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: 1. Provide comprehensive, professional assistance and services to the elderly and persons with disabilities residing in our communities by utilizing the expertise of the Elder Helpline, intake and Medicaid staff to provide assistance and services which includes the provision of information, referral, advocacy, crisis intervention, screening for service needs, program eligibility determination, public education, long-term options counseling, program education and waitlist maintenance in accordance with all applicable state and federal regulations. 2. Provide elders, individuals with disabilities and their families client-friendly access to services, seamlessly and efficiently, by minimizing multi-agency and program service fragmentation, reducing duplication of administrative paperwork and procedures, enhancing individual choice, supporting informed decision-making, and increasing the cost effectiveness of long-term care supports and delivery systems by employing quality customer service and oversight. 3. Utilize and expand collaborations with local, state, and national partners for continuous quality improvements, especially with the ADRC Local Coalition Workgroup and the SRA Advisory Council.

4. Utilize affordable technologies to streamline individual access to health and long-term care options, which includes use of a queue telephony system, public online resource databases.
5. Monitor ADRC efficacy through call monitoring, review of telephony reports, call volume, peak call times, and call abandonment rates to analyze trends.
6. Hire an additional Elder Helpline Specialist to increase the overall number of available specialists to answer the continued high call volume and complete the required 14-day follow-ups.
7. Provide additional training to all existing and newly hired Elder Helpline Specialists with specific regard to the 14-day follow-up contact requirement and the documentation of the outcome of the assistance/referrals provided.
8. Complete random monthly reviews of the Elder Helpline contacts to verify the 14-day follow-up is being completed and to ensure duplicative records are not being created, as required.

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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:

1. Increase public awareness about the importance of planning for long-term care – the potential costs; the probability of a longer lifespan; the likelihood of the need for LTC services; the LTC options available; and, the facts about insurance coverage limitations.
2. Increase public awareness of the limitations of Medicare as a singular long-term care solution.
3. Utilize the SRA website and e-newsletters for on-going information on healthy aging and long term support services.
4. Integrate education on long-term care planning into the activities of PSA 7 professionals and volunteers through training sessions and distribution of educational materials.
5. Conduct Medicare 101 presentations for individuals turning 65 as opportunities for SHINE/SMP/MIPPA volunteers to educate future Medicare beneficiaries on long-term care planning issues.
6. Provide Long Term Care Planning for the SRA Advisory Council to better equip members with information that could be shared within their circles of influence.
7. Promote retirement planning through the development of a guidebook to help consumers understand and navigate the senior service network.

OUTCOMES:

OUTPUTS:

<Enter Text Here>

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 the way people can connect to the information.

STRATEGIES/ACTION STEPS:

1. Continue expansion of current public and private profiles in the ReferNet resource database, to include seeking resources for the population of individual with disabilities.
2. Complete annual request for service provider profile updates from all agencies in the ReferNET resource database and remove all determined inappropriate profiles.
3. Provide a means of on-going electronic updates for all current and new access partners, either through ReferNET, the SRA website, and/or through email.
4. Continue to distribute a ReferNET registration form for new service providers, screening each provider as applicable prior to inclusion in the resource database.
5. Contact potential new service providers through community meetings, events, mail, email, website, and by phone to increase the number of ADRC partnerships, maintaining an annual registry of new partners.
6. Maintain a continuous working relationship with the ADRCs statewide, as well as the F4A Refer Workgroup for enhanced coordinated updates in the ReferNET database and collecting all required and applicable data.
7. Hire an additional Elder Helpline Specialist to assist with the continuous process of updating and maintaining the current REFER Resources database.
8. Evaluate the need to on-board volunteers to assist with the process of updating and maintaining the REFER Resource database.
9. Explore potential partnerships with 2-1-1 in Brevard and tri-county for assistance with resource updates.

OUTCOMES:

<Enter Text Here>

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:

1. Establish additional counseling sites to expand consumer access to the SHINE/SMP/MIPPA Program.
2. Utilize the SRA website, outreach events, presentations, and free Public Service Announcements to increase beneficiary utilization of local counseling assistance, particularly during the Medicare Annual Election Period, resulting in an increase in enrollment contacts and Part D enrollment contacts in compliance with the target goals set by DOEA.
3. Increase the numbers and types of SHINE program partnerships to maintain compliance with outreach benchmarks set by DOEA, prioritizing faith-based organizations, DCF ACCESS providers, Medicaid providers, and other local service providers.
4. Recruit new and diverse volunteers to increase the volunteer workforce and the diversity of counselors available to assist Medicare beneficiaries with an emphasis on increasing the total number *of active bilingual counselors* in compliance with the target goals set by DOEA – identifying community leaders in areas with high concentrations of minority populations and working with those leaders to recruit residents who could work within their own neighborhoods.
5. Increase volunteer retention by offering on-going training, educational and recognition activities.
6. Reduce confusion among consumers over the impact of the Affordable Care Act, Medicare, and Medicaid Reform in Florida through SRA outreach at community events; professional training offerings; public awareness presentations; website updates; and, expanded SHINE activities.
7. Reach out to corporate human resource departments to arrange for pre-retiree, in-service SHINE presentations.
8. Add a part-time, SHINE Program Assistant with a dedicated telephone line to increase the agency's capacity to serve more clients as an adjunct to the Elder Helpline.
9. Increase the number of SHINE Basic Training classes each year to minimize loss of interest in the waiting period for those who express an interest in volunteering.

OUTCOMES: <Enter Text Here>
OUTPUTS: <Enter Text Here>

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:

1. Provide in-service training for ADRC call center operators to enhance listening skills and crisis intervention techniques.
2. Keep the SRA website up-to-date with resource and service information to help elders and caregivers maintain their mental and physical health and independence.
3. Include mental and physical healthcare resource and service information in the SRA outreach activities.
4. Improve access to mental health counseling by advocacy efforts, the promotion of mental health information and seminars on the SRA website, and the distribution of mental health materials at outreach events.
5. Seek new partnerships with local behavioral health centers to ensure appropriate referrals, as needed, both for treatment options and for evidence-based interventions.
6. Explore utilization of the evidence-based “ASSIST” Program.

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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:

1. OAA service providers will submit an annual Targeting Plan for outreach strategies to reach targeted populations, including minority, low-income, limited English speaking, and rural populations.
2. SRA shall review each OAA provider's annual Targeting Plan activities to ensure progress toward targeting goals and provide technical assistance, as needed.
3. SRA staff will invite representatives from the Department of Children and Families, APS, DOEA CARES staff, Agency for Person with Disabilities, the Center for Independent Living, and other organizations to participate in the ADRC Local Coalition Workgroup and ensure coordination of activities for aging and disabled populations.
4. The SRA Advisory Council will have presentations to keep them informed of current issues affecting the disabled and aging populations, enhancing their advocacy efforts.
5. SHINE volunteers shall assist Medicare beneficiaries and dual eligible clients with health insurance questions to help them make informed decisions regarding all health plan options, including Special Needs Plans.
6. SRA will monitor OAA service providers to ensure services to those in greatest need, including intake, outreach, respite, adult day care, transportation, training, chore, counseling, legal assistance, and grandparent supportive services.
7. SRA will participate in outreach activities through the ADRC, ANE and SHINE/MIPPA/SMP Programs and conduct evidence-based health and wellness workshops in target areas identified in the Area Plan.
8. SRA will participate in local Commissions on Aging, CCR meetings, and local networking groups to develop new targeting strategies.

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, quality assurance, and grievance resolution services.

STRATEGIES/ACTION STEPS:

1. SRA/ADRC will provide assistance to individuals who are 18 years old and older, who request long-term care services by evaluating potential eligibility for enrollment in the SMMC LTC Program. This includes Long-term care Education, program information, completion of initial, significant change and annual screening for all potential Medicaid eligible individuals, including individuals with disabilities who are 18 to 59 years old; waitlist maintenance; and completing the re-contact when clients are released from the statewide enrollment management system.
2. SRA/ADRC will assist potentially Medicaid eligible individuals, who have been released by the Department via the Enrollment Management System process, with applying for Medicaid and SMMC LTC benefits, to include obtaining the form 3008 and if requested, financial documents,
3. SRA/ADRC will continue to assist individuals who were enrolled in SMMC LTC, lost their eligibility and have been dis-enrolled due to not regaining eligibility within the SIXT period.
4. SRA/ADRC will assist Medicaid recipients enrolled in the MLTCMC Program with informally resolving grievances through a managed care network's formal grievance process, including instruction for SMMC recipients on how to file complaints with managed care plans and the Agency for HealthCare Administration.
5. SRA/ADRC will continue to coordinate SMMC LTC related activities with DOEA, CARES, DCF, AHCA, and the enrollment broker, as required.
6. Quality assurance monitoring and review of the functions of the ADRC will be completed in accordance with all applicable policy and procedures, which include, but are not limited to such policies and procedures established by the ADRC, F4A and Department of Elder Affairs.

7. SRA/ADRC will utilize the available phone system reporting element to review inbound and outbound call activities, EHL and ADRC queue data summaries, to evaluate the call volumes, potential impacts on available staff and identify potential process changes to increase efficiencies and staffing capacity limitations.
8. SRA/ADRC will continue regular and routine analysis of identified causes of eligibility determination delays due to the incomplete or incorrectly completed 3008 forms received, staffing concerns within partner agencies that may contribute to delayed medical and financial eligibility determination being completed, and capacity limitations on the ADRC to complete timely screening due to escalating demands due to the increasing number of individuals seeking assistance and administrative rule and policy changes.

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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:

1. SRA/ADRC will administer the 701S tool approved by DOEA to screen potential clients, provide options counseling, and enroll them on appropriate waiting lists (APCL).
2. SRA/ADRC will contact clients scheduled for release from the APCL to determine current status and interest in enrollment, forwarding clients to the DOEA CARES unit and DCF for final eligibility determination prior to enrollment (APPL).
3. SRA/ADRC will release the highest priority clients first for provider enrollment in appropriate programs when funding is available – ranked, in order: APS high risk, DCF Aging Out clients, CARES Imminent Risk, Level 5, and Level 4.
4. SRA/ADRC will re-evaluate APCL clients to maintain current status of highest priority clients waiting for services, as required.
5. SRA/ADRC will assist clients with Medicaid eligibility determination process by phone and in-person, as required, to expedite the process.
6. SRA/ADRC Outreach Plan will promote the Elder Helpline in target areas to increase public awareness of the resources available and how to apply through the ADRC.
7. SRA/ADRC will utilize CMS low-income zip code data, updated 2010 U.S. Census data, DOEA Demographic Profile data and the Elder Needs Index data to identify target areas that need to be addressed in the SRA outreach activities.
8. SRA/ADRC will partner with the Memory Disorder Clinics in PSA 7 to expedite the Silver Alert Program and help ADRC clients access the other MDC services, as needed.
9. SRA/ADRC will provide a comprehensive array of resources and services to assist callers needing caregiver support.

10. SRA/ADRC will manage the new LSP contract for the Center for Independent Living and integrate health and wellness workshops into the programs for the disabled.
11. SRA/ADRC will implement targeting strategies as shown in Objective 1.6.

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.

- *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 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 customers who are at imminent risk of nursing home placement who are served with community-based services*
- *Percent of elders assessed with high or moderate risk environments who improved their environment score*
- *Percent of new service recipients with high-risk nutrition scores whose nutritional status improved*

<u>DOEA Internal Performance Measures:</u>

- 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 including identifying unmet needs and/or gaps through strategic partnerships and collaborations with other entities which have expertise in meeting the identified needs and/or gaps and developing specialized support services for aging caregivers.

STRATEGIES/ACTION STEPS:

1. Identify and solicit support from volunteers, faith-based organizations, philanthropic foundations, and other community agencies to expand the capacity of the aging network.
2. Develop and implement strategies to improve service delivery within PSA 7 by running regular CIRTS, CMS, and Refer reports to prevent duplication of effort, with close scrutiny of case management services; and, present service delivery issues to the Board of Directors, Advisory Council, and/or County Commissions on Aging, as needed, to solicit input for improvements in both publicly and privately funded services.
3. Review the active client count, monthly expenditures, average cost per client, and surplus/deficit reports to determine any corrective action that may be needed to better manage expenditures, providing technical assistance, as needed, for service providers, especially related to care plan utilization.
4. Expand non-DOEA services through innovative programs such as Neighbors Network, CarFit, Florida Health Networks, and other partnerships.
5. Conduct presentations for the Board of Directors, Advisory Council, County Commissions on Aging, Philanthropic leaders, and other partners to improve service coordination efforts and maximize the capacity of providers to serve the vast majority of elders and caregivers who do not qualify for publicly funded programs, but cannot afford the full cost of services.
6. Promote and support best practices in the community to encourage replication and expansion of services. For example, Brevard County's "Volunteers In Motion" Program has expanded transportation for seniors as an adjunct to their transit and paratransit systems. Osceola COA's medical clinic is staffed by volunteer physicians and supervised resident interns. Seminole, Brevard and Osceola providers have fully equipped kitchens, supplying thousands of meals to non-profit and for-profit organizations throughout each county. Share The Care maintains a very helpful website called "Caregiver Central."
7. Implement the Veteran's Directed Home and Community-Based Program in PSA 7.

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.

- *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 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 customers who are at imminent risk of nursing home placement who are served with community-based services*
- *Percent of elders assessed with high or moderate risk environments who improved their environment score*
- *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:

1. Negotiate with potential contractors to ensure unit cost efficiencies are in line with state average unit cost rates to maximize service delivery.
2. Monitor contractors to track average care plan costs for at-risk elders to ensure quality of care without unnecessary expenditures.
3. Conduct quarterly utilization review and annual monitoring to ensure full expenditure of all funding resources.
4. Complete annual quality assurance monitoring of the ADRC functions, to include: information, referral, intake screening, rescreening, priority list management, and prioritization release authorizations to providers, utilizing the ADRC APIP developed with input of the LCWG and reporting ADRC goal achievements to the LCWG annually.
5. Conduct a Local Coalition Workgroup (LCWG) meeting to advise in the planning and evaluation of the Aging and Disability Resource Center and to assist in the development of an ADRC Annual Program Improvement Plan. The LCWG consists of representatives from the Area Agency on Aging/Aging and Disability Resource Center, DOEA CARES supervisors, DCF Economic-Self Sufficiency, DCF APS, Agency for Healthcare Administration, Lead Agencies, ADI providers, OAA providers, SHINE counselor, local county law-enforcement, State Senator staff, local hospital, Florida Council on Compulsive Gambling, Geriatric Nurse Consultant and private services providers
6. The LCWG is responsible for collaborating with the key ADRC staff to identify appropriate ADRC scope of work areas in which efficiency and performance could be improved to further streamline processes and enhance the opportunity of the area's elderly and individuals with disabilities populations to receive identified services to delay or prevent institutional care. Continuous and regular communication occurs between key staff from the ADRC, the Department of Children and Families Economic Self-Sufficiency program and the local CARES offices to review the local SMMC LTC eligibility determination process and address identified challenges when capacity to do so exists.

7. An Annual Program Improvement Plan is developed jointly by the ADRC and LCWG, which details comments to be implemented to achieve improvements that require implementation recommendations from the Department of Elder Affairs, Chapter 430.2053, F.S.
8. The ADRC and LCWG has recognized the continued backlog of the ADRC's annual screenings as an area that improvement is needed and agreed the ADRC evaluate current staffing and staff workloads to seeking options to increase the number of available staff to address the overdue backlog. The ADRC has established individual staff member screening goals for the staff completing re-screenings, to include CIRTS data cleanup, to reduce the overall overdue backlog.
9. Monitor budget authorizations of the ADRC to ensure the most efficient and appropriate utilization of program funding.
10. Utilize assessment instruments for annual monitoring of evidence-based service providers in the OAA Title IIID program to ensure compliance with fidelity guidelines.
11. Ensure the administration of consumer satisfaction measurements for active clients; review results collected by providers; and, monitor corrective actions, as required.
12. Administer an annual consumer satisfaction survey of ADRC clients; summarize results; and, implemented corrective actions, as needed.
13. Identify best practices and share information with the provider network to acknowledge and award high performance achievement

OUTCOMES:

<Enter Text Here>

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 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 customers who are at imminent risk of nursing home placement whose needs are met with community-based services*

- *Percent of elders assessed with high or moderate risk environments who improved their environment score*
- *Percent of new service recipients with high-risk nutrition scores whose nutritional status improved.*

OUTPUTS:

<Enter Text Here>

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

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

STRATEGIES/ACTION STEPS:

1. Support prime contractors for the Alzheimer's Disease Initiative (ADI) – Share The Care, in Orange and Seminole; Osceola COA; and, the Brevard Alzheimer's Foundation – in their efforts to provide services, education, and referrals in target areas to meet the needs of individuals with dementia and their caregivers, including training, outreach, technical support, and participation in caregiver forums.
2. Collaborate with the Alzheimer's Dementia and Referral Center with cross-training, special events, and referrals, posting their on-going caregiver series on the SRA website.
3. Collaborate with the local Memory Disorder Clinics with cross-training, special events, referrals, and, specifically in the Silver Alert Program.
4. Collaborate with the Alzheimer's Association with cross-training, special events, referrals, and, specifically with representation on the SRA Advisory Council. Their support groups are for caregivers and sometimes for the person with dementia.
5. Coordinate efforts with the ReferNet Workgroup to promote the new "Lifespan Respite Program."
6. Promote an increased effort to diagnose people earlier in the disease process. Early diagnosis is important for patients to:
   (a) Get medical interventions that can delay the progress of the disease;
   (b) Make financial and legal decisions that will affect both the patient's and the family's future; and,
   (c) Become part of a care team that helps designate early on how they want their care planned in the future.
   (d) Participate in education programs to better understand and manage the disease; plan for future care; and learn about available resources.
7. Implement an expedited referral process to ensure that individuals with dementia have easy access to Alzheimer's Disease Initiative (ADI) and caregiver programs.
8. Promote the "Brain Fitness Club" and the Brain Flex Wellness" program, along with other resources and services through outreach activities.

OUTCOMES:

<Enter Text Here>

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 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 customers who are at imminent risk of nursing home placement who are served with community-based services*
- *Percent of elders assessed with high or moderate risk environments who improved their environment score*
- *Percent of new service recipients with high-risk nutrition scores whose nutritional status improved*

OUTPUTS:

<Enter Text Here>

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:

1. Execute and monitor OAA Title IIIE contracts that ensure the provision of services for caregivers age 55 and older as required by the National Family Caregiver Support Program, including intake, education, training and options to help caregivers make better decisions and deal with current and prepare for possible future needs – home delivered meals, companionship, socialization, homemaking, home maintenance and repair, in-home care training, daily calls to check on an isolated older adult, respite, adult day care, transportation, chore, counseling, legal assistance, and grandparent support services.
2. Provide staff support for OAA Title IIIE providers in public awareness campaigns, public forums, educational opportunities, and annual caregiver retreats.
3. Offer partnership opportunities and/or letters of support for Title IIIE provider grant applications to expand service capacity and expand caregiver support group options.
4. Maintain up-to-date caregiver information in the Elder Helpline resource database and on the Senior Resource Alliance website.
5. Highlight best practices such as the Seniors First Orange TV media spot to discuss dealing with caregiver stress.
6. Identify caregiver support groups and maintain a complete listing for referrals from the ADRC and other programs, as needed.

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.

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

OUTPUTS:

<Enter Text Here>

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:

1. Recruit, train, and schedule contracted and volunteer providers to implement evidence-based programs throughout the four counties, including™ A Matter of Balance,™ Chronic Disease Self-Management Program,™ Diabetes Self-Management Program,™ Programa de Manejo Personal de la Diabetes,™ and Tomando Control de su Salud.™
2. Implement a Direct Service Waiver (DSW) through the employment of a Master Trainer to ensure there are no gaps in service delivery and to expand capacity through the recruitment, training, and placement of volunteer "Coaches" and "Peer Leaders."
3. Establish partnerships to leverage the OAA Title IIID funds and expand the provision of evidence-based services, for example, with physician referral pads for Living Healthy workshops.
4. Monitor evidence-based providers to ensure compliance with fidelity guidelines.
5. Explore potential contracts with insurance companies to expand the provision of EB programs.
6. Continue the statewide partnership with "Florida Health Networks," an affiliate of the Health Foundation of South Florida, to expand the provision of EB programs and apply for accreditation as a Medicare provider.
7. Pursue Medicare accreditation through the implementation of a "pilot" DSMP workshop, integrating the assistance of a physician and registered dietitian under the supervision of Florida Health Networks.

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 these 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:

1. Contract for the provision of evidence-based programs that include nutrition education and promote physical activity to maintain healthy lifestyles, including an RD for the Medicare accreditation program.
2. Encourage provider participation in the Adult Care Food Program with information from the DOEA website.
3. Distribute health promotion information at outreach events throughout the year, including disease prevention and chronic disease self-management materials, such as the "Age Pages" and other free brochures from the Department of Health, CDC, NIH, NCOA, AoA, and other trusted sources.
4. Utilize a consultant to assist with the annual monitoring of OAA providers and ensure compliance with nutritional requirements. SRA and lead agencies will assist the department to ensure that C-1 funded meals are not used in Adult Day Care Centers serving low-income clients in an effort to maximize ACFP (100% federal funds) utilization and increase availability of C-1funds.
5. Develop social support for programs that promote active lifestyles and use of public facilities (e.g. walking or bike trails, classes at gyms or senior center, athletic fields, etc.)
6. Implement the Senior Hunger and new "Growing Bolder" Programs to inspire healthy, active living for older adults.

OUTCOMES:

OUTPUTS:

<Enter Text Here>

- *Number of congregate meals provided (Standard: 5,300,535)*

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, stress, socialization, engaging in enjoyable pursuits, etc.

STRATEGIES/ACTION STEPS:

1. Advertise the evidence-based programs through public service announcements, Orange TV, the SRA website, and other media venues.
2. Distribute educational brochures and flyers at community focal points and outreach events in target areas.
3. Mail SRA and health promotion information to clients on the ADRC APCL in target areas.
4. Distribute health promotion information and links to the Department of Health, CDC, NIH, NCOA, AoA and other key partners, at outreach events and on the SRA website.
5. Participate in each county's Commission on Aging and other community groups to promote the evidence-based programs.
6. Participate in the newly formed statewide "Florida Health Networks" project to expand the provision of EB programs and promote healthy behaviors.
7. Increase public awareness of the benefits associated with remaining active in the community through a new partnership with "Growing Bolder," utilizing the multi-media capacity of Full Sail University and an annual awards program.
8. Promote the Living Healthy programs through new partnerships with the VA.

OUTCOMES:

OUTPUTS:

<Enter Text Here>

OBJECTIVE 3.4: Promote social connectivity, community service, and lifelong learning to maintain positive mental health

EXPLANATION: The primary intent of this objective is to address the benefits to the individual and the community when elders are active and engaged in the community.

STRATEGIES/ACTION STEPS:

1. Promote public awareness of volunteer opportunities in SHINE, RELIEF, Senior Companion, home delivered meals, RSVP, Ombudsman, advocacy initiatives, and other local volunteer programs, through outreach activities, including community presentations, television, radio, website, and other multi-media outlets.
2. Provide employment opportunities for elders on the SRA website and increase public awareness of the education, experience, and maturity of older workers.
3. Increase public awareness of the benefits associated with remaining active in the community through a new partnership with "Growing Bolder," utilizing the multi-media capacity of Full Sail University and an annual awards program.
4. Provide in-service training for Board of Directors and Advisory Council members to increase their knowledge on key issues facing the elderly and disabled populations and cultivate their participation in resource development activities and advocacy efforts.
5. Use the SRA website to highlight best practices like Seniors First partnership with UCF student nurses and home improvement partners to expand community benefit opportunities.
6. Support and coordinate activities and educational opportunities, mutually beneficial to elders and youth, through partnerships with Volunteers for Community Impact and the Retired Senior Volunteer Program (RSVP).

OUTCOMES:

OUTPUTS:

<Enter Text Here>

OBJECTIVE 3.5: 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 needs for mental health and substance abuse services.

STRATEGIES/ACTION STEPS:

1. Keep the SRA website up-to-date with resources, information and activities to increase public awareness of mental and substance-use disorders and remedies, addressing issues related to nutrition, sleep habits, medication, and pain management.
2. Distribute mental and physical healthcare materials at outreach events to increase public awareness of prevention benefits.
3. Promote the benefits of evidence-based programs and group-based workshops, especially at Senior Centers, to help elders and caregivers maintain their health and independence.
4. Provide in-service training for Board of Directors and Advisory Council members to increase their knowledge on key issues facing the elderly and disabled populations and cultivate their participation in resource development activities and advocacy efforts.
5. Strengthen partnerships with Florida Council on Compulsive Gambling, the Center for Drug Free Living and other agencies that deal with behavioral and substance abuse issues.
6. Coordinate referrals with 2-1-1 and the crisis hotline and explore possible training in the EB “ASSIST” program for call center operators.

OUTCOMES:

OUTPUTS:

<Enter Text Here>

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.

STRATEGIES/ACTION STEPS:

1. Develop an annual Legal Services Action Plan through on-going joint planning between the aging network and legal assistance providers to identify target groups; establish priority legal issue areas; and, develop outreach mechanisms to ensure limited legal assistance resources are allocated in such a way as to reach those seniors who are most vulnerable and have the most critical legal needs.
2. Provide information on legal services and the Florida Senior Legal Helpline on the SRA website and in outreach activities.
3. Ensure compliance with OAA Title IIIB Legal Services Delivery Standards, including targeting requirements, through contractual language and annual monitoring.
4. Provide cross-training sessions for aging network and legal service providers.
5. Fully participate in the Department of Elder Affairs Older Floridians Legal Assistance (OFLAP) Program.
6. Facilitate on-going discussions related to older adult legal issues through legal service provider representation on the SRA Advisory Council.
7. Conduct research and educate the SRA Advisory Council on “Medical Legal Partnerships” to help promote this new partnership opportunity among local health care and legal professionals.

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:

1. Participate in local Coordinated Community Response (CCR) teams and other service networks to strengthen consumer advocacy efforts.
2. Provide opportunities for training to inform older adults, the public, and professionals about elder rights programs.
3. Promote an understanding of individual rights for personal empowerment to exercise choices; and provide information regarding the benefits of services and opportunities authorized by law among vulnerable and at-risk seniors.
4. Aging Matters, in Brevard County; Meals On Wheels, Etc. in Seminole County, and Osceola Council on Aging will continue contracting with the Legal Aid Society in their county to make legal services more accessible to seniors in greatest economic or social need and promote these services through their outreach and targeting plans.
5. Contract directly with the Legal Aid Society of the Orange County Bar Association to provide legal services in Orange County and ensure compliance with OAA Title IIIB Legal Services Delivery Standards for all providers through contractual language and annual monitoring.
6. Provide information on legal services and promote the Florida Senior Legal Helpline through outreach activities and the SRA website.

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:

1. Participate in statewide efforts to develop a uniform statewide reporting system for legal services; establishing mechanisms for utilizing data available to improve awareness of the importance of legal assistance; increasing access to legal assistance; and, addressing the quality of legal assistance provided.
2. Ensure compliance with OAA Title IIIB Legal Services Delivery Standards through contractual language and annual monitoring.
3. Review OAA Service Provider targeting reports to ensure targeting of elder rights programs in PSA 7.

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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:

1. Coordinate efforts of the SRA Adult Abuse and Prevention staff, ADRC staff, and service providers to increase outreach for public awareness, educational presentations, and cross-training events.
2. Provide public education to help consumers identify and prevent elder abuse, neglect and exploitation; promote financial literacy; and, prevent identity theft and financial exploitation of older individuals, including home health agencies, health fairs, independent and assisted living facilities, foster grandparents, Salvation Army, faith-based organizations, congregate meal sites, and other community events, as specified in the ANE Annual Activity Plan.
3. Conduct training for individuals; including caregivers, professionals, and paraprofessionals, on identification, prevention and treatment of elder abuse, with particular focus on prevention and enhancement of self-determination and autonomy.
4. Promote the Abuse Prevention Hotline and the Florida Senior Legal Helpline through the SRA website and on all appropriate outreach documents for public education of the special needs of elders and the risk factors for abuse in vulnerable adults.
5. Expand partnerships with agencies and organizations in order to augment abuse prevention services and activities and strengthen ties amongst community groups, including Lead Agencies, law enforcement agencies and local Triad groups.
6. Participate in local collaborative events to build relationships with partners and increase awareness of community resources.
7. Utilize the new ANE curriculum developed by F4A in accordance with the executed Memorandum of Agreement.

OUTCOMES: <Enter Text Here>
OUTPUTS: <Enter Text Here>

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

EXPLANATION: The intent of this objective is to expand existing efforts supporting abuse, neglect, and exploitation interventions.

STRATEGIES/ACTION STEPS:

1. Reduce the rate of recidivism through education and outreach for caregivers and clients to help them with coping skills and services to alleviate caregiver stress and possible family strife.
2. Coordinate efforts of the SRA Adult Abuse and Prevention staff, ADRC staff, and service providers to increase outreach for public awareness, educational presentations, and cross-training events.
3. Provide public education to help consumers identify and prevent elder abuse, neglect and exploitation; promote financial literacy; and, prevent identity theft and financial exploitation of older individuals, including home health agencies, health fairs, independent and assisted living facilities, foster grandparents, Salvation Army, faith-based organizations, congregate meal sites, and other community events, as specified in the ANE Annual Activity Plan.
4. Conduct training for individuals; including caregivers, professionals, and paraprofessionals, on identification, prevention and treatment of elder abuse, with particular focus on prevention and enhancement of self-determination and autonomy.
5. Promote the Abuse Prevention Hotline and the Florida Senior Legal Helpline through the SRA website, the "Senior Blue Book," Senior Scene, 50+FYI, and other media campaigns.
6. Expand partnerships with agencies and organizations in order to augment abuse prevention services and activities and strengthen ties amongst community groups, including Lead Agencies, law enforcement agencies and local Triad groups.
7. Participate in local collaborative events to build relationships with partners and increase awareness of community resources, including County Commissions on Aging, TRIAD, CCR, Florida Assisted Living Association, local health departments, and other local professionals, as specified in the ANE Annual Activity Plan.
8. Implement a new initiative called "Senior Emphasis Days" with local faith-based organizations.

OUTCOMES:

<Enter Text Here>

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 Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours (Standard: 97%)

OUTPUTS:

<Enter Text Here>

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:

1. Coordinate efforts of the SRA Adult Abuse and Prevention staff, ADRC staff, and service providers to increase outreach for public awareness, educational presentations, and cross-training events.
2. Provide public education to help consumers identify and prevent elder abuse, neglect and exploitation; promote financial literacy; and, prevent identity theft and financial exploitation of older individuals.
3. Conduct training for individuals; including caregivers, professionals, and paraprofessionals, on identification, prevention and treatment of elder abuse, with particular focus on prevention and enhancement of self-determination and autonomy.
4. Promote the Abuse Prevention Hotline and the Florida Senior Legal Helpline through the SRA website and on all appropriate outreach documents.
5. Expand partnerships with agencies and organizations in order to augment abuse prevention services and activities and strengthen ties amongst community groups, including Lead Agencies, law enforcement agencies and local Triad groups.
6. Participate in local collaborative events to build relationships with partners and increase awareness of community resources.
7. Protect, Detect, and Report Medicare Fraud through implementation of the Senior Medicare Patrol Program.

OUTCOMES:

OUTPUTS:

<Enter Text Here>

GOAL 5: Promote planning and collaboration at the community level that recognize the benefits and needs of its aging population.

OBJECTIVE 5.1 : Foster opportunities for elders to be an active part of the community

EXPLANATION: The intent of this objective is to collaborate with communities to identify opportunities for elders that benefit them and their community.

STRATEGIES/ACTION STEPS:

1. Promote volunteer services by and for older persons including the use of intergenerational activities that allow elders to "give back" while educating younger generations about the value elders bring.
2. Promote public awareness of volunteer opportunities in SHINE, RELIEF, Senior Companion, home delivered meals, RSVP, advocacy initiatives, and other local volunteer programs, through the implementation of the SRA Outreach Plan, including television, radio, website, and other multi-media outlets.
3. Provide in-service training for Board of Directors and Advisory Council members to increase their knowledge on key issues facing the elderly and disabled populations and cultivate their participation in resource development activities and advocacy efforts.
4. Identify best practices for innovative volunteer opportunities, especially intergenerational activities, and promote the replication of these models through the SRA website, information email updates, and training events.
5. Support, sponsor, and participate in Foster Grandparents, RSVP, and other volunteer events in PSA 7, as funding and staff capacity permits.
6. Support and provide recognition for volunteer and intergenerational projects.
7. Increase public awareness of evidence-based health and wellness programs, activities at local senior centers, and the need for volunteer leaders.
8. Promote better retirement planning through information on the SRA website to help consumers understand and navigate the senior service network and learn about volunteer opportunities.
9. Participate on local Commissions on Aging and promote the "Livable Communities" movement.

OUTCOMES: <Enter Text Here>
OUTPUTS: <Enter Text Here>

OBJECTIVE 5.2 : Promote safe and affordable communities for elders that will benefit people of all ages

EXPLANATION: The intent of this objective is to encourage communities to incorporate elements of universal design into new construction and renovations of streets, sidewalks, and other common areas that will support an elder's ability to age in place.

STRATEGIES/ACTION STEPS:

1. Provide information on the aging network for public and private organizations to encourage the development of indoor and outdoor environments that are accessible and user friendly.
2. Ensure that training is provided for case managers and clients to identify in-home environmental hazards and increase knowledge of strategies for in-home improvements.
3. Promote public awareness of in-home safety measures, including educational updates on the SRA website.
4. Participate in County Commissions on Aging and support "Livable Communities" projects to promote safety within the community environment.
5. Advocate for the housing needs of elders through participation in local affordable housing advisory committees, local housing assistance plans, or other venues, as appropriate.
6. Promote "Neighbors Network," Celebration's "Thriving In Place," home sharing programs, and other best practices.
7. Coordinate activities with Community Development Block Grant funded programs, Habitat for Humanity, and other housing development programs to promote safe and affordable communities.

OUTCOMES:

OUTPUTS:

<Enter Text Here>

OBJECTIVE 5.3 : Promote cultural competency and awareness of a diverse population

EXPLANATION: The intent of this objective is for the AAA to recognize and address the unique benefits, needs, and challenges of its diverse and aging population.

STRATEGIES/ACTION STEPS:

1. Facilitate 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; offering language assistance to individuals with limited English proficiency; and increasing awareness and access to programs and supports across literacy, ethnicity, race, gender, religion, sexual orientation, gender identity, and socioeconomic status.
2. Increase accessibility to services, expanding program delivery, and enhancing retention, as well as maximizing the health and well-being of diverse populations within the aging and disability communities.
3. Ensure that service providers offer training for case managers and other front-line staff to promote cultural sensitivity and multi-cultural activities.
4. Highlight best practices in cultural competency on the SRA website.
5. Increase public awareness of the benefits of cultural diverse activities and remaining active in the community through a new partnership with “Growing Bolder,” utilizing the multi-media capacity of Full Sail University and an annual awards program.
6. Strengthen partnerships with the Hispanic Chamber of Commerce; Latino Leadership; Telemundo Orlando; HOLA; the African American faith-based organizations; and, other culturally diverse organizations in Central Florida.
7. Utilize new bi-lingual Health and Wellness Program staff to promote SRA EB programs to limited English speaking elders.

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:

1. SRA/ADRC and providers continue to follow existing PSA specific and statewide monitoring standards and procedures to ensure high quality service delivery.
2. SRA/ADRC implements more comprehensive general revenue enrollment tracking measures, which collects data to analyze the length of time from release to assessment, priority ranking and score differentials, and reasons individuals do not wish to receive services.
3. SRA/ADRC implements a tracking system to ensure callers who leave voice messages are provided a call back and appropriate service to address the call reason timely and efficiently. The tracking system allows for management oversight, review and analysis on the performance of the ADRC.
4. SRA/ADRC and service providers adhere to PSA policies and procedures to address CIRTS data accuracy and integrity issues, to ensure compliance with all current standards.
5. SRA/ADRC continues to utilize available telephony data reports to evaluation and analyze aspects of the helpline, intake and Medicaid staff performance and to identify the limitations of the current staff.
6. SRA/ADRC continues to follow all F4A quality assurance policies and procedures, as well as participates in F4A workgroups, which includes collecting and sharing of critical data for statewide analysis.
7. The Advisory Council and Board of Directors oversee improvement objectives as identified through internal monitoring, performance-based standards, and outcomes for quality assurance.
8. Add a part-time staff member to assist in the regular and frequent review of CIRTS Data Accuracy report and communicate errors/exceptions with the service providers, as needed.
9. Revise the PSA CIRTS Data Policies and Procedures to decrease the threshold of allowable exceptions; increase the required frequency providers run MLTC, CIRTS Data clean-Up and DOD reports each month.

10. Require service provider CIRTS Data Accuracy Plans, including policies and procedures, timeframe for assessments; and, a fixed CIRTS report run date and time period to resolve and remove the exception/error.
11. Require CIRTS Data Accuracy reports to be submitted with invoices, withholding payments until excessive exceptions/errors are addressed and resolved.
12. Establish process to ensure the Aging Out report is run and reviewed regularly to accurately identify individuals who are active in either the CCDA or HCDA program and will turn 60 years old with 6 months.
13. Coordinate with DCF/APS to ensure that the DCF service recipients' required case file documentation is efficiently delivered to the AAA prior to the individual's 60th birthdate, so the transition from DCF to DOEA providers can take place.

    Review new active enrollees by assessment rank monthly for trends in low priority 701B assessments.

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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:

1. Track internal, OAA and Lead Agency expenditure levels on a quarterly basis to ensure utilization of resources throughout the annual fiscal period.
2. Notify contractors if quarterly expenditures fall below the 25% measure per quarter, confirming the transfer of underspent funds to other county providers, as needed.
3. Conduct monthly and annual analyses of assessed and collected co-pay amounts and provide technical assistance to ensure that consumers pay their share of the cost of services provided as prescribed in the co-pay requirements.
4. Maintain and utilize the Refer Resource database to offer local resources and funding alternatives to clients requesting assistance prior to relying on Community Care for the Elderly funds.
5. Identify and solicit support from volunteers, faith-based organizations, philanthropic foundations, and other community resources to expand the capacity of the aging network.
6. Expand the capacity of the service network through non-DOEA innovative programs such as CarFit, health and wellness partnerships, the Senior Hunger Program, Growing Bolder, and other collaborative efforts.

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 (Standard: 100%)

OUTPUTS:

<Enter Text Here>

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 and the availability of special needs shelters in times of disaster.

STRATEGIES/ACTION STEPS:

1. Strengthen relationships with county emergency management representatives through participation in local ESF meetings, as applicable, for the safety of senior citizens in PSA 7.
2. Monitor contractors to ensure that disaster preparedness plans are updated and provide technical assistance, as needed.
3. Expand partnerships with local agencies to improve coordination in times of disaster, with particular attention to the potential roles of 211 and the ADRC.
4. Include disaster preparedness coordination as an agenda item in 2nd quarter meeting with the prime contractors – updating MOUs and contact lists, as needed.
5. Maintain updated Disaster MOU with statewide Elder Helpline Aging Resource Centers to ensure coordination between ADRCs and the ReferNET® system during a disaster.

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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.

STRATEGIES/ACTION STEPS:

1. Monitor service providers monthly to ensure compliance with CIRTS requirements.
2. Ensure CIRTS data accuracy through the use of all applicable and available CIRTS Outcome, Assessments, Enrollments, Monitoring and Services reports for a monthly error rate reviews with corrective action procedures to address any non-compliance.
3. Run weekly APS exception reports and request follow-up action from providers to ensure compliance with all regulations, to include data accuracy in CIRTS, the ARTT system, and most importantly, the 72-hour service delivery standard for all High-Risk clients.
4. Run prioritized APCL report for release of clients for enrollment, as funding permits.
5. Run overdue assessment reports as well as incomplete assessment reports at least monthly as part of the internal monitoring of the ADRC.
6. Track CIRTS data on a weekly basis to ensure that all CARES imminent risk referrals are acknowledged in CIRTS by the ADRC and prioritized on the APCL, as required.
7. Compare CIRTS reports to mid-year and annual service provider targeting reports to monitor compliance with targeting measures.
8. SRA/ADRC implementation of PSA 7 policies and procedures to address CIRTS data accuracy and integrity issues, to ensure compliance with all current standards.

OUTCOMES:

OUTPUTS:

OBJECTIVE 6.5: Promote volunteerism by and for seniors when possible

EXPLANATION: The intent of this objective is twofold: 1) detail how incorporating volunteers might extend the AAA's capacity to provide services and 2) promote the benefit of elder volunteers to other entities who also provide services.

STRATEGIES/ACTION STEPS:

1. Promote public awareness of volunteer opportunities in SHINE, RELIEF, Senior Companion, home delivered meals, RSVP, health and wellness evidence-based programs, advocacy initiatives, and other local volunteer programs, through outreach activities, television, radio, website, and other multi-media outlets.
2. Provide in-service training for Board of Directors and Advisory Council members to increase their knowledge on key issues facing the elderly and disabled populations and cultivate their participation in resource development activities and advocacy efforts.
3. Identify best practices for innovative volunteer opportunities, especially intergenerational activities, and promote the replication of these models through the SRA website, information email updates, and training events.
4. Support, sponsor, and participate in Foster Grandparents, RSVP, and other volunteer events in PSA 7, as funding and staff capacity permits.
5. Promote the campaign for Florida's Intergenerational Week (first full week in December).
6. Promote Florida's Volunteer Recognition month and National Volunteer Appreciation Week (April).

OUTCOMES:

DOEA Internal Performance Measures:

- Develop strategies for the recruitment and retention of volunteers

OUTPUTS:

<Enter Text Here>