AAAPP will use zip code data to strengthen targeted outreach for areas expressing unmet needs exist.

**OUTCOMES:**

**OUTPUTS:**



**OBJECTIVE 1.7: Provide streamlined access to Medicaid Managed Care and address grievance issues**

**EXPLANATION:** The primary intent of this objective is for the AAA to provide details on the ADRC's provision of Statewide Medicaid Managed Care Long-term Program information, waitlist, eligibility, and grievance resolution services.

**STRATEGIES/ACTION STEPS:**

Helpline

- The Helpline is the entry point for the ADRC and so is the first step for accessing SMMCLTCP.
- Helpline staff link callers to screening and other Medicaid functions, including LTC education, grievance/complaint, and assistance with lost Medicaid. By putting requests in a central intake email box with a description of the needed service, Intake and Medicaid staff can see the workload, pull cases based on the type of assistance needed, and prioritize cases so that requests are taken in order. Managers can also see the workload in the central box and can see the current work in progress in each staff person's email folder.
- Clients requesting a re-screen based on significant change also enter via the Helpline and these requests also go to the central intake box marked as a re-screening request and whether the client is under 60.
- The Helpline provides information on the PACE program.
- Helpline staff may also provide information to active SMMCLTCP clients on how to reach their managed care organization (MCO)

Intake/Screening

- Clients are contacted and may be scheduled for screening. All clients interested in government funded programs will be screened using a 701S screening tool and will be enrolled on the waiting list for all appropriate programs, including SMMCLTCP.
- All ADRC staff have reference materials available to ensure that they are following DOEA 701S screening training instructions.
- Clients are provided eligibility information for SMMCLTCP and information on PACE. Those who need additional information on SMMCLTCP or Medicaid eligibility are connected to Medicaid staff who provide long-term education.
- Clients who remain on the wait list are re-screened annually with the goal of re-screening with 395 days of their last screening per DOEA performance measure. Clients due for annual re-screen are assigned to staff via an ACCESS database. Managers can monitor the progress of each worker's re-screen completion status using this database.
- Clients under the age of 60 are screened and re-screened by Medicaid staff.

#### Long-term Care Education and Grievance/Complaint

- Medicaid staff may provide LTC education as part of a screening or as a stand-alone function. The content of LTC education varies but can include eligibility information, an overview of the SMMCLTCP program, or a discussion of SMMCLTCP for clients in an ALF.
- Medicaid staff assist active SMMCLTCP clients who have a complaint, including providing information on submitting complaints to AHCA and filing a DCF Fair Hearing.

#### Medicaid Release and Eligibility Assistance

- Medicaid staff work with clients and health care providers to obtain a completed 3008 form on high priority clients before an EMS release per DOEA instructions.
- When DOEA provides an EMS release, PSA 5 follows the DOEA EMS Release instructions.
- Clients are triaged so that the appropriate DOEA letter is mailed.
- Released clients are assigned to Medicaid staff via an Access Database. Managers can review the database to monitor progress on cases.
- The client is contacted and steps in the eligibility process are conducted within the time standards in DOEA instructions and performance measures.
- Staff have access to DCF Florida and FLMMIS systems which is a critical component in helping clients understand and comply with the DCF financial eligibility process.
- Managers and staff communicate closely with DOEA CARES Unit, DCF ESS, and DOEA Medicaid contract manager as needed to resolve client specific issues.
- Managers run reports and maintain an Access database to track all cases and perform regular workload analysis.

#### Quality Assurance will continue to be provided according to F4A procedures

- Continue to record all “incoming” Helpline calls and monitor Helpline calls for QA purposes. Review Refer reports of Helpline staff to ensure data accuracy.
- Monitor screening and Medicaid calls from a remote location using 3 conference call of the telephone system.
- Review 701S screening calls and Long-term Education calls using the F4A QA tool to ensure staff follow DOEA 701S training protocols and provide accurate LTC Education.
- Review a sample of SMMCLTCP cases for compliance using the F4A file review form and following F4A policy.

- Provide QA review for each Intake and Medicaid staff person based on the F4A QA policy. Provide feedback to staff on their performance in an effort to recognize best practices and identify skills that can be improved. Any deficiencies will be addressed, including working with staff through training and mentoring to improve performance.
- Provide a quarterly QA report to DOEA per ADRC contract.

**OUTCOMES:**

**OUTPUTS:**

**GOAL 2:** Enable individuals to maintain a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers

**OBJECTIVE 2.1: Identify and serve target populations in need of home and community-based services (HCBS)**

**EXPLANATION:** The primary intent of this objective is twofold: 1) to address how the AAA will identify the target populations in the PSA, and 2) to address how the AAA will provide services to the targeted populations who may be in hard-to-reach areas.

**STRATEGIES/ACTION STEPS:**

The AAAPP will require Older Americans Act providers to provide outreach to older individuals with greatest economic need, individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas) and older individuals with limited English proficiency. Older Americans Act nutrition providers will also be required to provide outreach to older individuals with severe disabilities, Alzheimer’s disease and related disorders and individuals at risk for institutional placement.

Sub-contract with legal organizations in PSA5 to outreach and serve Grandparents raising grandchildren or other relative caregivers of children.

Utilize partnerships with the Children’s Home Network via the ADRC Workgroup to educate on program availability through the ADRC for grandparents raising grandchildren or other relative caregivers of children.

Staff to attend Kinship Care meetings regularly to promote community partnerships among agencies working with grandparents or relatives raising grandchildren.

The AAAPP requires each OAA provider detail annually in the service provider application a specific, measurable plan to provide outreach and completion of the outreach plan. Success in meeting stated objectives regarding targeting and outreach, is reviewed quarterly and at the annual monitoring.

Individuals will be served based on priority criteria identified by the Department of Elder Affairs and/or the objectives of the Older Americans Act (OAA) in order to address the needs of the frailest and comply with the OAA.

OAA Providers will develop and implement priority policies that place emphasis on service to elders in the greatest social or economic need and individuals at risk of institutional placement. Emphasis will also be placed on service to low-income minority individuals, older individuals with limited English proficiency and older individuals residing in rural areas.

The AAAPP will ensure through monitoring of the Older Americans Act providers, that targeting and prioritization of wait list consumers includes a primary emphasis on serving those at high risk.

The AAAPP will ensure case managers complete the on-line consumer assessment instrument training and the AAAPP will train case managers to prepare individualized care plans addressing all needs of not only clients, but also caregivers.

The AAAPP will sample newly enrolled service recipients to ensure that services were initiated to address needs.

The AAAPP will analyze care plan costs by program to ensure most cost-effective service delivery to avoid nursing home placement.

Information will be provided to case managers on assistive devices and community resources to encourage consumers to be more self-sufficient.

Train providers on memory disorders, outcome measures and resources to assist clients and caregivers in remaining in their homes.

The AAAPP will track CCE Clients who appear SMMC LTCP eligible to ensure clients are appropriately transitioned to SMMC LTCP as funding allows and per DOEA Notice of Instructions (NOI).

The AAAPP will run the CIRT report titled "New Active Enrollees by Assessment Rank" at least every other month to assure consumers with the highest priority are served first and to ensure assessment consistency.

The AAAPP will contract for the provision of the Emergency Home Energy Assistance for the Elderly Program (EHEAP) to assist eligible seniors in crisis situations regarding the heating and cooling sources for their homes.

The AAAPP will contract for the provision of home delivered and congregate meals and nutrition education and counseling to address hunger.

The AAAPP will ensure all providers are addressing the needs of caregivers based on annual review of assessments and files.

The AAAPP will prioritize referral for service utilizing the 701S and maintaining the waitlist for CCE, HCE, ADI and SMMC LTCP, to ensure that those most in need receive services as soon as possible.

Intake and Medicaid staff follow DOEA 701S training to improve consistency in asking and scoring the questions on the screening tool. All ADRC staff have access to reference materials as a quick guide to insure that use of the tool and prioritization is consistent.

Clients who are facing imminent nursing home placement may be marked “Imminent Risk” and, as a Rank 7, they are a high priority for service. However, this requires review and permission from the ADRC Director or Lead Medicaid Waiver Specialist, in writing in the CIRTS 701S screening and requires evaluation and permission from DOEA.

Continue facilitation, in partnership with Pinellas County, of the Older Americans Food Insecurity Work Group to collaborate and explore new ways of addressing senior hunger.

Expand Senior Community Health program to increase partnerships between AAAPP and medical providers, to positively impact the physical health of older adults at risk of nursing home placement through complex care social service coordination.

In order to enhance Outreach and Targeting activities the AAAPP conducts, the AAAPP has a Director of Outreach who oversees a majority of these activities and utilizes an “Outreach Plan” coinciding with the most current DOEA Elder Needs Index data sets.

Utilizing the recently completed “Community Assessment Survey of Older Adults” (CASOA), the AAAPP will use zip code data to strengthen targeted outreach for areas expressing unmet needs exist.

### **OUTCOMES:**

- Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours
- Percent of new service recipients whose Activities of Daily Living (ADL) assessment score has been maintained or improved
- Percent of new service recipients whose Instrumental Activities of Daily Living (IADL) assessment score has been maintained or improved
- Percent of elders assessed with high or moderate risk environments who improved their environment score

Note: The AAAs will not be monitored on the measures listed in italics, though the AAA must still include strategies to address them in this section.

- *Percent of most frail elders who remain at home or in the community instead of going into a nursing home*
- *Average monthly savings per consumer for home and community-based care versus nursing home care for comparable client groups*
- *Percent of customers who are at imminent risk of nursing home placement who are served with community-based services*
- *Percent of new service recipients with high-risk nutrition scores whose nutritional status improved*

DOEA Internal Performance Measures:

- Percent of high-risk consumers (Adult Protective Services (APS), Imminent Risk, and/or priority levels 4 and 5) out of all referrals who are served

**OUTPUTS:**

**OBJECTIVE 2.2: Ensure efforts are in place to fulfill unmet needs and serve as many clients as possible**

**EXPLANATION:** The primary intent of this objective is to address how the AAA oversees the service delivery system in the PSA.

**STRATEGIES/ACTION STEPS:**

The AAAPP will hold Public Hearing(s) in the PSA coinciding with the multi-year Area Plan process to invite input regarding community needs.

The AAAPP will update the Area Plan as needed, to address service gaps and reflect new resources.

The AAAPP will work with community organizations to efficiently use existing resources and respond to unmet needs in the community creatively.

Helpline staff will continue to add resources to the Refer database to address the needs of seniors, caregivers, and adults with disabilities.

The AAAPP will utilize volunteers and student interns from statewide universities to expand our programs and planning capacity.

The AAAPP will analyze care plan costs by program to ensure most cost-effective service delivery to avoid nursing home placement.

Provide information to case managers on assistive devices and community resources to encourage consumers to be more self-sufficient.

Train providers on outcome measures and resources to assist clients in remaining in their homes.

Train case managers in the development of care planning in order to meet consumer needs.

Monitor case managers to ensure informal service options are utilized when possible to meet client needs.

Provide training to case managers to utilize non-DOEA funded services.

Monitor 1% of newly enrolled client files to ensure Non-DOEA funded resources have been utilized as possible.

AAAPP will monitor consumer files to ensure needs identified in the assessment are addressed on the care plan and/or appropriate referrals.

AAAPP will manage CCE, ADI, HCE Vendor Agreements in both Pasco and Pinellas county to ensure services being delivered are authorized and appropriate.

AAAPP will meet with Lead Agencies regularly to discuss monthly CCE, HCE, and ADI expenditures and projected costs.

Collaborate with partners, board members, advisory council members and providers regarding available community resources to assist clients and aging caregivers.

The AAAPP will pursue partnerships in the PSA through Better Living for Seniors (BLS) and Pasco Aging Network (PAN) as a means to expand marketing; address gaps in services; identify new technologies and trends; and expand resources.

The AAAPP and our partners conducted a Planning and Service (PSA) wide Community Needs Survey. The AAAPP will use the data results from the survey to identify what unmet needs remain and any emerging trends.



The AAAPP will expand the Senior Community Health Program to continue building partnerships with healthcare entities/foundations in order to diversify our ability to serve seniors at risk under certain social determinants of health.

Utilizing the recently completed “Community Assessment Survey of Older Adults” (CASOA), the AAAPP will use zip code data to strengthen targeted outreach for areas expressing unmet needs exist.

**OUTCOMES:**

- Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours
- Percent of new service recipients whose Activities of Daily Living (ADL) assessment score has been maintained or improved
- Percent of new service recipients whose Instrumental Activities of Daily Living (IADL) assessment score has been maintained or improved
- Percent of elders assessed with high or moderate risk environments who improved their environment score

Note: The AAAs will not be monitored on the measures listed in italics, though the AAA must still include strategies to address them in this section.

- *Percent of most frail elders who remain at home or in the community instead of going into a nursing home*
- *Average monthly savings per consumer for home and community-based care versus nursing home care for comparable client groups*
- *Percent of customers who are at imminent risk of nursing home placement who are served with community-based services*
- *Percent of new service recipients with high-risk nutrition scores whose nutritional status improved*

**OUTPUTS:**

- Number of people served with registered long-term care services

**OBJECTIVE 2.3: Provide high quality services**

**EXPLANATION:** The primary intent of this objective is for the AAA to detail quality assurance efforts in the PSA.

**STRATEGIES/ACTION STEPS:**

**Program Management Strategies/Action Steps:**

The AAAPP will ensure those conducting assessments have completed the on-line assessment training to ensure client needs are identified.

The AAAPP will ensure case managers complete the on-line consumer assessment instrument training and the AAAPP will train case managers to prepare individualized care plans.

Ensure consistency in assessment completion to avoid large discrepancies in scoring.

The AAAPP will sample newly enrolled service recipients to ensure that services were initiated to address needs.

AAAPP will monitor a sample of consumer files at least quarterly to ensure that caregiver needs are being addressed.

AAAPP will monitor client files during monitoring visits to determine if appropriate services have been coordinated.

Monthly home visits will be conducted to determine if client needs are being addressed and to assess client satisfaction.

AAAPP will monitor providers' client satisfaction surveys annually.

AAAPP will conduct client satisfaction surveys annually for a selected sample.

AAAPP staff will monitor complaints and grievances received by each provider.

The AAAPP will provide follow-up on problems identified to ensure complaints are addressed and services are improved as appropriate.

The AAAPP will monitor the CCE, HCE and ADI vendors in Pinellas and Pasco counties annually to ensure services being delivered are documented, authorized, and follow all appropriate guidelines.

### Local Coalition Work Group (LCWG)

The AAAPP will maintain and utilize a Local Coalition Work Group (LCWG), known in Planning and Service Area (PSA) 5 as the **ADRC Work Group**.

The ADRC Workgroup will advise in the planning and evaluation of the ADRC and assist in the development of the Annual Program Improvement Plan (see below)

- The Workgroup shall consist of representatives from agencies and organizations serving elders, persons with disabilities and caregivers; Alzheimer's Association; housing authorities; Serving Health Insurance Needs of Elders (SHINE volunteers; local government, and selected community-based organizations, including social services organizations, advocacy groups and any other such individuals or groups as determined by DOEA. Local staff of both DCF and the DOEA CARES Unit are members of the ADRC Workgroup. *A detailed list of current ADRC Workgroup Members is included, following the last Goals and Objective.*
- The ADRC Workgroup will continue to meet twice a year, spring and fall/winter.
- The ADRC Workgroup will address the Annual Program Improvement Plan outlined below. Minutes of the Workgroup will document participation in development and implementation of the APIP.

### DCF/DOEA CARES Unit Partnership

- Local staff of both DCF and the DOEA CARES Unit are members of the ADRC Workgroup.
- Local staff of both DCF ESS/APS and the DOEA CARES Unit work closely and communicate frequently with ADRC staff. This benefits clients and facilitates the eligibility assistance provided to clients by the ADRC.
- PSA 5, 6, and 8 meet regularly with DCF ESS staff and staff from three DOEA CARES Units to foster communication and partnership.

**PSA 5 Aging and Disability Resource Center (ADRC)  
Annual Program Improvement Plan  
(Jan. 2020 – Dec. 2020)**

The Annual Program Improvement Plan (APIP) is developed with input from the local ADRC Workgroup. The Workgroup provides feedback on staff proposals and generates additional ideas and strategies for the APIP. During the year, ADRC Workgroup members will be asked to review progress and suggest strategies to improve performance.

Outreach

- Promote targeted outreach to increase awareness of the Helpline, Medicaid long-term care, and other funded programs.
  - Build capacity to provide outreach staff to reach diverse and targeted populations, including adults with a disability.
  - Collaborate with Disability Achievement Center to identify ways to outreach to adults with a disability.
  - Provide outreach materials to OAA service providers (such as home delivered meals and adult day care) to distribute to existing clients/caregivers. OAA services are targeted to those in greatest social and economic need. These clients may need additional services themselves or may know others in their community in need of assistance.
  - Have SHINE counselors & VOCA staff distribute outreach materials at SHINE events.
  - Utilize the agency's social media and other media options as a way to increase community outreach

Performance Measures

- Staff will share data on achievement of six Statewide Medicaid Managed Care Long-Term Care Program (SMMCLTCP) performance measures as provided by DOEA each quarter. Staff will discuss strategies used to monitor and improve performance. Staff will use ADRC Workgroup feedback to improve the process.
- Staff will share data on additional ADRC performance measures included in the final ADRC contract. Analysis and discussion with the ADRC Workgroup will include barriers to achievement and efforts to identify specific steps to address barriers and improve performance.

Quality Assurance (QA)

- Continue Customer Satisfaction Surveys of Helpline/Screening, OAA, and Lead Agencies and provide summary reports to the ADRC Workgroup.
- Continue the QA process and provide the ADRC Workgroup with a summary review of QA achievement. The QA process includes:

- Continue to record all “incoming” Helpline calls and monitor Helpline calls for QA purposes. Review Refer reports of Helpline staff to ensure data accuracy.
- Monitor screening and Medicaid calls from a remote location using 3 conference call of the telephone system.
- Review 701S screening calls and Long-term Education calls using the F4A QA tool to ensure staff follow DOEA 701S training protocols and provide accurate LTC Education.
- Review a sample of SMMCLTCP cases for compliance using the F4A file review form and following F4A policy.
- Provide QA review for each Intake and Medicaid staff person based on the F4A QA policy. Provide feedback to staff on their performance in an effort to recognize best practices and identify skills that can be improved. Any deficiencies will be addressed, including working with staff through training and mentoring to improve performance.
- Provide a quarterly QA report to DOEA per ADRC contract.

### **OUTCOMES:**

- Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours
- Percent of new service recipients whose Activities of Daily Living (ADL) assessment score has been maintained or improved
- Percent of new service recipients whose Instrumental Activities of Daily Living (IADL) assessment score has been maintained or improved
- Percent of elders assessed with high or moderate risk environments who improved their environment score

Note: The AAAs will not be monitored on the measures listed in italics, though the AAA must still include strategies to address them in this section.

- *Percent of most frail elders who remain at home or in the community instead of going into a nursing home*
- *Average monthly savings per consumer for home and community-based care versus nursing home care for comparable client groups*
- *Percent of customers who are at imminent risk of nursing home placement who are served with community-based services*
- *Percent of new service recipients with high-risk nutrition scores whose nutritional status improved*

### **OUTPUTS:**

**OBJECTIVE 2.4: Provide services, education, and referrals to meet specific needs of individuals with dementia**

**EXPLANATION:** This objective focuses on individuals with dementia to ensure that the specific needs of these individuals are not overshadowed by serving populations without dementia.

**STRATEGIES/ACTION STEPS:**

Monitor ADI client files, at least annually, to ensure service needs are being met as assessed, including caregiver needs.

Arrange and coordinate training by the Memory Disorder Clinic annually to ADI vendors, case managers and AAAPP staff.

Coordinate and partner with the Alzheimer’s Association – Florida Gulf Coast Chapter and the Alzheimer’s Family Organization in recognition of their dementia related expertise.

The AAAPP will analyze care plan costs for ADI to ensure most cost-effective service delivery in order to serve more clients and prevent nursing home placement.

The Helpline I&R/A provides access to government funded, non-profit, and for-profit community resources that serve adults with ADRD and their caregivers. Resources may include screening for ADI and other funded programs, PACE, memory disorder clinics, local and national organizations dedicated to Alzheimer’s and related dementias, respite services, and caregiver support groups. Information on resources is also available through the online database on the AAAPP website. DOEA’s Lifespan Respite Grant may provide additional respite resources in the future.

Title IIIIE National Family Caregiver Support program will continue to provide respite and other support services to caregivers of clients with ADRD. Dementia is one of the prioritization factors for clients awaiting services in this program.

The AAAPP will produce one “Aging on the Suncoast” television program to educate viewers in Pasco and Pinellas Counties regarding dementia and available community supports. Aging on the Suncoast is a 30 minute TV program on a topic of interest to seniors. It is produced monthly by the AAAPP. The show is broadcast an average of 60 times per month on the Pinellas and Pasco Government Access Channels reaching a diverse audience.

Educate SHINE volunteers about aging issues including dementia and Alzheimer’s Disease. Encourage SHINE clients who are caregivers to connect with the Helpline and to review the AAAPP website for caregiving resources and services.

Falling under the Dementia Care and Cure Initiative (DCCI), the AAAPP, the local Morton Plant Memory Disorder Clinic and a multitude of partners will shed information on Alzheimer's Disease and related Dementia Disorders (ADRD) resources throughout Pasco and Pinellas Counties.

**OUTCOMES:**

- Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours
- Percent of new service recipients whose Activities of Daily Living (ADL) assessment score has been maintained or improved
- Percent of new service recipients whose Instrumental Activities of Daily Living (IADL) assessment score has been maintained or improved
- Percent of elders assessed with high or moderate risk environments who improved their environment score

Note: The AAAs will not be monitored on the measures listed in italics, though the AAA must still include strategies to address them in this section.

- *Percent of most frail elders who remain at home or in the community instead of going into a nursing home*
- *Average monthly savings per consumer for home and community-based care versus nursing home care for comparable client groups*
- *Percent of customers who are at imminent risk of nursing home placement who are served with community-based services*
- *Percent of new service recipients with high-risk nutrition scores whose nutritional status improved*

**OUTPUTS:**

**OBJECTIVE 2.5: Improve caregiver supports**

**EXPLANATION:** The primary intent of this objective is to strengthen caregiver services to meet individual needs as much as possible. For example, existing caregiver support groups may not sufficiently address the differing challenges of spouse caregivers compared to adult child caregivers.

**STRATEGIES/ACTION STEPS:**

The AAAPP will contract with Lead Agencies to provide support to caregivers of elders through the Home Care for the Elderly and Alzheimer's Disease Initiative Programs.

The AAAPP will contract with Lead Agencies for Community Care for the Elderly to provide services to clients and their caregivers if applicable. Services allowable under Community Care for the Elderly include respite, home delivered meals, companionship, home repair, adult day care, and emergency alert response.

The AAAPP will ensure case managers complete the on-line assessment training which provides the necessary tools to adequately assess the needs of caregivers and address the needs in the care plan.

Data will be generated by providers and lead agencies indicating barriers to achieving the "caregiver ability" outcome measure. AAAPP staff and providers will review this information regularly to identify trends within the PSA that may be addressed to assist caregivers in continuing to provide care.

AAAPP will conduct annual outcome measure training, which includes discussion of improving caregiver supports.

New caregiver resources, community forums, and caregiver training will be shared with the providers to share with clients and caregivers they are working with.

AAA will continue to provide support and information on resources for caregivers through the Helpline. This includes providing information on non-profit and for-profit resources in addition to government funded programs. Information on resources state-wide is available in the online database. Resources may include adult day care, nutrition services, transportation options, PACE, respite services, caregiver support groups, kinship care, and screening for funded programs that provide a range of in-home services.



The AAAPP will continue to fund a wide array of services to address the needs of caregivers through the Title III E National Family Caregiver Support Program such as respite, adult day care, counseling, chore, and medical supplies.

The AAAPP will participate, if applicable, during outreach events, conferences, forums or coalitions targeted to caregivers.

The AAAPP will provide previously-filmed caregiver education sessions to audiences for free via the agency website and social media pages. These sessions address common issues Caregivers face, including but not limited to strategies for caring for individuals with ADRD.

The AAAPP will continue to explore the viability of offering the “Savvy Caregiver” Evidenced-Based program to communities in Pasco and Pinellas counties.

**OUTCOMES:**

DOEA Internal Performance Measures:

- *Percent of customers who are at imminent risk of nursing home placement who are served with community-based services (Standard: 90%)*
- *After service intervention, the percentage of caregivers who self-report being very confident about their ability to continue to provide care (Standard 86%)*

**OUTPUTS:**

**GOAL 3:** Empower seniors and their caregivers to live active, healthy lives to improve their mental and physical health status

**OBJECTIVE 3.1:** ▲ Continue to increase the use of Evidence-Based (EB) programs at the community level

**EXPLANATION:** The primary intent of this objective is for the AAA to detail how evidenced-based programs will be incorporated into the PSA.

**STRATEGIES/ACTION STEPS:**

The provider of OAA Title IIID funded services in PSA 5 will offer the Chronic Disease Self-Management evidence-based program in both Pasco and Pinellas counties to empower persons with chronic diseases to control their own health.

The provider of OAA Title IIID funded services in PSA 5 will offer Matter of Balance and Tai Chi evidenced based programs in both counties to address fall prevention.

In addition to the two evidence-based programs detailed above, the PSA 5 OAA IIID provider will be required to offer four additional evidence-based programs meeting ACL/AOA's highest tier criteria in Pasco and Pinellas counties.

To the extent feasible, the AAAPP will continue to participate in a statewide network in order to coordinate Evidenced Based Services under the umbrella of the Florida Health Network (FHN). This network will partner with MCOs/ACOs to assist managed care clientele reduce hospital recidivism for falls.

The AAAPP will produce one "Aging on the Suncoast" television program for broadcast in both counties to promote an evidence-based health promotion program sometime during the (3) year cycle. The show will be broadcast for one month, airing an average of 60 times on Pinellas and Pasco Government Access Channels and reaching a diverse audience.

The AAAPP will continue to research and investigate opportunities to build capacity and provide Evidenced Based Services directly.

The AAAPP will continue to participate with Better Living for Seniors (BLS) and the Pinellas County Emergency Medical Services (EMS) sponsored Falls Prevention Coalition Meetings in order to strategize fall mitigation practices and promote the use of Evidenced Based Programs either available through the AAAPP or within the community.

The AAAPP will continue to explore the viability of offering the “Savvy Caregiver” Evidenced-Based program to communities in Pasco and Pinellas counties.

The AAAPP will continue to monitor and promote increased completer rates for all Evidenced Based services administered by the sub-contracted OAA IID Provider

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 3.2: Promote good nutrition and physical activity to maintain healthy lifestyles**

**EXPLANATION:** The primary intent of this objective is to focus specifically on nutrition and physical activity, since they are two key components to maintaining health. Many elders are not aware of the long-term implications of a less-than-adequate diet and how it may exacerbate chronic health conditions. Likewise, they may be unaware of the positive effect physical activity might have on their overall health and/or chronic conditions.

**STRATEGIES/ACTION STEPS:**

The AAAPP will contract for the provision of home delivered and congregate meals and nutrition education and counseling in Pasco and Pinellas counties.

The AAAPP will contract for the provision of adult day care services in Pasco and Pinellas counties to promote activity and nutrition during attendance.

The Helpline will continue to help callers who need nutrition assistance. The Helpline database includes community resources for food and meals, including OAA funded home delivered meals, congregate meals, and private meals providers. The Helpline will also provide information on where to get assistance with SNAP applications. This information is available by calling the Helpline or online via the AAAPP website.

The AAAPP will designate community Focal Points, many of which provide nutrition and physical activity opportunities, and make this information available to the public.

The AAAPP will communicate health information, including but not limited to, nutrition and physical activity information, received from the DOEA, DOH, or any other organization with information supported by empirical data to Project Directors, ADRC Workgroup Members, Focal Point Contacts and Senior Center Directors.

Encourage the provider of the Title IIID Health Promotion and Disease Prevention Program to provide education about the connection between good nutrition and physical activity and to offer programs that address nutrition and physical activity.

The AAAPP will continue to sponsor and coordinate the local "Older Adult Food Insecurity" workgroup in order to promote acknowledgement of Food Insecurity in Older Adults and be a force in the reduction of hunger.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 3.3: Promote the adoption of healthy behaviors**

**EXPLANATION:** The primary intent of this objective is to focus on lifestyle choices beyond nutrition and physical activity as in objective 3.2. Lifestyle choices include such activities as smoking, alcohol, and/or drug consumption, average nightly hours of sleep, amount of stress, amount of socialization, engaging in enjoyable pursuits, etc.

**STRATEGIES/ACTION STEPS:**

The AAAPP will increase awareness of Falls Prevention by coordinating and collaborating with the BLS Fall Prevention Coalition/Committee.

The AAAPP will promote healthy behaviors and a focus on lifestyle choices that produce positive aging by including information on the agency's website, as well as incorporating messages directed at the public, community events, and support groups via use of the AAAPP's social media efforts.

The AAAPP will use OAA Title IIID Disease Prevention and Health Promotion funding to subcontract for the provision of Evidence-Based Health Promotion instruction that encourages healthy lifestyles, such as Chronic Disease Self-Management; Tai Chi - Moving for Better Balance; Healthy Eating Every Day; Chronic Pain Self-Management; Diabetes Self-Management; Active Living Every Day; and Matter of Balance.

The AAA will improve access to health care through the SHINE program, including outreach and education.

The AAA will produce one TV show on the topic of Health Promotion and Disease Prevention within the (3) year plan cycle.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 3.4: Advocate for prevention and early intervention of mental health and substance abuse services for elders**

**EXPLANATION:** The primary intent of this objective is to enable the AAA to focus on advocacy specific to the need for mental health and substance abuse services. Strategy examples can include the plan for the AAA to work with the Department to ensure that individuals who have been identified at-risk due to emotional or psychological distress receive the appropriate referral, and/or how the AAA tracks and confirms that an appropriate action is taken on behalf of each client in distress and the status update that is provided to the contract manager at the Department on a quarterly basis.

**STRATEGIES/ACTION STEPS:**

Contract for OAA/LSP funded mental health and gerontological counseling services in both counties. Encourage the provision of services in home or within the community.

Develop and/or maintain representatives of the mental health community and recovery advocates to the extent feasible on the AAAPP's various boards/committees, i.e., ADRC Workgroup, AAAPP Advisory Council, AAAPP Board of Directors, Better Living for Seniors, and Pasco Aging Network

Coordinate and communicate with National Alliance on Mental Illness (NAMI) in Pinellas County to stay abreast of mental health issues and resources.

Create and/or maintain pertinent mental health information related to increasing understanding of mental and substance-use disorders on our website and/or social media channels, as feasible.

The AAAPP will continue to explore “Telehealth” as a modality to provide needed Mental Health and Behavioral Health Services

**OUTCOMES:**

**OUTPUTS:**

**GOAL 4:** [Ensure the legal rights of seniors are protected and prevent their abuse, neglect, and exploitation](#)

**OBJECTIVE 4.1: Collaborate and coordinate within the community and aging network to increase accessible legal services**

**EXPLANATION:** The primary intent of this objective is to enable the AAA to detail efforts to make legal services more accessible to seniors in greatest economic or social need, as well as to improve the quality of legal services.

**STRATEGIES/ACTION STEPS:**

The AAAPP will provide information to the public on legal resources including OAA legal service providers, one of whom serves as the statewide Senior Legal Helpline. Information in the form of fliers or brochures will be distributed during events where AAAPP staff will be attending for reasons of Outreach.

Legal services will be maintained in the Helpline database, which AAAPP staff access to make appropriate referrals.

The AAAPP will distribute to providers, partners, and seniors, the Older Floridians Handbook and other brochures, when made available.

The OAA Title III B legal service providers are part of the ADRC work group that facilitates communication and coordination within the PSA network.

AAAPP staff will attend and participate in local legal forums dedicated to elder issues as well as issues facing individuals with developmental/intellectual disabilities and/or their caregivers.

The AAAPP will hold an annual Legal Joint Planning meeting including OAA Title IIIB legal providers and the aging network in order to identify senior legal priority issues and strategize effective legal service delivery.

The AAAPP funds the legal service providers to offer legal services to grandparents and relative caregivers under the OAA Title IIIEG program.

The Helpline will continue to assist callers who need legal help. Legal services will be maintained in the Helpline database, which Helpline staff access to make appropriate referrals. The database includes OAA funded legal resources, private legal resources, and the Senior Legal Helpline. These resources are also available in the online database through the AAAPP website.

**OUTCOMES:**

**OUTPUTS:**



**OBJECTIVE 4.2: ▲ Facilitate the integration of Older Americans Act elder rights programs into Aging Services**

**EXPLANATION:** The primary intent of this objective is to make legal services a more visible and mainstream part of the aging network package of services.

**STRATEGIES/ACTION STEPS:**

The AAAPP Elder Abuse Coordinator offers professional education to the staff of OAA funded Service Providers, Lead Agencies and professionals serving seniors in the community to raise awareness of elder rights.

The AAAPP Victim Advocate(s) will collaborate with the providers of OAA funded Legal Services to serve victims of crime age 60 and older.

The AAAPP will hold an annual Legal Joint Planning meeting including IIIB legal providers and the aging network at large in order to identify senior legal priority issues and strategize effective legal service delivery.

AAAPP staff will collaborate with the OAA Title IIIB legal providers to increase outreach and cross training in the Aging Network and in the community, including increased social media attention and attendance at meetings where information on legal services can be distributed.

The AAAPP will provide previously-filmed caregiver education sessions, specific to the episode covering “Legal and Financial Aspects” to audiences for free via the agency website and social media pages. These sessions address common issues Caregivers face, including but not limited to strategies for caring for individuals with ADRD.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 4.3: ▲Improve the identification and utilization of measurable consumer outcomes for elder rights programs**

**EXPLANATION:** The primary intent of this objective is to enable the AAA to document efforts to ensure targeting of elder rights programs in the PSA and to demonstrate the value and impact of those services.

**STRATEGIES/ACTION STEPS:**

The Pasco OAA Legal Service Provider has identified the prioritization of need for service in accord with Legal Service Corporation guidelines.

The Pinellas County OAA Legal Service Provider establishes priority for service in accord with the Older Americans Act.

AAAPP participates in the Older Floridians Legal Assistance Program (OFLAP).

The AAAPP will participate in statewide efforts to develop and utilize a uniform statewide reporting system for legal services and in coordination with the Older Floridians Legal Assistance Program (OFLAP).

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 4.4: Promote primary prevention of elder abuse, neglect, and exploitation**

**EXPLANATION:** The primary intent of this objective is for the AAA to expand existing education/outreach/awareness efforts such as websites, newsletters, presentations, etc., to include prevention of abuse, neglect, and exploitation.

**STRATEGIES/ACTION STEPS:**

The AAAPP will designate an Elder Abuse Coordinator responsible for collaboration with community organizations in Pasco and Pinellas to augment abuse prevention activities.

Quarterly, AAAPP staff will conduct a minimum of six education outreach events to educate the public about the special needs of elders and about the risk factors for abuse in vulnerable adults.

<http://agingcarefl.org/prevent-abuse-fraud/> provides information to the public on the identification and reporting of abuse and community resources for assistance.

The AAAPP will support existing relationships and build new relationships (e.g. District Adult Protective Services (APS), local law enforcement, State's Attorney, SHINE and Long-Term Care Ombudsman Program) to strengthen elder abuse prevention.

The Victim Advocate(s) will participate in the local Domestic Violence Task Force(s).

The Elder Abuse Coordinator will provide a minimum of two training sessions each quarter for professionals or paraprofessionals working with older adults using DOEA approved curriculums.

The AAAPP will conduct crime forums, joining with other service providers, to educate elders about consumer protection and to identify victims of crimes and/or elder abuse.

The Elder Abuse Coordinator will coordinate and promote World Elder Abuse Awareness Day activities.

The Elder Abuse Coordinator will collaborate with members of law enforcement, Adult Protective Services, Domestic Violence Task Forces and Victim's Rights Coalitions which improve coordination for public education and training of professionals and the response to victims of abuse.

The AAAPP will distribute Department approved elder abuse prevention and crime prevention materials at exhibits, festivals, health fairs and other forums.

The AAAPP will prepare and/or distribute one Public Service Announcement or other media contact per quarter to raise awareness of elder abuse.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 4.5: Reduce the rate of abuse, neglect, and exploitation (ANE) recidivism through education, outreach, and the provision of services**

**EXPLANATION:** The intent of this objective is to expand existing efforts supporting ANE interventions.

**STRATEGIES/ACTION STEPS:**

Lead Agencies will ensure High Risk referrals from Adult Protective Services (APS) will receive crisis-resolving services within 72 hours of the referral being made.

The AAAPP will monitor providers to ensure High Risk APS referrals are served within 72 hours as identified in the Memorandum of Understanding and APS Operations Manual.

The ADRC will prioritize individuals waiting for service according to DOE directives: Giving priority to High Risk APS referrals first, then referrals identified as Imminent Risk. Home Care for Disabled Adults (HCDA) and Community Care for Disabled Adults (CCDA) "Aging Out" clients are the next priority level. Individuals with priority ranking scores of 5 will then be released prior to individuals with lower ranking scores.

Lead agencies have entered into Memorandums of Understanding with the AAAPP and Department of Children and Families (DCF) as required by Notice of Instruction #092205-1ISWCBS and #121907-1-I-SWCBS and will acknowledge receipt of all APS referrals in ARTT the same day the packet is received. The crisis resolving service(s) will be initiated within 72 hours of receipt of the referral packet.

Coordination meetings will be held quarterly with representatives from the AAAPP, Lead Agencies and DCF to ensure each party is following the guidelines established in the Memorandum of Understanding and discuss any issues each party may be experiencing to better serve High Risk APS referrals.

The AAAPP, in consultation with DCF and Lead Agencies, will adhere to the Memorandum of Understanding for responding to High Risk APS referrals.

The AAA will ensure lead agencies will be available to respond to High Risk APS referrals 24 hours, 7 days/week, including weekends and holidays, through the review of provider policies and coordination meetings. All other referrals from APS will be received by the ADRC.

The AAA will review exception reports on a monthly basis to ensure services were provided to High Risk APS referrals within 72 hours.

The AAAPP will operate a Victim of Crime Act Program to address the needs of Senior Victims and facilitate the criminal justice process, as well as, secure resources for the victim and caregivers to restore the quality of life prior to the victimization.

The AAAPP Senior Victim Advocate will conduct crime forums to educate seniors regarding consumer protection.

The Victim Advocate(s) will maintain current certification of completion of the Victim Services Practitioner Designation by the Office of the Attorney General.

The Elder Abuse Coordinator will participate in statewide training conference calls when offered by the Department.

The AAA will participate in local partnerships and coalitions to address the needs of victims of elder abuse.

The Senior Victim Advocate will coordinate with Adult Protective Services (APS), local law enforcement, the State Attorney's Office, and the Office of the Attorney General to provide criminal justice support to senior victims.

The AAAPP will track the number of APS referrals.

The AAAPP will track the number of victims served by the AAAPP Senior Victim Advocate Program, including the types of crimes and types of services delivered by the AAAPP Victim Advocate(s).

**OUTCOMES:**

DOEA Internal Performance Measures:

Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours

**OUTPUTS:**

**OBJECTIVE 4.6: Increase the awareness of health care fraud and other elder rights issues**

**EXPLANATION:** The intent of this objective is for the AAA to use existing mechanisms to increase public awareness.

**STRATEGIES/ACTION STEPS:**

The AAAPP Senior Victim Advocate will conduct crime forums to educate seniors regarding consumer protection.

Annually, the AAAPP will produce one “Aging on the Suncoast” television program on at least one of the following topics: Prevention of Healthcare Fraud and promotion of the statewide Senior Medicare Patrol Project (SMP); Consumer Protection for Seniors; or Elder Abuse, Exploitation, & Neglect (ANE), for viewers in Pasco and Pinellas counties.

The AAAPP Website provides information on the detection and reporting of Elder Abuse.

The Elder Abuse Coordinator provides technical assistance and training to programs that provide or have the potential to provide services for victims of elder abuse, neglect, and exploitation and for family members of victims.

Utilize the AAAPP’s website and social media channels to increase awareness of health care fraud and other elder rights issues.

The AAAPP will conduct all activities related to the statewide Senior Medicare Patrol Project (SMP) within the PSA. Activities conducted will align with the SHINE program taking on a comprehensive and holistic approach to service callers to the ADRC Helpline

**OUTCOMES:**

**OUTPUTS:**

**GOAL 5:** Participate in community efforts to ensure your PSA is addressing the state’s mission to create livable communities by promoting this work through the eight domains of livability framework. Support the work DOEA is doing in collaboration with AARP and the World Health Organization’s (WHO) Age-Friendly Cities and Communities Program.

**OBJECTIVE 5.1: ▲ Community Support and Health System: Coordinate with community partners for increased access to affordable, person-centered health care and social services to promote active and independent living.**

**EXPLANATION:** The primary intent of this objective is to establish a working relationship with the local county health departments to promote planning and development of the age-friendly public health system.

**STRATEGIES/ACTION STEPS:**

Support the AARP/WHO “Age Friendly Communities Initiative as well as any DoEA commensurate initiatives and work with municipalities or counties wishing to pursue the aforementioned.

- Developing partnerships with DOH at the county level to identify community needs/concerns through joint community surveys.
- Collaboratively working with the county health department on the Community Health Improvement Plan (CHIP) to develop effective strategies to improve health outcomes and reduce costs.
- Promoting the availability of existing public health programs within the community that conveys a collaborative approach to support healthy aging.
- Increasing awareness of an age-friendly public health system by building a rapport between the public health and the aging sectors.
- Providing opportunities to participate in fun, unique programs that support being healthy, examples include offering free exercise programs in a local park and exploring sponsorship opportunities through private insurance companies.
- Promoting awareness of the Dementia Care and Cure Initiative (DCCI) task force in your PSA.
- Promoting awareness of the Memory Disorder Clinic (MDC) in your PSA and the services it offers.



**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 5.2: ▲ Housing: Promote safe, accessible, and affordable housing that supports aging in place!**

**EXPLANATION:** The primary intent of this objective is to work together with community partners to ensure a wide range of housing options are available for residents, and the community has access to home modification programs.

Support the AARP/WHO "Age Friendly Communities Initiative as well as any DoEA commensurate initiatives and work with municipalities or counties wishing to pursue the aforementioned.

- Developing partnerships with city housing departments to explore opportunities for affordable housing.
- Developing partnerships with the DCF Homeless coalition lead agency.
- Facilitating access to home modification programs.
- Promoting availability of resources that enhance personal independence.
- Bridging relationships between city, local builders, and developers on the importance of universal design in new construction.

Participate on the Emergency Food and Shelter Program Board of United Way.

Distribute safety cell phones to seniors in both counties to facilitate access to 911.

The AAAPP will increase knowledge of aging experience among university students through field placement of student interns at the AAAPP, maintaining partnerships with the University of South Florida, St. Leo College and Florida State University.

Maintain active involvement with Better Living for Seniors (BLS) and Pasco Aging Network (PAN) in support of private sector resources serving PSA 5 seniors.

Participate at the meetings of the Dunedin Committee on Aging and the St Petersburg Commission on Aging.

Serve on various Emergency Coordination coalitions, boards, work-groups to promote All Hazards Disaster Preparedness and Recovery benefitting residents within all communities.

Helpline will update Refer database with current housing options and resources and refer clients in need of housing to these available options.

AAAPP will continue to make referrals to the Disability Achievement Center for home modification requests.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 5.3: ▲ Transportation: Increase awareness of and promote safe and reliable transportation options to increase mobility and community participation.**

**EXPLANATION:** The primary intent of this objective is to make sure your community offers alternative transportation options that allows members to still have access to health care, shopping, social engagement programs, civic participation, employment, and services.

**STRATEGIES/ACTION STEPS:**

Support the AARP/WHO “Age Friendly Communities Initiative as well as any DoEA commensurate initiatives and work with municipalities or counties wishing to pursue the aforementioned.

- Partnering with local transportation coordinator through the Commission for the Transportation Disadvantaged.
- Promoting the work and resources of Safe Mobility for Life Program.
- Partnering with local agencies to ensure the community offers accessible, affordable, and reliable public transportation options.
- Partnering with DOT on safe, complete streets and intersections.
- Working with community transportation partners to develop ambassador leaders in the community to educate on the use of public transit system.
- Working with local governments to address availability of benches and shelters at bus stops.
- Creating partnerships to work together to implement neighborhood/community volunteer transportation programs.
- Promoting use of alternative transportation options: walk, bike, public transit, ride share.

AAAPP Helpline will update Refer with available transportation options and provide resources to callers in need of transportation.

AAAPP Helpline and Intake staff will refer callers in need of transportation to funded providers in Pasco and Pinellas counties to arrange service.

AAAPP will continue to participate in the Local Transportation Disadvantage Coordinating Boards in Pasco and Pinellas counties.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 5.4: ▲ Communication and Information: Increase access to information through various methods including print, tv, and digital media.**

**EXPLANATION:** The primary intent of this objective is to ensure multiple means of communication are being used within a PSA to link people to information, services, and resources. These efforts need to take into consideration persons with disabilities.

**STRATEGIES/ACTION STEPS:**

Support the AARP/WHO “Age Friendly Communities Initiative as well as any DoEA commensurate initiatives and work with municipalities or counties wishing to pursue the aforementioned.

- Developing assessment tools to determine how your community receives information and possible opportunities for improvement, with particular attention in rural areas and underserved populations.
- Developing strategies through community partnerships to ensure effective communication reaches residents of all ages.
- Partnering with local senior centers, universities, and private partners to offer technology classes.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 5.5: ▲ Respect and Social Inclusion: Promote, engage, and celebrate the valuable contributions of all adults in the community.**

**EXPLANATION:** The primary intent of this objective is to promote intergenerational programs through the PSA.

**STRATEGIES/ACTION STEPS:**

Support the AARP/WHO “Age Friendly Communities Initiative as well as any DoEA commensurate initiatives and work with municipalities or counties wishing to pursue the aforementioned.

- Developing strategies to ensure older adults are valued, respected, and involved in decision making in their communities.
- Developing intergenerational programs that bring together youth and older adults.
- Partnering with local schools to provide opportunities to learn about aging and respect. DCCI task forces can develop dementia sensitivity trainings for schools/universities/vocational schools.
- Implementing grand-friend programs: where older adults are paired with school children to improve their skills and offer mentoring.
- Promoting a culture that values diversity, fairness, dignity, and equal opportunity for all.
- Partnering with local neighborhood associations to develop check-in programs.
- Facilitating opportunities for cross-cultural interactions among clients, caregivers, and program staff. Promoting a diverse governance and workforce that are representative of the population being served.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 5.6: ▲ Civic Participation and Employment: Increase awareness of opportunities to contribute in the workplace and volunteer to make a difference in the community.**

**EXPLANATION:** The primary intent of this objective is to promote the Senior Community Service Employment Program (SCSEP), community service, and volunteer opportunities.

**STRATEGIES/ACTION STEPS:**

Support the AARP/WHO “Age Friendly Communities Initiative as well as any DoEA commensurate initiatives and work with municipalities or counties wishing to pursue the aforementioned.

- Encouraging older adults to stay engaged in the workforce.
- Partnering with the local SCSEP to provide community service training opportunities that could lead to sustainable employment.
- Promoting the local SCSEP and the importance of hiring elders.
- Building bridges across age and culture.
- Implementing programs with universities and senior centers to offer flexible education opportunities and intergenerational projects.
- Promoting the Create the Good volunteer program with AARP.
- Working with local agencies to promote volunteer and social engagement opportunities for older adults.
- Promoting volunteer opportunities through DOEA programs: SHINE, ombudsman, guardianship, home delivered meals.
- Developing recognition programs to show the value of your volunteers during the month of April.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 5.7: ▲ Social Participation: Increase awareness of and promote easy access to social and cultural activities for increased quality of life.**

**EXPLANATION:** The primary intent of this objective is to work collaboratively with the local senior centers and other organizations to prevent social isolation and increase engagement through evidence-based programs.

**STRATEGIES/ACTION STEPS:**

Support the AARP/WHO “Age Friendly Communities Initiative as well as any DoEA commensurate initiatives and work with municipalities or counties wishing to pursue the aforementioned.

- Promoting education and awareness to erase the stigma of ageism.
- Developing working relationship with faith-based organizations to work together to facilitate programs to promote engagement in the community.
- Collaborating with the local senior centers to make sure a variety of activities are offered to appeal to a diverse population and ensure there is communication to promote the availability of programs.
- Developing partnerships with community-based organizations, such as senior centers, community centers, faith-based organizations, and YMCAs to address loneliness and social isolation by establishing opportunities to increase social interactions and development of new friendships.
- Offering language assistance to individuals with limited English proficiency.
- Increasing awareness and access to programs and support across diverse populations within the aging and disability communities, regardless of a person’s literacy level, ethnicity, race, gender, religion, sexual orientation, gender identity, or socioeconomic status.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 5.8: ▲ Outdoor Spaces and Buildings: Work with community partners to ensure accessible, inviting, and safe outdoor spaces and buildings that encourage active participation and recreation.**

**EXPLANATION:** The primary intent of this objective is to work collaboratively with local partners to ensure safe, accessible outdoor spaces.

**STRATEGIES/ACTION STEPS:**

Support the AARP/WHO “Age Friendly Communities Initiative as well as any DoEA commensurate initiatives and work with municipalities or counties wishing to pursue the aforementioned.

- Working collaboratively with local parks and recreation department to ensure community parks for all ages.
- Advocating for safe, walkable sidewalks and entrances to building are safe, accessible, clearly visible for all.
- Developing working relationships with neighborhood associations.

**OUTCOMES:**

**OUTPUTS:**



## **GOAL 6:** Maintain effective and responsive management

### **OBJECTIVE 6.1: Promote and incorporate management practices that encourage greater efficiency**

**EXPLANATION:** Best practice strategies may include internal monitoring, quality assurance, and performance-based standards and outcomes.

#### **STRATEGIES/ACTION STEPS:**

The AAAPP holds regular “Leadership Meetings” on a monthly basis to discuss important topics affecting the agency, provider network or communities within PSA5

The AAAPP holds “All Staff Meetings” when appropriate to discuss agency operations

AAAPP will conduct client satisfaction surveys annually.

Results of surveys will be shared with the service providers to promote improvement.

Annually provide the Advisory Council with details regarding the AAAPP's monitoring process, monitoring schedule and encourage participation in the monitoring process.

Provide the Board of Directors with all fiscal and program monitoring reports for review, questions and motion to approve and file for audit.

The AAAPP will create and revise monitoring tools based on contractual requirements.

The AAAPP will monitor providers at least annually to ensure contractual compliance.

The AAAPP will complete quarterly 1% file review to ensure data integrity and compliance with all programmatic requirements.

Providers are required to submit monthly outcome measure reports, which are reviewed by AAAPP staff.

CIRTS reports are run monthly for the PSA and follow up completed with all providers as appropriate.

The AAAPP will monitor APS high risk cases monthly to ensure compliance.

Customer Satisfaction Surveys will be conducted to evaluate the Information and Assistance/Referral (I&A/R) and Screening service provision and to get feedback on the client's experience with the resources provided. Management reviews surveys and addresses any concerns. Surveys are done according to DOEA contract and the results are included in a report to the Local Coalition Workgroup.

Quality Assurance for Medicaid functions for SMMCLTCP is extensive. PSA 5 follows F4A policy and strives to achieve all requirements in the DOEA ADRC contract and DOEA mandated performance measures. Quality Assurance reports are sent to DOEA quarterly and QA achievement is shared with the Board of Directors and the Local Coalition Workgroup. (See APIP in 2.3 for details)

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 6.2: Effectively manage state and federal funds to ensure consumers' needs are met and funds are appropriately spent**

**EXPLANATION:** The intent of this objective is for all state and federal funds to be appropriately spent, as well as to identify alternate resources for funding. In addition, the intent is for the funds to be spent on those populations for which the funds were intended.

**STRATEGIES/ACTION STEPS:**

The AAAPP will track Lead Agency receipts of consumer co-payment collections monthly.

The AAAPP will provide technical assistance to agencies that are not collecting adequate co-pays to meet their goal.

The AAAPP will receive regular reports from lead agencies detailing co-payments that are waived for clients receiving services.

The AAAPP will track CCE clients who appear SMMC LTCP eligible to ensure clients are appropriately transitioned to SMMC LTCP as funding allows and per DOEA Notice of Instruction.

A Surplus/Deficit report and variance explanation will be provided to the AAAPP Board of Directors on a monthly basis.

The AAAPP will provide training on completion of the client care plan emphasizing the need to access alternative sources for assistance besides Community Care for the Elderly.

Case Management providers and the Helpline will identify volunteer services and resources to be utilized prior to using DOEA funded services.

The AAAPP will enforce DOEA policy requiring one case manager per client in order to avoid duplication of efforts.

The AAAPP will run CIRT reports from the CIRT Report Menu monthly to ensure services are not duplicated and there are no CIRT irregularities.

The AAAPP will provide oversight of all program expenditures to ensure funds are being utilized appropriately.

The AAAPP will contract with Lead Agencies for the coordination of services provided through CCE, ADI, and HCE.

The AAA will contract with Services Providers for the provision of OAA funded services.

The AAA will monitor on a monthly basis, expenditure levels for each provider and program.

The AAA will conduct monthly conference calls with Lead Agencies to discuss expenditures and especially if a transfer of funds is warranted.

The AAA will provide technical assistance to providers who appear to be under or over-spending.

The AAA will reallocate funds as necessary to ensure that all DOEA funds are expended in PSA 5.

The AAA will negotiate competitive rates with service vendors to ensure service dollars are used efficiently in both Pasco and Pinellas counties.

Vendor bills for CCE, HCE, and ADI services, in both Pasco and Pinellas counties, will be reviewed monthly to detect extraordinary or unusual service trends.

**OUTCOMES:**

Note: The AAAs will not be monitored on the measures listed in italics, though the AAA must still include strategies to address them in this section.

- *Average monthly savings per consumer for home and community-based care versus nursing home care for comparable client groups*
- *Average time in the Community Care for the Elderly program for Medicaid Waiver probable customers*

DOEA Internal Performance Measures:

- Percent of co-pay goal achieved
- Percent of state and federal funds expended for consumer services

**OUTPUTS:**

**OBJECTIVE 6.3: Ensure that providers continue to strengthen the disaster preparedness plans to address specific needs of elders**

**EXPLANATION:** Strategies may include the development of formal agreements with local, state, and federal entities that provide disaster relief and recovery. Consideration should also be given to the planning and identification of consumer needs, the availability of special needs shelters in times of disaster, and educating clients on the importance of pre-registering for special needs shelters. Examples of actions may include the dissemination of evacuation zone rosters and maps to staff and partners, to ensure client locations are known for preparation and relief efforts.

**STRATEGIES/ACTION STEPS:**

The Helpline will continue to work with DOEA and the other ten AAAs to provide information and referral coverage for areas impacted by a disaster. PSA 5 will function according to DOEA instructions and the F4A MOU related to disaster response.

Participate and support the disaster preparedness and recovery groups, meetings and efforts within the PSA and Tampa bay Region.

Maintain AAAPP CEMP/COOP as well as contracted Provider CEMPs/COOPs.

Meet at least annually with PSA5 service providers to assess readiness for hurricane season and All Hazards Planning.

The AAAPP Emergency Coordinating Officer meets with the Pasco County Emergency Management office and the Pinellas County Emergency Management office as appropriate.

The AAAPP participates in additional specialized groups (i.e. Special Needs, Department of Health) ESF8 and local (i.e. City of St. Petersburg) and regional committees (i.e. Tampa Bay Regional Planning Council) with meetings varying - bi-monthly, quarterly and semi-annually.

After a disaster the AAAPP will contact providers and the emergency management network to approximate the number of elderly persons affected by the disaster/emergency and communicate unmet needs information to DOEA appropriate personnel.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 6.4: Accurately maintain the Client Information and Registration Tracking System (CIRTS) data**

**EXPLANATION:** The intent of this objective is to ensure that data is entered accurately in CIRTS and that data is updated in a timely manner as to reflect changes. Examples of quality assurance actions may also include the AAA working to ensure that addresses for active clients were entered by staff and partners into CIRTS accurately and in the most effective format or to make corrections if a client location cannot be identified, to ensure that individuals' home addresses have the highest likelihood of being properly located and mapped by the Department to identify their assigned evacuation zone.

**STRATEGIES/ACTION STEPS:**

The AAA will train management and direct service providers on understanding CIRTS. Training will follow a reference checklist to ensure consistent coverage. Ancillary materials may include a current CIRTS ownership hierarchy and current list of CIRTS enrollment status codes.

The AAA will conduct a CIRTS User Group Meeting on an annual basis. The AAA will promote communication between providers to raise awareness of changes in client situations, to enhance timeliness of changes in data.

The AAAPP will use CIRTS data to train and motivate providers to ensure best practices.

The AAAPP will communicate all changes regarding CIRTS upon notification from DOEA, and provide training to staff and providers as needed.

The AAAPP will utilize CIRTS data to meet regular state reporting requirements as well as to promote future AAA initiatives.

The AAAPP will use CIRTS to enhance disaster recovery initiatives such as being able to contact clients and caregivers in the event CIRTS is unavailable. CIRTS users will be trained to enter addresses for active clients in the most effective format and to make corrections if a client location cannot be identified to ensure that individuals' home addresses have the highest likelihood of being properly located and mapped by the Department to identify their assigned evacuation zone.

The AAAPP will provide technical assistance regarding CIRTS reports and data integrity.

The AAAPP will run CIRTS reports monthly and work with all providers to correct exceptions. The reports included in the DOEA Interpretive Guidelines will be run monthly. These include: "Client Service, Not Enrolled"; "Active Client Not Served"; and "Assessment Due Report." The AAAPP CIRTS Procedure lists all CIRTS reports that are utilized.

The AAAPP will monitor data integrity by reviewing 1% of newly enrolled client files.

The AAAPP will monitor a percentage of client files during the provider's annual visit to ensure data integrity by use of CIRTS exception reports.

Intake runs CIRTS reports each month to identify clients who are APCL for case managed programs who are due for re-screening. The report is reviewed and re-screening is done according to DOEA requirements.

Intake encourages clients/caregivers to call anytime their situation changes to request an updated 701S so that they are waiting with the most accurate score possible.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 6.5: Promote volunteerism by and for seniors when possible**

**EXPLANATION:** The intent of this objective is to detail how incorporating volunteers might extend the AAA's capacity to provide services.

**STRATEGIES/ACTION STEPS:**

Work with local high schools and universities to provide appropriate volunteer and internship opportunities.

Track the number of volunteers in programs administered by the AAA and contract service providers. Track the number of consumers served by volunteers.

Submit Annual reports to DOEA on the AAA and contract service provider use of trained volunteers to provide direct services and indirect service to older individuals. This report details the activity level and value of the PSA5 volunteer network, which is the outcome of recruitment, recognition and retention efforts.

Annually the AAAPP will develop and implement a SHINE/SMP volunteer recruitment plan and recognize SHINE/SMP volunteers.

**OUTCOMES:**

DOEA Internal Performance Measures:

- Develop strategies for the recruitment and retention of volunteers

**OUTPUTS:**



**Goal 7:** Co-establish and participate in at least one Dementia Care and Cure Initiative (DCCI) Task Force in your Planning and Service Area (PSA).

**OBJECTIVE 7.1:** ▲ Coordinate with the Memory Disorder Clinic (MDC) and local community leaders in Alzheimer’s disease and related dementias (ADRD) in your area to create a DCCI Task Force.

**EXPLANATION:** The primary intent of this objective is to form a Task Force to increase awareness of dementia and services and support for those living with dementia, along with their families and care partners, through public and private partnerships. The Task Force shall accomplish this through strategic planning and implementation of outreach and educational programs, partnerships with community leaders, and action-oriented plans.

**STRATEGIES/ACTION STEPS:**

Forming a Task Force to increase awareness of dementia and of services and support for those living with dementia, along with their families and care partners.

Assisting the Task Force with planning and implementing outreach and educational programs, partnerships with community leaders, and action-oriented plans.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 7.2: ▲ Collaborate with Task Force members to designate community entities as Dementia-Caring.**

**EXPLANATION:** The primary intent of this objective is to provide free dementia sensitivity trainings to government and public service agencies, community entities, caregivers and families, first responders, health care professionals, businesses, and community organizations with dementia sensitivity trainings that will allow recipients to receive the designation of being Dementia-Caring.

**STRATEGIES/ACTION STEPS:**

Collaborating with the Task Force to provide free dementia sensitivity trainings to government and public service agencies, community entities, caregivers and families, first responders, health care professionals, businesses, and community organizations.

Supporting dementia sensitivity trainings that will allow recipients to receive the designation of being Dementia-Caring.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 7.3: ▲ Promote DCCI education and outreach activities throughout your PSA.**

**EXPLANATION:** The primary intent of this objective is to spread awareness and sensitivity about dementia throughout your PSA to encourage safe and inclusive communities for all who seek to continue to be engaged throughout their lifetime, and by linking those living with dementia, their families, and care partners to local resources.

**STRATEGIES/ACTION STEPS:**

Spreading awareness and sensitivity about dementia.

Encouraging safe and inclusive communities for all who seek to continue to be engaged throughout their lifetime.

Linking those living with dementia, their families and care partners to local resources.

**OUTCOMES:**

**OUTPUTS:**

**OBJECTIVE 7.4:** ▲ Identify areas of need within the ADRD community throughout your PSA.

**EXPLANATION:** The primary intent of this objective is to advocate for those living with dementia and recognize ways the Task Force can get involved in the community.

**STRATEGIES/ACTION STEPS:**

Advocating for those living with dementia and recognizing ways the Task Force can get involved in the community.

**OUTCOMES:**

**OUTPUTS:**