U.S. Department of Health and Human Services
U.S. Administration on Aging

Compendium of AoA Discretionary Grants Completed in FY2010

Under Title IV of the Older Americans Act

Table of Contents

Explanatory Notes

Section 432 of the Older Americans Act (OAA) requires the Assistant Secretary of Aging to prepare a report each fiscal year which describes completed projects and their findings supported under Title IV – Projects for Health, Independence and Longevity. This is the first year the Administration on Aging (AoA) has compiled this report. It is similar in format to the Compendium of AoA Grant Awards which has been compiled every year since 1984 and all projects included in this report have been included in earlier Fiscal Year editions which may be found on the AoA website. Most, but not all, of the new grant and final report compendiums are project grants funded under the Title IV OAA authority. To view past grant awards compendium go to

http://www.aoa.gov/AoARoot/Grants/Compendium/index.aspx

The project summaries in this report are taken from grantee final progress reports. They briefly describe the purpose, organizations involved, and activities; and summarize outcomes and major achievements accomplished during the lifetime of the project. Given that many were conducted over a period of several years, they may not fully describe the activities, evaluation conducted, or their findings. Readers are encouraged to contact the grantee if more information is needed.

Project summaries are ordered by state location of the grant organization, the program or initiative under which they were awarded, and the AoA organizational unit responsible for project monitoring. A grantee organization index is in the appendix ordered by type of organization. On-line readers may use the hypertext embedded in the Table of Contents to jump to program and initiative areas of the compendium and the grantee organization index. Descriptions of the AoA offices, programs and initiatives lead each compendium section.

Comments concerning this compendium can be made through the AoA website:

http://www.aoa.gov/AoARoot/About/Contact_Us/Index.aspx

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Center for Planning, Policy, and Evaluation

The Administration on Aging (AoA) Center for Planning, Policy and Evaluation conducts the agency's strategic planning, policy analysis, program development, and evaluation of program performance functions. The Title IV Older Americans Act (OAA) discretionary grants demonstrations supporting the Assistant Secretary of Aging's priorities included in this section are administered by the Office of Program Innovation and Demonstration, the Office of Performance and Evaluation and the Office of Policy Analysis and Development.

Aging and Disability Resource Centers

The Aging and Disability Resource Center Program (ADRC), is a collaborative effort of the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS), to establish information, counseling and referral services for older adults, adults with disabilities and their families needing public or private resources to plan and support their current and future long-term care needs.

The ADRC program began in FY2003 and as of FY2009 assisted over 200 centers in at least one community in 54 States and territories. At least 13 States provide State-wide coverage and over 30 States provide support for their centers. The goal is have State and national-wide coverage within a few years. The majority of AoA funded projects in this collaborative program included in this compendium were funded in FY2008.

Additional information about the ADRC program can be read on the AoA website

http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC/index.aspx

and the AoA funded ADRC Technical Assistance Exchange website:

http://www.adrc-tae.org.

Program: Aging and Disability Resource Centers

Grant Number: **90AM2994**
Project Title: **Arizona Aging and Disability Resource Center**
Project Period: **09/30/2005 - 09/29/2010**

Grantee:
Arizona Department of Economic Security
Aging and Adult Administration
1717 W. Jefferson PO Box 6132
Phoenix, AZ 85007

Contact:
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AoA Project Officer: Elizabeth Leef

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$
FY2007	$
FY2006	$
FY2005	$438,375
FY2004	$
FY2003	$
Total	$438,375

Project Summary:

The Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) awarded project funding through the Arizona (AZ) Department of Economic Security's Division of Aging and Adult Services (AZ DES/DAAS) for the development of AZ Links, the Arizona Aging and Disability Resource Center (ADRC) which serves as a single, coordinated system of information, assistance, and access for all persons seeking long-term care services but targeting persons 60 and older and individuals with physical and developmental disabilities.

AZADRC project goals were as follows: 1) to create a coordinated system of information, assistance, and access for all persons seeking long term care services, and 2) to create a programmatic process that is reflected in the form of an integrated data infrastructure that will allow aging, physical disability, developmental disability, health, and Medicaid systems to communicate. Key partners in this effort included: the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Governor's Advisory Council on Aging (GACA), the Arizona Department of Economic Security's Division of Developmental Disabilities (AZ DES/DDD), the Area Agencies on Aging (AAAs), Centers for Independent Living (CILs) and other local community partners.

AZ ADRC project achievements included: 1) establishment of the administrative and collaborative infrastructure for AZ Links, the AZ ADRC; 2) facilitation of individual choice by creating a self-help web portal (http://www.azlinks.gov) that is available to individuals through any computer connected to the Internet; 3) designation of AZ ADRC sites in 11 of 15 counties, where individuals can access counseling and assistance on long-term care

information, options and services; 4) creation and implementation of an AZ ADRC training, staff development and technical assistance plan; 5) creation and implementation of an AZ ADRC public education plan; 6) implementation of the AZ Links Screening Tool as a web-based tool for eligibility and streamlined access across agencies and populations; 7) provision of technical assistance to community partners; 8) establishment of new programs, including Care Transitions and Options Counseling; and 9) enhanced regional networking and cross-training of information and referral staff.

The concept of the Arizona ADRC was that it would serve consumers, caregivers and service providers as a “one stop” source of easily accessible and understandable information, assistance and linkages to a full range of aging, disability, long-term care service and support options that promote informed decision-making, individual choice, and healthy aging behaviors. A “no wrong door” approach was adopted in the desire to promote and educate the employees of all ADRC partners. The ultimate outcome is to allow the general public to approach any ADRC partner agency which, when fully educated, would be able to provide direction and assistance to the consumer regarding programs and services available through all the partner agencies.

The project began in Maricopa County (Region I) as the first pilot site. Once the Maricopa County ADRC implementation was complete, the remaining Arizona regions were targeted to be developed and added to the ADRC consortium over the course of the project. During the development of the pilot project, much of the ADRC related effort focused on assisting the different regions in developing their organizations as “hubs” for the statewide ADRC. After the Region 1 implementation was completed, (in order of participation) Region 4, Region 2, Region 5 and Region 3 joined the effort as fully functioning ADRC partners. Planning for ADRC participation in Region 6 has begun. AZ DES/DAAS is still working with the Native American Communities and Tribes to incorporate them into the ADRC.

AZ Links functions statewide as a consortium with AAAs serving as the hub of each regional partnership. The AZ Links consortium is guided by the AZ Links Steering Committee, chaired by a staff member of AZ DES/DAAS, which functions as the single entity overseeing all ADRC activities. The Steering Committee consisting of 30 representatives of state agencies, organizations and institutions designates subcommittees to develop programs and/or provide support functions, including the Customer Assistance Committee (CAC), the Uniform Assessment Instrument Committee (UAI), and the Options Counseling Committee (OCC).

The CAC was designated to collaborate on the development of training documentation and communication matrices to be used as standard materials for organizational-operational level training throughout the state. As an inter-agency team, the CAC developed in-depth educational materials focusing on Aging and Disabilities. The UAI Committee was asked to develop a screening tool which is a simple questionnaire designed to quickly and accurately identify a consumer’s most pressing needs, such as income or medical status and as an online intake and search system that integrates into a database of services and providers. OCC meetings were critical in planning and preparation of a successful grant proposal to implement options counseling as a service of AZ-ADRC.

Program: Aging and Disability Resource Centers

Grant Number: **90AM2995**
Project Title: **Colorado State Unit on Aging Aging and Disability Resource Center**
Project Period: **09/30/2005 - 09/30/2010**

Grantee:
Colorado Department of Human Services
1575 Sherman Street, 10th Floor
Denver, CO 80203

Contact:
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Email: todd.coffey@state.co.us

AoA Project Officer: Eric Weekly

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$
FY2007	$
FY2006	$
FY2005	$467,600
FY2004	$
FY2003	$
Total	$467,600

Project Summary:

The Colorado Department of Human Services (DHS) and the Colorado Department of Health Care Policy and Financing (HCPF) received support from the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) to fund a three-year Aging and Disability Resource Center (ADRC) in three areas of Colorado. The ADRC in Colorado is known as Colorado Adult Resources for Care and Help (ARCH). ARCH utilizes the resources and knowledge of an extensive network of agencies that provide information and assistance to seniors and disabled consumers in Colorado.

The Single Entry Point (SEP) Agencies provide case management services for Home and Community Based Services (HCBS) waivers in twenty-five geographic locations throughout the state. Older Americans Act (OAA) services are delivered to consumers via a network of sixteen Area Agencies on Aging (AAAs) in the state. Ten Centers for Independent Living (CILs) throughout the state provide people with disabilities the tools needed to fully integrate into community life including advocacy, peer support, independent living skill training, and information and referral. The geographic boundaries of each office are not always clearly defined since there are nine more SEP agencies than AAAs and fifteen more SEP agencies than CILs. The SEP agencies are monitored and contracted through the Department of Health Care Policy and Financing (HCPF) and the AAAs are monitored and contracted through the Department of Human Services (DHS) Aging and Adult Division. The CILs are monitored and contracted through DHS Vocational Rehabilitation Division. These variances left deficiencies in the coordination between agencies when serving consumers in Colorado.

The Colorado ARCH has provided an opportunity for these four information and assistance providers to coordinate together, along with other providers, to supply consumers with easier access to services. Colorado ARCH targets seniors age 60 and older and adults age 18 and older living with disabilities; however, no one who seeks information on long-term care services is turned away. Colorado ARCH has expanded to six sites during the grant period

rather than the three originally projected in the grant. The original site in Larimer County (Fort Collins) kicked-off on September 5, 2006; with additional sites opening between May and August 2010 - Mesa County (Grand Junction), Pueblo County (Pueblo), El Paso County (Colorado Springs), Alamosa, Conejos, Costilla, Mineral, Rio Grande, and Saguache Counties (Alamosa), and Otero County (La Junta). Mesa County has expanded to Garfield, Moffat, Rio Blanco, and Routt Counties. Otero is in the process of expanding to Baca, Bent, Crowley, Kiowa, and Prowers Counties. Colorado ARCH currently covers approximately 42,244 square miles or 41 percent of the total square miles of Colorado. Colorado ARCH is available to 28 percent of the current population. Colorado's population for those individuals over age 60 is projected to increase approximately 18 percent in the next 5 years and 4.2 percent for those under 60. Colorado ARCH assisted 12,632 contacts from September 5, 2006 when the first pilot, Larimer County, kicked-off through September 30, 2010. During that same time frame, Colorado ARCH served 8,083 clients. Of those clients, sixty-five percent were over the age of 60 and thirty-five percent were adults 18 and over living with a disability. Colorado is in the process of developing a plan to expand ARCH statewide in the next five years

Currently, Colorado utilizes the ARCH website through VisionLink Tapestry (http://www.coloradoarch.org). Resources for the first ARCH site, Larimer County, are listed on the website using the taxonomy system. The website has a secure site for case management documentation which includes all consumer data and is available for all ARCH sites to use. Three of the current ARCH sites use 2-1-1 agencies as a contracted partner with access to their MIS. The Denver Metropolitan Counties (Denver, Adams, Arapahoe, Broomfield, Clear Creek, Douglas, Gilpin, and Jefferson Counties) and Boulder County are currently using Network of Care for their information and assistance programs. As the ARCH expands to these areas the ARCH MIS will need to interact with Network of Care and share resources. Colorado is in the process of evaluating the most efficient means of maintaining a management information system.

Resource Specialists are employed at all six of the Colorado ARCH sites. Resource Specialists are available to provide assistance to consumers in securing the necessary documentation for services, completing application forms with consumers, and linking the consumer to a provider agency. There are two tiers of information and assistance services provided by the Resource Specialists. Tier one provides information and assistance to consumers by providing contact information for the services including telephone numbers, addresses, and websites. Tier two is more intensive options counseling which assists the consumer in exploring long-term care options and applying for long-term care programs. All Resource Specialists are required to track and document demographics of consumers served while maintaining a no wrong door policy.

In 2010, Colorado was awarded the Affordable Care Act Part B Options Counseling Grant. Colorado will be developing operating standards for options counseling based on the awarded proposal through the grant funding.

Program: Aging and Disability Resource Centers

Grant Number: **90AM2999**
Project Title: **Community-Based Aging and Disability Resource Center**
Project Period: **09/30/2005 - 09/30/2010**

Grantee:
Idaho Department of Health And Welfare
PO Box 83720
Boise, ID 83720

Contact:
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AoA Project Officer: Kevin Foley

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$
FY2007	$
FY2006	$
FY2005	$467,600
FY2004	$
FY2003	$
Total	$467,600

Project Summary:

The Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) awarded funds to the Idaho Department of Health and Welfare, Division of Medicaid, to develop a pilot Aging and Disability Resource Center (ADRC) in Idaho to provide elderly and physically disabled citizens better access to services and to help them remain independent. The goal was to provide elderly and physically disabled citizens better access to services and to help them remain independent. Specifically the ADRC staffs were to: 1) organize a community-based long-term care support system that enables target populations to make informed decisions about long-term care options; 2) improve coordination of service delivery between all local and state agencies that work with the targeted populations; 3) provide an integrated point of access for information, supports, and services designed to help individuals remain as independent as possible in their own homes and communities; and 4) promote public awareness of both private and public community-based alternatives to nursing home placement.

At the time the grant was written, it was believed that Idaho's ADRC model would achieve these goals in the following ways: 1) public awareness of both private and public long-term care support options would increase in targeted communities; 2) people age 60 or older, people with physical disabilities, and caregivers would access the ADRC for information and assistance; 3) consumers would use programs and benefits that can help them remain in the community; and 4) agencies involved with the ADRC will complete eligibility determinations for services in a way that appears seamless to the consumer and avoids duplication of information provision. Medicaid worked with representatives from the Idaho Commission on Aging (ICOA), Area Agency on Aging (AAA), the disability community, and others to design a model for the pilot ADRC. After a year of planning, the pilot ADRC opened in northern Idaho.

During the two year pilot, significant inroads were made to streamline access to services and help individuals and their caregivers in their efforts to remain independent and in their own communities.

The project team and four ADRC staff overcame a number of obstacles including the sparse population and Idahoans' highly valued sense of independence. Forty percent of Idaho's residents lived outside urban areas on 90 percent of the state's land. Idaho has 15.6 people per square mile, compared with the national average of 79.6 people per square mile. Twenty-six of Idaho's 44 counties are considered frontier, having six or less inhabitants per square mile

The communities in the pilot region came to truly support the ADRC effort. In time, it became apparent that the model for the pilot ADRC would not be sustainable statewide. As the grant period ended, project sponsors directed the team to seek alternative ways of expanding ADRC services statewide. An extension to the grant was awarded and the ICOA assumed management of the statewide ADRC. Their approach then and now includes utilization of existing AAA staffs as well as providing the public with access to a web-based searchable resource tool where resources can be found for services anywhere in the state. A statewide Steering Committee is now in place. The Committee, which includes Medicaid, is dedicated to developing and overseeing the ADRC five year strategic plan and exploring approaches for improving inter-agency communication and service coordination for long-term care services and supports.

The first year of the grant was a planning year. Twelve months after planning began, in 2006, Idaho's ADRC pilot, originally named Aging Connections, now known as Aging and Disabilities Connections, opened an office in Coeur d'Alene, Idaho. The Coeur d'Alene ADRC site was, and still is, housed in the Area Agency on Aging (AAA) office which served as the hub of the pilot ADRC operation. The pilot was staffed with four people; one community development specialist, one intake worker (hired by the AAA), and two options counselors. Two field offices soon opened, one in Sandpoint, Idaho, and one in Kellogg, Idaho. The Sandpoint ADRC site was located in the Senior Center and the Kellogg site was established in the Wellness Center. Options counselors staffed these two satellite sites approximately one day per week for the first year until it was determine this approach was not efficient and both satellite sites were closed. One staff person remained with Aging and Disabilities Connections in the AAA office in Coeur d'Alene and another was hired for that office by the AAA, so options counseling services continued. Most services were maintained and continue today.

While Medicaid had a vested interest in the success of the ADRC in Idaho, it was not practical for Medicaid to remain the lead agency in the day-to-day operations of the ADRC. It was ultimately decided that the statewide model should be managed by the Idaho Commission on Aging (ICOA) and a sub-grant was developed so they could do that work. The Coeur d'Alene AAA, where the original pilot was housed, is now a model to the other AAAs throughout the state on how to provide options counseling, information, referrals, and long-term care planning through the AAA.

Program: Aging and Disability Resource Centers

Grant Number: **90AM3002**
Project Title: **Aging and Disability Resource Center**
Project Period: **09/30/2005 - 06/30/2010**

Grantee:
Michigan Department of Community Health
320 Walnut Street - PO Box 30479
Lansing, MI 48913

Contact:
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AoA Project Officer: Joseph Lugo

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$
FY2007	$
FY2006	$
FY2005	$467,600
FY2004	$
FY2003	$
Total	$467,600

Project Summary:

The Michigan Office of Long-Term Care Supports and Services, the State Unit on Aging and state Medicaid agency, created a network of aging and disability resource centers (ADRC) with the Single Point of Entry (SPE) Program also called Michigan Long Term Care Connections (MILTCCs) demonstration project. Through a competitive RFP process, four MILTCC program sites (Detroit/Wayne County, West, Southwest and Upper Peninsula) were chosen to become Single Point of Entry entities/Aging and Disability Resource Centers (ADRC). The SPE demonstration project included support by State and Federal Medicaid programs.

The goals for establishing ADRCs were to: 1) establish comprehensive resources of long-term care; and 2) provide information and assistance in accessing services, and planning for long-term care financing and delivery, benefits outreach and proactive choice counseling. ADRCs have the capacity to improve access and enhanced consumer control to individuals needing either public or privately funded services, professionals seeking assistance/supports and services on behalf of their clients, and individuals planning for their own future long term care needs.

The original intent of MILTCC was to conduct medical and facilitate financial eligibility determinations for Medicaid-funded supports and services provided in nursing facilities and the MI Choice waiver. Use of the ADRC/SPE was to be mandatory for individuals seeking access to Medicaid-funded nursing facility programs. Original objectives included: 1) offering consumers more options; 2) establishing quicker access to services through streamlined eligibility and assessment; 3) reducing unnecessary institutionalization through diversion and transition; and 4) integrating consumers' voice into organizational governance.

Original anticipated outcomes were: 1) creation of modular assessment tool to be used across programs/systems/settings; 2) financial eligibility determination meets federal standard of promptness requirements; 3) fragmented intake processes integrated into a single coordinated process; 4) decreased numbers of individuals who are being served in institutions, as a result of transition services; and 5) more collaboration and involvement of local organizations in the long-term care supports system

When implemented MILTCC served as a single entry point to publicly administered long term supports and services including those funded under Medicaid and the Older Americans Act (OAA). MILTCC targeted services to the elderly (60+) and individuals with physical disabilities (18+) and their families.

The MILTCCs were successful in their mission to serve as Aging and Disability Resource Centers (ADRCs). Consumer satisfaction results indicated MILTCCs were visible and trusted places in the community where people received information and assistance on the full range of long-term support options. MILTCCs improved access and enhanced consumer control by providing: 1) comprehensive person centered information and assistance (I&A) for a range of supports, services, and resources; 2) options counseling and ongoing choice support to improve customer understanding of available long term care supports and services, facilitating the person-centered planning process with consumers; 3) information about nursing facility transitions and options, as preferences or conditions changed and when desired, and assistance in the development of a transition plan; 4) Medicaid functional eligibility determinations called Level of Care Determinations (LOCDs) for long term care services provided in nursing facilities and the MI Choice Medicaid Home and Community Based Services (HCBS) Waiver Program; 5) benefits counseling to help people learn about and apply for public and private pay benefits; 6) long term care information, assistance and counseling during crises, emergencies and nursing facility closures.

MILTCCs were eliminated via Executive Order on May 10, 2009 and closed 30 days later due to lack of legislative appropriation. MILTCCs developed, operated and were independently evaluated from January 2006 to mid 2009. SPEs did not have the opportunity to engrain fully into Michigan's long term care system for a sustained period of time. Without this opportunity, policymakers may not have grasped the potential cost-savings that could have been generated over time before deciding to withdraw funding. The State's need for a single-point of entry program as identified by the Michigan Medicaid Long Term Care Task Force still exists. There is strong commitment at multiple levels to continue long term care reform activities. Interagency workgroups continue to work on policy and program changes that were initiated. The Office of Services to the Aging (OSA) and Office of Long Term Care Supports and Services (OLTCSS) defined a new ADRC model based on a no wrong door approach using existing resources immediately following MILTCC closure. The OSA applied for and was awarded a 2009 AoA/CMS ADRC grant to rebuild ADRC capacity in Michigan by utilizing existing long term care resources and building on lessons learned from MILTCC demonstration project.

Program: Aging and Disability Resource Centers

Grant Number: **90AM3003**
Project Title: **Aging and Disability Resource Center**
Project Period: **09/30/2005 - 08/30/2010**

Grantee:
Mississippi Department of Human Services
Division of Aging
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Jackson, MS 39212

Contact:
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AoA Project Officer: Kevin Foley

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$
FY2007	$
FY2006	$
FY2005	$438,375
FY2004	$
FY2003	$
Total	$438,375

Project Summary:

The Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) awarded this grant to the Mississippi Department of Human Services (MDHS) Division of Aging and Adult Services (DAAS) in collaboration with the Governor's Medicaid Division and the Mississippi Department of Rehabilitation Services a grant to develop Aging and Disability Resource Centers (ADRCs) in Mississippi counties targeting persons 60 and older and adults with disabilities. ADRCs provide a single point of entry for culturally competent, coordinated services where consumers can get information and advice about a wide range of long-term care resources. Information concerning health care, income security, housing, and financial management are provided via a streamlined, easy to access one-stop resource for planning options for individuals, families and caregivers in supporting long term care.

The project goals were: 1) provide the target population with information on a full range of long-term care support options through a streamlined, single point of entry to all publicly funded programs and benefits; 2) create a management information system that will support all functions of the ADRC and provide ease of access to consumers; 3) create an increased awareness of long-term care options within the target population; and 4) create market awareness of ADRC services and functions among target population, major referral sources, service providers, and key community leaders. The anticipated outcomes of this grant were: 1) a sustainable coordinated system of information and access for all persons seeking long-term support; 2) higher customer satisfaction; 3) an increase in elderly and disabled living in their own homes; and 4) an increase in early planning for long-term care.

Mississippi had to delay the implementation of the ADRC by 5 months because of the unimaginable devastation that Hurricane Katrina left in her path, a period in which MDHS/DAAS' primary focus was assisting Mississippi Seniors in need. Mississippi hired an ADRC project director at the end of January 2006 and the project development gained momentum.

The overall plan strategy was to build the ADRC from the foundation of the local Area Agencies on Aging (AAA). The first physical ADRC site was developed in Central Mississippi covering seven rural and urban counties with diverse populations. The Central Mississippi Area Agency on Aging pilot project used the "One Stop" approach for accessing public and private services. Central's consumers are able to access long-term care options and resources through single point of entry, well coordinated and supported.

MDHS/DAAS recognized early on that a single ADRC entity for all of Mississippi was not feasible due to geography and the fact that not all 10 Area Agencies have the same types or quantity of service and resources for long-term care. However, it was important that there would be uniformity and standardization among the sites in key functions and processes, as outlined in federal criteria for a fully functioning ADRC, and that there would be a seamless system statewide. Mississippi now has three ADRC sites to include the Southern Mississippi Area Agency on Aging and North Central Area Agency on Aging. Building an infrastructure that is uniform yet flexible for other Area Agencies requires a tremendous amount of collaboration and planning. The progress was slow and intentional. The Area Agencies have continued a steady course towards achieving the State's vision to duplicate the ADRC based on the lessons learned from the pilot site. MDHS/DAAS is still evaluating the ADRC impact, but the preliminary results from Central, pilot site, indicate that there is an increased awareness of the ADRC and higher consumer satisfaction with its services.

Cross training has strengthened the knowledge base of the ADRC staff as they provide information and assistance, options counseling, short term case management and follow up, especially to those who require special attention and help. These are key ADRC functions that are being embedded in Mississippi's long term system. Participation and assistance from project partners reflect stronger relationships that have been built through the ADRC project. Through these relationships a strong foundation has formed for the positive change and streamline to long term care statewide.

Looking forward, the State is pursuing these developments: 1) Central, North Central, and the Southern Mississippi Area Agencies on Aging are seeking partnerships to sustain the website; 2) development of a common vision for the ADRC at the State level, manage partnerships and earn support of diverse stakeholders; 3) create formal partnership agreements between the aging, disability, and Medicaid programs at the state and local levels; 4) coordinate ADRC activities closely with other systems change initiatives and partner closely with Medicaid; and 5) Develop a cohesive statewide marketing strategy to raise awareness of ADRC services among consumers and community and state leaders.

Grant Number: **90AM2759**
Project Title: **Aging and Disabilty Resource Center: Building Upon Success**
Project Period: **09/30/2003 - 12/31/2009**

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$
FY2007	$
FY2006	$400,000
FY2005	$48,000
FY2004	$
FY2003	$750,158
Total	$750,158

Grantee:
New Jersey Department of Health And Senior Services
Division of Aging and Community Services
240 West State Street
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Contact:
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AoA Project officer: Joseph Lugo

Project Summary:

New Jersey's Aging and Disability Rresource Center (ADRC) grant established multiple ADRC sites at the county level to test the development and implementation of models that integrated information and assistance, assessment, eligibility determination, and access processes and staff across programs. New Jersey (NJ) built upon its extensive information, assistance and referral system (NJ EASE) to provide information and assistance 24 hours a day, 7 days a week, and 365 days a year through its toll-free number and a new interactive website. A new management information system supporting client tracking, needs assessment, care plans, and utilization was linked to a computerized universal application for services.

The initial ADRC grant funded the development of two ADRC pilot counties in NJ - Atlantic and Warren. The Building Upon Success grant originally outlined four specific goals: 1) to expand the model to 5 additional counties in the next two years and ultimately statewide; 2) to expand the Hospital Pre-Admission Screening (PAS) pilot to other counties to divert older adults and persons with physical disabilities from permanent placements in long-term care setting; 3) to increase visibility and access to long-term care (LTC) through public awareness efforts targeting consumers and community provider agencies; and 4) develop a managed care model utilizing ADRC as the key access point to all long-term care support.

It is the ADRC business process that is serving as the foundation for rebalancing and streamlining access to long-term care supports. The ADRC process ranges from the ability to handle the initial phone screening to a comprehensive assessment of a consumer's physical/health status care needs; from counseling consumers/caregivers to coordinating their home and community-based services (HCBS); and from streamlining their Medicaid

eligibility process to ensuring quality management strategies are incorporated across all business processes.

In June 2006, the New Jersey Independence, Dignity and Choice Long-Term Care Act (herein referred to as the Act) mandated the Department of Health and Senior Services to implement a system of statewide long-term care service coordination and management; to identify HCBS long term care models that are efficient and cost effective alternatives to nursing home care; develop and implement a consumer assessment instrument that is designed to expedite the process to authorize the provision of home and community based services through fast-track eligibility prior to formal financial eligibility determination; develop a quality assurance system; seek to make information available to the general public; and create a Medicaid Long-Term Care Funding Advisory Council.

At the Center of New Jersey's Independence, Dignity and Choice Act is a mandate to implement a client-tracking system that advances the ADRC objectives, including easy access to long-term care support services, streamlining eligibility determination and coordinating long-term care service and management. New Jersey's choice of such a client-tracking system, SAMS, is to be used for the following components: 1) compliance with federal Older American Act National Aging Program Information System (NAPIS) reporting; 2) deployment of SAMS for use in ADRC business process (intake, service planning, care management, service utilization/costs tracked by funding source); 3) an interface with the care needs assessment product to be used, and 4) redesign of the care management module to meet the needs of New Jersey.

Due to the statewide implementation of this management information system, full ADRC deployment in the first five ADRC counties was slowed to ensure that not only the five identified counties are using SAMS for ADRC and NAPIS, but also to ensure that the sixteen remaining counties were using SAMS for NAPIS reporting purposes. At the request of the Area Agencies on Aging (AAAs) involved with both implementations, a new strategy was then devised to first ensure all counties were up and running with SAMS and that the designated counties kept on target with initial planning and training efforts to become an ADRC.

The intent of the Hospital Pre-Admission Screening (PAS) Pilot is to enable hospital staff to screen and authorize placement for individuals seeking admission into either a nursing home or Medicaid waiver program by using the At-Risk Criteria screening tool to determine nursing facility placement. The primary goals of the Hospital PAS are to: 1) reduce the hospital length of stay for Medicaid recipients seeking placement for nursing home level of care; 2) free up DHSS staff to focus on Community Choice Counseling (OCCO) versus conducting the PAS in the hospital; and 3) encourage a more collaborative working relationship between hospitals/nursing facilities and the aging and disabled provider network. PAS is working to reduce hospital length of stay, frees OCCO nurses to do Community Choice Counseling (i.e. options counseling) and establishes a more formal working relationship between hospital staff and the Division's Office of Community Choice Options (OCCO).

Alzheimer's Disease Supportive Services – Innovation Projects

The Alzheimer's Disease Supportive Services Program (ADSSP) supports state efforts to expand the availability of community-level supportive services for persons with Alzheimer's Disease and Related Disorders (ADRD) and their caregivers. Formerly known as the Alzheimer's Disease Demonstration Grants to the States (ADDGS), the ADSSP was created by Section 398 of the Public Health Services Act. Under the Administration on Aging's leadership and in collaboration with the Aging Network, the ADSSP National Resource Center, and a variety of state and community partners, the ADSSP supports the creation of responsive, integrated, and sustainable service delivery systems for individuals with ADRD and their family caregivers across the United States.

Beginning in FY2007 the program was changed to focus on evidence-based interventions. Eighteen month cooperative agreements negotiated with States demonstrate how existing evidence-based interventions help people with ADRD and their family caregivers can be translated into effective supportive service programs at the community level. This compendium includes two (2) projects from earlier competitions.

Additional program information, current project grants and a compendium of resources may be read on the AoA website:

http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/Alz_Grants/index.aspx#resources

Program: Alzheimer's Disease Supportive Services – Innovation Projects

Grant Number: **90 AZ 2807**
Project Title: **Translating Evidence Based Alzheimer's Disease and Related Dementia Direct Service Research into Practice**
Project Period: **09/30/2007 - 12/31/2009**

Grantee:
California Department of Aging
1600 National Drive, 2nd Floor, Director's Office
Sacramento, CA 95834

Contact:
Janet A. Tedesco
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AoA Project Officer: Jane Tilly

Fiscal Year	Funding Amount
FY2009	$
FY2008	$
FY2007	$338,864
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$338,864

Project Summary:

The California Department of Aging (CDA), in collaboration with the five Alzheimer's Association chapters in California and the University of Texas, Health Science Center, implemented the Spanish language transformation of the Savvy Caregiver Program, "Cuidando Con Respeto," and delivered this program throughout California to better serve the State's ethnically diverse Latino caregivers. The five Alzheimer's Association chapters participating in this project were: The California Southland Chapter, Central Coast Chapter, Northern California Chapter, Orange County Chapter and San Diego Chapter. These chapters have committed to offer Cuidando in the future as part of their regular outreach to the Latino community.

The project's goal was to improve the availability of this evidence-based program for Spanish-speaking Alzheimer's caregivers by embedding the caregiver course within the State's service delivery network for older adults. The project's strategy was to transform the Savvy Caregiver Program to meet the needs of a low-literacy level, Spanish-speaking caregiver population in a manner that: 1) yields high caregiver satisfaction; 2) increases caregiver knowledge; and 3) reduces caregiver distress.

The measurable goals established for this project were that the Cuidando program: 1) produces high caregiver satisfaction; 2) increases the caregiver's knowledge of Alzheimer's disease and the caregiving role; and 3) reduces caregiver distress. Although not originally identified as a measurable outcome, the issue of maintaining fidelity to the original curriculum and the manner in which the course was delivered was of importance and was closely monitored. The Cuidando facilitators actively collected evaluation measures during each of

two sessions including participant satisfaction with the course, knowledge gained, Zarit Burden Scale and basic demographic information. In addition, data was collected three to six months after Cuidando through telephone follow-up interview with open ended questions. After the telephone interviews, the Zarit Burden Scale was mailed to the participants to complete and return. All data was sent to the University of Texas for analysis. Data was collected from 294 caregivers that attended the 20 Cuidando courses delivered throughout California over a period of eight months.

The majority of Cuidando participants, 74 percent, were female and 97 percent were Mexican American. The course evaluation and open-ended telephone interviews produced the strongest evaluation evidence to conclude that the program was successful in teaching caregivers the attitudes, knowledge, and skills that led to changes in caregiving practices. For instance, caregivers described specific changes they had made in their caregiving practices that could be traced directly to the content taught in Cuidando. The open-ended questions reported changes in attitude included less frustration; greater patience, tolerance and acceptance of AD in relatives; increases in acquiring skills in caring for AD family members; increased attention to caring for themselves; and greater awareness that others were having similar experiences; and an increase is discussing issues with and involving family members.

Outcomes from the knowledge test and the Zarit Burden Scale were inconclusive. The evaluators believe that the knowledge test showed no change in knowledge from pre- to post-test because the questions were either too easy or too confusing. At baseline, the responses to the Zarit Burden Scale did confirm that caregiving negatively impacts the lives of the caregivers. However, there was a low return rate of the mailed Zarit Burden Scale assessment tool and those that were returned were frequently incomplete. Additionally, there are other concerns regarding the meaning of “burden” for Latino caregivers who may feel a sense of duty, honor or responsibility for undertaking the role of caregiving that would negate their ability to acknowledge a sense of burden.

The products developed and disseminated include the Spanish version of a trainer manual and a participant manual (available through the University of Texas), two articles for submission to a peer-reviewed journal and a cost assessment methodology outlining estimated costs of project start-up and operating costs.

This grant permitted the University of Texas to complete/further refine several key resource materials needed to disseminate Cuidando more broadly. It also provided the resources for California to implement this program in many Latino communities and has benefited many Spanish-speaking families dealing with issues related to Alzheimer’s disease.

Program: Alzheimer's Disease Supportive Services – Innovation Projects

Grant Number: 90AI0018
Project Title: California's Innovation Grant to Better Serve People with Alzheimer's Disease and Related Disorders
Project Period: 09/30/2008 - 06/30/2010

Grantee:
State of California, Department of Aging
California Department of Aging
1300 National Drive
Sacramento, CA 95834

Contact:
Janet Tedesco
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AoA Project Officer: Theresa A. Arney

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$234,382
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$234,382

Project Summary:

The California Department of Aging (CDA), in partnership with local Alzheimer's Association chapters and a coalition of community organizations, developed an intervention to better serve ethnically diverse caregivers and improve early identification of the disease. The project's goal was to enhance the capacity of the State's aging services providers to better serve Vietnamese and Latino dementia-affected adults and their caregivers, with a special emphasis on earlier identification and early stage support for affected Latinos.

The project's objectives were: 1) to improve state policies and practices on dementia care, including building the capacity of four new Aging and Disability Resource Centers (ADRCs); 2) to increase access to home and community-based care for Latinos and Vietnamese people with dementia and their families; 3) to expand Latino services to increase earlier identification and development of supportive programs for an Early Stage population; 4) to provide direct respite and relief to families caring for people with Alzheimer's disease and related dementias (ADRD); and 5) to disseminate lessons learned. Anticipated project outcomes were an expansion of the two existing community collaborative that assist families in accessing dementia-related services and the development of culturally appropriate services for the target populations.

The Dementia Care Network model on which this project was based is a California innovation. Aware that families in many ethnic communities were not being served by mainstream dementia programs, state and local agencies and organizations came together to develop a model that would increase public understanding that dementia is not a normal part

of aging; that there are services that can help, and that having a family member with dementia is not a shameful thing that needs to be hidden. At the same time, the model works to build cultural competency among mainstream service providers so that they can serve these ethnic families. This project incorporated this same approach in developing this new Latino and Vietnamese Dementia Care Networks.

The model takes a two pronged approach: 1) developing a community coalition that includes the targeted ethnic group's community service organization(s) and mainstream health, aging, and social service organizations in that community to identify barriers these families face in accessing dementia care and strategies they can implement to make culturally competent services available; and 2) providing community outreach, family education and assistance to families in accessing services. The heart of this model is a Care Advocate who is bilingual and bicultural and has expertise in ADRD care giving issues. Care Advocates provide community ADRD education and acting as a care coordinator in assisting families to identify service options and enrolling in these programs (if help is needed). For project clients needing respite, some grant funding was available to help pay for the cost involved.

The project encountered four implementation challenges. They included difficulties in: 1) overcoming traditional cultural beliefs that dementia is a normal part of aging and conversely a sense of family shame that can occur when a family member exhibiting dementia symptoms; 2) securing written ADRD educational materials in Vietnamese; 3) identifying and serving persons in the early stages of dementia within the Latino Dementia Care Network; and 4) the decreasing ability of many families to pay privately for in-home or community based respite/dementia care due to reduced personal financial resources.

Throughout the grant new alternatives were sought to address these challenges. Overcoming traditional cultural beliefs takes time, but good community education provided by trusted community members and validation of these concepts through the ethnic media have repeatedly been found to be the most effective strategies. Although need for translating materials into Vietnamese was not identified, this was crucial and created much needed resources. On the other hand, the project was not successful in developing strategies to effectively identify and enroll Latinos in services for persons in the early state of dementia. The challenges families are having due to the economy and its negative impact on their ability to purchase services was beyond the capacity of this project to address, even though the Care Advocates tried to identify publicly funded programs to serve their clients.

Products developed during the grant included: Consumer brochures translated into Vietnamese which will continue to be available and available for broad dissemination, and a Replication Manual and Lessons Learned Report that can assist organizations interested in replicating the Dementia Care Network model and/or tailoring services specifically to Latino and Vietnamese families. In December 2010, the California Alzheimer's Disease Plan was released. The California Department on Aging has been an active member of the Taskforce involved in developing this Plan and we believe that it will be a valuable resource for the new Governor and State Legislators, who will face ongoing budget deficits for the foreseeable future, but will need to making policy and funding decisions on how to support the growing number of California families impacted by Alzheimer's disease.

Program: Alzheimer's Disease Supportive Services – Innovation Projects

Grant Number: 90AI0002
Project Title: Maine's Alzheimer's Diversion Initiative
Project Period: 09/30/2008 - 06/30/2010

Grantee:
Maine Department of Health and Human Services
Office of Elder Services
442 Civic Center Drive 11 State House Station
Augusta, ME 04333-0011

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Romaine.Turyn@maine.gov

AoA Project Officer: Priti Shah

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$236,236
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$236,236

Project Summary:

The Maine Office of Elder Services (MOES), in partnership with Maine's five Area Agencies on Aging, the Maine Alzheimer's Association, and the Muskie School of Public Service, developed, tested and implimented the Alzheimer's Diversion Initiative, a program to provide specialized services to rural Maine caregivers of adults with Alzheimer's Disease and Related Disorders (ADRD) who are at imminent risk of institutional placement and not yet eligible for Medicaid. Project innovative features included: 1) screening protocols for adults at imminent risk; 2) an evidence-based model, Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) expanded to a broader group of caregivers, testing its effectiveness in institutional diversion; and 3) formalized referral protocols for adults with challenging behaviors. The primary goal of the program is to divert people with ADRD from nursing home or residential care placement.

The objectives of the program were to: 1) develop an organizational structure that can sustain the initiative; 2) target adults at imminent risk; 3) extend Healthy IDEAS to include caregivers who are not currently receiving respite; 4) increase the effectiveness of screening and referring people with ADRD with challenging behaviors; and 5) assure caregivers have greater access to appropriately targeted services.

Given the depressive symptoms associated with caregivers of individuals with dementia, the Initiative studied the direct and indirect outcomes of the Healthy IDEAS designed for older adults with chronic conditions by translating it to promotion of the health and well being of

caregivers of individuals with dementia in rural Maine. The intended outcomes were to reduce the rate of admissions to nursing homes and residential care facilities, and reduce the rate of enrollment in Medicaid. The Initiative also provided insight into the complexities of integrating standardized evidence-based program into the diversified roles of staff at agencies on aging.

Statewide implementation of the Initiative was completed by OES in collaboration with Maine's five Area Agencies on Aging, Maine's Alzheimer's Association, the Muskie School of Public Service – University of Southern Maine, the statewide assessment agency (SAA) - Goold, and the state home care coordinating agency (HCCA) - Elder Independence of Maine.

Activities essential to implementation of the Initiative included: 1) train staff in Healthy IDEAS for caregivers of individuals with dementia, motivational interviewing and provide Initiative orientation; 2) identify caregivers of individuals with dementia; 3) refer caregivers to AAAs for participation in Healthy IDEAS; 4) complete database and evaluation component of the Initiative that was IRB approved; 5) complete intakes into the Healthy IDEAS study implementing Healthy IDEAS as designated by participation protocol; 6) maintain fidelity to the evidence-based Healthy IDEAS Program; 7) support coordinators in collecting and downloading data for tracking and analysis; 8) analyze data from the study; 9) develop and implement challenging behavior training and individualized challenging behavior consultation; and, 10) sustain components of the program after termination of the study.

An evaluation report of the Maine Alzheimer's Diversion Initiative was completed by Muskie School. The findings from the outcome evaluation showed that caregivers in the intervention group and the usual care group both had improvements in depression scores and in response to problem behaviors. Those in the intervention group showed significantly greater improvement. These results should be cautiously interpreted, however, because the intervention group had higher scores at baseline. Thus, the findings could be a result of the intervention; but they could also reflect a statistical tendency called regression to the mean.[1]

[1] J. Fralich, J, Bratesman, S, Richards, M, Payne S, Evaluation Report: Maine Alzheimer's Diversion Initiative, Muskie School of Public Service, University of Southern Maine, Portland Maine. 2010.

Program: Alzheimer's Disease Supportive Services – Innovation Projects

Grant Number: 90AI0001
Project Title: Expanding Service Usage in Early Stage Alzheimer's: Project LEARN (Listen, Educate, Adjust, Resolve, Navigate)
Project Period: 09/30/2008 - 06/30/2010

Grantee:
Missouri Department of Health and Senior Services
P.O. Box 570
Jefferson City , MO 65102

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AoA Project Officer: Theresa F. Arney

Funding:	
FY2010	$
FY2009	$
FY2008	$236,327
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$236,327

Project Summary:

The Missouri Department of Health and Senior Services (DHSS), in partnership with Central Missouri Area Agencies on Aging (CMAAA) and the four Missouri chapters of the Alzheimer's Association, undertook an 18 month Alzheimer's Disease Supportive Services Program (ADSSP) to improve efforts in Missouri to increase service usage by individuals in the early stages of Alzheimer's disease. The goal of Project LEARN was to serve 400 families during this grant period. Project LEARN (Listen, Educate, Adjust, Resolve, Navigate) was operated through the Missouri Alzheimer's Association Chapters. It was an intensive intervention to help early stage families learn about resources needed to cope with Alzheimer's disease and related disorders. It offers a consumer directed comprehensive set of support and education services for individuals with early stage dementia and their families.

Original objectives were to: 1) establish a referral process for Area Agencies on Aging, physicians and other professional care providers that requires limited effort for the provider and is non-threatening to the family; and 2) provide Project Learn, a comprehensive set of services for individuals in the early stage and their families, through the formulation of an individualized consumer directed plan that builds coping skills and addresses emotional, educational and planning needs. Expected outcomes were: 1) increased sense of competence and coping strategies in navigating the needs and challenges of Alzheimer's disease; 2) increased number of individuals with early stage dementia using services; and 3) family preparedness for continued home-based care through implementation of individualized action plans.

As part of Project LEARN a brief 8-question dementia screening tool (AD-8), was community tested by the Central Missouri Area Agency on Aging (CMAAA) subsequently integrated into their initial assessment process. The CMAAA represents a largely rural territory. The CMAAA, appropriate DHSS staff and staff from the Missouri Alzheimer's Association Chapters were trained by Dr. J.E. Galvin in the use of the AD-8. Care Coordinators from CMAAA made 725 visits during the grant period and administered the AD-8 717 times. Project LEARN served 520 unduplicated individuals from 240 families.

A professional care consultant conducted a structured initial assessment for each participant exploring reaction to diagnosis, concerns such as driving, legal and financial planning, home safety issues, and other family needs. The care consultant talked and listened to both the individual and caregiver to develop an individualized LEARNing plan. The LEARNing plan included the specific action steps designed to help each individual family. As needs were identified through the LEARNing plan, referrals were made to educate families on appropriate education programs and resources. All LEARN participants received education about community based services that helped them meet the goal of maintaining care in the home for as long as possible.

Care Consultants connected families to support groups, socialization programs and individuals support options and while working with them they were able to help families adjust to the changes that accompany Alzheimer's disease. To facilitate resolution and assist families in adjusting to changes, care consultants made follow-up contacts bi-monthly as needed to make sure all concerns or needs had been resolved.

Individuals and family caregivers received assistance from care consultants in navigating the network of services. Through a termination planning session, each family was provided with information and community resources that helped them transition out of Project LEARN. Participation in Project LEARN was available to individuals with early stage dementia throughout the state, with special emphasis in outreach efforts to rural and frontier counties and minority populations.

The products from this project are: a final report, including evaluation results and summary of key lessons learned, a manual for program replication, a tested screening tool used within the Area Agency on Aging network, and a cost analysis. The results of a Project LEARN evaluation were very positive. Families increased their competence in dealing with dementia and learning about needed services. CMAAA Care Coordinators agreed one hundred percent that every Area Agency on Aging should use the AD-8 dementia screening tool.

The Heart of America Chapter is continuing to provide the Project LEARN program. They have made advances in relationships/referral patterns with doctors and consider this project a success that will continue to build. All chapters are seeking funding and plan to continue the program including experimentation with subsidized fee for service models.

Program: Alzheimer's Disease Supportive Services - Innovation Projects

Grant Number: **90AI0019**
Project Title: **Early Stage Dementia Project Telehealth Early Phase Patient and Family Support Program (TESP)**
Project Period: **09/30/2008 - 03/31/2010**

Grantee:
Nevada Department of Health and Human Services
Division for Aging Services
1860 E Sahara Avenue
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AoA Project Officer: Theresa Arney

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$110,857
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$110,857

Project Summary:

The Nevada Aging and Disability Services Division (ADSD), along with its partners the Northern Nevada Northern California Alzheimer's Association, the Cleveland Clinic Lou Ruvo Center for Brain Health, and the University of Nevada Center for Cognitive Aging conducted an eighteen month innovation grant to better serve people with Alzheimer's disease and related disorders. The goal was to establish early intervention service delivery to Alzheimer's (dementia) patients and caregivers in rural and underserved communities of Nevada through the use of televideo and telemedicine.

The target population for this project was rural, financially compromised individuals with early phase Alzheimer's disease, family caregivers, Spanish speaking patients and families, and Native American patients and families. A special emphasis was given to Hispanic and Native American populations spread over the 95,763 square miles in the rural and frontier areas of Nevada. The remoteness of these areas and the sparse population complicate the service delivery options. Identifying specialists willing and able to serve these rural communities presents many challenges. The Nevada Early Stage Dementia Project Telehealth Early Phase Patient and Family Support Program (TESP) attempted to address these issues and allow access to specialists for rural patients and their caregivers through the use of technology.

The Center for Cognitive Aging Alzheimer Disease Diagnostic and Treatment Center used their telemedicine capacity to provide education for care recipients and their caregivers.

Their ability and capability to reach outlying areas and support to train patients and families helps reduce the burden associated with long term care costs through early intervention. Collaboration with the Alzheimer's Association of Northern Nevada provided specialty training for persons in the early stages of Alzheimer's disease and their families through this telemedicine video. Sessions included an overview of early stage dementia, medical and research updates on early stage dementia, legal and financial planning, managing change, family relationships, advocacy and planning for the future. Topics such as safety concern including three particular risks of falling and home safety were covered.

Surveys and interviews with participants found that a majority (80%) of Latino and Native American participants reported that the education/caregiving training they received increased their knowledge about Alzheimer's disease and dementia and that they learned something new that applies to their situation. Similarly 80% of rural participants reported that the education and caregiving training they received increased their knowledge about Alzheimer's disease/dementia and that they learned something new that applies to their situation and 80% of all participants in the telemedicine program reported that the educational information they received via this program was useful and helped them more effectively manage the care and safety of the care recipient. Following their training, 80% of telephone support group participants reported that the group increased their knowledge about dementia and helped them more be more effective in their work as a caregiver or support group facilitator.

In addition, 100% of Hispanic participants indicated information and care consultations provided increased their knowledge about Alzheimer's disease and 99% of rural participants who attended education and training indicated they learned something new that applies to their situation. All participants in the interactive televideo conferencing found the information very helpful in helping with the short and long-term care of their loved one with Alzheimer's disease.

The Nevada project achieved and surpassed these outcomes. The program was positive and beneficial for participates and their caregivers. A key component of this intervention was building relationships in the targeted communities. Relationship building takes time and must be ongoing to maintain the trust for continued interaction. To implement the Televideo program it is essential to ensure a strong coordination between the all sites in terms of support, operations and continuity. Also, outreach and relationship, including activities must be maintained and supported. Program partners are passionate about the services they provide and continue to seek funding opportunities to enhance these services from independent sources as well as from the State of Nevada, Aging and Disability Services Division through Federal and State funds.

Program: Alzheimer's Disease Supportive Services – Innovation Projects

Grant Number: **90AZ2790**
Project Title: **New Mexico Alzheimer's Program**
Project Period: **07/01/2004 - 06/30/2010**

Grantee:
New Mexico Aging and Long-Term Services Department
Community Involvement Bureau
2550 Cerrillos Road
Santa Fe, NM 87505

Contact:
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Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$
FY2007	$300,000
FY2006	$300,000
FY2005	$311,150
FY2004	$311,150
FY2003	$
Total	$1,222,300

AoA Project Officer: Jane Tilly

Project Summary:

The State of New Mexico (NM) Aging and Long-Term Services Department (ALTSD) developed and and implemented respite care services, particularly community-based adult day care, targeting underserved communities and tribes in rural New Mexico. The goal of New Mexico's project was to improve the capacity of the state's home and community-based long-term care service delivery system to better address the needs and issues of people with Alzheimer's disease and related dementias (ADRD) and their caregivers.

The objectives were to: 1) build Alzheimer's disease technical expertise at the state, area agency on aging, provider and consumer levels; 2) strengthen data collection, integration and integrity; and 3) strengthen options for evidence-based, consumer-directed services, especially adult-day care services. The expected outcomes of the project were: 1) trained and knowledgeable care coordination personnel; 2) increased access for consumers to resource information, personalized care coordination, and consumer-directed care; 3) increased coordination and collaboration among project partners; and 4) increased data integrity.

The project brought together the New Mexico Aging Network in a series of training events about ADRD and the resources available to address the needs of people with ADRD and their family caregivers. The emphasis on this topic during the award period created a renewed awareness of issues related to Alzheimer's disease and the services and supports available to address them. Training was provided to over eight hundred Aging Network personnel. The training was found to be effective in increasing participants' knowledge about ADRD and the services available from the NM Alzheimer's Association, the NM Aging and

Disability Resource Center (ADRC) and the Area Agencies on Aging (AAAs). NM ADRC counselors have been trained to recognize requests for dementia specific information and services and have an increased understanding of how to connect callers with appropriate services and supports.

Participants were very satisfied with the training received. Significant findings from the training included the need for adaptations in training format, as many participants were older adults, and many spoke English as their second language. Training materials were translated, simultaneous interpretation was provided and bi-lingual monitors were available to assist participants with filling out evaluation forms. Retention test scores improved when testing was conducted by phone in Spanish. The integrity of data related to the ADRD and the needs of caregivers was improved through the activities of this project. A more standardized approach to the collection and reporting of the data is now in place, creating improved opportunities for data analysis for program planning and quality improvement.

Access to consumer-directed respite services was increased by the project. Respite services, in particular adult day care programs, were provided with individualized consultation and training, and with this, increased access was gained to these programs by caregivers. Two evidence-based caregiver education and training programs currently operate in the state. Increased awareness of the consumer-directed respite voucher program administered by the New Mexico Alzheimer's Association was also a result of the training. This may have been the primary factor in the significant increase of both numbers of consumers and units of respite services provided from FY 2009 and 2010.

Publications, workshop and educational materials have been developed and distributed throughout the Aging Network. A task force has been formed to develop a "Dementia Plan" for the state. Key partnerships were established or enhanced. The New Mexico home and community-based long-term care service delivery system has increased its "dementia capabilities" to better serve the needs of people with ADRD and their caregivers.

In 2005, the ALTSD was awarded a five-year Systems Change Grant for Community Living from the Centers for Medicare and Medicaid Services. The intent of these funds was to help New Mexico continue to "build the infrastructure that will result in effective and enduring improvements in community-integrated services and long-term support systems." With this support, ALTSD over the course of the grant period: 1) improved access to long-term support services for the older adult and adults with disabilities, including persons with Alzheimer's disease and dementia, through a one-stop, single-point-of-entry system for home and community-based services; 2) developed a comprehensive, department-wide quality management system; and, 3) transformed information technology systems within the Department and across other state departments to support access to long-term care services. The system transformation efforts achieved through the Systems Change Grant for Community Living were aligned with and complemented the Alzheimer's Disease Supportive Services Program objectives.

Program: Alzheimer's Disease Supportive Services – Innovation Projects

Grant Number: **90AZ2788**
Project Title: **Continuing Partners in Care**
Project Period: **07/01/2004 - 12/31/2009**

Grantee:
Rhode Island Department of Ederly Affairs
John O. Pastore Center
35 Howard Avenue
Cranston, RI 02920

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AoA Project Officer: Jane Tilly

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$
FY2007	$325,000
FY2006	$294,050
FY2005	$294,050
FY2004	$294,050
FY2003	$
Total	$1,207,150

Project Summary:

The purpose of the Rhode Island (RI) Department of Elderly Affairs (RIDEA) Alzheimer's Disease project which was branded as ADAGE was: 1) to develop a comprehensive consumer-directed program which would provide community-based information, counseling, support and services for individuals with early stage dementia and their caregivers; 2) to provide subsidized community-based services for those with dementia who would not otherwise qualify for any existing state or federal subsidized programs; and 3) to provide ongoing training for Benefits Specialists at the RI Aging and Disability Resource Center (ADRC) to enhance their skills in "listening for dementia."

RIDEA developed and implemented this program in collaboration with: the Alzheimer's Association-Rhode Island Chapter; the Rhode Island ADRC ("The Point"); six regional community case management agencies that provide services statewide; and Ocean State Community Resources ("Options"), a non-profit statewide agency that served as the fiscal intermediary for the consumer-directed program account management.

The three target populations for the project were: 1) individuals with the early stages of dementia and their caregivers, who could benefit from the "Live and Learn" program; 2) individuals with dementia who needed community-based services to remain in the community with their caregivers and who did not qualify for any state or federal subsidized services; and 3) any consumer, caregiver or professional in Rhode Island seeking information, counseling and referral from The Point to assist individuals with dementia and/or their caregivers/families. The project made available information, counseling, referral and subsidized direct care services to all Rhode Islanders through two outlets - The Point, which has built a statewide network of community-based linkages to reach individuals in every

Rhode Island community and a statewide regional case management agency network. The "Live and Learn" program for those with early stage dementia and their caregivers was initiated in one central metropolitan county in Rhode Island but, over the course of the grant, the was expanded to other geographic areas of the state.

Findings were focused in seven areas: 1) the value of client participation and direction in the success of a program for those with early stage dementia; 2) the unanticipated "quality of life" benefits of an early stage dementia program; 3) the need for an effective counseling component for programs serving those with early stage dementia and their caregivers; 4) the location and accessibility of an early stage dementia program within the community; 5) the value of subsidized programs to serve as an incentive to individuals who are reluctant to enroll in community-based services; 6) the value of subsidized programs in assisting individuals to maximize their resources and to remain in the community as long as possible; and 7) the need for ongoing training of professionals and counselors in the area of dementia and related services.

Products developed during the grant period included assessment and eligibility forms for professionals and informational brochures for consumers, caregivers, and professionals. The program and policy implications generated by this project address the unique needs and challenges that face those with early and later stage dementia and their caregivers. There are significant implications for the value of consumer direction; the need for specialized counseling; strategies to maximize limited consumer resources; the significance of "quality of life" considerations in program design; and the psychology of program promotion and the introduction of a service model to reluctant participants. There were also significant program and policy implications for program design in the role of care coordination and effective information and referral services.

Program: Alzheimer's Disease Supportive Services – Innovation Projects

Grant Number: **90AI0015**
Project Title: **South Carolina Alzheimers Disease Demonstration Grants to the States Innovation Project**
Project Period: **09/30/2008 - 09/30/2010**

Grantee:
Lieutenant Governor's Office on Aging
1301 Gervais St., Suite 200
Columbia, SC 29209

Contact:
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AoA Project Officer: Michelle Boutaugh

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$383,912
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$383,912

Project Summary:

The goal of the Alzheimer's Disease Demonstration Grant to States (ADDGS) was to improve access to home and community-based services for individuals with Alzheimer's disease and related dementia (ADDRD) by targeting underserved minority and rural populations. The underlying problem which was the catalyst for the grant project is the prevalence of Alzheimer's disease among the African American population in conjunction with the tendency to go undiagnosed and/or receive care late in the course of the disease process.

The projects original objectives were to: 1) implement strategies that build familiarity and trust among underserved minority populations; 2) provide outreach and screening through a mobile ADRC in the Trident region; 3) provide outreach and education through Family Consultants who are congregants of local churches; 4) provide medical screening by the Medical University of South Carolina (SC) Alzheimer's Disease Clinical Core Research Group (MUSC-ADCCRG); and 5) provide vouchers that allow increased services through the SCAA, the ADRC, and the Family Caregiver Support Program. The target population for achieving these objectives lived in three counties of the South Carolina Lowcountry area (Charleston, Dorchester, and Berkeley counties).

The project was a collaboration of the SC Lieutenant Governor's Office on Aging (LGOA) in collaboration with the SC Alzheimer's Association (SCAA), the Trident Area Agency on Aging/Aging and Disability Resource Center (AAA/ADRC), and (MUSC- ADCCRG).

Expanded outreach was conducted through primary care physicians to provide education and training and facilitate referral of patients to the ADDGS case manager for assistance with

identified needs, to include advanced directives and information on long-term care insurance. This is especially crucial to those patients in early stage Alzheimer's disease, so they are able to be a part of the decision-making process for themselves. Anticipated outcomes were increased access to services and information; increased consumer control; increased trust, familiarity and willingness to use services; and effectiveness of interventions.

The project built upon a previous ADDGS grant project. Efforts were continued for outreach through the faith-based communities, to include recruitment and training of Family Consultants to serve as liaisons between their respective churches and the program staff. Additional outreach was provided through use of a mobile van. The case manager conducted outreach to primary care physicians to facilitate referral of newly diagnosed patients with Alzheimer's disease. It was initially estimated that 400 individuals would receive $500 vouchers to purchase supportive services with the possibility of increased benefits available based on assessed need and that this approach would increase access of minority and rural individuals with ADRD to home and community-based services. The concept included assisting families and caregivers; especially early stage Alzheimer's patients and their caregivers, with information for advanced planning through referrals from primary care physicians. Additionally, an innovative approach to support groups was launched in the form of "self-help clubs".

Building trust and credibility within the underserved minority communities was a priority in all daily program activities. Because of the economic downturn services to our most vulnerable populations have been curtailed and, in some cases, totally cut. This project's model is attempts to create a basic framework for services in outlying areas and provide a feasible alternative to more expensive urban-based dementia care. The case manager was able to visit with families in their homes, including those in remote rural areas. Likewise, she was able to provide easily accessible dementia care training in local neighborhoods, thereby enabling caregivers to recognize symptoms earlier and know how to respond effectively.

Participants were surveyed to determine whether outreach interventions provided were effective in increasing access to home and community based services and increasing consumer choice and control of resources. A series of Yes/No questions followed by open-ended questions afforded participants the opportunity to respond to questions regarding their control over the services provided and subsequently utilized. This includes what impact the program had on the participant's life and if it impacted the ability to stay in the home or keep a loved one in the home. Ninety-five percent of respondents indicated they felt they had control over what services were provided and how those services were used. All respondents agreed that this program made a difference in their lives. All respondents answered that they would recommend this program to a friend.

This initiative has laid the foundation for meaningful dialogue among collaborative partners from diverse backgrounds. The strides made through this project, with its innovative multidisciplinary approach using both volunteers and professionals, are a cost-effective approach in addressing critical needs, especially with declining resources.

Program: Alzheimer's Disease Supportive Services – Innovation Projects

Grant Number: **90AI0013**
Project Title: **Innovation Grants to Better Serve People with Alzheimer's Disease and Related Disorders**
Project Period: **09/30/2008 - 06/30/2010**

Grantee:
Tennessee Commission on Aging and Disability,
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AoA Project Officer: Shannon Skowronski

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$236,253
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$236,253

Project Summary:

The Tennessee Commission on Aging and Disability, in collaboration with the Tennessee Area Agencies on Aging and Disability, the Tennessee Respite Coalition, and the Mid-South Chapter Alzheimer's Association developed an intervention with the goal of extending the length of time caregivers can function effectively in their role.

Project objectives: 1) increase the likelihood that a person with Alzheimer's disease can remain at home; 2) decrease caregiver stress; 3) empower caregivers to make informed choices about care using natural networks; 4) utilize single entry points for all populations needing assistance through Area Agencies on Aging and Disability; 5) increase awareness and knowledge of Alzheimer's disease among African American communities, specifically churches; 6) design an evaluation plan to consider the fidelity of program implementation, measure consumer satisfaction, make recommendations regarding program improvement and project expansion, and monitor program quality; 7) reduce long-term care costs and Medicaid spend down; and 8) identify continuation funding.

Intended caregiver outcomes included less burden and stress related to caregiving role, increased satisfaction with family-directed respite care, increased choice and flexibility in managing respite services for loved ones, increased family-directed respite care and other services (especially among African Americans), increased use of natural networks, increased involvement of clergy and lay leaders in African American churches, and increased awareness and use of Alzheimer's diagnostic services and resources.

The Alzheimer's Association in coordination with Southeast Tennessee Developmental District and Greater Nashville Regional Council planned and executed follow up workshops following the success of presentations at the African American Clergy Conference. Television, Radio, and Newspaper Public Service Announcements were used to publicize these events. Information was distributed at numerous Health Fairs and Outreach/Awareness Events. These outreach efforts reached thousands of African Americans and afforded them the opportunity to learn about Alzheimer's through outreach efforts and planned workshops. Follow-up workshops for The African American Clergy Conference succeeded in reaching the target population of African American laypersons. And support groups have been formed to help serve the targeted African American population.

The workshops, conferences and seminars were held generated increased use of the single point of entry through the Area Agencies on Aging and Disability for enrollment in the Innovation Grant Program for respite services and identified the need for Community Support Groups. Caregivers have been provided education on caring for the person with dementia, as well as caring for themselves in order to maintain health and be able to continue as caregivers. The Alzheimer's Association currently offers 16 support groups for caregivers in Hamilton and surrounding rural counties. Three new support groups were initiated in November 2009. Cost analysis report indicate 142 number of participants were served including 72 with respite care, 49 with case management and 21 with assessment.

Follow up phone calls to survey the satisfaction of clients showed a great amount of satisfaction among the participants within the innovation grant program where respite is concerned and families are expressing a great deal of accountability and responsibility to their loved ones. Statements vary from appreciation of the program to grief or feelings of lost loved ones.

Challenges remain in reaching the targeted populations the grant was intended to serve. The African American and Hispanic population has received very little attention in the past from the media, medical community, clergy and professional communities. However, families may have identified the disease within, but not sought resources or services to assist them in dealing with their loved ones. The innovation grant partners have successfully been able to provide settings where training, awareness, testimonies and professional advice as well as support were presented. By providing these settings the targeted population has been reached that would not have been possible otherwise. Outreach to the Hispanic community remains limited due to limited staffing, mistrust of governmental agencies by this population and perceived beliefs that there is sufficient support already present within their community.

Project products include a summary of lessons learned, a how to manual and materials, and a cost analysis.

Program: Alzheimer's Disease Supportive Services – Innovation Projects

Grant Number: 90AI0012
Project Title: Early Stage Cognasium: A Supportive Services Program for Early Stage Alzhiemer's Disease and Related Disorders Client/Caregiver Dyads
Project Period: 09/30/2008 - 03/31/2010

Grantee:
Utah State Department of Human Services
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AoA Project Officer: Theresa Arney

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$292,355
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$292,355

Project Summary:

The Utah Division of Aging and Adult Services, the Alzheimer's Association Utah Chapter, and statewide Area Agencies on Aging collaborated to provide care consultation with geriatric health care services in early stage dementia for families whose loved one has just been diagnosed or who is in the earliest stages of detection and intervention in the city of Logan, Utah, and its surrounding rural areas of Cache County, and in Salt Lake City and its surrounding area including Ogden City, Utah.

The project goal was to provide a multi-component care consultation intervention to improve competency and well-being of caregivers (Caregiver Well-Being Kit) and increase self-efficacy of persons with early stage Alzheimer's disease and related disorders (ADRD). The featured intervention was known as "cognasium," a term coined for this project which teaches those who care for a person with early stage dementia and memory loss to focus on the person as a whole, rather than the disease. Cognasium is an activity-based focusing on the remaining capacities of the early stage person with Alzheimer's disease and related disorders (ADRD). Cognasium also supports communication within the caregiver/care recipient dyad to minimize disease symptom impacts for as long as possible. The early intervention begins with development of an Individualized Cognasium Plan (ICP), which records personal goals and commitments to action regarding a proactively brain healthy lifestyle with exercise, nutritional, cognitive and social activity the early stage person wishes to pursue. The "gymnasium for the brain" plan also includes practical cooperative activity to address mid- and long-term impacts on legal, financial and care coordination matters.

Project Objectives were to: 1) establish dementia care consultation sites at Area Agencies on Aging; 2) train Area Agency caregiver support staff as dementia care consultants; 3) initiate care consultation statewide for caregivers and persons with early stage ADRD to identify strengths, solve problems, and develop a collegial or family care system; and 4) provide statewide, standardized skills-building and life-enhancing workshops to implement "Maintain Your Brain" self-care and cognition training; "Partnering with Your Doctor"; early stage support groups dividing persons with early stage ADRD into their own groups emphasizing social engagement and "cognasium for the brain" program; and a community-based approach versus a single statewide conference. All objectives were met by the end of the project.

The Dementia Care Consultation Site (DCCS) in rural northern Utah is successfully functioning as an early stage intervention program with an orientation to brain health and early detection of memory impairment and an outreach program disseminating Information through the Logan Senior Center and four other rural-based senior centers in Cache and Morgan Counties. Key staff of the Bear River Area Agency on Aging function as care consultants at this facility which is designed and managed by a contractual arrangement with the Alzheimer's Association Utah Chapter. The Area Agency staff is trained as care consultants, support group facilitators, brain healthy lifestyle trainers, and early detection and diagnosis trainers by the Alzheimer's Association. Monthly brain health workshops, early detection and diagnosis workshops, and an Early Stage Cognasium Support Group take place at the DCCS. The early stage DCCS can assist a family with questions on medications prescribed for symptoms, making plans for the future, partnering with the primary care physician, treatment planning, participation in clinical trials, making changes to adjust to a new way of life, and assessing innovative programs for people in early stage dementia.

During the project period of September, 2008, through March, 2010, 53 rural northern Utah dyads/families were served through Care Consultation, support groups, Safe Return™, and/or information and referrals to community services. Of these cases, 28 early stage individuals were identified and enrolled in the Early Stage Cognasium program along with their primary caregivers and key family members. A total of 46 individuals, including caregiver/care recipient dyads and family care systems, are receiving ongoing early stage services in northern Utah.

The Care Consultation service also operates thorugh the Salt Lake City office of the Alzheimer's Disease Utah Chapter serving a 100 mile area fronting the Watsatch Mountains. During the project period 36 professional volunteers (in careers such as counseling and social work in the elder care industry) served as trained Care Consultants. Of 157 caregiver/care recipient dyads identified as early to moderate stage ADRD and served through Care Consultation, 68 dyads were enrolled in the Alezheimer's Disorder Ssupportive Services Early Stage Intervention Program in the Wasatch Front Area. These included two dozen Hispanic families served by the project's Early Stage Program. This system appears to be sustainable and is a threshold for future collaboration with Area Agencies on Aging in supporting dementia caregivers

Grant Number: 90AZ2799
Project Title: Dementia Partnerships for Service Integration
Project Period: 07/01/2005 - 03/31/2010

Grantee:
Washington Department of Social and Health Services
Aging and Disability Services Administration
P.O. Box 45600
Lacey, WA 98503-1045

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AoA Project Officer: Shannon Skowronski

Fiscal year	Funding Amount
FY2010	$
FY2009	$
FY2008	$
FY2007	$290,000
FY2006	$290,000
FY2005	$290,000
FY2004	$
FY2003	$
Total	$870,000

Project Summary:

The overall goal of the Dementia Partnerships Project (DPP) was to improve the responsiveness of Washington State's system of home and community-based services to the needs and preferences of individuals with dementia and their family caregivers by integrating dementia-capable services into existing state programs. The approach was to utilize the best knowledge and evidence, to optimize the expertise and infrastructure available, and to evaluate the feasibility and impact of the emerging service models for family caregivers of people with dementia. The project was supported by a state level advisory group made up of representatives from Aging and Disability Services Administration (ADSA), Alzheimer's Association, Alzheimer Society of Washington, Washington Adult Day Services Association (WADSA), University of Washington, and participating Area Agencies on Aging (AAAs).

Two area agencies on aging - Seattle-King County AAA (Aging and Disability Services) and Northwest Washington AAA (Northwest Regional Council - serving Island, San Juan, Skagit and Whatcom counties). - became the primary site locations in response to a solicitation for project support. Their responsibility was to target low income individuals with Alzheimer's disease and related disorders (ADRD), convene local partnership teams to serve ADRD individuals and their family caregivers, and arrange for ADRD day care services two days a week for 25 individuals, provide family support counseling to at least 26 client/caregiver dyads and counseling to at least 13 other caregivers each year.

Participants receiving counseling were required to meet several criteria, including living alone and receiving at least 40 hours of direct care and/or supervision per week from the primary family caregiver or are living with the primary family caregiver and not be in a licensed care

facility i.e., adult family home, boarding home or nursing home. In order to receive services, the person with dementia could not be using formal support services (*e.g.,* respite, in-home care) for more than 6 hours per week; could not already be using adult day services at time of entry into the program; and both the person with dementia and primary family caregiver had to agree to use the dementia day service two days per week.

The project addressed a number of challenges in the current support of ADRD individuals. Before this approach the majority of funds in this program were spent on in-home care services available throughout the state. Adult day services, a cost-effective approach to respite care as well as emotional and health supports for the individual with dementia, were considerably less accessible. Eligibility restrictions and funding limitations created disincentives for expanding or enhancing services for the dementia population – resulting in a gap in the state's continuum of care for those with dementia and their families. Another significant gap in the state's system of community based long-term care for individuals with dementia was the availability of individualized, dementia-specific information and support that can respond to the unique and diverse needs of individuals with dementia and their family caregivers.

The formation, training and use of local Dementia Partnership teams was intended to bring focus and coordination to the issue of dementia with the goal of improving access to, and utilization of, family caregiver support and respite care services. The local Dementia Partnership teams included, at a minimum, representatives from the Family Caregiver Support Program (FCSP) and Area Agency on Aging, local Alzheimer's-specific organization/s, and the dementia day service provider.

Anecdotal reports from partners over the last three years about the benefits of the Dementia Partnerships approach reveal generally positive findings in terms of building trust, relationships, improving the flow of information, and problem-solving. Effectiveness in regards to reaching the target goal for increased referrals was mixed due to a limited array of services in such an area and because where a community network was already established, referrals between agencies were already occurring fairly regularly. With the relatively limited target population and limited number of connections to be made, the potential for change was smaller than anticipated.

Measuring referrals, while informative in one aspect, does not describe the full benefit of the partnerships established. When Dementia Partnership team members were asked recently about the advantages of such an approach, respondents agreed that the teams had increased information-sharing opportunities among partners at the community level and contributed to a greater focus on the issue of dementia/caregiving, improved levels of coordination related to the issue of dementia/caregiving, improved awareness of and access to family caregiver support and respite care services for the dementia population.

Community Living Program

The Community Living Program (CLP), initially called the Nursing Home Diversion Program, funds projects that support development of State programs to assist individuals who are at risk of nursing home placement and spend down to Medicaid to enable them to continue to live in their communities with access to consumer directed home and community services. CLP grants are administered through the State Units on Aging (SUAs), in partnership with Area Agencies on Aging (AAAs) and in collaboration with community service providers, and other key long-term care stakeholders. The projects complement the Centers for Medicare and Medicaid Services (CMS) "Money Follows the Person Initiative" by strengthening the capacity of states to reach older adults before they enter a nursing home and spend down to Medicaid and utilize consumer directed services. It also supports states' long-term care rebalancing efforts.

CLP awardees in FY2009 received two year grant awards administered under cooperative agreements. Three projects described in this compendium were funded as Nursing Home Diversion programs and received no-cost extensions to complete their projects. Thirteen projects awarded under CLP in this compendium were funded in FY2008. Grants funded in FY2007 and FY2008 were funded for an 18 month period

Information about the program may be read on the AoA website at

http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/NHD/index.aspx

Additional information about these programs may be found on the website of the Aging and Disability Resource Center Technical Assistance Exchange.

http://www.adrc-tae.org

Grant Number: 90CD1187
Project Title: Arkansas Nursing Home Diversion Program
Project Period: 09/30/2008 - 09/30/2010

Grantee:
Arkansas Department of Human Services
Division of Aging and Adult Services
PO Box 1437, Slot S530
700 Main Street
Little Rock, AR, 72203

Contact:
Deborah K. Ellis
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Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$569,437
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$569,437

AoA Project Officer: Linda Velgouse

Project Summary:

The Division of Aging and Adult Services (DAAS), the State Unit on Aging for the State of Arkansas, currently administers a Nursing Home Diversion Modernization Program (NHDM) to rebalance its long-term care system and provide Arkansans with additional choices in how and where they receive long-term care services and supports. The goal of the project was to expand and strengthen this program to enable non-Medicaid eligible Arkansans, at imminent risk of nursing home placement and spend-down to Medicaid, to remain in the community and out of the nursing home.

The objectives of this project were to: 1) expand the current Nursing Home Diversion Modernization (NHDM) program; 2) work in collaboration with the Single Entry Point and Area Agencies on Aging (AAAs) to identify additional participants for the program; 3) develop and refine nursing home diversion and spend-down targeting criteria; 4) continue providing services to the 150 participants in the current NHDM and add up to 52 new enrollees to the program. Anticipated outcomes of the project were to: 1) provide services available under the NHDM program to additional Arkansans; 2) assess Arkansas's NHDM assessment and screening tools; 3) produce a report detailing the outcomes of the Nursing Home Diversion project; and 4) provide training opportunities and materials to the state's AAA network on the philosophy and implementation of Cash and Counseling models.

The Cash and Counseling Model on which the Administration on Aging (AoA) laid as a foundation to offer the Community Living Program (CLP) has been a success in Arkansas not

only for the persons served by the program, but also for the management of the four (AAAs) that offered the CLP. Arkansas was able to double the number of AAAs that would gain experience with the Cash and Counseling Model. This represents half of Arkansas's Area Agencies on Aging.

During the funding period, Arkansas expanded the service area of the Community Living Program (CLP) by doubling the number of participating Area Agencies on Aging. The Central Arkansas Area Agency on Aging (CareLink) and Northwest Arkansas Area Agency on Aging expanded the counties served. Together with those served by the Southwest Arkansas Area Agency on Aging and Southeast Arkansas Area Agency on Aging, a total of 184 Arkansans were offered the opportunity to enroll in the Community Living Program. Currently 56 persons remain active in the Community Living Program. CareLink has 35 CLP participants still active.

Southwest Arkansas Area Agency on Aging and Southeast Arkansas AAAs received the same training and support as CareLink and Northwest. Neither Southwest nor Southeast established financial management services, but were supported through grant funding by a contracted service. Three of the four AAAs are provided services to veterans through the Veterans Directed Home and Community-Based Services program. The fourth, South West AAA is interested in working with the Shreveport Veteran's Administration Medical Center (VAMC) and offering this needed service to veterans in southwest Arkansas. Each AAA was very familiar with the needs of people within their region and enrolling people into the CLP did not prove difficult. Arkansas's experience with Cash and Counseling and the resources available through both the Administration on Aging and the National Resource Center for Participant Directed Services afforded the necessary support to offer the fiduciary role. The CLP expansion served 184 persons with 56 persons continuing to be supported by the Area Agencies on Aging after the project grant period.

Expected goals of increasing the AAAs offering the Community Living Program were met. The project used the Minimum Data Set for Home Care (MDS-HC) and worked with Lewin and JEN Associates to collect data from participants and a comparison group enrolled in the State Medicaid waiver program to answer the question of whether the project properly targeted those at institutional risk. Preliminary results indicate that this was accomplished and that persons through diversion were able to enjoy the comforts of remaining in their communities for a longer period of time. The agency's work with Lewin evolved from its original design to become more comprehensive by testing whether the assessment instrument, the MDS-HC was targeting those at high risk of institutionalization. Lewin and JEN Associates worked together to compare the CLP MDS-HC assessments to 246 assessments used to determine eligibility for Home and Community-Based Services (HCBS) operated by the Division of Aging and Adult Services. The Lewin report will be available in 2011.

Grant Number: 90CD1179
Project Title: "CHOICES At Home Phase II" – Connecticut Nursing Home Diversion Modernization Project
Project Period: 09/30/2008 - 09/30/2010

Grantee:
Connecticut Department of Social Services
25 Sigourney Street
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Contact:
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AoA Project Officer: Carolyn Ryan

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$649,398
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$649,398

Project Summary:

The Connecticut Department of Social Services and its State Unit on Aging, in partnership with the Agencies on Aging of South Central and Western Connecticut and community providers, administered the Choices at Home (CAH) Community Living Project (CLP). The goal wass to help consumers who are at-risk of nursing home placement, but not yet eligible for Medicaid, to remain in their own homes. Project objectives were: 1) provide consumers in the south central and western areas with flexible service options, utilizing a Cash and Counseling (C&C) model with funds from the federal Caregiver and State Respite Care Programs; 2) target services to individuals in the areas who are at-risk of nursing home placement and spend-down to Medicaid; 3) enhance the Single Entry Point (SEP) established in the south central area and develop a new SEP in the western area that provides access to long-term care services and supports; 4) develop and implement formal protocols across key stakeholder organizations supporting the rapid provision of HCBS to target populations; and 5) design a comprehensive performance measurement program.

The following project outcomes were achieved: 1) consumers have a C&C option through the Caregiver and Respite programs in the Areas; 2) consumers can receive screening, assessment, LTC options counseling, and services for at-risk target group through the fully functioning SEP in the Areas; 3) individuals at-risk of nursing home placement and spend-down to Medicaid are effectively and efficiently identified through an assessment tool and served through existing programs; and 4) change can be sustained beyond the grant period and incorporated into the state's LTC system.

Connecticut's CLP/CAH), was a pilot project designed to utilize flexible service dollars and a Single Entry Point system (SEP) to help individuals residing in the South Central and Western regions of Connecticut avoid nursing home placement and spend down to Medicaid. The project was comprised of two separate components: 1) the addition of a C&C model of service delivery through the existing State funded Alzheimer's Respite Care program (CSRCP) and the National Family Caregiver Support program (NFCSP); and 2) the development of an Aging and Disability Resource Center (ADRC) to serve as Connecticut's SEP.

The C&C service delivery option was piloted in the south central region of Connecticut through the Agency on Aging of South Central Connecticut (AASCC) and the project was evaluated by the University of Connecticut, Center on Aging (UCONN). Connecticut proposed to serve 65 clients via the C&C option (40 via respite services and 25 through an expanded supplemental services option). However, there was slower than expected enrollment by existing caregiver program clients who were given the first chance to take advantage of the new service delivery option. In order to increase enrollment the C&C workgroup developed an aggressive outreach strategy to reach the general public and generate additional referrals to the program. At the same time that the marketing campaign was launched, the Governor closed enrollment to the CSRCP. Therefore, only 27 clients could be served through the respite portion of the C&C option (as apposed to the goal of 40). Remaining funds were reallocated and additional clients were served through the expanded supplemental services option. Connecticut exceeded the goal of serving 65 total clients but was unable to meet the goal of providing respite services to 40 of the 65.

As part of the project Connecticut established a functioning ADRC in the South Central and Western regions of the State. Both ADRCs operate through the Area Agency on Aging (AAA) and Centers for Independent Living (CIL) that serves the respective regions. In South Central Connecticut the ADRC is comprised of the Area Agency on Aging of South Central Connecticut (AASCC) and the Center for Independent Living, the Center for Disability Rights (CDR). In Western Connecticut the ADRC is comprised of Western Connecticut Area Agency on Aging (WCAAA) and the Center for Independent Living, Independence Northwest (IN).

A C&C assessment tool targeting individuals at-risk of institutionalization and spend down to Medicaid was developed and implemented by both regions; an ADRC assessment and screening tool targeting individuals at-risk of institutionalization and spend down to Medicaid was developed and implemented by both ADRCs; and at-risk individuals were served through existing programs including the C&C service option of the CSRCP and NFCSP by in both regions of the state during the grant period.

The 2008 CLP grant served as a critical step for the Connecticut State Unit on Aging to begin making meaningful changes to the way it and the agencies it funds provide long term care services and supports to consumers.

Program: Community Living

Grant Number: **90CD1189**
Project Title: **Nursing Home Diversion Modernization**
Project Period: **09/30/2008 - 09/30/2010**

Grantee:
Massachusetts Executive Office of Elder Affairs
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AoA Project Officer: Caroline Ryan

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$885,165
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$885,165

Project Summary:

The Massachusetts Executive Office of Elder Affairs (OEA) initiated a comprehensive nursing home diversion program to create a sustainable infrastructure that identifies older adults and people with disabilities, along with their family caregivers, who are ineligible for Medicaid, and helps them avoid placement in a nursing facility. This project pursed the following goals and objectives. Goal 1 - establish Aging and Disability Resource Consortia (ADRCs) throughout the state, with Long Term Care Options (LTCO) as a core service. Objectives of Goal 1 were to: 1) recruit, train and support ADRC staff to provide LTCO counseling; 2) connect clients with community-based services; and (3) establish protocols to support referrals. Goal 2 - identify and prioritize people at risk for nursing home placement and spend down to Medicaid. Objectives of Goal 2 were to: 1) assess to determine those in greatest need; 2) reach out to hospitals, nursing homes, rehabilitation facilities and Medicare Enrollment Centers to promote referrals; and 3) distribute materials explaining benefits of LTCO counseling and ADRC services. Goal 3 - incorporate support services for caregivers as part of nursing home diversion. Objectives of Goal 3 were to: 1) modify how respite dollars are allocated to support family caregivers; 2) incorporate caregiver training, and support into ADRC referral network. Goal 4 - develop the infrastructure necessary to support consumer-direction. Objectivesof Goal 4 were to: 1) train ADRC staff in consumer-directed care counseling; and 2) create a policy that all ADRCs will promote consumer-directed services.

Earlier programs and initiations, including establishment of Options Counseling as a mandatory service through passage of the Massachusetts Equal Choice Bill, initiation of its ADRC system through a grant from the AoA and Centers for Medicare and Medicaid Services (CMS), provided Massachusetts, the State funded home care Enhanced Community Options

Program (ECOP), and a CMS Systems Transformation grant served as a foundation to build an extensive and robust nursing home diversion program. This grant enabled Massachusetts to transform its nursing home diversion infrastructure from a network of just three ADRCs, ten Aging Services Access Points (ASAPs) offering consumer direction, and no trained Options Counselors, to a statewide network of eleven ADRCs actively providing Options Counseling and offering a consumer direction option to consumers throughout the state.

Train-the-trainer sessions on consumer direction for representatives from each of the twenty-seven ASAPs provided the consumer-direction training to their ASAP colleagues, principally care managers and registered nurses. The trainings consisted of two 90 minute sessions, followed by shorter sessions over subsequent months. Statewide availability of the consumer directed option throughout the Home Care Program required not only substantial training among Massachusetts' twenty-seven ASAPs, but also a change in culture among ASAP staff who traditionally have relied on a case management model to connect consumers with services and supports. By collaborating closely on cross-trainings, marketing, sharing of resources and outreach, ADRC partners have developed a much more expansive and comprehensive understanding of one another's consumer directed philosophies. Statewide rollout of consumer direction was informed by the experiences of a Person Centered Planning (PCP) pilot at BayPath Elder Services. This model is an alternative to the traditional case management approach and allows individuals the option to manage their own home care budgets and purchase goods and services that are not limited to the traditional services available through ECOP.

The project successfully achieved all of its proposed outcomes: 1) established an infrastructure to support consumer-direction across community-based programs; 2) created a statewide network of ADRCs; 3) implemented a sustainable Options Counseling model; and 4) strengthened capacity to provide information and services to help individuals remain in the community. These outcomes have enhanced Massachusetts' capacity to identify people at risk of nursing home placement and spend down to Medicaid, and to provide two service delivery models, Options Counseling and consumer direction, which increase consumers' knowledge of and access to services that can help them remain in the community. The project also developed and tested training curricula and protocols for Options Counseling which have provided a foundation for a more consumer focused approach to delivery of long term services and supports.

Statewide expansion of the consumer directed option under the Massachusetts Nursing Home Diversion Project permitted offering the consumer directed option to all 70,000 consumers of its Home Care Program. This represents an expansion on the project's original goal to offer consumer direction only to ECOP participants. To date, just over 200 people have opted for consumer direction, reflecting the newness of the concept, and the long-standing reliance Home Care consumers on traditional case management in guiding their choices. The Nursing Home Diversion Project has facilitated the creation of a statewide network of ADRCs, a corps of trained staff, training procedures and protocols that form the infrastructure to provide Options Counseling and consumer direction throughout Massachusetts. The Massachusetts Home Care Program will work with other policy makers to incorporate these services as integral, standard and permanent components of long-term care.

Program: Community Living

Grant Number: 90AM3161
Project Title: Michigan's Nursing Home Diversion Program
Project Period: 09/30/2007 - 09/30/2010

Grantee:
Michigan Department of Community Health
Office of Services to the Aging
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AoA Project Officer: Linda Vergouse

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$
FY2007	$500,000
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$500,000

Project Summary:

The Michigan (MI) Office of Services to the Aging partnered with three Area Agencies on Aging (AAA) to support of this Nursing Home Diversion (NHD) grant. This program was conceived and initiated through consumer input and collaboration with partners, particularly the Office of Long-Term Care and Supports Services (OLTCSS) with the following goals/objectives: 1) to implement targeting strategies for older adults "at risk" of nursing home placement and Medicaid spend-down, track "at risk" adults, and evaluate effectiveness of target indicators; 2) to increase consumer control by redirecting Federal and State funds directly to consumers for flexible spending plans, and 3) to implement single entry point systems to improve access to aging services and increase ability to target CLP clients.

Anticipated outcomes included: 1) "at risk" consumers would be identified and enrolled in the program; 2) consumers would have options for flexible spending and control of funds and a choice of where they receive services; and 3) AAAs would utilize single entry point functions to identify and serve "at risk" consumers.

Three workgroups were initiated at the state level to begin the work of developing targeting criteria, Person Centered Thinking (PCT) training, and policies and standards. A stakeholder group was convened at the beginning of program implementation, to look at criteria associated with functional and financial indicators of nursing facility placement. The goal was to develop a tool that could easily be used for screening environment by information and assistance (I&A) specialists. Functional criteria was based on research related to late loss of Activities of Daily Living (ADLs) associated with imminent nursing home placement, including

assistance needed for dressing, bathing, moving in bed, and mobility in the environment. In addition, there was an item related to loss of cognitive functioning. The targeting screen looked at imminent risk precipitated by major life events, such as loss of caregiver, hospital or nursing home discharge, APS referral, or other emergency. Information was collected on all of these indicators and combined for overall risk.

The first three CLP sites had a total of 473 participants. Of those, 244 had complete information on all elements of the targeting criteria and 55% were found to be eligible for the program. Nearly half of these had incomes under 300% of poverty with assets no higher than $50,000. The majority of CLP participants were able to remain in their homes for the year following consultation, with only 6% transferring to nursing facilities. The 6% who transferred into nursing facilities all had diagnosed dementia or reported severe memory problems that affected decision-making. An additional 36% of CLP participants with dementia or memory problems remained in their home of choice with supports and services.

The final targeting form/indicators worked well in practice. Sites were not mandated to use the form as developed; they could incorporate indicators into the face sheets/intake forms already in place in their work settings. The final targeting criteria were successfully used for the last two years of the project.

Flexible funding policies assisted participants in two ways. First, state policy was changed to allow community living consultation services to be covered under funding for access services. Second, Area Agencies on Aging (AAA)could use state funds to underwrite or provide vouchers or reimbursement for services so CLP participants could try out services they might consider paying privately for in the future.

CLP funds were supplemented by state funds to expand training availability to all 16 Area Agencies on Aging, staff of Centers for Independent Living, and staff of the Long Term Care Ombudsman program. Based on past experience with culture change as well as training participant surveys, it became clear that all levels within participating agency's required training in order to create and sustain organizational change to support person centeredness. In this light, training for AAA leadership teams and I&A specialists was also provided. Attempts at culture change without management support were unsuccessful. The training model required use of focus groups, and 12 focus groups were held with 109 people to determine levels of person centered knowledge and experience within job categories (I&A Specialists, care managers, AAA leadership teams, CIL staff and LTC Ombudsmen).

The CLP program impacted the long term care system in positive ways. Targeting criteria worked successfully and may influence how the ADRCs functions in the future. The Person Centered Thinking training is expanding to other audiences. Community Living Consultation has become institutionalized in multiple sites and CLP is built into implementation plans for the future.

Program: Community Living

Grant Number: **90AM3167**
Project Title: **Minnesota Nursing Home Diversion Project**
Project Period: **09/30/2007 - 03/31/2010**

Grantee:
Minnesota Board on Aging
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AoA Project Officer: Linda Velgouse

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$
FY2007	$500,000
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$500,000

Project Summary:

The original goals of Minnesota's Nursing Home Diversion Project were to: 1) further develop flexible service options for older adults and family caregivers who are eligible for Medicaid (Medical Assistance) and other public programs, as well as those who will fully private pay; and 2) develop a more consistent, effective and evidence-informed process to identify and triage individuals who are at high risk of nursing home placement and Medical Assistance (MA) spend down. The project also worked with area agencies on aging to plan and develop a Veterans Administration funded Veteran Directed Home and Community Based Option program.

The Minnesota Board on Aging partnered with two area agencies on aging - Arrowhead Area Agency on Aging (Arrowhead) and Minnesota River Area Agency on Aging (MNRAAA) to develop and refine the Live Well at Home program to provide flexible service options for older adults and their family caregivers. Over the course of the project, these objectives were pursued: 1) develop of triage and follow-up processes and protocols that can be replicated statewide; 2) identify older adults who have needs associated with risk of nursing home admission and MA spend down; 3) link identified older adults and/or family caregivers effectively to flexible service options to prevent or delay nursing home admission and MA spend down; 4) target Title III, Alzheimer's Disease Demonstration Grant to States (ADDGS) funds to identified high risk individuals, with an emphasis on consumer-directed services options; and 5) collect evidence that can inform the state's system development and service re-design.

Among the the project accomplishments were 1) development and pilot-testing of a screening tool that quickly identifies persons with risks associated with nursing home entry and MA spend down; 2) development of Live Well at Home support services that help high-risk persons mitigate risk factors and also link them to flexible service options, Title III funded programs and services including healthy aging, caregiver support and Alzheimer's Disease Demonstration Grant programs; and 3) collected data and conducted an evaluation of the pilot-test experience in order to inform statewide implementation.

For the entire grant period, a total of 820 persons were screened at various system access points with the new Live Well at Home (LWAH) Rapid Screen©. And, there were 258 persons who received individual LWAH support services (evaluation and management of risk factors, and assistance purchasing self-directed supports). During the course of the project Arrowhead Area Agency on Aging (Arrowhead) and Minnesota River Area Agency on Aging (MNRAAA) and their partners collected data and evaluated outcomes related to diversion from nursing homes and MA. This data collection/reporting experience helped improve the data collection/reporting process now being used under a new Community Living Program Grant (CLP). As a result of the project evidence-based programs have been integrated as a core component of the LWAH framework and offer proven interventions that can help the high-risk person successfully mitigate and stabilize risk factors. Easy and routine linkages to these services and programs in the AAA regions continued to be established.

The project also assisted the State Agency in developing a new Minnesota Live Well at Home website – http://www.mnlivewellathome.org) - which was launched in January 2010. The website is the on-line portal for Live Well at Home information, education, and tools. One goal of the website is to increase participation in evidence-based healthy aging, caregiver support, and memory care programs and to increase the use of consumer directed care support plans.

Program: Community Living

Grant Number: **90CD1186**
Project Title: **Consumer-Directed Approach to New Hampshire Family Caregiver Service Delivery**
Project Period: **09/30/2008 - 09/30/2010**

Grantee:
New Hampshire Department of Health and Human Services
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AoA Project Officer: Eric Weakly

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$649,398
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$649,398

Project Summary:

The New Hampshire Bureau of Elderly and Adult Services (BEAS), in collaboration with the ServiceLink Aging and Disability Resource Centers of Belknap, Merrimack and Rockingham Counties, the University of New Hampshire Institute on Disability (IOD) and the Grafton County and Monadnock Region ServiceLinks extended the scope of the systems transformation of service delivery to family caregivers caring for older adults building upon on a consumer-directed model supporting informal caregivers caring for older adults at risk of placement in a nursing facility and ultimate spend down to Medicaid. The project goal was to shift control from a primarily state-controlled, provider-driven model and transform Federal Title III-E and State funded Alzheimer's Disease and Related Disorders (ADRD) funds into flexible, consumer-directed service dollars managed locally at the Service Link Aging and Disability Resource Centers (ADRC's).

This system change was initiated in the pilot Nursing Home Diversion Modernization (NHDM) project and expanded to three additional ADRC's. Project objectives were: 1) expand recently established infrastructure under NHDM to three additional ADRC's; 2) expand the established Agency With Choice fiscal agent model to the proposed areas; 3) expand the devolution of the spending authority for Title III-E and state general fund Alzheimer's Disease and Related Disorders respite funds; 4) expand evidence-based caregiver education and consumer-directed training to the proposed areas; and 5) evaluate the efficacy of the program. Anticipated outcomes were: 1) participants' abilities would be strengthened through evidence-based training and support to prevent spend down to Medicaid; 2) staff would be trained in person-centered approach in supporting family caregivers; 3) expansion of the

Agency with Choice fiscal agent coverage area; 4) streamlined funding structures; and 5) an established single point of entry for family caregivers to access services.

The funding for services comes from a combination of Older Americans Act Title III-E caregiver funds, federal Alzheimers Disease State Supportive Services Program respite funds, and state ADRD respite funds. This model continues to enhance services to family caregivers by providing one on one consultation, opportunities for education and a comprehensive assessment of the primary caregiver culminating in a broad plan of support improving the family caregiver's ability to continue to provide care to another individual without sacrificing his or her own health and well-being and at the same time to delay or divert the necessity for nursing home placement.

ServiceLink staff, primarily the Caregiver Specialists, work under this model, with family caregivers on an individual basis to assess their needs as well as their existing informal and formal sources of support. The Caregiver Specialist acts as a guide in developing a multimodal plan of support or "Well-Being Plan" that is implemented by the caregiver. The plan may include goals identified in the assessment (examples of goals identified by caregivers include joining a book club, spending time with other family members, going out with friends, doing volunteer work), respite plans, skills training, support groups and other activities that would contribute to their overall well-being. The aim of this support is to improve, or at minimum maintain, the family caregiver's ability to continue to provide care without sacrificing his or her own health and well-being and at the same time delaying or diverting the necessity for nursing home placement. Caregiver Specialists as part of an individual plan can authorize funds for caregivers in need of respite services. The respite services can be paid for from Title III-E caregiver funds that are administered through a financial management service, using the 'agency with choice' model.

Consolidation of the three funding sources under this program allows for a single point of entry for all caregiver supports. As of this report there is now statewide authorization of the ADRD respite funds at all ServiceLink sites. Of particular significance is the decentralization of funding authorizations from the state to the local ServiceLink Resource Centers. Support funds are now authorized at the local level which provides for more efficient access to services. Another important benefit of the local control of funds is that the ServiceLink Resource Centers have taken on greater ownership of the program, providing leadership in their respective counties to ensure the effectiveness of this project. In addition, ServiceLink is recognized as the coordination point for supports for caregivers and older adults and aging adults with disabilities. Each site has served as leaders in connecting agencies that offer services to each other in order to build a stronger system of supports for caregivers and individuals receiving care.

Program: Community Living

Grant Number: 90CD1191
Project Title: Ohio's Nursing Home Diversion Project
Project Period: 09/30/2008 - 09/30/2010

Grantee:
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AoA Project Officer: Linda Velgouse

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$610,265
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$610,265

Project Summary:

The Ohio Department of Aging (ODA), in collaboration with the Area Agency on Aging District 7, Inc. (AAA7) implemented a consumer-directed long-term care services program in ten rural south/central Appalachian counties. The goal of the Nursing Home Diversion Project (NHDP) was to include non-Medicaid individuals who are at imminent risk of nursing home admission and Medicaid spend-down in long-term care system transformation efforts currently under way.

The original objectives of the project were to: 1) design prioritization processes that identify non-Medicaid older adults at imminent risk of nursing home admission and Medicaid spend-down; 2) expand Single Point of Entry to accommodate screening of high-risk, non-Medicaid individuals; 3) coordinate with Money Follows the Person transition coordinators to identify non-Medicaid nursing home residents who are at imminent risk of Medicaid spend-down and permanent admission; 4) enhance the technological infrastructure support of diversion activities; and, 5) incorporate self-directed care planning of Home and Cpmmunity Based Services (HCBS), based on the Choices Medicaid Waiver (with elements of the Cash and Counseling) model, for the Care Coordination and National Family Caregiver Support programs. Anticipated outcomes were that non-Medicaid individuals at imminent risk of nursing home admission and Medicaid spend-down would be diverted to community based services; appropriate screening, protocols, and self-directed care planning services are managed, resulting in increased nursing-home diversion; and policies developed reflect the role of nursing home diversion in the seamless unified long-term care system transformation underway in Ohio.

The project involved two paradigm shifts, first in implementing consumer-directed approach to service delivery which changed the way the agency, most notably options counselors, and its partners functioned; and second in the transformation of Older Americans Act funding to support consumer-direction. These changes were supported by extensive training of staff and service providers, by the development of computerized tools used for screening and assessing potential participants, and by the development of written policies for both staff and participants that will facilitate project continuation and replication.

The project planning and design occurred over a nine month period from October, 2008 through June, 2009. During this time period a series of activities occurred: 1) a targeting tool to identify and prioritize individuals who are at imminent risk of nursing facility placement and spend-down to Medicaid was created and tested; 2) expansion of the single point of entry through re-design of the agency website that included the creation of an online resource directory for individuals; 3) expansion of the non-Medicaid software program to collect project data from the target tool, the assessment tool, service delivery, and care planning modules; 4) development of the training manual and all policies for the self-directed non-Medicaid program; 5) training for agency staff, provider, and key stakeholders; (6) Hiring and training of care managers for the project; and, 7) regular agency and state-level meetings to assist in staff training and expansion of single point of entry.

Following the planning stage and development of all project materials, Ohio's project, named "My Care, My Way", began enrollment and subsequently enrolled 50 participants. A no cost extension of six months was granted by AoA to allow the agency more time to meet participant enrollment projections and collect outcome data. The project design supported the principles set forth by Ohio's Unified Long-term Care System Work Group including consumer choice, nursing home diversion and the development of a state-wide network of Aging and Disability Resource Centers.

The project successfully diverted 93% of participants who enrolled from spend-down to Medicaid and nursing facility placement. The agency utilized 25% of its State Senior Community Services funding to provide services for the project. After the 9/30/10 project completion date, the My Care, My Way Program was sustained by transforming Older Americans Act (OAA) funds to support the self-directed program from October 2010 through December 2010. OAA funds will be used to support the program into 201l, but for only 10% of the participants. Data collected and outcomes achieved show the project did save a significant amount of dollars through diversion activities and allowed the agency to make fundamental changes to assist in the process of establishing a fully functioning Aging and Disability Resource Network. It also created a foundation to begin statewide deployment of the Veterans Directed -HCBS program. The results of the project will be shared with the Unified Long-Term Care System Work Group to further assist in the state's rebalancing efforts and to be used as an advocacy tool to show how nursing home diversion activities can result in cost savings.

Additional program evaluation will continue at the agency as many other data elements can be analyzed. Any significant findings will be provided by ODA and the Administration on Aging.

Program: Community Living

Grant Number: **90AM3160**
Project Title: **Vermont Nursing Home Diversion Modernization Project**
Project Period: **09/30/2007 - 12/31/2009**

Grantee:
Vermont Department of Disabilities,Aging and Independent Living
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AoA Project Officer: Linda Velgouse

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$
FY2007	$500,000
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$500,000

Project Summary:

The Vermont Department of Disabilities, Aging and Independent Living (DAIL) developed a consumer directed flexible service option comprehensive nursing home diversion program targeting individuals at greatest risk of nursing home placement who are functionally eligible for the Medicaid- funded Choices for Care program, but do not yet meet the Medicaid long-term care financial eligibility criteria. Three components of the project were options counseling, consumer self-directed training and Flexible Choices PLUS services.

The original project objectives were to: 1) develop a non-Medicaid Flexible Choices PLUS cash and counseling program administered through select Area Agencies on Aging (AAAs); 2) develop targeting criteria to ensure services are available to individuals most at-risk of Medicaid spend-down; 3) expand existing support brokerage functions used for the current Flexible Choices option; 4) expand/modify the role of current AAA staff to perform options counseling for the targeted population; 5) develop a comprehensive options counseling curriculum based upon the work completed by the National Association of States United for Aging and Disabilities (formerly National Association of State Units on Aging) and the Independent Living Resource Utilization to facilitate the development of an interactive and informed decision making process; and 6) develop a training program on consumer self-directed care to support AAA and other aging network staff to translate into practice and service delivery the new language in the Older Americans Act regarding "self-directed care".

The anticipated outcomes were: 1) involvement of Vermont's Aging and Disability Resource Connection (Center) as a key player in referral and options counseling; 2) serve at least 200 persons in one of three components of the project; 3) expand the program from test sites to

all AAAs in the state; 4) have refined targeting criteria for serviing persons most at risk, and 5) overall consumer and system statisfaction with the program model.

Many of the objectives and outcomes were achieved in part or in whole despite unanticipated challenges including time needed to secure approval of the State legislature, develop partnerships, gain agreement on forms, protocal and targeting criteria, solicit and implement test sites in two AAAs, and building trust and support of hospitals as a source of referrals to the program. The project exceeded its goal of offering counseling, training or serves to 200 family members, including 123 individuals and/or caregivers received cash awards to continue support living in their communities. Case managers received training and a better understanding of options counseling, person-centered planning and consumer direction.

Targeting criteria was refined by the hiring of a registered nurse (RN) to conduct quality assessment and improvement including review of all of the enrollee interview and files from the two sites and comparing the clients of the Centers for Medicare and Medicaid Services and State funded Choices for Care participants with the enrollees in Flexible Choices Plus. Comparison of clients between the Choices for Care and Flexible Choices Pluse program found that clients of Choices were more independent in terms of ADLs, but more challenged in IADLs. This supported the belief that the protocal for this program addressed persons who while not yet qualified for the Choices program were at high risk of falls, overnight stays in hospitals and nursing home stays.

The RN also conducted sample home visits to validate the assessment and service plan conducted by the AAA staff and attended case manager meeting. She determined that all enrolled individuals met at least one of the high risk criteria, that more than half receiving one of the three components had a dianosis of dementia and 30% of those receiving services, and that only 5 of the program enrollees were either admitted to a nursing home or enrolled in the Choices for Care program.

Unfortunately the project of supporting individuals through this program could not be continued for financial reasons, there are lasting changes within the area agencies in internal operations, in knowledge of staff in areas such as options counseling, and linkages with the State and service organizations.

Performance Outcome Measurement Project (POMP)

The Government Performance and Results Act requires Federal agencies to use performance measurement, particularly outcome measurement, to improve the performance of Federal programs. The Office of Management and Budget has implemented a performance assessment process which placed increased emphasis on assessing program performance through outcome measurement.

Over the past nine years, AoA has sponsored the Performance Outcome Measurement Project for the Older Americans Act (OAA), Title III programs. This project with State Units on Aging and Area Agencies on Aging (AAAs) has produced a core set of performance measurement instruments. The instruments have been developed to obtain consumer-reported outcomes and quality assessment for critical OAA services. The instruments also measure special needs characteristics of the people receiving services. Results from earlier POMP projects have been instrumental in improving AoA's program assessment scores. In FY2010 five projects awarded in FY2004 came to a conclusion and are summarized in this compendium.

Projects awarded in FY2008 and continuing in FY2010 encompass developmental and planning work for Next Generation: POMP and the development and preparation of a "POMP TO GO" toolkit. The toolkit will assist the aging network and other interested parties in conducting surveys and using the information collected for program improvement and budget justification. Next Generation: POMP grantees were also asked to do developmental work on predictive modeling of nursing home placement using existing POMP survey data, participate in the development of longitudinal surveys to compliment the cross-sectional information of existing POMP surveys and to validate the nursing home predictor model that is currently being developed and to enhance its utility at the national level through replication and inclusion of community context variables (nursing home bed supply, community characteristics).

Additional information about POMP can be found on this website:

https://www.gpra.net/default.asp

Program: Performance Measurement Outcomes Project (POMP)

Grant Number: 90NG0007
Project Title: Arizona Next Generation: Performance Outcome Measurement Project
Project Period: 09/30/2008 - 07/31/2010

Grantee:
Arizona Department of Economic Security
Independent Living Support Unit
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AoA Project Officer: Cynthia Bauer

Fiscal Year	Funding Amount
FY2010	$
FY2009	$57,904
FY2008	$52,224
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$110,128

Project Abstract:

This project was conducted by the Area Agency on Aging, Region One, which covers the City of Phoenix and surrounding Maricopa County, Arizona, and its contractor, Westat, to study senior center participation and its relationship to the health and well being of older adults. Specifically, the project looked at the impact of senior center services and program on participants. Senior centers offer activities such as meals, nutrition education, exercise activities, disease prevention/health promotion and wellness initiatives, and recreation and socialization opportunities.

For this study, 138 new participants were identified in 2008 as having enrolled in 25 senior centers within one month of senior center registration. Participants were self-selected after an explanation of the study was described by senior center staff. There was no control or matched group. Participants signed a consent form to have their information used in an aggregate manner and understood that they could withdraw from the study at anytime. Participants were assessed by both objective and self-reported measures, including a questionnaire survey, a health screening, and a physical performance test either at their senior center or in their home. Participant reassessments occurred at approximately 6 months, 12 months, and 18 months to show changes over time. There was no “planned intervention” for the study period such as implementing evidenced-based classes or wellness programs. Participants were not recruited based on their choice of existing senior center programs or services, nor were programs recommended to them during this project.

The study collected data covering several topical areas, including: 1) basic demographic information, such as age, income, gender, and living arrangements; 2) quality of life, diet, exercise, and chronic health conditions, such as osteoporosis and diabetes; 3) height, weight, and blood pressure readings from the health screenings; and 4) the NIH/NIA Short Physical Performance Battery, which measures strength, balance, and gait, as indicators of risk for future disability and need for various wellness services. Health care professionals conducted and recorded the results of the health screening and performance tests. The surveys were administered by licensed practical and registered nurses. Data from the surveys, health screening results, and performance tests were keyed into computer files by Area Agency on Aging, Region One data entry staff.

The study found that the 25 senior centers in the study offer a broad range of social, recreational, and wellness programs, and they are recruiting new participants with a clear need for these services. Specifically, nearly two in five of the new participants in the study are age 75 and above, almost half live alone, and over 40 percent have annual incomes at or below $20,000. The study results showed a high incidence among some participants of health problems, such as obesity (33%), hypertension (29%), and low levels of physical activity per CDC guidelines (60%). Each of these is a risk factor for loss of independence, and in combination they are indicative of a high level of need for the types of preventative services that these senior centers can offer. The Short Physical Performance Battery, which measures lower extremity strength, balance, and gait is an indicator of risk for adverse health outcomes, such as falls. Nearly half of the new senior center participants in the study registered composite scores at baseline that indicated moderate to severe risk. This shows that recruitment procedures are identifying and registering older persons with a documented need for services to improve these scores. Senior center staff may want to explore appropriate and effective ways of encouraging new participants with scores in the at-risk range to participate in evidenced-based fall prevention classes such as “Matter of Balance.

In the nutrition area, large numbers of new senior center participants in the study reported that they did not consume the number of servings of various food groups that the 2005 USDA guidelines specify. In particular, participants’ daily consumption of fruits, vegetables, dairy products, and grains did not meet the minimum requirements. The study found that this shortfall was not unique to Maricopa County’s new senior center participants in the study, for there were similar patterns of consumption of these food groups in Older Americans Act congregate nutrition programs, nationwide, as shown by AoA’s national surveys. The follow-up senior center surveys did show improvement in levels of consumption for these food groups, especially at the low end of the spectrum, where the percentages eating zero or just one serving per day fell, as participants increased their consumption of these items. Senior centers may want to explore other ways to help participants improve their nutrition through initiatives such as increased nutrition education. The findings from this longitudinal study of new senior center participants provide an empirical basis for drawing conclusions about programs and making recommendations for improvements to enhance the well-being of older persons in Maricopa County. The overall conclusion reached from this study is that the structure and array of services and activities offered by senior centers is non-standardized to the point where attempts at "generic" performance outcome measurement or evaluation are unlikely to be productive.

Program: Performance Measurement Outcomes Project (POMP)

Grant Number: **90AM2877**
Project Title: **Florida Performance Outcome Measures Project: Advanced POMP**
Project Period: **09/30/2004 - 08/31/2010**

Grantee:
Florida Department of Elder Affairs
Planning and Evaluation Unit
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AoA Project Officer: Cynthia Bauer

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$99,434
FY2007	$69,957
FY2006	$59,943
FY2005	$50,000
FY2004	$15,000
FY2003	$
Total	$294,334

Project Abstract:

Florida is providing project leadership by independently developing a nursing home predictor model and sharing it with the grantee workgroup for broader testing. Florida served as the co-leader of the Advanced POMP workgroup and has developed the vision for Goal 1: Demonstrate Cost Avoidance Attributed to Older Americans Act (OAA) Programs. Florida is currently expanding the nursing home risk model to predict risk of other adverse events such as hospitalization, emergency room visits and functional decline. Objectives were to: 1) produce an algorithm to compute reductions in nursing home placements due to use of in-home services; 2) produce an algorithm to compute reductions in hospital use due to use of in-home services; and 3) produce an algorithm to compute reductions in acute medical care due to use of in-home services.

During the six years of the Advanced POMP Grant project, the Florida Department of Elder Affairs (DOEA) undertook a number of projects to document the cost effectiveness of providing home and community-based services. In addition, Florida worked with participating grantees on their Advanced POMP projects through consultations and conference calls. The projects funded in whole or in part by Advanced POMP through contracts with Florida State University, the University of North Florida and the University of South Florida were: 1) Predicting Nursing Home Entry Post-Assessment: Methods, Estimations, Results and Specification; 2) Establishing Algorithms for the Cost-Benefit Analysis of In-Home Services for Elderly in Florida; 3) Prioritization Analysis; 4) Cost Avoidance - Estimates of Medicaid and General Revenue Cost-Avoidance from Home and Community Based Services (HCBS) Utilization and 5) Ethnographic Study of HCBS Service Recipients.

The projects addressed the risk of nursing home admission by documenting the effectiveness of service provision in delaying nursing home admission and cost savings associated with home and community-based service provision compared to nursing home care. In addition to the above projects, the Advanced POMP Grant also supported a project to validate the Department's methodology for prioritizing individuals for the receipt of services based on need.

Results of these projects strongly show the impact of social factors (e.g. living alone), race, and mental health indicators as predictors of nursing home entry risk. Other health factors such as stroke, osteoporosis, and Parkinson's disease were not revealed as significant predictors. Develop of a predictor model should include: race, age, marital status, whether the client lives in public housing, whether the client receives food stamps, presence of cognitive problems, client currently receiving mental health services, client suffering from dementia, client having diabetes, and the client having enough money to buy food.

A model that includes services is also estimated and reveals an association between nursing home entry risk and service use. The cost analysis study of HBCS revealed evidence of Medicaid cost avoidance for clients enrolled in HCBS programs in Florida. When the total Medicaid costs were disaggregated, cost avoidance appears most consistently when analyzing nursing home costs. On the other hand, there is little consistent evidence of cost avoidance for inpatient hospital care.

Among challenges faced was difficulty in obtaining permission from the Centers for Medicare and Medicaid (CMS) to access the nursing home Minimum Data Set (MDS) data. This delay resulted in contractors having an unreasonably short amount of time within which to complete their deliverable. In one case the contractor did complete all the contract deliverables and the contract was terminated. In another case, the contractor completed the project well beyond the due date.

The Advanced POMP projects have contributed to the field of knowledge related to estimating the risk of nursing home placement and cost-effectiveness of providing home and community-based services. Specifically the research has increased understanding of nursing home risk and the value of providing services to clients with varying degrees of functional impairment and health compromise. Insight was gained about service delivery factors that increase service effectiveness. In addition, the ethnographic study findings suggested data elements for the Next Generation POMP to use in developing the Longitudinal/Predictive Survey that is still in development. Many elements could be added that have anticipated predictive value.

Program: Performance Measurement Outcomes Project (POMP)

Grant Number: **90AM2881**
Project Title: **Georgia Performance Outcome Measures Project: Advanced POMP**
Project Period: **09/30/2004 - 06/30/2010**

Grantee:
Georgia Department of Human Resources
Division of Aging Services
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AoA Project Officer: Cynthia Bauer

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$37,635
FY2007	$37,635
FY2006	$21,381
FY2005	$18,772
FY2004	$11,250
FY2003	$
Total	$126,673

Project Abstract:

Between FY 2004 and FY 2010 Georgia's Department of Human Services Division of Aging Services (DAS) worked cooperatively with the Administration on Aging (AoA) and its support contractors to explore methodologies that predict the likelihood of nursing home placement of clients receiving Older Americans Act (OAA) services. Two modeling approaches were executed.

The initial study examined the effect of the receipt of OAA services on the delay in nursing home placement among OAA service clients age 60 and older in Georgia. A time-to-event analyses (time to nursing home placement) was conducted using proportional hazards regression models applied to client data from DAS. Predictors in the models included demographics (age, gender, ethnicity, living arrangements, presence of a caregiver); measures of physical functioning from the revised Determination of Needs (DON-R) impairment and unmet needs scores; and receipt of OAA home-and-community-based services. The services included home-delivered meals, homemaker services, personal care and respite care. Service variables included not only indicators of the receipt of a particular service, but also measures of the intensity of use of that service and cost of the service. In addition, a variable was created to indicate a count of the total number of services received by each client. The outcomes were: 1) remaining in the community, 2) permanent nursing home placement, 3) mortality, 4) loss to follow-up, and 5) the end of the study period. All outcomes except for nursing home placement were considered censoring events. Thus, 'survival' was defined as any outcome other than permanent nursing home placement.

The scope of the study expanded into a cooperative research opportunity between DAS and Department of Foods and Nutrition of the University of Georgia designed to evaluate the impact of Older Americans Act Nutrition Programs (OAANP) on food insecurity among older Georgians. Food insecurity exists whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain. Older Americans Act Nutrition Programs, consisting of congregate meals and home delivered meals, have been a primary source of food assistance targeted to older adults with greatest economic and social needs. The 2006 amendments to the OAANPs specified reducing food insecurity as a priority (U.S. Administration on Aging, 2006).

Based on results from the earlier study that the absence of OAANPs could contribute to premature nursing home placement, this study quantified the feasibility and ability of implementing a food insecurity measure to detect the impact of Older Americans Act Nutrition Programs in Georgia. This project was also intended to develop and improve the program evaluation system as part of the normal OAANP administrative process by collecting robust performance outcome measures in a timely and accurate manner at the state and local levels in Georgia.

Self-administered mail surveys completed by community dwelling active and new OAANP participants as well as waitlisted persons using the mail-out survey format of the ongoing U.S. Administration on Aging's Performance Outcomes Measures Project testing system in Georgia. It involved both cross-sectional and longitudinal components. The cross-sectional surveys were conducted in a statewide representative sample of active OAANP participants (i.e., receiving meals at least 6 months) and waitlisted people (i.e. being on the waitlists at least 3 months) as of June, 2009 in Georgia. The longitudinal component consists of three waves of self-administered mail surveys that were conducted at 4-month intervals in all persons who began OAANP participation (CM new participants and HDM new participants) as well as those added to program waitlists (CM new waitlisted and HDM new waitlisted) between July and early November 2008. A self-administered survey measured food insecurity, various nutritional health status indicators, and socioeconomic status measures that were developed and adapted from previously validated survey tools.

Based on an analysis of the longitudinal study sample there is a critical need for OAANP in Georgia. About 57.4% of individuals requesting OAANP services, especially a majority of Home Delivered Meal (HDM) applicants, had to be on the waiting lists over the 19 week period when the economic crisis has deepened across the nation in 2008. Although smaller, the cross-sectional study sample shows that 3,160 older Georgians in need of OAANP (10% of total older Georgians enrolled in OAANP) were waiting for meals at least 3 months as of June 2009. Those requesting HDM services and waitlisted people were more likely to show poorer socio-demographic and nutritional health status than their counterparts. Based on analysis of a modified nationally validated 6-item HFSSM data set, food security can be reasonably measured to assess need status and outcome of OAANP. Overall psychometric properties observed in the food security data were comparable to the national food security statistics provided by the USDA. About 56% and 34% of older Georgians requesting HDM and CM were food insecure, respectively. These numbers are higher than any available data reported previously (e.g., 8.1% of the U.S. elderly population in 2008). The process, lessons learned, and findings from this project suggest that food insecurity can serve as one of the direct and sensitive measures of need status for and outcome of OAANP in older adults.

Program: Performance Measurement Outcomes Project (POMP)

Grant Number: 90AM2874
Project Title: New York Performance Outcome Measures Project: Advanced POMP
Project Period: 09/30/2004 - 08/31/2010

Grantee:
New York State Office for the Aging
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Project Officer: Cynthia Bauer

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$100,000
FY2007	$70,000
FY2006	$60,000
FY2005	$50,000
FY2004	$15,000
FY2003	$
Total	$295,000

Project Abstract:

The New York Advanced Performance Outcomes Measures Project (POMP) examined the effects of aging network home care provision on older adults' risk of nursing home placement, in order to demonstrate the benefits of aging network home care services. The Project also identified risk factors contributing to nursing home entry to assist aging network program managers in targeting high-risk consumers and developing preventive programs to divert vulnerable older adults from unnecessary nursing home placement. This study was the first to directly examine the impact of New York aging network home care services on nursing home risk. The results of this effort are intended to enhance our understanding of the impact of aging network home care services, and identify risk factors affecting older adults transitioning from aging network home care programs to nursing homes in New York counties. The enhanced knowledge resulting from this Project on the dynamics and key elements affecting the transition from home care to nursing home care also will assist policy makers in developing cost-effective programs and sound policy recommendation on long-term care reform for the current and coming generations of older adults.

Anticipated outcomes for this project were: 1) a nursing home predictor model developed and tested; and 2) appropriate comparison group data from national surveys identified to enable nursing home diversion estimation. During the time period of this project, objectives were: 1) to expand the time frame for longitudinal data collection; 2) to expand the number of POMP Area Agency on Aging (AAA) partners; and 3) to implement a comparable study of Medicaid consumers with those of Aging Network on the probablility of nurisng home placement. Expected outcomes included: 1) a demonstraiton of costs savings by Aging Network Services in western and centeral New York; 2) identifying nursing home risk factors

for targeting consumers for nursing home diversion; and 3) supporting the Nursing Home Diversion Modernization Project by providing baseline data.

Following an extensive literature search that was conducted to identify research articles related to nursing home risk model methodologies, pertinent nursing home admission predictors were identified and a data inventory form was constructed to identify the availability of data relating to nursing home admission predictors within the four New York counties participating in POMP. Data was collected from each of the four AAAs - Broome, Chautauqua, Erie, and Tompkins Counties – on services consumers aged 60 and older received between January 1, 2008 and June 30, 2009. Data elements included: demographic characteristic, socio-economic status, health status and physical functioning, prior health care utilization, living arrangements and family structure, and availability of support. Specifically, the data elements for this study included consumers' age, gender, ethnicity, marital status, income, and living arrangement, activities of daily living (ADL) and instrumental activities of daily living (IADL) scores. Health status variables, such as self reports of incontinence, stroke, Parkinson's disease, Alzheimer's disease, and mental status variables (such as dementia), and health event variables (such as hospitalization and emergency room use), were also included.

Services and units of services utilization were included in order to investigate not only the effect of total number of services usage but also the influence of the intensity of services on consumers' probability of entering into a nursing home. Two additional variables, an outcome variable and a combined service variable, were created for modeling nursing home risk predictors. The outcome variable "survival time" was calculated for each individual consumer as the difference (in months) between the date of the event (nursing home placement) or censoring (by death, movement out of the study area, end of the study period, or other loss to follow-up) and the date the consumer entered the aging network service system. A "total services" variable was created for each individual by counting up the total number of services received by that individual during the study period.

An analysis was performed by Westat, the Administration on Aging's (AoA) consultant company for this initiative. All available data elements were included in the initial first run of modeling. Based on empirical evaluation of the model fits, plausibility of the selected variables and analytical judgment, select predictor variables were included in the final modeling. Two reports were generated by Westat: Advanced NY POMP – Analysis of Nursing Home Risk Factors in Erie County and in Broome/Chautauqua/Tompkins Counties, and Risk Factors for Nursing Home Placement among OAA Service Recipients: Analysis of Data from the New York State Office for the Aging.

Preliminary results modeling show that age, Instrumental Activities of Daily Living (IADL) case management units, personal care units and total services, as well as living alone and race are significant factors for predicting nursing home risks. These are consistent with the literature. Additional work is needed to address other outcomes besides nursing home placement such as death, moving to assisted living, hospitalization and quality of life; as well as the need for a control group of person not receiving services, interactive effects of some predictors, and the need for a larger study population.

Program: Performance Measurement Outcomes Project (POMP)

Grant Number: 90AM2875
Project Title: North Carolina Performance Outcome Measures Project: Advanced POMP
Project Period: 09/30/2004 - 08/31/2010

Grantee:
North Carolina Department of Health and Human Services
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AoA Project Officer: Cynthia Bauer

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$100,000
FY2007	$70,000
FY2006	$49,500
FY2005	$40,000
FY2004	$15,000
FY2003	$
Total	$274,500

Project Abstract:

One goal of national Advanced Performance Outcome Measures Project (Advanced POMP) was the development of models for predicting risk of nursing home placement using client and service utilization data from grantee states. Each participating state undertook very different projects, based on the ability to access information identified as predictors of nursing home placement from national long-term care studies. The North Carolina Advanced POMP project was conducted in two phases with different foci.

The first phase was a retrospective study of former service recipients in a two-county area over a 27-month period to determine if former clients terminated services because they were placed in nursing homes/assisted living facilities and to analyze client and service utilization data for evidence of cost savings associated with delayed or prevented placement. The 27-month study project area included two counties in central North Carolina – one rural (Surry County) and one urban (Forsyth County, including the City of Winston-Salem). There were 1,686 service recipients included in the study.

The second round was a prospective study of service recipients in a 12 county area who left the Older Americans Act (OAA) service system with the timeframe of an 18-month project period. The 18-month study included the original 2 counties and added the contiguous counties in the same planning and service areas for Older Americans Act services. Data quality issues in the second round related to the roll-out of a web-based statewide data tracking system forced the NC Advanced POMP project to refocus on the 27-month, 2-county database as the framework for developing the NC model. NC service recipients age 60 and older were included in analysis.

Predictors in the model tested included demographics (age, gender, ethnicity, living arrangements), measures of physical functioning from Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) scores, and receipt of OAA home-and-community-based services (adult day services, congregate meals, home-delivered meals, homemaker services, personal care, and transportation services). The majority of clients (76%) received only one OAA service during the study period, with approximately 21% receiving two services, and only 3% receiving three or more services. The nursing home placement rate was 6.6% over the entire study period, with a mean "survival time" in the community of 17.4 months out of a maximum of 27 months.

Statistical support for modeling and analysis was provided by Westat. A summary of their draft report included 1) controlling for demographics and functional status, initial modeling efforts showed that there was a statistically significant lowering of the relative risk of nursing home placement with the increased use of OAA services (total number of services received); 2) service intensity was not significant in any of the models which included individual service indicators for adult day services, congregate meals, home-delivered meals, homemaker services, personal care, and transportation, each in combination with the "total services" count; but none of those individual indicators was significant when included in the same model with the control variables and the "total services" variable; 3) additional models tested included the units of service received per month, such as average number of trips or meals per month and average number of hours or days of service, but none of the average-service-per month variables was significant; 4) the interpretation of the finding for the "total services" variable is that the relative risk of nursing home placement was decreased for those clients receiving more than one service compared to the clients receiving only one service, but since none of the individual service indicators was significant in these analyses, the analysis suggests that it is the total program of services that is most important in lowering the relative risk of placement in this client population and not any one particular service; 5) the results for the "total services" counts are consistent with results of analyses of similar data sets from other states in the national Advanced POMP demonstration project and from the national Health and Retirement Survey.

For a subset of North Carolina service recipients who also were Medicaid eligible, an analysis included an examination of Medicaid claims information (nursing home claims and non-nursing home claims) as additional predictors. Half of the clients were Medicaid eligible at some point during the study period. Of the clients who were Medicaid eligible at some point, about 3% had a temporary nursing home stay before the end of the study period and about 57% had a non-nursing home Medicaid claim before the end of the study. The nursing home placement rate, at 11.9%, was much higher for this subset group. The original models were rerun, adding the two indicator variables of Medicaid claims. Results of this modeling showed once again that, controlling for demographics and functional status, there was statistically significant lowering of the relative risk of nursing home placement with the increased use of services among the Medicaid eligible North Carolina service recipients. In addition, clients who received non-nursing home Medicaid services in conjunction with the Older Americans Act services showed a decreased relative risk of nursing home placement, again suggesting that it is the total program of services that is most important in lowering the relative risk of placement and not any one particular service.

Program: Performance Measurement Outcomes Project (POMP)

Grant Number: **90NG0005**
Project Title: **Ohio's Next Generation POMP**
Project Period: **09/30/2008 - 07/31/2010**

Grantee:
Ohio Department of Aging
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AoA project Officer: Cynthia Bauer

Fiscal year	Funding Amount
FY2010	$
FY2009	$60,000
FY2008	$60,000
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$120,000

Project Abstract:

The Ohio Department of Aging (ODA) under this grant collaborated with the Administration on aging (AoA) and other grantee's to develop high level outcome models including nursing home diversion indicators, cost avoidance, and nursing home placement predictors. During the report period, the Advanced POMP team focused on two main objectives: 1) to develop a risk assessment tool that can be used statewide for Care Coordination programs, and 2) to identify a list of risk factors that are relevant to the elderly who reside in a rural area.

The POMP team began by gathering existing program outcome data and information including previous studies, reports, and information from Ohio community-based long-term care programs. It worked with other grantees to determine which domains to pursue and then to develop necessary instruments and protocols to collect data, and to analyze such data and report the program outcome results. In subsequent years, it continued our participation in the Advanced POMP workgroups with other grantees and identified nursing home predictor variables and piloted outcome models. The project was expanded and piloted at other Ohio Area Agencies on Aging (AAAs) using the "High Risk Screening Tool" that was developed for Ohio's AAA 10 B. Multiple efforts in Ohio were coordinated using program data to improve the quality of the home and community based programs and measured the cost/benefit of these programs.

Teleconferencing provided a venue for continued collaboration with other grantees for identifying and assessing additional nursing home predictors, while work continued on piloting and refining the High Risk Screening Tool Model for application to "care coordination programs" supported by Older Americans Act funding. ODA also investigated the integration of case management protocols with results from preliminary models.

The “New Advanced POMP” activities began on September 1, 2008 and represented a refinement of work previously accomplished and an expansion and enhancement of the “High Risk Screening Tool”. Such enhancement included development of the “eRisk” computer application that incorporated the tool along with a scoring scheme into one seamless computer operation. The focus of the work was on “care coordination programs” funded through the Older Americans Act. The expansion of the previous work allowed for two-additional years of data collection from three AAAs. This direction achieved compelling results in terms of predictability and statistical significance.

Analysis of data from the three AAA’s generated a list of risk factors that was significant and common to all based on univariate analysis, which include these ten components of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADSs): bathing, dressing, grooming, mobility bed, mobility locomotion, mobility transfer, toileting, telephone, transportation, and experience in nursing facility visits in the past year. The next step was to determine if these results would demonstrate cost savings associated with the ability to avoid pre-mature nursing facility placement through identification of “high risk consumers”, followed by focused and enhanced provision of home and community-based services.

After confirmation of the common data set that all three AAAs would collect and with the establishment of satisfactory data collection logistics, data collection during late spring of 2007. Unfortunately, there was insufficient enrollment history data to conduct multivariate logistic regression analysis. Thus, the risk assessment tool could not be developed at that time. However, with extended observation period going forward with new grant support, the POMP Team is confident the tool will be statistically sound and relevant to disenrollment from Care Coordination programs due to nursing home placement or death and other disenrollment reasons

Ohio Advanced POMP team is in the process of finalizing the risk assessment tool, applicable to Care Coordination Programs and supported by OAA funds, that is statistically sound and relatively easy to use and implement. Relevant assessment data has been gather data that are subject to rural factors for those who seek the Ohio PASSPORT support services in one Ohio planning and service area. Due to a very short observation period, however, it is strongly suggested that enrollment history data continue to be collected for those clients identified for this project. Having extended enrollment history data, preferably over 18-24 months that is an average length of stay among Care Coordination and PASSPORT program clients, instead of less than 6 months we had in this grant period, will result in a better model with more confident results. In addition, it will be very beneficial for case managers to use an easy to use computer software/application, which can calculate risk level based on those risk factors and odds ratio identified. In the same vein, development of the integrated care management protocols and ‘how to’ manuals for aging network staff can be pursed in parallel to the development of this application.

Center for Program Operations

The Administration on Aging (AoA) Center for Program Operations provides plans and directs the programs under the Older Americans Act designed to provide planning, coordination and services to older Americans through grant programs authorized under Titles II, III, VI, and VII. The project grants in this section are administered by the Center's four major units: The Office of Home and Community Based Services; the Office of Elder Rights; the Office of American Indian, Alaskan Native, and Native Hawaiian Programs; and the Office of Outreach and Consumer Information.

Aging Network Improvements

The Administration on Aging (AoA) has periodically since 1973 relied upon the support and cooperation of national organizations representing agencies administering programs supported under the Older Americans Act (OAA) to increase the capacity of the Aging Network not only to conduct OAA programs effectively and efficiently, but to integrate and coordinate aging service programs and activities supported by States and other Federal Agencies.

In FY2007, an unsolicited project was awarded to the Benjamin Rose Institute in Cleveland, Ohio, to examine recent studies by national organizations and think tanks on the current structure and proposed system changes in home and community based care and convened expert panels to develop reports making recommendations for AoA and Aging Network organizations.

Grant Number: **90AM3142**
Project Title: **Aging Strategic Alignment Project for the Aging Network**
Project Period: **07/01/2007 - 06/30/2010**

Grantee:
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AoA Project Officer: Robert Hornyak

Fiscal Year	Funding Amount
FY2010	$
FY2009	$200,000
FY2008	$300,000
FY2007	$399,915
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$899,915

Project Summary:

The Benjamin Rose Institute on Aging was supported by the Administration on Aging (AoA) to examine the extent to which and how members of the Aging Services Network, specifically State Units on Aging, were involved in “rebalancing” aging services, i.e., shifting Medicaid dollars from institutional to home- and community-based care. The 2006 Amendments to the Older Americans Act included important new provisions related to long-term care that underscore the national role of the Aging Services Network in home and community-based services. Through a cooperative agreement, the Benjamin Rose project established a roadmap that to help the Aging Network understand the significance and long-range vision inherent in the new long-term care provisions, and identify strategies and tactics that the various components of the Network can use to advance a coordinated approach to implementing the new provisions.

The Benjamin Rose Institute examined the extent to which and how members of the Aging Services Network, specifically State Units on Aging, were involved in “rebalancing” aging services, i.e., shifting Medicaid dollars from institutional to home and community-based care. Toward that end, the primary impact of this project was to obtain and disseminate comprehensive information about home- and community-based services (HCBS) under five funding streams for older adults and adults with physical disabilities in 48 states and the District of Columbia.

The Benjamin Rose project also identified systematic work with the National Association of State Units on Aging United with Disabilities (NASUAD), National Association of Area Agencies on Aging (N4A), readiness assessments, Lewin Group Aging and Disability Resource Center (ADRC) technical assistance, Cash and Counseling, evidence-based

disease and disability prevention, and the nursing home diversion grants, as critical components to a successful roadmap.

The first year of the project had three primary goals: 1) to bring together AoA's constituencies and build understanding and "buy-in" for AoA's vision and goals; 2) to produce and roll out a "roadmap" for the Choices for Independence initiative; and 3) to develop a plan to supply the State Units on Aging (SUAs) with technical assistance in their efforts to enact the vision. This plan was to be based on an assessment of the Aging Network's current capacity to fulfill AoA's strategic plan in order to identify and address gaps. For the second year of the project, the goals included: 1) profiling each State Unit on Aging's HCBS system and its infrastructure; and 2) formulating a plan for the ongoing collection, compilation, analysis and dissemination of this information.

The goal for the third and final year of the project was to assist AoA with rebalancing long-term care through policy recommendations for strengthening the states' HCBS infrastructure based on findings from the state profiles. The expected outcome for the last two years of the project was to achieve a clear understanding on the part of SUAs and other Aging Network members of the differences among states in their HCBS infrastructures, model programs and innovative initiatives in HCBS program design and delivery, and approaches to deliver a broader array of services to a larger number of older adults and adults with physical disabilities.

During the project period, some of the activities that were originally planned to meet the goals and objectives described above were modified due to changes in the larger environment and subsequent requests by AoA to add, expand or end activities. Goals pertaining to development and implementation of the Choices for Independence communication plan were altered as Choices became a demonstration and evaluation project included in the federal budget. The goal to develop and provide technical assistance in conjunction with the Community Living initiative was dropped due to overlap with other organizations and other experts already providing technical assistance related to various components of the initiative. A new goal was added in the third year of the project that involved convening a panel of experts on long-term caregiving issues related to paid direct-care workers; informal caregivers, including those employed in participant-directed HCBS programs; and the impact of the CLASS Act under health care reform.

Project products, included an overview report of HCBS programs across the states and 49 individual state profiles to help guide their efforts to expand and improve the availability, accessibility and quality of HCBS programs as alternatives to nursing home care. Another major contribution of this project was convening of two national expert panels which produced a reports with recommendations on a research design for evaluating the Choices for Independence Program and recommendations regarding the supply, retention, readiness and quality of the direct-care workforce, including family caregivers, to better position the Aging Network for HCBS expansion. To keep this extensive information current and useful for monitoring states' progress in expanding HCBS, rebalancing long-term care services and supports, and addressing the needs of the direct-care workforce, it is recommended that state profile information be updated biannually.

Model Approaches to Statewide Legal Assistance Systems

Model Approaches to Statewide Legal Assistance Systems (Model Approaches) is a discretionary grant program designed to help states develop and implement cost-effective, replicable approaches for integrating senior legal helplines into the broader tapestry of state legal service delivery networks. The cornerstone of these projects is statewide legal helplines which assist seniors in accessing quality legal services to ensure their rights and financial security, and to enhance their choice and independence.

Such systems include: integration of a low-cost senior legal helpline with Older Americans Act Title III-B legal services and other low-cost mechanisms to achieve cost-efficiency and maximum impact from limited legal resources; effective targeting of scarce resources to older persons in greatest social or economic need; focus on the most critical legal issues confronting target populations; and integration of the legal service delivery system with the broader aging services network.

As of FY2009, 24 States have received Model Approaches grants and in FY2010 AoA issued a program announcement to support up to seven (7) new projects in States that had not previously been supported. The majority of the nine projects in this compendium were first funded in FY2006.

Information about Statewide Legal Assistance Systems Model Approaches and the legal services supported under Titles III and VII OAA may be read on the AoA website:

http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Legal/index.aspx

Program: Model Approaches to Statewide Legal Assistance Systems

Grant Number: 90AM3098
Project Title: Alabama's Model Approach to Statewide Legal Assistance Systems
Project Period: 09/30/2006 - 12/31/2009

Grantee:
Alabama Department of Senior Services
State Unit on Aging
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AoA Project Officer: Valerie Soroka

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$100,000
FY2007	$100,000
FY2006	$100,000
FY2005	$
FY2004	$
FY2003	$
Total	$300,000

Project Summary:

Alabama's Model Approach to Statewide Legal Assistance Systems is a statewide, low-cost legal assistance system which provides delivery of legal services to better protect the rights and financial security of older Alabamians, enhancing their choice and independence. Partners include an Elder Rights Advisory Board, the Governor's Office of Faith-based and Community Initiatives, Hispanic Interest Coalition of Alabama, AARP, and several university law school clinics. The program focuses on the three most vulnerable elderly populations in the state: Hispanic, African American, and rural seniors. Support from this grant was used to expand coverage and enhance services of its telephone hotline and develop materials for seniors on elder law issues and how to receive assistance when needed.

This grant helped launch the eldercare hotline and support its operation throughout its three years. Approximately 100,000 calls were received originating from every county in Alabama. Approximately 2,000 of these calls were handily directly by the hotline with the major referred to other sources for assistance. The issues of most concern to seniors were housing, wills, advanced health care directives, real property/ownership, bankruptcy and foreclosure. The hotline was aided by volunteer attorneys who assisted callers on issues not normally handled by legal assistance staff including administering and probating estates and consumer issues such as bankruptcy. A call script was written to serve as a learning tool for interns and volunteers and a helpline survey developed and implemented with results showing most callers were satisfied with the service they received.

A number of improvements were made in providing legal services to older Alabamans including implimentation of a new reporting system and a standard contract for legal

providers. A universal request for proposal (RFP) was developed for area agencies on aging to assist them in selection of the best and most appropriate legal service provider serving their planning and service area. Placement of the RFP on the Alabama State Bar Association website was useful in expanding attorney awareness of the Older Americans Act Title III-B program.

The Elder Rights Guide for Older Alabamians was developed and placed on the Alabama Department of Senior Services website in November of 2008. The placement of this guide on the website has proven to be an effective resource for seniors who are searching for information regarding issues directly affecting them. The guide provides information regarding issues specific to seniors such as decision making powers for health care, Medicare, Long Term Care, and Social Security. The Alabama Department of Senior Services has received requests from various agencies and states asking for copies of the guide as well as comments from seniors who have been very complimentary regarding the information contained in the guide and the usefulness of the information.

A statewide brochure was developed and has served as an introduction to the Legal Assistance network. The brochure includes information on the types of legal assistance older individuals can expect as well as contact information for local legal providers and the helpline. During the grant period, this brochure has continually been distributed at numerous outreach and education events across the state of Alabama in order to educate and inform older individuals about the legal assistance available to them.

A monitoring tool consisting of 66 questions to be directed to the legal providers was distributed to Alabama area agencies on aging and has been implemented by some of these agencies. This monitoring tool enables the identification of potential problems and areas of service that need to be addressed and improved. It was hoped that face-to-face sessions could be held with area agencies however budget restraints have been a major factor in the state's inability to hold the sessions as planned. The budget constraints have also constrained the ability of the legal providers to reach and target the rural and hard-to-reach areas of the state.

Despite budget constraints, the overall success of the legal assistance program is due in large measure to the assistance received under this grant. The Elder Law Helpline and the legal providers will continue to meet the legal needs of the seniors they serve. The Elder Rights Guide for Older Alabamians has proven to be and will continue to be an effective tool for seniors when seeking information and guidance regarding legal issues specific to them. The development of the legal brochure has proven to be a very effective outreach tool. The RFP, model contract and reporting system will continue to improve the quality and delivery of services throughout the State.

Grant Number: 90AM3101
Project Title: Model Approaches to Statewide Legal Assistance Systems
Project Period: 09/30/2006 - 05/31/2010

Grantee:
Idaho Commission on Aging
3380 Americana Terrace, Suite 120
Boise, ID 83706

Contact:
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AoA Project Officer: Valerie Soroka

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$100,000
FY2007	$100,000
FY2006	$100,000
FY2005	$
FY2004	$
FY2003	$
Total	$300,000

Project Summary:

The goal of this project is was to create an integrated, statewide legal services delivery system targeting and more efficiently serving larger numbers of low-income Idaho seniors and related social service organizations. Targeted were low-income and limited-English proficiency seniors in rural areas, migrant worker seniors, Hispanic seniors, and Native American seniors. Project implementation was guided by a Senior Legal Resources Advisory Committee. Stakeholders included Area Aagencies on Aging, ombudsmen, senior centers, the Senior Health Insurance Benefits Association, the University of Idaho College of Law, and the Idaho Volunteer Lawyers Program, in addition to the Idaho Commission on Aging (ICOA) and Idaho Legal Aid Services (ILAS).

Activities included an assessment of the current legal needs of Idaho seniors, review of Idaho's existing legal services delivery system, and development of a plan to effectively incorporate low-cost mechanisms to address Idaho's seniors community needs, including: 1) re-establishment of a statewide senior legal hotline with full-time attorney staff; 2) creation of the nation's first web-based senior legal form library linked to document automation and assembly software; 3) an increase in senior-related materials available through the Idaho Legal Aid Services website and offices; and 4) greater coordination of services between senior legal service providers. Anticipated outcomes were: 1) an increase in the numbers of low-income Idaho seniors, their caregivers, and the social service organizations that assist them, who are served by an integrated, statewide legal services delivery system; and 2) pro bono attorneys, senior caregivers and service providers will be aided by the resources of the helpline and the senior library in serving seniors and resolving their legal problems.

Senior Legal Needs Assessment findings guided ICOA and ILAS program development. For example, the Assessment showed that seniors are interested in long-term care planning,

management of their public benefits and estate planning. These findings guided ICOA development of its Aging and Disability Resource Connections (ADRC) program which assists consumers to understand available services, access those services, and improving their quality of life.

An advisory committee which met 14 times on a monthly basis included representatives from Area Agency on Aging Directors, Long-Term Care Ombudsman, Idaho Supreme Court Assistance Services, Idaho Healthcare Association, Idaho Volunteer Lawyers Program, Idaho Guardianship Monitoring Pilot Project, Nez Perce Tribe, AARP, Idaho Commission on Hispanic Affairs, Lewis-Clark State College Center for Rural Aging and Mr. Bob Aldridge, a private elder law attorney. The advisory committee successfully guided the project by facilitating 1) evaluation of the current senior legal delivery system; 2) the creation of a plan to enhance the senior legal delivery system; 3) coordination of the delivery of legal services, including legal education and training to aging network staff and seniors on elder law topics; 4) dissemination of project materials; 5) monitoring of project effectiveness; 6) suggestions of improvements to the project based on review of project monitoring results; and 7) increasing collaborative efforts amongst aging providers.

The Hotline served almost 6,000 seniors and provided centralized senior intake. The Interactive Senior Legal Forms Library consisting of interactive court forms frequently sought by seniors that were placed on the web allowed almost 2,000 persons to assemble forms. The project was marketed to seniors (including specific outreach to Native American and Hispanic seniors) and service providers. Almost 6000 seniors were served on the Senior Legal Hotline (Hotline) and the Hotline and Senior Library were utilized by pro bono attorneys, caregivers and service providers. The ICOA and ILAS published the project in their newsletters and annual reports.

Re-establishment of the Hotline was probably the most successful part of the project. The Hotline improved the efficiency of the senior legal delivery system by increasing the utilization of low-cost legal services. The Hotline attorney provided legal advice and counsel as well as linked callers to the most appropriate level of legal resources including the Interactive Library, Court Assistance Office Project, Idaho Volunteer Lawyers Program, regional ILAS offices, and other appropriate referrals. Idaho's senior legal delivery system is stronger today than at the project's inception. While the scope of some services may be reduced the infrastructure made possible by the project (Senior Library, Hotline, legal materials, level of provider collaboration) will be maintained.

The primary recommendation is that senior hotlines be supported wherever possible to reach seniors in rural areas, those with limited mobility, or those who cannot afford to talk to an attorney. ILAS was forced to limit Hotline services to low-income callers at the grant's expiration. Despite emails and press releases about Hotline service restrictions, Hotline turned away 167 seniors the month following the grant's expiration. Most had no other service options.

Program: Model Approaches to Statewide Legal Assistance Systems

Grant Number: 90AM3099
Project Title: Iowa Senior Legal Assistance Integration Project
Project Period: 09/30/2006 - 05/31/2010

Grantee:
Iowa Department of Elder Affairs
510 E. 12th Street, Suite 2
Des Moines, IA 50319-9025

Contact:
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AoA Project Officer: Valerie Soroka

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$100,000
FY2007	$100,000
FY2006	$100,000
FY2005	$
FY2004	$
FY2003	$
Total	$300,000

Project Summary:

The Iowa Senior Legal Assistance Integration Project developed and implemented an integrated and comprehensive state legal assistance delivery system for older Iowans merging Iowa's existing senior legal helpline with all of Iowa's Title III-B legal services providers and other available resources. Target populations for this integration are older Iowans who are low-income, minority, non-English speaking, rural, homebound or otherwise disadvantaged or vulnerable. The Iowa Senior Legal Assistance Integration Project Statewide Planning Group included Area Agencies on Aging, Iowa Legal Aid and the other Title III-B providers, Iowa's two law schools, the Long-Term Care Ombudsman, various volunteer lawyer projects, the Senior Health Insurance Information Program, the Attorney General's Office, and the Iowa Department of Veterans Affairs. The project also developed a model plan and materials to encourage and assist the senior networks in eight other Midwestern states to develop an integrated state legal assistance delivery system for older adults.

Included among the accomplishments of the grant were: 1) bringing traditional and non-traditional partners together; 2) expanding the legal hotline coverage areas; 3) the development of a legal assistance policy exception for low-income older adults; 4) recruiting and training volunteer lawyers on elder law issues; 5) creation of best practices for the legal assistance program; 6) community education and training events; 7) legal issue articles and legal mails; 8) face to face focus groups with older adults and their caregivers; and 9) the first ever legal needs assessment tool and report. Due to the success of our educational sessions, the Hotline for Older Iowans was able to receive foundation funding to continue offering these sessions around the state to older adults, caregivers and service providers and will partner with the Iowa Department on Aging and the Legal Assistance Developer as hosts.

Original objectives of the project were: 1) the expansion of services provided to older Iowans by private attorneys; 2) the development of statewide standards to improve the quantity and quality of legal assistance to older Iowans; and 3) an analysis of the effectiveness of follow-up services. Anticipated outcomes were: 1) many more Iowans will make better informed decisions regarding critical legal issues (such as health care directives and consumer protection); 2) direct legal assistance to older Iowans will increase by more than 57% over existing services; and 3) thousands of other older Iowans will increase their ability to deal with legal issues through increased training and community legal education to provide self-help legal offices in over 200 senior centers.

To implement the expansion of the hotline, Iowa Legal Aid reassigned existing attorney staff to the hotline. Once this was accomplished, the Hotline contacted each Area Agency on Aging (AAA) that was previously receiving only limited service. These AAA's were informed that the Hotline services would be available to all older adults in their planning and service area, regardless of their financial circumstances. The Hotline also contacted each Title III-B legal provider to create an exchange of referrals and client intake information. This was accomplished by ensuring that the providers were agreeable to receiving and making referrals and to discover what types of cases each current provider handles so that only appropriate referrals were made. A comparison of cases opened and closed between two time periods before and after the grant was awarded showed an increase of 34% in cases handled by the hot line.

A total of 1,600 older Iowans, caregivers, and service providers increased their ability to deal with legal issues involving health care, Medicaid, Medicare, elder abuse, resident rights, consumer protection, public benefits, guardianship, conservatorship, advanced planning matters in training sessions throughout the State. Legal articles were posted on websites, sent to media, AAA's and senior programs as well as printed in the Iowa Legal Aid Equal Justice Journal which is sent to over 7,000 low-income Iowans. Among the products developed were an Elder Law seminar training packet, a survey report of legal needs of older Iowans, Iowa Legal Assistance Program best practices, a checklist of public benefits and legal issues, and a Guide to Developing an Integrated and Comprehensive Legal Assistance Delivery System: An Iowa Model.

The senior legal assistance integration project was key to bringing legal assistance issues and needs to the forefront of public policy discussions. This project put a face on what the legal assistance program does and is capable of doing to help older persons. Also, the project was able to discuss with the consumers of the legal assistance system and obtain real data on the issues older Iowans and their caregivers are facing as well as their perceived needs. The project also shed light on the importance of a Legal Assistance Developer to the state unit on aging, the legal and aging networks and to the older persons of the state. The Legal Assistance Developer was the driving force behind building the partnerships and ensuring that each partner was included in the process. Each state unit on aging should have a Legal Assistance Developer who can serve in this capacity and is not merely an individual holding the title.

Program: Model Approaches to Statewide Legal Assistance Systems

Grant Number: 90AM3102
Project Title: Maryland Statewide Legal Assistance Project: A Collaborative Effort to Expand Maryland Legal Services
Project Period: 09/30/2006 - 05/31/2010

Grantee:
Maryland Department of Aging
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Baltimore , MD 21201

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AoA Project Officer: Valerie Soroka

Fiscal year	Funding Amount
FY2010	$
FY2009	$
FY2008	$100,000
FY2007	$100,000
FY2006	$100,000
FY2005	$
FY2004	$
FY2003	$
Total	$300,000

Project Summary:

The goal of the "Model Approaches to Statewide Legal Assistance Programs" project conducted by the Maryland Department of Aging (MDoA) in partnership with the Legal Aid Bureau, Inc. (LAB) was to coordinate among various aging programs, Area Agencies on Aging, and legal services providers to increase knowledge among each other's aging and legal services staff, and support and expand the innovative Senior Legal Helpline operated by the Legal Aid Bureau. This collaboration resulted in a better-coordinated legal services system targeting underserved seniors statewide, and focused on two critical legal areas – advance directives and assisted living.

The specific objectives were to: 1) improve services to elders concerning advance directives for English and limited English proficiency seniors; 2) provide elder residents with legal advice and brief services, as well as placement of their cases with appropriate IIIB providers; 3) create an Online Resource Center on Assisted Living targeted to operators of small residences (1-4 beds) and families of residents; and 4) provide Helpline callers with accurate legal information and guidance on civil law topics to include assisted living and advance directives. Anticipated outcomes included: 1) expanding advance directive legal advice including preparation of documents for seniors speaking Korean, Chinese, and Spanish; 2) legal assistance to an average of 3,500 seniors each year on the Helpline; 3) providing access to model policies and procedures to assisted living providers via an Online Resource Center; and 4) creating two law outlines on advance directives and assisted living issues to guide Helpline attorneys.

To increase understanding amongst those providing services to seniors, LAB conducted collaborative trainings with MDoA program providers including Senior Information and Assistance (I&A), Public Guardianship Managers, Senior Health Information Assistance Program (SHIP) counselors, and Long-Term Care Ombudsmen. At these trainings, LAB shared brochures on the various programs run by the LAB and a fact sheet on the grant's objectives. MDoA also presented information to LAB's Elder Law Task Force (ELTF) to familiarize members with MDoA's many resources. The ELTF brings together elder law practitioners from all Legal Aid's offices statewide, and other non-Legal Aid offices (such as Baltimore City's IIIB program. The outcome was considered quite successful as all groups involved reported an increased understanding of what services the other organizations can provide.

A second initiative, conducting a Senior Legal Needs Assessment, required a wide spread survey of seniors and those who provide services to them ("gatekeepers"). The Original intention was to conduct the survey only in English; however was later decided to conduct the survey in three other languages – Spanish, Chinese and Korean with the goal getting surveys from seniors across the state, representing a wide variety of the seniors in Maryland. Over nine hundred surveys were collected through outreach by having LAB offices ask their senior clients to fill out a survey and by conducting a phone survey of seniors.

A third initiative called for the creation of an Assisted Living Online Resource Center for small assisted living facility operators. This site was created and is located on the award winning Peoples Law Library website

A fourth initiative was to expand seniors' access to and knowledge of advance directives through distribution of 2,500 copies of a 37-page Planning for Incapacity advance directive booklet. Another goal was to distribute advance directive booklets translated into Spanish, Chinese and Korean as well as to provide outreach and training to members of those communities. The advance directive booklet was translated into Spanish, Chinese and Korean, but has not yet been published. During the grant period, we conducted 14 outreach events in 9 different counties speaking to over 350 seniors.

A fifth initiative was continuation of the Maryland Senior Legal Helpline ("Helpline"), providing callers with accurate legal information and guidance on assisted living and advanced directives. Many callers were provided with brief services, including providing clients with handouts, brochures, other written materials such as form letters, consulting with other advocates, conducting extra research, and making contact with other agencies/organizations to help with their legal problem(s). During the grant, the Helpline served an average of 3,500 seniors per year, or about 14,000 seniors total. Helpline staff was trained on advanced directive and assisted living facility law. Work furthering all of the grant's objectives (except maintenance of the Online Resource Center) is continuing and has been integrated into the Helpline's regular services.

Program: Model Approaches to Statewide Legal Assistance Systems

Grant Number: 90AM3173
Project Title: Coordinated Legal Assistance in Michigan for Seniors (CLAIMS)
Project Period: 09/30/2007 - 05/31/2010

Grantee:
Michigan Department of Community Health
Michigan Office of Services to the Aging
Chandler Building Plaza 300 E. Michigan Avenue
Lansing, MI 48933

Contact:
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AoA Project Officer: Omar Valverde

Fiscal Year	Funding Amount
FY2010	$
FY2009	$115,043
FY2008	$115,043
FY2007	$115,043
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$345,129

Project Summary:

The Coordinated Legal Assistance In Michigan for Seniors (CLAIMS) project was developed to build and promote a statewide, seamlessly integrate legal service delivery system for seniors featuring the state's existing and successful Legal Hotline for Michigan Seniors (LHMS) which was updated Legal and augmented with resources from the private bar, local law schools, and lay advocates.

Original project objectives included: 1) convening an Elder Rights Coalition (ERC) to coordinate services between aging, legal and private bar resources; and 2) prioritize legal services around elder abuse, financial exploitation, predatory lending, tax foreclosure, bankruptcy, identity theft, consumer fraud, unclaimed public benefits and other identified needs. The Elder Rights Coalition partners, led by the Office of Services to the Aging (OSA), included: the LHMS, Title IIIB and LSC legal services, Area Agencies on Aging, the Long Term Care Ombudsman Program, Adult Protective Services, the State Health Insurance Counseling Program (aka MMAP), Michigan Poverty Law Program, Legal Services Association of Michigan, Michigan State Bar Foundation, and other key legal and aging advocates. Other project objectives included conduct of a senior citizen legal needs assessment; modification of Title IIIB service delivery standards and the reporting system to promote outcomes-based service delivery; crafting and implementing an integrated service delivery plan; and reshaping the LHMS from a call-back to a direct answer system.

Achievement of these objectives has created a more accountable and integrated legal service delivery system. All partners involved in this development recognized the importance of targeting, with a focus on the groups specifically identified in the Older Americans Act.

LHMS focused on the most economically needy and helped thousands of seniors in Michigan find additional sources of income or protect their Social Security from unlawful garnishment. The new service delivery standards and statewide reporting system helped start a move away from trying to generate numbers to targeting services impacting those most vulnerable.

LHMS established the Benefits Enrollment Center in 2009 as a way to help seniors throughout the state determine if they qualify for additional benefits and to help them apply for those benefits. The Benefits Enrollment Center assisted 3,293 clients with screenings for benefits such as Medicare Saving Program, Low-Income Subsidy, Supplemental Nutrition Assistance Program, Low Income Home Energy Assistance Program (LiHEAP), etc. Ninety percent of those screened were found eligible for at least one additional benefit. The attorneys at LHMS also helped seniors during this grant period with problems such as income garnishment and foreclosure. With the help of over 25 law students during the grant period, LHMS provided assistance to 253 clients to protect their Social Security from unlawful garnishment, thereby helping them maintain their income.

A project objective was to increase legal information and services to terminally ill and limited speaking adults. During the first six months of 2010, LHMS assisted 52 Hospice patients and 8 non-English speaking clients. This is an increase of 174% for the Hospice target group and a 33% for the non-English speaking clients for a comparable preceding period. The majority (89%) of Hospice patients that call LHMS are able to find the legal information and advice that they need without having to be referred for full service assistance from the Title III-B program or a private attorney. While LHMS met the goal for non-English speaking clients, this is a target population that is still drastically underserved, and finding bilingual staff or volunteers for LHMS has been a challenge to meet the needs of this population.

The data also demonstrates that the grant is having the desired effect of the moving full service providers into taking more extensive cases while the Hotline handles more volume. There was already a good working relationship between the legal service providers, including LHMS, and the aging service providers. Discussions to design and implement the Legal Services Information System resulted in strengthened referral relationships and a better understanding of the role that LHMS can play in the overall service delivery system. Discussions to update our legal service delivery standards resulted in a new way of looking at legal services from many of the aging service providers, namely the area agencies on aging (AAAs). The new standards have taken the focus away from delivering large numbers to allowing the Title III-B providers that contract with the AAAs to focus on more impact cases. This project has laid groundwork for continued change; however, a change of this magnitude cannot be accomplished in a short three-year period. The partners are committed to continue the process.

Program: Model Approaches to Statewide Legal Assistance Systems

Grant Number: 90AM3164
Project Title: Center Legal Assistance Services for Seniors
Project Period: 09/30/2007 - 05/31/2010

Grantee:
Nevada Health and Human Services
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Reno, NV 89502

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AoA Project Officer: Omar Valverde

Fiscal Year	Funding Amount
FY2010	$
FY2009	$100,000
FY2008	$100,000
FY2007	$100,000
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$300,000

Project Summary:

The Nevada Aging and Disability Services Division (Division) was awarded a three-year grant to establish a statewide helpline that would provide legal assistance to seniors throughout Nevada. The emphasis of the helpline was to be on seniors living in rural Nevada who did not have access to assistance as seniors living in Clark County and Washoe County do through the two Senior Law Projects established with Title IIIB funding. The Division entered into a sub-grant with Nevada Legal Services (NLS) to operate the helpline that began as the Centralized Legal Assistance Services for seniors or CLASS, which was changed to Senior Legal Helpline or SLH.

The innovation of this model was to use a statewide telephone system, as a "single point of entry" for the senior population through: 1) direct legal advice to callers while on the phone; 2) intake and immediate connection for further legal representation by NLS, the Washoe County Senior Law Project Project, other legal services, State Bar Lawyers Referral and Information Services; 3) referral to other resources; and 4) cooperation with senior centers statewide, providing their clients with legal assistance using Project NEON (Nevada Elders on the Net) computers.

NLS invested the funding in the telephone system hardware and software that would support a Voice Over Internet Protocol (VOIP) helpline system and had the VOIP system installed before the grant was awarded. The Administration on Aging (AoA) grant provided the funding to hire the staff that would operate the helpline. An attorney was hired who oversaw the work of the SLH project and managed the grant. NLS also hired a staff attorney and two paralegals that answered the telephone calls and provided the legal information or legal assistance to the callers.

The first phase of the helpline was to include all the rural counties and excluded Washoe County and Clark County. The help line's primary purpose was to provide assistance to rural seniors who had no other assistance available to them. Washoe and Clark Counties had Senior Law Projects funded, in part, through the State's Title IIIB funds. These two Counties contain the vast majority of the State's population between them (88% of the State's total population) and the Division and NLS wanted to establish the helpline in the rural Counties before adding what was expected to be an overwhelming demand on the system for assistance from the more populated Counties.

SLH went operational in the fifteen rural Counties as soon as the AoA grant award was received. The toll-free helpline number had a "soft" opening at first as only the Directing Attorney had been hired as of the beginning of the grant. The Staff Attorney began working for SLH with the beginning of the second year of the grant. During the first six months of operation, SLH staff traveled throughout rural Nevada conducting outreach and bringing along brochures advertising the SLH and the services it provided. SLH staff visited each Senior Center and public library in rural Nevada and taught Senior Center and Library staff how to navigate the Nevada Law Help website to find information on various legal topics, the forms most frequently needed by seniors, and how to complete and submit those forms.

Once the helpline was established in the rural NLS and the Division began working with the Washoe County Senior Law Project on Phase II of the helpline, which was adding service to Washoe County Seniors. The goal of the second phase was to create a seamless provision of legal assistance to Seniors in Washoe County, with the Helpline serving as the initial contact point for intake and quick advice and direct referrals being made to the Washoe Senior Law Project ("WSLP") for direct representation in legal issues. This system for Washoe County was put into place during the eighth month of the help line's existence.

The inclusion of Clark County during the third and final phase of the helpline was originally envisioned in the original grant. Clark County was phased into the helpline in February 2009. This system continues to work today. With the phasing in of the two most populous counties, SLH staff conducted the same outreach to the communities to advertise the helpline that was conducted in the rural counties when the helpline first became operational. During the outreach that was conducted in the rural counties, SLH and NLS staff were made aware that the residents of the rural counties much preferred the in-person, one-on-one contact that was provided during outreach events. Clients and the staff at the Senior Centers both explained that the preference was for in-person contact rather than the use of the helpline. As a result of the feedback that was received, NLS changed the scope of work under the grant a bit. The helpline became a hybrid helpline-direct services project. The adapted helpline model was in place for the last year and half of the grant.

During the grant period, SLH assisted 2,014 seniors with various legal issues 582 seniors in fifteen rural counties and 1,432 seniors in Washoe and Clark Counties, In addition to the Seniors that were counted under the AoA grant, NLS general staff assisted a further 1,309 Seniors under other grants.

Program: Model Approaches to Statewide Legal Assistance Systems

Grant Number: 90AM3168
Project Title: New Hampshire Senior Legal Access Network
Project Period: 09/30/2007 - 05/31/2010

Grantee:
New Hampshire Department of Health and Human Services
Bureau of Elderly and Adult Services
129 Pleasant Street
Concord, NH 03301-3857

Contact:
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AoA Project Officer: Omar Valverde

Fiscal Year	Funding Amount
FY2010	$
FY2009	$97,582
FY2008	$97,582
FY2007	$97,582
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$292,746

Project Summary:

The New Hampshire Bureau of Elderly and Adult Services (BEAS), with funding and guidance of the Administration on Aging through the Model Approaches Grant, was able to take advantage of the well-established senior programs already existing in the state to build and expand the quality and quantity of affordable legal services for seniors in New Hampshire. The goal of the project was to develop a fully integrated, coordinated legal system that incorporated pro bono and reduced fee legal services with the services offered by our state's Title III-B legal services and senior legal helpline provider to ensure that all socially and economically disadvantaged seniors in our state receive the help that they need.

Project objectives were to: 1) increase access to the helpline and to increase the number of cases handled for extended representation by Title IIIB and pro bono programs; 2) meet the legal needs of seniors subject to financial exploitation; 3) enhance the presence and integration of the helpline and Pro Bono program in aging and disability resource centers; 4) conduct needs assessment and develop a statewide legal service delivery plan; 5) evaluate the impact of proposed interventions; and 6) disseminate project and evaluation information.

The grant partners created the New Hampshire Senior Legal Access Network (NHSLAN). This program was formed to enhance the delivery and coordination of low cost legal services to vulnerable New Hampshire seniors. NHSLAN built upon well-established senior programs and expanded the services, relationships and collaboration that existed in New Hampshire in order to better serve seniors with legal needs.

The following entities make up NHSLAN: 1) BEAS which includes New Hampshire's Legal Services Developer, Adult Protective Services, and oversees a statewide network of Aging and Disability Resource Centers (ADRCs); 2) New Hampshire Legal Assistance (NHLA), a legal services organization that for more than 30 years has served as New Hampshire's Title III-B legal services provider through its Senior Citizens Law Project (SCLP) and since 1998 has operated the state's senior legal helpline, the SCLP Advice Line (Advice Line); 3) the pro bono referral Program of the New Hampshire Bar Association (Pro Bono); 4) ServiceLink Resource Centers (ServiceLinks), a statewide network of Aging and Disability Resource Centers that provides a single point of access for services for seniors and adults with disabilities; and 5) the 2-1-1 New Hampshire Call Center (2-1-1), a phone-based information and referral system that was launched in 2008 by the United Ways of New Hampshire.

The project partners collaborated with the state's legal services providers to expand access to legal services for seniors and enhance coordination and integration of legal services into our state's network of aging and disability resource centers. Throughout the project the partners had to make some adaptations due to the challenges posed by the changing economy. However, the needs assessment helped to highlight what help seniors need and the members of NHSLAN now know how to most effectively use our scarce resources to focus on the largest unmet needs. This project has also enabled NHSLAN partners to strengthen working relationships and develop new relationships with organizations and programs serving seniors. These working relationships will continue past the project period and will help sustain the changes made by the project.

The measurable outcomes established were an increase in the number of calls answered live and an increase in the number of calls the Advice Line returned. Prior to this award, the Advice Line tracked the number of calls answered live and the number of calls returned so we were able to establish a baseline and track improvement in access to the Advice Line throughout the grant period. The project was particularly successful in achieving this specific outcome. Prior to the initiation of the project the Advice Line had one intake worker answering the calls for the entire state but had other duties including taking calls from agencies requesting information, performing administrative functions and performing intakes and referrals. When the Advice Line had only one intake worker, 72 calls were answered live each month and averaged 321 returned calls. The staffing changes made as a result of the grant award led to measurable improvement in calls answered live and calls returned. From January 2008 through March 2008 with two intake workers, NHSLAN averaged 166 calls answered live each month and averaged 347 returned calls. From April 2008 through May 2008 an average of 192 calls were answered live per month and 376 calls returned per month.

The project was successful in increasing the number of individuals who were served by the helpline and in improving the ability of providers to make referrals and share resources. A special focus of the project was to raise awareness of the issue of financial exploitation and the topic was central to many of the major communications activities. Now that the project has ended it will be important to maintain increased access to the state's senior legal helpline and continue to train and educate service providers, seniors and others linked to the senior community about the issues most important to seniors.

Program: Model Approaches to Statewide Legal Assistance Systems

Grant Number: 90AM3170
Project Title: Model Approach to Pennsylvania's Legal Assistance System for Seniors
Project Period: 09/30/2007 - 05/31/2010

Grantee:
Pennsylvania Department of Aging
State Government
555 Walnut Street
Harrisburg, PA 17101-1919

Contact:
Anne Kapoor
Tel. (717) 783-0509
Email: akapoor@state.pa.us

AoA project Officer: Omar Valverde

Fiscal year	Funding Amount
FY2010	$
FY2009	$100,000
FY2008	$100,000
FY2007	$100,000
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$300,000

Project Summary:

The Pennsylvania Department of Aging (PDA), in partnership with SeniorLAW Center and its Pennsylvania HelpLine, administered a three-year project to create an integrated delivery system of legal services for seniors to reduce the disparity in services statewide and strive to ensure that older Pennsylvanians, particularly underserved language, racial and ethnic minorities, the homebound, persons with disabilities and rural and low-income populations, receive the legal assistance they need. Pennsylvania has had a relatively decentralized aging services network, with 52 Area Agencies on Aging operating in expansive rural areas, and major metropolitan zones with concentration of low-income and immigrant seniors. Pennsylvania has been aware of this disparity and used the Model Approaches grants to gain a better understanding of the overall problem, and determine where statewide interventions would have the most impact.

The project scope was broad in that it assessed the existing services provided by its help line, the private bar, Title III providers and Legal Services Corporation organizations with the goal of making improvements and expanding services. The project objectives were to: 1) strengthen Pennsylvania's current system of legal services for seniors by enhancing the continuity of services offered by Pennsylvania's Area Agencies on Aging and identifying unmet legal needs; 2) develop a plan to maximize existing resources and develop new cost-effective legal service mechanisms to meet those needs; 3) expand the SeniorLAW HelpLine to provide legal counseling, referrals and limited advocacy to increased numbers of seniors and their families; 4) educate seniors, their caregivers, and aging services providers on

seniors' legal rights, proactive protection, and accessing resources; and 5) maximize resources and reach more seniors by creating pro bono and other legal resources.

The project began with a assessment of the legal needs of older Pennsylvanians as the basis for preparing a strategic plan of action. Four surveys asked practicing attorneys what kinds of legal issues they were asked to address other than traditional elder law topics; how they handled them when they could not help the individual or when the person in need could not afford their fees, and if they were willing to perform pro bono work on behalf of seniors. Organizations involved in development of the plan were involved in its implementation included: the Pennsylvania Bar Association as the pro bono coordinator, the Elder Abuse Unit of the Office of the Attorney General, the Pennsylvania Legal Aid Network, the Pennsylvania Immigration Coalition, the Pennsylvania Association of Area Agencies on Aging, and the Penn State University's Dickenson School of Law.

Implementation of the plan including its wide spread dissemination led to an expansion of the Pennsylvania HelpLine services including effective use of pro bono attorneys and law students; improved coordination among partners, and a better understanding of the provision of legal services by Area Agencies on Aging and other service providers. While the survey found a generally widespread assistance for seniors on traditional elder law issues, there was comparatively less availability of assistance on consumer, public benefits, housing and health care issues and a failure to keep up with the growing number of seniors in the State. The resources provided by the grant help support the only statewide legal services program in the State and maintain expanded hours of operations, recruit and training more law students and volunteer attorneys, and prepare for expansion of counseling referrals and limited advocacy services to meet unserved populations.

Various measures were used to evaluate the anticipated four benefits of the project which were to: l) Increase access for underserved, vulnerable Seniors to appropriate and expanded legal services and resources; 2) strengthen relationships with community, faith-based, immigrant and other services organizations that serve targeted populations; 3) increase awareness and understanding of legal issues affecting seniors, and legal needs among PA attorneys in a range of settings; and 4) Increase knowledge of Pennsylvania seniors and their families, caregivers, and service providers about legal rights and where to turn for legal assistance. Case management software collected data from callers of the HelpLine on demographics, issues addressed and time required to respond. Follow-up calls to 15% of those assisted indicated a very high degree of satisfaction. The goal of serving 4,040 seniors over the lifetime of the project was exceeded by 352. An additional 16 law students were recruited and trained as volunteers during the project period. Approximately 1,750 individuals and organizations received the E-News newsletter including a special addition encouraging its replications and distribution at State and local meetings and conferences.

The strategic plan report was and will continue to be used as a key component of reaching out to members of partner organizations and the Aging Network and is being used to reevaluate existing Older Americans Act Title III service contracts as well as future collaborative efforts between the State's legal services and aging services organizations and networks.

Program: Model Approaches to Statewide Legal Assistance Systems

Grant Number: **90AM3097**
Project Title: **North Dakota Senior Legal Hot Line**
Project Period: **09/30/2006 - 03/31/2010**

Grantee:
North Dakota Department of Human Services
Aging Services Division
600 East Boulevard Avenue, Department 325
Bismarck, ND 58505-0250

Contact:
Lynne Jacobson
Tel. (701) 328-4613
Email: sojacl@nd.gov

AoA Project Officer: Valerie Soroka

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$100,000
FY2007	$100,000
FY2006	$100,000
FY2005	$
FY2004	$
FY2003	$
Total	$300,000

Project Summary:

The goal of this project was to develop a statewide legal services hotline with a special emphasis on services to Tribal entities. It focused on six objectives to gain statewide recognition for the Hotline Services in North Dakota: 1) to coordinate all the efforts of all senior legal services providers; 2) to use a single toll-free number for access to all senior legal services programs; 3) to add expertise in the Native American and Immigration Law to the Legal Services; 4) to add a full time attorney to the Senior Legal Hot Line; 5) to promote the Senior Legal Hotline in Native American and immigrant communities as well as the rural and disabled while utilizing the Aging Network referral source; and 6) to expand pro bono and reduced fee services for seniors and immigrants through the State Bar Association.

Prior to this grant there were 4-5 different agencies providing legal services at a free or reduced fee with limited or no interaction between them with respect to scheduling, services provided, or even general networking. As a result of achieving its objectives, all service providing programs are coordinated through a network that includes sharing scarce resources which now include funds allocated by the State agency and a reserved pool of funds by the State legislature.

Implementation of a statewide toll free hotline was reached through an agreement between the State Bar Association and the State University Law School. Publicity surrounding its operation and emphasis on having a “real person” answer inquiries instead of a menu system proved so successful that an additional person was needed to respond to handle the volume of inquries.

Outreach to Native American communities was an important part of the project. Culturally appropriate clothing including caps and T-shirts were distributed with informational brochures and placed in hundreds of locations, including Powwow's, tribal community halls, senior citizens centers, and doctor offices. It was noted after the hotline became operational that use by Native Americans was more limited than anticipated in part because of more limited language skills and lack of comfort in using the telephone to discuss issues with a stranger. Despite increased training with staff on Native American law issues, the project ultimately conceded that overcoming Native American tradition and its distrust of personal contact which was not face to face could not be achieved.

The project also found barriers in responding to limited English immigrants, however it added a full time attorney with expertise in immigration law to respond to referred contacts. In fact, experience with the hotline determined that having a full time attorney respond to calls in this very rural State was not efficient thus an intake specialist was hired to triage calls and refer inquiries to all attorneys by cell phone, including the expert in immigration law.

The hotline is now the primary referral used by aging information and referral services in the State when they receive an inquiry that has legal implications. Its sustainability is enhanced not only by support of the State aging agency and legilature, but the North Dakota School of Law, the State Bar Assocation, and the Attorney General and Prosecutors Offices. A significant achievement was to have the State Bar Association adopt a resolution supporting pro bono and reduced fee services which has greatly increased the referral pool of attourneys that can be reached through the hotline.

National Legal Services Resource Center

The National Legal Resource Center (NLRC) is a network of organizations funded under cooperative agreements with the Administration on Aging (AoA) to serve as a centralized access point for a national legal assistance support system serving professionals and advocates working in legal and aging services networks. The organizations seek to enhance state and local efforts that promote and provide legal assistance and elder rights protections to elders most in need.

The activities of the NLRC are mandated in section 420 in Title IV of the Older Americans Act (OAA) which requires provision, development and support of case consultation; training; legal advise and assistance; and assistance in the design, implementation and administration of legal assistance delivery systems to local providers of legal assistance for older individuals. The NLRC works closely with State legal assistance developers supported in OAA Title VII and the legal service assistance services supported under OAA Title III.

Grant awards for organizations within the NLRC are competed every three years. Only one of these projects ended in FY2010. Information about AoA's support of legal assistance services including the NLRC may be read on the AoA website:

http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Legal/index.aspx

Detailed information about the NLRC may be found on the website developed by the grantee profiled in this compendium:

http://www.nlrc.aoa.gov

Grant Number: 90LA0005
Project Title: Legal Services National Technology Assistance Project
Project Period: 09/30/2008 - 12/31/2009

Grantee:
Legal Services National Technology Assistance Project
2118 Wilshire Blvd. #292
Santa Monica, CA 90403-5784

Contact:
Kathleen Brockel
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Email: kathleen@lsntap.org

AoA Project Officer: Omar Valverde

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$75,000
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$75,000

Project Summary:

The purpose of the project was to develop website content for the National Legal Resource Center (NLRC) to serve as a point of centralized access to the national legal assistance support system. The NLRC website at http://www.nlrc.aoa.gov was launched in December 2010. The role of the National Legal Services Technical Assistance Project (NLDTAP) was to develop all the content for the NLRC website and work with the AoA developers on the design, navigation and features. Partners in the project were NLRC members: the American Bar Association Commission on Law and Aging, the Center for Elder Rights Advocacy, the Center for Social Gerontology, the National Consumer Law Center, and the National Senior Citizens Law Center. Going forward the site will be managed by NLRC partner The American Bar Association Commission on Law and Aging.

All of the projected outcomes of the project were met including: Profiles of NLRC partners; on line access to case consultation and training and technical assistance; links to vital components of aging and legal services delivery networks; links to informational resources related to law and aging, calendar listing, posting of legal cases, reports, manuals, websites and other information of interest to elder law advocates; information on the progress of Model Approaches demonstration projects and other informational resources.

The target audiences for the website are: States participating in the Model Approaches to Statewide Legal Assistance Systems Program, Senior Legal helplines, Title III-B legal assistance providers, Legal Services Corporation (LSC) providers, State Legal Assistance Developers, Elder law and/or consumer law attorney in the public and private sector, member

of the judiciary, aging services staff of Area Agencies on Aging, ADRCs, or State Units on Aging, Long-term care ombudsman staff and other legal aid, agency, or services providers.

Many materials were produced during the grant period and all can be viewed in the in the Legal Issues, best practices, resources and identification of legal services providers in the aging network.

The development of site has increased the working relationship among the NLRC partners who suggest topics and materials for the site and work to develop and test mechanisms for the site that offer key NLRC services to elder law advocates. Now that the site has launched the impact of the project will be measured in terms of increased activity on the site from month to month. Lessons learned from undertaking the project include learning more about the NLRC partner services and learning about the Aging Network and how all these mesh together to offer a comprehensive array of information and services to elder law advocates nationwide.

Pension Counseling

Since 1993, the Administration on Aging (AoA) has funded the Pension Counseling and Information Program (the Program) to help individuals understand and exercise their pension rights. Originally a demonstration project, pension counseling became a permanent program under Title II of the Older Americans Act (OAA) in 2000 and consists of multiple counseling projects and a single national technical assistance project. In FY 2001 and 2002, AoA shifted its funding focus from local and statewide projects to multi-state, regional projects in order to move the Program toward nationwide coverage.

Seven projects ended during FY2010: five were awarded in FY2007 and one in each in FY2008 and FY2009. AoA currently funds six regional counseling projects that serve 29 states. AoA also funds a national technical assistance and resource center that provides the counseling projects with legal training, case consultation and operational support.

Current information about AoA's support of pension counseling projects is on its website:

http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Pension_Counseling/index.aspx

Grant Number: 90AM3150
Project Title: New England Pension Assistance Project - Pension Counseling and Information Program
Project Period: 09/30/2007 - 07/31/2010

Grantee:
University of Massachusetts Boston
Gerontology Institute
100 Morrissey Blvd.
Boston, MA 02125-3393

Contact:
Paula Noonan
Tel. (617) 287-5371
Email: paula.noonan@umb.edu

AoA Project Officer: Valerie Soroka

Fiscal Year	Funding Amount
FY2010	$
FY2009	$200,000
FY2008	$200,000
FY2007	$157,500
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$557,500

Project Summary:

The Gerontology Institute of the University of Massachusetts Boston continued operation of the New England Pension Assistance Project (NEPAP) under this three year grant which provides free assistance to individuals from all six New England states (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) who have questions or problems with their pensions. The goal of the NEPAP is to increase workers' and retirees' knowledge of, and access to, retirement benefits.

The objectives of the project are: 1) to maximize individuals' retirement standard of living; 2) to educate older workers, retirees, and the community about pensions and retirement income, as well as issues affecting eligibility; 3) to identify recurring problems faced by workers in obtaining adequate pensions; and 4) to target outreach to women, low-income and minority workers and retirees, and elders with limited English proficiency.

The current project accomplished its goals through a program of individual counseling and referrals, case investigation, legal research, community education, and outreach. The expected outcomes were to help clients secure the benefits to which they are entitled and to increase awareness of pension rights, issues and problems among clients and the general population. The Project met its objectives through its ongoing work on individual cases. A range of services were provided depending on the nature of the client's needs ranging from brief written or verbal advice, factual investigation, contact with government agencies and/or plan administrators, and/or advocacy in the pension plan's administrative appeals process. During the three-year grant period, we opened cases for eight hundred twenty-six (826)

clients. NEPAP resolved cases for 867 clients, some of which were cases opened prior to October 1, 2007. The total number of cases worked on during the grant period was 965. Benefits were obtained for approximately 25% of the full-service clients whose cases were closed during this grant period. Lump-sum benefits obtained during the grant period totaled $931,125. Monthly benefits with an actuarial value of $6,198,743 were also secured for our clients or a total value of $7,129,868 in benefits obtained during the grant period.

During the grant period, 130 cases were referred out to either private attorneys, financial advisors, or other appropriate professionals. Three cases for clients originally based on fees collected by the project were eventually referred to a private attorney. The private attorney brought a class action on behalf of our clients and settled the case for $6.25 million in March 2010. Of the clients whose income was reported, 52% had incomes of less than $20,000. Approximately 11% of our clients identified themselves as African-Americans, while 17.9% described themselves as non-white.

Client satisfaction surveys collected on an ongoing basis and used as feedback to improve the project overwhelmingly reported that the project had been extremely useful to them and expressed by the high ratings in the area of staff courtesy and professionalism, clarity and utility of information provided, as well as overall satisfaction with the Project.

During this grant period, the project experienced some significant staffing changes. Three of the project's experienced counselors resigned during this three-year period. Two of the three vacancies left by our departing counselors were filled. The number of counselors has been reduced to four due to budgetary constraints. Paid and unpaid staff members all rose to the challenges presented by these circumstances and were able to provide clients with the same level of professionalism and expertise which the project has always provided.

Staff continued to conduct an active outreach campaign throughout the grant period aimed at publicizing services, educating individuals about their benefits, and educating professionals and elder and community service organizations about the issues confronting plan participants. These goals were accomplished through the distribution of educational and outreach materials; maintaining and updating the website; providing workshops on pension issues; and obtaining media coverage of pension issues and of our services. In the aggregate, the Project distributed 17 thousand brochures, posters and Finding a Lost Pension booklets; participated in 25 workshops and conferences; received coverage in 12 media outlets; and had more than 800 thousand hits on its web site.

The major challenge faced by NEPAP during the grant period was to maintain and increase visibility in light of increasing costs and the lack of adequate and stable funding. During the past year and a half, the Project lost grant funding which we had received fairly consistently from two sources, the Massachusetts Bar Foundation and the Boston Bar Foundation. We are actively seeking additional funding sources. NEPAP maintaining an active and focused outreach campaign on a continuous and ongoing basis and are working closely with the Pension Rights Center and their outreach efforts.

Grant Number: **90AM3148**
Project Title: **Mid-America Pension Rights Project**
Project Period: **09/30/2007 - 07/31/2010**

Grantee:
Elder Law of Michigan, Inc.
3815 W. St. Joseph St., Suite C-200
Lansing, MI 48917

Contact:
Katherine B. White
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Email: kwhite@elderlawofmi.org

AoA Project Officer: Valerie Soroka

Fiscal Year	Funding Amount
FY2010	$
FY2009	$200,000
FY2008	$200,000
FY2007	$157,500
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$557,500

Project Summary:

In 2007 under this grant the Mid-America Pension Rights Project, led by Elder Law of Michigan, Inc. (ELM), expanded on the success of the Great Lakes Pension Rights Project and remodeled the project into a centralized regional pension counseling project. The goal was to provide equitably distributed pension counseling and information services to individuals in Michigan, Ohio, Pennsylvania, Kentucky and Tennessee. The approach used specialized toll-free telephone service with "quick call" responses from attorneys who are pension specialists, a project website, and pension-specific/exclusive outreach.

Project objectives were to: 1) establish a regional approach to the five-state area using a centralized toll-free number, a common website and joint marketing materials; 2) implement creative outreach strategies to reach all pensioners, including those who have limited English proficiency, cognitive impairments and profound health problems; and 3) provide intensive and consistent pension counseling services to Michigan and Ohio, with expansion into Pennsylvania and Kentucky and, in year 3, Tennessee. Expected outcomes included: 1) improvement of the financial situation and security of retirees and their spouses; 2) enhancement in the understanding of pension benefits, rights, and options; and 3) increases in the availability of, and access to, high-quality pension counseling and information in Kentucky, Pennsylvania, and Tennessee.

The support of this grant was based on the evolutionary history development of elder law services in five states. In 1998, ELM created a pension counseling and information project built on a legal hotline service-delivery model. The project, originally titled the Michigan Pension Rights Project, provided telephone advice and information and when appropriate, provided pension advocacy services. In 2001, ELM and Pro Seniors, Inc. collaborated to bring pension counseling and information services to Ohio residents. Pro Seniors utilized the

legal hotline service-delivery model to provide pension advocacy services as the Ohio Pension Rights Project. In 2006, the Michigan and Ohio Pension Rights Projects strategic partnership began operating under the umbrella title of the Great Lakes Pension Rights Project (GLPRP). Also in that year, the GLPRP subcontracted with Pennsylvania's SeniorLAW Center and the Access to Justice Foundation of Kentucky to extend its services into those states. In 2007, the GLPRP remodeled itself into a regional pension counseling and information project, the Mid-America Pension Rights Project (MAPRP). MAPRP partnered with the Tennessee Alliance of Legal Services in 2008 to extend services into that state and create a 5-state region.

MAPRP achieved the measurable outcomes set out in its grant proposal. The project increased access to pension counseling and information services for retirees in Pennsylvania, Kentucky, and Tennessee; including those who are vulnerable, have limited English proficiency, or live in rural areas. As MAPRP increased access to its services, it also pledged to serve 600-700 pensioners each grant year. The project met this measurable outcome in Year 1 by providing service to a total of 641 individuals. In Year 2, the number of pension inquiries fielded by MAPRP staff greatly increased to 924. This increase may have resulted from the economic downturn of 2008 and the financial insecurity that it engendered. In Year 3, the number of individuals assisted by MAPRP staff stabilized at 845. The project served a total of 2,410 clients over the entire grant period. This represents an increase of 15% over those assisted during the previous grant period. Of the 2,410 clients served, MAPRP staff resolved 1,279 pension inquiries during the initial telephone contact. Project staff referred 1,131 for further investigation of their claims and advocacy as required. The MAPRP regional project recovered pension benefits presently valued at $15,483,393.

MAPRP developed and implemented a client follow-up outcome survey that the staff of the Ohio and Michigan offices administered through telephone interviews and electronic recording of client responses. The outcome survey measured 7 basic areas of the client's MAPRP experience measuring the client's impressions of the intake process, the overall MAPRP experience, the nature of any investigative services provided and the client's understanding of information received, impact on the client's life, and the effect that MAPRP-recovered retirement benefits have had on the client's well-being. The survey also sought to gauge the project's third measurable outcome of the empowerment of retirees to understand the current condition of their pension and the impact of their elections on their spouses and survivors. MAPRP offices were pleased that surveyed clients responded very positively and felt overwhelmingly empowered. However it was surprising to learn that only about half of the surveyed clients who recovered a pension benefit were more stable and better able to meet their financial needs during retirement.

MAPRP staff have learned that changing the project's identity is not as simple as changing its name. Regionalization entails not only a change in how the public perceives the project, but also a change in how the staff views their role and responsibilities as the project grows and evolves. MAPRP is pleased to have met this challenge and is excited to continue its proud history of providing excellent pension counseling and information service as the project expands its services into Indiana.

Grant Number: **90AM3149**
Project Title: **The Mid-Atlantic Pension Counseling Project**
Project Period: **09/30/2007 - 07/31/2010**

Grantee:
South Brooklyn Legal Services
105 Court Street
Brooklyn, NY 11201

Contact:
Gary Stone
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AoA Project Officer: Valerie Soroka

Fiscal Year	Funding Amount
FY2010	$
FY2009	$200,000
FY2008	$200,000
FY2007	$157,500
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$557,500

Project Summary:

Legal Services for the Elderly under this project grant continued its operation of the Mid-Atlantic Pension Counseling Project (MAPCP). The goal of the project is to provide pension counseling and information for the New York and New Jersey region. The objectives were to: 1) resolve the caller's pension problem by providing specialized services, ranging from information to direct counseling and assistance; 2) reach people throughout the region; 3) collect information about the services rendered; and 4) share the experiences of the project. The expected outcomes were: 1) increases in clients' financial stability; 2) increases in clients' informed decision-making; and 3) provision to clients of specialized, expert assistance.

The focus of the project is to provide high-quality pension counseling and advocacy services to as many individual clients as possible. Most clients can not afford to hire private counsel for legal assistance or find that the cost of doing so would outweigh the value of their individual claims. The project targets retired workers and pension claimants with focused outreach and services. Isolated and homebound clients are also targeted for outreach through telephone access and through the use of radio and newspapers for outreach concerning pension services. Non-English speaking clients are also targeted through the use of bi-lingual staff and on-demand translators.

Success was measured by evaluating the volume of clients assisted and the breadth of the legal serivces provided. Case-management software enables measurement of outcomes by recording data on clients servces, geographical areas covered and dollars recovered. In the nearly three years of this grant, the MAPCP served over 944 clients. Of these, the majority (626) lived in other states (Florida in particular). Using its case management system,

MAPCP was able to track the results of outreach efforts designed to increase the client base in New Jersey. A total of 85 new cases were opened compared with a period before the outreach campaign when 43 cases were opened.

A total of 635 individuals received pension counseling during the project period and an additional 136 individuals received brief services and non-litigaiton advocacy. Brief services included responding to inquiries to a pension plan, review of relevant documents, and assessment of client rights and options. These additional services either resolved the individual's problem or provided tools and information needed for them to proceed on their own. Staff provided formal representation before pension plans, including extensive preparation and legal argument on behalf of 113 clients. More than $779,000 in retroactive and lump-sum benefits were obtained for clients. More than $21,000 in monthly lifetime benefits were obtained. The project also advocated on behalf of clients who had been mistakenly overpaid retirement benefits through no fault of their own. Most payments were the accumulation of years of small discrepancies that clients could not affort to pay back without significant hardship. Through advocacy during this period, clients were absolved of paying back more than $154,000.

The project took an active role in providing training, technical asistance, and mentoring to colleagues whose clients encounter pension probems. In partnership with Legal Services for New York City, MAPCP provided a Continuing Legal Education (CLE) symposium for 20 attorneys and in collaboration with the Brooklyn Bar Association Volunteer Lawyers Project, presented a CLE program focused on pension issues that commonly arise in matrimonial disputes. Attendees were attorneys who pledged pro bono assistance to low-income New Yorkers. MAPC also assisted attorneys representing supervisors of domestic violence.

Extensive outreach and information sharing activity occurred during the grant period. Every Area Agency on Aging in the region (78), 1ocal bar assocations (46) and 27 Members of Congress, state senators and state assembley members were contacted and information about MAPCP services was distributed. A number of information materials and guides were produced or revised and made available at no cost to individuals concerning their pension rights and benefits.

A major challenge which MAPCP and other legal service providers have faced recently is the decline in other funding sources due to the economic downturn. Even with the support of the Administration on Aging, MAPCP could only provide advice and referral to the private bar, primarily the National Pension Lawyers' Network. Resources are maximized by relying on pro bono assistance and MAPCP has been fortunate in recruiting a number of high quality attorneys to assist clients. A significant challenge for clients is record retension. Standard business practice is to retain records for no more than seven years and as a result older adults often cannot locate their pensions or find they are unable to prove their entitlement. It is recommended that the law be amended to require pesnion plans and their sponsors to retain records much longer. Another challenge is the absence of protections for the surviving spouses in the public secotor commpared to the private sector. Under the Retirement Equity Act of 1984, spouses of most private sector retirees are guaranteed survivor benefits. Public retirement systems generally do not provide this protection.

Grant Number: **90PC0001**
Project Title: **South Central Pension Rights Project**
Project Period: **09/30/2008 - 07/31/2010**

Grantee:
Texas Legal Services Center
815 Brazos, Suite 1100
Austin, TX 78701

Contact:
Roger Curme
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Email: rcurrme@tlsc.org

AoA Project Officer Valerie Soroka

Fiscal Year	Funding Period
FY2010	$
FY2009	$200,000
FY2008	$200,000
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$400,000

Project Summary:

The Texas Legal Services Center provides of pension counseling, information, and advocacy services in Texas, Oklahoma, Louisiana, Arkansas, and Missouri as the South Central Pension Rights Project. The project goal was establishment of a regional pension counseling and information service for the South Central region in an effort to protect financial security and foster independence in retirement. The project's objectives were to provide regional pension counseling and information services, and outreach, in a manner programmatically consistent with other projects funded by the Administration on Aging (AoA) through: 1) individual counseling; 2) case investigation and non-litigation client advocacy; 3) regional intake and referral services; 4) specialized outreach; 5) dissemination of specialized publications; 6) staff development; 7) use of volunteers and law students; 8) data collection, analysis and reporting; and 9) shared learning across the AoA-funded pension projects.

Anticipated outcomes included increased: 1) access to regional pension counseling services; 2) access to pension counseling by low-income, non-English speaking, Native American, minority, rural and females workers, retirees, and beneficiaries; 3) financial well-being of retirees; 4) awareness of project services among potential referral sources; 5) and awareness of pension rights among workers and retirees in the service region.

The South Central Pension Rights Project (SCPRP) provides pension counseling and information services in an effort to protect financial security and foster independence in retirement. SCPRP serves the south central region made up of Arkansas, Louisiana, Missouri, Oklahoma and Texas; and serves individuals regardless of age, income or value of the claim, who reside or resided, work or worked, or seek pension benefits that are or were sponsored, administered, trusted or provided to workers, within SCPRP's region. Assistance includes answering questions about complicated employee pension

laws; obtaining and explaining retirement plan documents; correcting pension miscalculations and claiming retirement benefits that have been denied; tracking down benefits from past employers; and providing referrals to lawyers, actuaries, and other pension professionals as appropriate.

Arkansas, Missouri, Oklahoma and Texas had been served by previous pension counseling projects that were discontinued in September of 2007. SCPRP quickly restarted services to those states and established services to Louisiana. During the period from October 1, 2008 through July 31, 2010, SCPRP opened 475 client matters, closed 281 client matters and recovered $2,374,535 in pension benefits for clients. About half the clients served were women, over a quarter were African American, and over half were from households with income not above $30,000. SCPRP also increased awareness of project services among potential referral sources (ADRCs, Area Agencies on Aging, employee unions, elected officials, and others).

The main impact the Project has had to date is the instant reestablishment of regional pension counseling and information services to Arkansas, Missouri, Oklahoma and Texas and establishment of services to Louisiana. This restart resulted in virtually instant regional pension counseling and information services, regional outreach activities and programmatic consistency.

Among the lessons learned is that pension counseling projects should use the Pension Rights Center for technical assistance on outreach, training, legal assistance with cases, and other matters for which it was established, and should draw on the knowledge and experience of the other regional pension counseling projects. Outreach efforts targeting the general public or small groups have proven less effective over time at consistently generating pension counseling clients. Outreach activities such as public presentations, workshops, classes, seminars or other educational efforts significantly reduce project resources that could otherwise be dedicated to pension counseling or more direct outreach activities. While a portion of the project's outreach activities must be targeted to reach underserved and hard-to-reach seniors, including those with limited-English proficiency, the primary purpose of outreach activities is to generate pension clients.

Products include a website, client intake materials, outreach materials, client satisfaction surveys, and regular periodic reports.

Senior Medicare Patrol (SMP)

The Senior Medicare Patrol (SMP) program) empowers seniors through increased awareness and understanding of healthcare programs to protect themselves from the economic and health-related consequences of Medicare and Medicaid fraud, error and abuse. SMP projects also work to resolve beneficiary complaints of potential fraud in partnership with state and national fraud control/consumer protection entities, including Medicare contractors, state Medicaid fraud control units, state attorneys general, the Office of the Inspector General (IG); and the Centers for Medicare and Medicaid Services (CMS)

SMP grants are funded with a combination funds appropriated for the Health Care Fraud and Abuse Control (HCFAC) Program, authorized by the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and appropriations for Title IV of the Older Americans Act (OAA).

General information about SMP may be read by going to the AoA website:

http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/SMP/index.aspx.

Additional information about the SMP program may be found on the website of the National Consumer Protection Technical Resource Center which provides training and technical assistance to SMP projects, provides key consumer services such as fraud alerts, and maintains the SMP locator by state:

http://www.smpresource.org//AM/Template.cfm?Section=Home

Grant Number: 90SM0007
Project Title: Integration with Current Senior Medicare Patrol Project to Empower Seniors to Prevent Healthcare Fraud.
Project Period: 09/30/2008 - 06/30/2010

Grantee:
Arkansas Department of Human Services
Divison of Aging and Adult Service
700 Main Street
P.O. Box 1437, Slot S530, AR 72203

Contact:
John Pollett
Tel. (501) 682-8504
john.pollett@arkansas.gov

AoA Project Officer: Doris Summey

Fiscal Year	Funding Amount
FY2010	$
FY2009	$142,597
FY2008	$57,403
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$200,000

Project Summary:

This two-year project supported the Arkansas Department of Human Services, Division of Aging and Adult Services and the University of Arkansas at Little Rock (UALR) Integration project on expansion and integration of program coverage within the Arkansas-Delta, one of the poorest, most rural areas in the nation using an innovative community outreach, education and research model that can be successfully replicated by other Senior Medicare Patrols (SMPs) across the country. Partnerships with organizations in the Arkansas Delta, the Tri-County Rural Health Network, and the one-of-a-kind Senior Justice Center facilitated this initiative.

The two-phase intervention involved: 1) determining what Medicare beneficiaries who are underserved by virtue of their isolation want and need – know and don't know – and educating them about Medicare benefits and the potential for healthcare fraud associated with those benefits; and 2) conducting a research study to determine the best method(s) to reach out to rural seniors by asking them face-to-face in their home or in focus groups how they would prefer to receive health-related public awareness information and what is the best way to get their attention.

The objectives were to: 1) determine what underserved Medicare beneficiaries want and need to know, and to educate them about Medicare benefits and the potential for healthcare fraud associated with those benefits; and 2) conduct a research study to determine the best method(s) for reaching out to rural seniors, either through personal inquiry in their homes or in focus groups. Expected outcomes were to achieve: 1) a better understanding of how rural

seniors prefer to receive health-related information; 2) increased beneficiary awareness of the need to prevent healthcare fraud and abuse; 3) and changes in beneficiary behavior as they apply what they have learned about preventing healthcare fraud, avoiding becoming the victim of healthcare scams prevalent in the Delta, and accessing entitled benefits.

As the Arkansas SMP project staff and partners began to implement new initiatives to reach senior beneficiaries in the Arkansas Delta and other low income rural areas, it was apparent that while there were communication challenges in overcoming economic, racial and literacy barriers, the major challenge was that of understanding and accepting the cultural issues. To be effective in its work in the Delta, staff had to first gain the trust and respect of a very closed and wary community who are suspicious wondering why they should trust the "government."

Following a stakeholders meeting where the cultural issues were openly discussed, it was determined that a major outreach campaign in each community was needed with involvement of local residents in the conduct of the project. In the early stages of the community outreach it was found that partnering with "people" known in the communities could open doors that may not have been opened. Conducting community meetings where the agenda was simply to introduce the people involved and get acquainted in the hope of developing trust proved to be very successful.

The two year research component involved collection of interview, survey and field data from multiple sources which responded to quesitons about specific Medicare\Medicaid fraud practices. Interviews were held in the homes and community centers of four counties (Lee, Philips, Monroe and St. Francis) with a sample size of 105 beneficiaries ranging in age from 50 to 95. After the interviews were completed, seniors were given material on how to read Medicare summary notices, a Senior Justice Center flyer, a business care and a copy of the consent form. Results from 102 usable interviews showed that 81% knew the term health care fraud, but only 20% could itentify a specific type of fraud they believe affect them.

In the second year focus groups attended by 132 community members were held in the four counties to discuss with seniors the results of the first year interviews and to discuss the best approaches to increase awareness and detection of health care fraud. The top three preferred approaches for learning about fraud were mail, one-one one contact and telephone which contracticted the favored first year finding of attending community meetings.

Measured outcomes detected: 1) increased beneficiary awareness of the need to prevent healthcare fraud and abuse; and 2) changed beneficiary behavior as they apply what they have learned about preventing healthcare fraud, avoiding becoming the victim of the healthcare scams prevalent in the Delta, and accessed benefits to which they are entitled (e.g., the Medicare Part D Low Income Subsidy). The most important outcome was a better understanding of how rural seniors prefer to receive health-related information.

Products included the results of data collection and analyses shared with AoA, other SMPs, the Aging and Disability Resource Network, and the nationwide aging network via a study report to be published in a scientific journal dedicated to aging issues.

Program: Senior Medicare Patrol

Grant Number: **90SM0003**
Project Title: **SMP Integration Grant**
Project Period: **09/30/2008 - 06/30/2010**

Grantee:
Maryland Department of Aging
301 West Preston Street, Room 1007
Baltimore, MD 21201

Contact:
A. Cassaundra Brown
Tel. (410) 767-1278
Email: acb@ooa.state.md.us

AoA Project Officer: Doris Summey

Fiscal Year	Funding Amount
FY2010	$
FY2009	$100,000
FY2008	$100,000
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$200,000

Project Summary:

The goals of the Maryland Senior Medicare Patrol (SMP) Integration Grant were: 1) to expand the reach of the SMP program, using the SMP fraud prevention message; 2) to educate rural, isolated senior Marylanders and tribal elders who are Medicare beneficiaries; and 3) to strategically partner with Area Agencies on Aging (AAAs), and Aging and Disability Resource Centers (ADRCs) in outreach initiatives.

The objectives were to: 1) identify isolated populations in rural and tribal areas; 2) ensure that the SMP fraud message reaches rural isolated senior Marylanders and tribal elders; 3) provide necessary skills, knowledge and tools to help prevent fraud, error or abuse in healthcare; 4) empower seniors to take action to report instances of suspected fraud, error or abuse; 5) develop regional outreach in counties that do not have the SMP program (Calvert, Charles, Cecil, Allegany, Garrett, Washington); 6) ensure coordination in targeted counties where there is an ADRC already partnered with an AAA; 7) develop and implement a rural outreach plan with the Rural Maryland Health Council; 8) develop new partnerships with Native American organizations in Southern Maryland; 9) identify and test best practices to reach the isolated populations in rural and tribal areas; 10) provide customized training and education in rural and tribal areas; 11) recruit and train volunteers in rural and tribal areas; and 11) foster program visibility and consistency.

Expected outcomes were: 1) two regional SMPs established in coordination with the existing ADRCs in rural western Maryland and the lower Eastern Shore; 2) an outreach sub-committee created to assist and advise the creation and implementation of an outreach plan targeted to rural, isolated senior Marylanders and tribal elders; and 3) a SMARTFACTS data system in use. Anticipated products were a targeted outreach plan; customized SMP educational materials; media samples; and a final report, as required.

The SMP project included working with rural isolated elders, in three counties of Western Maryland (Allegany, Garrett and Washington Counties), developing outreach plans in southern Maryland in Calvert and Charles Counties, developing innovative strategies to reach a small group of tribal elders of the Piscataway Indian tribe, and assisting with efforts in reaching rural seniors of Cecil County along Route 95 and the corridor of Northeast Maryland. The Project Manager sought out partnerships that have worked well with this population, could provide support to the project as a member for the SMP Advisory Group and help recruit SMP volunteers.

The Maryland Department on Aging (MDoA) was committed to developing appropriate antifraud messages that would be effective for reaching out to seniors who have difficulty reading and comprehending written information covering Medicare and other health care topics. SMPI staff developed strategies to collaborate with a variety of partners throughout the state, Area Agencies on Aging (AAA), the Aging and Disability Resource Centers (ADRCs) and the local Senior Health Insurance Assistance Program in the counties identified for this grant. The Rural Maryland Council agreed to partner with MDoA and to contribute to the project by doing what they do best, connecting agencies, services and the people of rural Maryland to help identify and bring to light issues of rural living that affect the economic welfare, education and employment, access to affordable, quality health care and other vital public services, and the environment where natural and cultural resources are being sustained for future generations. MDoA also sought out and contracted the services of a Native American consultant to provide services and experiences to advise MDoA in developing an outreach strategy, introduction and marketing materials for reaching out to Native Americans in Southern Maryland. This strategic collaboration resulted in successful attainment of project goals and objectives: the statewide implementation of SMPs as planned and the development of targeted outreach and marketing materials.

While each of the anticipated outcomes was achieved, there were a number of adjustments and modifications to the grant that had to be made. During the first quarter of the grant, Worcester County Health Department lost funding from a major private foundation and had to reassign their health department liaison to another county program, leaving this grant without the commitment of local health department staff. The problem was resolved when the Area Agency on Aging Director agreed to take over the responsibility for the Aging and Disability Resource Center (ADRC) and implement the SMP project in Worcester County. In Western Maryland an experienced Social Security retiree was hired to work specifically for the project covering the three counties of the Western Maryland Regional SMP (Allegany, Garrett and Washington Counties). However, within the first year, the senior manager retired and the new regional SMP Coordinator was left to run the program without having the anticipated support of a seasoned supervisor. This challenge was handled within the Department of Aging and MDoA by providing technical support to the new SMPI Regional Coordinator. We limited reporting information to SMART FACTS to outreach and volunteer activity only.

The products for this project are: 1) a targeted outreach plan; 2) customized SMP educational materials for rural, isolated senior Marylanders and tribal elders; 3) media materials and PSAs; and 4) production of a final report.

Grant Number: 90AM3062
Project Title: Nebraska ECHO Project (Educating and Empowering Consumers of Healthcare Organizations)
Project Period: 07/01/2006 - 05/31/2010

Grantee:
Nebraska Department of Health and Human Services Services
State Long Term Care Ombudsman Office
P.O. Box 95044
Lincoln, NE 68509-5044

Contact:
Madhavi Bhadbhade
Tel. (402) 471-2309
Email: madhavi.bhadbhade@nebraska.gov

AoA Project Officer: Kathleen Votava

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$150,000
FY2007	$150,000
FY2006	$150,000
FY2005	$
FY2004	$
FY2003	$
Total	$450,000

Project Summary:

The three-year grant to the Nebraska Office of Long Term Care (LTC) Ombudsman supported improvements to the Senior Medicare Patrol (SMP) program known as the Nebraska ECHO Project (Educating and Empowering Consumers of Healthcare Organizations). The goal of the ECHO Project was to increase awareness among Nebraska's beneficiaries on how to identify, report and prevent Medicare and Medicaid fraud, error and waste and to empower and assist them in protecting their rights. This includes the right to be billed accurately for services received and to not be victimized by fraud schemes. The objectives of the Nebraska SMP gramt was to: 1) disseminate project information to beneficiaries, their caregivers, and the general public; 2) recruit, train and support qualified volunteers and enlist their efforts on behalf of beneficiaries; 3) develop and maintain a network of partnerships that will work together to eliminate healthcare fraud, error and waste; 4) provide outreach and advocacy to the most vulnerable of beneficiaries; and 5) provide targeted education to hard-to-reach populations. The expected outcomes of this project were: 1) beneficiaries would have an increased awareness of healthcare fraud, error and waste, and initiate positive changes in their behavior; 2) additional volunteers would be recruited and trained; and 3) an increased number of inquiries and complaints would be resolved or result in some action, including the savings or recoupment of healthcare dollars.

The SMP program was initated in 2000 as a project coordinated by the Nebraska Office of the Long Term Care Ombudsman and as such uniquely creates awaress of Medicare and Medicaid fraud for those residing in long term care facilities. SMP coordinators are certified ombudsman and physically located in Area Agencies on aging across the State. The

programs growth and success stem from: 1) partnerships with key agencies and organizations; 2) its location within the Nebraska Department on Aging; and 3) well training and effective staff and volunteers.

Activities under the grant included extensive and varied methods of outreach to to communities and residents across the State including conferences, fairs, seminars, workshops and materials place in libraries, senior centers, healthcare provider offices and clinics and almost any location where seniors congregate. The success of presentations was measured by responses to Group Educational Surveys with returns boosted by including copies of Healthcare Journals as a reward for completion.

Avocates for reaching residents and families in long term care facilities were recrutied, training and placed through cross training of long term care ombudsmen. In addition to training on how to prevent, report and prevent fraud, abuse and waste, volunteers were trainined to detect financial fraud which is a risk for long term care residents being dischared because of non-payment. The process of reporting financial fraud was streamlined with the Medicaid Fraud Control Unit of the Mebraska Attorney General's Office and its chief investigator was a member of the SMP Steering Committee.

The project supported education of staff and volunteers of programs directly working with seniors, including local area agencies on aging, State Health Insurance Information Programs (SHIPS), AARP and the Nebraska Medicare Coalition. In addition to presentations at community, religious, cultural, health and issue focused group presenations, the SMP project developed releases for the press, televisions, and radio as well as articles for newsletters. An effort was made to reach culturally different and English as a Second Language groups employing brochures in Spanish, Russian, Chinese, and Vietnamese, recruting minority volunteers, and meeting with minority community organizations.

Over the course of the project the two major challenges faced were adaptation of reporting information through the national SMP program SmartFacts data system and meeting the recrutiment, training and deployment needs of volunteers. These were successfully addressed as evidence by the annual increase in many of the Office of the Inspector General Reports for the State. The State was recognized in August 2009 at the national SMP conference for being the highest State in dollar amounts referred.

The SMP program in Nebraska will continue its pursit of its goal and ourtomes in the years ahead with continued support from AoA and the colllaborations within the State established during this project grant.

Program: Senior Medicare Patrol

Grant Number: **90AM3056**
Project Title: **Nevada's Senior Medicare Patrol Project- Senior Nevada Advocates on Guard (SNAG)**
Project Period: **07/01/2006 - 03/31/2010**

Grantee:
Nevada Office of the Attorney General
555 East Washington Ave., #3900
Las Vegas, NV 89101

Contact:
JoAnne Embry
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Email: jembry@ag.nevada.gov

AoA Project Officer: Dennis Dudley

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$180,000
FY2007	$180,000
FY2006	$180,000
FY2005	$
FY2004	$
FY2003	$
Total	$540,000

Project Summary:

The Nevada SMP was designed to educate Medicare beneficiaries and their caretakers to become critical health care consumers enabling them to identify suspicious situations or billings. These efforts increase the likelihood that the Medicare system is solvent for future generations. Under this project Nevada SMP effectively reached beneficiaries throughout the State by initiating presentations and information activities including taking advantage of the Attorney General's annual Rural Road Trips. Over the project period virtually all areas of the State (15 of the 17 counties) were visited and 111 outreach/education events, and 87 group educational sessions/SMP presentations conducted. Approximately 140 one-on-one counseling sessions were conducted as a result of (or during) these events and presentations.

There were presentations/discussions of the SMP Program's mission with topics of Medicare fraud issues, how to avoid being a victim of fraud and information about the SMP's volunteer program. The presentations took place in senior centers, town hall meetings, recreation centers, community centers, and tribal centers.

The SMP messages were enhanced by collaborations in events, organizational meetings, SMP presentations, newsletter articles and web site linkages with more than 50 organizations and task forces including: Nevada Elder Abuse Task Force, Nevada Division for Aging Services – primarily the SHIP program; Nevada Health Care Fraud Task Force - led by the US Attorney's Office and the FBI; Attorney General's Bureau of Consumer Protection & Chief of Investigations; Governor's Office of Consumer Health Assistance; Aging Services Directors Association; NV Senior Coalition; Seniors United; Nevada Beneficiary Coalition;

National Committee to Protect Social Security and Medicare; Community Coalition on Victim Rights (CCVR); Clark County Senior Advisory Council and Senior Advocate Office; University of Nevada, Reno Sanford Center for Aging; Volunteer Center of Southern Nevada; Provider Hospital Groups and Medicare Contract Groups; Clark County Public Guardian Office; Nevada Senior Resource Network; and a number of senior, community, and community health centers; and civic organizations.

During this period, funds were used to coordinate and produce the Attorney General's Conference on Senior Protection, which took place on December 4, 2009. The audience for the conference included senior service providers, senior advocates, and members of the legal and law enforcement communities. The topics covered included Medicare/Medicaid fraud; financial exploitation and fraud against senior citizens; elder abuse in long term care settings and group homes; investigation and prosecution of elder abuse; depression, mental illness and substance abuse; domestic violence and elder abuse; and protecting elders and their assets.

Several different radio campaigns were held during this grant period in collaboration with the Nevada Broadcasters Association. In 2008 and 2009, 12 week radio campaigns featured statewide Non-Sustaining Commercial Ads (NSCAs) aka public service announcements with two, 60-second spots, and four, 30-second spots in both Spanish and English. These campaigns realized over half a million dollars worth of in-kind broadcast.

Nevada SMP uses the national program's SMARTFACTS that allows it to track virtually everything – complaints, material dissemination volunteers, and partners. Since the SMP programs inception in September 2006, Nevada SMP logged approximately 297 complaints, of which close to 88% have been resolved.

Challenges to continuing the program's operations include cuts in the Nevada budget, limitations of having a two person staff, securing cooperation from investigatory and law enforcement agencies to determine when complaints handled and referred result in collection of funds or prosecution of Medicare and Medicaid contractors to demonstrate the SMP program effectiveness; and with the scarce resources available being able to recruit and train volunteers to follow-up with the partnerships established.

Program: Senior Medicare Patrol

Grant Number: **90AM3058**
Project Title: **Senior Medicare Patrol Program**
Project Period: **07/01/2006 - 05/31/2010**

Grantee:
North Carolina Department of Insurance
11 South Boylan Avenue
Raleigh, NC 27603
Contact:
Stephanie Bias
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AoA Project Officer: Name: Dorothy Smith

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$180,000
FY2007	$180,000
FY2006	$180,000
FY2005	$
FY2004	$
FY2003	$
Total	$540,000

Project Summary:

The North Carolina SMP Program (NCSMP) housed within the Seniors' Health Insurance Information Program (SHIIP) at the North Carolina Department of Insurance was supported with a three year grant to reduce Medicare/Medicaid error, fraud and abuse through statewide coordinated efforts of educational and promotional activities and to encourage reporting by Medicare/Medicaid beneficiaries and caregivers.

The target population was Medicare beneficiaries, caregivers, aging community network and professionals. Activities and materials were primarily designed to reach traditionally underserved populations in rural, isolated, minority and hard to reach settings. The program's educational and outreach targeted Medicare beneficiaries not only in the rural sections of the state, but in the larger, also in the more populated areas. The catalyst behind the success and growth of the project over the three year period was the partnership with the seven Area Agencies on Aging across the state and the efforts on behalf of the NCSMP mission by the volunteers and NCSMP staff, which with the AARP Scam Jam Team operating in seventy five percent of the state's 100 counties was a significant vessel to educate Medicare beneficiaries about the importance of reading their Medicare statements and for keeping a personal health care journal. Each attendee at the Scam Jams received a NCSMP Personal Health Care Journal. NCSMP participated in the implementation of SMART FACTS, training webinars, OIG report writing, mentor calls, stakeholder committees and regional conference presentation on Successful Practices.

Project objectives were to: 1) provide and expand educational/promotional activities to Medicare/Medicaid beneficiaries, caregivers and traditionally underserved populations; 2) recruit, train and retain volunteers; 3) receive and resolve complaints of error, fraud and abuse; 4) network with statewide partners to serve as advisors and trainers that provided

counseling assistance with resolving error, fraud and abuse issues; 5) develop and disseminate educational materials to the SMP Technical Resource Center and projects; 6) participate in the SMP complaints management system and integration strategies (SMART FACTS); and 7) evaluate program outcomes.

Anticipated NCSMP project outcomes were to: 1) evaluate the change in beneficiaries/caregivers behavior to read, understand, resolve, appeal and or/report the Medicare Summary Notices (MSNs), Medicare Part D Explanation of Benefits (EOBs) and/or related health care billing statement(s) for errors and reported waste, fraud and abuse to NCSMP; 2) resolve or appeal billing errors and reported waste fraud and abuse to NCSMP, providers and carriers; 3) increase the number of reported and resolved complaints; 4) increase the number of educational activities provided to beneficiaries and caregivers; and 5) develop educational materials and strategies to serve as examples for other SMP projects. The anticipated products were: 1) written reports (AoA six month progress, year end financial statements and semi-annual OIG reports); 2) educational, promotional and training materials; and 3) educational and outreach activities.

Staff, partners and volunteers were given goals each year of the grant period to meet in the above referenced areas. SMP Post Education Surveys were distributed with 1,423 returned in settings which were appropriate and the findings were entered into Smart Facts or sent to the Center. Outreach, education and media activities were entered into Smart Facts and Office of Inspector General reports were submitted semi-annually. Complaints were logged into Smart Facts as well. SMP activities conducted by NCSMP are summarized as follows for the three year grant period:

- 15 volunteers participated in 720 training hours and conducted 3674 hours of work
- 1,511 media outreach activities (website hits, television programs, radio campaign, print ads. press release, newspaper articles)
- 414 community outreach education events were conducted and reached 52,553 people
- 1,095 group education sessions were conducted and reached 70,170 people
- 1,467 one-on-one counseling sessions were conducted
- 3,160 Simple Inquiries were received
- 269 Complex Issues were received and resolved

A challenge for the North Carolina SMP Program (NCSMP) was reaching a large beneficiary population to receive program messaging. To resolve this challenge, the partnership chain was formed resulting in many opportunities to promote NCSMP messaging. Examples include, but are not limited to, aging conference sponsorships, presentations and exhibits, , press releases, consumer articles, television programming broadcast statewide, and mailings to each beneficiary from consumer line, radio campaign, print interviews and articles.

NCSMP far exceeded the goals set forth at the beginning of the project period as reflected in the prior progress reports and summarized in this final report. It is the belief of NCSMP made great strides in the SMP mission to empower seniors to prevent healthcare fraud.

Grant Number: 90AM2807
Project Title: National Consumer Protection Technical Resource Center
Project Period: 09/30/2003 - 08/31/2010

Grantee:
Hawkeye Valley Area Agency on Aging
2101 Kimball Avenue, Suite 320
Waterloo, IA 50702

Contact:
Ginny Paulson
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gpaulson@hvaaa.org

AoA Project Officer: Barbara Lewis

Fiscal Year	Funding Amount
FY2010	$59,944
FY2009	$646,773
FY2008	$909,997
FY2007	$645,000
FY2006	$300,000
FY2005	$300,000
FY2004	$300,000
FY2003	$300,000
Total	$3,461,714

Project Summary:

Hawkeye Valley Area Agency on Aging (HVAAA) operated the National Consumer Protection Technical Resource Center (The Center) in collaboration with several subcontractors, including Health Benefits ABCs, The American Health Quality Foundation (AHQF), the American Institutes for Research (AIR), and Linda Graff & Associates. The Center collaborates with subcontractors AoA via e-mail, web meetings, and face-to-face meetings to ensure that the project efforts were in coordination with AoA policies, expectations, and other ongoing efforts to advance the SMP program and mission. The Center supports the nationwide network of Senior Medicare Patrol (SMP) projects with training and technical support. The goals of this project were to: provide training and technical assistance to SMP projects to increase their knowledge and ability to meet their mission, and increase national visibility and integration of the SMP Projects into the aging and fraud prevention network.

Project objectives were to: 1) advance the Administration on Aging's strategic priorities for the SMP Program; 2) improve beneficiary education and inquiry resolution for health care fraud; 3) improve the efficiency and quality of the SMP program; 4) help SMPs target training and education to hard-to-reach populations; 5) increase SMP program visibility; and 6) enhance SMP program consistency. Anticipated outcomes of this project were to: 1) achieve mastery of SMART FACTS as a reporting and program management tool; 2) increase the number and appropriateness of SMP referrals to resolution entities; 3) standardize volunteer certification program implementation plan and curriculum development; 4) increase the number of nationwide entities who are familiar with the SMP program; 5) increase training and education tools available to SMPs for reaching hard-to-reach populations; 6) increase tools available to SMPs to promote a unified fraud prevention, detection, and reporting message; 7) increase SMP satisfaction with and utilization of such

tools; 8) increase SMP staff knowledge of health care fraud and consumer protection issues; and 9) the project evaluation using Re-AIM will reflect positive results in SMP ability to achieve their program mission consistently and with quality.

The project was successful in assisting SMP projects in meeting the five national strategic objectives of the SMP program which are: 1) foster national and statewide program coverage; 2) improve beneficiary education and inquiry education and inquiry resolution for other areas of health care fraud; 3) foster national program visibility and consistancy; 4) improve efficiency of the SMP program while incrasing results; and 5) target training and education to isolated and hard to reach populations.

The Center was able to achieve the project goals based on evaluation data collected through an annual survey and feedback from SMP projects which reported satisfaction with the Center's services. In short, the Center during this grant period, increased SMP projects' capacity to meet AoA strategic objectives and increase their efficacy with use of SMART FACTS as well as impacting SMP competency, accuracy of reporting, national consistency, and national visibility. The Center consistently improved the capacity and performance of the nation's SMPs in protecting beneficiaries, Medicare, Medicaid, and other health care-related programs from financial loss, poor care, and other hardships that result from fraud, abuse, and errors in the nation's health care systems.

Products to achieve the project's and SMP program objectives included development and hosting of a number of webinars; establishment of a website for hosting SMP resources; development and distribution of national instructional manuals; development of a training curriculum and fact sheets; support of a mentoring program; fostering partnerships with national organizations; and maintenance of the web-based national reporting and program management system "SMART FACTS."

Lessons learned included the need to: 1) clearly define for SMPs the role of AoA versus the role of The Center; 2) improve communication practices for greater efficiency, accuracy, relevance, and compliance with copyright and licensing laws; and 3) increase the scope of networking events and outreach materials to better meet SMP needs. It also learned that: 1) it is unwise and inefficient to rush a product and publish it prior to a thorough, SMP network-wide review period; 2) that redesign and implementation of a technical assistance website with limited access to selected areas can be more challenging that anticipated; and 3) demand for assistance from SMPs often exceeds the capacity of the Center to respond to SMP projects training needs, including individualized training for volunteers, subcontractors, partners, and newly hired support.

A major challenge is seeing that the information reported by SMP projects through SMART FACTS is accurate and uniform. SMART FACTS training is dependent upon the roles and responsibilities of the various users. The possibility for making mistakes would be high if individualized training were conducted by someone not familiar with and not involved with management of the program. Due to the sensitive nature of some of the information within SMART FACTS, individualized training of support staff needs to be conducted under the supervision of the state SMP.

Health Disparities among Minority Elders

In FY2006 conducted a competition for National Minority Aging Organizations (NMAO) Technical Assistance Centers to address health disparities among minority elders to respond in part to provisions in the Older Americans Act of 1965 which direct AoA to "increase awareness of citizens of all ages of the need to assume personal responsibility for their own longevity." The FY2006 funding opportunity charged Centers to respond to the goal of reducing or eliminating health disparities among racial and ethnic minority elders by promoting positive health behaviors and encouraging healthier life styles and objectives which supported the Departmental goal of reducing or eliminating health disparities among racial and ethnic minority [older] persons

As a result of the competition AoA entered into cooperative agreements with four (4) NMAOs for the development of culturally competent and linguistically appropriate front line health promotion and disease prevention strategies for racial and ethnic minority older individuals. These projects developed practical, nontraditional, community-based interventions for reaching older individuals who experience barriers to accessing home and community-based services due to language and low literacy as well as other barriers directly related to cultural diversity. Three of these projects ended in FY2010 and are included in this compendium.

Information regarding the Health Disparities among Minority Elders initiative and the National Minority Aging Organization Technical Assistance Centers may be read on the AoA website:

http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Minority_Aging/index.aspx

Program: Health Disparities among Minority Elders

Grant Number: 90AM3128
Project Title: The National Minority Organizations Technical Assistance Centers Program
Project Period: 09/30/2006 - 06/30/2010

Grantee:
Asociacion Nacional Pro Personas Mayores
234 E Colorado Blvd, Ste 300
Pasadena, CA 91101

Contact:
Carmela G Lacayo
Tel. (626) 564-1988
Email: anppm@aol.com

AoA Project Officer: Dianne Freeman

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$289,475
FY2007	$294,622
FY2006	$294,622
FY2005	$
FY2004	$
FY2003	$
Total	$878,719

Project Summary:

The Asociacion Nacional Pro Personas Mayores (ANPPM) conducted a 36 month project titled “Project Puente.” The project goals were: 1) to design a community-based health intervention project for limited English proficient Hispanic elders and their families, i.e. older Hispanic individuals and families with low income and low literacy; and 2) to promote the concept that knowledge is the best medicine by using diverse language and cultural competence approaches to disease prevention, health education and training.

The project was conducted in collaboration with national organizations and networks of the American Society on Aging, the N4A, Eastern Washington University Center on the Studies of Aging, Hispanic and FBOs, the Senior Community Service Employment Program partner national sponsors and their networks of multiple community health centers and nonprofit hospitals who have signed host agency agreements.

Major objectives included: 1) designing health promotion materials that emphasize appropriate cultural literacy levels for use by older Hispanics and their families; 2) enhancing the aging network's ability to provide culturally competent services to Hispanic older individuals; 3) enhancing the services of established faith-based organization (FBO) church volunteer programs as a community support system for low-income older Hispanics; and 4) establishing and sustaining partnerships with local targeted health care and Hispanic CBOs to develop and implement the goal and objectives of Project Puente.

In addition to the Project’s main objectives, this project was enhanced by the addition of two major outreach projects that were directed through this AOA grant. In partnership with the

National Association of Area Agencies on Aging (N4A) the ANPPM was the Hispanic outreach associate for two major senior outreach projects, the LIS/Medicare Part D campaign and the Digital TV Keeping Seniors Connected National campaign. Through these additional community outreach projects ANPPM reached over 50,000 Hispanic seniors and their families throughout the U.S.

Key findings of this grant were the continued barriers that these very low income Hispanic older persons face by their lack of knowledge and access to much needed services, especially health care and the use of churches and Faith Based community organizations as a the primary focal point for reaching the poorest older Hispanics. ANPPM will continue this project by providing culturally appropriate training to these community-based organizations and the Aging network helping them to reach out and serve the Hispanic Community.

Project Puente's final products include: 1) a community caregivers volunteer training program, targeted to Faith-Based organizations and churches in Hispanic communities; 2) a Hispanic Family Caregivers guide: "La Familia Lopez, listening with their heart"; 3) sample lectures for MSW and gerontology undergraduate and graduate programs on older Hispanics, demographics, health profiles and community outreach models; and 4) dissemination of all Project Puente products through ANPPM's web site.

Grant Number: 90AM3127
Project Title: The National Minority Aging Organizations Technical Assistance Centers Program
Project Period: 09/30/2006 - 12/31/2009

Grantee:
Inter Tribal Council Of Arizona, Inc.
2214 North Central Avenue, Suite 100
Phoenix, AZ 85004

Contact:
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AoA Project Officer: Meg Graves

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$125,098
FY2007	$127,669
FY2006	$127,669
FY2005	$
FY2004	$
FY2003	$
Total	$380,436

Project Summary:

The project goal of this project were to develop accessibility of current and newly developed health promotional materials and disease prevention strategies for American Indian Elders, caregivers in through translation into culturally compentent and linquistically apporpriate versions and targeting isolated American Indian communities. This was accomplished by promoting and replicating two-evidence based health promotion programs – the Chronic Disease Self-Management Program (CDSMP) and Enhance Fitness Program (EFP) – as well as developing supplementary instructional and outreach materials.

The CDSMP program developed by Stanford University educates individuals on taking control of their own wellness including: 1) techniques to cope with symptons associated with their chronic condition such as fatique, pain and self-isolation; 2) appropriate use of medications; and 3) how to communicate with health care professionals, friends and family. CDSMP was implimented in four Alaskan and American Indian tribal communities: the Chugachmiut, Inc. of Alaska; Oneida Tribe of Wisoncin; the Hopit Tribe of Arizona; and the Inter Tribal Council of Arizona which is a designated Area Agency on Aging. Involvement of tribal leaders and use of “talking circles” were some of the adaptations made to gain elders acceptance of the program.

EFP began as a low cost senor wellness project in Seattle Washington which evolved through research and testing supported by the Robert Wood Johnson Foundation to be an evidence based health promotion program which through one-hour sessions offers cardiovascular exercise, strength training, and stretching with intervals and a pace

comfortable for older adults. EFP was adapted for use at two senior centers of the White Mountain Apache Tribe.

Through this grant, four culturally appropriate health promotional materials were developed: a fact sheet, “Walking Your Way to Better Health; a “Walking Physical Activity Sheet;” a project Technical Assistance Center (TAC) brochure, and a walking public assistance announcement. In addition to dissemination of these materials, extensive outreach efforts were performed in the targeted communities as well at Native American conferences. Over 250 Walking Physical Activity Kits were distributed which included a fanny pack, a walking log, a pedometer, pen, hot/cold pack and the TAC brochure. To increase physical activity, the DVD “Seated Strength: Chair Activities for Native Americans” was offered to tribal elders and tribal senior service programs. An assessment of its use was reported as a product of the grant.

The majority of tribal elders who completed either the CDSMP or EFP programs testified that they are better managing their chronic conditions by exercising, maintaining a balanced diet and through self advocacy in communicating with personal health providers, physicians and other health care staff.

Among the lessons learned was that no single model will be acceptable to American Indian Communities due to differences in culture and tradition, the remoteness of their location, the availability of resources and the cost of a program. Barriers faced included lack of transportation, lack of master trainers within their area, need to change materials to be sensitive to the culture, and difficulty in maintaining a program over a long period as required in one of the evidence based programs.

Despite the challenges above, as well as many others, the grantee will continue much of the programming within is planning and service area using Title III Older Americans Act health promotion support and that of the Arizona Division of Aging and Adult Services.

Program: Health Disparities among Minority Elders

Grant Number: **90AM3129**
Project Title: **Healing Zone**
Project Period: **09/30/2006 - 12/31/2009**

Grantee:
The National Caucus and Center on Black Aged
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Washington, DC 20005

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AoA Project Oficer: Diane Freeman

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$289,475
FY2007	$294,622
FY2006	$294,622
FY2005	$
FY2004	$
FY2003	$
Total	$878,719

Project Summary:

The goal of the Healing Zone, a faith-based community health leadership project, was to reduce obesity and risk factors leading to chronic diseases among older African Americans such as cardiovascular disease, hypertension, diabetes, kidney failure, glaucoma, and other obesity related diseases. The project's major focus was to increase awareness of the negative impact of unhealthy lifestyle practices and support of the adoption of good nutrition and exercise habits among participating seniors in Baltimore, Buffalo, Detroit, Richmond and Hinds County in Mississippi.

In collaboration with regional partners, churches and community organizations, the Healing Zone Project brought seniors together for eight weeks to participate in weekly support groups called "Healing Circles." Led by Senior Health Adovates (SHAs), the goal of Healing Circles was to increase participant's knowledge about self-care strategies to combat weight problems and obesity, promote physical activity, encourage weight loss, and engage in health advocacy activities. Guest speakers, such as health care experts and academics, were invited to give presentations on health-related topics. Sessions were also used to share information of special interest to the group such as the Medicare discount drug program and strategies to combat depression. Sprituality and fellowship were interwinded within the Healing Circles.

Fourteen churches and a number of other local organizations participated in the sponsoring Healing Circles in the final year of the project supported by a lead partner organization in each location. The sustaining partners were GROUP Ministries in Baltimore and Buffalo, Senior Connections/Capital Area Agency on Aging in Richmond, the Detroit Area Agency on Aging, and the Central Mississippi Planning and Development District in Hinds County,

Mississippi. Twenty-eight (28) trained SHAs served as peer health counselors responsible for organizing, recruiting, and facilitating Health Cirdles which were attended by 240 participants in 2009. Participants were primarily African American, 91 percent female, with an average age of 65.

The evaluation design included collection and analysis of quantitative and qualitative data . A health data form was used to collect data on weight and blood pressure. A senior participant survey was administered to determine knowledge and behavior change in terms of their knowledge and use of health nutrition practices and physlical activity. A senior health advocate survey was used to assess the effectiveness of Health Circles at the end of their eight week cycle to assess how well they helped participants achieve intended outcomes. A semi-structure interviews with key informants and site coordinators were conducted at each project site to address the question of sustainability of the intitiatives.

Questionnaires were returned from 183 of the 240 participants. Nearly all (99%) stated they increased their knowledege of nutrition and behaviors promoting good health and an equal percentage stated they had improved their eating habits. A high proportion (96%) indicated they had increased their physical activity since beginning participation in the Healing Circles and when asked what two most important things they had learned, responded that they were making better food choices and were better aware of what they needed to do to have a healthier lifestyle.

Evaluation data on weight loss measured at the beginning and end of participation showed some weight was lost, but could be subject to error in measurement. However in the three years of the program, the total weight loss reported increased each year indicating the intervention was having some success. Measurements of blood pressure and pulse were taken at multiple times over eight weeks at all locations. Measurable improvement in blood pressure was recorded at four of the five sites.

Interview data with informants and the survey of SHAs indicated a majority of participants were enthusiastic participants and that most sites were interested in continuing the Healing Circles after the project ended. There was clear indication that the project gained support of church leaders in giving greater attention to the health issues of seniors and offering programs supporting their education and behavioral changes for health living.

Resource Centers for Older Indians, Alaska Natives, and Native Hawaiians

The AoA has supported at least one Resource Center for Older Indians, Alaska Natives, and Native Hawaiians since 1994 to serve as the focal points for developing and sharing technical information and expertise for Native American organizations, Native American communities, educational institutions, and professionals working with elders in culturally competent health care, community-based long-term care, and related services. AoA has also funded support for development of its Older American Act (OAA) Title VI Grants for Native Americans grants to tribal organizations under its National Minority Aging Organizations (NMAO) Technical Assistance Centers Program.

For more information about the resource centers and Title IV grants go to the AoA website:

http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/Native_Americans/index.aspx

Program: National Resource Centers on Older Indians, Alaska Natives and Native Hawaiians

Grant Number: 90AM3081
Project Title: National Resource Centers on Older Indians, Alaska Natives and Native Hawaiians
Project Period: 09/01/2006 - 06/30/2010

Grantee:
University of Alaska Anchorage
College of Health and Social Welfare
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AoA Project Officer: Cecelia Aldridge

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$218,116
FY2007	$221,995
FY2006	$221,995
FY2005	$
FY2004	$
FY2003	$
Total	$662,106

Project Summary:

The National Resource Center (NRC) for American Indians, Alaska Natives and Native Hawaiian Elders at the University of Alaska, Anchorage has three goals: 1) empowering Native communities to incorporate traditional ways of treating Elders within community care systems; 2) providing technical information to promote culturally sensitive and appropriate services to maintain social well being within a spiritually Elder-focused environment; and 3) increasing visibility of Native Elder-care issues. Proposed product outcomes were to increase the national visibility of Native Elder health care issues through: 1) conferences of Elders; 2) an Elder-care needs assessment "tool box" for use by Native communities; 3) summer field institutes to train families and health professionals; 4) summary papers on Best, Promising and Emerging Practices, "Elder mistreatment and prevention," and when possible the status and updates of long term care efforts; 5) technical assistance; and 6) a website.

Measurable outcomes established for the project were: 1) the use of Native Elder values to better understand appropriate Native Elder-care standards and how these stated values can be used by the Title VI programs in their training; 2) definition of clinical and behavioral needs of Native communities and assisting them in conducting assessments of Elder's desires and health services for their own care; 3) identification of "best, promising and emerging practices" of the current incorporation of culture-based Native Elder-care services by Title VI Programs.

The project has given voices to Alaskan Elders by providing meetings in all the regional centers across the state of Alaska. Over the project period, the NRC was in contact with 32

regional Title VI directors in the rural villages and hubs and disseminated information that the Elders of the villages could call for assistance and have their issues addressed or passed on through the vast network of collaborators and providers that the NRC has developed over its short lifespan. The NRC provided a communication conduit that has worked hard to understand Elder health needs but also Elder communication needs. Much of the distress of Elders has been frustrated communications channels of western ears missing the content of Elder communications. The NRC through updating and maintaining the link with the regional directors is the connection portal that can also translate the need to other resources.

The continuing analysis of the material gathered from Elders on their view of respect is proving to be extremely valuable and amenable to practical implementation. Elders believe that patterns of Elder abuse did not exist in healthy functioning traditional cultures. This is what they mean by restoration of traditional values. They want the actual pre-western indigenous governments reestablished. Those governments were based on a shared set of values. NRC is continuing to work on papers based on this information collected from the Elders that will put back traditional governance infrastructure and thereby reducing or eliminating Elder abuse.

Many remote villages are being overtaxed with faxes that reel off reams of paper and ink, and internet emails with slow dial up connections being jammed with unsolicited data. Many of the partner collaborators are doing the same thing the NRC is doing to take the burden off the end user: emphasizing our web resource and direct communications. During the course of the project, there was a significant amount of work on finding links by direct search and also by communications with partners. The course of these communications with partners brought up valuable discussions with partners about listserve spam, internet email dial up capacity, lack of information technology support in the villages, high cost of fax communications to the recipient and strategies for effective electronic support protocols or considerations for entities with goals of information distribution (such as NRC) on target audiences. Conscious of the target audiences needs and costs, and circumstances, the NRC is trying to emphasize more web based resources and direct communications or partner support actions to address needs.

Based on feedback from other service providers, it is known that the resources that have been made available through NRC have been used and replicated for other programs. NRC is considered to be a valuable central resource for Elder care providers across the state. It is expected that project activities will be sustained through agreements with Alaska Native Tribal Health Consortium and Alaska Community Services, Inc.

Program: National Resource Centers on Older Indians, Alaska Natives and Native Hawaiians

Grant Number: 90AM3080
Project Title: National Resource Centers on Older Indians, Alaska Natives and Native Hawaiians
Proj. Period: 09/01/2006 - 06/30/2010

Grantee:
University of North Dakota
School of Medicine and Health Sciences
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Grand Forks, ND 58202

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AoA Project Officer: Cecilia Aldridge

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$336,020
FY2007	$383,998
FY2006	$341,995
FY2005	$
FY2004	$
FY2003	$
Total	$1,062,013

Project Summary:

The National Resource Center on Native American Aging, located at the Center for Rural Health, University of North Dakota School of Medicine and Health Sciences has been of service to American Indian, Alaska Native, and Native Hawaiians since 1994. The Center's efforts have concentrated on the goal of "raising the quality of life for Native elders to the highest possible level" through technical assistance, training, conducting needs assessments, and research. To reach that goal, the Center used this grant to pursue three continuing objectives: 1) continue to assist an increasing number of the 561 federally recognized tribes and tribal organizations with determining the needs of their elders by conducting the Identifying Our Needs: A Survey of Elders. Assist with new locations and with those who have already conducted the needs assessment by re-administering the survey to help collect longitudinal data during the 2006 - 2009 project period; 2) continue to provide feedback for those who have conducted the Identifying Our Needs: A Survey of Elders and to improve that feedback by providing information regarding best practices, exemplary projects and promising innovations; and 3) continue to conduct training for service providers working with elders on a regular basis at national and regional conferences and monthly seminars hosted by, but not limited to, the Administration on Aging Regional Offices, Kauffman and Associates and the National Indian Council on Aging.

The needs assessment survey collected 14,791 surveys with data analyzed in conjunction with results from a secondary survey developed in partnership with the National Society on American Indian Elderly (NSIAE). This second survey was designed for use in a longitudinal study of a cohort of elders to track changes over time, however difficulties with tracking

cohort selection and staffing issues caused termination of the NSIAE study after 734 respondents were added to the database.

The Native Elder Caregiver Curriculum was created in collaboration with the Cankdeska Cikana Community College in Spirit Lake, North Dakota with the input of tribal stakeholders aimed at providing education and training for people providing care for native seniors. Designed in modular format, the curriculum can be used to train everyone from medical professionals to family caregivers, the curriculum is available as a printed manual and through the Center website.

The WELL-Balanced project was designed as both a physical activity and wellness curriculum for training community members, elder care stakeholders, and elders themselves. It helps participants improve their physical well-being and decreases or diminishes the risk of falls among the elderly. It also assists in control and copying with various chronic conditions such as diabetes and arthritis.

The Center crated training sessions on how to conduct needs assessment using the survey instruments developed under the grant. These are presented at Title VI Grants for Native Americans and the National Indian Council on Aging conferences as well as on reservations. Future plans are to develop webinars and DVDS of the training modules. A college level class for training native researchers has been funded.

The Center has created and maintains a website – http://www.nrcnaa.org – that contains copies of all publications and presentations as well an interactive services locator for Native American elders. While the Center has introduced the use of social media through Facebook with enrollment of over 600 users, many tribes still have little or no access to the internet. Non-users can contact the center through a tool free telephone number and are reached through publication os a quarterly newsletter mailed to over 3,000 subscribers with nearly 300 receiving it electronically.

A number of challenges made achievement of objectives difficult during this grant, including the sudden death of its director in 2007, the retirement of the chief researcher in 2008, and the resignation of the project coordinator in 2009. Other challenges were replacement of obsolete equipment and the training of new personnel in the use of software to process survey instruments. A lack of funding for continuation of the Journal of native Aging and Health caused its suspension although the Center is continuing to seek funding through the University of North Dakota and other sources.

Project activities that will be sustained include needs assessment assistance to additional tribes, maintenance of national databases, conduct of training sessions, continuation of the toll-free telephone number, publication of the quarterly newsletter in print and electronic forms, and creation of Fact Sheets. The Center website which is part of the Center for Rural health will be updated to make usage easier for all levels of users, using video clips rather than words to describe and illustrate programs. Work will continue to update, disseminate and providing training for the caregiver and WELL-Balanced programs.

National Education and Resource Center on Women and Retirement Planning

The Administration on Aging (AoA) has supported the National Education and Resource Center on Women and Retirement Planning since 1998, which partners with the AoA to assist the National Network on Aging to facilitate access to the principles of basic financial and retirement planning for low income women, women of color and other hard to reach women, including those with limited English speaking proficiency.

Studies continue to show that which 75% of Baby Boomers are not prepared for retirement and that many will retire or be forced to retire unexpectedly due to poor health, caregiving responsibilities or job loss. The impact of these factors is more pronounced among women. Median Social Security income for women is 70% of that for men and women retirees are likely to earn only half the average pension benefits a man earns because only about 45% of women versus 54% of men even participate in pension plans.

AoA's support for the Center's is periodically competed. The grant ending in FY2010 is reported in this compendium. A new grant was awarded in FY2010 to the Women's Institute for a Secure Retirement and is included in the companion AoA FY2010 Discretionary Grant Awards compendium.

Program: National Education and Resource Center on Women and Retirement Planning

Grant Number: 90AM2801
Project Title: National Education and Resource Center on Women and Retirement Planning
Project Period: 09/30/2003 - 07/31/2010

Grantee:
Womens' Institute for a Secure Retirement
1146 19th Street, NW Suite 700
Washington, DC 20036

Contact:
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AoA Project Officer: Dianne Freeman

Fiscal Year	Funding Amount
FY2010	$
FY2009	$245,520
FY2008	$241,470
FY2007	$245,520
FY2006	$248,376
FY2005	$248,376
FY2004	$248,376
FY2003	$248,376
Total	$1,726,014

Project Summary:

The Women's Institute for a Secure Retirement (WISER) has developed and maintained the National Education and Resource Center on Women and Retirement Planning (the Center) as part of a cooperative agreement with the U.S. Administration on Aging. The Center is dedicated to integrating financial information and resources on retirement into the National Aging Network and Older Americans Act programs by using innovative interventions, tools and technology. The Center's goal is to help women avoid the significant risk of poverty in retirement and assist them in developing financial security with better choices in health care and long-term care, consistent with Choices for Independence. Women's longevity risks require reliable information to make the best financial decisions and avoid making financial mistakes.

Throughout the recent grant period, WISER worked with a wide cross-section of partners from the financial industry, non-profit sector, and federal, state and local governments to reach vulnerable women across the nation. It produced a broad array of materials to reach the target populations using a variety of media including booklets, workbooks, and toolkits that are disseminated through an extensive group of partner organizations, and via the Center's website.

Major partnerships and coalitions have been formed with a range of private sector organizations to target low-income and minority women. Diverse private sector organizations include: MANA, National Latina Women's Organization, Mother's Voices/Multi-Ethnic Community Retirement Project, Coalition of 100 Black Women, General Federation of Women's Clubs, Profit Sharing Council of America, MetLife, MFS Investment Management,

and the Society of Actuaries. Federal agency partners include the Federal Deposit Insurance Corporation, Social Security Administration , Department of Labor's Women's Bureau, Dartment of Agriculture Extension Service, and the Comptroller General of the US.

During this grant period, WISER convened a Women's Financial Security Forum: The Future of Women's Retirement Security; a symposium, Pulling It All Together: What Government, Employers, and Individuals Can Do to Strengthen Women's Retirement Security and the Women's Retirement Income Roundtable on managing assets in retirement. In addition, the Center co-sponsored and participated in several conferences with partners. It worked with employers to document educational programs and helped identify best practices for government agencies. During this grant, WISER heavily promoted the Center and the message about women's retirement issues through the national media, as well as the aging community. Online webinars, a series of financial and retirement planning podcasts, a Women's Retirement Blog and an "Ask the Expert" feature were highlighted as part of the newly developed website. In an effort to further expand outreach, WISER developed retirement education workshops with associated materials, which are used to conduct WISER workshops and to train program partners who will conduct retirement financial planning workshops in their local communities.

The operation of the Resource Center has continuously provided learning opportunities for better understanding of the population it seeks to help. The rural partners in South Dakota, Nebraska, and Maine have stated that without WISER's programs, they would not have access to retirement planning. Debt is a big challenge for many of the women reached, and until they get it under control, they cannot hope to focus on planning and saving for the future. Employers are trusted messengers especially for women and are in an important position to be able to help employees make solid financial decisions by providing information that could reduce the higher incidence of women spending lump-sum retirement distributions. An aspect of financial planning that is gaining more and more attention and increased interest is in options to create income for life. Most of the women reached do not have sufficient savings to turn their money into a lifetime income stream consequently the subject of lifetime saving and investing for retirement continues to be a priority.

WISER has produced many consumer-oriented publications; developed and updated dozens of fact sheets on women's retirement security issues; replicated model financial education workshops for specific populations; produced many articles and publications that provide in-depth discussions of the unique issues women face; fielded surveys; and produced nine WISERWoman newsletters, available in hard copy and electronically. WISER attended all of the major aging conferences during each year of the grant and used these opportunities to disseminate information to hundreds of Area Agencies and state units on aging. WISER also engaged in new technology to reach the target audience, and we now have a series of recorded webinars and podcasts on the Resource Center website, as well as interactive features to the site, including a blog and an "Ask the Expert" feature. WISER was featured in 5 television interview segments on the Wealth Channel at the American College of Financial Planning. It also sponsored and co-sponsored symposia and other events to bring attention to the issue of women's retirement security.

National Alzheimer's Call Center

The National Alzheimer's Call Center (the Center) is a national information and counseling service for persons with Alzheimer's disease, their family members, and informal caregivers. The Center is available to people in all States, 24 hours a day, 7 days a week, 365 days a year to provide expert advice, care consultation, and information and referrals at the national and local levels regarding Alzheimer's disease. Trained professional customer service staff and masters degree social workers are available at all times. The Call Center is accessible by telephone, website or e-mail at no cost to the caller. In the 12-month period ending July 31, 2009, the National Alzheimer's Call Center handled over 250,000 calls through its national and local partners, and its on-line message board community recorded over 4.8 million page views, with nearly 75,000 individual postings.

Program: National Alzheimers Call Center

Grant Number: **90AZ2766**
Project Title: **National Alzheimer's Call Center**
Project Period: **08/01/2003 - 07/31/2010**

Grantee:
Alzheimer's Disease and Related Disorders Assoc., Inc.
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AoA Project Officer: Amy Wiatr-Rodriguez

Fiscal Year	Funding Amount
FY2010	$
FY2009	$963,500
FY2008	$963,500
FY2007	$963,500
FY2006	$977,130
FY2005	$979,104
FY2004	$1,001,177
FY2003	$993,500
Total	$6,841,411

Project Summary:

The Alzheimer's Association operates an Alzheimer's National Call Center (Contact Center) for individuals with Alzheimer's and related dementias, their caregivers and persons wanting to learn more about various aspects of the disease. The goal of the project is to improve the quality of life for people impacted by Alzheimer's disease through an integrated network of information specialists and care consultants who provide personalized information, support, care consultation and crisis intervention by telephone and electronically, 24 hours a day, seven days a week and 365 days a year. The Contact Center operates through a single 1-800 line, web site, and e-mail address which links callers seamlessly to information experts and care consultants in local Association chapters nationwide, with default to the national Center when local responders are unavailable.

Over the 7 years of this grant, a number of milestones were reached. In the first four years (2003-2007) the goal of full Alzheimer's Association nationwide chapter network participation in the Contact Center's 24/7, 365 days a year helpline was attained. In essence, this meant that callers throughout the county were able to use the 800-272-3900 number and the http//ww.alz.org website to access the Contact Center and other Alzheimer's Association services. Another highlight in this initial phase was inclusion in 2004 of the Spanish Portal on the Association's website followed in 2005 by the offering of full website services and publications in Spanish. Significant outreach to African Americans, including publications of four brochures targeted specifically to this population, were introduced in 2006 and are still in high demand. Creation of a bevy of on-line caregiver resources in partnership with the Eldercare Locator was attained through the 2006 launch of Carefinder, a comprehensive web-based resource toolkit for caregivers.

A strong bond between the Alzheimer's Association and the Eldercare Locator was formed during Phase I and remains in play today. Call Center and chapter staff increasingly referred callers to services provided by the Area Agencies on Aging and regional partners. The Call Center continued to educate and refer callers to resources provided by other aging network partners including the Long-term Care Ombudsman Program, Senior Medicare Patrol and the Legal Counseling Program. Grant monies provided by the AoA allowed for the launch of the Alzheimer's Association's On-line Community in January 2005. The on-line forums presented a variety of opportunities for persons with dementia as well as their caregivers to seek support and camaraderie, as well as to consult with the Call Center's care consultants. Forums were introduced in Spanish as well as English. Membership and posting in the On-line Community grew steadily throughout Phase I with a quadruple increase in usage during its first year and an average increase of 30% during each subsequent reporting period. The On-line Community opened a form of "support group" access to all constituents—particularly those in rural areas less likely to be served by in-person group services as well as caregivers—often homebound due to travel limitations presented by caring for someone with dementia.

Surveys throughout Phase I indicate that approximately 10% of callers were African-American and 6% were of Hispanic origin. Call Center brochures were published in Chinese, Russian, Polish, Korean and Vietnamese, in addition to other brochures available on the website. A Language Line offering translators for over 150 languages was employed by the Contact Center and chapter network with Spanish remaining the predominant requested language. Use of the language line was not as high as expected throughout Phase I. In 2006, the Coalition of Limited English Speaking Elders (CLESE), who provided training to Call Center staff, indicated that many non-English speaking elders are not comfortable using an interpreter and would rather speak directly to someone who knows their language.

The past three years have ushered in a period of continued service growth and outreach for the Contact Center accomplished through the generosity of the grant provided by the Administration on Aging and the collaboration of the Alzheimer's Association's National and chapter staff. Highlights during the past three years include the ongoing, rapid growth of the On-line Community, intensified outreach and introduction of services to the Hispanic, African-American, Asian-American and rural communities, the launch of the Virtual Library, the standardization of Association-wide services through the Common Program Plan and the introduction of TrialMatch, a clinical studies matching service for constituents.

During the past 34 months of Phase II, the 800 number has handled over 750,000 calls at the National Contact Center and chapter level. An estimated 47% of these calls were handled by the centralized Contact Center location at an average of 8800 calls per month. Working in conjunction with library staff, the Contact Center expanded its outreach to the public by providing additional care consultation through the nationwide interlibrary "Ask Away, Ask a Librarian" service. This additional direct on-line care consultation continues to be provided to caregivers throughout the United States via the library system. The Contact Center will continue with a new grant from AoA. With 10 million American baby boomers predicted to develop Alzheimer's disease its services are even more vital than ever.

National Center for Benefits Outreach and Enrollment

The Administration on Aging (AoA) in conjunction with the Centers for Medicare and Medicaid (CMS) awarded support in 2008 to establish the National Center for Benefits Outreach and Enrollment (NCBOE) with funding authorized under the Medicare Improvements for Patients and Practitioners Act to service as resource center to help coordinate and collect information about outreach activities of State grants informing older Americans about available Federal and State benefits. Following the award of the project grant reported in this compendium, the Patient Protection and Affordable Care Act of 2010 was passed authorizing additional benefits for older adults and funding for expansion of outreach activities by State and Area Agencies on Aging, State Health Insurance Counseling and Assistance Programs (SHIPs), and Aging and Disability Resource Centers (ADRCs). AoA awarded a new grant in FY2010 to continue support of this Center including work with CMS and AoA in supporting the conduct of State outreach and educational activities on new Medicare benefits.

Program: National Center on Benefits Outreach and Enrollment

Grant Number: 90SB0001
Project Title: Meeting the Need: Proposal to Create a National Center on Benefits Outreach and Enrollment
Project Period: 09/30/2008 - 09/29/2010

Grantee:
National Council on Aging, Inc.
1901 L Street, NW - 4th Floor
Washington, DC 20036

Contact:
Hilary Dalin
Tel. (202) 479-6626
Email: hilary.dalin@ncoa.org

AoA Project Officer: Katherine Glendening

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$1,939,514
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$1,939,514

Project Summary:

The National Council on Aging conducted the National Center on Senior Benefits (The Center) to assist States and Area Agencies on Aging in conduct outreach and entrooment of eligible older adults and adults with disabitlies in Federal programs. The Center goals are specifially 1) to be the nationally recognized source of timely and useful information and assistance on benefits outreach and enrollment for the aging and disability networks; 2) to increase participation of seniors and younger adults with disabilities in public benefits programs; and 3) to position the aging network as the hub for person-centered enrollment for public benefits. Expected outcomes under this grant were development of a national network of Benefit Entollment Centers (BECs); increased numbers of consumers and caregivers receiving information, counseling and enrollment assistance with public benefits; increased use of web-based benefits screening and enrollment tools; and increased numbers of professionals receiving training and technical assistance about benefits outreach, screening, enrollment, and follow-up strategies, as well as other issues related to public benefits.

The Center) supports on an annual competitive basis BECs in 10 areas of the country to foster and demonstrate cost-effective benefits outreach and enrollment strategies in the aging and disability services provider networks to find and enroll people with limited means in public benefits; increased the use of web-based decision support, screening and enrollment tools by consumers, families and caregivers; maintain, update; enhanced the usability of current benefits screening and enrollment systems; provided training and technical assistance to BECs and to the larger aging and disability networks on cost-effective, promising practices and other topics related to benefits outreach and enrollment; and developed an online information clearinghouse on promising practices related to benefits outreach and enrollment.

In late 2008 during this grant peirod, the Center issued a call for proposals inviting nonprofits and state agencies to apply to become BECs offering person-centered benefits outreach and enrollment to seniors and younger adults with disabilities. BECs were asked to specifically focus on enrollment in several core benefits programs: the Part D Low-Income Subsidy (LIS/Extra Help), Medicare Savings Programs (MSPs), Supplemental Security Income (SSI), Medicaid, the Low Income Home Energy Assistance Program (LIHEAP), the Supplemental Nutrition Assistance Program (SNAP/Food Stamps), and State Pharmaceutical Assistance Programs (SPAPs, where applicable). In March 2009, the Center granted awards of $100K to 10 BECs that committed to work towards implementation of coordinated, seamless systems of benefits access in their communities. The 10 grantees represented a broad range of geographic areas, and came from both the state agency and nonprofit sectors; several targeted specific subsets of underserved older population groups (e.g. immigrant communities, Native American tribes, persons in frontier areas) as well as younger adults living with disabilities.

The Center monitored the progress of its ten BEC grantees through monthly all-grantee and frequent one-on-one calls. The Center also conducted extensive interviews with each BEC in order to gather more information about their challenges and successes and were compiled into a year-end lessons learned report entitled Person-Centered Benefits Access. The interviews were used to inform the creation of the Center's call for proposals for the next cohort of BECs to be funded under a new AoA cooperative agreement. These interviews also helped the Center to identify two key areas of concern regarding the future of the BECs: including the need for BECs to better understand and track whether submitted applications actually lead to receipt of benefits so they could intervene to remedy delays or problems that arose to assure meaningful outcomes, and the need for better planning for long-term sustainability of their efforts after this funding expires. How they would handle these two considerations became critical components in the proposals the ten BECs submitted for their second year of funding.

Center staff used promising practices and lessons learned from the BECs to inform discussions with the 49 states awarded monies under the Medicare Improvements for Patients and Providers Act (MIPPA), for which the Center also serves as Technical Resource Center. A joint conference with the BECs and all MIPPA grantees will be held in Washington, DC in March 2011, to provide further opportunities to enhance knowledge sharing and problem solving with the grantees. This conference funded under a separate AoA cooperative agreement will be the first time all of these leading benefits outreach and enrollment experts will have convened face-to-face.

The ten Benefits Enrollment Centers funded through the Center under this grant assisted more than 125,000 low-income individuals with applying for more than $238 in public benefits. It permitted the Center to continue promotion and enhancement pf its online screening and enrollment tool, BenefitsCheckUp®, as well as disseminate knowledge of what works in benefits outreach and enrollment more broadly. Despite these achievements, there remains a significant challenge in ensuring that those who apply for benefits actually receive them, use them, and retain those benefits.

Office of the Deputy Assistant Secretary for Aging

The Office of the Deputy Assistant Secretary for Aging supports the Assistant Secretary on Aging in providing executive direction, leadership and guidance for programs and operations. It also coordinates the operations of the Regional Support Centers and through it responds to the needs of older individuals following a Presidential disaster declaration, oversees disaster assistance and reimbursement activities described in Section 310, Title III of the Older Americans Act.

Disaster Assistance Grants

Disaster Assistance grants are authorized under Title III of the Older American Act for State Units on Aging (SUAs) and tribal organizations to reimburse costs associated with activities supported under Title III when they are impacted by a catastrophic event and only within geographic areas specified in a Presidential Disaster Declaration. Section 310 of Title III requires the Assistant Secretary on Aging to set aside 2% of funds appropriated for Title IV discretionary activities to make these awards. If no declarations are made under the Robert T. Stafford Relief and Emergency Assistance Act during a fiscal year, the funds are available for other title IV awards.

Appropriations for Title IV activities in FY2009 was slightly more than $18 million, which meant that approximately $360,000 was available to respond to applications from States and tribal organizations. These funds were used to award the three projects included in this compendium.

Program: AoA Disaster Assistance

Grant Number: 90DA2856
Project Title: Disaster Response Activities Resulting from a Winter Storm Following a Presidential Declaration of Disaster.
Project Period: 03/01/2009 - 02/28/2010

Grantee:
Arkansas Department of Human Services
Division of Aging and Adult Services
PO Box 1437, Slot S530
Little Rock AR 72203-1437

Contact:
Gwen Ervin-Mclarty
Tel. (501) 683-7964
Email: Gwen.McLarty@arkansas.gov

Fiscal Year	Funding Amount
FY2010	$
FY2009	$20,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$20,000

AoA Project Officer: Irma Tetzloff

Project Summary:

A Disaster Assistance grant award was granted to the Arkansas Department of Human Services/Division of Aging and Adult Services for expenses incurred during the major ice storm which covered the northern third of the State in late January and early February, 2009. Thirty-two counties were included in the Federal Emergency Management Agency Disaster Declaration on January 30 with six additional counties added on February 6. Massive power outages occurred throughout the area, much of which is rural and difficult terrain. A second wave of a major wind storm destroyed much of the repair work already completed. Many low-income seniors who live in the area had minimal food, water and heat for an extended period of time. Generous staff and neighbors, who helped with the recovery, depleted available resources as they helped seniors return to their homes.

The three Area Agencies used the OAA funds to assist in the ongoing recovery and partially reimburse senior centers and nutrition sites for some of the additional costs. The areas affected included areas with a high proportion of retired seniors who needed prescriptions; help with insurance and utility companies and heavy chore services to remove debris.

Program: AoA Disaster Assistance

Grant Number: **90DA2854**
Project Title: **Disaster Assistance Provided to Seniors and Adults with Disabilities during and after the Storm on September 14, 2008**
Project Period: **11/26/2008 - 11/25/2009**

Grantee:
Kentucky Cabinet for Health and Family Services
Department for Aging and Independence
275 East Main Street 3 W-F
Frankfort , KY 40621

Contact:
Phyllis Culp
Tel. (502) 564-6930
Email: phyllis.culp@ky.gov

Fiscal Year	Funding Amount
FY2010	$
FY2009	$8,432
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$8,432

AoA Project Officer: Irma Tetzloff

A Presidential disaster was declared to cover the heavy damages incurred through high wind in the western counties and counties bordering the Ohio River valley on October 9, 2008. The Kentucky Cabinet for Health and Family Services received a disaster assistance award of $8,432 on November 26, 2009 to help cover the costs incurred in the aftermath of the storm. Many elderly, particularly in the sparse rural areas, were without heat, food and any means of contact with the outside world due to extensive power outages. Area Agency staff checked door-to-door, provided meals ready to eat and helped with debris clean-up.

Grant Number: **90DA2855**
Project Title: **Kentucky 2009 Jan/Feb Winter Disaster**
Project Period: **03/01/2009 - 02/28/2010**

Grantee:
Kentucky Cabinet for Health and Family Services
Department for Aging and Independence
275 East Main Street, 3W-F
Frankfort, KY 40621

Contact:
Carol Hall
Tel. (502) 564-6930
Email: Carol.Hall@ky.gov

AoA Project Officer: Irma Tetzloff

Fiscal Year	Funding Period
FY2010	$
FY2009	$20,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$20,000

Project Summary:

A Disaster Assistance grant award was issued to the Kentucky Cabinet for Health and Family Services for expenses incurred during the major ice storm which covered most of the State in late January and early February. 2009. Ninety-three of the State's 120 counties were included in the Federal Emergency Management Agency Disaster Declaration on February 3 and approximately 673,000 persons over the age of 60 live in the affected counties. Most of the declared areas suffered massive power outages because of ice up to four inches thick decimating light poles and trees. The western counties were the hardest hit areas with restoration of power taking up to a month or more in these areas.

Many of the seniors in the affected areas had to move into temporary shelters and senior centers. The State's National Guard assisted aging services providers in going door-to-door to check on seniors in need and provide food and water where needed. Gradually, as roads re-opened, aging services providers were able to supply food, sanitary supplies, fuel, transportation and various kinds of chores services to help seniors obtain prescriptions and travel to doctor appointments. The Aging Services network used the funds to conduct individual assessments and help seniors apply for FEMA assistance and other benefits.

Congressional Identified Projects

The Administration on Aging (AoA) awards the majority of its project grants competitively in response to competitions that focus on specific topics addressing areas authorized in legislation including, and most often, the Older Americans Act. However for a number of years AoA also supported projects, commonly known as "earmarks" identified in Congressional appropriation committee reports accompanying its annual appropriations.

Beginning in FY2008 Congress changed its way of identifying member sponsored projects sponsored by naming them directly in appropriation language. Before FY2008, AoA allowed organizations designated to receive support as earmarks to designate project periods longer than 12 months if the specified funding amount permitted. Since FY2008 Congressional Identified Projects, are limited in at the time of award to 12 months with a limited no-cost extension permitted when requested near the end of the grant. Consequently nearly all of the Congressional Directed Award projects ending in FY2010 were awarded in FY2008 or FY2009.

A majority of the twenty-nine project summaries in this section are community aging in place demonstrations including "Naturally Occurring Retirement Communities." The were conducted by either non-profit agencies or by neighborhood residents who organize themselves to support continuation of their independent living. Information about Congressional Directed Awards for NORC projects may be read on the AoA website:

http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/NORC/index.aspx

Beginning in FY2009 AoA initiated, under Section 422 of Title IV in the Older Americans Act, support for the Community Innovations for Aging in Place program which supports through three year competitive grants project having similar goal and activities to this group of Congressional Identified projects. The first of the Community Innovations for Aging in Place projects will end in FY2012. Information about this program may read on the AoA website:

http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/CIAIP/Index.aspx

Other Congressional Identified Projects ending in FY2010 addressed a multitude of activities supporting locally defined needs of community organizations and institutions. Their commonality is that they supported activities generally permitted under the provisions of the Older Americans Act.

Grant Number: 90MA0002
Project Title: Culturally and Linguistically Appropriate Fall Prevention Program for Monolingual Seniors (Spanish and Korean)
Project Period: 08/01/2009 - 07/31/2010

Grantee:
St. Barnabas Senior Services
St. Barnabas Senior Center of Lost Angeles
675 S. Carondelet Street
Los Angeles, CA 90057

Contact:
Rebecca Benard
Tel. (213) 388-4444 x.206
Email: rbenard@sbssla.org

AoA Project Office: Michele Boutaugh

Fiscal Year	Funding Amount
FY2010	$
FY2009	$133,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$133,000

Project Summary:

St. Barnabas Senior Services (St.Barnabas) used this one year grant to build upon its InSTEP (Increasing Stability Through Evaluation and Practice) program for seniors to increase their physical stability and reducing risk of falling and adapt it for culturally and linguistically isolated Korean and Spanish-speaking seniors.

The objectives were to: 1) provide a culturally and linguistically appropriate fall prevention program for Korean and Spanish-speaking seniors in the greater Los Angeles area that incudes a five-pronged approach: community outreach, medical and psychosocial assessment, home risk assessment, home modifications, and a 12-week exercise class; 2) evaluate the effectiveness of this program; and 3) disseminate the results of the evaluation to policy, peer and public organizations that would benefit from this information.

The anticipated outcomes were increased public awareness in the Korean and Spanish-speaking communities concerned with falls measured by administration of pre and post program participant evaluations of self-confidence, independence, and falls or risk of falls. Home fall-prevention measures were to be identified and implemented; and wellness and healthy aging promoted. through the dissemination of program findings with key constituents.

In California, costly and serious falls occur frequently, with an average of two older adults dying every day due to fall-related injuries. In an effort to reduce the risk of falls, specifically in ethnic populations that are culturally disparate and linguistically isolated, St. Barnabas Senior Services offered a fall prevention program to reach monolingual Korean and Spanish-

speaking seniors who are at much greater risk of falls than their English-speaking and culturally mainstreamed counterparts in the Los Angeles community.

This year long, evidenced-based, multi-faceted program was comprised of three components: 1) medical risk assessment; 2) group-based exercise; and 3) home assessment and modification. The program was modeled after the Fall Prevention Center of Excellence's InSTEP (Increasing Stability Through Evaluation and Practice) Program, and was culturally and linguistically modified for the target ethnic population. Sixty-six seniors participated in the program, 37 Korean and 29 Hispanic. The majority of the participants who enrolled in the program were at moderate-to-high risk for falls based on known fall risk factors and their performance on balance measurement tests, with 32% categorized as high risk for falls. Significantly more females (62%) enrolled in the program compared to male participants (38%), although the Korean-speaking group was nearly gender equivalent.

Korean and Spanish-speaking older adults who participated in the program conducted at St. Barnabas Senior Services demonstrated significantly improved balance, strength, and functional mobility following the 12-week program. Moreover, the program was highly valued by participants, improved their overall knowledge of fall prevention, and provided them with practical strategies for lowering their fall risk.

The adaptation of the program from English to Spanish and Korean was straightforward and reliable, and it is evident that the program can be successfully implemented with older adults who are monolingual with little need to adapt any of the core components of the program. It is recommended that fall incidence and near-fall rate data be collected in future program offerings to measure statistical efficacy of the program. With the increase in physical stability and the knowledge of fall prevention techniques, combined with an expanded social network, it is concluded that the fall prevention program at St. Barnabas Senior Services promoted healthy aging, prolonged independence, and enhanced the dignity of a diverse community of elders in Los Angeles.

St. Barnabas Senior Services is committed to sustaining an ongoing fall prevention program. An evaluative report documents the complete findings of this program, and it will be shared with prospective sponsors and peer agencies, as appropriate.

Program: Congressional Identified Projects

Grant Number: **90MA0008**
Project Title: **California Senior Legal Hotline**
Project Period: **08/01/2009 - 07/31/2010**

Grantee:

Legal Services of Northern California
Senior Legal Hotline
517 12th Street
Sacramento, CA 95814

Contact:
David Mandel
Tel. (916) 551-2142
dmandel@lsnc.net

Fiscal Year	Funding Amount
FY2010	$
FY2009	$238,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$238,000

AoA Project Officer: Valerie Soroka

Project Summary:

Legal Services of Northern California used this one year grant to increase the capacity of California's Senior Legal Hotline to provide legal assistance to the states elders. The Hotline focused on targeting, reaching, and helping the most needy especially those who face daunting challenges due to limited means, isolation, disability, discrimination, lack of English proficiency, or other disadvantages. The overall goal was improved delivery of legal assistance to California seniors through increased hotline capacity and better coordination.

The objectives were to: 1) handle significantly more cases than would be possible otherwise; 2) advance development of the Hotlines technological capacity and content management for better sharing of resources online among California's senior legal services network, and enabling volunteer retired attorneys to perform hotline work from remote locations; and 3) work with the California Department of Aging and others on strategic planning for better statewide coordination. The expected outcome was that more California seniors will receive crucial, timely, legal help, more coherently delivered, to help them resolve disputes, achieve planning goals, prevent exploitation and maintain maximum independence.

The challenges faced during the project were: 1) a continuing high demand for help, far outpacing capacity; and 2) increasing specialization of staff and volunteers in response to the fact that most remaining funding is for more narrowly focused projects, especially the wave of foreclosures that has struck the nation, affecting elders in particularly devastating ways. Temporarily, the funding served the Hotline's mission of enabling more California seniors to receive crucial, timely legal aid, efficiently delivered through a proven, established delivery

system, helping them resolve disputes, achieve planning goals, prevent abuse and maintain independence.

A daylong training event for potential volunteers and senior legal services staff from around the state was held in March at a nearby conference center. It was well attended many of the 65 participants attended multiple sessions. About a dozen attorneys applied to volunteer after the event, but many of the offers had to be declined, with existing attorney staff overburdened with legal and administrative work and unable to take on supervision of additional volunteers.

Thanks to an ongoing Administration on Aging funded model approaches project, some progress has been made toward statewide coordination. To a significant extent, the Hotline continues to lead in promoting communication among and training opportunities for the state's 40 local senior legal services providers, the state Department of Aging, policy makers and senior advocates. Staff developed new print and online resources for providers and educational material for clients. It also continues to participate in advancing the national effort to win stable, comprehensive support for a network of senior legal hotlines in every state.

At a time of extreme and simultaneous challenges in both client needs and scarcity of resources, the receipt of a significant grant for core work sustained the hotline for a year postponing the cutbacks occurring now and enabling the Hotline to provide crucial services to many elders who would otherwise have suffered severe consequences for lack of legal help. However given that grant support was for one year only, and that it was unlikely to be replaced anytime soon, it was difficult at times to respond to the volume of calls even before the funds ran out.

While important and valuable work continues to be accomplished its nature has changed drastically. The program is much less a high-volume hotline and more a hodge-podge legal program for seniors based on certain areas of law plus service to local clients. On the one hand, the adjustment has ensured survival, but it has clearly hampered efficiency and productivity, reversing many years of efforts to become known as a source of legal help for all California seniors on all subjects. The Hotline will continue to persevere, performing what services it can and accepting that they too contribute.

Program: Congressional Identified Projects

Grant Number: **90AM3180**
Project Title: **Colorado Senior Connections**
Project Period: **08/01/2008 - 01/31/2010**

Grantee:
Allied Jewish Federation of Colorado
300 S. Dahlia St., Suite 300
Denver, CO 80246

Contact:
Beth Ginsberg
Tel. (303) 316-6460
Email: bginsberg@ajfcolorado.org

AoA Project Officer: Greg Case

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$286,899
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$286,899

Project Summary:

The Allied Jewish Federation of Colorado (AJF), in partnership with Jewish Family Service of Colorado (JFS) conducted a demonstration project, Colorado Senior Connections (CSC), supporting programming for older adults residing in three apartment complexes in the Denver, Colorado, Metropolitan Area.) Colorado Senior Connections' goal was to help seniors achieve maximum quality of life, independence, self-determination, and community engagement through its programming and support of activities. Community partners in providing services included the Volunteers of America, St. Anthonly's Passport Program, and the Dominion Sisters Home Health Agency.

The three project sites - Edgewater Plaza, Sheridan Blen and Berkshires at Lowry - have high concentrations of older adults and are in effect, Naturally Occurring Retirement Communities (NORCs). Needs assessment surveys at each site collected information on the unmet needs and desires of resident both prior to developing programming and during the course of the project. This allowed the partners to provide and change programming unique to each site, but collectively includes special events and parties, weekly wellness clinics, a resident council, volunteer run clubs, personal care assistance, homemaker help, and casemanagement services. Over the course of the project more than 300 residents were enrolled, the majority female and white. Most residents lived alone and were neither receiving assistance or giving care to another person.

Community Connections was staffed by a project director, a program coordinator, a site coordinator, and two volunteer/activity coordinators. The program and site coordinators were

social workers and provided among their duties social work and case management services. The volunteer/activity coordinators rotated among sites and spent much of their time in recruiting participants and volunteers, planning events and programming, and overseeing resident run activities.

Sites residents varied in age, marriage status, income and education. At Berkshires the average age was 84 (highest) and 70 at Sheridan Glen (lowest). At Edgewater Plaza 86% were widowed or divorce (highest) compared with 65% at the Bershires (lowest). Only 3% of the residents at Sheridan Glen were married and 15% were single and never married. All residents at Sheridan Glen had incomes under $20,000 compared to 26% at the Berkshires. Residents in all locations at enrollment in the program were lower than others in their age group for extent of chronic conditions, but more frequent in their visits to health care professionals and hospital emergeny rooms.

JFS contracted with the Center for Policy Research in Denver to conduct an evaluation of Community Connections. A process evaluation gathered information through obserations, focus groups and interviews with participants, apartment complex staff and representatives of partner agencies about the steps involved in designing, implementing, and operating programs at the three locations, and perceived outcomes and impacts. Data was gathered from intake forms which provided baseline measures on social isolation, health status, and ability to conduct daily living tasks. A follow-up survey asked many of the same questions in addition to the level of participation on the program. Particpation was also measured by use of sign-up sheets and requests for nurse and casemanagement services.

About 1/3 of residents that completed intake forms completed follow-up surveys providing data on the impact of the project in terms of social isolation, health and physical limiations, connection to other residents and the community, and perception of quality of life. A high proportion of respondents felt Community Connections increased their contact with neighbors and participation in social activities as well as gave them a reason to leave their apartments. A majority acknowledged they increased their knowledge and use of community services and who to go to for assistance, information and referrals. High proportions of partipants stated they were taking better care of their health and that the program helped them feel more independent and able to stay in their homes. Residents at the two less affluent sites rated their quality of life significantly higher because of their particpation. A low percentage of residents stated participation increased their interest in volunteering which the evaluators attributed in part because a significant number of residents were already volunteering before participation in the program.

JFS plans to continue the Community Connections program by offering new programming at existing sites and explansion to a fourth site in downtown Denver to establish a neighborhood NORC program for Gay, Lesbian, Bisexual, Transgener (GLBT) seniors.

Program: Congressional Identified Projects

Grant Number: 90AM3190
Project Title: Smart Technology and Universal Design to Support Elders in Maintaining Independent Living
Project Period: 8/01/2008 - 07/31/2010

Grantee:
University of Florida
Division of Sponsored Research
219 Grinter Hall PO Box 115500
Gainesville, FL 32611

Contact:
Thomas E Walsh
Tel. (352) 392-1582
Email: ufawards@rgp.ufl.edu

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$95,305
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$95,305

AoA Project Officer: Greg Case

Project Summary:

The project goal of this grant was to increase the number of older Americans who are supported by the latest assistive technologies, home monitoring systems, and application of the principles of universal design. The objective was to increase knowledge in this area among older Americans, their informal care providers, and therapists who provide community support services for elders.

The project's specific focus was on dissemination of information on smart assistive technologies for people as they age which was addressed in three ways. A workshop was, developed under a subcontract to the American Occupational Therapy Association (AOTA) and held at the 2009 AOTA Conference to train occupational therapists. This workshop was planned and presented in April, 2009, with close to 100 therapists attending. Attendee evaluations were very positive.

The second component was to write a book with the same title as this project. The book is still in progress. Dr. Glenn Le Prell, was included as a second author the preparation of this book. Mr. Le Prell is a bio-engineer who works with Dr. Mann at the Veterans Health Administration Rehabilitation Outcomes Research Center. The explosion of devices and computer and smart phone applications has increased the complexity of writing this book. However, content identification has been completed for every chapter, and a final manuscript is expected to be delivered to a publisher in 6 months (August 2011). A textbook publisher Jones and Bartwell is interested in publishing the book but the grantee feels the book should

be targeted at a broader audience including those with disabilities, their care providers as well as practicing professionals who prescribe/recommend assistive technology.

The third component is a website on smart technology. The grantee has added content to a section of the University of Florida Center for Telehealth and Smart Assistive Technologies website. Content will continue to be added until the completion of the book, as much of the new information on the website was drawn from the research for the book.

Grant Number: **90AM3188**
Project Title: **Naturally Occurring Retirement Community Supportive Services Program**
Project Period: **08/01/2008 - 12/31/2009**

Grantee:
Jewish Community Services of South Florida, Inc.
735 N.E.125th Street
North Miami, FL 33161

Contact
Joyce L. Kagan
Tel. (305) 673-6060
Email: JKagan@JCSFL.org

AoA Project Officer: Greg Case

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$118,866
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$118,866

Project Summary:

The purpose and scope of this project was to assist the residents of a condominum community in Miami-Dade County in planning, promoting and implementing community activities which would reduce social isolation and foster a sense of community interdependence and cooperation. An important component was collaboration with existing social service agencies and to increase resident awareness of supportive services and opportunities to participate in health education and wellness activities.

The Greater Miami Jewish Federation, in partnership with Jewish Community Services of South Florida (JCSSF), implemented a Naturally Occurring Reitement Community Supportive Services Program (NORC-SSP) pilot program at the 17 mid-rise building Point East Condominiums in Aventura, Florida in 2003. Point East is a mid-rise condominium community with limited existing amenities housing nearly 1,500 residents aged 55 and older in 1,200 units. The original objectives of the project were to: 1) establish an infrastructure at the NORC-SSP site to support seniors who are aging in place; 2) develop/maintain a volunteer corps group within the community; 3) develop community resources and linkages; 4) provide additional services and activities, i.e. social services, arts and culture, health and wellness, 5) evaluate the impact of added activities/services; and 6) disseminate project information.

Initial assessment of East Point as a potential NORC-SSP program revealed a number of unmet needs and conditions which needed priority attention. Built in 1967, the complex initially attracted primarily older white residents who were largely able to care for themselves

by using privately owned vehicles to meet their daily living needs. Over time the residents grew older and with resident turnover becoming an increasing diverse population. The older, original aging in place residents began to lose their mobility and required public transportation which had not been needed and therefore not readily available. The division between residents of various demographic and cultural backgrounds impeded the ability to work as group to address community and individual needs.

During the life of this project and early on, JCSSF hired a full time coordinator located at East Point to organize a wide variety of social, educational and physical activities to promote and strengthen social networks and physical activities. A volunteer corps (NORC Ambassadors) was organized to enhance service delivery and resident access to their buildings and to the complex's community center which under the project was re-established as an activity center. Connections were established with the Miami-Dad County Alliance for Aging and local supportive services.

Under this project 257 unduplicated residents participated in wellness and exercise classes. In partnership with two local hospitals, 659 residents participated in mobile screening and education programs. An on-site congregate meal program served 84 unduplicated residents through the JCS Senior Meals Program. Residents participated in 16 off site visits to music and dance concerts, monthly community birthday celebrations and holiday events at East Point. A total of 270 residents and family members received information and referral. Nearly 60 volunteers provided almost 1,000 hours of service during the project period.

A "life and leisure survey" was given to assess attainment of these outcomes: 1) a reduction in social isolation and/or increase in socialization; 2) improvement in exercise behaviors by program participants; 3) reduction in food insecurity and increase in ability to use limited income for other basic need by participants of congregate meals; 4) increased sense of security, greater sense of empowerment, and increase access to services by participants of the NORC-SSP. The responses from 76 surveys reveal high levels of attaining these indicators.

The greatest indicator of value of NORC-SSP is that it will be sustained beyond the federal funding it has received over the past few years and ending with this grant. The management of East Point has hired the coordinator to continue her positions. JCS, the local hospitals and other groups have pledged support to continue support of many of the activities. The NORC Ambassador volunteers will continue as will a monthly newsletter. The congregate meals offered at the site's community center will continue through Title III OAA support.

A number of lessons were learned over the period in which federal support was received, foremost learning that when facilities and residents age and personal resources decrease at a rate greater than in a mixed age community problems arise that cannot be addressed by the residents themselves. Reestablishing, developing and supporting a community structure to address personal and community needs is not only costly, it requires leadership and involvement of a knowledgeable person (or persons) to navigate the complexity of linking the development to the greater community and their support.

Grant Number: **90MA0004**
Project Title: **Financial Scam and Fraud Elder Awareness Project**
Project Period: **08/01/2009 - 07/31/2010**

Grantee:
Stetson University, Inc. dba Stetson University College
Center Excellence Elder Law
1401 - 61st Street South
Gulfport, FL 33707

Contact:
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AoA Project Officer: Doris Summey

Fiscal Year	Funding Amount
FY2010	$
FY2009	$95,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$95,000

Project Summary:

The Center for Excellence in Elder Law in the Stetson University College of Law conducted a one-year pilot project designed to inform and educate elder individuals about financial scams and frauds in four Florida counties – Hillsborough, Pasco, Pinellas and Manatee. Stetson has a nationally recognized and establish elder law center and multiple elder law programs with ongoing support and concern for issues, matters and concerns about and relating to elder individuals.

The objectives for this project were to: 1) decrease the occurrence of, and minimize the potential for, financial scam and fraud victimization among elder individuals; and 2) to produce a sustainable and replicable project that can be duplicated and implemented throughout the State of Florida, as well as in other individual states nationwide.

In the course of the twelve months of the project a total of 75 speaking engagements were held and hosted a Bay Area Elder consumer Protection Expo which was free and open to the public. A number of educational materials were produced and disseminated including two project mailers, four elder consumer awareness brochures, an elder consumer alert pamphlet, seven consumer alert articles, three newsletter articles, one public service announcement video and five elder consumer awareness scam fraud education videos. The project also developed and launched a new user friendly website providing information and access to services and resources.

The project had three measurable outcomes: 1) increase in awareness among elder individuals about financial scams and frauds; 2) creation of educational and informational

written, digital and resource materials and services providing and promoting financial scam and fraud awareness; and 3) production of a replication handbook providing a model for project duplication and implementation.

A survey was developed and distributed to all attendees at presentations with responses providing feedback to gauge whether an attendee was helped, made aware, or influenced beneficially by the speaker and if there was intention to change one's behavior. It also provided feedback to the presenter as to his or her effectiveness in conveying information about financial and consumer scams and frauds. Similarly the project developed and used a survey distributed to attendees of the exposition. Analysis of survey responses indicated that both speaking engagements and expos were effective in community education and professional development.

There were two notable challenges faced by the project. The first challenge was use of the project's materials and services by agencies and entities throughout the four counties. Recurring monthly in-person speaking engagements scheduled with three senior centers in Pinellas County and six senior centers in Hillsborough County helped meet that challenge, however, speaker engagements were more difficult to arrange in the other two counties. To further meet the challenge, the project developed and sent two mailers to more than 30 agencies and organizations which included highlights of materials and services they could request of the Center. The second challenge was to respond to increased requests outside of the four counties. The project attempted to provide materials and services when and where possible while remaining within the scope and funding limitations of the project.

Major products developed were a comprehensive legislative and statuatory information database on adult protection statutes and elevated crime/age-based reclassification statutes for the fifty U.S. States, District of columbia and U.S. territories and development of a replication handbook with examples of materials and services to be used as a reference and resource guide.

The Center considers the goals and objectives of this project were successfully met and while the Center continues to be engaged by public and private entities at the local, regional and state levels in strategic and collaborative efforts regarding elder financial and consumer scam and fraud awareness and protection, it will continue to serve the four counties targeted in this project with informational and educational materials and services.

Grant Number: 90MA0011
Project Title: Broward County Family Caregiver Access Network Demonstration Project (FCAN)
Project Period: 08/01/2009 - 07/31/2010

Grantee:
United Jewish Community of Broward County, Inc.
Community Relations/Planning
5890 S. Pine Island Road
Davie, FL 33328

Contact:
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AoA Project Officer: Greg Link

Fiscal Year	Funding Amount
FY2010	$
FY2009	$167,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$167,000

Project Summary:

United Jewish Community of Broward County, Inc., doing business as the Jewish Federation of Broward County, as the lead agency, supported the Broward County Family Caregivers Access Network Demonstration Project (FCAN) in collaboration with Jewish Family Services of Broward County, local senior service agencies and United Jewish communities. The goal of the project was to foster improved well-being of family caregivers and increased ability to sustain caregiving.

The project objectives were to: 1) identify community services for family caregivers and understand their needs, strengths and interests; 2) increase community knowledge about family caregiving and promote increased caregiver self-identification; 3) increase the quality/quantity of caregiver assessments; and 4) increase service coordination for family caregivers. The overall approach included conduct a community assessment; implement multifaceted outreach; and conduct caregiver support groups, individual assessments, and service coordination. The target population iwere family caregivers of any age or ethnicity who are caring for older adults living in Broward County, Florida.

The anticipated outcomes were: 1) 85% of participants will improve their knowledge of family caregiving; and 2) 80% of family caregivers who attend a support group or service coordination will report an improved sense of mental well-being and ability to continue caregiving.

Partners for the FCAN project were sought and found to avoid duplication of service in the community. Partnering with a number of cities in the county helped to provide the venues for both the workshops and ongoing support groups at community centers and senior centers. Caregiver brochures and caregiver resource guides were distributed at each presentation and group as well as at various other agencies, offices and organizations throughout the county.

Caregiving workshops were presented at various venues throughout Broward County via power point and facilitated by a social worker. Information was disseminated through educational seminars, caregiver brochure and a comprehensive caregiver resource guide. An article in a local newspaper, information on the lead and partner agencies' websites and information about the program was distributed at caregiver conferences. Many community resources were offered to attendees that included programs such as senior centers and respite. Caregiver support groups were also offered at these same locations.

The evaluation tools used in the project were a sign-in sheet in each workshop and in each session of the support groups, participants were given pre and post-test questionnaires. The goal to reach 300 people in Broward County was nearly met by reaching 250 caregivers during the project period.

The greatest challenge was to encourage caregivers to leave their loved ones and their homes to attend the educational workshop. Some caregivers were reluctant to commit to attending the support groups twice monthly. Actions taken to address these challenges included having the workshops and support groups located throughout the county at four ongoing locations. This accommodated the caregivers by bringing the groups to their communities, thereby minimizing their need to travel far. FCAN advertised in local newspapers, the agency's website, community newsletters and the senior centers and community centers. The various cities also posted the workshop and support groups on their websites. FCAN addressed the challenge of getting caregivers to leave their homes and loved ones by scheduling the workshops and support groups at a time that was conducive to the caregiver/care recipient's lifestyle.

The project made an impact on the individual caregivers. It gave them the recognition and acknowledgment as a social group and helped to boost their confidence that funding for much-needed services for caregiver will become more readily available. It was found that caregivers have a great need for peer support. They were extremely appreciative for each group they attended and the attention they received from the facilitator and the other participants. Additional needs were found for bereavement groups to be offered at various times throughout the day, as well as for individual therapy on a sliding fee scale.

The products from the project include a brochure, flyer, web pages, resource list, an outreach presentation, and a final report with evaluation results.

Grant Number: 90MA0019
Project Title: Georgia Naturally Occurring Retirement Communities (NORC) Initiative
Project Period: 08/01/2009 - 07/31/2010

Grantee:
Jewish Federation of Greater Atlanta
1440 Spring Street, NW
Atlanta, GA 30309

Contact:
Deborah Akstein
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AoA Project Officer: Greg Case

Fiscal Year	Funding Amount
FY2010	$
FY2009	$95,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$95,000

Project Summary:

The goal of this project was to continue to support development of the Naturally Occuring Retirement Communities (NORC) Initiative in Georgia which is to help older adults live in their homes as long as possible with true quality of life, to prevent hospitalization, to build the capacity of the community to age in place, and to replicate the model in different communities with different populations and foci. Six NORC locations are currently supported in Savannah, the City of Atlanta, the greater metropolitan area of Atlanta, and a rural county.

Project objectives were: 1) development and addressing of unmet needs of older adults in each community; 2) increasing neighborhood awareness of senior issues; 3) greater coordination of services between agencies; enlisting additional partner agencies, particularly non-traditional partners; 4) disseminating information about the Georgia NORC initiative; 5) building sustainability, and 6) evaluating impact factors affecting seniors' ability to age in place. Expected outcomes were: reducing social isolation; increasing home safety; increasing knowledge of and access to community resources; and improving senor's ability to maintain a healthy life style and manage chronic disease and/or health challenges.

This project supported older adults in four communities in Atlanta, one in Savannah and one in rural Candler County. Approximately 2,169 seniors were served by NORC in these communities. Four of the NORC sites are made up of seniors living in single family homes, and wo serve older adults living in high rise apartments. (One of the NORC high rises in Atlanta is now self sustaining and is not managed by the NORC partners.) The Georgia NORC communities are quite diverse, but the overwhelming majority of seniors served by NORC have low income. Across sites, the average age of the seniors who participated in

annual surveys is 74.8 years. Most surveyed participants are female (79%) and white (73%) with 47% Jewish and 44% divorced. Of these participants, 61% are likely to live alone.

A new aspect to care transition was implemented at the Meyer Balser NORC, where the average participant age is 83 with 77% of the members over the age of 80. A nurse coach assisted frail participants and checked in on persons upon hospital discharge. As part of the Care Transitions Initiative, the Meyer Balser NORC is offering Meals on Wheels to all members discharged from the hospital or from an emergency room for a period of up to 30 days. Home-care services were provided to members following surgery. Escorted transportation to physician offices and diagnostic testing were also offered. Assessment results showed the effectiveness of this program and other safety net programs at all the NORCs where most seniors reported that they had not been in the hospital or emergency room (66%) or experienced a fall that resulted in medical attention (82%).

Transportation vouchers using volunteers improved seniors' quality of life and provided services more cost effectively. Rural Candler County piloted a voucher transportation program that served 41 seniors, engaged 43 volunteer drivers and transported seniors 11,767 miles at a cost of approximately $8,500 ($.72 per mile).

A lesson learned was the value of maintaining old and the potential of new partnerships. Leveraging partnerships enabled us to provide seniors with services of occupational therapy (OT) students and OT professionals as well as industrial design students, nutrition and nursing students. Students under the supervision of their professors provided nutrition education, blood pressure screenings and health education on chronic diseases. OT and industrial design students conducted home assessments and provided minor additions and adjustments to the seniors' homes to make them safer. On a less positive note, we learned the importance of diversifying funding sources when we lost staff dollars for one of the NORCs due to a loss of funding from the State of Georgia. Only 46% of the seniors surveyed volunteered suggesting more efforts are needed to engage seniors in volunteer opportunities.

Products developed include articles in local newspapers, a Columbia University video on a day in the life of NORC members that was also published by an online version of The New York Times, printed voucher materials, and presentations to Emory University's School of Public Health. A local TV station aired a segment featuring a NORC member who received $100 to shop for others and then received $100 to spend on herself as part of their Random Acts of Kindness program.

Program and policy implications include finding that cost savings can be realized by using alternatives to traditional service delivery, such as the transportation voucher program and monthly or bi-monthly meal programs associated with an educational or entertainment program. Also, cost-effectiveness can be achieved by working with partners, ranging from universities to faith-based and secular nonprofits, instead of working with for-profits or even traditional nonprofits, like senior centers. Our recommendations would be to maximize the potential of partnerships and to explore alternatives to traditional service delivery.

Program: Congressional Identified Projects

Grant Number: **90MA0016**
Project Title: **2009 Congressional Mandates: Non-NORC**
Project Period: **08/01/2009 - 07/31/2010**

Grantee:
SOWEGA Council on Aging, Inc.
1105 Palmyra Road
Albany, GA 31701

Contact:
Kay H Hind
Tel. (229) 432-1124
khhind@dhr.state.ga.us

Funding:	
FY2010	$
FY2009	$95,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$95,000

AoA Project Officer: Leslie Swann

Project Summary:

The grantee, SOWEGA Council on Aging, serving 14 counties in rural Soutwest Georgia supported this health promotion/disease prevention program educational project in collaboration with other local organizations. The project goal was to provide extensive education and monitoring of health conditions that affect the senior citizens living the service area of the area agency on aging.

Project objectives were to: 1) promote better lifestyles through education about diseases and conditions prevalent in our area; 2) monitor health conditions among senior center participants; 3) develop linkages to local and national resources; 4) expand assessment and intervention services; 5) evaluate the impact of the added services; and 6) disseminate project information. The expected outcome of this project was that clients would increase their ability to make positive changes in their health conditions. Measurable outcomes would be reflected in pre- and post-tests results.

With people living longer today the SOWEGA Council on Aging strives for health promotion/disease prevention programs that will benefit the older population. SOWEGA Council on Aging reaches approximately 600 current congregate participants and 800 home-delivered meal participants. The four focus counties for this grant included: Dougherty, Worth, Early, and Miller, which targeted 100 congregate participants.

The wellness team, consisting of a wellness coordinator and a wellness assistant, administered pre-tests to 100 seniors participating in the improvement study, focusing on diabetes self-management and fall prevention. Along with several community partners, the team presented a variety of programs over a 12 week period related to the two focus areas.

Several pieces of exercise equipment were purchased for the senior centers to expand their exercise programs as well as including a wellness video, brochure, and manual, along with monthly newsletters and fact sheets. The latter were distributed to 14 county senior centers and several church groups as part of the program. The intent for this intervention motivation of older adults to change one or two behaviors to help prevent or manage diabetes and reduce the risk of falls, therefore, making a positive change in their health and well-being.

Positive results were achieved with the educational activities, lessons, and testing, through improvement in A1C levels, and upper and lower body strength, and balance in all four focus counties. For this study, the SOWEGA Council on Aging Wellness Program chose five focus senior centers located within four focus counties of the Southwest Georgia region. Participants were asked to partake in a three month study that would run from the month of January to March. The study consisted of presentations and lessons that were centered around the prevention and care of Diabetes as well as the prevention and care of osteoporosis, the risk of falling, and fall related fractures. Pre-testing was held after volunteers were recruited for the study to determine where participants were in their daily activities. When the study was complete, we conducted post-testing to analyze the improvements made, and in what areas they were made. We only chose the diabetic participants to perform the A1C tests. A physical test was also performed with the participants to measure their lower body strength, balance, and coordination. The data concluded a successful improvement study, in which the results were evidence that we reached our goal in improving or maintaining the health and wellness of seniors.

At times the project had limited resources, but adding resources from outside counties helped in these areas. Scheduling and conducting pre-tests for 100 senior participants was also a challenge. Concluding the improvement study proved to be a challenge when it was realized after the course of the study that some of the participants had either dropped from the program due to relocation or death, or they simply did not wish to participate any longer. The project made sure to extend our programs to all senior center participants, and not just those signed up to complete the specified study. Their results were taken into consideration when evaluating the program.

The project has reached 35% of SOWEGA’s entire senior center population. One hundred percent of the clients who participated in the improvement study improved or maintained their conditions by the completion of the project. Purchasing new exercise equipment and walking poles has increased the physical activity of the senior participants by 40%. Diabetes awareness and prevention programs have allowed for SOWEGA’s entire senior center population to receive the proper education in preventing or maintaining Diabetes. Undertaking this project has allowed SOWEGA to discover the needs of its senior center participants and the extent to which the needs must be addressed.

Grant Number: 90MA0026
Project Title: Congressional Mandate: NORC
Project Period: 08/01/2009 - 07/31/2010

Grantee:
Intergenerational Resource Center, Inc.
444 Edgewood Ave. S.E.
Atlanta, GA 30312

Contact:
Brenda Sanford
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AoA Project Officer: Danielle Nelson

Fiscal Year	Funding Amount
FY2010	$
FY2009	$56,947
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$56,947

Project Summary:

The Intergenerational Resource Center (IRC) helps older adults and veterans through its its adult day health program to address the factors that lead to dementia and other mental health conditions such as borderline personality disorder. The goal of this project was to create a model program that provides "novel" tasks to enhance cognitive functioning for participantsand help them form the social connections needed in order for participants to bond with their families, friends and peers. An expanded model for services was developed in respond to the needs of veterans and non-veterans who present mental illness, PTSD, drug abuse and disability.

The process and intervention for desired outcomes was piloted with five of the clients from the Intergenerational Resource Center, their families and the center's staff. The program offers one-on-one and group meetings to assess problems and establish goals for care plan development and collaborates with public and private agencies to offer case management services that address participant goals and foster continuity care. Anticipated participant outcomes included a decrease in impulsive and disruptive behaviors and improved interpersonal relationships. Other expected outcomes included a model intensity scale instrument, psychosocial definitions for use with each level of care, a staff training module; and an evaluation instruments for use in determining behavioral changes.

An intake form was constructed which included assessments of stressful life events, psychiatric, medical and treatment history, substance abuse history, current symptoms assessment, risk for suicide, psychosocial assessment, and a summary of all assessments. The assessment protocol also included care recommendations. Reassessment was conducted every three months.

Patients selected for this project were based upon the staff's assessments of individuals needing psychiatric treatment for mental health disorders and substance abuse. Five individuals, three men and two women, were selected to participate in the piloting of the program. Clients met monthly in groups and as needed individually with a psychiatrist and a licensed counselor. The treatment plan employed Cognitive Behavioral Therapy (CBT), as an approach for intervention. Based upon the therapeutic sessions and the evaluation of the psychological team, in consultation with the staff and family, a treatment plan was developed and monitored.

The staff of the IRC was taught counseling and behavior modification techniques utilizing CBT and Dialectic Behavioral Therapy. They were also instructed on the etiology, causes and treatments for mental illness and alcohol and drug abuse. Staff was provided information on resources for mental health and drug abuse. Family members were educated on the treatment and provided referrals to enhance their involvement in the therapeutic process from the time of the initial meeting and during quarterly sessions.

Family caretakers indicated that their participation in the sessions provided important insights on mental illness and drug abuse that they were not aware of before. They indicated that the experiences provided and reinforced approaches for modifying the behaviors of their family members. Most importantly it provided them with approaches for responses to the behaviors of family members that were less stressful for them while achieving results. Overall they indicated that the process was extremely helpful.

The responses from the IRC staff demonstrated that they viewed the training as positive and effective as it promoted sensitivity, expanded their knowledge base, and equipped them for working with the families. Interviews with staff indicated that the training and their participation in the development of intervention resulted their becoming more sensitive and insightful about mental illness and especially drug abuse. Staff members saw the information that they received and the way that it was presented as valuable and important for their work. However there was some indication that the staff did not fully comprehend CBT but did see it as another tool for their work, as a new approach. The responses indicated that the staff was attempting to integrate the approach in their ongoing work with the patients and their families.

Grant Number: 90AM3198
Project Title: Services to Naturally Occurring Retirement Community Seniors in Indianapolis
Project Period: 08/01/2008 - 07/31/2010

Grantee:
Jewish Federation of Greater Indianapolis
ElderSource
6705 Hoover Road
Indianapolis, IN 46260

Contact:
Lori Moss
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Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$603,273
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$603,273

Project Abstract:

The Jewish Federation of Greater Indianapolis through its program affiliate, ElderSource of Greater Indianapolis, and formal agreements with several dozen community organizations used this grant support to enhance and expand its social support and services to assist neighborhood residents over the age of 60 safely age in place. The project boundaries of the Elder-Friendly Communities program, also known as a Naturally Occurring Retirement Community or "NORC" program, include a 1.5 square mile section in northwest Indianapolis, as well as an apartment building with over 100 low-income residents. The goals of Elder – Friendly Communities are to enhance the ability of seniors in its targeted areas to continue living safely and independently within the community through increased access to supportive services, and to involve seniors in strengthening the community as a whole.

Project objectives were to: 1) provide a multidisciplinary team of professionals to coordinate and offer services to older adult residents; 2) outreach to neighborhood residents through individual, congregate, volunteer or community wide venues; 3) develop and enhance neighborhood partnerships and collaborations; 4) create volunteer opportunities; 5) provide access to transportation resources; and 6) create neighborhood councils to guide planning and development. Anticipated measurable outcomes were: 1) a newly created and/or expanded community; 2) accessible community resources to build community and age in place: 3) reduced social and physical isolation; 4) replicable program models created to benefit community-based older adults; 5) older adults capable of continuing to live safely in their own homes; and 6) opportunities for intergenerational involvement and engagement. In addition to older adults ability to age safely in their homes and improved physical and emotional health, anticipated outcomes included usable tools for evaluation and community and individual assessment, an effective internet presence and a final report.

The Elder-Friendly Communities “footprint” of 1.5 square miles includes nearly 2,000 households and 18 self-defined neighborhoods with single-family homes, condominiums, and apartment complexes. Most residences in this catchment area were built in the early 1950’s without sidewalks, bus stops and commercial businesses in close proximity which typically differentiates the suburban living environment from urban downtown living. The age-integrated, but spread-out, environment creates a challenge for organizing support for and for gaining the participation of older persons who are “aging in place.” Consequently a major focus of the program is in the conduct of outreach using media and presentations to community and resident groups. The most effective methods found for reaching residents have been through publication of a newsletter and word of mouth, resident by resident.

The program operates out of a community center with minimal staffing including a director, program coordinator and a community resource coordinator. The key for meeting resident needs has been through referral of residents to and coordination with existing social and health service organizations including the Area Agency on Aging. Elder-Friendly Communities “fills in the gaps” to needed services and organizes group activities to help reduce social isolation. Among services arranged and/or conducted under this grant were 5,320 hours of homemaker and personal care attendant services, in-home assessments for 26 individuals and families, transportation for 170 residents, in-home modification for 5 residents, and home health care and respite for 25 residents. The program planned and supported a number of activities to reduce social isolation and promote health living, including a monthly book club, computer instruction, walking and fitness activities, aquatic programming and offered 45 educational sessions on a variety of issues.

Although nearly all initiatives and programming conducted under this grant were successful and appreciated by residents based on satisfaction surveys, the expectation that the program could create a volunteer cadre and establish block captains for the various neighborhoods within its boundaries was not met. Staff concluded that residents preferred to not have formal or regular responsibilities in that they have retired and enjoy not having these types of obligations or personal commitments.

The most significant challenge is finding permanent funding for program sustainability. In an effort to seriously look at the issue of sustainability, the Resident Advisory Board initiated an increase in the cost share per resident; however additional funding sources are needed to maintain the program’s activities and services.

Grant Number: 90MA0018
Project Title: Supportive Services in Naturally Occurring Retirement Communities
Project Period: 08/01/2009 - 09/30/2010

Grantee:
Jewish Family and Childrens Services of Waltham
Senior Services
1430 Main Street
Waltham, MA 02451

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AoA Project Officer: Greg Case

Fiscal Year	Funding Amount
FY2010	$
FY2009	$95,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$95,000

Project Summary:

This project continued development of three NORC programs for frail older residents in senior housing developments in Malden, Brookline and Framingham, Masachusetts drawing on their existing strengths and buliding new connections between them. The goal of these programs is to enable residents to live with dignity in their own homes for a long as possible.

Project objectives were: 1) to increase physical activity, social connection, and improve awareness of healthy, low cost nutrition through existing and new activities; 2) to encourage participation of residents in planning, embracing and sustaining activities that maintain or improve their health and wellness; and 3) cross train NORC sites in best practices such as cost effective program development and implementation and evaluation tools and techniques.

Cost effective preventive health and social services were brought to each site through collaborative relationships with community partners and volunteer resources. Outcomes anticipated were: 1) increased awareness of healthy and cost-effective nutrition; 2) improved health indicators; 3) increased social connection; 4) increased satisfaction of resident advisory group members and staff with their leadership roles; and 5) new knowledge regarding the experience of cross-training and implementing an evidence based walking program at three NORC site.

The project expands on a menu of specific supportive services in apartment buildings at three sites - Malden, Brookline and Framingham, Massachusetts - where 500 low-income well to extremely frail elderly reside. It builds on the experience of Aging Well at Home programs in

Malden and Brookline where each site has its own unique character responsive to the cultural (e.g. Chinese, Russian) mix of residents and the overall community environment. The populations include some active, older adults who are leaders and volunteers within their building and often the larger community and some older adults who are more frail and socially isolated. The majority of residents are low-income women in their 80s and 90s with one or more chronic illnesses. The program also serves some younger residents who are disabled. In Framingham, the average age of the residents at the Healthy Partners NORC is 82 and each person is living with at least one chronic illness.

The focus of this project was on active collaboration between the three sites to stimulate new ideas for reaching out to and involving residents. In particular, the goal was to increase participation in health and wellness activities beyond a core group of residents. It is known from experience that the appeal of specific types of physical and social activity varies dramatically from NORC to NORC. It can take weeks or even months of regular contact to persuade some NORC residents (especially the least active) to participate in any activity. Whereas previously each site had its own goals, objectives and activities, this project created an initiative – Steps for Life – across all sites. Though activities and recruitment techniques for Steps for Life would be site-specific, the project strove to foster shared language, outcomes and measures across sites.

Though activities and recruitment techniques were home-grown, the collaborative model – Steps for Life which was resident named - stimulated new ideas across sites for boosting physical activity and social connection. Each site's implementation pace and strategies varied but the project focused on residents and staff sharing techniques and experiences within and across sites. A nutrition awareness and education program - Food $ense - produced replicable fact sheets and recipes as well as a pre/post survey measuring knowledge of facts, awareness and use of information. A resident survey was developed to capture data at two points (baseline and 12 months) on health status, social and physical activity, satisfaction with life, and chronic health concerns. Residents at all sites contributed to the development (e.g. content, format/design, distribution) of a user friendly publication - Easy Steps for Your Everyday Health - of simple exercises that can easily be incorporated into one's life.

This project goes beyond "if you've seen one NORC, you've seen one NORC" and demonstrates the value of cross-pollination in sparking energy and interest in helping create new approaches to enhancing the experience of aging in community. New funding sources will allow successful aspects of the project to continue.

Grant Number: 90MA0010
Project Title: 2009 Congressional Mandates: Non-NORC
Project Period: 08/01/2009 - 07/31/2010

Grantee:
Jewish Federation of Metropolitan Detroit
6735 Telegraph Road
Bloomfield Hills, MI 48301-3141

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AoA Project Officer: Greg Link

Fiscal Year	Funding Amount
FY2010	$
FY2009	$238,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$238,000

Project Summary:

The Family Caregiver Access Network (FCAN) is a non-sectarian project of the Jewish Federation of Metropolitan Detroit (JFMD) and its constituent agencies. Jewish Family Service, a JFMD Constituent agency, is the lead agency partnering with the Brown Jewish Community Adult Dare Care Program and in collaboration with other organizations, to support family caregivers of older adults in their caregiving roles.

FCAN's goal is to reduce caregiver burden, thereby improving the lives of caregivers and those for whom they are caring and reduce premature institutionalization. The objectives of this grant were: 1) to address barriers that lead to underutilization of caregiving support services; 2) increase caregiver self-identification; 3) connect caregivers with needed resources and services; 4) implement a more seamless and coordinated service delivery system of local agencies and supports; 5) improve the lives of care recipients as their caregivers experience reduced stress, and receive services and supports; 6) diminish early or avoidable institutionalization of care recipients; and 7) develop a replicable model that can be shared with other eldercare agencies.

The expected outcomes of the project were that family caregivers would experience reduced burden and stress levels, feel healthier, feel more supported in their caregiving roles and feel that they are more able and more likely to continue in those roles. Pre and post tests measured caregiver burden and statistics were kept on institutionalization rates.

Implementation of the project included convening a series of workshops for family caregivers and professionals to identify and discuss challenges to maintaining frail older adults in their homes covering such topics as elder law issues, planning for long term care, reducing falls,

and caregiver basics and medication management. Support groups were formed and held monthly at two sites – the Dorothy and Peter Brown Jewish Community Center and Jewish Senor Life and Jewish Vocational Service. A total of 115 persons attended these groups during the project year.

Support services provided during the project included transportation, case management and home care. During the year 76 families received assessment of their caregiving needs and onlgoing coordination of services. Nearly 1,000 hours of personal care, respite care and/or homemaker services was delivered.

To assess the effectiveness of the program, the project created a caregiver survey based on a tool devleoped by the Federations of North America. It assesses caregiver stress at the beginning of the program and when service is provided. A survey response rate of 65% was achieved from caregivers. The majority reported that their health remained the same or improved during the period of assistance and that nearly all favored the assistance given which lead to the conclusion that the program was achieving its goal.

Through the Michigan Department of Community Health and Michigan Office of Services to the Aging, the FCAN Coordinator begame a leader in the six week long evidence based program, Personal Action Toward Health (PATH) and has planned to teach classes for the Jewish Family Service and the Arthritis Foundation of Michigan. A temporary web page was established as a more permanent web page for FCAN was planned with implementation shortly after the end of this project period.

The program achieved much in it first year of operation with the assistance of this one year grant. It established an infrastructure to help family caregivers, hired staff, modified procedures and materials used in other programs, addressed barriers to other caregiver programs and what resources exist that could be incorporated, identified families needing support and initiated services. FCAN will continue to seek as its goal a seamless service delivery system to support caregivers keeping their loved ones at home and independent as possible.

Program: Congressional Identified Projects

Grant Number: 90AM3189
Project Title: Naturally Occurring Retirement Communities – Nurturing Our Retired Citizens
Project Period: 08/01/2009 - 12/31/2010

Grantee:
Jewish Family and Children's Service of Minneapolis
13100 Wayzata Boulevard Suite 400
Minnetonka, MN 55305

Contact:
Mari Forbush
Tel. (952) 542-4812
mforbush@jfcsmpls.org

AoA Project Officer: Greg Case

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$191,593
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$191,593

Project Summary:

Jewish Family and Children's Service of Minneapolis used this grant to continue development and refinement of its model aging in community service support program in suburban St. Louis Park and Hopkins, adjacent to the City of Minneapolis, Minnisota. The program goal is to enable older adults to stay in their homes and community for as long as they can, with the support they need to be healthy, safe and engaged. The vision is to create a replicable, sustainable environment that nurtures healthy aging and inspires residents of all ages to work toward this goal. Objectives were: 1) to educate seniors and their families, especially caregivers, about available resources and access to them; 2) to reduce senior isolation by creating interventions for ongoing transportation issues; and 3) to work with diverse stakeholders (government officials, service providers, and seniors) to plan for sustainability of successful programs piloted through the NORC process.

A primary approach to accomplish objectives was to increase training and expand outreach activities of congregational nurses serving churches and synagogues in the two targeted cities. Anticipated outcomes were: 1) increased knowledge of and access to services by seniors, caregivers, and other community members; 2) reduced transportation challenges and with other activities, 3) reduced isolation of senior residents; and 4) increased support by the cities of Hopkins and St. Louis Park for programs creating sustainable, aging-friendly communities.

Community partners of the on-going program include the Faith Community Nurse Network of the Twin Cities, Sholom Community Alliance, Lenox Community Center, Hopkins Activity

Center, MN Vital Aging Network, Hennepin Co., City of St. Louis Park, Park Nicollet Senior Center, Louis Park, Park Nicollet Senior Center, Louis Park Senior Program, City of Hopkins, the Hopkins Senior Service Providers, Minneapolis Sabes Jewish Community Center, St Louis Part Housing Authority, Minnesota Board on Aging, the Metropolitan Area Agency on Aging Vital Aging Network, and the Minneapolis Jewish Federation.

Two projects were initiated and completed under this grant. "Connecting Generations through Story" uses flash cards which prompt an older person to finish sentences which begin with life changing events and significant milestones in ones life, (e.g. "A defining moment for me was ---"). "Proactive to Stay Alive" is a tool to assist individuals and family supporters to develop a blueprint or plan which identifies desires, strengths, community connections, resources and needs before crises occur.

During this project congregational nurses were trained on use of the University of Wisconsin – Milwaukee T-Care screen which identifies caregivers under stress for referral to caregiver counselors. Other efforts focused on educating seniors on services in their community and working with local fire and police departments to perform home safety assessments in conjunction with the File for Life program (storing medical information in a location with an identifying sticker recognized by emergency personnel).

The project provided support for the planning and coordination of an annual transportation summit held in St. Louis Park. The focus of the summit it to discuss and problem solve issues related to transportation for families and seniors in the local communities; educate the community about transportation options for seniors; and foster networking between transportation service providers on areas for collaboration.

During this project 4 quarterly newsletters were produced and distributed to more than 16,000 households, agencies and businesses in the two communities promoting an active and proactive lifestyle for older adults living independently. In addition to the materials developed for the "Connecting Generations through Story" and "Proactive to Stay Alive" programs, the Jewish Family and Children's Service disseminated a replication guide for communities to develop aging in place programs which is available through their website: http://www.norcmn.org

Program: Congressional Identified Projects

Grant Number: 90AM3013
Project Title: Technology to Enhance Aging in Place at Tiger Place
Project Period: 09/29/2005 – 12/31/2009

Grantee:
University Of Missouri
School of Nursing
310 Jesse Hall
Columbia, MO 65211

Contact:
Marilyn J Rantz
Tel. (573) 882-0258
Email: RantzM@health.missouri.edu

AoA Project Officer: Greg Case

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$
FY2007	$
FY2006	$
FY2005	$979,104
FY2004	$
FY2003	$
Total	$979,104

Project Summary:

This project began as a collaborative effort between the University of Missouri and the Medical Automation Research Center (MARC) at the University of Virginia to test the effectiveness of installation of sensor monitoring systems in the rooms of an independent senior living facility to detect falls and gait deficiencies in residents. In 2007, MARC was disbanded and the School of Nursing at the University of Missouri assumed full responsibility for the project.

Wireless sensor systems were installed in a total of 26 apartments to passively monitor 27 resident volunteers living in TigerPlace, an independent senior living facility located near the campus of the University of Missouri and managed cooperatively by the Sinclair School of Nursing and Americare, a senior living company which manages senior living communities in four Midwestern states. The sensor systems included a comfortable bed sensor that detects high, normal, or low pulse and respiration, and higher, high, normal or low restlessness while in bed; motion sensors throughout the apartment to detect activity; stove sensor for detecting unsafe use of stove; and in some apartments bed sensors in recliner chairs to detect restlessness, pulse and respiration while resting in recliner chairs (often used by older people with health problems rather than sleeping in bed). The sensor system reliable captured motion and bed sensor data which through a web-based interface displays data for health care providers, residents and their families.

Project objectives were to: 1) install, implement, and develop an integrated monitoring system that reliable captures data about elder residents and their environment in a

noninvasive manner which balances the needs of health safety, and privacy; 2) collect and interpret sensor data in TigerPlace, demonstrating the possibilities for expanding such technology to other elder settings; 3) describe supportive health care services needed to maximize benefits of the integrated monitoring system; 4) evaluate usability of the technology and investigate fundamental issues in human-computer interaction for older adults; and 5) evaluate usability of videophone technology to increase and enhance communication between residents their family members encouraging family involvement.

Because the fall and gait sensors developed by the University of Virginia MARC lab did not function as projected at TigerPlace, the University of Missouri research team pursued other options for fall and gait detection. These options included a silhouette method of observing for falls that assures privacy. The team worked on an option using sound vibrations, not in the voice range so that privacy is maintained, and other ideas to develop fall and gait sensors that can be passively (not requiring residents to wear something or activate a device). Additional grant funding was received from the National Science Foundation to perfect the silhouette method.

Privacy concerns of using vision sensing silhouettes of residents rather than full images are used in the senor system were addressed. Focus groups and interviews indicated that elderly residents accepted the use of silhouette imagery even if they reject cameras. Video cameras tested comparison of the silhouette senor system with others based on video detection. Using inexpensive web cameras falls and potential false alarms were performed by research staff and stunt actors trained to fall in ways representative of typical elderly falls. Commercially available GAITRite and Vicon systems were used for validation. Subjects performed different walking gait patterns in the lab with varying gait patterns to demonstrate walking in an independent senior housing facility. Residents living in that facility acted out scripted scenarios with daily activities including walking, sitting down, standing up, and reaching into a cabinet, while web cameras collected data. Agreement between the GAITRite, Vicon, and camera system was achieved indicating gait variations and falls can be detected.

An ongoing process of self-assessment, collective knowledge production, and cooperative action in which the residents participated substantively in identification of issues, the design of the evaluation, the collection and analysis of the data, and the action taken as a result of the evaluation finding was conducted. Interviews were conducted with all participating residents which addressed overall perceptions of the sensor technologies and allowed residents to report any problems or concerns, whether the technology interferes with daily activities, whether the resident thinks of the technology or whether visitors have noticed the sensors. Residents expressed positive perceptions of the sensor technologies and with few exceptions did not feel they interfered with their daily activities. The sensor systems deployed during the AOA grant will be sustained in the apartments of residents at TigerPlace. In addition, the website developed and refined to display the sensor data will be maintained and used to enhance the health care of residents of TigerPlace.

Program: Congressional Identified Projects

Grant Number: **90AM3200**
Project Title: **Las Vegas Senior Lifeline Program**
Project Period: **08/01/2008 - 06/30/2010**

Grantee:
Jewish Federation of Las Vegas
2317 Renaissance Drive
Las Vegas , NV 89119

Contact:
Jackie Kassower
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jackie@jewishlasvegas.com

AoA Project Officer: Greg Case

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$574,780
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$574,780

Project Summary:

The goal of the Las Vegas Senior Lifeline NORC Supportive Services Project was to better equip low income, frail older adults to age-in-place, maintain a high quality of life and save the government and families the cost of unnecessary institutionalization. The approach was to expand the services for low income, frail seniors and to integrate the psycho-social aspects of care.

The objectives were to: 1) initiate an outreach program to connect seniors and their families to available services in the community; 2) provide case management services to link seniors to a variety of services, and follow-up to assure that needed services are being provided; 3) utilize our senior adult center for congregate meals, socialization, recreation, educational and informational classes; 4) establish a "cooling center" at the senior adult center where seniors may go to enjoy air-conditioned comfort during the intense summer heat in order to prevent hyperthermia; 5) provide a nutritional support program, including a congregate meal program and a Kosher Meals on Wheels program for those seniors who follow the dietary laws of Kashrut; 6) provide transportation support for seniors to attend congregate meals, cooling center days, medical appointments, and grocery shopping; 7) provide a home modification and safety program to the living environment to increase ease of use, safety, security and independence of older adults; 8) provide a prescription assistance program that provides assistance with medication costs, co-payments, and supplies to frail, low-income seniors; 9) provide home care services to older adults with medical conditions who require assistance with housecleaning, laundry, and meal preparation.

Expected outcomes of the Las Vegas Senior Lifeline project were increased awareness and utilization of home and community-based services and reduction in institutional placement.

During the period of the project considerable effort was given to outreach activities with community and faith based organizations, individuals, local congregate senior facilities and community centers and local libraries. Where referrals could not be made, these services were provided case Management Services to 409 seniors; homemaking services of 5,214 hours to 212 seniors; prescription assistance to 302 seniors and 11,140 prescriptions filled; 2403 Congregate Meals to 130 clients; 2,059 round trips on transportation to shopping, medical appointments and the Goldberg Senior Center for 143 clients; 84 clients with wheelchair ramps, grab bars and other durable medical equipment; 470 meals to 54 clients through the Kosher Meals on Wheels program. As a result of these services, 95% of Las Vegas Senior Lifeline clients were able to remain living independently in their own homes. This was at an average cost of $2000 per year per client as opposed to the cost of $60,000 to $70,000 per year in nursing home care.

Las Vegas continues to have a growing senior population and the infrastructure is increasingly challenged with the growing demand for services. As other agencies experience cutbacks in their dollars allocated for senior needs, the important role that Las Vegas Senior Lifeline plays in the local Las Vegas community continues to grow each and every day. More and more agencies are referring their clients to Las Vegas Senior Lifeline for needed services.

A significant finding continues to be the importance of interagency collaboration. Because of the extensive network of partner agencies that Las Vegas Senior Lifeline has developed during the course of the overall program, the more agencies involved with the aging in place initiative, the more services and additional dollars can be leveraged for the collective mission of serving seniors in need to assist them maintaining their independence. A multiple approach system to elder care for purposes of aging in place seems to succeed exponentially.

The main challenge faced was securing reliable transportation for clients for medical transportation to doctor appointments. However, in working with the Regional Transportation Commission, a partnership was arranged with the Southern Nevada Transportation Coalition (SNTC) to begin transport clients to medical appointments and takeover the transportation for grocery shopping and the senior center.

Through grants from the State of Nevada Division of Aging and Disability Services, the Regional Transportation Commission, the City of Las Vegas, United Way of Southern Nevada and support from the Jewish Federation of Las Vegas the Lifeline Program will continue to provide ongoing services to our clients in the areas of homemaking, transportation, prescription co-pay assistance, congregate meals, home safety modifications and case management services.

Grant Number: 90MA0005
Project Title: Home Companion Programs to Help Keep Low-Income Seniors independent
Project Period: 08/01/2009 - 07/31/2010

Grantee:
Nevada Rural Counties RSVP Program, Inc.
3303 Butti Way - Building 1
Carson City, NV 89701

Contact:
Janice Ayres
Tel. (775) 687-4494
Email: branded@rsvp.carson-city.nv.us

AoA Project Officer: Richard Nicholls

Fiscal Year	Funding Amount
FY2010	$
FY2009	$95,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$95,000

Project Summary:

The RSVP Home Companion Program is an innovative volunteer program to deliver a comprehensive support system, whose goal is to assist low-income and homebound seniors so that they can remain independent and in their own homes, preventing premature institutionalization.

The objectives of this project were to: 1) provide basic everyday needs services including social companionship, help with correspondence, transportation to medical, dental and vision appointments, prescription pick-up, grocery shopping, provision of respite care to full-time caregivers, and help with monitoring assistive technology to which the senior may have access such as Lifeline, and the RSVP program that provides security for seniors living alone with an emergency telephone system; 2) recruit and train volunteers to provide these services; 3) inform the communities in which we serve that this free program is available and explain how it benefits low-income seniors and the community as a whole; and 4) collaborate with local senior centers, city and county social service agencies, other area non-profit agencies, the regional United Way organizations and the Nevada Division for Aging Services to help maximize all services for seniors in need.

The anticipated outcomes were that these seniors would remain independent in their own homes where they are happiest and thus healthier, to continue as productive members of their communities, while living out their lives with dignity. The anticipated products from this program were RSVP Field Representative volunteer evaluation reports of client service, Home Companion volunteer training session summaries, website assistance for clients and

volunteers alike, volunteer recruitment advertising, and participation in community service fairs.

The RSVP Home Companion Program volunteers provide basic needs quality help to frail homebound seniors with essential social companionship and interaction; help with correspondence; transportation; medical, dental and vision appointments, respite for family caregivers, telephone reassurance and other services. Volunteers are trained and given referrals and assistance when necessary by field representatives operating in each county served. The best practices of the RSVP Home Companion Program are shared with other social service non-profit organizations and the Corporation for National and Community Service Senior Corps (CNCSSC) grantees through there listserv and web site. In 2008 CNCSSC modeled its “Independent Living Curriculum” training program after the RSVP Home Companion Program.

The primary outcome sought is that caregivers assisted by RSVP volunteers have reduced stress and thus improved health. Program evaluation is conducted by analysis of volunteer time sheets and activity reports, biannual client surveys, and one-on-one interviews and telephone surveys.

RSVP targets prospective families through a multifaceted outreach program including media announcements with network and cable television outlets, radio stations and newspapers. With this grant it produced a 30 second spot featuring U.S. Senators Harry Reid and John Ensign who appeal for more volunteers to assist caregivers. It has also produced a respite care training video inspired by the experiences and stories collected from participants at a caregiver workshop organized by the Cleveland Clinic Lou Ruvo Center for Brain Health and the University of Nevada at Las Vegas Gerontology Center.

The project recruited 167 new volunteers during the project period and a total of 308 volunteers provided 47,203 hours of service to low income, homebound seniors in rural Nevada counties Barriers continued to be encountered are that some seniors for reasons of pride will refuse help they need. The training program of RSVP is designed to help overcome this resistance. Recruitment of volunteers is also a challenge because many older adults continue to work well past their retirement age which will increase as the baby-boomers are needed to fill the gap in volunteers between themselves and the older generation.

Program: Congressional Identified Projects

Grant Number: **90AM3178**
Project Title: **The Nevada Rural Counties RSVP - Home Companion Program**
Project Period: **08/01/2008 - 07/31/2010**

Grantee:
Nevada Rural Counties RSVP Program, Inc.
3303 Butti Way, Building 1
Carson City, NV 89701

Contact:
Janice Ayres
Tel. (775) 687-4680
branded@rsvp.carson-city.nv.us

AoA Project Officer: Dennis Dudley

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$95,305
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$95,305

Project Summary:

The RSVP Home Companion Program (HCP) is an innovative volunteer program designed to provide a comprehensive support system for seniors. The goal is to assist low-income and homebound seniors to remain independent and in their own homes, and prevent premature institutionalization.

The objectives of this project were to: 1) provide services for basic needs, e.g. social companionship, help with correspondence, transport to medical, dental and vision appointments, prescriptions or grocery pick-up, respite care to caregivers; and monitoring any assistive technology to which a senior may have access, such as Lifeline, an emergency telephone system that provides security for seniors living alone; 2) recruit and train volunteers to provide these services; 3) inform the communities in which we serve that this free program is available, and explain how it benefits low-income seniors and the community as a whole; and 4) collaborate with local senior centers, city and county social service agencies, other area non-profit agencies, regional United Way organizations and the Nevada Division for Aging Services to maximize services for seniors.

The anticipated outcomes were that seniors will remain independent in their own homes, where they are happiest and thus healthier; continue as productive members of their communities; and live their lives with dignity.

RSVP recruited and trained 167 new volunteers for HCP more than doubling those already in service. A total of 308 volunteers provided 47,203 hours of basic need services to low-income, homebound seniors living in Nevada's rural counties allowing them to continue to live independently in their own homes. The HCP Director and RSVP field represenatives met

with community leaders, senior center directors, community partners and church groups to create community awareness of the program and schedule training sessions developed in collaboration with the American Red Cross and Nevada Energy. In a program within a program, 25 volunteers were trained to provide respite for caregivers. Together with 8 other volunteers, they provided 7,731 hours of respite.

Challeges faced inclluded recruting volunteers willing to provide direct services and identifying seniors willing to accept these services. Seniors tend to view acceptance of assistance as an admission of frailty and loss of independence. Rural Nevada presents its own challenges because of the vast distances that must be travelled for many to receive services. The established reputation of RSVP and its community partners went a long way to gain the trust of communities and seniors.

The value HCP is not only the services it provides but its cost effectiveness. The service can be replicated easily and its instrisic value makes it easy to promote and publicize through local media and inclusion in membership bulletins of local organizations. RSVP will continue to pursue federal, state, foundation and local government support to continue the service.

Program products/services will include: RSVP Field Representative evaluation reports of client service; client satisfaction surveys; volunteer training session summaries; website assistance for clients and volunteers; participation in community fairs; and public service volunteer recruitment announcements.

Grant Number: 90AM3191
Project Title: Aging in Place: Meeting the Challenge for Middlesex County, New Jersey NORC-SSP Highland Park
Project Period: 08/01/2008 - 01/31/2010

Grantee:
Jewish Federation of Middlesex County
230 Old Bridge Turnpike
South River , NJ 08882-2000

Contact:
Sara Levine
Tel. (732) 432-7711
Email: SaraL@jfvs.org

AoA Project Officer: Greg Case

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$238,755
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$238,755

Project Summary:

Jewish Family and Vocational Service (JFVS) of Middlesex County, New Jersey conducted a Naturally Occurring Retirement Community (NORC) project in Middlesex County with the goal of maintaining the independence and enchance the quality of life of senior adults residing in the age-integrated neighborhood of Highland Park. The original proposal was to establish programs in four communities (Edison, Meuchen and Older Bridge), however it was quickly discovered that the complexity of the intervention required resources that were unavailable to assure success, thus efforts were focused in the one community. The original objectives were to: 1) assess and identify available resources to meet the needs, interests, desires, preferences, and strengths of senior adults; 2) link senior adults to community resources; 3) expand availability of assessment and case management services; 4) develop linkages between agencies serving senior adults; 5) evaluate project impact; and 6) disseminate program information.

The JFVS-NORC original goals were to offer a client-centered, senior-friendly approach to service delivery with core services including case management and other social work services, healthcare management, educational and socialization programs, and volunteer opportunities. Ancillary services were to be determined by needs assessments. Expected outcomes for senior adults were that: 1) physical health would be stabilized; 2) psychological well-being would be enhanced; 3) safety would be improved; 4) community engagement increased; and 5) caregivers feel supported.

In general these goals were achieved beginning with an assessment of needs through the collection and analysis of 68 out of 108 questionnaires which indicated the primary needs in Highland Park was transporation and education on aging issues and formation of a Senior

Adult Advisory Council. Engagement of seniors was accomplished by development of a monthly educational series held at the community center with the first being a presentation by the Middlesex County Department of Transportation and followed by presentations by other community organizations and spokespersons on such topics as sleep disorders, relaxation techniques, breast cancer awareness, and poison prevention. Cooking classes were established as an outgrowth of another presenation. An existing caregiver support group was moved to the community center and a number of the same topics presented during monthly sessions.

A local resource directory for seniors was prepared and disseminated through the ocmmunity center, hourse of worlship, and the Highland Park Community Fair as well as through individual contact with seniors. Included were programs and services offered by JFVS including an emergency food pantry, adult social daycare, friendly vistors, Meals on Wheels, Senior Medicare Patrol, vocational/career services, immigration services and mental health counseling. Referrals for local residents were facilitated by an intake coordinator who could direct those in need to formal assesment and case management services.

A Professional Advisory Council assisted the project throughout, including respresentatives from the Middlesex county Department on Aging, Middlesex County Department of Human Services and the United Way of Central Jersey. They were instrumental in assisted development of an evaluation tool to be used as a follow-up questionnaire. Analysis of returned questionnaires found that most particiapations felt activities meaningful and wanted them to continue, however they did feel the project's services had enhance their connectedness to the community and other seniors.

Challenges included gaining the confidence of the Highland Park Department of Aging who initially saw the project as competition for resources and serivces, but by the end of the project agreement that no new programming would be created to duplicate existing activities and continual dialogue on aging in place issues between the organizations solidified their relationship. A second challenge was trying to gain approval of apartment managers to open their doors to senior residences. This challenge was not overcome and meetings were ocnducted at houses of worship and the community center.

Among the lesson learned was that residents are accustomed to selecting services based upon their place of residence but in a greater community which if parts are not included in the program creates frustration and sometime anger of other residents within that natural community. Another is that NORC models need to provide services in accessible community sites and should capitalize on existing senoir centers and other community centers as the natural meeting place for senior adults.

Program: Congressional Identified Projects

Grant Number: 90MA0001
Project Title: Yorktown Senior Center – Wellness through Active Living
Project Period: 08/01/2009 - 07/31/2010

Grantee:
Town of Yorktown, NY
363 Underhill Avenue
Yorktown Heights, NY 10598

Contact:
Lorraine DeSisto
Tel. (914) 962-6565 x. 327
Email: ldesisto@yorktownny.org

AoA Project Officer: Danielle Nelson

Fiscal Year	Funding Amount
FY2010	$
FY2009	$333,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$333,000

Project Summary:

The project goal was to provide comprehensive programs and services to enhance the dignity and promote the independence of adults 50 years and older. The basic approach was to expand services at the Yorktown Senior Center and integrate bio-psycho-social activities and care to serve existing clients as well as "new" older adults. As a result, the enhanced center provides an environment conducive to the development of a social support system reducing loneliness and depression and enhancing life satisfaction. Outreach specialists deliver information and programs for individuals that will enable them to explore new possibilities, connect with peers, and discover pathways to significant service. A health promotion program helps older adults to cultivate healthy attitudes and behaviors.

The original objectives of this project were as follows: 1) to respond to the needs and interests of Yorktown's diverse community, 2) to increase older adults' opportunities for socialization and education, and 3) to promote healthier lifestyles. The expected outcomes were that senior center participants would maintain a healthier lifestyle through active living.

The project supported programs in health and wellness, nutrition, and physical activity. It arranged classes and programs with Westchester County, the Hudson Valley Hospital Center, Support Connection, Elderserve and the John C. Hart Library. Center participants organized a weekly dinner out program at local restaurants with flyers distributed where seniors visited and lived including the senior center, senior housing and the library.

Before activities were offered, a survey was given to community seniors which resulted in some surprising results that impacted how services were expanded. Over 50% of the respondents requested computer lessons rather than play Bingo and other activities sterotypically typical of older senior centers. A senior adviosory board was created by the

Town which continues to meet twice a month to make and follow up on recommendations for changes in the center. While not all of the planned activities were initiated during the grant period due to unforseen delays, the Town plans to have all implimented within a year of the project conclusions, including installation of computers in a dedicated room for users and adding volunteer instructors. The Town has also pledged to hire a full time professional to teach senior programs.

A full time social worker was hired by the town to both carry out this project and make home visits expecially to persons living in senior housing faclities. As a result of her visits a new collaboration of community organizations including the center developed a program for senior caregivers.

Publicity about the project included a print and on-line newsletter, newspaper articles and publicity on the Town's website. The increased interest in the community helped create a sustainable partnership of the senior center with other community organizations including the hospital, library and other senior agencies. The generation of interest resulted in over 2,000 signatures of support for the Town to revitalize the center and a pledge to continue support for its expanded sponsored activities conducted both in the center and collaboratively with community partners.

Grant Number: 90AM3176
Project Title: C.L.A.S.P.- Caregiver Linkages Assessment & Support Program
Project Period: 08/01/2008 - 06/30/2010

Grantee:
Durham-Chapel Hill Jewish Federation
3622 Lyckan Parkway, Suite 6002
Durham, NC 27707

Contact:
Debbie Zoller
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dzoller@shalomdch.org

AoA Project Officer: Greg Link

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$123,799
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$123,799

Project Summary:

The Durham-Chapel Hill Jewish Federation conducted a pilot project called Caregiver Linkages Assessment and Support Program (CLASP) to provide support for family caregivers through an innovative, personalized, community-based caregiver assessment and consultation services. The goal of the project was to improve the health and well-being of family caregivers and increase their ability to sustain their efforts in positive ways.

Project objectives included: 1) reaching out to individuals who are new caregivers or not previously identified as family caregivers; 2) providing personalized assessment services to evaluate the needs and strengths of each caregiver; 3) serving as a resource for professionals in the community looking to refer and link caregivers with appropriate services and resources; 4) evaluating the impact of personalized caregiver consultation services; and 5) seeking funding to ensure project sustainability.

Anticipated outcomes were increased caregiver self-reporting of empowerment; decreased levels of stress, anxiety and burden; and physicians and healthcare providers will use and report satisfaction with the CLASP service.

A Project Manager was hired to research existing resources in the community and to develop and implement program components. This research identified two existing family caregiver support programs in the immediate area: 1) Duke Family Support Program; and 2) Orange County Department on Aging. Both groups provide caregiver support services, with a focus on caregivers of loved ones living with Alzheimer's or other dementia. A partnership was established with both organizations, and the professionals in charge of these services served on the CLASP advisory board made up of professionals in the fields of social work, health

care, and research to assist in program development. It recommended that CLASP focus on individual assessments, education and resource referral.

Despite partnerships with the above organizations and the work of the CLASP Advisory Board, CLASP did not reach as large an audience of individual unpaid family caregivers as initially expected. CLASP expanded its focus from that of individual services and was highly successful in reaching groups of caregivers through educational screenings, workshops, and other events, as well as participating as a conference exhibitor.

Caregivers reported that individual assessments were not popular or desired; many caregivers resisted being formally "assessed" with a screening tool and resisted the label, "caregiver". An additional problem was that caregiver assessments often identify problems for which there are no solutions or services, such as the need for finances to pay for alternative living arrangements. Most family caregivers contacting CLASP were in need of two primary resources: money and time. Caregivers were looking for funds to: 1) provide physical assistance with the care of their family member; 2) help offset or outright pay for assisted living arrangements for their family member; and 3) pay for an adult day care facility or an aide to sit with their family member. As part of the evolution of CLASP and the program's attempt to better meet the needs of caregivers, the Program Manager underwent training to become an Integrative Health Coach to provide "Caregiver Coaching" services for free to unpaid family caregivers (Duke Integrative Medicine, Professional Integrative Health Coaching Training Program). Caregiver Coaching services were offered beginning June, 2010.

CLASP's greatest success was in group work and community programs, such as the screening of The Alzheimer's Project; Powerful Tools for Living course; Chronic Disease Management course, and an ongoing "daughter's" support group. In addition, a partnership is being formalized with Guiding Lights, a newly formed, private non-profit organization that will serve family and professional caregivers through a comprehensive support center. Guiding Lights is opening its first Caregiver Support Center in Raleigh, NC, in October, 2010. and a Durham satellite center to be housed in the new Federation building (the Jewish Community Center) beginning in June, 2011.

This grant allowed Jewish Family Services of the Durham-Chapel Hill Jewish Federation to develop and implement a support program for unpaid family caregivers. Jewish Family Services has adapted the program to fill the gap in caregiver support services and provide new, innovative programming, such as Caregiver Coaching and community programs. Caregiver support is now integrated into the comprehensive services provided by Jewish Family Services for caregivers in the Durham-Chapel Hill region regardless of faith, race, or socioeconomic status.

Product from this project were a final report, evaluation results, articles for publication, abstracts for national conferences, and a web site.

Grant Number: **90MA0023**
Project Title: **Jewish Family and Childrens Naturally Occuring Retirement Community (NORC) Project**
Project Period: **08/01/2009 - 09/30/2010**

Grantee:
Jewish Family and Childrens Services of Portland
Lifeline Program
1130 SW Morrison, Suite 316
Portland, OR 97205

Contact:
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AoA project Officer: Greg Case

Fiscal year	Funding Amount
FY2010	$
FY2009	$95,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$95,000

Project Summary:

The Jewish Family and Childrens Services of Portland (JFCS) Naturally Occurring Retirement Community (NORC) project supported and enabled isolated seniors in the North Portland neighborhoods of Overlook, Peninsula park, Piedmont, University Park, Arbor Lodge, Portsmouth, and Kenton, to successfully "age in place" by providing a comprehensive system of innovations to participating seniors.

Project objectives were to: 1) decrease isolation among participating seniors; 2) increase senior service coordination, resource development and dissemination; and 3) support the independence and ability of seniors to "age in place." The intended outcomes were: 1) that seniors will report increased participation of activities outside the home; increase friendships/relationships, have less isolation, and an increase in quality of life; 2) that participating seniors will report an awareness of and access to senior resources and services, and increase in the number of services available to seniors to help them age in place; 3) there wouuld be an increase in opportunities for seniors to improve their overall health and well being; 4) improvement would occur in communication and collaboration among service providers; and 5) seniors wouldl report an increase in their successful utilization of resources and services and increase in overall independence, health and well being.

The NORC program attracts seniors interested in participating in social, recreational, and educational activities and events that promote healthy living and decrease isolation. Activities include chair yoga, movies and a reading group. JFCS connected NORC participants with the agency's homemakers services program and to its skilled volunteer

program. An eight member advisory group gathered seniors input, helped guide services, and evaluate the program's achievements.

Two survey activities were conducted during the project outcomes. The first was a survey of seniors after they participated in an ongoing activity or one-time event. The second was an annual survey. During this project, 35 events were conducted attracting 242 participants (78 unduplicated). Both surveys showed a high percentage of participants satisfied with the program.

The program's success was demonatrated by the partnerships developed, including a local church that serves as a satellite office, a senior apartment complex with multipurpose space, a children's center, a community center and hother human service providers. These partnership allowed the Program Coordinator to conduct meetings, operate collaborative activities and projects, recruit participants, disseminate information and make reciprocal referrals.

JFCS found that seniors appreciate low-cost, interactive activities that gave them opportunities to socialize and that service delivery is most effective and efficient when offered through a community hub. It is integrating the NORC model info its existing Lifeline services to empower seniors to age in place and in its exploration of the Village model for future programming. Lifeline includes homemaker services, counseling, case management, information and referral, and emergency aid for older adults and their families.

Grant Number: 90MA0013
Project Title: Reducing the Risk of Serious Falls Among the Nation's Elderly
Project Period: 08/01/2009 - 07/31/2010

Grantee:
Cedar Crest College
Nursing
100 College Drive
Allentown, PA 18104

Contact:
Lisa A. Lacko
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lalacko@cedarcrest.edu

AoA Project Officer: Sherri Clark

Fiscal Year	Funding Amount
FY2010	$
FY2009	$95,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$95,000

Project Summary:

Cedar Crest College developed, implemented, and evaluated a one-year project, entitled Reducing the Risk of Serious Falls among the Nation's Elderly. The goal of this assessment and intervention project was to reduce the risk of serious falls and, thus, the number of hospitalizations that result from them across the nation. The proposed approach used baccalaureate and master's level nursing students to conduct the program, under the supervision of nursing faculty.

The objectives were to: 1) conduct individualized client and environmental risk assessments in a community-dwelling elderly population in the Lehigh Valley region of Pennsylvania; 2) implement both individualized and exercise interventions designed to prevent falls; 3) evaluate and measure the results; and 4) incorporate the study into the Cedar Crest College baccalaureate and masters in nursing curricula to sustain the project. The expected outcomes of this project were that participants would remain in independent housing for longer periods of time as a result of reduced falls and injuries; Medicaid costs for hospitalizations related to falls would be reduced; and future nurses will be educated to recognize risk factors and design appropriate interventions.

This model fall-prevention project was incorporated into the curricula and served as an alternative geriatric clinical experience for the students. Seventy-seven undergraduate nursing students, as part of this geriatric curriculum, received a specific educational program that focused on the seriousness of falls in the elderly, and highlighted the importance of fall prevention strategies and key assessment parameters. Following the educational session, the students completed 82 comprehensive fall assessments, in three different independent

senior housing centers, as part of their clinical requirements for this course. These assessments were completed prior to and at the completion of the exercise intervention.

The sites for the program were chosen in coordination with the local Area Agency on Aging and a large local Senior Center. The community-dwelling elders were asked to participate in one of three seven-week exercise programs. The three exercise programs consisted of Yoga, Tai Chi, or Gait and Balance training classes. The Yoga and Tai Chi classes were offered by exercise specialists from the local Senior Center and the Gait and Balance class was taught by a licensed physical therapist. Prior to starting the exercise classes, informed consents were collected from the participants for the collection of sociodemographic and medical information, balance measurement and self-reported fear of falling measures. In addition, a signed waiver from the certified instructor for suitability to participate was also collected

Data were collected over an 8-week period and 48 community-dwelling elders participated in the three different exercise programs. In addition, 47 students attended at least one exercise class with the participants. Measures of gait and balance were collected using the Tinetti Balance and Gait Evaluation instrument and self reported fear of falling was measured by the Tinetti's Falls Efficacy Scale (FES). The students' perception of the elderly was measured by the Kogan's Attitudes Toward Old People Scale (KOP) and was completed prior to and after participating in this alternative geriatric clinical experience. Preliminary analysis has revealed positive outcomes in both student and participant responses. Participants reported that they have enjoyed spending time with the students, were eager to par take in the exercise programs and appear to have improved in both the balance and gait measures as well as in the fear of falling scores. Additional interviews, which were conducted by the students, revealed that the participants felt that the program was a positive experience and that they were very grateful for the opportunity to participate in the program.

The project demonstrated that nursing students are eager and capable of completing comprehensive fall assessments. The program could be enhanced by an additional clinical experience whereby students have the opportunity to share their individualized plans with the participants prior to evaluation. The program also highlights the benefits of regular exercise and the intergenerational interaction appears to have enhanced participation. The program can be easily replicated and is ongoing within the Cedar Crest College Nursing curriculum within several other nursing courses.

The products from this project were a final report, including evaluation results; a redesigned baccalaureate and master's in nursing geriatric curriculum; and articles for publication and presentation at local and national nursing conferences.

Program: Congressional Identified Projects

Grant Number: 90AM3193
Project Title: Integrated Service Delivery for Closed Naturally Occuring Retirement Community (NORC) Model In Pennsylvania , Delaware and Montgomery County
Project Period: 08/01/2008 - 07/31/2010

Grantee:
Jewish Family and Children's Service of Greater Philadelphia
Senior Services
2100 Arch Street 5th Floor
Philadelphia, PA 19103-1300

Contact:
Karen E. Reever
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kreever@jfcsphilly.org

AoA Project Officer: Greg Case

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$85,480
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$85,480

Project Summary:

Jewish Family and Children's Service of Greater Philadelphia (JFCS) developed Naturally Occurring Retirement Community (NORC) programming in two suburban neighborhoods outside Philadelphia: Elkins Park in eastern Montgomery County; and Wynnefield, adjoining Wynnefield Heights, which straddles the border between Montgomery County and the City of Philadelphia. The project goal was to provide an avenue for seniors to access information, build networks within their communities, and successfully age in place safely and with dignity. This involved identification of and engagement with "at risk" elderly. A partner in this effort is the Albert Einstein Health Network .

The objectives were: 1) engage additional site locations to establish NORC supportive services; 2) establish advisory committees unique to the NORC site chaired by the community seniors; 3) provide ongoing programming within the seniors' community, which promotes wellness, prevention, socialization; and 4) provide access to a professional who can serve as a safety-net and link the individual with services and benefits that exist in the community at large. Expected outcomes included: 1) development of two new NORC locations; 2) decreased isolation among NORC residents/participants; and 3) development of collaborative relationships with community partners to promote sustainability.

Over the two year grant period, JFCS exceeded one of its three anticipated outcomes by developing new NORC support programs in four locations. Three NORC support programs were started in high-rise apartment/condo buildings in the Eastern corridor of Montgomery

County including Elkins Park House, The Plaza, and The Towers at Wyncote. The fourth neighborhood NORC support program was started this past year in a community defined by three zip codes in west Philadelphia and neighboring Montgomery County.

The NORC support programs in the three buildings provided ongoing access to a social worker and monthly group luncheon presentation on health and wellness topics. The neighborhood NORC, known as Senior Resource Link, provided phone access to a social worker, cab vouchers for needed transportation, minor home repair, quarterly group luncheon presentations on health and wellness, and a quarterly newsletter. In total, 450 older adults participated in some aspect of these NORC support programs. On average 80 percent of participates surveyed reported satisfaction with the program, decreased isolation, and improved safety and social support.

The three high rise buildings, selected because of their high proportion of older residents, worked with JFCS to explore adding a NORC support program. The Towers at Wyncote decided, after creating a community advisory group, holding several group events and completing a survey of residents' needs and interests; that the management and resident council could respond to its older residents without the help and expense of outside partners. The Plaza and Elkins Park House reached similar conclusions after longer periods of working with JFCS, one year and two years respectively, to more fully develop a NORC support program. The later two buildings defined their experience as "graduating" from the NORC support program started by JFCS. JFCS continues to provide assistance to the individual residents of these buildings when they need assistance with support to live at home.

At the conclusion of the grant period, Senior Resource Link continues with a robust group of 20 partners from agencies, civic groups, businesses, faith-based groups, and older adults who are committed to creating an aging-friendly community. Senior Resource Link has added a volunteer exchange program, spearheaded by a group of older residents, which encourages neighbor to help neighbor. It is the unique combination of committed community partners that is the source this neighborhood NORC's successful beginning. The future of Senior Resource Link hinges on the ability of its partners to grow in their contribution of time and resources toward its common vision of an aging-friendly community.

Program: Congressional Identified Projects

Grant Number: **90MA0024**
Project Title: **Non-NORC Congressional Mandate**
Project Period: **08/01/2009 - 08/01/2010**

Grantee:
Utah State Division of Aging
120 North 200 West, # 325
Salt Lake City, Ut 84103

Contact:
Darren Hotton
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Email: dhotton@utah.gov

AoA Project Officer: Richard Nicholls

Fiscal Year	Funding Amount
FY2010	$
FY2009	$95,000
FY2008	$
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$95,000

Project Summary:

The Utah Division of Aging and Adult Services (DAAS) used this grant to enhance and expand the State's Senior Health Insurance Information Program (SHIP) to provide additional SHIP trained temporary staff, expanded ethnic outreach, placement of proper computer technology, and additional SHIP staff training. DAAS has been the host to SHIP for the last sixteen years. Utah SHIP program is a national program that offers one-on-one counseling and assistance to people with Medicare, caregivers and their families. Utah SHIP provides free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities.

Objectives were: 1) provide temporary trained staff to local AAA SHIP staff; 2) provide statewide ethnic outreach and education through expanded collaborations with statewide, regional and community organizations; 3) increase the number of computers available to seniors in rural senior centers; and 4) opportunity for local AAA SHIP coordinators to receive expanded training. Anticipated outcomes were: 1) educate Medicare beneficiaries, their families and caregivers to become knowledgeable, responsible consumers; 2) empower Medicare beneficiaries, their families and caregivers to take an active role in their healthcare; and 3) empower local AAA SHIP contracts to be the Medicare experts in their area (SHIP services branding).

The Utah SHIP program provided temporary staff at five out of the 12 local Area Agencies on Aging (AAAs) SHIP programs (Salt Lake County, Bear River, Six County, Five County, and Uintah Basin). The original grant proposed 6 AAAs. The remaining AAAs either did not want to participate in the grant (expanded work) or were not eligible for the grant opportunity. Over the last two years, budget cuts have affected each of the local AAAs. The local AAA SHIP

staffs were assigned other AAA duties on top of their regular SHIP functions. When the grant opportunity was presented to them only a few welcomed the extra money. Some AAAs were regulated by local county government rules which did not allow hiring of a temporary employee or there was a hiring freezes place. Other AAAs did not apply for grant money because they would not have additional county money to continue the temporary employee after the grant money ran out.

Each county government had different rules and procedures to hire temporary staff or the lack of ability to hire temporary staff. By the time the AAA received proper procedures to apply for the grant, the time limit had passed and the awards were sent out. Another factor was county wide hiring freezes. Even though the county wanted to take the money, they were not allowed to hire a temporary staff member. The need was there but the local SHIP program could not accept the money, therefore the Utah SHIP program was able only to give out 5 grant awards for temporary staff.

The measurable outcome for this goal was the increased number of services provided in these respective areas documented in SHIPTALK. SHIPTALK is the Centers for Medicare and Medicaid Services (CMS) tracking system for all SHIP services. The five AAAs have their performance reviewed at their yearly monitor during the spring of 2011 and based on preliminary numbers, services have increased in each area.

At the end of this grant, the temporary staff will be released. All the AAAs stated that if additional county or SHIP money becomes available, they will hire the temporary staff as full or part-time staff members. This type of project is not sustainable, given the temporary nature of the funding. Nevertheless, the impact has was a great success. Temporary staff can focus on the SHIP program and not be distracted by other AAA duties. The new temporary staff is fully dedicated SHIP staff. What the Utah SHIP program is that temporary staff works as a supplement to existing AAA resources.

The Utah SHIP program with conjunction with the Utah Senior Medicare Program (SMP) started an Ethnic Workgroup within DAAS. The workgroup comprised other state agencies and leaders in the African American, Hispanic, Pacific Islanders, and Refugees communities. This workgroup discussed issues related to Medicare education, outreach, and possible way to reach the community. Several outreach events were held. The original grant proposed working with two non-profit ethnic community groups to provide contracted Medicare education and assistance to their respected community. This task of contracting with the proposed groups became a difficult task. Each group targeted were presented with contract opportunities, but both groups either did not return a grant proposal or were not interested. The Utah SHIP program is still working with the ethnic workgroup to find possible community groups for Medicare outreach. Outside of the events, the remaining money was moved to other targeted areas.

Program: Congressional Identified Projects

Grant Number: **90AM3195**
Project Title: **Coming of Age in Northern Virginia**
Project Period: **08/01/2008 - 07/31/2010**

Grantee:
Jewish Social Service Agency
Aging Services
3018 Javier Road
Fairfax, VA 22031

Contact:
Beth Shapiro
(301) 991-3700
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AoA Project Officer: Greg Case

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$143,449
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$143,449

Project Summary:

Jewish Social Service of Fairfax, VA, collaborated with Jewish Council for the Aging, Jewish Community Center of Northern VA, and the Jewish Federation of Greater Washington to create the Coming of Age (COA) program in suburban Fairfax. The goal was to help older residents continue to live independently by reducing risks and increasing access to supportive services and programming. The pilot project built upon current programming; assessing effectiveness of services to date; and assessed the most effective ways to meet needs and interests of additional seniors in Fairfax County. Partner agencies identified unmet or under-met needs in transportation, socialization, information and referral, mental health, and access to services, regardless of ability to pay.

The project was designed to address these needs, with emphasis on service integration by collaborating agencies and others in Fairfax Co. Coming of Age increased the number of sites offering similar programs, allowing more seniors to participate. Project objectives were: 1) offer social, cultural, and recreational activities at additional conveniently located satellite sites, providing transportation to many who would find it difficult or impossible to participate; 2) expand capacity to act as a portal through which fragile seniors and their families can access a variety of social services, i.e. case mgmt., counseling, crisis intervention, LTC planning, support groups, and resource referral; 3) continue to engage seniors by developing a range of services offered at more locations; 4) reach out to active, healthy seniors, as well as those struggling with mild to moderate cognitive difficulties; 5) evaluate the impact of added sites and services; 6) attract new participants; 7) disseminate project information; and 8) evaluate the project model's effectiveness. Expected outcomes were: 1) reduced social

isolation; 2) improved access and information; and 3) increased quality of life. Interim and final reports will include program evaluation and measurable outcomes.

COA was designed to address the risks and potential effects on older adults age 60+ facing isolation in Fairfax County, VA, a suburb of Washington, D.C. Research findings concluded that a significant majority of participants reported COA had created easy access to services, improved participation rates, and provided accessible transportation, and that these activities together led to reduced risk of social isolation.

A collaborative project of four non-profit agencies, COA served hundreds of area residents each month at seven satellite sites throughout the region, providing a proven complement of social, recreational, and educational programs and workshops, resource referrals, counseling, case management, and transportation assistance. COA was a portal for seniors to learn about and access vital social services.

COA reached hundreds of the area's most at risk and underserved seniors. Program service numbers burgeoned to 550--600 seniors per month from the 150 originally projected. It offered safe wheelchair accessible transportation, relevant activities under the guidance of trained facilitators, case management, counseling, and emergency financial assistance.

Products developed included on-site social work groups and recreation programs designed to attract older adults to participate and build new relationships through which access support services could be realized as they were needed. For the broader community COA held workshops, hosted a website, a monthly newsletter, an annual Positive Aging Fair, and brought extensive mental health advocacy to the targeted community. COA supported the Annual Positive Aging Fair, which was comprised of interactive and informative programs promoting active aging through healthy lifestyles. It collaborated with over 40 senior service providers in Northern Virginia to provide over 200 older adults with a variety of workshops and information booths on housing, aging-in-place resources, and other subjects such as fitness, the arts, and entertainment.

The project is continuing after the AoA grant ended, for example In partnership with Arlington County, COA planned a three day Health and Wellness Retreat to be held at the Pearlstone Conference and Retreat Center in Reisterstown, MD in May 2011.

Program: Congressional Identified Projects

Grant Number: **90AM3179**
Project Title: **Active Caregiving**
Project Period: **08/01/2008 - 09/30/2010**

Grantee:
Shenandoah Area Agency on Aging, Inc.
207 Mosby Lane
Front Royal, VA 22630

Contact:
Pamela Dodge
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Email: pamela.dodge@shenandoahaaa.com

AoA Project Officer: Greg Case

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$143,449
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$143,449

Project Summary:

The Shenandoah Area Agency on Aging (SAAA) supported the Active Caregiving (AC) demonstration project entitle “You and Me” in collaboration with students of the Occupational Health Department of Shenandoah University and the Winchester Active Living Center operated by the Winchester Parks and Recreation Department. The goal was to give early support services for Care Partners and their Care Recipients in ways that promote health and ease the stress of 24-hour caregiving for a relative with early to mid-stage Alzheimer's disease.

Project objectives were to: 1) open a part-time social model group respite site, providing a friendly safe place for persons with Alzheimer's disease or related dementia and 10-hours of respite for Care Partners; 2) pilot "You and Me" - a one-day a week program of activities designed for couples dealing with a diagnosis of Alzheimer's disease; 3) offer a nutritional component that includes classes in the preparation of nutritious, appealing meals and "Dinners to Go" for the Care Partner to take home; 4) recognize and reward Care Partners for the sacrifices they make by offering Spa Days to help the caregiver relax, feel pampered and appreciated; 5) evaluate the impact of this new approach; and 6) disseminate project information and insights gained. The expected outcomes of the project were: 1) improved or maintained physical health of both the caregiver and the care recipient; 2) that Care Partners gained knowledge of Alzheimer's disease and demonstrate the use of practical caregiving strategies learned; and 3) couple's relationship is strengthened during the first year after the diagnosis of Alzheimer's disease, and Care Partner assumes an active role, placing importance upon health promoting choices and learning to balance needs with those of the care recipient.

The You and Me program offers interesting information and activities on four areas of “brain health” including good nutrition, physical exercises, mental stimulation, and stress management. Participants receive information about resources and caring support to support them over the changes that occur in stages of Alzheimer’s disease following diagnosis and counseling and support as needed.

The occupational therapy students developed a curriculum component of the program which consisted of a musical “bingo” game, a CD of special music, and an accompanying manual. They also designed a poster which serves as a quick reference demonstrating specific exercise movements to improve health and physical ability for endurance, strength, balance and flexibility.

The program was publicized through distribution of a brochure to Aging Network Groups, Alzheimer’s support groups, hospitals, doctor’s offices, AARP and other health and community organizations; in a program broadcast by a local television station; and in articles published in five local newspapers. Despite all the publicity, a major challenge was to enroll participants. Initially only one couple agreed to participate in the two day a week program. While caregivers were interested in the program, most stated they wanted information immediately and did not want to commit to attending the program at the community center. Given that a major goal of the program was to build a peer support group, low attendance nullified this objective. The project was also challenged by the death of a staff member and leave of absence of another for surgery. A no-cost extension of the grant was requested to complete the project.

Program: Congressional Identified Projects

Grant Number: **90AM3183**
Project Title: **Education and Enforcement against Elder Financial Exploitation**
Project Period: **08/01/2008 - 07/31/2010**

Grantee:
Coalition of Wisconsin Aging Groups
Legal Services
2850 Dairy Drive, Suite 100
Madison, WI 53718-6742

Contact:
John Hendrick
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Email: jhendrick@cwag.org

AoA Project Officer: Stephanie Whittier-Eliason

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$162,117
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$162,117

Project Summary:

The grantee, the Coalition of Wisconsin Aging Groups, provided presentations and publications to prevent elder financial exploitation before it occurs and to increase reporting and prosecution of elder financial exploitation after it occurs. The goals of the project werer: 1) to prevent and increase the reporting of elder financial exploitation throughout the State of Wisconsin; and 2) increase criminal prosecution of financial crimes against older adults across Wisconsin.

The objectives were: 1) to educate seniors and professionals on preventive measures; 2) to point out warning signs of elder financial exploitation that should trigger a report to the elder-adult-at-risk agency in each county; 3) work with banks and other financial institutions to protect the assets of their customers and to increase reports from financial institutions to elder-adult-at-risk agencies; 4) train law enforcement and prosecutors in which criminal statutes apply to financial exploitation of older adults; and 5) promote cooperation and investigative techniques that can lead to successful prosecutions. The anticipated outcomes of this project were: 1) increased reports of elder financial exploitation, as measured by the Wisconsin Department of Health and Family Services; 2) increased prosecutions of financial crimes against adults aged 60 and up; and 3) increased number of abuse-reporting MOUs between financial institutions and county elder-adult-at-risk agencies.

The project was facilitated and enhanced by collaborations with some of the grantee's public and private "SeniorSafe" partners including the Wisconsin Departments of Health Services and Department of Justice and the Wisconsin Automated Clearinghouse Association, an association of financial institutions including nearly all banks and credit unions in Wisconsin.

The grantee's public and private partners in SeniorSafe assisted the Coaltion in development of presentations and materials to prevent elderl financial exploitattion and increase criminal prosecution of exploitation after it occurs. Law enforcement officials were included in multidisciplinary training sessions easing the way for elder abuse reports to become police reports and for social workers and police to prepare cases that convince prosecutors. Presenters included current and former prosecutors. The SeniorSafe partnership allowed the grantee to hold a training session for judges which was not originally planned

The greatest challenge to the project was the weather which caused cancellation of a number of presentations during the first six months of the project. The challenge was met by doubling up on some presentations and resceduling others during the second six months and through a no-cost time extension. Another challenge was the need to reduce publication costs of materials. This was met by including materials on the grantee's website and by making publications available through partner organizaitons. The Coaltion gave a presentation on this project at the 2009 National Victim of Crime Conference which stressed as a model its partnership with State government and private organizations.

A significant product of the grant was development of a consumer resource guide which the Coalition will continue to update and use in conjunction with other handout materials developed under the grant which provide warning signs of exploitation and its prevention.

Program: Congressional Identified Projects

Grant Number: **90AM3202**
Project Title: **Nursing Home Transition**
Project Period: **08/01/2008 - 09/30/2010**

Grantee:
Disability Rights Wisconsin, Inc.
131 West Wilson St., Suite 700
Madison, WI 53703

Contact:
Lynn Breedlove
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lynnb@drwi.org

AoA Project Officer: Greg Case

Fiscal Year	Funding Amount
FY2010	$
FY2009	$
FY2008	$148,000
FY2007	$
FY2006	$
FY2005	$
FY2004	$
FY2003	$
Total	$148,000

Project Summary:

Disability Rights Wisconsin (DRW) used this grant to develop a Nursing Home Transition Initiative to respond to the large number of Wisconsin nursing homes which are closing or downsizing. The goal of the project was to ensure that relevant state and federal laws are adhered to and that nursing home and other institution residents move into high quality in-home or community living arrangements of their choice during the current nursing home closing, downsizing and discharge planning process taking place in Wisconsin. The approach included establishing a presence in closing/downsizing facilities, providing clear information to residents, and providing individual advocacy assistance as requested.

Project objectives were: 1) ensure that residents are aware of the availability of DRW assistance; 2) ensure that residents are well informed of their rights and choices; 3) ensure that residents who need discharge planning assistance receive it; and 4) monitor the closing/ downsizing process to ensure that statutory requirements are adhered to. Anticipated outcomes were: 1) the majority of residents wouldl be aware of the availability of DRW assistance; 2) the majority of residents would be informed of their rights and choices; 3) all residents who request DRW advocacy assistance wouldl receive it and consequently their rights and choices will be respected; and 4) nursing homes would comply with all relevant laws in the closing/downsizing process.

During the grant period, DRW established a close relationship with the Wisconsin Department of Health Services (DHS) which resulted in DRW receiving prompt notification of all facility closings or downsizings during the period of the project. A variety of methods were used to inform residents and guardians of DRW's assistance, including speaking at "closing meetings" attended by a substantial number of residents, family members and guardians. In

the closing meetings and in one-on-one interactions with residents, guardians and families, knowledgeable DRW staff explained applicable residents' rights and helped people understand their choices of alternative living situations.

As a result of the above outreach activity, DRW received over 100 inquiries and requests for assistance. For some of these people, DRW provided phone advice, information on rights and choices, referral, etc. However, in over 30 instances, DRW provided intensive advocacy representation over an extended period of time. Most of the individuals in these cases were nursing home residents wanting to live in more integrated settings. There were also some residents of Intermediate Care Facilities and Medicaid Intermediate Care Facilities for the Mentally Retarded (specialized nursing homes for people with developmental disabilities), specialty hospitals, rehabilitation facilities, and psychiatric hospitals. All of this assistance was provided for free. DRW was the primary "watchdog" agency for many of these facility closings, along with the Wisconsin Board on Aging and Long Term Care (BOALTC), the state's LTC ombudsman program. The two agencies were virtually the only agencies drawing the state's attention to violations of Medicaid or Wisconsin's law related to nursing home closings.

A number of challenges were met. State officials were preoccupied with the expansion of Family Care, a new managed long term care program. As a result, they were not investing as much energy in nursing home closings as in previous years. DHS staff members were re-deployed to other activities and did not adequately monitor the closing process. DRW had to take on extra responsibility for holding facilities accountable. The Family Care managed care organizations (MCOs) did not consider it a high priority to assist nursing home residents in the closing process to find suitable alternative living arrangements. This placed an extra burden on DRW and BOALTC in the individual planning process. (This project helped to cover some of the costs of this individual planning assistance.) Some of the facility closings were in remote parts of the state, far from any of DRW's three offices. With the help of this project, DRW was able to make it a priority to assist residents and guardians, wherever they are and traveled to all remote locations as necessary. Finally, during the course of this project DHS decided to discontinue the idea of "closing teams," which previously had provided an effective mechanism for advocates, counties, MCOs, and state officials to monitor progress and team up around each closing. DRW protested this decision by pointing out examples of poorly planned and executed closings in the absence of closing teams and as result closing teams were re-established.

This project has played a crucial role in ensuring that all the facility closings that took place during the project period were generally in compliance with the state's facility closing law, resulted in the large majority of residents moving to more integrated settings, and enabled most residents and guardians to make informed choices re where to live in the future. DRW's successful advocacy to convince DHS to re-establish closing teams for all future facility closings will have a longstanding impact well into the future.

Organization Index

Academic Institutions

American Indian, Alaskan Native and Native Hawaiian Organizations

Area Agencies on Aging

Non Profit State and Local Organizations

State Government Agencies and Units on Aging

Alabama
Department of Senior Services **73**
Arizona
Department of Economic Security **3,56**
Arkansas
Department of Human Services - Aging and Adult Services **39,104,139**
California
Department of Aging **6,18**
Colorado
Department Of Human Services **5**
Connecticut
Department of Social Services **41**
Florida
Department of Elder Affairs **58**
Georgia
Georgia Department of Human Resources **50**
Idaho
Commission on Aging **75**
Department of Health And Welfare **7**
Iowa
Department of Elder Affairs **77**
Kentucky
Cabinet for Health and Family Services –
- Department for Aging and Independent Living **140,141**
Maryland
Department on Aging **79,106**
Massachusetts
Executive Office of Elder Affairs **20,43**
Michigan
Department of Community Health, Offices of Services to the Aging **9,45,81**
Minnesota
Board of Aging **47**
Mississippi
Department of Human Services, Division of Aging **11**
Missouri
Department of Health and Human Serivces **22**
Nebraska
Department of Health and Human Services **108**
Nevada
Department of Health and Human Services **24,83**
Office of the Attorney General **110**

New Hamshire
Department of Health and Human Services **49,85**
New Jersey
Department of Health and Senior Service,
Division of Aging and Community Services **13**
New Mexico
Aging and Long-Term Services Department **26**
New York
New York
Office for the Aging **62**
North Carolina
Department of Insurance **112**
Department of Health and Human Services **64**
North Dakota
Department of Human Services - Aging Services Division **89**
Ohio
Ohio Department of Aging **51,66**
Pennsylvania
Department on Aging **87**
Rhode Island
Department of Elderly Affairs **28**
South Carolina
Lt. Governor's Office on Aging **30**
Tennessee
Commission on Aging and Disability **32**
Utah
Department of Human Services - Division of Aging and Adult Services **34**,**191**
Vermont
Department of Disabilities, Aging and Independent Living **53**
Washington
Department of Social and Health Services - Aging and Disability Services **36**
Wisconsin

National Organizations

California
Asociation Nacional Pro Personas Mayores **117**
District of Columbia
National Caucus and Center on Black Aged, Inc **121**
National Council on Aging **135**
Illinois
Alzheimer’s Association **132**
Massachusetts
Womens’s Institute for a Secure Retirement **129**