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

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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 professional, efficient, and effective call center services for older adults, the disabled, and their caregivers to have full access to a comprehensive array of resources.

2. Utilize highly trained personnel to staff the Elder Helpline for Information and Referrals services, including appropriate triage to local, state, and federal programs.

3. Utilize highly trained call center specialists for intake and assessment to determine eligibility for the Community Care for the Elderly (CCE) program.

4. Utilize highly trained Medicaid Specialists for intake and assessment to determine eligibility for the Statewide Medicaid Managed Long-Term Care (SMMLTC) program.

5. Provide on-going training to ensure that all call center staff provide quality access services, including consumer advocacy; crisis intervention; screening for service needs; program eligibility determination; long-

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term options counseling, as appropriate; increased awareness of available resources; and, waitlist management in accordance with all applicable state and federal regulations.

6. Provide seamless, client-friendly access to services, 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 service delivery systems by employing quality customer service.

7. Continue expanding the capacity of the service network through the development of new local community partners, as well as regional and statewide partners, evidenced by a minimum 10% increase per year from the approximate 50 partners currently on-board.

8. Utilize affordable technologies to streamline individual access to long-term care services and supports, including the purchase of a new queue telephony system; the SRA website; and social media platforms.

9. Monitor the efficacy of the ADRC on at least a monthly basis through call monitoring and telephony reports, analyzing call volume, peak call times, abandonment rates, productivity and performance trends.>

OUTCOMES:

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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, long term support services, and the importance of retirement planning.

4. Integrate education on long-term care planning into the activities of PSA 7 through training sessions and distribution of educational materials.

5. Conduct Medicare 101 presentations for individuals turning 65 as opportunities for SHINE 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 coordinated activities with AARP.

8. Distribute information on long-term care planning to service providers assisting caregivers in PSA 7, including the National Family Caregiver Program, the Alzheimer's Disease Initiative, and Volunteers for Community Impact.

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OUTCOMES:

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OUTPUTS:

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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:

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 and the F4A Refer Workgroup for enhanced, coordinated updates in the ReferNET database in compliance with data collection and reporting standards established through F4A and DOEA collaboration.

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OUTCOMES:

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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. < Evaluate the effectiveness of all 25 SHINE counseling sites in PSA 7 to ensure that volunteers maintain a good participation rate; adequate space and equipment; publicity; and, privacy.

2. Close ineffective SHINE sites, as necessary; and, make inquiries of newly identified sites in target neighborhoods to expand consumer access to the SHINE Program (refer to Area Plan 2020 target sites).

3. Utilize the SRA website, outreach events, presentations, press releases and free Public Service Announcements to increase beneficiary utilization of local counseling assistance, particularly during the Medicare Annual Election Period (AEP).

4. Increase beneficiary and enrollment contacts in compliance with the benchmarks established by DOEA.

5. Maintain good communications with existing 50+ outreach partners while, at the same time, reaching out to new diversified partners, especially in target areas of PSA 7, with the goal of at least one new collaboration each quarter, prioritizing faith-based organizations, DCF ACCESS providers.

6. Recruit new volunteers to increase the workforce and the diversity of counselors available to assist Medicare beneficiaries with an emphasis on increasing the total number *of active bilingual counselors.*

7. Reach out to community leaders in areas with high concentrations of minority populations to recruit residents who could work within their own neighborhoods.

8. Increase volunteer retention by offering on-going training sessions; educational presentations; and, appreciation activities, including quarterly meetings and annual volunteer recognition events.

9. Reduce confusion among consumers over the impact of the Affordable Care Act, Medicare, and Medicaid Long-Term Care programs in Florida through SRA outreach at community events; professional training offerings; public awareness presentations; website updates; and, expanded SHINE activities.

10. Assist dual eligible clients with health insurance questions to help them make informed decisions regarding all health plan options, including Special Needs Plans.

11. Reach out to corporate human resource departments to arrange for pre-retiree, in-service SHINE presentations.

Continue to support 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.>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

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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. Continue partnership with 2-1-1 for crisis intervention referrals.

3. 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.

4. Include mental and physical healthcare resources and service information in the SRA outreach activities.

5. Increase public awareness of community health fairs and seminars through the SRA website community calendar.

6. Strengthen partnerships and cross-training with local behavioral health centers to ensure appropriate referrals, as needed, both for treatment options and for evidence-based interventions.

7. Promote SRA's *Living Healthy* and fall prevention programs through the distribution of community flyers, websites, e-news, and social media.

8. Prepare "Value Propositions" to partner with local health care providers for potential referrals to SRA's evidence-based health and wellness programs.

9. Partner with the Winter Park Health Foundation and the YMCA to maximize utilization of their new *Center for Health and Wellbeing*.>

OUTCOMES:

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OUTPUTS:

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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. < Prioritize outreach and partnership development in rural, outlying and underserved target areas identified in the Area Plan, distributing information on the Elder Helpline and ADRC programs.

2. Ensure that OAA Service Provider Applications include a Targeting Plan for outreach strategies to reach target populations, including minority, low-income, limited English speaking, and rural populations and review each OAA provider's Targeting report annually, providing technical assistance, as needed.

3. Meet with the Agency for Person with Disabilities, the Center for Independent Living, and other representatives of the aging and disabled populations to establish collaborative activities for training, outreach, and education.

4. Assist dual eligible clients with health insurance questions to help them make informed decisions regarding all health plan options, including Special Needs Plans.

5. Ensure a smooth transition of clients "Aging Out" of DCF disability services into ADRC programs.

6. Analyze CIRTS reports to track progress on targeting goals established in the Area Plan on Aging.

7. Keep SRA Advisory Council members informed on current issues affecting the disabled, caregivers and aging populations to enhance their advocacy efforts and increase public awareness of the Elder Helpline.

8. Monitor OAA National Family Caregiver Support Program 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.

9. Follow-up with ADRC wait list clients to let them know about service options.

10. Conduct Outreach Presentations and evidence-based health and wellness workshops in target areas identified in the Area Plan, focusing on individuals with limited English proficiency, low-literacy, low-income, rural, and disabled.

11. Continue partnership with the "Table 60" coalition in Central Florida for joint efforts to fight hunger in the community.

12. Participate in local provider Alzheimer forums and fund raisers to support their efforts.

13. Reach out to partners identified in areas with high concentrations of Alzheimer's and dementia residents to increase public awareness of resources available for clients and caregivers.

14. Distribute information from the Alzheimer's Association to community partners and maintain up-to-date information on the SRA website.>

OUTCOMES:

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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:

1. < 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. 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. 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 required period.

4. 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. Continue to coordinate SMMC LTC related activities with DOEA, CARES, DCF, AHCA, and the enrollment broker, as required.

6. Complete quality assurance monitoring and review of the functions of the ADRC 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. 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. 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.

9. Continue to utilize specific dedicated ADRC Medicaid funded specialists to complete significant change rescreening and annual rescreening of wait listed clients, not to impede or negatively impact the ADRC Medicaid functions, analyzing monthly tracking reports and modifying procedures, as necessary, to enhance productivity.

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OUTCOMES:

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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

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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. < Administer the 701S tool approved by DOEA to screen potential clients, provide options counseling, and enroll them on appropriate waiting lists (APCL), ensuring adherence to prioritization guidelines.

2. 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. 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. Re-assess APCL clients to maintain current status of highest priority clients waiting for services, as required.

5. Assist clients with the Medicaid eligibility determination process by phone and/or in-person, as required, to expedite the process.

6. Promote the ADRC/Elder Helpline through outreach activities in target areas, as specified in the Area Plan, to increase public awareness of the resources available and the application process, especially in rural areas.

7. Contact potential partners identified in each target area, listed in the Area Plan, to explore opportunities for outreach presentations and distribution of resource information.

8. Ensure that OAA Service Provider Applications include a Targeting Plan for outreach strategies to reach targeted populations, including individuals with limited English proficiency; low-literacy, low-income individuals

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in rural populations; disabled persons who receive Medicare but are under the age of 65; grandparents caring for grandchildren; people with developmental disabilities; and dual eligible across any Special Needs Population.

9. Review each OAA provider's annual Targeting Plan reports to ensure progress toward targeting goals and provide technical assistance, as needed.

10. Continue partnership with Senior Hunger Program through "Table 60" coalition.

11. Continue partnership 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.

12. Continue to provide a comprehensive array of resources and services to assist callers needing caregiver support.

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OUTCOMES:

<Enter Text Here>

- 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:

<Enter Text Here>

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:

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 model programs such as Neighbors Network; CarFit; Florida Health Networks; AARP Cooperative Agreements; a potential new transportation program; and, other innovative projects.

5. Initiate strategic planning activities with the SRA Board of Directors and 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. Contract with Orange County Legal Aid Society for Title IIIEG outreach, education, and training to increase public awareness of resources available for caregivers and grandparents raising grandchildren.

8. Continue expansion of the Veteran's Directed Home and Community-Based Program in PSA 7.

9. Provide training on cultural diversity for the Advisory Council and service providers in PSA 7.>

OUTCOMES:

<Enter Text Here>

- 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:

<Enter Text Here>

- 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:

< **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 monthly quality assurance monitoring of the ADRC functions, to include: information, referral, intake screening, rescreening, wait list management, and prioritization for releases to providers.

5. Maintain compliance with a regularly updated ADRC Annual Program Improvement Plan (APIP) developed with input of the Local Coalition Workgroup (LCWG).

6. Conduct a minimum of one annual 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 Improvement Plan (Note: membership includes representatives from SRA, DOEA CARES supervisors, DCF Economic-Self Sufficiency, DCF APS, Agency for Healthcare Administration, Lead Agencies, ADI providers, OAA providers, SHINE, local county law-enforcement, local hospitals, Florida Council on Compulsive Gambling, Center for Independent Living, Geriatric Nurse Consultants, and other public and private services providers).

7. Coordinate quality assurance efforts with key LCWG partners to evaluate areas where efficiency and performance could be improved for streamlined processes to better serve older adults, the disabled, and caregivers and ensure appropriate progressive care.

8. Maintain on-going communication between ADRC staff, the Department of Children and Families Economic Self-Sufficiency program and the local DOEA CARES offices to expedite the SMMLTC eligibility determination process.

9. Establish Continuous Quality Improvement strategies to evaluate current staffing, productivity, call volume, and other program performance measures to address call center deficiencies and set new performance goals.

10. Monitor monthly performance measures to ensure the most efficient and appropriate utilization of program funding.

11. Ensure the administration of consumer satisfaction surveys for active clients; review results collected by providers; and, monitor corrective actions, as required.

12. Analyze on-going consumer satisfaction surveys of Elder Helpline and ADRC clients; summarize results; and, implemented corrective actions, as needed.

13. Maintain compliance with the agency's complaint resolution policy.

14. Require lead agency case manager supervisors to implement file monitoring of all APS high-risk referrals to ensure services are activated within the 72 hour mandate and documented accurately; conduct monthly reviews of all worker logs; and, submit documentation to the AAA for monitoring.

15. Continue to utilize specific dedicated ADRC Non-Medicaid funded specialists to complete significant change rescreening and annual rescreening of wait listed clients, not to impede or negatively impact the ADRC Medicaid functions, analyzing monthly tracking reports and modifying procedures, as necessary, to enhance productivity.

16. Complete monthly reviews of referrals sent to general revenue service providers to ensure compliance with prioritization regulations.>

OUTCOMES:

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- 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:

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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:

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. This includes 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 Family 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.

5. Coordinate activities with providers to promote RELIEF (Respite for Elders Living in Everyday Families), the National Family Caregiver Support Program and the efforts of the Lifespan Respite Alliance.

6. Support Advent Health in the development of a new evidence-based caregiver support program with possible implementation of workshops in 2020-21.

7. Distribute information on Alzheimer's and dementia related programs in all target areas identified in the Area Plan, especially rural, outlying and underserved areas.

8. Promote local initiatives like the *Brain Fitness Club* and the *Brain Flex Wellness* programs through training opportunities and website information.

9. 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.

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OUTCOMES:

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- 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:

<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. < Monitor OAA Title IIIE contractors to ensure the provision of services for caregivers age 55 and older as required by the National Family Caregiver Support Program, including intake, education, training, home delivered meals, companionship, socialization, homemaking, home maintenance and repair, in-home care training, daily calls to check on isolated older adults, 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 forums.

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. Include best practices on the SRA website and highlight special programs dealing with caregiver support.

6. Identify caregiver support groups and maintain a complete listing for referrals from the ADRC and other programs, as needed.

7. Coordinate activities with providers to promote RELIEF (Respite for Elders Living in Everyday Families), and the efforts of the Lifespan Respite Alliance.

8. Support Advent Health in the development of a new evidence-based caregiver support program with possible implementation of workshops in 2020-21.

9. Distribute information on Alzheimer's and dementia related programs in all target areas identified in the Area Plan, especially rural, outlying and underserved areas.

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OUTCOMES:

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DOEA Internal Performance Measures:

- *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*

OUTPUTS:

<Enter Text Here>

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

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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 (MOB); Un Asunto de Equilibrio (UAE); Chronic Disease Self-Management Program (CDSMP); Tomando Control de su Salud (TCS); Diabetes Self-Management Program (DSMP); Programa de Manejo Personal de la Diabetes (PMPD); and, the Diabetes Empowerment Education Program (DEEP).

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. Utilize EB sites map provided by FHN to provide workshops in underserved areas, specifically those areas in each county identified in the Area Plan targeting report.

4. Extend value propositions to establish new partnerships with healthcare providers and leverage OAA Title IIID funds, expanding the provision of evidence-based services in target areas throughout PSA 7.

5. Explore potential contracts with insurance companies to expand the provision of EB programs.

6. Monitor evidence-based providers to ensure compliance with fidelity guidelines.

7. 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.

8. Positively impact the falls prevention program projections for the State Health Improvement Plan (SHIP) by achieving the performance measures established by DOEA: "Individuals age 60 and older who complete an EB fall prevention program, increasing 2.5%, 5% and 7.5% each year respectively contingent upon funding levels (Baseline: 328 completers in 2018).

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OUTCOMES:

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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:

1. < Contract for the provision of evidence-based programs that include nutrition education and promote physical activity to maintain healthy lifestyles, especially at congregate meals sites and other target areas.

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. Continue to participate in the "Table 60" Senior Hunger Program coalition in Central Florida for joint efforts to fight hunger in the community.

6. 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.)

7. Increase awareness of the "Growing Bolder" Program to inspire healthy, active living for older adults.

8. Monitor OAA nutrition providers to ensure the provision of nutrition education and healthy, well-balanced meals, in accordance with all state and federal guidelines.>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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:

1. < Advertise the evidence-based (EB) programs through public service announcements, Orange TV, the SRA website, and other media venues.

2. Distribute EB program flyers in target areas and specifically to potential partners identified in the Area Plan.

3. Distribute health promotion information and links to the Department of Health, CDC, NIH, NCOA, AoA and other key partners, including "Age Pages" at outreach events and on the SRA website.

4. Participate in each county's Commission on Aging and other community groups to promote the evidence-based programs.

5. Participate in the statewide "Florida Health Networks" project to expand the provision of EB programs and promote healthy behaviors.

6. Increase public awareness of the benefits associated with remaining active in the community through promotion of the *Growing Bolder* initiative; the new *Center for Health & Wellbeing*; *Neighbor's Network*; *Thriving In Place*; and, other service provider active living programs.>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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:

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. Ensure compliance with policies concerning intake, screening, and referrals for high-risk callers, using the three-way call option with 2-1-1 Crisis Hotline, as necessary, tracking documentation on these distress callers in the ReferNet system for appropriate referrals, intervention, and follow-up.

7. Provide quarterly status reports to DOEA, as required.

>

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

GOAL 4: Ensure the legal rights of seniors are protected and prevent their abuse, neglect, and exploitation

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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:

1. < Conduct on-going coordination and an annual Joint Planning Meeting with the aging network and legal assistance providers to identify target groups, establish priority legal issue areas, and develop outreach mechanisms to ensure 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. Maintain an annual Legal Services Action Plan as a guide for monitoring Legal Assistance providers; joint grant applications; joint outreach events; and, other coordinated activities.

3. Provide information on legal services and the Florida Senior Legal Helpline on the SRA website and through outreach events.

4. Ensure compliance with OAA Title IIIB Legal Services Delivery Standards, including targeting requirements, through contractual language and annual monitoring.

5. Expand access to legal services through the utilization of OAA Title IIIEG funding, along with Title IIIB.

6. Maintain compliance with the Department of Elder Affairs Older Floridians Legal Assistance (OFLAP) Program.

7. Conduct research and educate the SRA Advisory Council on "Medical Legal Partnership" best practices to explore potential applications in PSA 7. >

OUTCOMES:

<Enter Text Here>

OUTPUTS:

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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. < Provide in-person and/or on-line cross training and the use of available technology and media outlets to inform older adults, the public, and professionals about the legal services available in PSA 7.

2. Promote an understanding of individual rights; developing personal empowerment to exercise choices; and provide information regarding the benefits of services and opportunities authorized by law among vulnerable and at-risk seniors through outreach activities in PSA 7.

3. Execute OAA contracts with *Aging Matters*, in Brevard County; *Meals On Wheels, Etc.* in Seminole County, and *Osceola Council on Aging* for legal assistance through the Legal Aid Society in their county; and, monitor these contractors to ensure that legal services are accessible to seniors in greatest economic or social need.

4. 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.

5. Provide information on legal services and promote the Florida Senior Legal Helpline through outreach activities and the SRA website. >

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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 and Older Floridians Legal Assistance Program (OFLAP) reports to ensure targeting of elder rights programs in PSA 7.>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

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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, including the specific site contacts listed in the target areas identified in the Area Plan.

2. Conduct a minimum of six public education events per quarter 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 a minimum of two training seminars per quarter for volunteers, caregivers, professionals, and paraprofessionals on identification, prevention, and mandatory reporting of elder abuse, neglect, and exploitation.

4. Promote the Abuse Prevention Hotline and the Florida Senior Legal Helpline through the SRA website, SRA E-Newsletter, and on all appropriate outreach documents for public education on the risk factors for abuse in vulnerable adults.

5. Expand partnerships for abuse prevention activities with law enforcement agencies, CCRC's, county TRIAD/SALT groups, and new sites identified in the Area Plan target areas.

6. Distribute ANE information as part of on-going local collaboration meetings, presentations, and community events.

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 (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:

1. < Monitor the ADRC/CCE intake, assessment, and release procedures to ensure prioritization of the high-risk APS referrals to service providers have the appropriate services initiated within the 72 hour requirement.

2. 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.

3. 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, including the specific site contacts listed in the target areas identified in the Area Plan.

4. Conduct a minimum of six public education events per quarter 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.

5. Conduct a minimum of two training seminars per quarter for volunteers, caregivers, professionals, and paraprofessionals on identification, prevention, and mandatory reporting of elder abuse, neglect, and exploitation.

6. Promote the Abuse Prevention Hotline and the Florida Senior Legal Helpline through the SRA website, SRA E-Newsletter, and on all appropriate outreach documents for public education on the risk factors for abuse in vulnerable adults.

7. Expand partnerships for abuse prevention activities with law enforcement agencies, CCRC's, county TRIAD/SALT groups, and new sites identified in the Area Plan target areas.

8. Participate in local collaborative events to increase awareness of community resources, including County Commissions on Aging, Florida Assisted Living Association, local health departments, and other local professionals, as specified in the ANE Annual Activity Plan. >

OUTCOMES:

<Enter Text Here>

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:

<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. < Recruit, train, and activate SHINE volunteers to implement the Senior Medicare Patrol (SMP) program and participate in the DOEA SMP Leadership Team.

2. SHINE/SMP volunteers provide local outreach, education, and assistance to Medicare beneficiaries to protect them from the economic and health-related consequences associated with Medicare fraud, error, and abuse.

3. Coordinate efforts of the SRA Adult Abuse and Prevention staff, ADRC staff, SHINE/MIPPA/SMP volunteers, and service providers to increase outreach for public awareness, educational presentations, and cross-training events, including the specific site contacts listed in the target areas identified in the Area Plan.

4. Conduct presentations to help consumers identify and prevent elder abuse, neglect and exploitation; promote financial literacy; prevent health care fraud; 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, in compliance with the benchmarks established by DOEA.

5. Conduct presentations for volunteers, caregivers, professionals, and paraprofessionals on identification, prevention, and mandatory reporting of elder abuse, neglect, and exploitation.

6. Promote the Abuse Prevention Hotline and the Florida Senior Legal Helpline through the SRA website, SRA E-Newsletter, and on all appropriate outreach documents for public education on the risk factors for abuse in vulnerable adults, including information on potential scams.

7. Expand partnerships for abuse prevention activities with law enforcement agencies, CCRC's, county TRIAD/SALT groups, and new sites identified in the Area Plan target areas.

8. Participate in local collaborative events to increase awareness of community resources, including County Commissions on Aging, Florida Assisted Living Association, local health departments, and other local professionals. >

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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:

1. < Develop partnerships with DOH at the county level to identify community needs/concerns through joint community surveys.

2. Work collaboratively with the county health department on the Community Health Improvement Plan (CHIP) to develop effective strategies to improve health outcomes and reduce costs.

3. Promote the availability of existing public health programs within the community through collaborative activities to support healthy aging – sharing website links; distributing each agencies flyers; and, other coordinated activities.

4. Build relationships between the public health representatives and aging network service providers to promote an age-friendly public health system and increase public awareness of the available resources.

5. Provide opportunities to participate in fun, unique programs that support being healthy, including *Healthy Living* programs sponsored by health care providers and private insurance companies.

6. Promote awareness of the Dementia Care and Cure Initiative (DCCI) task force in PSA 7.

7. Promote awareness of the Memory Disorder Clinic (MDC) and the services it offers in PSA 7.

>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

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OBJECTIVE 5.2: ▲ <u>Housing</u>: 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.

STRATEGIES/ACTION STEPS:

1. < Develop partnerships with city housing and county planning departments to increase awareness of the lack of affordable housing in PSA 7, especially for older adults.

2. Develop partnerships with the DCF Access Centers and the Homeless coalitions in PSA 7 to increase awareness of the support services available through the aging network and coordinate outreach activities.

3. Facilitate access to home modification programs in PSA 7, working closely with the Center for Independent Living (CIL) and the services provided through the State Housing Initiative Partnership Program (SHIP).

4. Promote availability of resources that enhance personal independence, including innovative alternatives like the "Silver Link" shared housing program in Brevard County and other senior cohousing opportunities.

5. Advocate for the integration of universal design in new construction with, local government, developers, and builders in PSA 7.>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

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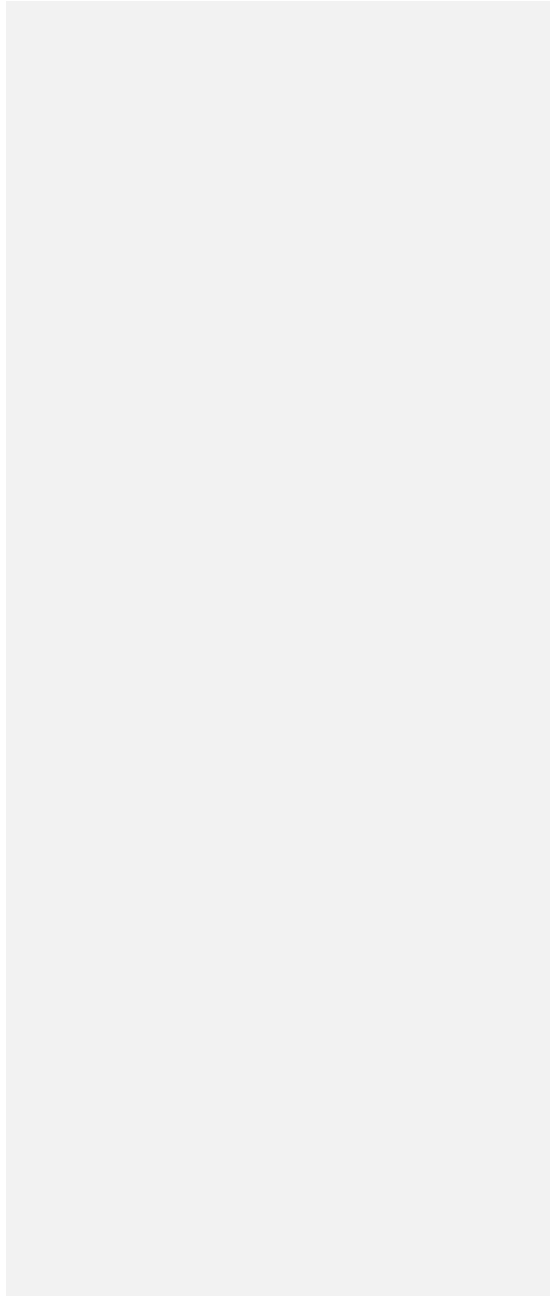
OBJECTIVE 5.3: ▲ **Transportation: Increase awareness of and promote safe and reliable transportation options to increase mobility and community participation.**

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:

1. < Remain active members of the Brevard County Space Coast Area Transit (SCAT) and tri county Metroplan Orlando Commissions for the Transportation Disadvantaged.

2. Promote the work and resources of Safe Mobility for Life Program, including an on-going contract for implementation of the statewide Car Fit Program managed by PSA 7.

3. Partner with local agencies to ensure the community offers accessible, affordable, and reliable public transportation options, including the "Volunteers In Motion" and "TranServe" RSVP Program in Brevard County and LYNX in tri county and the possible development of a new senior transportation program managed by SRA.

4. Partner with DOT on safe, complete streets and intersections, providing information on the needs of older adults and the disabled in PSA 7.

5. Work with community transportation partners to develop ambassador leaders in the community to educate riders on the use of public transit systems.

6. Work with local governments to address availability of benches and shelters at bus stops.

7. Create partnerships to work together to implement neighborhood/community volunteer transportation programs, like *Neighbors Network* and *Thriving In Place* village movements in PSA 7.

8. Promote the use of alternative transportation options, including safe walking and biking areas, public transit, ride share options.>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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:

1. < Develop assessment tools to determine how your community receives information and possible opportunities for improvement, with particular attention in rural areas and underserved populations, using sign-in sheets and/or survey cards as an on-going way to capture this information.

2. Develop strategies through community partnerships to ensure effective communication reaches residents of all ages, including multi-media press releases, PSAs, ads, and the Orange TV spots in PSA 7.

3. Promote the availability of technology classes offered at local senior centers, universities, libraries, and other agencies in PSA 7.>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

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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:

1. < Develop strategies to ensure older adults are valued, respected, and involved in decision making in their communities, by ensuring representation on the Advisory Council; equipping the members with information on successful aging and the challenges of "ageism;" and, providing opportunities to advocate for an elder-friendly environment.

2. Develop intergenerational programs that bring together youth and older adults, working with Foster Grandparents, RSVP, and service providers in PSA 7 to support and promote the replication of model programs.

3. Partner with DCCI task forces to offer dementia sensitivity trainings for schools, universities, and vocational schools, helping students learn about aging and respect for vulnerable populations.

4. Promote a culture that values diversity, fairness, dignity, and equal opportunity for all, with local experts presenting to the SRA Advisory Council on Cultural Diversity in health care and social services and participation in the Central Florida Diversity Learning Series.

5. 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.

6. Offer Senior Service Presentations to local neighborhood associations, encouraging the development of check-in programs.

7. Facilitate opportunities for cross-cultural interactions among clients, caregivers, and program staff.

8. Promoting a diverse governance and workforce that are representative of the population being served.>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

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OBJECTIVE 5.6: ▲ <u>Civic Participation and Employment</u>: **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:

1. < Encourage older adults to stay engaged in the workforce through increased public awareness of volunteer opportunities in SHINE, RELIEF, Senior Companion, home delivered meals, RSVP, advocacy initiatives, and other local volunteer programs, utilizing television, radio, website, and other multi-media outlets.

2. Partner with the local SCSEP to provide community service training opportunities that could lead to sustainable employment.

3. Promoting the local SCSEP and the importance of hiring elders.

4. Increase public awareness of evidence-based health and wellness programs and free training opportunities for volunteer leaders.

5. Implement lessons learned from cultural diversity training to build bridges across age and culture.

6. Reach out to higher education institutions to explore flexible education opportunities and intergenerational projects at senior centers and other community sites.

7. Promote the *Create the Good* volunteer program with AARP.

8. Work with local agencies to promote volunteer and social engagement opportunities for older adults.

9. Develop recognition programs to show the value of volunteers during the month of March or April.>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

OBJECTIVE 5.7: ▲ <u>Social Participation</u>: **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:

1. < Promote education and awareness to erase the stigma of ageism through training and advocacy efforts.

2. Develop working relationships with faith-based organizations to facilitate programs for community engagement, especially with target area potential partners identified in the Area Plan.

3. Collaborate 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.

4. Develop 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.

5. Promote the accessibility of programs 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.

6. Utilized the SRA website and E-Newsletter to maintain up-to-date information on social and cultural activities for increased quality of life.>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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:

1. < Continue to participate in the County Commissions on Aging in PSA 7 to have positive impact on the integration of *Livable Community* strategies to (a) work collaboratively with local parks and recreation department to ensure community parks for all ages; and (b) advocate for safe, walkable sidewalks and entrances to building are safe, accessible, and clearly visible for all.

2. Develop working relationships with neighborhood associations, especially in target community sites identified in the Area Plan, offering presentations on services and distributing resource information.

>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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. < Develop standards, criteria, and/or specific procedures to be used by the service providers, in compliance with local, state, and federal regulations; and, monitor service providers annually for quality assurance.

2. Analyze service provider performance and performance gaps based on monitoring, quality assurance indicators, and performance-based standards and outcomes - monthly, quarterly, and/or annually, as needed.

3. Analyze progress on any service provider corrective action plans and/or improvement objectives based on monitoring, quality assurance, and performance-based standards and outcomes, in accordance with established deadlines and as needed.

4. For ADRC internal monitoring, comply with F4A data collection and analysis requirements and quality assurance activities that are commensurate with F4A policies and procedures (current and as updated over life of this plan).

5. Maintain a tracking system to ensure callers who leave voice messages are provided a call back and appropriate services to address the reason for the call in a timely and efficient manner; analyze the length of time from release to assessment, priority ranking and score differentials, and reasons individuals do not wish to receive services.

6. Utilize available telephony data reports to evaluate and analyze aspects of the helpline, intake and Medicaid staff performance and identify gaps in service and staff limitations.

7. Provide operational reports to the SRA Advisory Council and Board of Directors in the analysis of improvement objectives as identified.

>

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. < Effectively report budgetary surplus/deficit projections, as required by DOEA.

2. Analyze management policies to reduce and eliminate unspent contracted program funds.

3. Enhance communication and collaboration with providers to ensure the appropriate and documented transfer of funds among providers.

4. Track internal, OAA and Lead Agency expenditure levels on a quarterly basis to ensure utilization of resources throughout the annual fiscal period.

5. Notify contractors if quarterly expenditures fall below the 25% measure per quarter, confirming the transfer of underspent funds to other county providers, as needed.

6. 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.

7. 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.

8. Identify and solicit support from volunteers, faith-based organizations, philanthropic foundations, and other community resources to expand the capacity of the aging network through non-DOEA innovative programs.

9. Work with DOEA to explore a potential policy that would cap the cost of care plans not to exceed ICP.

>

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.
- *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:

<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, 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:

1. < Develop and maintain formal agreements with local, state, and federal entities that provide disaster relief and recovery.

2. Identify and plan for consumer needs and the availability of special needs shelters in times of disaster.

3. Disseminate evacuation zone rosters and maps to staff and partners, to ensure client locations are known for preparation and relief efforts.

4. Monitor contractors to ensure that disaster preparedness plans are updated and provide technical assistance, as needed.

5. Expand partnerships with local agencies to improve coordination in times of disaster, with particular attention to the integrated roles of 211 and the ADRC.

Maintain updated statewide Disaster MOU with F4A 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. 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:

1. < As part of the monitoring process, compare CIRTS data to information in client files to verify the accuracy of CIRTS data, sampling data at regular intervals as a tracking mechanism.

2. Provide training and ongoing technical assistance to ensure that employees understand how appropriately use CIRTS.

3. Ensure that addresses for active clients are entered in CIRTS by staff and providers accurately and in the most effective format, making corrections if a client location cannot be identified; ensuring that individuals' home addresses have the highest likelihood of being properly located and mapped by the Department to identify their assigned evacuation zone.

4. Ensure CIRTS data accuracy through the use of all applicable and available CIRTS Outcome, Assessments, Enrollments, Monitoring and Services reports for monthly error rate reviews with corrective action procedures to address any non-compliance.

5. 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.

6. Run prioritized APCL report for release of clients for enrollment, as funding permits.

7. Run overdue assessment reports as well as incomplete assessment reports at least monthly as part of the internal monitoring of the ADRC.

8. 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.

9. Update CIRTS data policy to require client data entry within specific time periods, including 701S screening data and 701(A)(B)(C) data with monthly data accuracy reports as required back-up to requests for payment and expenditure reports.>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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:

1. < Identify, evaluate, and implement "best practices" that enhance the recruitment and use of trained volunteers in providing direct services to older individuals and individuals with disabilities.

2. 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.

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 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. Promote the campaign for Florida's Intergenerational Week (first full week in December).

7. Promote Florida's Volunteer Recognition month and National Volunteer Appreciation Week (April).>

OUTCOMES:

<Enter Text Here>

DOEA Internal Performance Measures:
- Develop strategies for the recruitment and retention of volunteers

OUTPUTS:

<Enter Text Here>

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:

1. < Assist in the formation of 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, including Share The Care, in Orange and Seminole; Osceola COA; the Brevard Alzheimer's Foundation; the Alzheimer's Dementia and Referral Center; the Alzheimer's Association; and, the three MDCs in PSA 7 – East Central Florida MDC, serving Brevard and Osceola; Orlando Health Center for Aging & Memory Disorder Clinic, serving Orange County; and, Florida Hospital Maturing Minds MDC, serving Seminole County.

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

OUTCOMES:

<Enter Text Here>

OUTPUTS:

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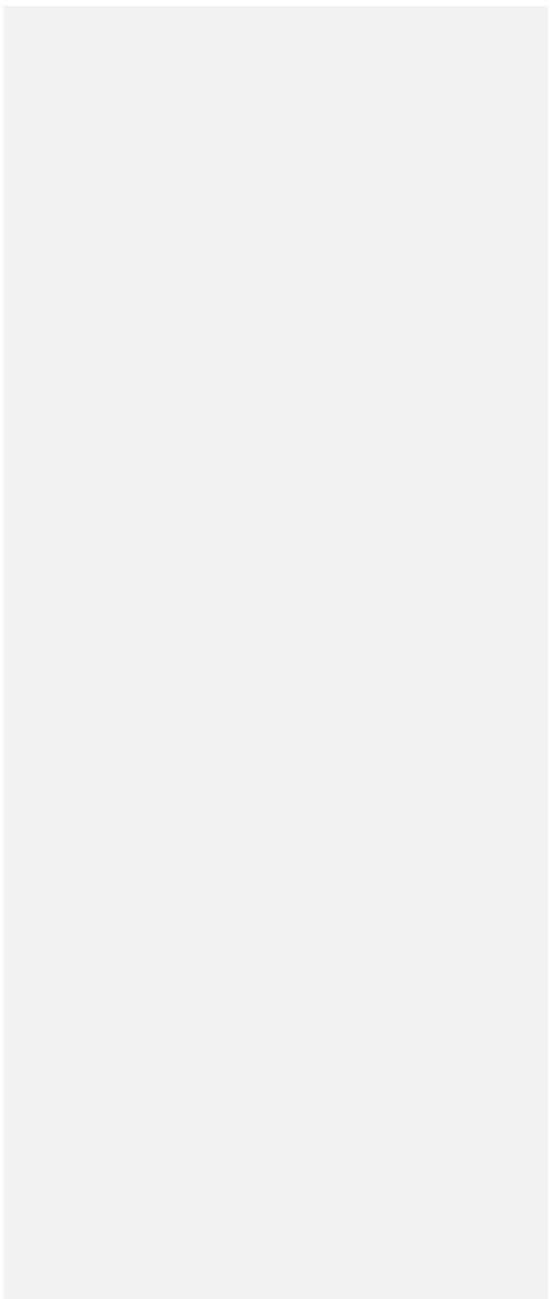
OBJECTIVE 7.2: ▲ Collaborate with Task Force members to designate community entities as Dementia-Caring.

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:

1. < Collaborate 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.

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

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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:

1. < Spread awareness and sensitivity about dementia.

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

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

4. 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. This includes training, outreach, technical support, and participation in caregiver forums.

5. Collaborate with the Alzheimer's Dementia and Referral Center with cross-training, special events, and referrals, posting their on-going Family Caregiver Series on the SRA website.

6. Collaborate with the local Memory Disorder Clinics with cross-training, special events, referrals, and, specifically in the Silver Alert Program.

7. Collaborate with the Alzheimer's Association with cross-training, special events, referrals, and, specifically with representation on the SRA Advisory Council.

8. Coordinate activities with providers to promote RELIEF (Respite for Elders Living in Everyday Families), the National Family Caregiver Support Program and the efforts of the Lifespan Respite Alliance.

9. Support Advent Health in the development of a new evidence-based caregiver support program with possible implementation of workshops in 2020-21.

10. Distribute information on Alzheimer's and dementia related programs in all target areas identified in the Area Plan, especially rural, outlying and underserved areas.

11. Promote local initiatives like the *Brain Fitness Club* and the *Brain Flex Wellness* programs through training opportunities and website information.

12. Promote an increased effort to diagnose people earlier in the disease process. Early diagnosis is important for patients to:

13. Get medical interventions that can delay the progress of the disease;

14. Make financial and legal decisions that will affect both the patient's and the family's future; and,

15. Become part of a care team that helps designate early on how they want their care planned in the future.

16. Participate in education programs to better understand and manage the disease; plan for future care; and learn about available resources.>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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:

1. < Advocate for those living with dementia and identify ways the Task Force can get involved in the community.

2. Identify potential partners in areas with high percentages of probably Alzheimer's Disease as shown in the Area Plan and schedule meetings and presentations to conduct needs assessments; increase awareness of the resources; and, increase participation in the advocacy efforts of the DCCI.>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>