SUA Resource Library:

Task Force Materials

Foreword

In 2012, the Administration for Community Living (ACL), an operating division of the US Department of Health and Human Services, began a comprehensive evaluation of its National Family Caregiver Support Program (NFCSP). This was the first comprehensive federal evaluation of the NFCSP, which serves over 800,000 family caregivers annually. The NFCSP evaluation has three broad goals to benefit policy and program decision-making:

1. Collect and analyze information on program processes and site operations;
2. Evaluate program efficiency and cost issues for approaches best suited to specific contexts; and
3. Evaluate effectiveness of the program's contribution to family caregivers in terms of maintaining their health and well-being, improving their caregiving skills, and avoiding or delaying institutional care of the care recipient.

As part of the evaluation survey, State Units on Aging (SUAs) were asked to submit relevant documents if they answered 'yes' to any of the following five questions:

- Do you have a statewide task force, commission or coalition specifically to examine family caregiver issues?
- Have community needs assessments for caregiver support services been conducted?
- Does your state have a standardized caregiver assessment?
- Does your SUA conduct routine programmatic monitoring of the NFCSP program?
- Do you use a uniform caregiver satisfaction survey across all AAAs?

ACL received assessment tools and grouped them into the following categories:

1. Community Assessment Materials
2. General Customer Satisfaction Survey Materials
3. Grandparent Assessment Materials
4. High-Level Administrative Materials
5. Program Monitoring Materials
6. State Caregiver Assessments
7. State Care Recipient Assessments
8. Task Force Materials
9. Uniform Satisfaction Materials
10. Other Materials

While ACL does not specifically endorse these tools, we are sharing them because they may be helpful to other programs. For more information on the NFCSP please go to: http://www.aoa.acl.gov/. For more information on the evaluation of the NFCSP please go to: http://www.aoa.acl.gov/Program_Results/Program_Evaluation.aspx

Task Force Materials

Georgia – Caregiving in Georgia 3

Georgia – Caregiving in Georgia: A Second Report 56

Ohio – Lifespan Respite Strategic Plan 94

Oklahoma – Caregiver Coalition Report 112

Tennessee – State Plan on Aging 2014 - 2018 113

Texas – Report to State Legislature 580

Utah – State Commission on Aging Annual Report 2013-2014 617

Caregiving in Georgia

A State Report from the

Georgia Caregiver Resource Center

Prepared by Dr. Kathy Scott, R.N., C.,
For the Georgia Division of Aging Services

Winter, 2002

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Acknowledgments

The Division of Aging Services would like to thank the following individuals and organizations for their contributions to this report:

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AARP Georgia contributed funds towards the research project and the printing of this report.

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Beverly Littlefield, Section Manager for Program Development and Operations
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Georgia Area Agency on Aging Directors and Staff
These individuals were invaluable in assisting to locate caregivers in their areas to participate in the focus groups.

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Focus Group Participants
Last, but certainly not least, we want to acknowledge and thank the many focus group participants who were willing to share their time and experiences in order to assist others in gaining a better understanding of caregiving for older adults in Georgia.

Individuals whose photographs are included in this report are not actual caregivers interviewed for this research.

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Jim Martin, Commissioner
Maria Greene, Division Director

Georgia Department of Human Resources
Division of Aging Services • Two Peachtree Street, NW • Suite 9.398 • Atlanta, Georgia 30303-3142 • (404) 657-5258

Dear Friend:

Family caregivers play a significant role in maintaining the health and independence of older persons. According to a national study conducted by the National Alliance for Caregiving and AARP, more than one in four U.S. households have been involved in caring for a frail older person in the previous twelve-month period.

Since Georgia has one of the fastest growing elderly population in the United States, the Division of Aging Services (DAS) has been intensifying its efforts to look at where we should go with programs and services for older persons and their caregivers.

We also know that there is an abiding interest in caregiving at both the state and federal levels, and we needed to assure ourselves that our programming addressed the issues and concerns of consumers, not just second-guessed their needs. We decided that we should not substitute our judgment in pre-supposing the concerns of various types of caregivers.

We had some resources, but not a great deal. DAS staff began brainstorming, and approached Dr. Kathy Scott, a consultant to aging programs, about working with us to plan and conduct focus groups around the state so that we could hear directly from a variety of caregivers.

The Division anticipated that this feedback might not always be as complimentary or positive in nature as we would like, but we realized that it would be the basis for the improvement of our service system, rather than a threat to our existence. We were ready to subject ourselves to the same scrutiny as any other partner in the long-term care community.

Our operating principle has been that the truth may hurt sometimes, but can truly be liberating if individuals, organizations, and communities are open to taking some risks and are committed to the continuous improvement of the long term care system. Our goal was, and continues to be, to define issues, so that we can make informed decisions about where we should commit our resources, both fiscal and human, in program development.

We sincerely hope that the findings and recommendations in this report will be valuable to our partners in the aging network, service providers, legislators, and policy makers, as we strive to improve the quality of life for older Georgians and their caregivers.

Sincerely,

Maria Greene

Maria Greene, Director
Division of Aging Services

Serving Older Georgians and Their Families

Preface

The National Family Caregiver Support Program, signed into law by President Bill Clinton in January, 2000, is designed to help families sustain their efforts to care for an older relative who has a chronic illness or disability. The program, which is administered by the Division of Aging Services in partnership with Area Agencies on Aging, includes providing the following five basic components:

1. Information about resources that will help families in their caregiver roles;

2. Assistance to families in locating services from a variety of private and voluntary agencies;

3. Caregiver counseling, training and peer support to help them better cope with the emotional and physical stress of dealing with the disabling effects of a family member's chronic condition;

4. Respite care provided in a home, an adult day care center, or over a weekend in a nursing home or a residential setting such as an assisted living facility; and

5. Limited supplemental services to fill a gap that cannot be filled in any other manner.

The Division of Aging Services and the Georgia Caregiver Resource Center believe that the most effective and efficient programs are those that are designed and implemented with direction and perspective from the persons who will utilize the services. It is the hope of the Division that the information contained within this report, data obtained from Georgia's caregivers, will reach many different audiences and serve as a guide to those persons legislating, funding, designing, implementing, and experiencing programs related to caregiving of older adults.

If the information appears to suggest an urgent or crisis situation in caregiving, then the translation to paper has been successful. Caregiving is a public health issue that demands and deserves attention. This state report is intended to be a step in that direction.

Georgia Caregiver Resource Center

The **Georgia Caregiver Resource Center (GCRC)** was initially funded in 1992 by the Georgia General Assembly, to provide information, services, and training to caregivers throughout the state. A part of the Division of Aging Services, GCRC funding to the aging network has facilitated the development of new day care programs and has provided in-home respite, enabling caregivers a break from their 24-hour-a-day caregiving responsibilities.

In conjunction with an Alzheimer's Demonstration Grant received from the U. S. Administration on Aging (AoA), GCRC funds have been utilized to conduct Alzheimer's education/training events all across Georgia. More than 8,500 family caregivers, health care professionals, clergy, law enforcement personnel, and the general public have learned more about Alzheimer's Disease, coping skills, and available programs and services. These events were sponsored by 12 Area Agencies on Aging and the Division of Aging Services.

GCRC, through the caregiver focus groups described in this report, continues to expand its efforts to assist family and professional caregivers. GCRC's strategic plan is described later in this report.

The Division of Aging Services (DAS) is one of five Divisions within the Georgia Department of Human Resources, the state department charged with the responsibility for administering human service programs for the State of Georgia. The Division of Aging Services provides state leadership, manages contracts with lead agencies (Area Agencies on Aging), administers federal and state funding, and provides programmatic direction, regulations/guidelines and continuously seeks to improve the effectiveness and efficiency of the services provided to elderly Georgians and their families.

Area Agencies on Aging (AAAs) are designated by DAS to provide local responsibility for the implementation of services. Currently, twelve Area Agencies are identified by DAS across the state of Georgia by geographical boundaries called Planning and Service Areas (PSAs). The Area Agencies on Aging are the primary focal points for aging services within the State. All community-based services for the elderly are coordinated through these agencies. The Area Agency on Aging is responsible for the quality of service through its contractual arrangements with service providers, and for monitoring their performance. A list of Georgia's Area Agencies on Aging is located in the References/Appendices section of this report.

A. Vision Statement

Guiding and sustaining Georgia's caregivers.

Mission Statement

In partnership with the state aging network, the Division will provide leadership to establish a comprehensive array of programs and services for Georgia's increasing number of older adults and their caregivers.

B. Value Statements

In providing programs and services for Georgia's caregivers, certain values are basic in all that we do. The values that are an integral part of our work include the following:

Consumer-Centered Care: We believe that caregivers and care recipients should be involved in the planning and service delivery to the fullest extent that they are able to participate.

Quality: We believe that services should be delivered as planned and promised, in a manner acceptable to the caregivers and the care recipients.

Flexibility: We recognize the need to be open to new ideas and new ways of delivering services, always keeping in mind that serving caregivers and care recipients is our ultimate goal.

Dignity: We respect our basic self-worth and that of all people. We are dedicated to preserving the human dignity of all older Georgians.

Empowerment: We believe in the right to self-determination for all our customers. We support the right of caregivers to make choices and assume responsibility for their own decisions.

Accountability: We are good stewards of the trust and resources that have been placed with us. We base our decisions on data analysis. Our services produce the desired results that can be measured.

C. Initiatives

The Division proposes four initiatives that will fully implement the Georgia Caregiver Resource Center. Each initiative is designed to ensure that caregivers are able to access information and resources in a variety of ways. The components are to provide leadership in the following areas:

1. Research and Strategic Planning
2. Education and Training
3. Program and Resource Development
4. Information Dissemination

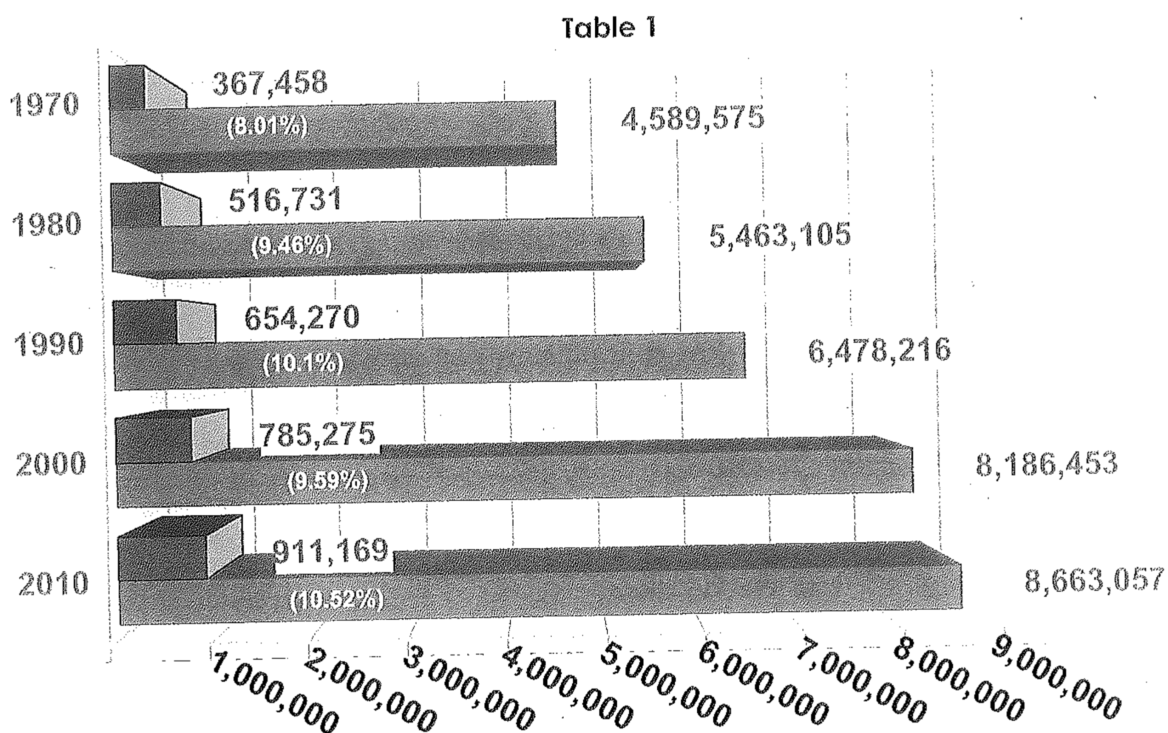
Introduction:

Aging Are Us!!

We are all familiar with the adage, the "Graying of America." But the significance in and the impact of this phenomenon often get overlooked or underestimated. (See Table 1)

Georgia Trend in Population, Ages 65+ [37]

Table 1

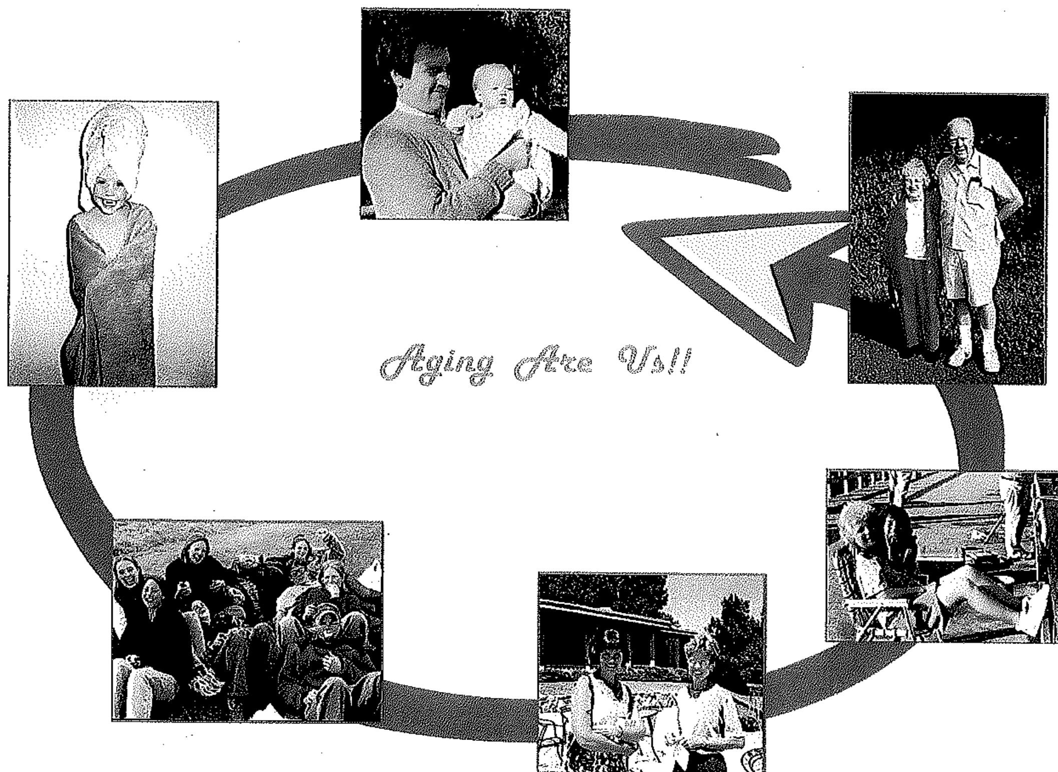


Legend
- Georgia Residents [Age 65 and Older]
- Total GA Population

Nationwide, there will be a dramatic increase in persons 65 and older between 2010 and 2030 as the "baby boomers" become "senior boomers". Even older Americans are now living longer, with life expectancy at 65 outpacing the gains in life expectancy at birth[20]. Currently, one out of 8 persons over the age of 65 is 84 years old or older. At the crest of the senior boom, there will be 4 times as many people 84 years and older as there are now. Georgia data indicates similar trends, as reflected in Table 1.

While we are living longer, we cannot necessarily conclude that we are living healthier. The majority of older adults have one or more chronic illnesses. According to Tennstedt[37], approximately 25% of all people aged 65 and over in the U.S. are in need of some form of long-term care. A 1999 report by the American Academy of Actuaries[37] purported that the numbers of severely disabled older adults will increase to 90% by the year 2040...requiring assistance for personal care (bathing, toileting), domestic care (cleaning, cooking), and skilled care from paid agencies and institutions.

Discussion surrounding the "Graying of America" often takes place as if it were an "us" versus "them" phenomenon. But for the readers of this report, make no mistake--we are all doing it and you are encouraged to read this report from the perspective of being both a potential caregiver as well as a potential care recipient. Indeed, Aging Are Us![35]



Executive Summary of Caregiving

A. Caregiver Facts

Caregiving is a universal issue. The majority of us have been involved in caregiving in some form or another, either in providing care or receiving care. If we have not, it is very likely we will be at some point during our lives. Nearly one out of every four U.S. households [22.4 million] provides care to a friend or relative over the age of 50 years[5]. According to the AoA, 65% of non-institutionalized older adults needing assistance depend solely on family and friends.

B. Caregiver Context

Caregiving for older adults has always been a role that families and friends have assumed, although it may vary in form, level, intensity, and length. There are now many contextual factors that are re-shaping the reality of the caregiving role and supply. Included in the many factors are

a) decreasing birth rates,
b) decreasing family size,
c) increasing geographic mobility,
d) delayed childbearing,
e) growing rates of divorce and marital disruption, and
f) the increasing number of women in the workforce.

C. Caregiving Costs

Caregiving to older adults can be an extraordinarily happy and satisfying experience. It can be a time of reflection that benefits both members of the caregiving dyad. However, the costs of care provided to an older adult can be high. It can take its toll financially, emotionally, physically, socially, and spiritually on caregivers. The following serves to exemplify the seriousness of this issue:

- Approximately 2/3 of working caregivers report increased conflicts and challenges between their paid work and caregiving, leading to the need to change their work schedules, to work fewer hours, to pass up promotions, or to take unpaid leave of absence[8,9]. Between 9-12% of caregivers have had to quit their jobs to provide care, which translates into loss of direct income and benefits, increased out of pocket expenses, decreased social security contribution/credit, and loss of retirement benefits[8,10].
- As might be expected, social participation decreases dramatically for caregivers. The lack of time also includes less interaction with children, spouses, and less time for oneself [8,20], all of which can have very high costs.
- Caregiving can significantly impact the health of the caregiver. The addition of responsibilities along with the uncertainty of caregiving can place very heavy emotional strain on the caregiver. Caregivers use prescriptive medications two to three times more often for depression, anxiety, and insomnia than non-caregivers[9,16]. Caregivers are

also more likely to develop physical illnesses because of a weakened immune system associated with the caregiver stress.

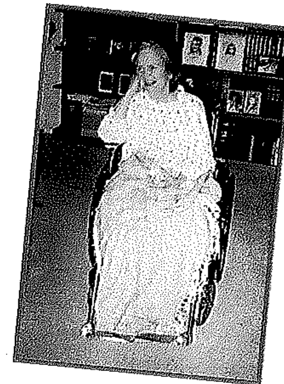
All of these factors lead to the reality that the demand for caregiving far outweighs the supply of potential caregivers and will only become more imbalanced in the next few decades [see Illustration 1][20].

The demand for caregiving far outweighs the supply of potential caregivers and will only become more imbalanced in the next few decades...The primary challenge is to address this issue before it becomes more of a crisis.

D. Caregiver Challenges

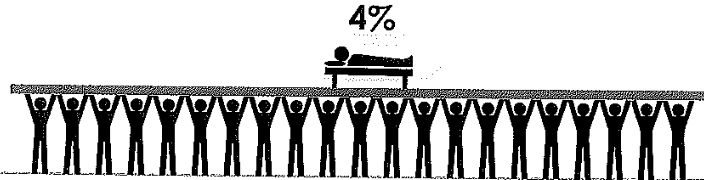
Caregiving in this country is making itself known through sheer volume. Individually and collectively, members of this society will be affected by this phenomenon in a number of ways.

The challenges of caregiving are many. The primary challenge is to address this issue before it becomes more of a crisis...to further understand the needs of those receiving care, to hear the needs of those providing care, and to create a broad-based system to support the caregiving relationship in the most appropriate setting and in the most cost-effective manner.

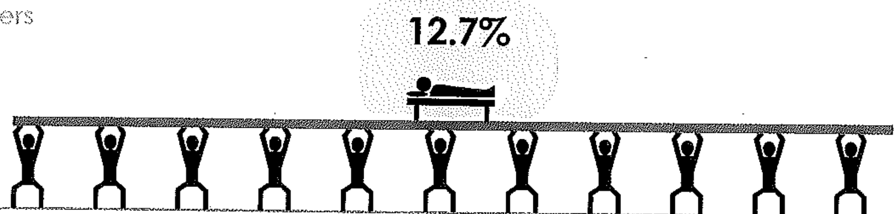


Ashes, Ashes, We All Fall Down...

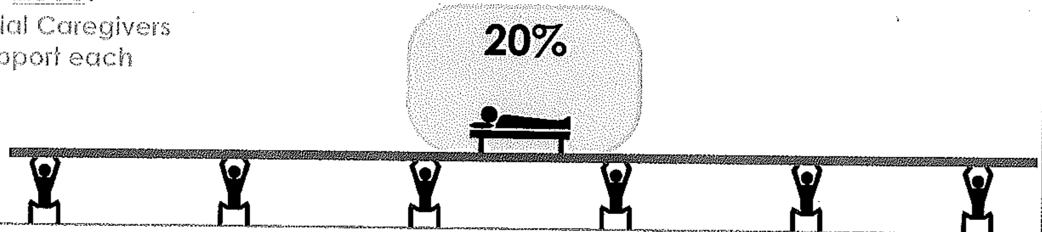
In 1970:
21 Potential Caregivers
to support each



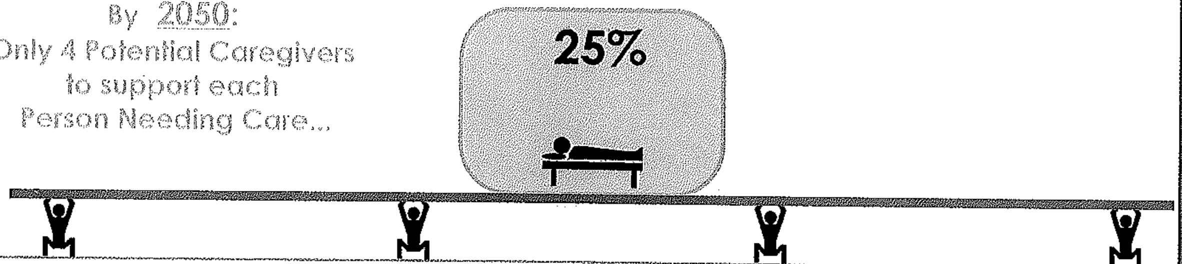
In 1990:
11 Potential Caregivers
to support each



In 2030:
6 Potential Caregivers
to support each



By 2050:
Only 4 Potential Caregivers
to support each
Person Needing Care...



The Direction of Caregiving for Older Adults

Illustration 1

Overview and Background of Study

Focus Group Method

A. Research Approach

A phenomenological design was used to explore the experiences of caregivers of older adults in the state of Georgia. A focus group approach was the primary data collection method used to elicit the shared meaning of everyday experiences from particular subgroups.[21] The advantage of the focus group approach is the synergy created among the members of each group which:

1. fosters the production of information that is difficult to obtain in individual interviews;
2. emphasizes participants' interactions and points of views;
3. provides opportunities for participants to validate information shared by others;
4. clarifies arguments and reveals diversity in perspective; and
5. facilitates the collection of a large amount of information in a relatively short time.

B. Sample and Setting

The population of interest was people who give care to older adults in the state of Georgia. Although family members provide the majority of care to older adults, there are also many others that constitute the larger pool of caregivers to this population. A decision was made to recruit persons with varying perceptions of the caregiving experience who would most likely represent all persons who are providing care to older adults in this state.

Focus group participants were selected from six groups in six different locations in Georgia.

Group 1: Traditional/Non-Professional

This group, from West Central and Southwest Georgia, included family and friends providing care to one or more older adult(s) in a rural setting. Consistent with national trends, the majority were women (75%) and included spouses, daughters, and granddaughters. The male caregivers were spouses of those receiving care.

Group 2: Non-Traditional/ Non-Professional

This group consisted of diverse community members from an inner city, urban area of the state who were providing some form of volunteer care or assistance to older adults at various sites. Again, the group was primarily women (75%) who assisted in a respite care facility, made nursing home visits, provided transportation to church members, and other similar activities. Also included in this group was a member from a local church providing care to gay individuals.

Group 3: Traditional/Professional

This group of caregivers was from the Northeast and East Central part of the state. Participants in this group included paid professionals who are traditionally involved in the care of older adults, such as registered nurses, social workers, and senior center directors. There was one male in the group, a business owner.

Group 4: Non-Traditional/Professional

This group of caregivers from rural and urban Central Georgia were also paid professionals. While extraordinarily important to the industry, this group has not had a lengthy or large presence in the arena of caregiving for older adults. Included in this group were professionals such as eldercare attorneys, discharge planners, care managers, and hospice nurses. Five of 8 were female.

Group 5: Traditional/Non-Para Professional

This group of caregivers was from rural South Georgia. All of the participants in this group were female nursing assistants from home health care who operated under the regulations of Medicare and/or Medicaid.

Group 6: Traditional/Non-Para Professional

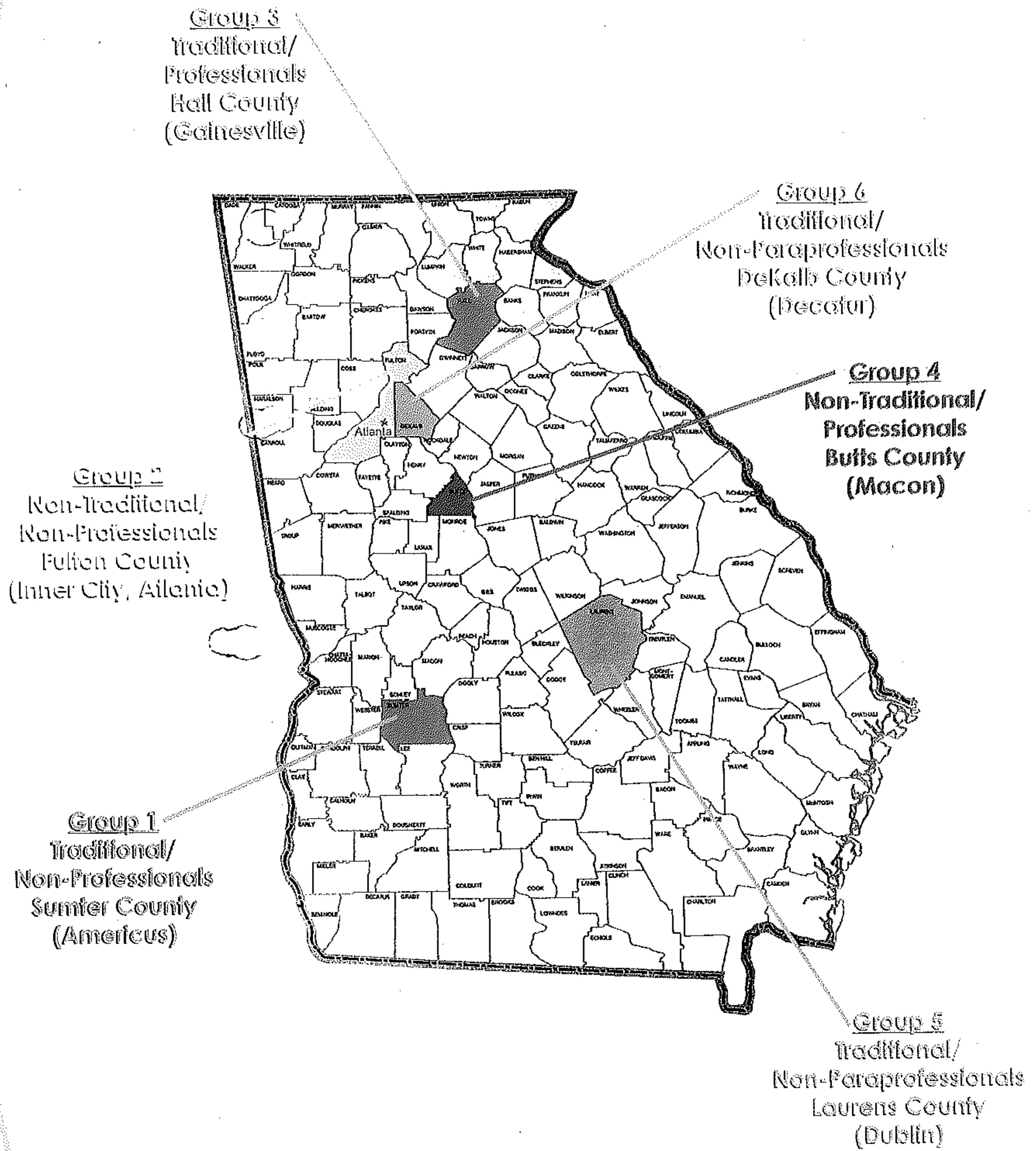
This group of caregivers from the metropolitan area of the state were also nursing assistants. However, these nursing assistants were from the home care industry, operating out of a private pay industry.

Focus Group Sample Demographic Data

Table 2

	GENDER		AGE	RACE			
	Female	Male	Range	African-American	Hispanic/ Latino	Caucasian	Other
Group 1 Traditional Non-Professional (n=12)	9	3	40-80	0	0	11	1
Group 2 Non-Traditional, Non-Professional (n=11)	9	2	29-80	6	0	5	0
Group 3 Traditional Professional (n=14)	13	1	38-61	2	0	12	0
Group 4 Non-Tradional, Professional (n=8)	5	3	33-52	3	0	5	0
Group 5 Traditional Non-Para-professional (n=11)	11	0	26-69	6	0	5	0
Group 6 Traditional Non-Para-professional (n=8)	8	0	35-56	7	1	0	0
Total (N=64)	55 (85.9%)	9 (14.1%)	26-80	24 (37.5%)	1 (1.56%)	38 (59.4%)	1 (1.56%)

Overview and Background of Study



C. Focus Group Procedures

It is generally recommended that focus groups be limited to ten to twelve participants to allow for maximum participation. Following that recommendation, these steps were taken:

1. Agencies located in the varying parts of the state with knowledge of persons who met the criteria of interest from each of the six sub-groups were asked to provide names and numbers of potential participants;
2. Recruitment letters were then sent to potential participants explaining the intent to conduct focus groups in their area and requesting their participation;
3. Each person who agreed to participate was then contacted by telephone.

Sixty-four of the 72 who were recruited agreed to participate in the focus groups. All groups were of the same approximate size.

The focus group team consisted of a four-person planning group who first identified the need to conduct focus groups as a way to gain a broad understanding of the caregiving experience to older adults. This team included a manager from the Division of Aging, an aging consultant who conducted all six focus groups, and two persons who served as non-participant observers during the group sessions. The team identified the different caregiver categories, the areas of the state to conduct the focus groups, and the intermediaries in the varying parts of the state who assisted to identify potential participants, and also assisted in the final analysis of the data.

D. Data Analysis

All focus group discussions were audiotaped and transcribed verbatim, omitting any identifying information about participants. After each session, discussion was held and observation notes were recorded by the group moderator and the non-participant observers to document any non-verbal data or activities during the meeting not picked up by the recorder.

Analysis of the data was completed by the group moderator using a phenomenological methodology developed by Colaizzi and adapted by Scott[34]. Verbatim transcripts from the audiotapes, observations notes and demographic data provided the basis for analysis. The data was initially analyzed by group. After each analysis, the interpretation was sent to the participants to clarify previous comments and to provide feedback on the interpretations of the data. The data was then analyzed collectively across groups. Themes were organized based on common phenomena or experiences across the six caregiver groups. The essence of the sessions and the development of themes across all six groups were reviewed by other team members and one outside person for credibility purposes.

Focus Group Results

Each focus group was comprised of different types of caregivers. Themes were deducted from each individual group to reflect their experience. An analysis was also conducted to determine the themes that existed throughout each of the six focus groups and themes that each group had in common. Out of the context of "Compassion Fatigue and Frustration," three major themes emerged for these caregivers:

1. Lack of Information
2. Needs Exceed Availability
3. Ageist Providers

Compassion Fatigue

Frustration

1. Lack of Information / Coordination

2. Needs Exceed Availability

3. Ageist Providers

--Inadequately Educated

--Inadequately Supported

--Inadequately Monitored

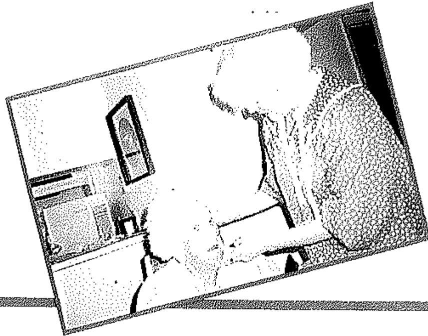
Contextual Perspectives

The overarching theme that provides the context for the three experiential themes is what is referred to as "**Compassion Fatigue and Frustration**"[33]. Context is defined as the conditions or circumstances which affect something.[44] For example, one's context, or value system of past experiences, could influence which woman is seen first in illustration 2 (i.e., the older or the younger woman). Moreover, one's context can greatly influence how s/he perceives, for example, the need to place a loved one in a nursing home.

While all of the caregiver participants seemed to enter their caregiving role for various reasons, a common thread throughout was that they all seemingly accepted the role and wanted to do a good job. This was evidenced, in part, by the fact that all who were invited to participate in these groups did actually participate, and often at considerable cost and effort to do so. However, despite the motivation and effort of these caregivers, another common thread was that they were all quite weary and frustrated. The statement on the next page by a granddaughter caregiver exemplifies this overarching theme.

Contextual Perspectives

Illustration 2



"Well, I had to quit my job to take care of her and just like some of these others, you never know what she's gonna do or whatever. It's just day by day. Like one morning, I got up, she got up before I did. I walked into the living room and I smelled gas. And as I got closer to the kitchen and what she had done, she was going to fix her a cup of coffee and we have a gas stove. And she turned it on and she didn't notice that the flame didn't catch, and she turned her back and didn't pay no more attention to the pot and the gas was just building up and we had to open doors and windows and then one day last week, I was sitting in the living room and she was in the kitchen, and she was going to fix herself a cup of coffee and she put the pot on the stove without water in it and the next thing I knew the smoke detector went off—scared me half to death. Here I was jumping up trying to find where the fire was at. And now she's at the point where she don't want to take a bath and I don't have.....it's hard for me to talk...(starts crying). I was raised you don't talk back to your elders and it's hard. And my sister she lives here with my mother in Montezuma and my father, they're divorced and both remarried, my father lives in Florida and I don't have any help. And I don't know who to turn to ask for help.

"We're tried everything. Like last week we tried to get her in the tub, even my husband tried to get her in the tub. She picked up a flashlight and she was going to hit us with it. I went and ran her water and I told her, 'If you don't go ahead and get in your water's going to get cold.' 'I'm not taking a bath.' And there we've been in her house since November and she hasn't taken a bath yet."

Story told by granddaughter caregiver in February, 2000.

Frustration seemed to be high because of underlying beliefs and expectations regarding caregiving responsibility. Within each of the groups there was finger pointing, not necessarily consciously, as to WHO should be doing WHAT, and WHEN, but in their estimation was not! There was a great deal of assumption of **who "should" assume responsibility for certain caregiving activities.** These beliefs regarding caregiving responsibilities served as a constant source of tension among caregiver groups and seemed to shape the experience of caregiving, leading to more frustration and fatigue.

Churches: "And I'm not sure that the churches are stepping up to the plate. I've been here a long time and raised in the church, but I'm not sure if the church is doing what needs to be done."

"Churches should have more programs, teaching-type programs about the disease." (Alzheimer's Disease)

Families: "And like the other two were talking, everybody leaves you. Her brothers and sisters, and she had six, never called, came, never sent a card...Our own children, two churches, and she taught Sunday School for ten years, nobody!"

Doctors: "This is the big thing that I see is that the physicians do not give out enough information to the people...you just don't see the information in the doctor's offices. The doctors are so rushed...you're not addressing the whole person... The doctor needs to have a staff person (to give out information)."

Government: "You need money put into programs so that you don't have people going back to the hospital, staying in the hospital because they can't get transportation back to the nursing home. There are so many services that need to be funded to keep people out of the acute care."

When the caregiving experience did not conform to their expectations, it served as a major source of tension and, at times, anger.

Yet another source of frustration clearly evident in all groups was that the caregivers' expectations of the ideal or desire for care was not what was available [did not exist, was not enough, or not in their area] or seemingly affordable to them or the care recipient. **When the caregiving experience did not conform to their expectations**, it served as a major source of tension and, at times, anger.

Non-Paid or Family Caregiver:

Sitters

"She was finally able to send me a lady once a week for the 4 hours, which allowed me to go to Columbus and buy groceries and like you were saying, it is not enough time. By the time I drive to Columbus and back it is almost 2 hours. So to buy groceries and do whatever else I have to do business-wise, banking, whatever, it just ate it up…I never have a minute to call my own."

Nursing Assistants

"You have to have a new one (nursing assistant) every week, you got to train them that day and it takes all of your time to get them into the routine and then the next week they send someone else and then you've got to go through all that again."

Respite Care

"You can take your patient out there and leave them for $100 a day. Well, you can't do a whole lot of that if you're an average person, like we all are….I think they need to have respite on weekends and at night. Because it's hard…I think there should be some program for 24 hour respite…and we need some funds."

Discharge Planning

"I think the hospital and doctors should say we know what you need when you go home…your bathroom, you can't get in…we were not prepared [to go home.]"

Everyone's caregiving filter was slightly different, but frustration abounded when their beliefs and expectations did not square with reality. It seemed that the caregiver participants were continually looking externally for the cause or the party responsible for their frustrations; a phenomenon referred to as the "blaming and shaming" of caregiving [35].

Paid Caregiver Non/Paraprofessional

Types of Clients

"I had a case where this person had a dog. We went in to take care of this woman. She had a dog that was real old, real ill. My agency has a tendency to say, 'You're going to love this person, they are really nice. You won't have a problem.' Even though they never met the person before. [This is a hot issue.] Well, I got there, she was real nice. There was no problem with her. But the dog was a sick dog. We had to give the dog insulin. We had to groom the dog. Take the dog out 3 times in my shift, which was a 12-hour shift, take the dog out 3 times. Well, I happened to mention to one of the other caregivers that I don't like taking care of the dog. I don't. I just don't. And when I tried to give the dog insulin, the dog growled at me. And I thought, you do it, to my patient. She got upset to me because I was scared to do it. And I mentioned it to the other caregiver, I don't like doing this, I really don't like taking care of this dog. She went back and told the client and I was dismissed. I was glad because, when you go in a place, they tell you [that] you have this client you are going to care for. They don't tell you everything that goes along with caring for that client."

Caregiving Politics

"I worked for an agency one time that I had to go to an assisted living to take care of somebody for them and I went at 7:00 in the morning and she was covered in BM from her head to her feet and she was living in an assisted living. So I cleaned her and I complained about it and called the agency.... Then somebody called me, the supervisor called from the agency. 'Do you know we have a lot of patients in that assisted living and we don't want to make any trouble for them because we don't want to lose any patients?' "

Caregiving Environment

You go in and find cat feces all over the house. And when the husband is highly intoxicated, he goes to the bathroom - he may have feces all over the floor or the commode. It's not my job to clean up behind this person. But it's unsanitary to leave it there because then if somebody came in from the state behind me and they saw - how could she just leave this? Well, it's not my job to clean up the husband; you know what I'm saying. So to me that's unsanitary to have the animal feces all over the house then the husband is no better. The house is just filthy. I mean that it just is not sanitary. "

Number of Clients

"You're taking care of a lot of clients...you end up taking care of everybody. You even become the babysitter sometimes."

It is from the context of "Compassion Fatigue and Frustration" that the three major experiential themes were derived.

Three Major Experiential Themes

1. Lack of Information / Coordination of Resources

The need for more information was evident in each of the groups, no matter whether or not they were professionals or the length of time they'd been providing care. At times, it was clearly articulated that they needed more information about what services and products were available, clarity on what those services provided, and help in locating the services or products and the reimbursement source of the services but that it was very difficult to get to. In some cases, these individuals had portions of information but not enough to act on.

Compassion Fatigue

Frustration

Most expressed the idea that while information might be available, it was often hidden or obscured or so loosely coordinated that gathering all necessary information was a challenge and sometimes not worth the effort. For instance:

- "You have to be a very aggressive person to dig out all this information. I didn't know it was there and they don't tell you anything, but if you just keep at it and you find out one thing, then you find something else."
- "And I've called DFACS that don't even know what's available in the rest of the community. We at least need our own agencies to know what each other's doing...we don't even know that."
- "If we started out around this table, I bet we could come up with 100 services that people in this room [professional care givers] don't know about. And it's access to this information and getting this information out....the communication is not there. There is so much that needs to be out there."
- "We (Home Care Agency) get calls 3, 4, 5 times a week with people needing something that we don't do but don't know where to refer."
- "Alzheimer's Association puts out a lot of information about the disease, I'll give them an A+. But they tell me nothing about where I can receive help. That was my big problem."
- "The doctors don't even know the resources there."

And lastly, the participants identified that there was much misinformation in the communities that affected the caregiving experience. For example:

- "A lot of misinformation on the part of adult children who are still, well they haven't even discussed this (Power of Attorney) in the first place. ....There's a lot of myth of legal issues surrounding old age and guardianship and powers of attorney."
- "A lot of myths around Medicaid reimbursement for nursing homes."

Most expressed the idea that while information might be available, it was often hidden or obscured or so loosely coordinated that gathering all necessary information was a challenge and sometimes not worth the effort.

2. Needs Exceed Availability

Compassion Fatigue

Frustration

A second major theme from the focus groups was "Needs Exceed Availability." Frustration and even a sense of impotence were evident in this theme. The words speak for themselves as these care providers attempted to explain the experience when there was not enough funding or service for medications, transportation, home care, geriatricians, nursing assistants, and even nursing home beds. This theme was undergirded by the ethical dilemma whereby the majority of the caregivers had been educated and/or encouraged to carefully assess and assist the care recipient to access resources necessary for care...and yet, many times they were unable to fully meet their needs or find the resources identified as needed. This phenomenon was particularly true as it related to transportation, medications, and home care. For example:

Transportation:

- [Senior Center Director] "I want to go back to transportation. We don't even have a hospital. I spend a good amount of time just arranging for transportation, people to doctors, to hospitals, to specialists, to imaging centers. I have 3 churches that have mobility teams, and transportation is a big issue. It takes a lot of my time trying to organize a volunteer to take them to Gainesville. It may take a half a day or it may take 6 hours. All for one person."

- "The Medicaid transportation system is the biggest disaster we've had in years. We're talking about repeatedly we've had people have to stay extra nights in the hospital because their services didn't pick them up to take them to the nursing homes."

Medications:

- "Everybody falls through the cracks....if you need a meal, we can give you a meal. If you need transportation, we can give you transportation. But what if you need someone to give you medication. There's nobody to do that. Because if you don't get your medication, then all of the meals I send are not going to help you."

- "Getting back to this medication, when patients can't afford it, they do without it. You find a lot who do without it because they can't afford it...when they don't take the medication, that causes other problems. That means they have to be hospitalized..."

- "We had to admit 10 patients to the hospital strictly because they did not have their medicine to take because they couldn't buy it; they didn't have money to buy it. They did not have Medicaid because they have too much money. Medicare doesn't pay for it. By the time they've paid for their living expenses, it was a choice of, 'Do I buy food or do I buy medicine?' And they chose food over medicine."

It is a real paradox to enter a profession because you want to help people, then discover repeatedly that you cannot due to the lack of resources.

Home Care:

- "...it's almost daily somebody comes in with a need and we go out there. They don't need it 3 months from now, 4 months from now. We just went to a funeral last week of somebody in that position. We sent somebody into the home with no reimbursement to help while we could, but how much can you do this? We're too slow to respond."

- "And if they're slow or they have problems or they get sick while you're there, they have to go to the bathroom, you clean them up. They have to go to the bathroom again, well, it takes a lot of time sometimes...and a lot of people that are in management don't understand the things...I mean, I understand the financial aspects of it; you got to be able to live within the guidelines of the Medicare program. I understand that. But you know when you're working with people, things don't always go like the guidelines say to go. 'Well, you can't go to the bathroom; I've got to go.' "

This phenomenon may help to account for some of the turnover in this industry. It is a real paradox to enter a profession because you want to help people, then discover repeatedly that you cannot due to the lack of resources.

3. Ageist Providers

Compassion Fatigue

Ageism is discrimination against individuals based on age alone. It lurks around in many different forms including apathy, complacency, and ignorance related to older adults. Ageism was strongly reflected in the participants' message related to caregiving. In each of the six groups, the conversation took place at one time or another that the persons providing care were not adequately trained, educated, monitored, or supported enough to take care of the older population. This comment was inclusive of everyone from the family, physicians providing primary care, registered nurses, social workers, and nursing assistants involved in some aspect of the older adults' care in an institution, home, or community. In each and every group the insinuation was how ageism compounded the frustration and fatigue of caregiving. Some of the participants were hesitant to make a direct statement and were quite soft in the way they assessed the situation. Others were not so timid; in fact, they were adamant and angry!

Frustration

Inadequately Educated:

- "...because the internists are not trained, they don't have much experience with gerontology and they are stumped and they make very stupid comments to families."
- "My mother complained that medical people, especially physicians, treat older people as though they were children. Condescending."
- "With our client and personal care homes we are spending a large portion of our time trying to undo damage that has been done because their doctors don't understand the geriatric population. They don't understand the effects of medications on older people, which are different than the effects on younger people. They're not medicating them appropriately and we're having to go behind their backs, up to the nurses, trying to manipulate them because it is hard to address them directly. And I think there are a whole lot of doctors out there that need much more understanding of geriatric medicine."

Inadequately Supported:

- "...supposed to see 6 people a day in 8 hours, you're not supposed to do any overtime. But some of these people, they're old, they're slow, and I can't just tell somebody like that hurry up so I can get to my next one so I can get through and not do overtime. I can't do that."
- We expect someone making minimum wage to bathe, diaper, feed someone that they don't know and not have any particular close feeling for and yet we're expecting them to do it lovingly as we would do it."
- "Contract labor pays $6 an hour. And I say you can't afford to work for $6 an hour and raise your own transportation, pay your own social security and your taxes. I said, "What planet are you from?" I mean, common sense tells you, if you only make $2, you pay 35% tax, then you have the use of your car. Anybody who's worked there for a living, they're going in the hole."

In each of the six groups, the conversation took place at one time or another that the persons providing care were not adequately trained, educated, monitored, or supported enough to take care of the older population.

Inadequately Monitored:

- "I think the hardest thing was finding help. Competent help. That probably caused me more frustration than my husband did. The help was so bad. Not reliable. So many of them (nursing assistants) had no training, if they came from an agency. They were not reliable at all, most of them...or doing what you asked them to do. I had to ask them not to send several different ones they were so bad. You had to have them but to find competent ones?"
- "I think another thing we're going to have to realize that the people need to be high quality people giving the care. We pay very little. As long as there's a family member there, they are very attentive, but once the family member leave, the attention stops. And I think part of that is simply because these people are not trained."
- "I've had to cancel a doctor's appointment because they (nursing assistants) did not show up."

Recommendations

The following are recommendations that were common to the six groups of participants. It is the hope of the Division of Aging that each recommendation be viewed carefully and considered with due care. These were the comments and suggestions that the focus group participants stated would facilitate continued, quality care for older adults and their caregivers in this state.

Information

What

1 Community Resources/Providers - Many of the participants wanted and needed to know what kind of service providers were available to assist in caring for the older adult in their own communities and at large. Often bogged down in the everyday activities of caregiving, they either didn't have time to find out or didn't know where to begin. Many simply did not know the questions to ask, or when they did, they felt like they had to go to too many different places to get the answers.

2 Community Resources/Products - Participants also wanted information on products that might assist in the caregiving process. Some had heard of certain products, like an emergency response system or Velcro clothing, but didn't really understand what they were, how they could be beneficial to them, or how to obtain the products.

3 Low Cost/No Cost Medications - This was a repeated topic in all groups. Given the number of medications most older adults are taking, the associated costs, and implications of doing without other needed items because of the costs, all groups identified the need to get financial assistance with medications.

4 Emergency Services - There was a thread of concern in each of the groups as to what would happen to the older person being cared for if the primary caregiver were unable to provide that care, such as when the caregiver had to have surgery. Expressed within the groups was the need for more information on who, if anybody, was available to "step in" until arrangements could be made.

5 Home Preparation - Most groups expressed the need to have more information provided to caregivers on what preparation [change in physical structure, equipment, etc] is needed to care for an older person in the home safely. Several described situations where an older adult was discharged from the hospital without any preparation and in one instance, the husband could not even get his wife's wheelchair through the door.

6 Reimbursement Systems - The need for more information on who pays for what, when, and how much was evident in each of the groups. Much confusion still exists on the differences between Medicare and Medicaid and other reimbursement systems. The confusion often creates expectations of what will be provided, only to become a major disappointment and at times, a setback, when it doesn't bear out.

7 Legal Issues - Across the groups there were legal questions that needed answers ranging from basic questions related to the Living Will to more complex issues on financial and Power of Attorney issues.

8 Future Planning - More information was requested by the groups on issues like the A,B,C's of planning a funeral and how to avoid getting the estate tied up in court. Also included were issues related to role loss.

How

1 Create a 1-800 System of Information - Each of the groups talked about how scattered information on services and products seemed to be, adding to the frustration and stress of the caregiving day. A central source, like a 1-800 number came up in each group...a place where both family and professional caregivers could call and get the information they needed without spending hours on the phone tracking people, places, and products.

2 Use the Media - Several groups mentioned how each of them uses different sources to get information on a daily basis, such as the radio, the television, and/or the newspaper. Hence, they felt it would be a good way to publicize information on caregiving and community resources and to reach a larger audience.

3 Place Information in Doctors' Offices - While many stated they did not always get information from their doctor, they did say that they would read what is available in the office. Since many are making frequent or regular doctors' visits, they saw this as a way to get information on a routine basis.

4 Place Caregivers on Boards of Organizations - There was a strong direction from these groups to include actual caregivers on boards related to older adults and caregiving. This was viewed as a way to get "the real picture" to those making decisions on their behalf.

Direct Services

What

1 **Counseling and Advance Planners** - There were requests for the direct services of professionals such as care managers who could provide an overall evaluation of the older adult and help caregivers sort out exactly what services were needed and where to obtain them.

2 **Expansion of Respite** - The need for caregiver respite was evident in all groups. In some situations, the request was for extended hours in the evening and on weekends. For many, respite was not available in their community in any form, so the request was for any hours of respite.

3 **Expansion of Home Services** - Those involved with or receiving home services, such as personal hygiene care by a paraprofessional, stated that there was not enough time allotted for each client. The request was that the time and the frequency allowed for home visits be extended to account for the "reality" of the situation.

4 **Expansion of Transportation** - Transportation seemed to be an irritant for almost all participants as it was virtually unavailable to most. As they stated, you can have all of the resources and providers in the world, but if you can't get to them, they are useless. There was a strong cry for an increase in transportation venues.

5 **Financial Assistance with Medications** - While some participants wanted information on how to obtain low costs medications, others had gone that route with little to no results. The recommendation from them was a program, such as vouchers, to assist in actually paying for the medications.

6 **Emergency Services for Caregivers** - Again, there was concern voiced that there may be a time during an emergency when the primary caregiver could not provide the necessary care. These persons wanted to see communities provide a program where someone could step in temporarily until other arrangements could be made.

7 **Creation of a 1-800 Information System** - Once again, the 1-800 system came up as a way to address the many concerns voiced throughout the focus groups.

How

1 **Streamline Services** - The recommendation here was related to the frustration in having to go to many different agencies/groups for each individual service needed. Their wish was for a more consolidated approach in order to decrease fragmentation and the resulting frustration.

2 **More Supervision/Quality Control/Accountability for Services** - Most participants expressed their concern about what they viewed as loosely controlled/supervised services. If the provider did not deliver what was promised, they felt like they did not have anyone to turn to for recourse. The recommendation was to provide more oversight to those providing services in order to increase accountability and standards.

3 **Creation of Exchange Program** - Many of the participants recognized that it was not possible for "someone else" to provide all of the needed services. Their recommendation was for caregivers to exchange their talents and skills with each other. For instance, caregiver #1 might be able to provide transportation to the grocery store every week for caregiver #2 if caregiver #2 would provide a 2-hour respite for caregiver #1 every week.

Providers

What

1 **More Training and Sensitivity for ALL Levels** - Repeated concern was expressed regarding service providers who were ill-prepared to care for older adults and their caregivers. The recommendation was to have more training for all levels of providers to provide knowledge about older adults and to address the attitudes toward older adults. The contention was that without adequate knowledge and sensitivity to this group, quality or compassionate care could not be delivered, only adding to the frustration and fatigue of their caregivers.

2 **Vouchers/Support for Family Caregivers** - Comments were made that caregivers often lost time at work or had to give up their jobs to provide care. Moreover, the services available by traditional reimbursement sources, such as Medicare, were not always the best services for the individual older adult. The recommendation was made that money be put into vouchers to be used by families to purchase the services they saw that would best fit their needs.

3 More Support for Nursing Assistants/Home Care Aides - Much discussion took place in every group regarding the demands on nursing assistants/ home care aides with very little reward [wages, benefits, respect, acknowledgment] and that, in fact, the lack of support may help to account for the large turnover in this industry. There was a strong consensus that, for the work they did, they deserved more recognition and reward.

How

1 Increase Pay/Benefits/Respect for Nursing Assistant/Home Care Aides - Over and over there was support that the wages for this group should be increased significantly along with a benefit package.

2 More Supervision/Oversight of Home Care Staff - While it was strongly recommended that the support for home care staff should be increased, an equally strong message came through that there should be more oversight for these individuals. Having someone monitor their hours and the quality of their care was noted as something rarely witnessed but desperately needed.

3 Decrease Administrative Costs of Programs - The concern here was that too much of available funds were spent on administration rather than the programs themselves.

4 Screen Potential Home Clients More Efficiently - Numerous times it was mentioned that home care agencies would accept clients without screening them properly. As a result, the home care staff felt like they would go into situations that they were inadequately informed about or prepared for. The recommendation was to gather more information about the situation before hiring someone for that job in order to avoid potential disagreements or points of tension.

5 Provide Incentives and Recognition for Nursing Assistants/Home Care Aides - This recommendation is along the line of more support for nursing assistants. However, this area included more than an increase in wages or benefits. The recommendation was to look at ways to increase the self-worth and self-image of the nursing assistant such as "Nursing Assistant of the Year" award.

6 Include Nursing Assistants/Home Care Aides in Care Planning - Since nursing assistants spend the majority of the time with the client, the recommendation was that they provide their input by being included in the care planning meetings at their agencies.

Training

What

1. Course on Compassion for Health Care Providers - Examples were provided throughout the focus groups of how health care providers could be insensitive or seemingly uncaring toward older adults. While it was actively debated whether compassion could be taught, it was strongly recommended that such a course be developed and offered to all levels of health care providers.

2. Communication Skills - The recommendation for this course was also meant for all providers to incorporate clarity, compassion, and respect into their daily communication. How each could better communicate with their older clients [including those with dementia] and their families, how health care providers could better communicate among their peers, and how professionals could improve their skills in communicating with other team members, like the paraprofessionals.

3. Legal Issues - Most participants felt like they did not have enough information regarding the legal issues encountered in caregiving and would like to have more courses offered in this area.

4. Personal Care/Hygiene - Many participants, including the nursing assistants, felt like they needed more class work and practice/clinical in this area. There was a special need for this in areas where the older adult had dementia and may resist personal hygiene.

5. Normal Aging Issues - The question insinuated by many participants was, "What constitutes normal aging?" Not having the answer left many in uncertain situations of knowing the correct action to take during caregiving. The request was more classes on normal aging changes and challenges.

6. Ageist Issues - Repeated concerns about the attitude and treatment of older adults by health care providers, particularly their physicians, led to this recommendation. Class work on examining our own values and biases about the older population was suggested as a way to make people more aware of their actions and the associated consequences to them, the older adult, and the caregiver.

7. Alzheimer's and Other Like Dementias - Much discussion took place on the special challenges for everyone involved in the care of someone with Alzheimer's Disease and other dementias. Requests were made to keep workshops, seminars, and classes offered in the community for all to participate.

8 Complexities of Caregiving - Each group of caregivers discussed the notion that "other groups" [i.e. other caregivers, legislators] did not quite understand the caregiving responsibilities, tasks, and toll of what they did. Although never directly stated per se, the inference was that they would like a forum to relay that information in order to come to a better understanding and perhaps change in perspective of each other.

9 Community Resources - Related to wanting written information and a 1-800 number to learn more about community resources was the suggestion that seminars be held to make people more aware of what is available to older adults and their caregivers.

How

1 Extended Training for Nursing Assistants with Clinical Time - Despite the number of hours nursing assistants spent in training, participants did not feel like it was enough. Even many of the nursing assistants in the focus groups felt ill-prepared for the care they were charged with and wanted more clinical hours or "hands on" before being assigned a client.

2 More Advanced Seminars for Health Care Providers - Many of the professionals in the focus groups requested more advanced seminars on gerontological issues including dementia care, falls, and medications.

Georgia Caregivers Resource Center

Strategic Plan

In partnership with the state aging network, the Georgia Caregiver Resource Center (GCRC) will provide leadership to establish a comprehensive array of programs and services for Georgia's increasing number of older adults and their caregivers.

To fully implement the work of the GCRC, four initiatives have been established. Short-term plans for the GCRC are described under each of the initiatives.

1. Research and Strategic Planning

Additional caregiver focus groups are planned to add to the data provided in this report. These groups will be held in various parts of the state, and will target ombudsmen and nursing assistants working in assisted living, among other groups.

On behalf of the aging network, the GCRC will also seek additional funding for caregiver programs and services, including funds for demonstration grants.

2. Education and Training

The findings and recommendations from the caregiver focus groups were utilized by the Division in selecting topics for caregiver education and training. With input from the Area Agency on Aging (AAA) network, a format of one-day education/training forums was selected. Three forums will be held in various parts of the state each year, and respite will be provided, enabling family caregivers to attend.

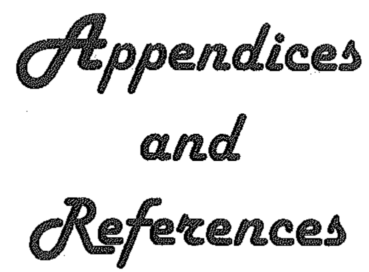
The GCRC works collaboratively with other organizations, such as the Rosalynn Carter Institute (RCI), in promoting RCI's programs and services for family and professional caregivers, and with the Georgia Gerontology Society's Annual Conference by coordinating workshop tracks and plenary sessions on caregiving issues. GCRC will also work with the newly formed Georgia Alliance for Staffing Solutions, which will be addressing the problem of long term care staffing on a number of fronts.

3. Program and Resource Development

The GCRC will be establishing an Advisory Committee to assist in carrying out its mission statement. A list of caregiver websites has been developed, which has been disseminated to the AAA network and will be more widely circulated in the future. Plans are underway to expand the Division's webpage to include a linkage to state and national caregiving resources.

4. Information Dissemination

The GCRC will identify groups of caregivers and their particular needs and interests, developing and/or obtaining targeted information, products, and services for these groups. Groups will include but not be limited to grandparents caring for grandchildren as well as caregivers of persons with chronic or degenerative diseases, such as Alzheimer's Disease.


Appendices
and
References

Caregiver Focus Group
Sample Questions

1.) Please describe your caregiving experiences.

2.) What has this experience meant to you?

3.) How is it that you came to be in this role as a caregiver to an older adult?

4.) Describe the aspects of the caregiving experience that have been the most surprising to you.

5.) Describe the aspects of the caregiving experience, if any, that have been the most satisfactory to you.

6.) What specifically made these aspects satisfactory to you?

7.) Describe the aspects of the caregiving experience, if any, that have been the most challenging or difficult for you.

8.) What specifically made these aspects challenging or difficult?

9.) What would assist to diminish or reduce the difficulty?

10.) Describe those things [products, services, people, education sources], if any, that have been the most useful to you in your caregiving experiences.

11.) How did you hear about these things?

12.) The most helpful way for you to learn about these things is what?

13.) What would you have done without these things?

14.) What other things might have been useful to you in implementing your role?

15.) If you had a crystal ball and you could have known that you would be involved in this caregiving experience years ago, what would you have done differently for yourself or those you are working with, if anything?

16.) What areas, if any, do you see related to caregiving that need to be addressed by health care providers?

17.) If you were in charge of caregiving for the state, what sort of programs would you put into place immediately? In five years? Down the road?

Appendix A: **Caregiver Focus Group Sample Questions**

Caregiving Internet Resources

Georgia Caregiver Resource Center,
A Part of the Georgia Division of Aging Services

Organization	Address & Phone	Web Address
Administration on Aging (AoA)	330 Independence Ave., SW Washington, DC 20201 Eldercare Locator: 1-800-677-1116 AoA Information Center: 202-619-7501 FAX: 202-260-1012	www.aoa.gov
Alzheimer's Association	919 North Michigan Avenue Suite 1100 Chicago, Illinois 60611-1676 Phone: 800-272-3900 312-335-8700 FAX: 312-335-1110	www.alz.org
Alzheimer's.com		www.alzheimers.com
American Association of Geriatric Psychiatry	7910 Woodmont Avenue Bethesda, MD 20814-3004 Phone: 301-654-7850 FAX: 301-654-4137	www.aagpgpa.org
American Association of Homes & Services for the Aging	2519 Connecticut Ave., NW Washington, DC 20008-1520 Phone: 202-783-2242 FAX: 202-783-2255	www.aahsa.org
American Association of Retired Persons (AARP)	601 E Street, NW Washington, DC 20049 1-800-424-3410	www.aarp.org
American Health Assistance Foundation	15825 Shady Grove Road Suite 140 Rockville, MD 20850 Phone: 301-948-3244 FAX: 301-258-9454 Toll Free: 1-800-437-2423	www.ahaf.org
American Health Care Association	1201 L Street, NW Washington, DC 20005 Phone: 202-842-4444 202-842-3860	www.ahca.org
Caregiver Survivor Resource		www.caregiver.com

Caregiving Internet Resources

Organization	Address & Phone	Web Address
Caregiver Zone		www.caregiverzone.com
Caregivers-AgeNet Eldercare Network	17 Applegate Ct. Madison, WI 53713 Phone: 608-256-0488	www.caregivers.com/index.asp
Caregiver-Today's Caregiver Magazine	6365 Taft Street, Suite 3006 Hollywood, FL 33024 Phone: 954-893-0550 FAX: 954-893-1779	www.caregiver.com
Caregiving Newsletter	Tad Publishing Company P.O. Box 224 Park Ridge, Illinois 60068 Phone: 847-823-0639	www.caregiving.com
Careguide, Inc.	210 N. University Dr, Suite 700 Coral Springs, FL 33071 Phone: 954-796-3727	www.careguide.com
CareScout	36 Washington Street, Suite 250 Wellesley Hills, MA 02481 Phone: 781-431-7033 781-431-7034	www.carescout.com
Carethere	635 Clyde Avenue Mountain View, CA 94043 Phone: 1-888-236-3961	www.carethere.com
Eldercare	Eldercare Online Richard O'Boyle 54 Amuxen Court Islip, NY 11751 **No phone numbers given	www.ec-online.net
ElderWeb	1305 Chadwick Drive Normal, Illinois 61761 Phone: 309-451-3319 FAX: 866-422-8995	www.elderweb.com
Empowering Caregivers		www.care-givers.com
Family Caregiver Alliance	690 Market Street, Suite 600 San Francisco, CA 94104 Phone: 415-434-3388 FAX: 415-434-3508	www.caregiver.org

Appendix B: **Caregiving Internet Resources**
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Caregiving Internet Resources

Organization	Address & Phone	Web Address
Getcare	700 Murmansk St. Suite 4, Building 590 Oakland, CA 94607 Phone: 510-986-6700 FAX: 510-986-6707 Toll Free: 1-888-438-2273 (1-888-Get Care)	www.getcare.com
Go 60	335 Old Quarry Road, N Larkspur, CA 94939 Phone: 415-464-0511 FAX: 415-464-0105	www.go60.com/caregiving/htm
Health A to Z	Cedar Brook Corporation Park 3 Cedarbrook Drive Cranbury, NJ 08512 Phone: 609-409-8200 FAX: 609-409-8130	www.HealthAtoZ.com
Healthy Caregiver	The Healthy Caregiver Magazine 12 West Willow Grove Ave. PMB 190 Philadelphia, PA 19118-3952 Phone: 215-753-1780	www.healthycaregiver.com
Innovative Caregiving Resources	P.O. Box 17809 Salt Lake City, Utah 84117-0809 Phone: 801-272-9806 Toll-Free: 800-249-5600 FAX: 801-272-9805	www.videorespite.com
Medscout	4676 Commercial St., SE Suite 135 Salem, Oregon 97302-1902 Phone: 503-769-6565 FAX: 503-769-9676	www.medscout.com
National Family Caregivers Association (NFCA)	10400 Connecticut Avenue, #500 Kensington, MD 20895-3944 Phone: 1-800-896-3650 FAX: 301-942-2302	www.nfcacares.org

Caregiving Internet Resources

Organization	Address & Phone	Web Address
National Institute on Aging	Building 31, Room 5C27 31 Center Drive, MSC 2292 Bethesda, MD 20892 Phone: 301-496-1752	www.nih.gov/nia
Resources for Aging – The Caregiver Sourcebook	1265 Erie Avenue North Tonawanda, NY 14120 Phone: 716-693-3554 FAX: 716-693-5099 Order Desk: 1-888-243-4636 (1-888-Age Info)	www.ageinfo.com
Rosalynn Carter Institute for Human Development	Georgia Southwestern State University 800 Wheatley Street Americus, GA 31709 Phone: 229-928-1234 FAX: 229-928-2663	www.rci.gsw.edu
South Georgia Care-Net	109 W. Moore Street Valdosta, GA Phone: 229-293-6145	www.valdosta.edu/sowk/CareNet.html
ThirdAge	ThirdAge Media 585 Howard St., First Floor San Francisco, CA 94105-3001	www.thirdage.com/family/caregiving
Transitions, Inc.	1121 Douglas Avenue South Minneapolis, MN 55403 Phone: 612-998-5077	www.asktransitions.com

Area Agencies on Aging / Lead Agencies

<table>
<tr><th colspan="2">PLANNING & SERVICE AREA</th><th>AREA AGENCY ON AGING DIRECTOR
NAME OF AGENCY
ADDRESS AND PHONE NUMBER</th></tr>
<tr><td colspan="2">Atlanta Regional Commission</td><td rowspan="2">Cheryll Schramm, AAA Director
Atlanta Regional Commission
40 Courtland Street, N.E.
Atlanta, GA 30303

Tel: 404 / 463-3100
FAX: 404 / 463-3264
Aging Connection: 404 / 463-3333
Toll Free: 800-676-2433</td></tr>
<tr><td>Cherokee
Clayton
Cobb
DeKalb
Douglas</td><td>Fayette
Fulton
Gwinnett
Henry
Rockdale</td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="2">Central Savannah River</td><td rowspan="2">Jeanette Cummings, AAA Director
Central Savannah River RDC
3023 Riverwatch Parkway, Suite A
Augusta, GA 30907-2016
P.O. Box 2800
Augusta, GA 30914-2800

Tel: 706 / 210-2018
FAX: 706 / 210-2024
Toll Free: 1-888-922-4464</td></tr>
<tr><td>Burke
Columbia
Glascock
Hancock
Jefferson
Jenkins
Lincoln</td><td>McDuffie
Richmond
Screven
Taliaferro
Warren
Washington
Wilkes</td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="2">Coastal Georgia</td><td rowspan="2">Eleanor Helms, AAA Director
Coastal Georgia RDC
P.O. Box 1917
Brunswick, GA 31521-1917

Tel: 912 / 264-7363 Ext. 228
Information Link #: 1-800-580-6860
FAX: 912 / 262-2313

Physical Address:
127 F Street, 31520</td></tr>
<tr><td>Bryan
Bulloch Camden
Chatham
Effingham</td><td>Glynn
Liberty
Long
McIntosh</td></tr>
</table>

Area Agencies on Aging / Lead Agencies

PLANNING & SERVICE AREA		AREA AGENCY ON AGING DIRECTOR NAME OF AGENCY ADDRESS AND PHONE NUMBER
Coosa Valley / Northwest Georgia		Debbie Studdard, AAA Director Area Agency on Aging of Northwest Georgia P.O. Box 1793 Rome, GA 30162-1793 Tel: 706 / 295-6485 FAX: 706 / 802-5508 Screening for Services: 1-800-759-2963 or 706 / 802-5506 Physical Address: 1 Jackson Hill Drive, 30161
Bartow Catoosa Chattooga Dade Fannin Floyd Gilmer Gordon	Haralson Murray Paulding Pickens Polk Walker Whitfield	
Georgia Mountains		Pat Viles Freeman, AAA Director Legacy Link, Inc. P.O. Box 2534 Gainesville, GA 30503-2534 Tel: 770 / 538-2650 FAX: 770 / 538-2660 Toll Free: 800 / 845-5465 Physical Address: 508 Oak St, Suite 1, 30501
Banks Dawson Forsyth Franklin Habersham Hall Hart	Lumpkin Rabun Stephens Towns Union White	
Heart of Georgia Altamaha		Gail Thompson, AAA Director Heart of Georgia Altamaha RDC P.O. Drawer 1260 Baxley, GA 31515 Tel: 912 / 367-3648 FAX: 912 / 367-3640 Toll Free: 888 / 367-9913 Physical Address: 505 West Parker Street, Appling County
Appling Bleckley Candler Dodge Emanuel Evans Jeff Davis Johnson Laurens	Montgomery Tattnall Telfair Toombs Treutlen Wayne Wheeler Wilcox	

Area Agencies on Aging / Lead Agencies

Planning & Service Area		Area Agency on Aging Director Name of Agency Address and Phone Number
Middle Georgia		Amy Tribble, AAA Director Middle Georgia RDC 175-C Emery Highway Macon, GA 31217 Tel: 478 / 751-6466 FAX: 478 / 751-6517 Toll Free: 888 / 548-1456
Baldwin Bibb Crawford Houston Jones Monroe	Peach Pulaski Putnam Twiggs Wilkinson	
Northeast Georgia		Peggy Jenkins, AAA Director Northeast Georgia RDC 305 Research Drive Athens, GA 30610-2795 Tel: 706 / 369-5650 FAX: 706 / 369-5792 Toll Free: 800 / 474-7540
Barrow Clarke Elbert Greene Jackson Jasper	Madison Morgan Newton Oconee Oglethorpe Walton	
Southeast Georgia / South Georgia		Southeast Georgia RDC 3395 Harris Road Waycross, GA 31503-8958 Tel: 912 / 285-6097 FAX: 912 / 285-6126 Toll Free: 1-888-732-4464
Atkinson Bacon Berrien Brantley Brooks Charlton Clinch Coffee Cook	Echols Ben Hill Irwin Lanier Lowndes Pierce Tift Turner Ware	

Area Agencies on Aging / Lead Agencies

Planning & Service Area		Area Agency on Aging Director Name of Agency Address and Phone Number
Southern Crescent **(Formerly Chattahoochee-Flint/McIntosh Trail)**		Bobby Buchanan, AAA Director Southern Crescent AAA P.O. Box 1600 Franklin, GA 30217-1600 Tel: 706 / 675-6721 (Atl. 770 / 854-6026) FAX: 706 / 675-0448 Toll Free: 1-866-854-5652 Physical Address: 13273 GA Hwy. 34 East
Butts Carroll Coweta Heard Lamar	Meriwether Pike Spalding Troup Upson	
Southwest Georgia		Kay Hind, AAA Director Southwest Georgia COA 308 Flint Avenue Albany GA 31701-2508 Tel: 229 / 432-1124 FAX: 229 / 483-0995 Toll Free: 800 / 282-6612
Baker Calhoun Colquitt Decatur Dougherty Early Grady	Lee Miller Mitchell Seminole Terrell Thomas Worth	
West Central Georgia **(Formerly Lower Chattahoochee/ Middle Flint)**		Jewel Fuller-Demars, AAA Director West Central Georgia AAA 1428 Second Avenue P.O. Box 1908 Columbus, GA 31902-1908 Tel: 706 / 256-2910 FAX: 706 / 256-2908 Toll Free: 1-800-249-7468
Chattahoochee Clay Crisp Dooley Harris Macon Marion Muscogee	Quitman Randolph Schley Stewart Sumter Talbot Taylor Webster	

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Caregiving in Georgia

A Second Report

A State Report
Prepared by Dr. Kathy Scott, R.N., C.
For the Georgia Division of Aging Services

Summer, 2003

Jim Martin, Commissioner
Maria Greene, Division Director

Georgia Department of Human Resources
Division of Aging Services • Two Peachtree Street, NW • Suite 9.398 • Atlanta, Georgia 30303-3142 • (404) 657-5258

Dear Friend:

In 2002 the Department of Human Resources Division of Aging Services published the first comprehensive "state of the State" report on the issue of caregiving for older Georgians. Our goal, was and continues to be, to define issues, so that we can make informed decisions about where we should commit our resources, both fiscal and human, in program development.

The research was conducted through a series of focus groups composed of a variety of caregivers, both traditional family caregivers and paid professionals and para-professionals. They were anxious to share their experiences, those both gratifying as well as frustrating. The central theme of "compassion fatigue" emerged from both types of caregivers, and three significant related issues were identified -

that caregivers, regardless of their relationship to those for whom they provide care, need more information and assistance;

that the needs for supports and services exceed the resources available;

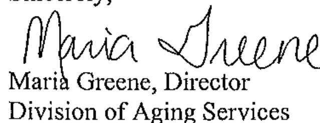
and

that many providers of supports and services are "ageist"

Because we were interested in the views of other groups of caregivers, we continued the focus groups into 2003, concentrating on obtaining input from more family caregivers, as well as those of staff in the Georgia Long Term Care Ombudsman Program, which protects the rights of residents of long-term care facilities. Kathy Scott, Ph.D., R.N., C., continued as our consultant-partner in the caregiver research.

We are pleased to offer this addendum to our original report, with findings which are consistent and which provide an even more comprehensive view of caregiving in Georgia. We hope this additional information will assist policy makers, the aging network and caregivers to make more informed decisions in this very critical area of long term care.

Sincerely,



Maria Greene, Director
Division of Aging Services

Serving Older Georgians and Their Families

Acknowledgments

The Division of Aging Services would like to thank the following individuals and organizations for their contributions to this second report:

Focus Group Participants
Once again, we want to acknowledge and thank the many focus group participants who were willing to share their time and experiences in order to assist others in gaining a more in-depth understanding of caregiving for older adults in Georgia.

Georgia Area Agency on Aging Directors and Staff
These individuals were invaluable in ocating caregivers in their areas to participate in the focus groups.

Programs Assisting Community Elderly, Inc. (P.A.C.E.)
Kathy Scott, R.N.,C., Ph.D., President
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Roswell, GA 30076
(770) 754-3146
Dr. Scott conducted the focus group research and prepared the report.

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Beverly Littlefield, Section Manager for Program Development and Operations
Cliff Burt, MPA, Caregiver Specialist

Digital Vision, who graciously allowed the use of their photography in this report.

Individuals whose photographs are included in this report are not actual caregivers interviewed for this research.

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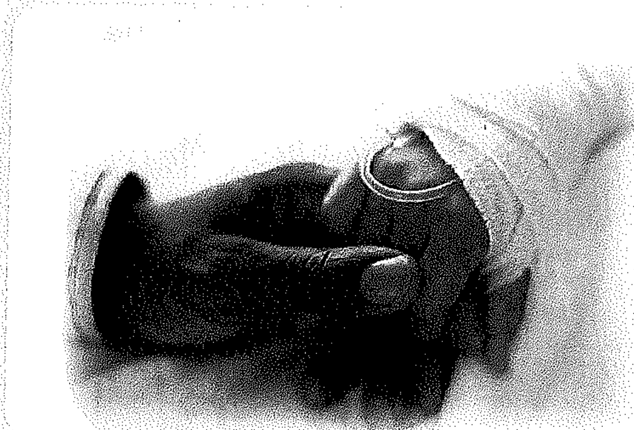


4

Summary of Caregiver Report 2002

Results

The following three pages represent a synopsis of the *Caregiving in Georgia* report of 2002. Please refer to this report for more detailed information via the website, www.dhr.state.ga.us. Pages 9 through 30 represent the data from five new focus groups conducted in 2002 and 2003.

A focus group approach was used as the primary data collection method to explore the meaning of the caregiving experience of six caregiver subgroups, 64 individuals, from different areas of Georgia (see table, page 10). The subgroups included family members [spouses, daughters, and granddaughters], community members who were providing volunteer care at various sites, paid professionals from a variety of disciplines [nursing, social work, care management, law, and aging services], and nursing assistants in home care and home health care.[1,2]

An analysis was completed using a phenomenological methodology[1,2] to determine the themes that existed throughout the six focus groups. Out of the context of "Compassion Fatigue and Frustration," three major themes emerged for these caregivers which included 1) Lack of Information/Coordination of Services, 2) Needs Exceed Availability, and 3) Ageist Providers.

The overarching theme of "Compassion Fatigue and Frustration" is best described as the constant state of willingness, weariness, and frustration of the caregivers as they forged ahead in an attempt to provide the care they perceived to be needed. The state of fatigue and frustration seemed to be highly influenced by the caregivers' underlying beliefs and expectations about caregiving activities.[1,2]

Lack of Information/Coordination of Services was one of the three major themes, reflecting the need for easier access to information on 1) what services and products were available, 2) clarity on what was included in those services, and 3) assistance in locating the services, products, and reimbursement sources. In some cases, the caregivers suggested that finding assistance [information or services] was as or more difficult than providing care itself.

Needs Exceed Availability was the second major theme. This theme reflected the frustration caregivers experienced around the lack of funding or lack of services available to address the needs that existed during the caregiving process. The lack of availability or assistance was particularly acute in relation to medications, transportation, home care, geriatricians, nursing assistants, and nursing home beds.

Ageist Providers was the essence of the third major theme. Caregivers repeatedly described the frustration in their experience with health care providers that were not knowledgable in the care of older adults. Additionally, many were concerned over the lack of supervision or monitoring of the nursing assistants responsible for care in the home.

It is out of the context of "Compassion Fatigue and Frustration" and the three major themes that approximately 40 rec-

ommendations were generated by the six subgroups.[1,2] These recommendations were intended for a wide audience for the purpose of addressing the concerns revealed during the focus groups. Some of the recommendations required funding while others included "no cost" interventions such as including family caregivers on social service organization boards. The following is a synopsis of the activities and initiatives that have occurred as a result of the recommendations from the original report.

1. Actions Taken to Create a Two-Way Flow of Information:

* Caregiver focus group findings were shared with the Area Agencies on Aging (AAA's) for use in developing their four-year area plans. The results were also shared at the Rosalyn Carter Annual Caregiving Conference, and the Annual Women's Health Forum. A presentation was made at the Division's Annual Nutrition Conference, with a new track, *Balancing Careers and Caregiving.*
* Five additional focus groups have been conducted with Long-Term Care Ombudsman program staff and family caregivers from across Georgia.
* *Caregiving in Georgia* report, with support from AARP, has been printed and disseminated statewide to selected committees on the Georgia General Assembly, AAAs, AARP, members of COAGE, Georgia Council on Aging, and other public and private sector organizations. The report can be accessed via the Department of Human Resources website, www.dhr.state.ga.us, which is going to be the home page for the Division of Aging Services.
* A list of caregiving Internet Resources has been compiled and disseminated to AAAs.

2. Actions Taken to Improve Direct Services

* The Georgia Cares program has been designed and implemented statewide to educate and help seniors apply for all available low-cost prescription drug assistance programs.
* Georgia's *Mobile Day Care* program, an innovative service delivery model which enables rural communities to have their own day care program several days per week while sharing staff that travel between locations, has been featured in the rural health section of *Successful Farming Magazine.*
* AAAs allocated over $750,000 of new funding available through the National Family Caregiver Support Program for respite services.
* Several AAAs are expanding options available to family caregivers for overnight in-home or out-of-home respite.
* The Rosalynn Carter Institute has received funding from the U.S. Administration on Aging to develop CARE-NETs within six AAA regions of Georgia. CARE-NETs are collaborative networks of representatives of professional and family caregiving organizations, as well as individuals, that work together to develop service and educational programs for caregivers.
* Several AAAs are providing counseling for caregivers either in the home or through forums.
* Several AAAs have developed programs and services for grandparents raising grandchildren, including counseling, support groups, health monitoring, and mentoring.

* A number of AAAs are employing caregiver specialists to assist family caregivers.

3. Actions Taken to Bolster Training

* With leadership provided by the Georgia Council on Aging, the Georgia Alliance for Staffing Solutions was formed. This network of 30 agencies and organizations has sponsored two forums to explore possible solutions to the crisis in long-term care staffing.

* With funding from the Georgia Caregiver Resource Center (GCRC), the Division provides funding to four AAAs per year to develop regional caregivers forums. Some forums will provide respite care to care receivers, enabling family caregivers to be able to attend. The Rosalynn Carter Institute has presented at some of these events.

* Division staff chaired plenary sessions and workshop tracks at several Georgia Gerontology Society Annual Meetings which highlighted issues such as the crisis in long-term care staffing, developing career ladders for nursing assistants, and self-directed care voucher programs.

* Area Agencies on Aging sponsored caregiving trainings and forums with funding from the National Family Caregiver Support Program.

* Beginning in 2002, the Greater Georgia Chapter of the Alzheimer's Association received funding from the Georgia General Assembly to provide 26 education/training sessions to family and professional caregivers around the state. The funding is on-going.

* The State office of AARP has begun an education/training program to enhance knowledge and skills of nursing aides, with sessions provided across the state.

* Through CARE-NETs established by the Rosalynn Carter Institute and participating Area Agencies on Aging, several *Caring for You, Caring for Me* forums for family caregivers have been conducted.

4. Actions Taken to Support Service Providers

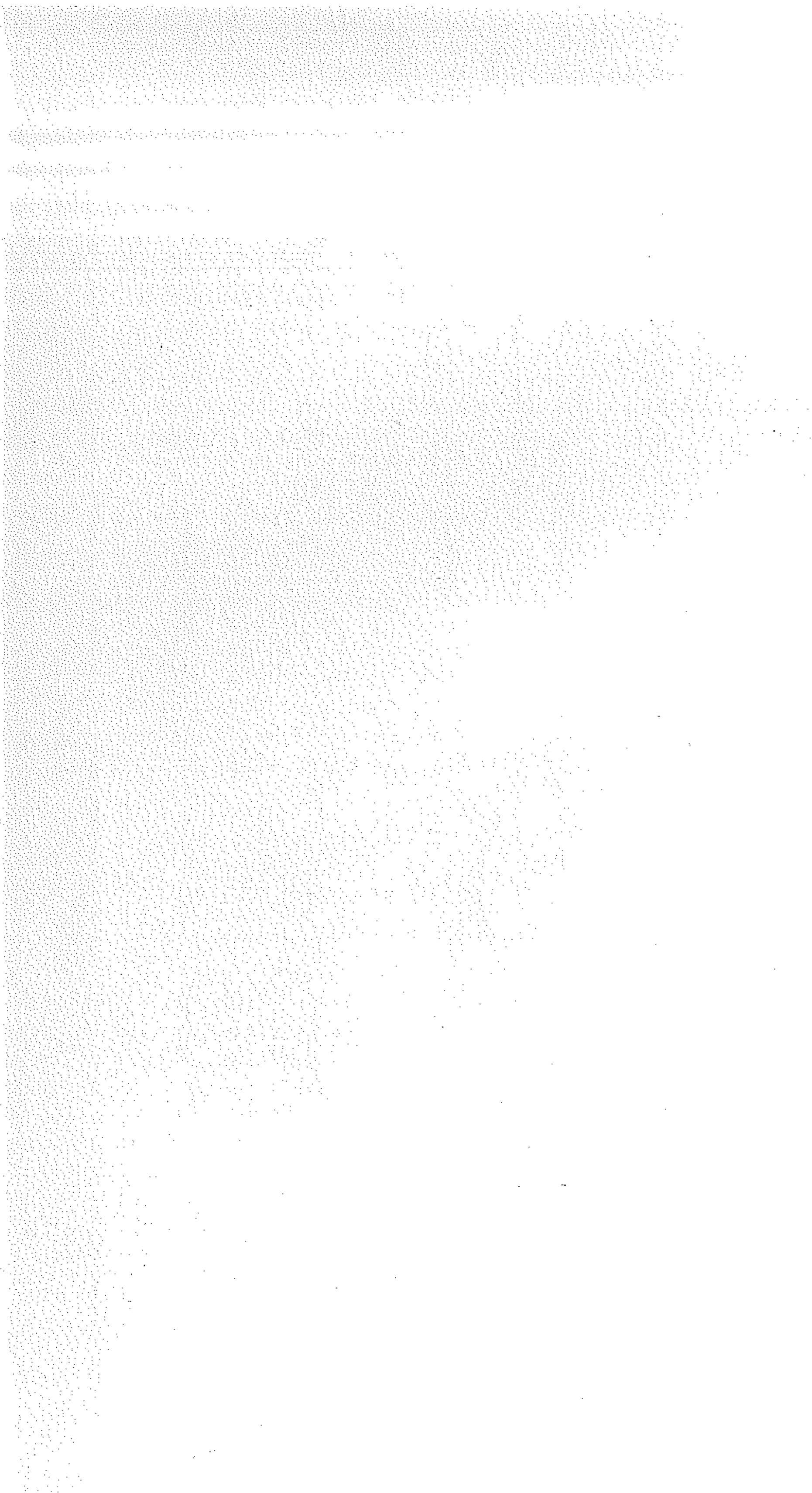
* Through a national competitive grant process, the Division received funding from the U.S. Administration on Aging (AoA) for a self-directed program, enabling caregivers to hire family and friends to provide services. Georgia received the third highest grant awarded by the AoA for these funds from the National Family Caregiver Support Program.

* Division and AARP staff were successful in developing a special track for nursing assistants at the 2001 Georgia Gerontology Society Meeting; over 140 nursing assistants attended.

* Numerous education/training initiatives have begun, and are listed above in "Actions Taken to Bolster Training."

* Policies and Procedures for adult day care/adult day health, respite, senior centers, homemaker, nutrition services, and personal care have been developed and revised. These policies establish requirements to be followed when AAAs provide or contract for the provision of services.

* Review guides to assist AAA staff to measure compliance and performance of services have been developed or revised. These guides are for nutrition services, care management, home repair, respite, information and referral, elder legal assistance programs, outreach, and adult day care/adult day health.



Additional Focus Groups, 2003

A. Research Approach

As in the original report, a focus group approach was the primary data-collection method and the phenomenological methodology was used to analyze the data of the most recent groups.

B. Sample and Setting

The sample for these five groups was persons who give care to older adults in the state of Georgia. The selection was expanded from the first report to include two groups of ombudsman program staff, and to better represent the predominant caregiver to older adults, three additional groups of family members were included. Participants were selected from five different areas of the state in order to broaden the perspective of the caregiving experience. (See map, page 11.)

Groups 7 and 8: Non-Traditional/ Professional

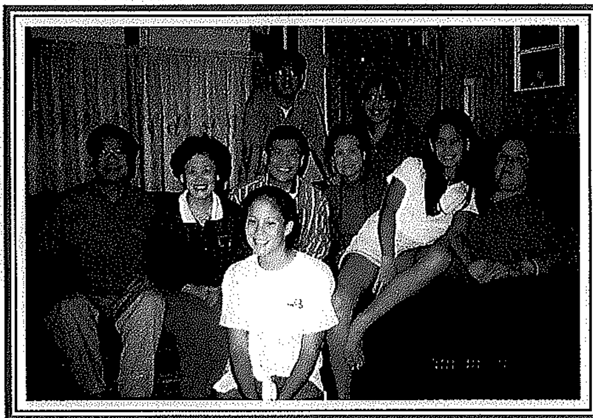
These groups of caregivers represented all 12 regions of the state and included state ombudsman and their supervisors.

Groups 9,10, and 11: Traditional/ Non-Professional

These groups represented family members from predominantly rural settings in Northwest, Southeast, and Coastal Georgia. Family members providing care were spouses and children.

C. Focus Group Procedures

The focus group team was the same group as described in the original report. The focus group procedures for recruitment of participants, the collection of data, the sample questions and analysis also remained the same.[1,2]



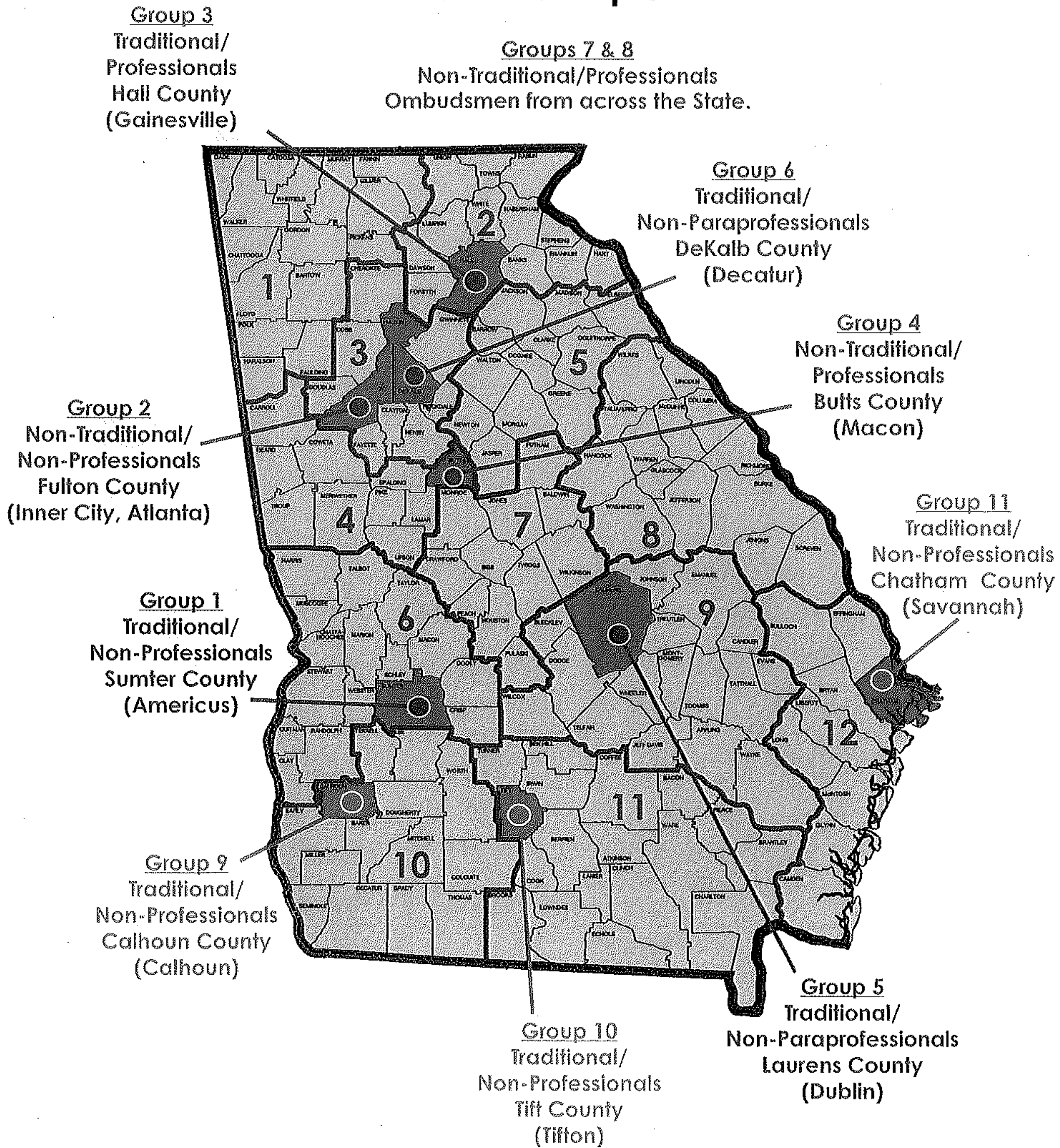
In many families, it is often difficult for an outsider to determine who might be in need of care or who is providing the care.

Focus Group Sample Demographic Data

The focus group results from the original report--groups 1 through 6--are represented in purple. The second set of focus group results is represented in blue, and the tan area is the total of all groups.

	Total in Group	Gender		Age	Race			
		Female	Male	Range	African-American	Hispanic / Latino	Caucasian	Asian / Not Specified
Group 1 Traditional, Non-Professional	12	9	3	40-80	0	0	11	1
Group 2 Non-Traditional, Non-Professional	11	9	2	29-80	6	0	3	2
Group 3 Traditional Professional	14	13	1	38-61	2	0	12	0
Group 4 Non-Traditional Professional	8	5	3	33-52	3	0	5	0
Group 5 Traditional Non-para-Professional	11	11	0	26-69	6	0	5	0
Group 6 Traditional Non-para-Professional	8	8	0	35-56	7	1	0	0
Groups 7 & 8 Non-Traditional, Professional	30	28	2	33-71	4	0	24	2
Group 9 Traditional, Non-Professional	6	3	3	40-70	0	0	6	0
Group10 Traditional, Non-Professional	13	11	2	40-76	2	0	11	0
Group 11 Traditional, Non-Professional	10	9	1	42-83	4	0	6	0
Totals:	123	106 (86%)	17 (14%)	Range 26-83	34 (27.6%)	1 (.8%)	83 (67.5%)	5 (4%)

State of Georgia Planning and Service Areas Map
Focus Group Sites



The counties colored purple were included in the original Caregivers report that was published in 2002. Those in blue, as well as the ombudsmen from the 12 districts, were added in 2003 and are part of this report.

11

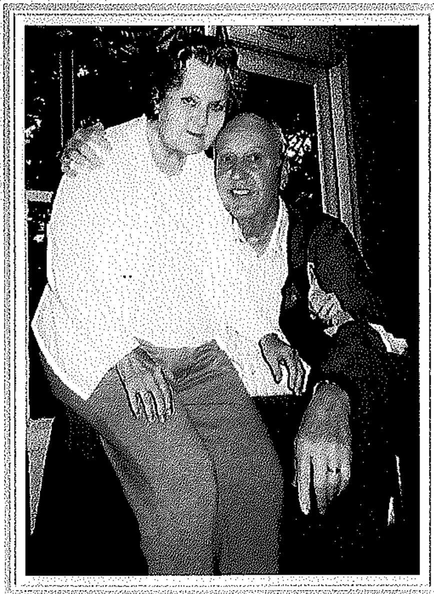
Focus Group Results

Compassion Fatigue — Frustration

Consistent with the previous six participant groups, "Compassion Fatigue and Frustration" served as the overarching theme for the caregiving experience of these participants. Although the majority were in their roles willingly and by choice, most of them shared stories that were wrapped in exasperation and exhaustion.

- *"We all have a lot of sleepless nights, I think."*
- *"I don't have stress anymore...I don't have anything. I get numb, I'm so tired. ...I've gone beyond stress...there's no way to express it to you."*
- *"I was just looking around there thinking, I honestly don't know where to start, what am I doing today? I want to go to work at Qwik Trip...at Qwik Trip something good can happen."*

The following provides a common scenario and the resulting fatigue and frustration:



- *"Yeah, I care for my wife [about 6 years]. She's only 64 years old. Her mind doesn't correspond with her hands or her feet...any moving whatsoever. Because she, [you] have to spoon feed her, take her to the bathroom and then she doesn't want to sit down when I get her to the bathroom. She doesn't know when she has to go to the bathroom. She gets very ill, you could say it's mean. She's getting that way. She tells me she wants me to leave. I'm there seven days a week, 24 hours a day. I can't leave her....She does not want to get a bath whatsoever. Never wants to get a bath and get her hair washed...I'm afraid I'm starting to come apart inside..I do...Okay, sometimes I may look at her and she'll just be sitting there on the couch leaning over like this...sideways...and I walk in there and I look at her and I just stand and cry."*

Contextual Perspectives

The contextual issues that compounded the compassion fatigue in the previous groups were beliefs about who "should" be assuming responsibility for caregiving and the frustration of not having specific resources available or accessible to assist in the caregiving process. These factors indeed continued to hold true. Additional contextual factors that were more evident in the five new groups included a) mode of entry into caregiving, b) the number and ages of the persons they were caring for, c) the level of intensity of caregiving, and d) their own health issues.

Mode of Entry

The participants in these groups stated they were caring for their loved ones for varying amounts of time....from 3 months to over 20 years. The following serve as examples as to the mode of entry into caregiving or how they came to be caregivers, which often seemed to be precipitated by a crisis event:

- *"...my mother's 94 and she lived by herself...she lived 7 miles from me. And I would check on her every day there about nine years. So, one afternoon late she decided to go to the peanut field to get her some peanuts. So, she fell and she couldn't get back up. And, so it got closer to night so we went down there and couldn't find her anywhere. She wasn't in the house.....We found her up the little dirt road where she had tried to slide from the peanut field to the house. Well the fire ants had eaten her up. So the EMTs came and got her and carried her to the hospital and since then we brought her to the house."*

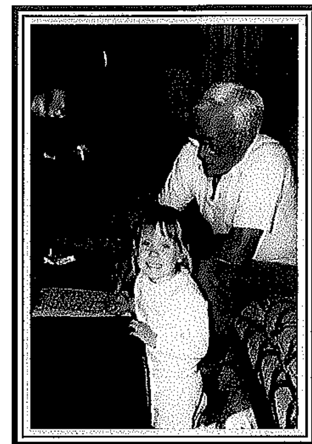
- *"She's [my mother] be 84 in April. She almost got burnt up in a house fire. I had just come home from work. I was going to take her medicines and she came out of the house and all her clothes were burnt off of her. Her hair had burnt off of her and I called 911 and got them out there. ...she was swollen and looked like a monster...didn't know she was in the world."*

- *"We live in a motor home and have ever since we have been married. I thought I could care for him better in a smaller space....We were going to Florida and we stopped at a rest area. We came back to the motor home and he said, 'How do I make it go?' This is a 38-foot piece of motor home and I thought [raised her eyebrows] ...but he still wasn't willing to let me drive. And, then when we got parked and he said, 'How do I make it backup?' This was the last time he drove. And...then he tried to jump out of the car going 75 miles per hour on the expressway because he thought I was his mother and his mother couldn't drive and was going to wreck us."*

From these and many other examples shared by participants, it seems that one of the main precursors to participants' perceiving themselves as caregivers was indeed a crisis and the resulting physical care or increased assistance with activities of daily living. However, similar to the way that persons have symptoms of Alzheimer's [and experience the consequences of them] before they are officially diagnosed, it appears that caregivers were often providing various levels of care [ie. cooking, cleaning, daily checks] for extended periods of time before they were actually providing "physical" care and considered themselves as caregivers.

Double and Triple Duty Care

As was true in the previous groups, these individuals were often caring for more than one person at a time; providing double and triple duty care.



- *"I care for my mother, she's one hundred last month......Now I just found out last week my husband's got dementia real bad and he's had open heart surgery. And I'm raising a special needs grandson that's ADD and all. I had to take him - my daughter's got cancer."*

- *"I have been taking care of my mother since '85. She's, she'll be 84 in April.....I am her caregiver plus [I have] custody of a four year old."*

- *"My husband and I have his mother with Alzheimer's who is 92 and my father who will be 95 and my mother just passed away week before last...and my husband is a heart patient."*

- *"....three years ago I moved my Mom and Dad in a mobile home behind our brick home....and I have a husband who also had a brain tumor removed a couple of years ago."*

- *"....I'm taking care of my 75-year-old husband who has had a series of illnesses for the past ten years. I also have a mentally retarded daughter who has been under my care."*

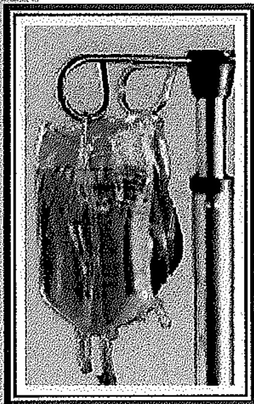
Of particular note in these groups was not just the numbers of persons they were caring for but the variance in age of the those persons. These were age groups with potentially different care demands and different resources needed to meet those demands. While caregiving is often viewed as the same for all groups, the challenges of someone who is middle aged and caring for a 100-year-old individual and a four-year-old warrants serious consideration and can have considerably different implications for support.

Level of Care Intensity

"My father is blind, (he) has Alzheimer's, he's paralyzed... my mother had a massive GI bleed... and then she had a stroke in July... she can't speak... She's paralyzed, so she is total care as well as my father... I just honestly feel like if they weren't with me I wouldn't have them alive, because they are fragile."

As much as the length of caregiving and the number of persons being cared for, it is important to note the level of intensity of physical care provided. The stories shared by these participants were those that might have been shared by skilled providers at long-term care facilities in the not so distant past. The following provides examples of the level of care:

- *"There's been many challenges but there have been many rewards as well. My parents moved in with me five months ago after my mother had a stroke. My father had a stroke, his first stroke, two and a half years ago, and he became total care. They lived with me for awhile, but then they wanted to go back home. With a lot of support they moved back home. But, they lived very nearby. Mother was the primary care person. I was in the background, but I was really more than I let her realize, because she was losing her vision and her health was poor."*



- *[husband has leukemia] "Because when I first brought him home they say, well, nothing else they could do for him and I had to flush the tube hanging out of his heart...I had to stay there until I learned how to do these things and they had everything set up when I got home...He developed two hip sores, we have to turn every 15 minutes now. And now one coming in his back...I've dressed his heels...and keep the heels dressed."*

- *[Mother was in a fire and severely burned...in a burn unit for 3 months]. "I stayed up there... slept on the floor... chairs for three months. Had to put my job on hold. So, when I brought her home I had to take care of her because she had a trach, she has all kinds of machines and things I had to learn to operate and do...She still has the trach and I have to suction it out. And then I have to...she's a bad diabetic...she has oxygen at night. She has the oxygen machine in her bedroom. Then I have a humidifier. Then she gets those Albuterol treatments I give her....there's a lot of nights I don't even put night clothes on...if I get to sleep I do it sitting on the couch or in a chair. It's been that way since '85..."*

- *"[My mother]. She has had encephalitis, which the doctors said when she had it, said her fever was so high that it messed up some of her membranes. She's had a triple bypass...She has swelling of the legs. When they did the surgery, it messed up her throat...she cannot swallow or eat good. She chokes constantly. She falls a lot...This time she fell and spent three hours in the floor*

till she got to the phone and called me...She has problems with her bladder...every time she stands she just goes on herself... Her speech is slurred real bad...she's just limited."

In addition to the physical care that is necessary, the psychological or emotional stress that comes from caring for loved ones is evident in the following statements:

- *"I take care of my mother...It's been going on over twenty years. She can still talk to you but she'll repeat things to you. She worries a lot. She has to have heart surgery. You know I take care of her... causes a lot of problems at home. My wife complains that I don't spend much time with the kids. But I tell her, 'Ain't nobody else gonna help her'....I told my wife, even if it costs me my marriage I'm not going to put her in a nursing home. If I have to I'll take care of her....I'm trying to get her some help so somebody can sit with her so I don't have to worry about it....It's stressful because I worry about her. I wonder if she's fell or hurt or whatever."*

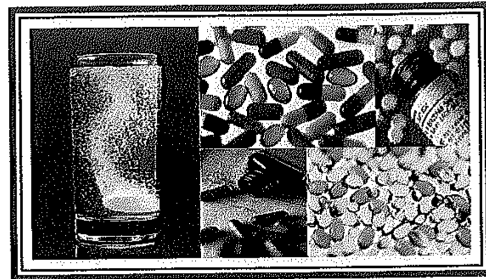
- *"...a man's point of view is going to be different just like there's gonna be a lot fewer men caregivers. There's a sense of frustration and this comes out of...it's your own personal inadequacies because you think you're supposed to be able to do something...but you can't."*

- *"And it scares me because she [mother] been my best friend for so long...So, it's just really hard, the idea that I've been so close to her and she's been my confidante for so long and my best friend and I feel like I am losing my best friend..it's a real loss."*

Caregiver Health Issues

Lastly, the health issues of the caregiver also provide context for the compassion fatigue and frustration experienced. The following examples demonstrate how, in some cases, the concern was how their own health problems interfered with their caregiving abilities and in others it shows how caregiving indeed exacerbates their health issues.

- *"They just found out that I have Hepatitis C and my doctor said because of my liver enzyme with my blood pressure...I mean the diabetes that's what they kept looking at it for....they want to go in and do a biopsy of the liver....we had an MRI this morning."*



- *"Finally, they put her on hospice because of her age, not because she's dying...in order for me to get some rest...because I have got medical problems. ..I've got diabetes and high blood pressure and heart failure and all this other stuff. The stress gets me down sometimes. I've tried to get disability and because I'm not laying flat in the bed and because I'm saying I'm taking care of them...you're not disabled. They don't realize...I have no resources toward medicines and I'm on about 8 different kinds. ....Well you're taking a shot [insulin] every morning you have no idea what your blood sugar is cause you can't buy that strip. ...you're playing Russian roulette with your life."*

- *"...this past two years, I mean I was a pretty vigorous person. Unfortunately, this arthritis kicked in and now I have to wear a brace on my leg. The walking, I mean it's an inconvenience, but it really gets to be an inconvenience when you start to take care of somebody and they getting up and down. You don't realize how many times you're up and down until it gets to be a problem. [His doctor told him] 'You get help or you're going to die'.'*

- *" But I got very sick this year and I was just not eating right and running....And I would just grab the cake and I came down with diabetes. When I went to my doctor my blood sugar was 348. I didn't even know I had sugar. But it can come from stress. It came back the other day...about a month ago and it went up again to 300 and then it dropped to 41 and he told me I needed to go to the hospital."*

Six Major Experiential Themes

Six major experiential themes were revealed in the data:

1.) **Lack of Information and Coordination of Resources;**
2.) **Needs Exceed Availability;**
3.) **Ageist Providers;**
4.) **The Lone Caregiver;**
5.) **Pushing Against the Tide; and**
6.) **Living a Dilemma.**

The first three themes existed in the previous data and were noted in the original report. The last three themes are discussed here with supportive data from these five focus groups.

Lack of Information and Coordination of Resources

A sense of frustration was clearly evident as these participants described their inability to locate information on services, both specific and general caregiving services, despite their many efforts. They described how they attempted to locate this information on their own and then turned to those who they traditionally counted on for this information [ie. doctors, health department, aging agencies]...still to no avail.

"...we can't get off the ground. I know there are resources available from a place...a program called Community Care. I know it's there, but you can't get off the ground, you can't get any help. And that's what aggravates me.....I've called everybody. I have spent days on the phone and I don't know what else to do. I know the resources are there but it's like you can't get to them."

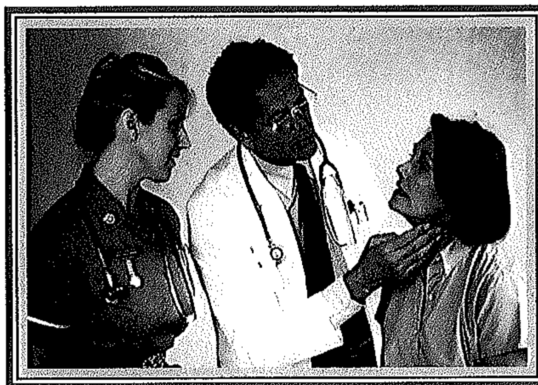
"...and I started looking for a support group and didn't know how to find it. I was not from this area...I didn't know how to reach the resources. I went to the health department [in the area]. They didn't know anything about any kind of help group. I went to the senior center. I thought surely they would know. They didn't know anything about it. I don't remember how...I think I saw a notice in a paper and finally got me to one and... then we were able

"A lot of times I get frustrated because I'm the only one making all the connections to the other agencies ... calling legal services ... calling here ... following up. I'm always the one making that call to check and see if the job is being done or if legal services did their part or whatever. So, yeah, what she's saying is true, you feel very frustrated..."

to make connections...I was really shocked that the health department in a county did not know anything available for Alzheimer's in that county. There is just some breakdown in communication... that a place that should be providing health care for a county knows nothing about Alzheimer's."

- *"Her doctor is no help... And I again I referred to this thing (CCSP)... the lady in my church she tried it for her mother on her own and didn't get anywhere. She got her mother's doctor to call them and it speeded up the proces. So I said 'All I am asking you to do is call and talk to them and tell them that we need some help.' The response I got was, 'We really don't know what's available and we can't really help you.' So he knew nothing ... his nurse knew nothing... it was a dead-end road."*

- *"I had to have some tests done at the hospital last week. I'm supposed to get the results back today. If it happens the way I'm kind of expecting I'll have to go in the hospital. And at this point I have no idea what to do with my mother."*



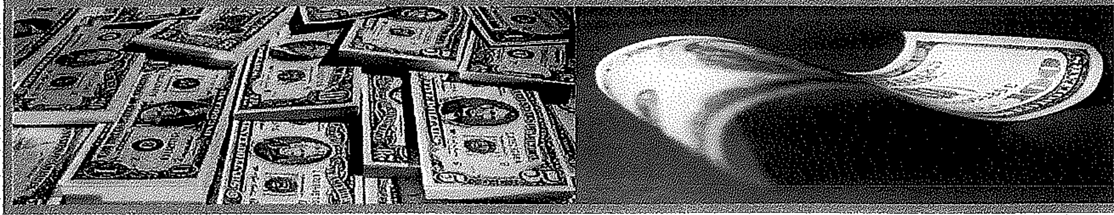
- *"I think one of our biggest problems is information... where do we go for this... who knows what?"*

- *"I know it's out there it's just....you can't get to it. And that's what's aggravating. There's too much red tape."*

Each participant experienced his or her own degree of frustration related to this theme, but without a doubt the lack of information and coordination of resources can take it's toll on an already stressed system. The following is a statement from a caregiver helping to care for his mother:

- *..and here are people that need help...that have worked their whole life...paid their taxes their whole life and can't get it, and that is wrong. I can understand why somebody would go ballistic and go to a place and want to kill everybody in there. I can understand that. When you work your whole life trying to find...you know help that is out there and you can't get to it...what are you supposed to do?"*

Needs Exceed Availability



The needs of caregivers are varied, and the resources to meet those needs are perceived to be limited. What has been shared, again, by the caregiver groups is that, too often, the needs exceed what is available or accessible to them. In some cases, the need was financial in order to purchase the services needed. In other situations, the service was needed because they were unable to provide it themselves. A predominant pattern under this theme was the frustration of knowing there were services available that they qualified for but, because of the increased demand, they were placed on a waiting list of unknown length and duration.

- *...unfortunately, some of us aren't financially able to handle a lot of the expenses that go along with caregiving. I had to quit my job and retire for my social security in order to take care of my mother..."*

- *...we've signed up for the program [CCSP] but we haven't gotten on any of them. They keep saying we're on the next, when they pull up the next list....We'll be on the next list, but so far we haven't been called."*

- *"...I'm on the waiting list. Yeah, they don't have funds available every time."*

- *" [Takes care of his mother]. It would be nice [having respite with varying hours/days]. I haven't been outside the house after sundown since my wife passed. She died March of last year...this March will be two years....I'm limited on being able to go to church. I can't go to evening services".*

- *"...she was saying that her husband draws $65 too much...that's where a lot of this is falling into ...we make too much money. We don't have enough money, we can't hire private help, and we don't fall into the other category...what do we do?"*

- *"Because being on the waiting list we need help now, we don't need help six months down the road. We need help today."*

- *[referring to 64-year-old mother with Alzheimer's]. "We were trying to put her on disability...can't do that. She's not old enough for Medicare...you know Dad has the drug card that the drug company put out because he's over 65. But, see it doesn't apply to her because she is only 64. It's like you're fighting an uphill battle."*

- *"And I've got a letter back from [location] that says she qualifies...she's eligible for it but, they say there's a waiting list. I can't get to that."*

- *"She's liable to get up in the morning time and try to go to the bathroom and just fall...she hits her head...I may not find her for days.....I got her on a waiting list.....they said it could be a month, it could be a year....there's such a long list, they don't know when they can get to you."*

> "Like I had to tell my doctor that to you she is a patient, to me she's a person, it's my mother. I love her--that's the thing, and she's more important than things."

- *"I called the community people before hospice came and they said they wouldn't have anymore resources until after January...they were frozen".*

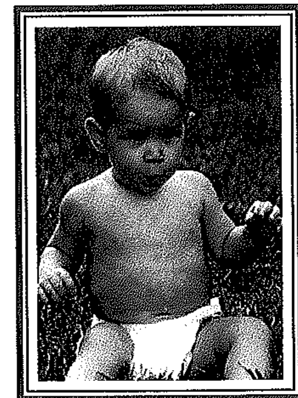
In some cases what is the most apparent missing resource is staff. The following exemplifies this phenomenon:

- *"...the nurses complained about the fact that they were short staffed [in the nursing home]. On Sundays I have to get up and cut her meat because there's nobody there on Sundays of course."*

- *"You know the CNA has constraints of under staffing... and then corporate comes down... and they are not addressing crap!"*

Ageist Providers

In much the same way as the previous group, ageism showed up in stories shared in these five groups. Ignorance, disrespect, apathy, and complacency were all threads of the ageism that they suggested of providers. For instance:



- *"...the whole medical profession needs to listen to what the person or the resident is saying..part of it is just making them see that resident as a real person ...not a child."*

- *"I saw this first hand [demeaning, disrespectful care] not long ago when I attended a care plan session for one of our residents...I sat down, I looked, I said "Where's my resident?'*

[They said] Oh, she's in her room. [when they finally brought her in, they did not place her at the table]...she was perfectly capable of hearing and understanding. It's as if the resident doesn't exist."

- *"...we couldn't find the right kind of doctor to go to. They kept giving him medication for depression...well, he wasn't depressed, that wasn't the problem."*

- *"In our hospital...to me they don't have enough knowledge or training in Alzheimer's...any type of dementia..they just look at you."*

- *"I tried to find a doctor in Chattanooga and I was sure as large as Chattanooga is...that I could find a doctor who could specialize in working with older people. The only one I found was in a nursing home and she didn't want to take private patients... They treat them like... after the age of 90...'Oh, we can't do nothing, so just let it go.' "*

- *"Her doctor is no help....he's got her on things [medicines] that is just costing Dad that she doesn't need."*

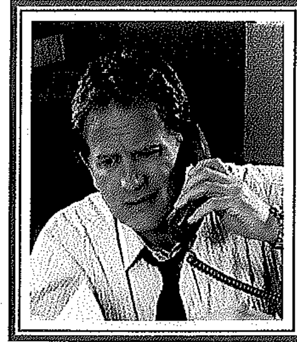
- *"Like doctors sometime when you have an older person...some of them feel like "well they've lived their life, you know, they're eighty something and they've lived the best of their life....and I don't like doctor like that because I think they are still living so there's hope and they should be treated like anybody else."*

- *"Respite care is fine...but are they [the staff] gonna take good care of her...and the issue I have is because they are not trained..they do not have a profession....They don't have the knowledge."*

- *"And then there's the basic issue of respect. I think CNAs and the residents both are treated with a tremendous lack of respect...CNAs are not going to treat residents with respect if they're not treated with respect. Especially with CNAs. They only in some cases have two weeks training, others six weeks training... There's no way anyone could understand this in six years, let alone six weeks."*

" It's inhuman to me, I've had the physicians, the nurse, the doctors say 'Why don't you let him go? What are you trying to do? Sign this so if he stops breathing or whatever....I told one of the doctors I said, 'Listen, you're not God, you do not have the last word over him, you do whatever you can do for him and when you are through you discharge him to go home, I will take him home'...so it takes a lot out of you."

The Lone Caregiver



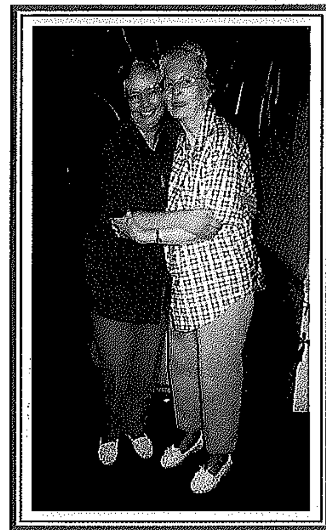
One of the primary new themes that came out of this data was related to the perspective that each participant saw himself as the sole caregiver; there was no one else to do it or to provide assistance. This belief seemed to hold true whether or not others were available, as the primary caregiver did not perceive them to be accessible or willing to participate.

- *"At times I have felt like no one cares. You just feel like you are all alone. It has been difficult...It seemed like the church neglected him for awhile. They help me if I ask for help with things but they don't come to me. Like we have a new preacher and he hasn't been to visit yet."*

- *"The only one that could help me is my brother. My other brothers and sisters wouldn't because they all say they've got a family. I've got a family too, don't stop me. Out of six children, my oldest brother and I are the only ones to help and I help more than any of them. I go over to the house and help her [mother] clean and check on her...cook her something to eat. None of the others will help her...because if she can't get me and she can't get my oldest brother, and they won't go over there and see her. I just ask God and I do most of it myself."*

- *"There is (sic) five of us, but she [mother] thinks that there is nobody but me. I am her caregiver plus [I have] the custody of a four year old.... So, it's just me. My sisters say 'I can't learn to do what you do'... because they can't suction her out, they can't do all this stuff they say."*

- *"I have nine brothers and sisters. My husband and I, before we moved back, we talked to everyone in the family. They assured us that we would have help. I had a brother living in the home with my mother and father... so we came home to help him. Two months after we arrived, he moved out.... so I had my Mom and Dad that I was caring for. So now that leaves me as the primary caregiver... It's difficult, because we had all these promises of help and they are not forth coming. The primary care responsibility falls to me."*



In some cases this belief was founded on the fact that there were no children or siblings to assist.

- *"I'm the sole caregiver of my 87 year old mother. My wife died March of last year and it's been just left with me since then. I have no siblings to help. I've got the whole ball of wax. So, it's kind of difficult. Especially being a man taking care of a woman."*

- *"I'm an only child, so that tells you what I have to do."*

- *"I think we all probably have a limit that we will individually go to... and every now and then I'll have a case like the lady who had no one to go to her house and get the dresser out of this awful house...But there was no one else to do it...so I did."*

- *"The only thing I can say is that maybe I get up and I do it [caregiving] everyday because I'm fearful that nobody else will do it. Nobody will follow through when I know that needs to be done so I'd better do it because it needs to be done. I just know that if I don't do it then it won't get done...."*

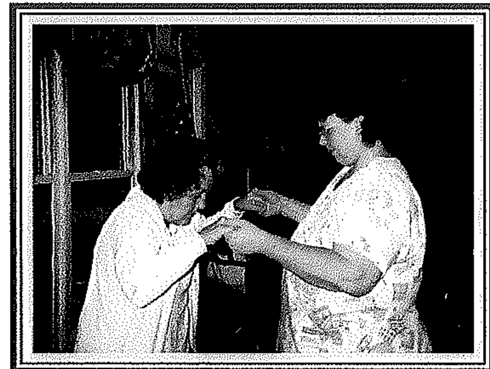
In other circumstances, children, siblings, or friends were available but it was not perceived as appropriate or acceptable by the care recipient.

- *"As the saying goes, I am the glue that holds the pot together. No brothers or sisters....nobody except my son - he's 35 - he's not married. ..Cause he can't get off of the job to do this."*

- *"The care that my Mom needs we [me and my brother] can't do for her because we are boys...it needs to be a female to come in and do that and provide what she needs that we cannot do. So, I feel like our hands are tied."*

- *"I have nobody else to sit... I'm either on the road [with her] or at her house. That's the biggest thing that I see...she don't want me out of her sight...that's stressful."*

- *"My wife is the proverbial clinging vine, she doesn't want me in another room let alone going out the door. She's alright as long as I'm doing housework... So, she wants you there... she won't let anybody else do anything."*



Pushing Against the Tide

Compounded by the perception of being the "Lone Caregiver" was the belief that, from the outside, they were being misunderstood or judged either for "doing too much," "not doing enough," or taking advantage of the care receiver. These caregivers were still attempting to do what they believed was right for the person receiving care and yet so many times standing in the face of criticism or lack of validation from others. Some described it as "pushing against the tide." The following excerpts serve as examples:

- *"The biggest surprise for me was the perception of other people towards my situation. It's overwhelming the number of people in my family that have said, "You can't find someplace to put them?" And I always just stop and take a breath and say, 'I found a wonderful place for them right here in my house.' ...but it was shocking to me the people that would come in...even the physicians...they would come in and they'd shake their heads and walk out."*

- *"They don't understand....like you said physicians, they're like "what are you doing? What's the point? Why don't you put them somewhere and forget about it? Anyway, that made me angry. And the other thing that used to make me angry is...they would be like 'Oh you take care of your mom? You're just sitting around the house all day; what's the big deal?' Yeah, you don't have a job. You don't go to work, that's no big deal."*

- *"That opinion is really hard because I don't work either and people think you're just at home all the time...you're not doing anything and that you haven't used very good judgment.*

- *"But there was no one else to do it...so I did.....And I know I'm being shamed over there [referring to others within the group]."*

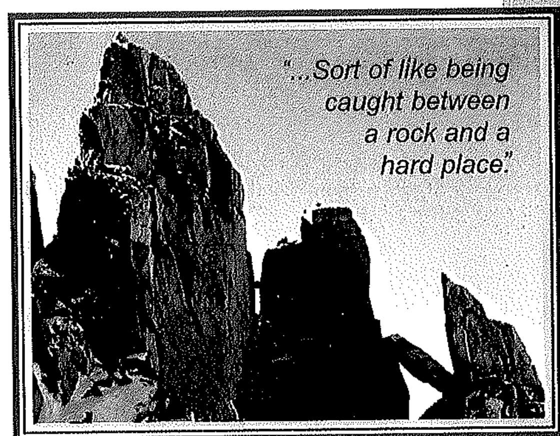
- *"It feels like they are stabbing you. It's like everything that I'm doing is...they're questioning... it's like they think we're stupid. 'Why would you do this to yourself? Just get it over with, just get rid of them. My brothers said to my husband and I, 'How could you quit your job? I could never quit my job.' They don't want to get too close because they feel like you're gonna ask them to help.*

- *"Last year, with my aunt who is 90 now, over 90 years old. She became critically ill in her home. She still lived alone with her dog and had to be put in a nursing home. Well, you know the nursing home kept her for a short time. And she had reached the point where she was able to ambulate by herself with a walker. But, she knew clearly what she wanted...Her whole community of friends and everybody was like 'you can't let her go home.. you have to stop her from going home.' But she went home, she had Meals on Wheels, she had homemaker aides from DFACS that come twice a week. She still has periods of confusion...she still has periods where she is incontinent..she still has times that she probably doesn't eat like she should. But this lady is so much happier. You know I had people calling me from up there, after I came back home. 'You've got to come up here and put her back in a nursing home' and I had to explain to them, I can't put her back in the nursing home...you can't force somebody in a nursing home if they don't agree to it..it's her choice."*

Living a Dilemma

This theme is reflective of yet another layer of complexity that exists in caregiving.... whereby caregivers are faced with situations and making choices between equally unsatisfactory actions. For instance, one may be very willing and desirous of caring for an aged parent but have to quit their job in order to do so. Quitting their job may not be an option because they would have no way to provide for themselves or their parents, but not taking care of the parent is not satisfactory either. This theme had the feel of being "between a rock and a hard place." Variations on this theme were revealed many times throughout these caregiver groups. One participant described a situation where a decision had to be made between perceived safety and individual choice:

- *"Those are the hardest things when you have to advocate for something that's happening that's harmful to a resident or keep your mouth shut about something that's happening that's harmful to a resident."*



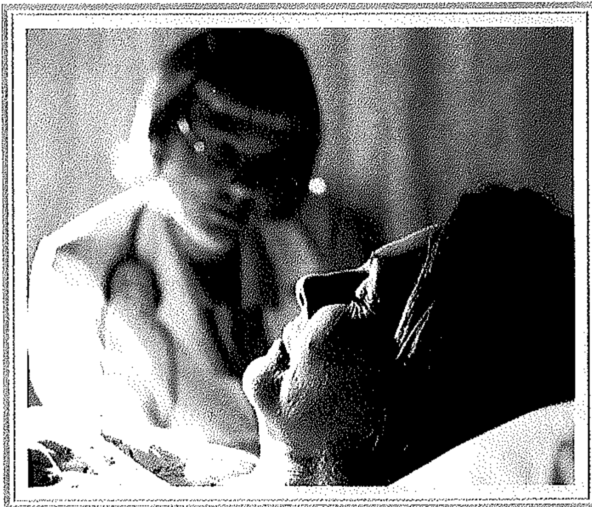
- *"It most certainly is [hard] because when you have to advocate for someone to go home that in your mind you know that individual doesn't really need to go home. But what I think and what I feel doesn't matter, I have to focus totally on what that resident wants and what that resident thinks and what he or she feels. I had to advocate for a blind resident to go home and live with a caretaker who was a drug addict or an alleged drug addict. Noth-*

ing would have it but she go home. She did and tried it. But it was her choice, broke my heart, but I advocated for what she wanted."

Others spoke of the dilemma in making requests for an exhausted resident and an overloaded caregiver:

- *"It's overwhelming. Cause I remember being in a facility just a few weeks ago from like 4:30 till about 6:00 at night and I've been doing this for sixteen years. But I stood there looking around going, 'Where do I start?, What do I do? Why am I here?' You know because there were so many issues they were just hitting me, every hall I went down there were more issues. And it was you know, a resident saying 'I'm so tired, I've been sitting in this wheelchair all day long...all I want to do is go to bed'. And I know it's going to be two hours before they [staff] have time because that's what it is every night. And when I look around for the CNAs, there was one CNA on that hall and she was working her rear off trying to do the best she could and you know I could have gone to her and said 'Excuse me, this resident wants to go to bed right now, could you take care of that?' And she would have done it because I'm the ombudsman, but I didn't feel like it was fair to her either or to the resident because she was trying to get into bed. You know the nurses were trying to pass medicine, some were feeding in the dining room and it was obvious residents' needs were not being met and this is at one of the better facilities in [location] that had a great reputation and I was just looking around there thinking, 'I honestly don't know where to start.' "*

- *"I've had several experiences with talking to the CNA and when a resident voices a complaint about 'I have to wait so long for this or so long for that'. I'll ask the CNA and I'll say 'How many residents do you have? 'Oh 12 or 13'. 'How many are total care?' 'Well more than half' and then that CNA is in trouble for talking to me, you know. I'll come again and he or she is doing that because they were called on the carpet...You know the CNA had constraints of the under staffing , overworked, underpaid, treated with disrespect... often times, the administrator's hands are tied because of corporate, you know... and it's very frustrating talking to residents and then you get into all these other things: 'well, please don't say anything I'm afraid of retaliation'... family members the same type of thing...well, what can you do? And I'm thinking, I can't do jack!"*



Many of the participants spoke of the dilemma of having nursing assistants coming into the home. All described the need for respite and at times they would use this service, however having outside assistance was often perceived as more work or doing more harm than it was worth. Here is one participant's story:

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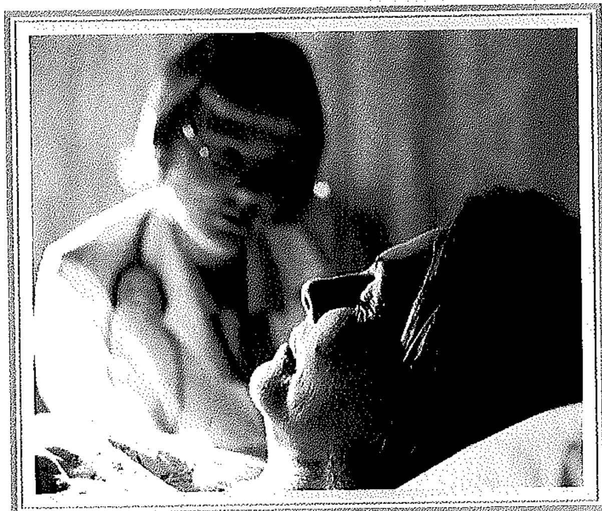
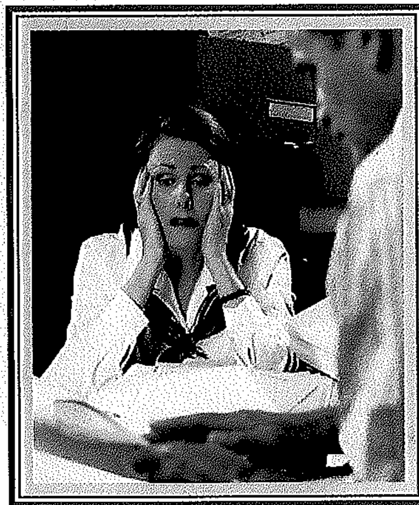


Many of the participants spoke of the dilemma of having nursing assistants coming into the home. All described the need for respite and at times they would use this service, however having outside assistance was often perceived as more work or doing more harm than it was worth. Here is one participant's story:

"Well...they do sometimes send caregivers... send people as caregivers to take some hours off. But, it always seems to be my problem is that I have to sit in with her [nursing assistant] and another thing you gotta watch them all the time. One time they will come in and do a little something for you. But the last time all they wanted to do was sit. The last lady that came she was up in years...she was sort of like a boss with my husband and I would go in and talk to him and her together and I tried to suggest to her to let him do things..it was really a disaster...I left to go somewhere and I come back...my husband, she had him in the bathroom. She sent him back into the living room and the door was open and I warned her and warned her and warned her NEVER to leave that door unlocked. Now, the door was open, he was right out the door...he went down the steps, he got on the side of the street started running and the first thing you know he fell...bruised himself all up...he broke his arm. Caregivers, I could have sued them for everything they had. My granddaughter was downstairs and she heard that woman talk to my husband like he was a dog ....he was crying at the table...It was a disaster."

For others the dilemma presents itself around the decision of where care is provided, at home or in an outside facility like a nursing home.

"...Because I never want him to go in a nursing home, that was just unthought of. With his condition, I need a lot of equipment at the house to take care of him properly... my responsibility is to take care of him, that's what the Bible told me, that's what the Bible teaches... I have to see because it's my duty to be there..but it's my duty to be there but I can't go any further...I can't do what a nurse can do..It's nice to be at home with him but everyday you got to be there."



And lastly, the diversity of opinions in regard to care serves as a dilemma in many cases. One participant described in this way:

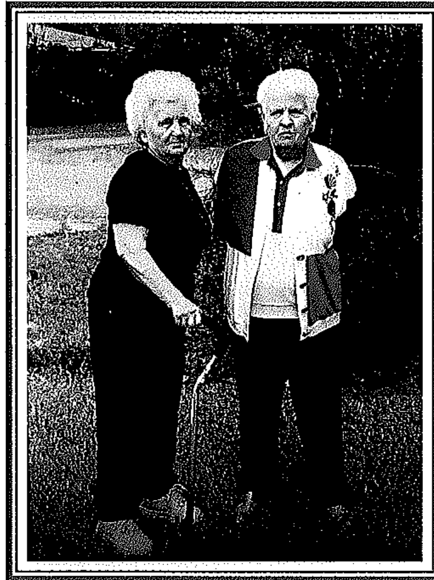
- *"...you get a call from a family member who has complaints and you go see a resident...and I've had residents say to me 'Oh my daughter she blows everything up...she gets upset over everything.' You know, there are those times that residents do not want us to do anything or don't want to tell about what the problem is because they're fearful. There are also many people, particularly in our elderly population, who don't want to cause waves, don't want to get somebody in trouble, or 'I'll just do what the daughter wants and they will go along.' And we are there to be the person who says 'No, it's what you want, we're here to help you not have something forced on you, whatever that something may be,' even if it's something that we know would, healthwise, be best for the resident... And we're there to speak for that choice even if it's going to be detrimental to their health and goes against what everybody else thinks... 'You're being abused here and you don't want to leave, ok. I'll be back next month.' "*

Focus Group Recommendations

From each of their stories about caregiving, the participants shared what they thought would be helpful for them to continue quality care for the individuals in their care. The majority of them concurred with the participants in the first report which included a) the need for more coordinated information on services and providers, b) the need for more services with a particular emphasis on respite care in the home, financial assistance, and emergency services for caregivers, c) more adequate training for providers at all levels, and d) more financial and backup support for families and nursing assistants.[1,2]

Additional recommendations from these five groups included the following:

Education of the Faith Community
Several persons raised concerns that the church served as support as long as the loved one had an acute illness. However, when the nature of the disorder became more chronic, the support of the church seemed to diminish and was sorely missed. The recommendation was made that the church community be given reports like this one to learn of the reality and the stresses of caregiving as a way to prepare themselves for outreach work.



Social Support of the Caregiver
The need for specific services has been evident in all groups. The need and request for more social support, such as "carrying on an adult conversation" with someone, came out in these five groups. It was recommended that even a "friendly visit" or "friendly telephone call" would be welcome in the midst of the caregiving chaos. This will become increasingly important as the number of caregivers decreases and the number of those they are caring for, along with the variance in age, increases.

Contingency Planning
While this recommendation is not entirely new to these groups, it seemed to carry a lot more weight particularly given the health status of many of the caregivers. Most responded that they did not have a plan in place, were not sure of how to put one in place, and that having no plan created a lot of background stress for them in the caregiving process.

Division of Aging Services
Strategic Plan for Caregiver Initiatives

In partnership with the state aging network, the Georgia Division of Aging Services (GA DOAS) provides leadership in establishing a comprehensive array of programs and services for Georgia's increasing number of older adults and their caregivers.

GA DOAS has established four intiatives to fully implement a continuum of care within Georgia for caregivers. A complete description of activities undertaken by the aging network related to these intiatives may be found on pages 5 through 7 in this report.

The GA DOAS continues to work collaboratively and support the Rosalynn Carter Institute, the Georgia Gerontology Society, the Georgia Alliance for Staffing Solutions, and AARP as they address issues such as long term care and caregiving.

The four intiatives of the GA DOAS are as follows:

Research and Strategic Planning
The Division has continued to conduct additional caregiver focus groups to add to the data provided in the original caregiver report, culminating with the publishing of this report, which details the findings from five groups with family caregivers and ombudsmen. As resources are available, the GA DOAS will conduct focus groups targeting the interfaith community statewide.

Education and Training
The findings and recommendations from the caregiver focus groups are utilized by the Division and the aging network in developing curriculum for caregiver education and training. A variety of education/training formats have been used to reach both family and professional caregivers, including support groups, one day workshops/seminars, and multi-part caregiver education series that take place over the course of several weeks. Evaluations of education/training sessions are routinely completed by caregivers attending events, and indicate that caregivers continue to seek information about available services, how to access services, how to provide personal care without injury to the caregiver or care receiver, and dealing with behaviors of persons with dementia.

Program and Resource Development
Through the continuation of caregiver research, GA DOAS now has data which can be used by Area Agencies on Aging (AAAs) to identify issues and trends in caregiving within their regions and as a basis for planning needed programs and services. GA DOAS is working with Dr. Rhonda Montgomery, a prominent researcher on caregiver issues in the United States from the University of Wisconsin on field-testing a new caregiver burden scale. AAAs are helping to determine the instrument's uses for 1) prioritizing caregivers for receiving services; 2) targeting services more efficiently and effectively, and 3) identification of needed caregivers resources for long-range program planning and development.

Information Dissemination
The original *Caregiving in Georgia* report has been posted on the Division's website. Presentations on Georgia's

mobile day care, caregiver mediation project, and self-directed care programs have been made via tele-conference, and the United States Senate Special Committee on Aging.

With leadership from the Atlanta Regional Commission Area Agency on Aging, Georgia's AAAs have developed and funded a caregiver magazine entitled *Georgia Generations*. Published quarterly by JAM Publications, the magazine has featured topics such as affordable prescription drugs, grand parenting, depression, and personal histories. Additionally, each feature includes an article written by each Area Agency on Aging regarding particular programs and services within its respective region.

Division

of

Aging Services

of the

Georgia Department

of Human Resources

http://www2.state.ga.us/departments/dhr/aging.html

References

1. Scott, C. B. (2002) Caregiving in Georgia: A State Report from the Georgia Caregiver Resource Center

2. Department of Human Resources website:
http://www2.state.ga.us/departments/dhr/aging.html
Choose link to home page for the Division of Aging Services.

AREA AGENCIES ON AGING / LEAD AGENCIES

PLANNING AND SERVICE AREA	COUNTIES INCLUDED			AREA AGENCY ON AGING DIRECTOR NAME OF AGENCY ADDRESS	PHONE AND FAX NUMBERS
Atlanta Regional Commission	Cherokee Clayton Cobb DeKalb	Douglas Fayette Fulton	Gwinnett Henry Rockdale	Cheryll Schramm, AAA Director Atlanta Regional Commission 40 Courtland Street, N.E. Atlanta, GA 30303	Tel: 404 / 463-3100 FAX: 404 / 463-3264 Aging Connection: 404 / 463-3333 Toll Free: 800-676-2433
Central Savannah River Area	Burke Columbia Glascock Hancock Jefferson	Jenkins Lincoln McDuffie Richmond Screven	Taliaferro Warren Washington Wilkes	Jeanette Cummings, AAA Director Central Savannah River RDC 3023 Riverwatch Parkway, Suite A Augusta, GA 30907-2016 P.O. Box 2800 Augusta, GA 30914-2800	Tel: 706 / 210-2000 FAX: 706 / 210-2006 Toll Free: 1-888-922-4464
Coastal Georgia	Bryan Bulloch Camden	Chatham Effingham Glynn	Liberty Long McIntosh	Eleanor Helms, AAA Director Coastal Georgia RDC P.O. Box 1917 Brunswick, GA 31521-1917 Physical Address: 127 F Street, 31520	Tel: 912 / 264-7363 Information Link #: 1-800-580-6860 FAX: 912 / 262-2313
Coosa Valley / Northwest Georgia	Bartow Catoosa Chattooga Dade Fannin	Floyd Gilmer Gordon Haralson Murray	Paulding Pickens Polk Walker Whitfield	Debbie Studdard, AAA Director Area Agency on Aging of Northwest Georgia P.O. Box 1793 Rome, GA 30162-1793 Physical Address: 1 Jackson Hill Drive,	Tel: 706 / 295-6485 FAX: 706 / 802-5508 Screening for Services: 1-800-759-2963 30161
Georgia Mountains	Banks Dawson Forsyth Franklin Habersham	Hall Hart Lumpkin Rabun	Stephens Towns Union White	Pat Viles Freeman, AAA Director Legacy Link, Inc. P.O. Box 2534 Gainesville, GA 30503-2534 Physical Address: 508 Oak St, Suite 1,	Tel: 770 / 538-2650 FAX: 770 / 538-2660 Toll Free: 800 / 845-5465 30501
Heart of Georgia Altamaha	Appling Bleckley Candler Dodge Emanuel Evans	Jeff Davis Johnson Laurens Montgomery Tattnall Telfair	Toombs Treutlen Wayne Wheeler Wilcox	Gail Thompson, AAA Director Heart of Georgia Altamaha RDC 331 West Parker Street Baxley, GA 31515 Physical Address: 505 West Parker St.,	Tel: 912 / 367-3648 FAX: 912 / 367-3640 Toll Free: 888 / 367-9913 Appling County

Area Agencies on Aging / Lead Agencies

Planning and Service Area	Counties Included			Area Agency on Aging Director Name of Agency Address	Phone and Fax Numbers
Middle Georgia	Baldwin Bibb Crawford Houston	Jones Monroe Peach	Pulaski Putnam Twiggs Wilkinson	Amy Tribble, AAA Director Middle Georgia RDC 175-C Emery Highway Macon, GA 31217	Tel: 478 / 751-6466 FAX: 478 / 752-3243 Toll Free: 888 / 548-1456
Northeast Georgia	Barrow Clarke Elbert Greene	Jackson Jasper Madison Morgan	Newton Oconee Oglethorpe Walton	Peggy Jenkins, AAA Director Northeast Georgia RDC 305 Research Drive Athens, GA 30610-2795	Tel: 706 / 369-5650 FAX: 706 / 369-5792 Toll Free: 800 / 474-7540
Southeast Georgia / South Georgia	Atkinson Bacon Ben Hill Berrien Brantley Brooks	Charlton Clinch Coffee Cook Echols Irwin	Lanier Lowndes Pierce Tift Turner Ware	Wanda Taft, AAA Director Southeast Georgia RDC 1725 South Georgia Parkway West Waycross, GA 31503-8958	Tel: 912 / 285-6097 FAX: 912 / 285-6126 Toll Free: 1-888-732-4464
Southern Crescent ***(Formerly Chattahoochee-Flint/McIntosh Trail)***	Butts Carroll Coweta Heard	Lamar Meriwether Pike	Spalding Troup Upson	Bobby Buchanan, AAA Director Southern Crescent AAA P.O. Box 1600 Franklin, GA 30217-1600 Physical Address: 13273 GA Hwy. 34	Tel: 706 / 675-6721 (Atl. 770 / 854-6026) FAX: 706 / 675-0448 Toll Free: 1-866-854-5652 East
Southwest Georgia	Baker Calhoun Colquitt Decatur Dougherty	Early Grady Lee Miller Mitchell	Seminole Terrell Thomas Worth	Kay Hind, AAA Director Southwest Georgia COA 1105 Palmyra Road Albany GA 31701-1933	Tel: 229 / 432-1124 FAX: 229 / 483-0995 Toll Free: 800 / 282-6612
Lower Chattahoochees	Chattahoo-chee Clay Crisp Dooley Harris	Macon Marion Muscogee Quitman Randolph Schley	Stewart Sumter Talbot Taylor Webster	Tiffany Ingram, AAA Director West Central Georgia AAA 1428 Second Avenue P.O. Box 1908 Columbus, GA 31902-1908	Tel: 706 / 256-2910 FAX: 706 / 256-2908 Toll Free: 1-800-249-7468

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Lifespan Respite Strategic Plan

2013 - 2018

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Special thanks to Felicia Sherman, Project Manager at the Ohio Department of Aging, for facilitating the development of this Strategic Plan.

Executive Summary

The Ohio Respite Coalition (ORC) is a statewide collaboration among family members, caregivers, advocates, respite providers, agencies, community groups, and state and local government officials who believe all caregivers could use a break once in a while.

This strategic plan highlights the Ohio Respite Coalition's five-year approach to increasing the availability of respite services in the state. The coalition is supported by a three year (2011-2014) Lifespan Respite Program grant from the Administration on Aging (AoA) (now part of the Administration for Community Living (ACL), administered by the Ohio Department of Aging. The goals, strategies and tactics outlined in this plan will set a framework for how the Coalition will approach year three of the grant and beyond. More specifically, this plan includes the following:

Section 1 highlights the Ohio Respite Coalition's Mission and Vision Statements and provides Ohio's definition of respite.

Section 2 provides an environmental scan of national and Ohio-specific factors influencing the future direction of respite services. Key topics include existing respite services in Ohio, coordination of respite services and a summary from Ohio's regional summits.

Section 3 outlines the top three strategic issues that emerged during Ohio's respite summits. These issues were further discussed during ORC's strategic plan development process and the group agreed that these issues would serve as the foundation for defining the strategic plan goals for this five-year plan. Participants at this meeting further fleshed out strategies and tactics to ensure successful completion of these goals.

Goal 1: By September 2017, develop high-quality training, education, and outreach materials for respite consumers, providers and the general public to promote clear and consistent messaging about respite and align respite service requirements across systems statewide.

Goal 2: By September 2015, expand the availability of respite services in Ohio, including development of a statewide respite system with a central access point for information and services.

Goals 3: By September 2014, develop and implement a business plan for the Ohio Respite Coalition to ensure sustainability through membership growth and infrastructure enhancements.

Mission, Vision and Respite Definition

ORC Mission

To educate, advocate, and promote access to respite options for people who care for a loved one.

ORC Vision

All caregivers regardless of location or circumstances have access to quality, person-centered respite services and are able to use them in a timely and effective manner.

Definition of Respite for Ohio

Temporary relief from the responsibilities associated with caregiving.

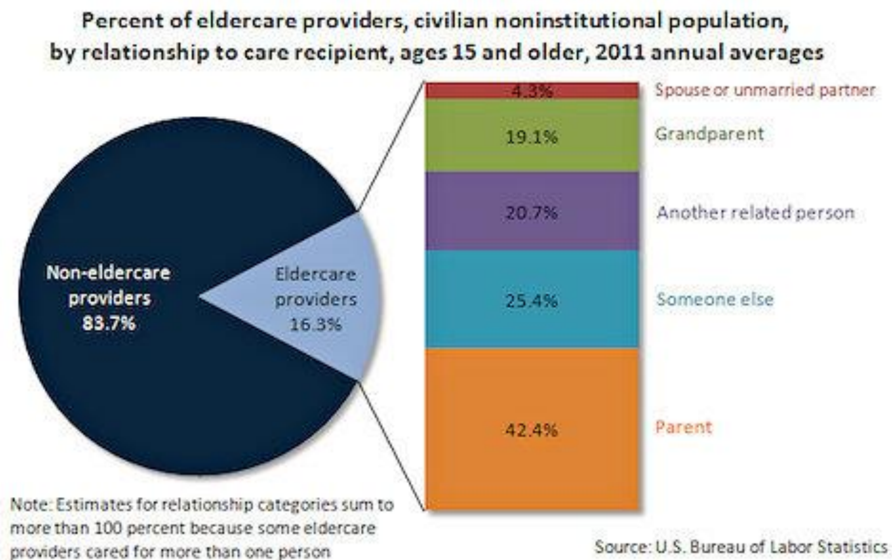
Environmental Scan

Background

As the U.S. population ages, demand for long-term services and supports is growing dramatically. Family caregivers of older adults are regarded as the backbone of the long-term care workforce (Noelker, 2001), and respite is an important resource for alleviating or preventing the stress they experience and for maintaining older adults in the community. In order to support and retain family caregivers in the caregiving role, a national panel of experts, convened in 2010 by the Benjamin Rose Institute on Aging under a cooperative agreement with the U.S. Administration on Aging, suggested that an increase in funding for caregiver services, particularly respite services with 24-hour availability, is critical (Noelker, L. S., Rose, M., Ejaz, F. K., Castora-Binkley, M., & Browdie, R. (2010)).

Research consistently shows that having respite time is the most desired and needed service reported by caregivers (Lund, Wright, Caserta, & Utz, 2006). A three-year research project conducted by the University of New Hampshire's Center on Aging and Community Living found that serving family caregivers through discretionary funding and emotional support helped them to maintain physical and emotional well-being even as their family members' health or abilities declined. (AUCDigest – July 2012; http://www.aucd.org/docs/digest_2012/AUCDigest%20July%202012.pdf). Moreover, caregivers who use respite report high levels of satisfaction with the service. Studies on the impact or outcomes of respite for caregivers, such as reduced caregiving burden and decreased depression, have shown mixed results. This phenomenon has been attributed to variations in research design and measures as well as to caregivers using too little respite, for too short a time period, or too late into the caregiving process. Consequently, respite service experts recommend that caregivers use respite early in the caregiving career, use it regularly, engage in personally meaningful activities during respite time, and use respite in conjunction with other services such as education and support groups (Lund et al., 2006).

Nationally, about 11% (3.7 million) of older Medicare enrollees received personal care from a paid or unpaid source in 1999. Recent data from the Bureau of Labor Statistics' 2011 American Time Use Survey showed that over a three-month period, 39.8 million people (aged 15 and older) provided unpaid care to someone over 65 "because of a condition related to aging." (Retrieved from: http://www.bls.gov/news.release/atus.nro.htm).



The survey, which began in 2003, includes 12,500 respondents who are asked how they spent their previous 24 hours; starting last year, respondents were also asked about caregiving. Almost a third of respondents reported taking care of two or more older people, and 23% also had a minor child in their households.

Almost all community-resident older persons with chronic disabilities receive either informal care (from family or friends) or formal care (from service provider agencies). Over 90% of these older persons with chronic disabilities received informal care and/or formal care and about two-thirds received only informal care. About 9% of this chronically disabled group received only formal services. (*A Profile of Older Americans 2011*: *http://www.aoa.gov/AoAroot/Aging_Statistics/Profile/2011/docs/2011profile.pdf).*

Existing respite services in Ohio

In Ohio, some 1,728 persons received caregiver respite services, and 879,058 service units were provided, according to the Administration on Aging's FY2010 Profile of State Older Americans Act (OAA) Programs. Title III expenditures were more than $2.6 million, while total services expenditures exceeded $2.7 million. These numbers served through the OAA represent a small portion of the estimated 1.31 million caregivers in Ohio in 2010 (*Caregiving Across the States: Publically Funded Programs*, Family Caregiver Alliance. Retrieved from: http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1789). Ohio provides respite through the National Family Caregiver Support Program, its PASSPORT HCBS Medicaid Waiver

Program, and its state-funded Alzheimer's Respite Program. All three statewide programs administered by the Ohio Department of Aging offer respite in the form of adult day services and in-home personal care. Overnight and weekend/camp respite are offered by the Family Caregiver Support Program and the Alzheimer's Respite Program. Caregivers do not have to live with the care receiver to qualify for respite under any of these programs and there is no respite cap.

The primary source of funding for respite services in Ohio is through Medicaid waivers. Medicaid waivers are programs offered through the Ohio Department of Job and Family Services (ODJFS), the Ohio Department of Developmental Disabilities (DODD), and the Ohio Department of Aging. For individuals with developmental disabilities, DoDD offers both the Individual Options (IO) waiver and the Level 1 waiver for some types of respite. The IO waiver covers informal respite provided by an approved independent provider or friend, up to 90 days of residential respite in an institution, and recently approved by CMS, community respite, which can take place in a variety of locations – camp, recreation centers or other places where an organized community program or activity occurs. Level 1 provides informal and residential respite. However, there are 27,000 people on the waiting list for these waiver services.

Custodial parents may be able to access respite services through the local mental health board if their county board provides funding for that service. The local county boards of developmental disabilities receive an annual allotment of Family Support Services dollars. These funds are then allocated to families who apply and can be used for respite service. The annual average family allotment in 2009 was $869. This amount has been decreasing in each biennium budget.

The Ohio Home Care Program, through ODJFS, offers services through the Ohio Home Care Waiver and Transitions Waiver. These waivers are designed to meet the home care needs of people who have certain medical conditions and/or functional abilities that would qualify them for Medicaid coverage in a nursing home or hospital. Consumers may receive care and services at home, or they may choose to receive their care in a nursing facility. The Transitions Carve Out Waiver is designed to meet the needs of consumers who are age 60 and over but is not open to new enrollees. To qualify, consumers must first be on the OHC Waiver and be "transitioned" due reaching age 60.

There are over 92,000 Veterans with disabilities in Ohio. A new program in Ohio for Veterans with a skilled nursing facility level of care need called the Veteran-Directed Home and Community Based Services Program allows the Veteran to purchase respite services.

Individual provider organizations provide respite services to families, mostly through private pay. Many conduct fundraising to assist families with the cost of respite. Usually this financial subsidy is based on financial need. This additional source for providing respite services is critical to meet the needs of many more consumers who do not enroll in state or federally funded programs. It is difficult to capture the amount of funding and number of consumers covered through private pay options.

Coordination of respite

Care coordination, an ongoing component of an effective system of care for children and youth with disabilities and special health care needs and their families, is not available to all families in Ohio. Even those families who receive services through one of Ohio's governmental systems are not always able to access care coordination due to the high costs associated with delivering this service. The researchers in "Caring for Children with Disabilities in Ohio" (Goudie, 2010) concluded that improved health care coordination and the delivery of family centered health care services for children with disabilities would help by offering prevention strategies related to family stress.

As part of this Lifespan Respite grant, the Benjamin Rose Institute on Aging has begun collecting information to help Ohio build a network of resources database.

To date, sources of information that have been identified include:

- ARCH National Respite Locator

  http://archrespite.org/respitelocator

  http://archrespite.org/respite-locator-state-search/227-ohio-search

  Ohio – yields 192 results

- Connect Me Ohio (no longer in service)

Previous search for respite care yielded 54 results

- Ohio Respite Coalition Research Committee
  - Alzheimer's Association (Allison Gibson, Delaware County Social Worker) supplied respite provider lists for the Central Ohio, Cincinnati, Cleveland, Miami Valley/Dayton, and Northwest Ohio areas
  - Greene County (Renee Lammers, Family Stability Coordinator)
    - Family and Children First Council list of respite care resources and respite policy
    - Description of respite program availability/providers in the county
  - Mahoning County (Pam Petras, Help Hotline Crisis Center [www.helphotline.org], Special Navigator for Families with Special Needs)
    - Paper copy of 2012 "Respite and Summer Programs for Families with Special Needs"
- Area Agencies on Aging

  Organizations, with contact information, that provide respite services under contract with the AAA or in its service network were supplied by four AAAs (4, 6, 7 and 10B) in conjunction with a survey of respite funding offered by Ohio Area Agencies on Aging.

Ohio's Regional Respite Summits

During the March 2011 Ohio Respite Summit attendees identified lack of effective coordination of care as a primary weakness in Ohio's system of services. Related to this issue, the group recognized the lack of coordination within and across systems such that caregivers have to be their own care coordinators, that services are not consistent from one county to the next, that cross-agency cooperation is infrequent, that there is limited coordination and linking across funding silos, and that service coordinators are not universally informed about what's available and who's eligible for services.

Throughout 2011 and 2012, Ohio held regional respite summits in Chillicothe, Cincinnati, Mansfield, Columbus, and Cleveland. In all, 247 attendees, including professionals, family caregivers, provider agency and government staff, and advocates, from 30 counties participated. A list of organizations that participated in the regional summits is in the Contributors section starting on page 16.

The most critical need areas discussed included education, training and outreach, and a statewide respite services network. Consistent feedback from participants focused on the following areas:

- Improve respite training curricula and programs with certification for providers (paid, unpaid, and volunteer)
- Provide specialized training for serving consumers with special needs (e.g., on vents, behavioral disorders, autism)
- Develop public awareness campaigns for families and professionals (including physicians and legislators) on the need for and how to access respite
- Develop education and outreach campaigns for consumers with attention to caregiver age differences and emphasis on wellness
- Develop advocacy campaigns to increase funding for respite
- Create single point of entry into respite services
- Develop a statewide inventory or clearinghouse of respite services for caregivers
- Increase funding through advocacy and policy changes
- Standardize access to respite across programs and counties, including rural areas

- Eliminate waiting lists
- Create a coordinated statewide system of care
- Coordinate respite with other health and social services
- Address caregiver/client guilt and mistrust through education and improved respite workforce
- Address age eligibility requirements that create service gaps
- Standardize assessment of caregivers and their respite needs
- Systematically monitor caregiver satisfaction with and outcomes of respite use
- Conduct cost-benefit analyses of respite service programs

Strategic Goals & Objectives

On July 15, 2012, the Ohio Respite Coalition held a Strategic Plan Retreat to develop Ohio's priorities over the next five-years. There were representatives present from multiple disciplines including state government, local providers, and consumer advocates. The group focused on the following three goals for this strategic plan period:

Goal 1: Training, Education, Outreach

By September 2017, develop high-quality training, education, and outreach materials for respite consumers, providers and the general public to promote clear and consistent messaging about respite and align respite service requirements across systems statewide.

Strategies & Tactics

I. Review existing training programs for commonalities and facilitate communication among systems
   a. Develop common curriculum or adapt existing curriculum with a goal of having the state adopt a common certification for respite providers
   b. Develop dissemination approaches for curricula (web-based, train-the-trainer, mechanisms in place to share resources)

II. Develop specific training packages for unique populations
   a. Identify what is existing and what is needed and add stackable certificates
   b. Establish PATHS program for direct service providers in DD adult community

III. Outreach
   a. Develop marketing campaign and messaging targeting I&R, 2-1-1, ADRN, etc.
   b. Motivate/educate providers, caregivers, and general public on respite, benefits of respite, how to access (wellness strategies conveyed using respite as a communication strategy)
   c. Understand and develop marketing message to address why an individual might not want to be a respite provider. Establish federal/state/local forgiveness for nursing students who work in home health providing nursing services to pediatric patients.
   d. Using a variety of vehicles, inform people of the needs and opportunities, and create awareness of respite

e. Develop websites, printed materials, PSAs, media placements, and add to story bank
f. Develop advocacy campaign to increase and sustain funding for respite
g. Develop a respite roadshow / speakers bureau
h. Develop consistent message for marketing materials

Goal 2: Develop a statewide respite system with central access point

By September 2015, expand the availability of respite services in Ohio, including development of a statewide respite system with a central access point for information and services.

Strategies & Tactics

I. Develop central access point/website as promotional/education/resource tool
   a. Develop education materials for each target audience (consumers, providers, etc.)
   b. Include linkages to available resources (services, training opportunities)
   c. Use existing access points (Red Tree House, ADRN, 211, I&R, etc.)
   d. Develop and use common data system that includes inventory of respite providers
   e. Gather information on funding
   f. Gather information on how to become a provider
   g. Review what other states are doing regarding central access point

II. Expand Ohio's Statewide Respite Network
   a. Determine what services can be used for respite
   b. Develop provider inventory/gap analysis
   c. Engage in advocacy with funders for common definition/use of terminology
   d. Define role of unpaid respite providers
   e. Allow respite searches at Central office for those not connected to the web
      i. Data tracking capability
      ii. Personal service for those who need it
      iii. 1-800#

f. Locate advocates in existing system who can help direct individuals to services/care/support
   i. Identify those with skill, interest, experience
   ii. Use Listserv for information sharing
g. Offer resources to build skills to provide respite as a career
   i. Link to Direct Service Workforce initiative through Governor's Office of Health Transformation (OHT)
   ii. Advocate to add curriculum for respite providers
   iii. Develop Train-the-Trainer curriculum
   iv. Integrate Curriculum/How-to manual from ARCH
h. Develop Volunteer Respite Network that connects to volunteer agencies/organizations
i. Develop a coalition road show on respite

III. Develop legislative advocacy team (funding, awareness, policy/rules)
   a. Develop and implement sustainable funding strategies
   b. Determine appropriate oversight of certification process

Goal 3: Develop an ORC Business Plan to Ensure Future Sustainability, Growth and Succession Plan

By September 2014, develop and implement a business plan for the Ohio Respite Coalition to ensure sustainability through membership growth and infrastructure enhancements.

Strategies & Tactics

I. Submit Lifespan Respite legislation with funding appropriation
   a. Develop planned strategy for ongoing advocacy to continue appropriation
   b. Identify specific legislators who have influence and interest
   c. Establish a budget for appropriation

   d. Identify hard objective data available that establishes evidence of need for respite and for a coalition
   e. Determine philanthropic opportunities

II. Develop membership recruitment and retention plan
   a. Develop strategic plan for the coalition
   b. Seek regular contact among members of the coalition
   c. Establish what is needed of members
   d. Develop recognition program for those who participate and contribute
   e. Provide/establish virtual presence for networking and sharing of information (regularly)
   f. Recruit affiliate sponsors with related mission

III. Determine governance structure with leadership responsibilities and succession plan
   a. Explore most appropriate organization type (e.g., 501(c)(3), LLC)
   b. Establish organizational structure
   c. Consider a stand-alone or part of something larger
   d. Address logistics (office locations, staff, website maintenance, support services, etc.)
   e. Research outside experts who could help with business plan

IV. Develop / purchase data tracking system to support accountability of the coalition and sustainability
   a. Gather baseline data
   b. Determine hardware and software requirements
   c. Identify key elements
   d. Incorporate in-house research capabilities or hire research consultant
   e. Establish valid measurement tool
   f. Demonstrate cost savings to system
   g. Measure caregiver satisfaction
   h. Develop measurable respite outcomes

V. Determine need for financial support beyond appropriation
   a. Develop a membership program -- identify benefits for members
   b. Develop a donation program -- financial support structure (e.g., PayPal)
   c. Identify and apply for grants from philanthropic entities
   d. Determine appropriate in-kind support from sponsoring organization(s) or like-minded entity(ies)
   e.

VI. Support for delivery of services

a. Establish how appropriations can used
b. Determine role of coalition in distributing new funds
c. Establish central office/regional offices

Contributors

Ohio Respite Coalition
Benjamin Rose Institute on Aging
Easter Seals of Ohio

Organizations that participated in Regional Respite Summits during 2011-2012

Achievement Centers for Children, Camp Cheerful
Akron Children's Hospital
Akron Rotary Camp for Children with Special Needs
All Care Services
Alzheimer's Association, Cincinnati/KY
Alzheimer's Association, Greater East Ohio Area Chapter
Alzheimer's Association, Central Ohio Chapter
Alzheimer's Association, Cleveland Area Chapter
Alzheimer's Association, NW Ohio Chapter
American Cancer Society
American Red Cross
ARC Southwest Ohio
Area Agency on Aging - PSA5
Area Agency on Aging - PSA6
Area Agency on Aging - PSA7
Area Agency on Aging - PSA8
Area Agency on Aging - PSA10A
Ashland University/Help Me Grow & Family and Children First Council
Associated Healthcare of Ohio
Beech Brook
Benjamin Rose Institute on Aging
Brain Injury Association of Ohio
Brooks House Assisted Living Community
Camp Allyn for Children with Special Needs
Campbell Group
Catholic Charities (SWO)
Cincinnati Children's Hospital Medical Center/Perlman Center/UCEDD
Cincinnati Public Schools
Cleveland Clinic Children's Hospital for Rehabilitation
Compassionate In-Home Care, Inc.
Connections
County (Delaware) Council for Older Adults
County (Licking) Aging Program
County (Union) Senior Services
County (Wyandot) Council on Aging

Crestwood Care Center
DD Board, Delaware County
DD Board, Huron County
DD Board, Knox County
DD Board, Licking County
DD Board, Ross County
DD Board, Union County
DD Services, Butler County
DD Services, Hamilton County
Department of Job and Family Services, Geauga County
Department of Job and Family Services, Richland County
Down Syndrome Association of Greater Cincinnati
Easter Seals Northern Ohio, Inc.
Easter Seals (Goodwill) Miami Valley
Elmwood Assisted Living
Epilepsy Foundation of Greater Cincinnati
Family and Children First Council, Butler County
Family and Children First Council, Crawford County
Family and Children First Council, Cuyahoga County
Family and Children First Council, Dayton
Family and Children First Council, Gallia County
Family and Children First Council, Scioto County
Family and Children First Council, Vinton County
Family Voices of Ohio
Firstlight Home Care of Columbus
Franklin Woods Nursing Rehab.
Griswold Special Care
Hearth Consultants LLC
Home Instead Senior Care
Hospice of the Western Reserve
Inner-Circle Communities
Joyful Acres
Judson at University Circle (Judson Park)
Kindred Transitional Care & Rehabilitation - Newark
Linking Employment, Abilities & Potential (LEAP)
Long Term Care Ombudsman, Cuyahoga County
Mental Health Services for Homeless Persons
Michael Carter Group
Mid-Ohio Board for an Independent Living Environment
Mill Run Place
Montefiore/The Weils
Mount Carmel Health System/Hospice
NAMI, Richland County

National Church Residence/Ashland University
National MS Society, Buckeye Chapter
National MS Society, Ohio Valley Chapter
Nationwide Children's Hospital
New Avenues to Independence
Northwest Counseling Services
Ohio Care Planning Council
Ohio Center for Autism and Low Incidence
Ohio Department of Aging
Ohio Federation for Children's Mental Health
Ohio Senior Health Insurance Information Program
Partners of Marion Care & Rehab.
Providence Baptist Church, Alzheimer's Support Group
Providence House
Rehab & Nursing Center @ Firelands
Rehab Center, The
REM Ohio
Resident Home Corporation (RHC)
Richland Newhope
Rose-Mary Center
Senior Independence Home Health and Hospice
Silver Lining Group
Southeastern Ohio Center for Independent Living
Southwest General Health Ctr. Hospice, Geriatric Assessment, and Home Health Services
St. Augustine Health Ministries
St. Catherine Manor of Washington Court House
St. Joseph Home of Cincinnati
Stepping Stones Respite Center
T. C.'s Helping Hands Inc.
University Hospitals Case Medical Center
Visiting Nurse Association of Mid-Ohio
Vitas Innovative Hospice Care of Columbus
Wesleyan Village
Willow Brook Christian Communities
Winchester Place Nursing and Rehabilitation Center
Wingspan Care Group/Applewood Centers, Bellefaire JCB
Zangmeister Center

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03/12/15

The last meeting of the Oklahoma Respite Resource Network (ORRN) was September 23, 2014. Four meetings were held in 2013 (May 3, June 13, August 14, and October 9) and the last meeting convened was September 23, 2014. The Oklahoma Respite Resource Network began in 1997 as a public and private partnership including state agencies and organizations such as the Dept. of Human Services/Family Support Services Division, Developmental Disabilities Services Division, Division of Children and Family Services, Office of Child Care, Oklahoma Health Care Authority, Oklahoma's University Center for Excellence, Center for Learning and Leadership, the Developmental Disabilities Council, Oklahoma City Veterans Administration (Coordinator of Geriatrics and Extended Care Social Work) and Oklahoma Area-Wide Services Information System (OASIS). In 2010, the Department of Human Services Aging Services Division, in conjunction with a few of the leaders of the ORRN applied for the Lifespan Respite Grant with the Administration for Community Living and began to focus on new start projects or expansion of existing respite programs for Caregivers across Oklahoma. Oklahoma Aging Services has conducted the respite voucher program and awarded seed grants for new start and expansion of existing respite programs around the state during the grant period. A second Lifespan Respite Grant was received in 2013 and focused on "sustainability" of existing and funded programs as well as continued funding seed grants to make additional opportunities for respite for caregivers available across the state.

The Oklahoma Respite Resource Network (ORRN-the former Respite Coalition) has begun a major change. Where in the beginning, the network was committed to respite voucher programs to cover the whole state and writing for grants with Aging Services, the network is now re-thinking its mission. There were retirements in key positions of leadership in the Department, which affected the leadership of the coalition. Although still involved in the network, those people have had to reduce the time spent on support and leadership of the coalition. That meant that new leadership would need to be developed for the changing coalition. The group has every intention of continuing its work. One of the last meetings, the group was reviewing its mission and voted to 1) change the name of the coalition/organization and 2) broaden its mission. There was discussion of too much focus on respite vouchers and recommendation that the coalition adjust its mission and activities to a broader scope of supports for caregivers, with less of a focus on "respite". The fact that the respite voucher programs are well established and varied in their target audience of caregivers is part of this shift in focus.

Tennessee State Plan on Aging 2014 - 2018

Submitted to the U.S. Administration for Community Living by the Tennessee Commission on Aging and Disability

VERIFICATION OF INTENT

The 2014-2018 Tennessee State Plan on Aging is hereby submitted to the Administration for Community Living for approval. It includes all assurances and plans to be conducted by the Tennessee Commission on Aging and Disability under provisions of the Older Americans Act. The Tennessee Commission on Aging and Disability has been given the authority to develop and administer the State Plan on Aging in accordance with all requirements of the Act, and is primarily responsible for the coordination of all State activities related to the purpose of the Act; i.e. the development of comprehensive and coordinated systems for the delivery of supportive services, including multipurpose senior centers and nutrition services, and to serve as the effective and visible advocate for older Tennesseans.

This Plan is hereby approved by the Governor and constitutes authorization to proceed with activities under the Plan upon approval by the Assistant Secretary of Aging.

The 2014-2018 State Plan on Aging hereby submitted has been developed in accordance with all Federal statutory and regulatory requirements.

May 31, 2013
Date

Jim Shulman, Executive Director
Tennessee Commission on Aging and Disability

I hereby approve this 2014-2018 State Plan on Aging and submit to the Administration for Community Living.

6/7/13
Date

Bill Haslam, Governor
State of Tennessee

ACKNOWLEDGEMENTS

The Tennessee Commission on Aging and Disability would like to acknowledge the assistance of the following persons and agencies in the development of the 2014-18 State Plan on Aging.

Ken Kisiel, Chair of the Tennessee Commission on Aging and Disability and Chair of the Strategic Planning Committee

The members of the Tennessee Commission on Aging and Disability

First Tennessee Area Agency on Aging and Disability

East Tennessee Area Agency on Aging and Disability

Upper Cumberland Area Agency on Aging and Disability

Greater Nashville Area Agency on Aging and Disability

South Central Area Agency on Aging and Disability

Southeast Area Agency on Aging and Disability

Southwest Area Agency on Aging and Disability

Northwest Area Agency on Aging and Disability

Aging Commission of the Mid-South

The Senior Centers of Tennessee

Patti Killingsworth, Bureau of TennCare

The Policy Academy on Aging, Substance Abuse and Mental Health

The Staff of the Tennessee Commission on Aging and Disability

Jean Renfro, Consultant and Writer

All the Citizens, Service Providers, and State Agencies that participated in the Listening Tours and Public Meetings held across the State

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Attachment D: State of Tennessee Policy of Non-Discrimination

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Attachment F: Statewide Comprehensive Needs Assessment Data and Analysis

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Attachment H: Map of Area Agencies on Aging and Disability

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Attachment L: Cost Sharing Rule

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Executive Summary

The Tennessee Commission on Aging and Disability (TCAD) has reached a milestone. TCAD has provided services to the aging population for 50 years. In celebration of its anniversary and as TCAD prepares for the future, TCAD is taking on the task of re-evaluating its programs and services to make certain that they continue to be efficient and cost effective.

In 2011, the first baby boomer achieved the age of 65 and it is estimated that 10,000 individuals will turn 65 each day. Currently, an estimated 75 million individuals are identified as baby boomers. In the next 15 years, an additional 1,245,064 Tennesseans or 20 percent of the current population will reach the age of 65, representing an 65 percent increase in the number of Tennesseans who will require programs and services. Programs and services will be required to address this emerging population with a different orientation toward aging. However, while the **Tennessee State Plan on Aging 2014-2018** looks forward, it must also address the needs of the current population. In addition, the needs of adults with disabilities must be addressed. As of December 2011, 179,325 individuals in Tennessee are disabled. Of that number, 121,844 individuals are between the ages of 18 - 64 (68 percent) and 32,142 are 65 and older (18 percent).

The **Tennessee State Plan on Aging 2014-2018** will provide the framework for a comprehensive and coordinated system to begin to address programs and services that will be required. The Older Americans Act and other home and community based programs administered by TCAD will continue to play an important role in addressing the growing needs. The **Tennessee State Plan on Aging 2014-2018** will allow for changes in demographics, new funding opportunities and resources, and the budgetary challenges that Tennessee will face in the coming years.

Programs and services such as, but not limited to, health promotion and prevention, elder rights, long term care, home and community based services, self-directed care, affordable and accessible programs and services, respite, a healthy aging plan and a guide to healthy aging, and an array of community services and programs will be required to meet the current and future needs. Independent living options for those at risk of assisted living or nursing home placement, self-directed care, self-determination, single point of entry, CHOICES (Tennessee's Medicaid program for long term care services), private pay options, Alzheimer's disease and related dementia, care transitions, and Veterans' Directed Home and Community Based Services have all become a part of aging programs and services and are included in the **Tennessee State Plan on Aging 2014-2018**.

The **Tennessee State Plan on Aging 2014-2018** will continue to target minority, low-income, low-income minority, and rural populations as well as the newer populations, initiatives and terminology outlined in the 2006 amendment to the Older Americans Act. According to the 2010 census, 16.9 percent of Tennesseans are below the poverty level as compared to 14.3 percent for the United States. The median income is also lower than the national average.

During February and March 2013, the Tennessee Commission on Aging and Disability (TCAD) conducted a Listening Tour across the Tennessee in each of the nine (9) regions served by the

Area Agencies on Aging and Disability (AAAD). The Listening Tour was conducted to allow community members to discuss the challenges facing the aging and disability population; to gather suggestions about addressing these challenges; and to provide input on what can be done to make programs and services more accessible, efficient, and effective. At each of the sites, participants completed a survey focusing on 1) current aging and disability issues, 2) issues faced by "baby boomers" as they age, and 3) programs and services that are currently working in the community. Participants also participated in small focus groups. The data from Public Hearing on the **Tennessee State Plan on Aging 2014-2018** held on May 7, 2013 is included.

The comprehensive needs assessment consists of the results of the surveys and the small focus groups, stakeholders' meetings, review of literature of the differences between the current senior population and baby boomers, and a review of the previous data provided by the State Plan 2009-2013. Utilizing the data from the comprehensive needs assessment and other identified sources, the **Tennessee State Plan on Aging 2014-2018** was developed. The **Tennessee State Plan on Aging 2014-2018** provides policy makers, service providers, and the general population with appropriate data about trends and implications for the current population as well as the impact of the increase in the aging population due to the aging baby boomer population.

Tennessee will be facing many challenges in addressing the aging and disability populations according to the multiple data sources used to develop the **Tennessee State Plan on Aging 2014-2018**. The long-term challenge will be the ability to keep up with the increasing demand for programs and services with stagnant or decreased funding. With the baby boomers reaching retirement age and the "frail elderly" aged 85 and older becoming the fastest growing segment of the aging population, TCAD's ability to keep up with the demand is compromised.

The primary challenges were identified:

- TCAD's infrastructure must be ready to support the increase in the programs and services that will be needed by the growing population of adults age 60 and over and adults with disabilities;
- aging and disability programs, services, and funding are currently beyond maximum capacity while the growth of the baby boomer population has not yet achieved maximum demand;
- current discretionary grant funding has ended or is ending September 30, 2013, for Alzheimer's Evidence Based, Alzheimer's Innovation Grant, Care Transition Grant, Chronic Disease Self-Management Program, and Lifespan Respite Grant and the future of discretionary grant funding is unclear, however, TCAD will be poised to apply should further grant opportunities become available; and
- the need for a more integrated system of services and programs to meet the needs of the growing aging and disability population will require that current partnerships become more inclusive of the public and private sector and strengthened through cooperation and coordination.

Additional discussion of these challenges is contained in the narrative of this document.

The goal and objectives in the **Tennessee State Plan on Aging 2014-2018** reflects the work that must be done to maintain and grow programs and services for the current population while planning for the resources that will be required to meet the increased needs of the baby boomer population. To meet the challenges of the present and the future, infrastructure of the State Unit

on Aging (SUA) must be effective and efficient and personnel have the necessary skills, knowledge, and competencies. Goal 1 will begin the process by ensuring the current SUA programs and services for adults age 60 and over and adults with disabilities are cost effective and meet best practices.

In order to accomplish Goal 1, the following SUA programs and services will be reviewed, evaluated and modified, as needed: the internal structure of the SUA to ensure effective and efficient management and monitoring of programs and services and of state and federal funding; the state and federally funded home and community based (HCBS) programs; Family Caregiver program; Nutrition program; Ombudsman; Elder Rights program; Legal Assistance; Guardianship program; Senior Center program; emergency preparedness plan; and SUA's fiscal policies and procedures to ensure all reports are accurate and meet state and federal guidelines.

Goal 2 addresses funding and resources by diversifying funding and partnerships to sustain effective services and programs to meet current needs and to expand and/or implement additional services and programs to meet the emerging needs of the baby boomer population. The SUA will continue to identify and pursue sources of funding; maintain and grow relationships with partners and stakeholders with statewide influence; and build infrastructure and capacity at the state and area agency level to include marketing, grant writing and grant management expertise, and other payment options and capabilities.

Goal 3 is directed toward building the capacity of program and services utilizing strategies that can be cost effective, implemented incrementally, and integrated into the current programs and services. SUA will partner with agencies and organizations addressing Alzheimer's disease and related dementia; implement evidence based programs for healthy aging and disease prevention; enhance transportation services that are easier to access; identify and maintain professional volunteer coordinators at the SUA and nine (9) AAADs; develop and implement a healthy aging plan; and promote healthy aging through a healthy aging guide.

Goal 4 will ensure that the AAADs, serving as the Aging and Disability Resource Centers (ADRC) in Tennessee provide easily accessible, user-friendly access to programs, services, and resources regardless of payment type so that individuals can get help quickly and without hassle. This goal will be achieved by ensuring that the ADRC/AAADs meet the fully functioning criteria and standards set by the Administration on Community Living (ACL), market the ADRC as the single point of entry/first stop for aging and disability issues, provide objective one-on-one counseling, information, distribution, and assistance, and ensure that the ADRC Options Counseling program meets the national standards, collaborate with local hospitals and other healthcare organizations to implement the care transitions concept, and partner with VAMCs in Tennessee for Veterans' Directed Home and Community Based Services.

Goal 5 focuses on collaborating with state agencies to develop a seamless system of accessible services and programs for adults age 60 and over and adults with disabilities. This will include mapping the current service system and the state agencies providing aging services, and establishing a seamless system of accessing and delivering services and programs that reduces and prevents fragmentation and curtails duplication of cost and services.

Chapter 1
Tennessee Commission on Aging and Disability

Mission

The Tennessee Commission on Aging and Disability brings together and leverages programs, resources, and organizations to protect and ensure the quality of life and independence of older Tennesseans and adults with disabilities.

Foundation

Tennessee should be a state where all people are respected and valued regardless of their age or disability; are able to reside in livable communities that are safe, affordable and accessible; and are able to live a healthy lifestyle with access to information and support. Care provided by dedicated family and friends is vital to helping people remain in their homes and independent for as long as possible.

History & Current Status

The Tennessee Commission on Aging and Disability (formerly the Commission on Aging) was created by the Tennessee General Assembly in 1963. The commission is the designated state unit on aging and is mandated to provide leadership relative to all aging issues on behalf of adults age 60 and over in the state.

The Tennessee Commission on Aging and Disability (TCAD) has been administering the Older Americans Act services and providing oversight as mandated by the United States Administration on Aging (AoA) since 1965. In 2001, the Tennessee Legislature expanded the authority of the TCAD to provide home and community based services to older persons to include adults with disabilities under age 60 in the state funded Options for Community Living Program. The Options Program was designed for individuals who do not qualify for long-term care services under the state medical assistance program. TCAD has administered federal funds from the Centers for Medicare and Medicaid Services to operate the statewide State Health Insurance Assistance Program (SHIP) since 2003. In 2004, the state Medicaid Agency, the Bureau of TennCare, designated TCAD as the operating agency for the Statewide Home and Community Based Services Waiver for Elderly and Disabled. In 2008, the CHOICES Act enabled TennCare to contract with Managed Care Organizations (MCO's) to manage Medicaid-funded long-term support services. TCAD also administers state funds for multi-purpose senior centers, public guardianship, homemaker and personal care services, and home-delivered meals.

Long Term Care Community Choices

In 2008, the Tennessee 105th General Assembly unanimously voted into law the Long Term Care Community CHOICES Act of 2008 (CHOICES Act) to rebalance and reorganize Medicaid long-term care in the state. CHOICES is an integrated Medicaid Managed Long-Term Services and Supports (MLTSS) program that serves persons who are age 65 and older and adults age 21 and older with physical disabilities. Managed Care Organizations (MCO's) are responsible for coordinating physical and behavioral health and long-term care services. Members who qualify for nursing facility care have freedom of choice of the setting in which care will be received, so long as their needs can be safely met in the community at a cost that does not exceed institutional care.

TennCare was awarded the "Money Follows the Person" (MFP) demonstration project in 2011 to transition 2,225 individuals over five (5) years, primarily persons in nursing facilities, but also including 50 persons in intermediate care facilities for individuals with intellectual disabilities. As of March 2013,

the State has transitioned 536 people under MFP, including 279 adults age 65 and over, 234 adults with physical disabilities, and 23 adults with intellectual disabilities.

The nine (9) Area Agencies on Aging and Disability (AAADs) in Tennessee serve as the Aging and Disability Resource Centers (ADRCs), the single point of entry for the services provided through the Older Americans Act, the Options for Community Living Program, the State Health Insurance Assistance Program, and the Public Guardian for the Elderly Program. In CHOICES, they serve as the single point of entry for non-Medicaid eligible individuals seeking long-term services and supports (LTSS). (MCOs assist their current members who need LTSS.) Non-Medicaid eligible persons seeking home and community based services must go through the single point of entry (SPOE) in order to enroll in CHOICES; persons in a nursing facility may go through the SPOE, but are not required to do so.

The AAADs provide counseling and assistance, screening and intake, and facilitated enrollment for Medicaid financial as well as medical (or level of care) eligibility. In addition, TennCare contracts with AAADs to conduct face-to-face Quality of Life Surveys for the State's Money Follows the Person Rebalancing Demonstration, and more recently, for an expanded CHOICES Quality of Life Survey which is part of the State's Quality Improvement Strategy.

The ADRC/AAADs reach out to the public to foster understanding and use of all long term care and health options available to help keep people as independent as possible for as long as possible. The public has easy access to information, counseling, and assistance, and linkage to a full range of long-term support services and living options.

TCAD has provided leadership in advocating for and implementing a statewide system to provide in-home services for people who choose to stay at home rather than being cared for in a long term care facility. The average annual cost of nursing home care per patient is significantly higher than in-home care. By providing a system for in-home services, TCAD has not only championed the cause for Tennesseans age 60 and over and adults with disabilities to be cared for in the setting of their choice, but has also saved taxpayers millions of dollars.

Chapter 2
Focus Areas and Programs

Older Americans Act Programs (OAA)

The Older Americans Act (OAA) funds provide a comprehensive array of services and the administrative infrastructure to deliver all OAA programs. As the designated State Unit on Aging (SUA), TCAD receives an annual allotment under Title III of the Older Americans Act as amended, from the Administration for Community Living (ACL) in the U.S. Department of Health and Human Services. TCAD allocates OAA funds to nine (9) Area Agencies on Aging and Disability (AAADs) based on an approved intrastate funding formula. The AAADs plan, develop, and implement a system of services for persons age 60 and over in their respective Planning and Service Areas (PSA). They also oversee multi-purpose senior center activities. This comprehensive and coordinated system of services is described in the AAAD's Area Plans. OAA programs administered by TCAD include:

OAA Title III–B Supportive Services/In- Home Services

Supportive services funds provide a wide range of social services aimed at helping adults age 60 and over remain independent in their own homes and communities. Some of the services offered under Titles III-B of the Act include services such as information and assistance, transportation, case management, legal assistance, adult day care, and activities in senior centers.

- Information and Assistance: TCAD contracts with the nine (9) Area Agencies on Aging and Disability (AAADs) for the Aging and Disability Resource Center (ADRC) that provide information, assistance, referrals, initial screening for program eligibility, and long term care options counseling. The ADRC/AAADs act as a single point of entry for federal and state programs. Information and Assistance is provided directly by the ADRC/ AAADs. This service may be accessed through the toll free, statewide number 1-866-836-6678.

- Transportation: AAADs contract with senior centers or human resource agencies to provide limited transportation services that assist adults age 60 and over with accessible rides to medical appointments, senior center activities, meal sites, grocery stores, and pharmacies.

- Case Management: AAADs provide case management for clients who receive home and community based services funding through the Title III-B and State Options. The in-home services primarily include case management, personal care, homemaking, and home delivered meals.

- Legal Assistance: Provides legal advice and representation by an attorney to older individuals and also includes counseling or other appropriate assistance by a paralegal or law student under the supervision of an attorney. Clients may be referred to a private attorney after screening by legal staff to determine if the needed services fall within the predetermined case-handling priority guidelines. Referrals may also be made to another community service provider. Public education is also provided.

- Adult Day Care: AAADs contract for adult day care, as needed.

- Senior Centers: An important part of Tennessee's Aging Network is multipurpose Senior Centers that serve as local community focal points for information on aging and aging activities in at least

one location in each of Tennessee's 95 counties. They offer a wide variety of group and individual services that promote healthy lifestyles, provide learning opportunities, and provide social interaction and volunteer opportunities. Senior Centers in Tennessee are supported through a combination of federal, state, and local funds.

OAA Title III–C Nutrition Services

Nutrition Services provide meals, nutrition education and counseling, and socialization to adults age 60 and over in congregate settings such as senior centers or senior housing. Home-delivered meals are also provided to eligible adults age 60 and over in their own homes. The purposes of the program are to reduce hunger and food insecurity, promote socialization among adults age 60 and over, and provide meals to frail consumers in their homes.

OAA Title III–D Disease Prevention and Health Promotion

TCAD contracts with the nine (9) AAADs to provide health promotion activities across the state that are evidence-based best practices. Individual or group sessions, most often conducted at senior centers, assist participants to understand how their lifestyles impact their physical and mental health and to develop personal practices that enhance their total well-being, including physical, emotional and psychosocial factors. Examples are programs such as Chronic Disease Self-Management, Silver Sneakers, Matter of Balance, and Tai Chi.

OAA Title III–E National Family Caregiver Support Program

This program provides assistance to family caregivers caring for adults age 60 and over or to grandparents or other older individuals who are relative caregivers. The Caregiver program provides information and assistance, individual counseling, respite and supplemental services on a limited or one time basis.

OAA Title IV Activities for Health, Independence, and Longevity Aging and Disability Resource Center (ADRC)

The Tennessee Aging and Disability Resource Center (ADRC) grant project was first awarded to TCAD in 2005 to develop pilot models of comprehensive, single point of entry Aging and Disability Resource Centers. Subsequently, additional grants were awarded to enable all nine (9) AAADs to become fully-functioning ADRCs. The AAADs serve as the single point of entry for all Older Americans Act funded programs as well as the CHOICES program (Medicaid Waiver). A website, www.tnaaad.org was also developed to provide internet access to information about all aging and disability resources in Tennessee.

OAA Title VI Services for Native Americans

Tennessee does not have an officially recognized Indian Tribal Organization and does not receive funding from the Older Americans Act for Grants for Services for Native Americans.

OAA Title VII Elder Rights Protection

- Elder Rights
  TCAD advocates for the protection of older Tennesseans from physical and emotional abuse, theft, negative stereotyping, and discrimination. The Tennessee Vulnerable Adult Coalition was established in 2008, to bring the state's public and private agencies together to promote the

collaboration necessary to prevent abuse, neglect, and exploitation of vulnerable adults.

- Long Term Care Ombudsman
  The state and the nine (9) District Long Term Care Ombudsman staff are advocates for adults age 60 and over residing in nursing homes, residential homes for the aged and assisted care living facilities. The Ombudsman Program is available to help qualified residents of long-term care facilities when residents and their families cannot resolve their problems through consultation with the facility staff or governmental agencies involved. Trained Volunteer Ombudsman Representatives are a component of this program. Public education is also provided.

Options for Community Living Program (Options): State-funded Home and Community Based Long Term Care Services

Since 2000, the SUA has received state funds for home and community based long term care services for adults age 60 and over and adults with physical disabilities who do not qualify for Medicaid long term care services. The Options Program provides homemaker, personal care, and home-delivered meals.

Public Guardianship for the Elderly Program

The Public Guardianship for the Elderly Program is designed to assist adults age 60 and over who are unable to manage their own affairs and have no family member, friend, bank, or corporation willing or able to act on their behalf. Public Guardians (Conservators) assist clients in obtaining the basic necessities of life including making decisions regarding their finances or needed medical care. Legal proceedings (court order) are required prior to service delivery.

State Health Insurance Assistance Program (SHIP)

SHIP provides free and objective information, counseling and assistance to consumers, their adult children, caregivers, health care providers and other advocates about Medicare and all other related health insurance. An important aspect of the program is to provide information and assistance with enrollment in Medicare Part D and target outreach to low-income Medicare beneficiaries eligible for the Medicare Part D Low-Income Subsidy and Medicare Savings Programs and Duals with mental disabilities or illness. The Centers for Medicare and Medicaid Services (CMS) funds the nationwide program. The statewide Tennessee SHIP operates through a small, but highly trained, paid and volunteer staff and through partnerships to provide this service. In addition to counseling, program staff and volunteers perform community education and outreach on Medicare and current related issues.

OTHER GRANTS, PROJECTS & STATEWIDE PROGRAMS

Innovation Grant to Better Serve People with Alzheimer's Disease and Related Disorders

Activities through this grant provide Alzheimer's disease and related dementia (ADRD) training/education for primary care and family physicians, emergency room personnel, hospital case managers for discharge planning, first responders, and persons with ADRD and family members in two (2) Tennessee regions. Counseling and support services are also provided for persons with ADRD, their family members, and caregivers.

Senior Medicare Patrol: Empowering Seniors to Prevent Healthcare Fraud

Senior Medicare Patrol (SMP) is a nationwide program designed to help combat fraud, waste, and abuse in the Medicare and Medicaid programs and is funded by the Administration on Community Living. In

Tennessee, the program is administered by the Upper Cumberland AAAD and provides statewide coverage through the participation of all nine (9) AAADs. Retired professionals across the state are recruited and trained to serve as volunteer community experts, educating Medicare and Medicaid beneficiaries on how to better monitor what is paid on their behalf and report discrepancies. SMP programs work cooperatively with SHIP programs described above, including but not limited to, joint training and utilization of statewide volunteers.

Community Based Care Transitions Program

Current ADRC funding supported five (5) local ADRC/AAADs in developing care transitions programs in their regions. The funding supported meetings with local hospitals and Qsource and trainings in evidence based models such as Coleman's Care Transition Intervention. Four (4) of the AAADs applied for the 3026 funding under the Affordable Care Act. One (1) AAAD has received funding for their project and is in the process of implementation. One (1) AAAD is poised to apply should funding become available. Several projects moved forward without grant funding to implement components of a community based care transitions program. All five (5) of the ADRC/AAADs have continued to meet and discuss how to address the issues around hospital readmissions regardless of funding.

Older Americans Policy Academy

TCAD partnered with the Department of Mental Health and Substance Abuse Services and TennCare (State Medicaid Agency) to participate in a Policy Academy. As a result, a plan was developed to address the awareness of mental health, suicide prevention, prescription abuse, Alzheimer's, and depression in the aging and the baby boomer population. The first event will be a conference to be held in June 2013. The Policy Academy will also work to enhance substance abuse and mental health screening capabilities for the aging population and increase intervention services with those identified as needing counseling and treatment options.

Discretionary Grants

TCAD discretionary grants received during the implementation of the previous State Plan on Aging 2009-2013 have ended. These grants include the Alzheimer's Evidence Based, Care Transition Intervention Grant, Chronic Disease Self Management Program, Lifespan Respite Grant, Medicare Enrollment Assistance Program (MIPPA) and the Aging and Disability Resource Center Grant. TCAD is poised to apply for future grant opportunities as they become available.

Chapter 3
Statewide Needs Assessment

Overview

During February and March 2013, the Tennessee Commission on Aging and Disability (TCAD) conducted a Listening Tour including a statewide comprehensive needs assessment in each of the nine (9) regions served by the Area Agencies on Aging and Disability (AAAD). The Listening Tour was designed:

- to hear from community members about challenges facing the aging population and adults with disabilities;
- to gather suggestions from community members about how everyone together might address these challenges;
- to allow attendees the opportunity to complete the needs assessment; and
- to provide input on what can be done to make aging and disability programs and services more accessible, efficient, and effective.

Attendees included adults age 60 and over, adults with disabilities, baby boomers, senior center personnel and volunteers, AAAD staff, Aging Network members, for profit and non-profit providers and organizations, and local/regional officials.

The comprehensive needs assessment consisted of results of the surveys, the small focus groups, the stakeholders' meetings, review of literature of the differences between the current senior population and baby boomers and a review of the previous data provided by the State Plan 2009-2013. In addition, data were gathered from two (2) meetings held in Nashville:
1) Stakeholders' meeting held January 23, 2013 and 2) the quarterly meeting of the Commission held February 5, 2013.

Survey Findings

Utilizing the data from the comprehensive needs assessment, the challenges that face TCAD and other state departments and agencies serving adults age 60 and over and adults with disabilities were identified and the **Tennessee State Plan on Aging 2014-2018** was developed. The **State Plan 2014-2018** provides policy-makers, service providers, and the general population with appropriate data about trends and implications for the current population as well as the impact of the increase in the aging population due to the aging baby boomer population.

The survey focused on the current aging and disability issues, issues faced by baby boomers as they age, and the programs and services that are currently working in the community.

- Identify the ***aging and disability issues*** that are most important to you.
- ***What are the hard things that "baby boomers" face? How should the State of Tennessee help?***
- ***What is currently working well in your community? (like agencies that help, neighbors who help each other, van service, senior centers, meal sites, food pantries, healthcare clinics, nursing home sidewalks, police presence, grocery stores that deliver)***

The major findings are included in this section. A copy of the questionnaire is included in the Appendices.

Aging and Disability Issues: Each participant completing this survey question could identify one (1) or more of 38 issues listed on the survey as being most important. Space was also provided to include other issues that were not on the list.

The total number of questionnaires completed was 555 with 812 individuals attending the Listening Tour meetings, a 68 percent response completion rate. The top ten items that received 60 percent or above are as follows:

Response	***# of responses***	***%***
1. Affordable dental care, hearing care and eye exams and glasses	388	69.9
2. Not having enough insurance or money to pay for doctors or medicine	386	69.9
3. Being able to get help when needed quickly and without hassle	385	69.4
4. Transportation for people who don't drive cars	384	69.2
5. Learning new things	384	69.2
6. Being able to get accessible transportation	382	68.8
7. Keeping healthy through exercise and eating healthy foods	376	67.7
8. Getting care at home instead of in a nursing home	366	65.9
9. Respite services	340	61.2
10. Training for aid workers who help older adults and people with disabilities	333	60.0

The two (2) least important issues were as follows:

Response	***# of responses***	***%***
1. Help with drinking too much alcohol or taking drugs	88	16.0
2. Being able to get accurate information from a website and being able to apply for services on line	139	25.0

Impact of Baby Boomers: A major issue impacting Tennessee's aging system will be the aging baby boomer generation. Baby boomers are defined as individuals who were born between 1947 and 1964. Currently, an estimated 75 million individuals are identified as baby boomers. In 2011, the first baby boomer reached the age of 65 and an estimated 10,000 individuals reach the age of 65 every day. The baby boomers represent a very diverse population with the peak of the boomer generation occurring between 1952 and 1957 with their formative years occurring during the 1960's. (*"What's a Boomer?"* Baby Boomer Headquarters (bbh.com).

According to "*10 Ways Baby Boomers Will Reinvent Retirement", **US News and World Report***, February 16, 2010, "[t]he baby boomers redefined each state of life as they passed through it. This generation also will retire in a way that is distinct from their parents and will set the standard for generations to come." Currently in Tennessee, the 65 & over population represents 13 percent of Tennessee's population. In the next 15 years, an additional 1,245,064 individuals or 20 percent of Tennessee's current population will reach the age of 65, representing a 65percent increase.

In response to the survey question ***What are the hard things that "baby boomers" face?,*** most of the respondents indicated that the current lack of accessible and affordable services and programs and the lack of funding will only increase as the retired population increases and lives longer than their parents. The primary concerns faced by baby boomers are identified by category. Examples of the responses are included for clarification.

- Retirement: can't afford to retire; having enough money to retire; retirement benefits; saving for retirement; part-time job to supplement retirement
- Health Insurance: high cost of medical care; able to afford insurance; availability of insurance

- Economic Concerns: insecurity about the economy and/or shrinking economy; lack of assets; loss of savings from a bad economy; increasing cost of gas, utilities, food; hard to live on Social Security; fewer resources for middle income families; rising cost of living will outpace retirement benefits; reduced/fixed income; rising costs and declining income
- Social Security, Medicare, Medicaid: will they be there?; future of Social Security and the possibility of insolvency, raising the age eligibility requirements
- Caregiving: caring for aging parents while working; raising a family while caring for aging parents; shortage of caregivers; increase in Alzheimer's and dementia
- Maintaining Health: staying active physically and mentally; need more education and programs/facilities; health promotion; senior center hours not accessible for working adults age 60 and over; just now beginning to provide programs for baby boomers
- Transportation: affordable, accessible, and safe transportation; more city and rural transportation; more choices in transportation
- Healthcare: mentally challenged have limited resources; availability of health care; paying for medications; veterans exposed to Agent Orange; services for aging in place; services for the disabled and for low income; services for people living in rural counties, services are already lacking; not enough home and community based services; adult day care
- Technology: automated everything; quickening pace; keeping up/computer skills
- Housing: affordable, accessible, safe; affordable/available home repairs; livable and walkable communities; decreasing options for housing; investment friendly housing; housing to match abilities

All of these differences will significantly impact the aging services and programs to be designed in the next few years. In response to the second part of the question ***How should the State of Tennessee help?***, several responses reflect the lack of answers to this question: so many retiring at the same time, money and provisions will run out; so many – government can't take care; and don't know.

What Works in the Community: The survey question "***What is currently working well in your community?"*** asked participants to identify what programs and/or services they thought were working. Some of the programs and services identified may not be statewide. One (1) participant had the following statement: "The services that are available are great, but so few can access."

The programs and services that are currently working included: meals (meal/nutrition sites, meals on wheels, mobile meals), van services, senior centers, grocery and pharmacies that deliver, Second Harvest Food Bank, food pantries, Elder Watch; Senior Citizen Awareness Network (SCAN), local church assistance, Project Live, Office on Aging, Alzheimer's Tennessee, United Way, Community Gardens, Area Agency on Aging and Disability (AAAD), police involvement with Seniors and Law Enforcement Together (S.A.L.T.) and the S.A.L.T. conference, networking, sidewalks, home and community based services, law enforcement and sheriff's office, Loaves and Fishes, dental care three (3) days a week, Room in the Inn, Human Resource Agencies (HRA), SHIP, Senior Companion Program, Helping Hands, Ombudsman, Habitat for Humanity, legal aid services, homemaker services, Public Guardianship for the Elderly, CHOICES and Options, healthcare clinic, aquatics available, commodity distribution, Silver Sneakers, Matter of Balance, Cancer Society's Road to Recovery, and physical fitness programs.

Small Group Focus Sessions

The Small Group Focus Sessions were asked to expand upon the aging and disability issues facing Tennessee and to identify the factors impacting those issues. Since the sessions were open-ended, the responses from the multiple groups were overlapping and provided examples to re-enforce the identified issues:

- Not enough programs and services and lack of funding

- More affordable, accessible, and flexible transportation
- Tracking services provided by churches, the community, etc.
- Need for more education and training programs
- Lack of health insurance or money
- Financial assistance for food, heating, medications, utilities, etc.
- Limited computer skills and/or internet access
- Limited assisted living, retirement communities, especially in rural areas
- Solicitation calls, frauds and scammers
- More accessible services and user-friendly information
- Affordable, accessible, and safe housing and home repairs
- Lack of financial resources for dentures, hearing aids, glasses for adults age 60 and over and adults with disabilities
- Waiting lists for services and programs
- Depression and loneliness
- Lack of in-home services – home and community based services
- Poor attitude toward adults age 60 and over
- High cost of medications
- Too many places to call for services and/or programs and how to qualify for services
- Decrease in people paying into system, benefits, and workers in the field
- Coordination of services
- Elder Abuse
- Caregiving

Chapter 4
Challenges

The State of Tennessee will be facing many challenges in addressing the aging and disability populations according to the multiple data sources used to develop the **Tennessee State Plan on Aging 2014-2018.** The long-term challenge will be the ability to keep up with the increasing demand for programs and services with stagnant or decreased funding. With the baby boomers reaching retirement age and the "frail elderly" aged 85 and older becoming the fastest growing segment of the aging population, TCAD's ability to keep up with the demand for services is compromised. Primary challenges are:

- TCAD's infrastructure must be ready to support the increase in the programs and services that will be needed by the growing population of adults age 60 and over and adults with disabilities;
- aging and disability programs, services, and funding are currently beyond maximum capacity while the growth of the baby boomer population has not yet achieved maximum demand;
- current discretionary grant funding has ended or is ending September 30, 2013, for Alzheimer's Evidence Based, Alzheimer's Innovation Grant, Care Transition Intervention Grant, Chronic Disease Self Management Program, Medicare Enrollment Assistance, and Lifespan Respite Grant and the future of discretionary grant funding is unclear, however, TCAD will be poised to apply should further grant opportunities become available; and
- the need for a more integrated system of services and programs to meet the needs of the growing aging and disability population will require that current partnerships become more inclusive of the public and private sector and strengthened through cooperation and coordination.

Fiscal Challenges

The major long-term challenge facing Tennessee is funding. Beginning July 1, 2013 – June 30, 2014, as the result of sequestration, federally funded programs must cut their budget by five percent; thus, impacting the amount of money available for aging services. Preliminary analysis of the sequestration shows that the nutrition program will receive the greatest impact with approximately $855,229 cut in funding resulting in the elimination of 149,500 (congregate and home-delivered) meals affecting 1,050 consumers. Additional program cuts include 27,242 hours of supportive service affecting 401 consumers and $127,018 from the caregiver support program impacting approximately 64 consumers. The State Health Insurance Assistance Program was also cut by $45,175 which will mean a reduction in available staff to provide Medicare counseling and outreach.

Other challenges currently facing the State of Tennessee include state budget reversions impacting home and community based services such as home delivered meals, personal care and homemaker services. In Tennessee, state revenue is dependent upon sales tax collection. The Governor has decided to pursue a third option regarding the expansion of Medicaid through the Affordable Care Act, known as the Tennessee Plan, and at this time, we are unsure whether or not the federal government will accept this plan, and therefore, uncertain of how the plan could impact programs and services.

Federal funding requires matching funds from the state and securing a match may be difficult if aging and disability are not prioritized. In addition, 17 state agencies have some responsibility and funding for providing aging and disability services in addition to TCAD. According to the needs assessment, participants in the Listening Tour found it difficult to get help when needed quickly and without hassle and identified it as a priority.

Another fiscal challenge identified by participants in the survey was not having enough insurance or money to pay for doctors or medicine. The U.S. Department of Labor reports that "fewer than half of Americans have calculated how much they need to save for retirement; in 2010, 30 percent of private

industry workers with access to a defined contribution such as a 401(K) plan did not participate; and the average American spends 20 years in retirement."

Capacity of Programs and Services

Waiting List: The current capacity of TCAD and state departments and agencies to provide programs and services is inadequate to address the immediate needs of the aging population resulting in waiting lists for all programs and services. Statewide, the Options Program currently has a waiting list of 9,000 individuals seeking these services in order to remain in their home. Publicizing a toll free number and services and then being told there is a waiting list is frustrating for both the person seeking help and the provider trying to help.

Support Services: The need for support services will continue to increase as the aging population increases.

- Transportation: Transportation continues to be a challenge, especially in rural areas. More affordable, accessible, and flexible transportation services are needed to meet the needs of the aging and disability population. Adults age 60 and over are outliving their ability to drive safely by an average of seven (7) to 10 years.
- Meals: A waiting list exists for home delivered meals. Cost effective alternatives must be implemented in order to serve more individuals as well as the need for additional funding.
- Housing: Affordable and accessible housing becomes a problem when the house is no longer able to accommodate a person who has become disabled or may have stairs the person can no longer navigate, the house may no longer be in a safe environment, and/or have access to services such as grocery stores if driving is no longer an option.
- Senior Centers: Senior Centers serve as local community focal points for information on aging services and aging activities in at least one location in each of Tennessee's 95 counties offering group and individual services that promote healthy lifestyles, providing learning opportunities, and providing social interaction and volunteer opportunities. Although senior centers were an example of what is currently working well in the community, the senior centers are seeking funding to continue their services and programs.
- Caregiving: The need for caregiving and respite services are increasing and there is a concern about the shortage of caregivers as baby boomers age. Family and informal caregivers are providing care for many of Tennessee's adults age 60 and over, adults with disabilities and grandchildren. This unpaid caregiving is saving the state considerable resources, but also impacts the emotional well-being, health, employment, income, and financial security of the caregiver. According to an article in the New York Daily News (March 18, 2012) written by Heidi Evans, one (1) in three (3) seniors over the age of 65 now die with Alzheimer's. "Cost of care of Alzheimer's patients was $200 billion last year and could reach $1.2 trillion by 2050, with costs to Medicare and Medicaid increasing more than 500 percent."

Baby Boomers

The aging baby boomer population will strain the capacity of the state to provide aging and disability programs and services. Baby boomers will be living longer than previous generations, have greater need for services, and will impact the system for a longer period of time. The baby boomer generation is also referred to as the "sandwich" generation as they are caught between caring for elderly parents and raising their children and grandchildren. The baby boomers may not only impact the quantity of the programs and services, but the kinds of programs and services that are delivered and how those programs and services are delivered.

Learning New Things

Those responding to the surveys identified "learning new things" as important. "Most retired baby boomers today go directly from full-time work to full-time retirement, according to a 2011 AARP survey… The worst thing retirees can do - especially those accustomed to decades of long, stressful days - is stop challenging their brains with new tasks and experiences. Dr. Anne Fabiny, chief of geriatrics at the Cambridge Health Alliance, said retirees should be changing paths, not speed." (*Staying engaged: Learning new things, staying engaged are keys to a sound body and mine* by Nancy Reardon Stewart, ***The Boston Globe***, May 20, 2012) Senior Centers are one source for "learning new things"; however, senior centers may have to provide more variety in services and programs to attract baby boomers.

Adults with Disabilities

As with the population of adults age 60 and over, adults with disabilities living independently in a neighborhood/community rather than in an institution will be a challenge. They will need safe housing in livable communities with accessible transportation. Self-determination must be the cornerstone of all programs and services for the aging and disabled populations. Wheelchair accessible vans must be available. Communities must have sidewalks so that adults with disabilities can move around independently - wheelchairs cannot navigate in gravel on the side of the road. Help is needed for persons with visual impairments such as the need for large format telephones. Home modifications such as higher commodes will allow adults with disabilities to live independently. Training volunteers to work with adults with disabilities is a necessity. Public buildings and stores must be accessible in order for adults with disabilities to be able to meet their needs for living independently.

The results of the data also indicate that gaps exist in the system for adults with disabilities. Current state funding administered by TCAD is limited to older adults and adults over the age of 18 who have physical disabilities. Other state agencies provide services for adults with intellectual and developmental disabilities, behavioral health issues and employment issues. Little collaboration among the state agencies has existed in the past. However, strides are being made through efforts such as: 1) the Policy Academy sponsored by the Substance Abuse and Mental Health Services Administration and the Administration on Community Living; 2) the Transportation Committee sponsored by the State Legislature; 3) the "Yellow Dot" initiative sponsored by the Tennessee Department of Transportation; 4) the Council on Injury Prevention sponsored by the Health Department, 5) cross-training with the Tennessee Department of Intellectual and Developmental Disabilities, and 6) the Tennessee Vulnerable Adult Coalition sponsored by TCAD and the Department of Human Services—Adult Protective Services.

Tracking In-Kind Funding and Volunteer Services

Many of the programs and services provided for adults age 60 and over and adults with disabilities in Tennessee would not exist without the assistance of volunteers, such as transportation, food delivery, senior center activities, and caregiving. Another need is being able to use State and Federal funding to leverage additional funds to meet the needs of adults age 60 and over and adults with disabilities. Currently, there is no consistent statewide system to track the in-kind services or leveraged programs, such as transportation or food pantries provided by community organizations or churches. Unpaid caregiving is saving the state considerable resources.

Additional Challenges identified by the data include staying healthy in mind and body; depression and mental health; elder abuse; and alcohol and drug abuse.

Chapter 5
Planning for the Future
Goals, Objectives, Strategies, Performance Measures

As the baby boomer generation ages, the increase in numbers of adults age 65 and over will require a State Plan that utilizes all available resources, including both people and money, in the most efficient and effective manner. A plan that will require solutions that:

- "think outside the box",
- provide a greater diversity of services and programs to meet the needs of all populations,
- develop and implement approaches to address both immediate needs of current retirees and the needs of future retirees,
- create easier access to services and programs, and
- streamline the current programs and services

However, this is only the starting point for TCAD.

TCAD will continue to engage policy-makers in decision-making processes that elevate the needs of adults age 60 and over and adults with disabilities to the forefront while recognizing the strengths and contributions of this population. TCAD will also continue to seek state and federal funding aimed at addressing the need for home and community based services. Despite budget concerns and other issues, TCAD will strive to maintain quality services, programs, and staff.

The goals, objectives, strategies, and performance measures have been developed for the **Tennessee State Plan on Aging 2014-2018** utilizing the following: Statewide Listening Tour and the Needs Assessment conducted in February-March 2013; Stakeholders' Meeting (January 25, 2013); Commission Meeting (February 5, 2013); TCAD's 2011 Strategic Plan (developed by the Commission Members), the Governor's Conference on Aging (September 1, 2011), The Lewin Group's Aging and Disability Resource Center Fully Functioning Assessment June 2012, and the Public Hearing to be held May 7, 2013.

The following are the goals, objectives, strategies and performance measures for the **Tennessee State Plan on Aging 2014-2018**: (Please note that * denotes that the item comes from the Commission Strategic Plan; ** denotes that the item comes from the Governor's Summit on Aging; and *** denotes The Lewin Group's assessment of Tennessee's ADRC under State Status areas: Area for Growth and Partially Meeting Criteria)

Goal 1: **Ensure that current SUA programs and services for adults over the age of 60 and adults with disabilities are cost effective and meet best practices**

Objective 1: Evaluate and modify, as needed, the internal structure of the State Unit on Aging (SUA) to ensure effective and efficient management and monitoring of programs and services and of state and federal funding

Strategies

1. Identify the competencies, knowledge, and skills needed for each SUA position in accordance with the current State Plan on Aging to align employee performance with agency mission using the Tennessee Department of Human Resources SMART (specific, measurable, achievable, relevant, and timely) tool
2. Redesign and implement staffing patterns and job plans to match the new competencies, knowledge,

and skills required for each position
3. Review and revise the Program and Policy Manual to describe both programmatic and fiscal requirements for operation and to ensure a greater understanding of those requirements
4. Review and revise, as needed, monitoring tools for each program to be used by the SUA and AAADs that corresponds to the Program and Policy Manual revisions and contract requirements
5. Review and revise the contract scope of service for each program and service provided by the SUA based on the revised policies and procedures for that program
6. Ensure that the data systems for tracking programs and services are in place and providing accurate data and the data can be used to identify trends or patterns in program service utilization in order to modify or make adjustments in planning/operation
7. Rewrite, submit, and implement the quality assurance plan annually according to state guidelines (Policy 22 Monitoring Plan/Title VI Civil Rights Plan) as required by the State of Tennessee

Objective 2: Evaluate and modify, as needed, the state and federally funded home and community based (HCBS) programs to maximize the number of people served with the funding

Strategies

1. Evaluate the number of persons served in each district compared to the funding provided through the intrastate funding formula using data currently provided by the SAMS database
2. Evaluate the trends in frequency and amount of services needed and provided compared to Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) of the consumers utilizing data currently provided by the SAMS database
3. Evaluate the waiting list and determine if there are ways in which to redesign the HCBS delivery system to be able to serve more people
4. Evaluate the HCBS to determine cost effectiveness of the current funding and determine how much additional funding would be needed to further reduce the waiting list
5. Create a usable continuum of care that would incorporate three funding sources (Title III-B, Title III-E, and State HCBS) to provide needed and appropriate services and programs to the individual based on the number of ADLs, IDLs, and family supports identified for each individual to ensure cost effectiveness and reduce the waiting list
6. Increase the availability of self-directed care in all nine (9) AAAD regions based on the current policies and procedures to ensure that all consumers have choices for HCBS services
7. Provide training on person-centered concepts and self-determination (Example: Boston University on-line training through the ADRC)
8. Ensure that the individual receiving HCBS and family members, if available, are personally involved in the development of the Plan of Care so that the Plan of Care is person-centered and self-determined
9. Review and revise, if needed, the contract scope of service based on the revised policies and procedures and the best practices for HCBS
10. Work with the AAADs and the service provider network to identify training needs for in-home workers and develop guidelines for the training

Objective 3: Evaluate and modify, as needed, the Family Caregiver Program to ensure that the program is managed in the most cost effective manner and maximizes the number of people served with the funding

Strategies

1. Evaluate the number of persons served in each district compared to the funding provided through the intrastate funding formula utilizing data currently provided by the SAMS database
2. Evaluate the Family Caregiver program delivery system and re-design the program to focus

specifically on respite and redirect funding to respite to serve more caregivers and reduce the waiting list
3. Partner with the AAADs and the Tennessee Respite Coalition (TRC) to ensure that the Family Caregiver program focuses on the needs of the caregivers by providing respite and by providing other support services on an as needed basis such as training, education, and supplies
4. Determine the amount of additional funding that would be needed to further reduce the waiting list after identifying and implementing cost effective measures to the current funding
5. Revise, if needed, the contract scope of service based on the revised policies and procedures for the Family Caregiver program

Objective 4: Evaluate and modify, as needed, the Nutrition program to ensure that the program is managed in the most cost efficient manner to maximize the number of people served with the funding, to provide nutritious meals that are tasty and attractive according to customer satisfaction, and to provide supportive services to prevent, delay, or manage chronic health conditions

Strategies

1. *Determine the actual costs of current congregate and home-delivered meals in each district and evaluate the cost effectiveness
2. Identify the most cost effective methods of reducing the costs of meals without jeopardizing nutrition and attractiveness
3. Evaluate methods of providing nutritious meals that could reduce costs such as the use of statewide vendors; use of volunteers; unit cost reimbursement; cook chill; and/or vouchers and incorporate these cost saving measures, if feasible
4. Provide nutrition counseling and education to individuals that have elevated risk factors for nutritional problems as determined by the Independent Living Assessment (ILA)
5. Partner with faith-based organizations to enhance their food programs, such as meal programs, food pantries, gleaning, and commodities
6. Provide education on the value of community gardens, the healthy benefits, the importance of eating fresh fruits and vegetables, and the resources available in the community to help
7. Initiate changes that will reduce costs, enable more customers to be served, and reduce the waiting list through the development of appropriate policies, procedures, and contracts
8. *Partner with all entities providing access to food and nutritious meals to evaluate the current state of the delivery system and design ways to improve the system
9. *Develop an accessible and easy-to-understand curriculum based upon evidence-based information for statewide use by dietitians to provide a greater focus on nutrition education

Objective 5: Identify and implement strategies to ensure that the Ombudsman program is more effective and efficient in advocating for all patients in all long-term care facilities

Strategies

1. Ensure that the data from the Ombudsmanager database is accurately recorded and in a timely manner
2. Ensure that the database is used to evaluate and improve the program
3. Ensure that all Ombudsman federal and state reports are submitted annually as required
4. Evaluate how to distribute funding for the Ombudsman program more efficiently and effectively taking into consideration the location of the long-term care beds
5. Increase monitoring and technical assistance for District Ombudsman programs to ensure that programs are meeting the goals and guidelines
6. Develop a Volunteer Ombudsman Representative (VOR) manual and training materials

7. Conduct volunteer on-line and face-to-face training in each district annually led by the State Long-term Care Ombudsman
8. Continue to stay updated on the emerging Ombudsman issues such as the role of the Ombudsman program in the Managed Long Term Care Support Services
9. Implement the peer program in each district (Pennsylvania's Empowered Expert Residents) that provides training for a cadre of residents to serve as advocates
10. Revise, if needed, the contract scope of service based on the revised policies and procedures for the Ombudsman program

Objective 6: Increase awareness and access to information regarding the prevention of abuse, neglect, and exploitation

Strategies

1. Pursue greater collaboration among Legal Assistance Providers through training and quarterly meetings to identify issues and solutions
2. Promote the use of the statewide www.onlinetnjustice.org , www.legalinfotn.org and hotline 888-aLEGALz for attorney consultations and self-help
3. Seek additional funding sources to strengthen the legal assistance program such as the "Model Approaches to Statewide Legal Assistance Systems" grant opportunity
4. Develop curricula on the prevention of financial exploitation to be delivered by SUA staff and legal assistance providers

Objective 7: Support and enhance multi-disciplinary responses to abuse, neglect, and exploitation of adults over age 60 and adults with disabilities by involving Adult Protective Services (APS), Ombudsman, legal assistance, law enforcement, healthcare professionals, and financial institutions

Strategies

1. Identify the best practices for increasing public awareness about elder rights and addressing elder abuse prevention, such as the Year of Elder Abuse Prevention (YEAP) Toolkit provided by the AoA
2. Partner with Tennessee Vulnerable Adult Coalition to implement initiatives that utilize the identified best practices and maintain the social networking site for the purpose of disseminating elder abuse prevention information
3. Enhance the partnership with APS to build awareness of APS services and how citizens should contact APS for needed services

Objective 8: Identify and implement strategies to ensure that the Guardianship program is more effective and efficient in serving clients who cannot make their own financial and healthcare decisions and have no one else to assist them

Strategies

1. Ensure that the client data in the SAMS database is accurately recorded and in a timely manner
2. Ensure that the client data is used to evaluate and improve the program
3. Review the current Guardianship funding formula and modify, as necessary, to ensure that the funding is distributed consistently and cost effectively
4. Update and modify, as needed, the volunteer manual

5. Conduct volunteer recruitment, training, and retention activities in each region to ensure that each client has friendly visitations and someone to quickly identify any issues or problems that need to be reported to the Guardian
6. Review and implement best practices for the public guardianship program, for setting and collecting fees for services, and for developing statewide program standards in partnership with Conservatorship Association of Tennessee (CAT) in order to ensure a cost effective and efficient program
7. Conduct training for guardians twice a year
8. Advocate for alternatives to public guardianship such as mediation, advance directives, and training family guardians
9. Review and revise, as needed, the policies and procedure governing the Guardianship Program

Objective 9: Evaluate and modify, as needed, the Senior Center program and provide support to senior centers that are striving to meet the needs of the current population and to embrace the needs of the emerging baby boomer population

Strategies

1. Identify best practices for Senior Centers and conduct training and technical assistance for senior center directors and staff
2. Create incentives for Senior Centers that develop and implement programming geared for meeting the needs of the baby boomers, such as computers and competitive mini-grants
3. Assist Senior Centers with fundraising activities to support best practice programming
4. Assist Senior Centers with diversifying funding and developing programs and services that are self-sufficient and/or profitable
5. Provide technical assistance and training to assist senior centers in becoming AIRS certified
6. Provide technical assistance to the senior center board of directors and center directors to enable Level 3 and Level 4 senior centers to apply for and achieve accreditation

Objective 10: Review emergency preparedness plans submitted by the AAADs and senior centers to ensure that plans meet best practices as determined by the Tennessee Emergency Management Agency (TEMA).

Strategies

1. Continue to provide staff as “Emergency Services Coordinator” to participate in TEMA training, certification, and plans
2. Annually, review emergency preparedness plans of the AAADs and senior centers
3. Provide regional training on emergency preparedness for agencies and individuals
4. Monitor to ensure that the AAADs have completed the on-line FEMA emergency preparedness training

Objective 11: Review and modify, as needed, all SUA’s fiscal policies and procedures to ensure that all budgeting, accounting, contracting and reporting follow state and federal guidelines and that all reports are accurate, submitted on-time, and in accordance with accepted procedures

Strategies

1. Provide technical assistance to the AAADs in regard to fiscal management, budgeting, and quarterly reporting
2. Review AAAD expenditures quarterly and compare to number of consumers served as reported in

SAMS to determine if programs and services are on target with performance goals to meet contract requirements
3. Determine the amount of additional funding needed to serve people on the waiting lists based on fiscal and programmatic data provided by the management and program staff of SUA
4. Determine budgets for all SUA programs and grant applications with the assistance of management and program staff
5. Conduct fiscal and programmatic monitoring of all contracts to determine contract compliance and ensure that all state and federal guidelines are met

Outcomes and Performance Measures for Goal 1

1. By, 2014, align employee performance with agency mission by using the SMART Formula Planning Tool to determine competencies, knowledge, and skills for each SUA positions as evidenced by TN Department of Human Resources approval of Performance Plans and all new Job Classifications
2. By 2015, implement uniform customer satisfaction survey statewide for each funded program as evidenced by Program Instruction issued to AAADs for each funded program
3. By 2015, complete evaluation and modification of all SUA programs as evidenced by the issuance of a Program Instruction to the AAADs of the Revised Program and Policy Manual
4. Ensure that current funding is serving the appropriate number of consumers as evidenced by FY15 AAAD contract scope of service outlining performance measures based unit cost
5. By 2018, increase by five (5) percent the number of people served from the waiting list as evidenced by comparing the number of people served from the waiting list in FY13
6. By 2018, ensure that there is a five (5) percent increase in the specified number of individuals that will be served home-delivered and/or congregate meals by each AAAD as based on a identified cost per unit in the Contract Scope of Service and as evidenced by data recorded in SAMS
7. Annually, increase by five (5) the number of Ombudsman volunteers in four (4) targeted rural areas as evidenced by the OmbudsManager data
8. By 2018, three (3) communities per region will implement community gardens
9. By 2018, 50 percent of senior centers will have a minimum of two (2) AIRS certified staff
10. By 2018, increase by 10 percent the number of respite hours provided in each region as by comparing the FFY14 to FFY18 data reported in the State Program Report
11. By 2018, five (5) senior centers will achieve accreditation
12. By 2018, increase by 10 percent the number of consumers in each region who choose to participate in nutritional counseling as compared to FFY14 to FFY18 State Program Report

Goal 2: ***Diversify funding and partnerships to sustain effective services and programs to meet current needs and to expand and/or implement additional services and programs to meet the emerging needs of the baby boomer population**

Objective 1: Continue to identify and pursue sources of funding, including grant and foundation opportunities

Strategies

1. Research new and/or alternative sources of funding and non-traditional funding
2. Determine the feasibility of developing grant and foundation applications with potential grant partners such as Alzheimer's Tennessee, Senior Centers, Mental Health America, and Area Agencies on Aging and Disability
3. *Seek grant applications for evidence-based, proven practices to serve adults over 60 and adults with disabilities
4. *Partner with corporations, universities, and foundations as potential funding sources

5. Continue to partner with State departments such as, but not limited to, the Department of Health and the Department of Mental Health and Substance Abuse Services to seek joint federal and state funding to serve adults over 60 and adults with disabilities
6. **Utilize public, private, and non-profit resources to leverage funding to provide needed evidence-based, proven services and programs for adults over 60 and adults with disabilities
7. Track funding for programs and services that have been leveraged by State and Federal funds

Objective 2: Maintain and grow relationships with partners and stakeholders including key state agencies, statewide organizations, universities, and private and non-profit entities with statewide influence

Strategies

1. Create a forum to review resources, determine where costs can be saved and funding can be redirected to unmet needs, and identify where there is duplication of services or potential for duplication
2. Partner with universities to develop innovative programming regarding healthy aging issues and training of aging network staff
3. Partner with Council on Aging, Alzheimer's Tennessee, Mental Health America, Alzheimer's Association and other non-profits that serve as subject matter experts
4. Promote advocacy for adults over 60 and adults with disabilities by providing information and education to legislators, policy-makers, and community organizations
5. *Partner with corporations, universities, and foundations to strengthen the ability to reach baby boomers through information and education about services and healthy aging; to utilize subject matter expertise; to increase volunteerism; and to raise awareness about how these partners will be impacted by the aging population

Objective 3: *Build infrastructure and capacity both at the state level and at the area agency level to include marketing; grant writing and grants management expertise; and other payment options and capabilities such as private pay and cost-share

Strategies

1. Develop and implement marketing strategies that are best practices geared to reach the baby boomer population
2. Redirect staffing at the state and area agency levels to include competencies in facilitation, grant writing, and grants management
3. *Revise policies and procedures to include private pay and cost-share payment options to underwrite the cost of services and programs
4. Provide staff training and technical assistance on the development of payment options such as private pay and cost-share

Outcomes and Performance Measures for Goal 2

1. By 2016, add five (5) new partners assisting in obtaining funding for programs and services for adults 60 and over and adults with disabilities
2. Annually, add 4 new applications annually for funding (federal, state, foundation, etc.)
3. By 2018, all regions will have private pay option as evidenced by the implementation of private pay option in three (3) districts per year
4. Annually, increase by one (1) percent statewide the number of consumers who contribute through cost share as evidenced by the SAMS database

Goal 3: **Build the capacity of programs and services to serve more adults 60 and over and adults with disabilities by identifying strategies that can be cost-effective, implemented incrementally, and integrated into the current programs and services**

Objective 1: Partner with Alzheimer's Tennessee, Alzheimer's Associations, Mental Health America, Area Agencies, the Aging Network, and other aging service providers to coordinate planning, public awareness, and program development efforts to address the increase in Alzheimer's Disease and Related Dementia (ADRD) with the increase in the number of aging baby boomers

Strategies

1. Review the 10-year Alzheimer's State Plan submitted to the Governor in 2009; identify the components that have been implemented; and identify goals and objectives that can be addressed in the next four (4) years
2. Seek funding to implement the goals, objectives, and recommendations of the updated Alzheimer's State Plan
3. *Support families of individuals with ADRD by sustaining current services and developing additional services
4. *Provide and grow dementia capable training and professional development opportunities for healthcare professionals, first responders, and physicians about ADRD
5. Provide a "no wrong door" access to ADRD services by coordination and cross-training with the ADRC/AAADs, Alzheimer's Association, Alzheimer's Tennessee, Mental Health America, and Tennessee Respite Coalition
6. Increase respite care for families of individuals with Alzheimer's Disease using current funding and new funding
7. Re-direct SUA staffing to include responsibilities for liaison and coordination with ADRD partners

Objective 2: Implement evidence-based programming that promotes healthy aging and disease prevention

Strategies

1. Ensure that current federal Administration for Community Living (ACL) funding for health promotion and disease prevention targets evidence-based programs such as, but not limited to, Chronic Disease Self-Management, Arthritis Self-Management, Silver Sneakers, Tai Chi, and Matter of Balance (fall prevention)
2. Partner with the Department of Health to ensure that all seniors have access to the Chronic Disease Self-Management Program
3. Work with the Department of Mental Health and Substance Abuse Services to implement evidence-based prevention and intervention programs to address depression and use of alcohol and drugs in the aging population
4. *Pursue funding (federal, foundation, public and private sectors) to implement evidence-based practices for healthy aging and disease prevention
5. *Designate, when possible, traditional state and federal funding toward effective evidence-based practices that address, but not limited to, health promotion and disease prevention, medication management, volunteer coordination, and senior center programs

Objective 3: Enhance transportation services that are easier to access for adults age 60 and over and adults with disabilities

Strategies

1. Review and map current transportation services available to adults 60 and over and adults with disabilities
2. Identify best practice models in other states and move to implement best practices statewide including, but not limited to, the Independent Transportation Network (ITN)
3. Identify the current and emerging needs for transportation using data available from the State Listening Tours, Area Agencies, ITN, and other sources
4. *Convene partners and transportation leaders to explore issues and opportunities to develop innovative partnerships for the purpose of planning that are user friendly, affordable, and accessible
5. Identify gaps in current transportation services and develop a plan to address mobility needs of adults 60 and over and adults with disabilities including door-to-door and door-through-door (assisted transportation or escort) accessibility
6. Seek grant opportunities and transportation funding
7. Provide planning and grant development technical assistance to urban and rural communities that are pursuing grant opportunities for transportation funding and interface with the National Center for Senior Transportation
8. Advocate for "livable communities" and "aging in place" initiatives
9. Advocate for increased capacity to serve adults 60 and over that helps them stay independent and stay connected such as, but not limited to, accessible transportation to senior centers, nutrition sites, grocery stores, pharmacy, hairdresser, and shopping
10. Partner with companies that have an interest in reaching aging customers to develop transportation services to their stores
11. *Actively participate in the legislative appointed Transportation Coordination Committee (Public Law #198), to which SUA was appointed by the Governor

Objective 4: Identify and maintain professional volunteer program coordinators at the SUA and each of the nine (9) AAADs to implement a volunteer program targeting baby boomers to meet the growing needs of the aging population

Strategies

1. Review and revise, as needed, volunteer program recruitment, training, and retention plans for each of the following programs: Ombudsman, Guardianship, Legal Assistance, State Health Insurance Assistance Program (SHIP), Nutrition, and Transportation
2. Develop policy and procedures for the professional volunteer program coordinator including job description and qualifications
3. *Designate existing federal funding for the purpose of developing a volunteer infrastructure with a volunteer program coordinator in each of the AAADs and at the SUA
4. Reach out to the faith-based organizations to encourage program development and community activity and volunteerism regarding services to adults over the age of 60 and adults with disabilities
5. Develop a toolkit for the recruitment, training, and retention of volunteers geared toward faith-based organizations for the purpose of facilitating easier access to information and education and participating in community service projects
6. Provide cross training on specific volunteer roles for each program such as, but not limited to, caregiver, guardianship, elder rights, etc. that utilize volunteers and encourage volunteers to move from one program to another
7. Grow volunteers to become program leaders so that a program might become self-sustaining

8. Identify organizations (government and non-government) that serve the aging and disability populations and form collaborations/partnerships to address specific issues impacting this population, such as, but not limited to, affordable and accessible dental care, eye examinations and glasses, and hearing tests and hearing aids/devices

Objective 5: Develop and implement a *Healthy Aging Plan for Tennessee "Baby Boomers"*

Strategies

1. Organize a task force with prospective partners such as, but not limited to, universities, state agencies, healthcare providers and professionals in the healthcare field, such as physicians and nurses, to discuss strategies for healthy aging for baby boomers
2. Provide recommendations for a Healthy Aging Plan for Tennesseans
3. Develop a Healthy Aging Plan for Tennesseans based on the recommendations

Objective 6: Promote healthy aging through the ***Healthy Aging Guide for Tennesseans***

Strategies

1. Design and publish a Healthy Aging Guide that includes easy to read and understand strategies that can be implemented to assist people to stay active in mind and body
2. Develop and implement a plan for distribution of the Guide specifically targeting baby boomers
3. Implement information and education programs that encourage healthy lifestyle behaviors
4. Identify and emphasize the opportunities for exercise currently available such as Silver Sneakers, dance classes, and Tai Chi.
5. Provide information and education on programs and services to enhance economic security
6. Identify and educate about the opportunities for community involvement and the importance of socialization for staying healthy
7. Include activities that require new or different ways of thinking to encourage an active mind
8. Educate about the importance of a healthy diet and provide some examples of meals that are tasty and inexpensive to prepare
9. Provide information and education on fiscal planning for retirement and adequate health insurance
10. Provide a list of contacts for information should the contacts be needed at some future date

Outcomes and Performance Measures for Goal 3

1. By 2019, increase by 20 percent statewide the number of volunteers providing programs and services to adults 60 and over and adults with disabilities
2. By 2016, publish and distribute statewide the ***Healthy Aging Guide for Tennesseans***
3. By 2018, add one (1) new transportation initiative in each district
4. By 2018, implement one (1) recommendation each year from the 10-year Alzheimer's State Plan

Goal 4: **Ensure that the Area Agencies on Aging and Disability serving as the Aging and Disability Resource Centers in Tennessee provide easily accessible, user-friendly access to programs, services, and resources regardless of payment type so that individuals can get help quickly and without hassle**

Objective 1: Ensure that the ADRC/AAAD meets the fully-functioning criteria and standards set by the Administration on Community Living

Strategies

1. Gather and verify that the data for all functions of the ADRC are entered correctly into the State Reporting Tool (SRT) and reports all of the data available
2. Ensure that the current tracking and case management system meets the needs of the ADRC for data collection
3. ***Continue to actively market the ADRC to all Tennesseans needing assistance regardless of method of payment for services (marked as Area for Growth in the June 2012 assessment of Tennessee ADRCs)
4. Review the data to make certain that all adults 60 and over and adults with disabilities are being served and being referred to the appropriate programs and/or services
5. Review the consumer satisfaction surveys to determine what issues, if any, are impacting the functions of the ADRC
6. Ensure that the ADRC meets the policies, procedures, and standards for the delivery of a comprehensive, fully functioning ADRC
7. Identify and implement ways for reducing the waiting lists for services and programs that are provided through the ADRCs and the AAADs
8. Ensure that the ADRCs have access to telephone technology to make "soft" transfers
9. Provide aging and disability training issues for all staff, including the AAAD, SUA, Department of Intellectual and Developmental Disabilities, and Department of Mental Health and Substance Abuse Services
10. ***Implement strategies to address the Lewin Group's Tennessee ADRC Fully Functioning Assessment June 2012 criteria that the assessment indicates the criteria are Partially Meeting Criteria and/or Area for Growth

Objective 2: Market the ADRC as the single point of entry/first stop for Information and Referral/ Assistance on aging and disability issues

Strategies

1. Ensure that all ADRC personnel who provide Information and Referral/Assistance have Alliance for Information and Referral Systems (AIRS) certification
2. Ensure that the ADRC implements standardized processes for referrals and promotes consistency in how services are delivered and received for the Information and Referral/Assistance service
3. ***Conduct follow-up on ADRC contacts receiving the Information & Referral and Assistance services to collect identifying information on the appropriateness of the referrals; the information met the individual's need; the individual was able to make the necessary connections and if not, why not; and determine if further assistance is needed
4. Provide education, information, and cross-training statewide about the "no wrong door" access to programs and services for adults 60 and over and adults with disabilities available through the Aging and Disability Resource Center (ADRC)
5. ***Cross train staff so that all agencies can be of service to adults 60 and over and adults with disabilities regardless of the service for which the individual is applying
6. Update resource database regularly to ensure accuracy of listings
7. Ensure that inquiry calls are answered within 48 hours

Objective 3: Provide objective one-on-one counseling, information, distribution, and assistance to people with Medicare, potential Medicare consumers, their families, and other advocates through the State Health Insurance Assistance Program (SHIP) and provide public education

Strategies

1. Maintain a cadre of trained SHIP counselors and volunteers in each district
2. Disseminate information about Medicare and related insurance benefits that help to maintain healthy aging
3. Design and implement community outreach to individuals eligible for Medicare Part D Low-Income Subsidy, Medicare Savings Programs, and other benefits
4. Assist beneficiaries with finding affordable prescription drugs and working to assist Duals with mental illness and/or disability with prescription drug availability on an annual basis and access to drugs not covered under Medicare Part D
5. Ensure that all SHIP staff and volunteers receive annual training to update the information needed to provide accurate and effective counseling services

Objective 4: Ensure that the ADRC Options Counseling program meets the national standards based on the AoA national draft of Options Counseling standards

Strategies

1. Ensure a “no wrong door” approach to implementing the ADRC Options Counseling Program
2. Develop policy and procedures that incorporate the national standards
3. ***Incorporate cross-training, particularly focused on working with special populations and cultural competencies, to ensure consistency and quality in services delivery by the ADRC
4. ***Ensure that all ADRCs use common Options Counseling tools to provide consistency, promote team approaches to delivery of Options Counseling, facilitate data sharing, and improve the quality and measurement of quality of services
5. ***Ensure that all ADRC personnel meet expectations for staff education, training, and experience for a base level of knowledge for all Options Counselors
6. ***Continue to conduct follow-up contacts with individuals receiving Options Counseling to determine if the individual was able to follow through on the steps outlined in the action plan, what decisions he/she made, identify barriers experienced when implementing the action plan, and determine if further assistance is required and if the Options Counseling was helpful
7. ***Collaborate with the State’s Medicaid office to implement an effective data sharing system that will serve to meet federal requirements for a fully functional ADRC with streamlined access to services
8. Determine the status and the success of the implementation of the online training program developed around the Options Counseling Standards
9. ***Ensure that consumers, partners, and stakeholders are actively involved in the ADRC through, but not limited to, advisory boards, formal and informal partnerships, and consumer surveys
10. Partnership with other State Departments and Agencies serving the aging and disability population to ensure a collaborative approach to ADRC sustainability

Objective 5: Collaborate with local hospitals and other healthcare organizations to implement the care transitions concept focused on reducing hospital readmissions

Strategies

1. Review the current Care Transitions programs currently in operation to determine their effectiveness and identify lessons learned
2. Support a collaborative partnership among the ADRC/AAADs, hospital and healthcare facilities, community partners, and Qsource to implement the Care Transitions program in each region

3. Ensure that an evaluation component is included in the implementation of Care Transition program

Objective 6: Partner with Memphis VA Medical Center; Mountain Home VAMC in Johnson City; Tennessee Valley Healthcare System in Nashville and Murfreesboro; ADRC/AAADs, and Public Partnership, LLC (PPL) to implement the Tennessee Veterans' Directed Home and Community Based Services

Strategies

1. Implement a contract with each VAMC partner to provide the VD-HCBS
2. Review and revise, as needed, The Tennessee Veterans Directed Home and Community Based Services Program Guidelines and the Tennessee Veteran Directed Home and Community Based Services Consumer Handbook to make certain that the documents meet the needs of each VAMC
3. Review protocol for linking veterans with needed long term support services and making mutual referrals from each VAMC to the ADRC/AAAD
4. Ensure that staff at the ADRC/AAADs will serve as the Support Brokers and that PPL will serve as the fiscal intermediary
5. Ensure that veterans will be able to make their own decisions about who will provide their in-home services if they choose

Outcomes and Performance Measures for Goal 4

1. By 2016, implement VD-HCBS in the three (3) VAMCs
2. By 2018, implement the care transition concept in three (3) ADRC/AAADs
3. By 2018, implement the National Standards for the Options Counseling Program in all nine (9) districts

Goal 5: Collaborate with state agencies to develop a seamless system of accessible services and programs for adults 60 and over and adults with disabilities

Objective 1: *Map the current service system and the state agencies providing aging services

Strategies

1. Identify the state agency and programs and services that are currently being provided to the target population
2. Identify gaps in and/or barriers to the needed programs and/or services
3. Evaluate the success and cost effectiveness of current services
4. Identify the emerging programs and services that will be needed to meet the needs of baby boomers

Objective 2: Establish a seamless system of accessing and delivering services and programs that reduces and prevents fragmentation and curtails duplication of cost and services

Strategies

1. Enhance cooperation, coordination, and communication among state agencies that provide aging services to address the concerns of the aging and disabled population and identify possible strategies to address those concerns
2. Develop a system to share data on programs and services to avoid duplication
3. *Establish standards of services that reflect care with compassion
4. *Establish a collaborative network and structure to create ease of accessibility to services, including,

but not limited to, State Agencies and Governmental entities with common aging and disability issues, the Aging Network, and other partners
5. *Develop an infrastructure to include a broader pool of services providers and organizations in the greater aging network
6. Integrate and coordinate services and funding sources to ensure timely and appropriate services as needed
7. Provide a comprehensive continuum of services and programs that include medical, behavioral, and social services
8. Provide information and education on the “no wrong door” and “first stop” approaches to programs and services and the function of the Aging and Disability Resource Center
9. Meet with state agencies

Outcomes and Performance Measures for Goal 5

1. By 2015, complete the mapping of services and programs as evidenced by the publication of the services map on the TCAD website and updated annually
2. Annually, TCAD will document meetings with a minimum of nine (9) state agencies to ensure better coordination of programs and services for the aging and disability population

Attachment A

State Plan Assurances and Required Activities

FY 2014 State Plan Guidance
Attachment A

STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES
Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2006.

ASSURANCES

Sec. 305(a) - (c), ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging

will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-
(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);
(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) legal assistance;
and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);
(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--

(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:
in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and
(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--
(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(17)Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--
(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—
(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and
(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—
(A) identify individuals eligible for assistance under this Act, with special emphasis on—
(i) older individuals residing in rural areas;
(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iv) older individuals with severe disabilities;
(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall
(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by

the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made--
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order

FY 2014 State Plan Guidance
Attachment A (Continued)

REQUIRED ACTIVITIES

Sec. 307(a) STATE PLANS

(1)(A)The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and
(B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:
(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.

(5) The State agency:
(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

Signature and Title of Authorized Official	Date

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Attachment B

Information Requirements

Section 305(a)(2)(E)

The mechanisms for assuring that preference will be given to providing services to older individuals with the greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) include:

1. The Intrastate Funding Formula is weighted to address the population age 60 and over; low-income elderly; low income minority elderly; elderly living in rural areas, and the population age 80 and above.
2. The State Unit on Aging is in compliance with Title VI (Civil Rights) and submits a Title VI Implementation Plan to the Tennessee Commission on Human Rights annually for approval. The plan includes how outreach and services are provided and monitored in each district annually.
3. The Area Plans include a section on "Targeting" low-income, rural and minority populations.
4. Monitoring activities include the evaluation of persons served who are low-income, rural, and/or minority.

Section 306(a)(17)

The mechanisms for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery include:

1. The Tennessee Emergency Management Agency (TEMA) requires that all state agencies have a Department Operational Guide (DOG) and a Continuity of Operation Plan (COOP). TEMA requires that each state agency designate an Emergency Services Coordinator (ESC) who serves as the staff who has the authority to coordinate emergency services under the auspices of the agency. TEMA also requires that the ESC has completed the TEMA certification training.
2. The SUA has a certified ESC and an alternate.
3. The SUA has a DOG and a COOP (emergency preparedness plans).
4. All Area Plans contain a section on Emergency Preparedness.
5. Each AAADs and senior center is required to have an Emergency Preparedness Plan that is reviewed by the State ESC.

Section 307(a)(2)

1. The SUA develops the budget categories for the budgets contained in each Area Agency Plan. The budget categories include:
   a. Planning and Administration
   b. III-B Supportive Services (including information and assistance, senior centers, legal services, ombudsman, transportation, in-home services; adult day care)
   c. IIIC-1 Congregate Meals
   d. IIIC-2 Home Delivered Meals
   e. IIID- Preventive Health
   f. IIIE-Family Caregiver
   g. VII-Ombudsman; Elder Abuse
   h. Options HCBS (state funds)
   i. Other
2. Area Plan budgets are approved by the Fiscal Director as part of the annual Area Plan approval process.

Section 307(a)(3)

In regard to services for older individuals residing in rural areas, 15% of the Intrastate Funding Formula is weighted for rural elderly. 15% of the total funds projected for FY2014 and the next 3 years that is targeted for the rural elderly would be $3,187,590 (OAA total $21,250,600).

Section 307(a)(10)

The Intrastate Funding Formula is weighted and takes the needs of older individuals living in rural areas into consideration. The weights are as follows: population over age 60 is 35%; low income elderly is 30%; low income minority elderly is 10%; elderly living in rural areas is 15%; and population age 80 and over is 10%. According to the Social Assessment Management Software (SAMS) database records, 96,043 individuals received AoA registered services, non-registered services, and family caregiver services in FY2012 . Of those individuals served 46,220 resided in rural areas (48%).

Section 307(a)(14)

The number of low-income minority older individuals in Tennessee is 20,132 and 2.1 % of all people living in Tennessee do not speak English. As described above in Section 305(a)(2)(E), the Title VI Implementation Plan describes outreach to low-income minority older individuals and individuals with limited English proficiency. The State has a contract with Avaza Language Services Corporation for translation services. The translation service is available at all AAADs. Posters are displayed prominently at the SUA and AAADs that list the 23 languages that can be translated by the service along with directions on how staff can access the services.

Section 307(a)(21)

There is no identified Native American tribe or reservation in Tennessee. According to the Native American Indian Association of Tennessee, there are 10,000 Native American residents in Tennessee. The Association states that "there has been no state or federal recognition of the Indian population and no services directed to them."

Section 307(a)(29)

As described above in Section 306(a)(17), the SUA has an emergency preparedness plan called the Departmental Operational Guide and a Continuity of Operation Plan as required by the Tennessee Emergency Management Agency.

Section 307(a)(30)

As described above in Section 306(a)(17), the SUA follows the lead of the Tennessee Emergency Management Agency (TEMA) which requires all State Departments to have a Departmental Operational Guide and a Continuity of Operation Plan. The State Department of Health is required to have the plans and the coordinating entity is TEMA.

Section 705(a)(7)

As described in Attachment F, a statewide needs assessment was conducted in 2013 that incorporated listening tours in all nine regions of the State. Participants included citizens, the aging network, and stakeholders. The information was analyzed and the top ten needs were identified. The goals and objectives of the State Plan target the needs identified. A public hearing was held on the State Plan in which the identified needs and goals and objectives were discussed. Area Agencies are required to hold public hearings prior to the submission of the 4-year area plan and in each year if there are significant changes.

The Area Plan format includes goals and objectives for the Elder Rights program, Ombudsman, and Legal Assistance.

The SUA developed and routinely up-dates its *Program and Policy Manual* in which all programs administered by the SUA are outlined and policies issued, including fiscal policies and procedures. From time to time, as policies need to be revised, workgroups are comprised of SUA staff and Area Agency staff to make recommendations. Program Instructions are issued to the Area Agencies and contractors when changes take place.

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964
IMPLEMENTATION PLAN
FY 2012-2013

TENNESSEE COMMISSION ON AGING AND DISABILITY

JIM SHULMAN,
EXECUTIVE DIRECTOR

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Introduction

The purpose of the Title VI Implementation Plan of the Tennessee Commission on Aging and Disability is to outline a process for identifying areas where services should be more accessible, outlining needed policies for system improvement, and defining and delivering training and technical assistance. This Implementation Plan is intended to meet the new requirements under the state rules and regulations.

1. Overview

A. Mission Statement

The Tennessee Commission on Aging and Disability brings together and leverages programs, resources, and organizations to protect and ensure the quality of life and independence of older Tennesseans and adults with disabilities.

The General Assembly created the Tennessee Commission on Aging to plan, develop, and administer the Older Americans Act. In 2001, the General assembly passed Public Chapter 397 renaming the agency the Tennessee Commission on Aging and Disability and expanding the commission's authority to include services to adults with disabilities.

The Older Americans Act provides federal funds for administration and direct services. These services include congregate and home delivered meals, protection of elder rights, supportive and in-home care, senior centers, transportation, and family caregiver services. The Commission also administers federal funds from the Centers for Medicare and Medicaid Services (CMS) to operate the State Health Insurance Assistance Program (SHIP), which provides consumer education and counseling about Medicare, and all other related health insurances. The commission also administers state funds for multi-purpose senior centers, Public Guardianship, homemaker, and personal care services and home-delivered meals. (See appendix A for the Organizational Chart.)

B. Non-Discrimination Policy

Pursuant to the State of Tennessee's policy of non-discrimination, TCAD does not discriminate on the basis of race, sex, religion, color,

national or ethnic origin, age disability or military service in its policies, or in the admission or access to or treatment or employment in, its programs, services, or activities.

Equal Employment Opportunity/Affirmative Action inquiries or complaints would be directed to the Tennessee Commission on Aging and Disability, EEO/AA Officer, Nashville, Tennessee 37243-0860, 615-741-2056. Americans with Disabilities Act inquiries or complaints should be directed to the Tennessee Commission on Aging and Disability ADA Coordinator at the same location.

Assistance for those with hearing and visual impairments is available through the Tennessee Relay Center at 1-800-0299.

2. Federal Programs or Activities

Older Americans Act Programs (OAA)

Older Americans Act (OAA) funds provide, in addition to a comprehensive array of services, the administrative infrastructure to deliver all OAA programs. As the designated state unit on aging, TCAD receives an annual allotment under Title III of the Older Americans Act as amended, from the Administration on Aging (AoA) in the U.S. Department of Health and Human Services. TCAD allocates OAA funds to nine Area Agencies on Aging and Disability (AAADs) based on an approved intrastate funding formula. The AAADs plan, develop, and implement a system of services for older persons age 60 and over in their respective Planning and Service Areas (PSA). They also oversee multi-purpose senior center activities. This comprehensive and coordinated system of services is described in the AAAD's Area Plans. OAA programs administered by TCAD include:

• OAA Title III–B Supportive Services/In- Home Services

Supportive services funds provide a wide range of social services aimed at helping older people remain independent in their own homes and communities. Some of the services offered under Titles III-B of the Act include services such as information and assistance, transportation, case management, legal assistance, adult day care and activities in senior centers.

Information and Assistance

TCAD contracts with the nine Area Agencies on Aging and Disability (AAADs) to provide information, assistance, referrals, initial screening for

program eligibility, and long term care options counseling. The AAADs act as a single point of entry for federal and state programs. Information and Assistance is provided directly by the AAADs. This service may be accessed through the toll free, statewide number 1-866-836-6678.

Legal Assistance

Provides legal advice and representation by an attorney to older individuals and also includes counseling or other appropriate assistance by a paralegal or law student under the supervision of an attorney. Clients may be referred to a private attorney after screening by legal staff to determine if the needed services fall within the predetermined case-handling priority guidelines. Referrals may also be made to another community service provider. Public education is also provided.

OAA Title III–C Nutrition Services

Nutrition Program for the Elderly

Nutrition Services provide meals and socialization to older persons in congregate settings such as senior centers or senior housing. Home delivered meals are also provided to eligible older people in their own homes. The purposes of the program are to reduce hunger and food insecurity, promote socialization among older people, and provide meals to frail consumers in their homes.

Senior Centers

Another important part of Tennessee's Aging Network is multipurpose Senior Centers which serve as local community focal points for aging activities in at least one location in each of Tennessee's 95 counties. They offer a wide variety of group and individual services that promote healthy lifestyles, provide learning opportunities, and provide social interaction and volunteer opportunities. Senior Centers in Tennessee are supported through a combination of federal, state and local funds.

OAA Title III–D Disease Prevention and Health Promotion

Disease Prevention and Health Promotion

TCAD contracts with the nine AAADs to provide health promotion activities across the state. Individual or group sessions, most often conducted at senior centers, assist participants to understand how their lifestyle impacts their physical and mental health and to develop personal practices that enhance their total well-being, including physical, emotional and psychosocial factors.

OAA Title III–E National Family Caregiver Support Program

National Family Caregiver Support Program

This program provides assistance to family caregivers caring for persons over the age of 60 or to grandparents or other older individuals who are relative caregivers. The Caregiver program provides information and assistance, individual counseling, respite and supplemental services on a limited or one time basis.

OAA Title IV Activities for Health, Independence, and Longevity

Aging and Disability Resource Center (ADRC)

The Tennessee Aging and Disability Resource Center (ADRC) grant project was awarded to TCAD in 2005, 2009, and 2012 to develop comprehensive, single point of entry Aging and Disability Resource Centers. The purpose of the ADRC is to increase visibility and awareness of the services provided by the AAAD in order that the public will recognize the AAAD as a trusted, objective, reliable source of information and assistance for aging and disability services.

OAA Title VII Elder Rights Protection

Elder Rights

TCAD advocates for the protection of older Tennesseans from physical and emotional abuse, theft, negative stereotyping, and discrimination. The Tennessee Vulnerable Adult Coalition (TVAC) was established in 2008, to bring the state's public and private agencies together to promote the collaboration necessary to prevent abuse, neglect and exploitation of vulnerable adults.

Long Term Care Ombudsman

The state and nine District Long Term Care Ombudsmen are advocates for older persons residing in nursing homes, residential homes for the aged and assisted care living facilities. The Ombudsman is available to help qualified residents of long term care facilities when residents and their families can not resolve their problems through consultation with the facility staff or governmental agencies involved. Trained Volunteer Ombudsman Representatives are a component of this program.

Federal Funding:

Total federal funding includes, Title III Older Americans Act and Title VII Elder Abuse funds and Discretionary grants from the Administration on Aging, and State Health Insurance Program funds from the Centers for Medicaid and Medicare services. There are no FFA applications pending.

The Tennessee Commission on Aging and Disability (TCAD) is directed by the Administration on Aging to designate 9 Area Agencies on Aging to provide all of the services (programs) listed in this section. Under the Older Americans Act, these are the nine sub-recipients receiving funding for the Older Americans Act (OAA) programs listed.

The TCAD also applies for discretionary funds from the Administration on Aging to explore evidence-based programs. These grants are usually limited to 2 or 3 years. When the discretionary grant announcements are made there is usually a 6 to 8 week turn-around time for a response. TCAD follows the Office of Contract review guidelines for all contracts

The Sub-recipients for the Older Americans Act and the SHIP funds are the nine Area Agencies on Aging and Disability. These AAAD's encourage participation of minority owned businesses in the provision of home and community based sevices.

AOA, Title III, TitleVII, Discretionary and SHIP
Total Federal Funding, $31,170,700

3. Organization of the Civil Rights Office/Civil Rights Coordinator

Title VI Planning and Compliance, Staffing and Duties

The function of the Title VI Coordinator is divided into two activities, planning and compliance; therefore, the Planning and Grants Supervisor is responsible for the planning function and the Supervisor of Quality Assurance is responsible for the compliance function.

Since Title VI impacts all of the programs provided by TCAD contractors, it is more than signage and a lack of complaints. The many services offered through the AAADs allow older persons to remain in their own homes;

therefore, it is crucial that these services be accessible to all Tennesseans. As a part of their annual update of the four-year plan, AAADs are required to outline their plans and strategies to reach all Tennesseans. As a result, the AAADs submit a Title VI plan as a part of their Area Agency Plan. In addition, the Area Plans outline minority contractors, as well as minority staff as a part of their staffing plan. Each Area Agency has a designated Title VI coordinator. Area Plans are reviewed by TCAD staff prior to their approval.

Based on the Area Plan, contract requirements and signed assurances, the TCAD Quality Assurance (QA) staff will monitor progress in the Agency's Title VI and targeting plan when on site as well as any signage and or complaints. The minority demographics of older Tennesseans, in the region, are used to compare the distribution of services in proportion to the targeted group of older minorities. It should also be noted that Title III of the Older Americans ACT requires all programs to target rural, poor and minority populations.

The Planning Supervisor serves the planning function by reviewing Social Assistance Management Software (SAMS) data and census information and by writing this plan, and the QA Supervisor reviews Area Agency Title VI plans and the policies, training, monitoring and outreach conducted by the AAADs.

TCAD has a total of 30 staff members, and the TCAD provides no direct services to the public. The mission is carried out through contracts with the nine AAADs.

4. Data Collection and Analysis

The AAADs enter minority participation information into the SAMS data base for their various programs and services. The intent of analysis by Title VI coordinators and Area Agency staff is to review the data and compare to community demographic figures. This data identifies areas of under service which TCAD can address by training and technical assistance.

Minority Representation

Recently enacted legislation has changed the composition of the members of the Commission. The Governor appoints one person from each of the 9 Public Service Areas. In addition the Governor appoints a member of his

personal staff, 1 person who is an active member of a chartered, statewide organization that advocates exclusively for older persons, 1 person who is an active member of a federally chartered organization with statewide membership and chapters chartered in this state, that advocates exclusively for older persons, and 1 person who is an active member of a chartered, statewide organization that advocates exclusively for disabled persons. In addition, the governor appoints the Commissioners of the Departments of Health, Mental Health, Intellectual and Developmental Disabilities, Human Services, TennCare, and Veterans Affairs and the Director of the Council on Developmental Disabilities as ex officio, voting members. Two non-voting representatives are nominated from the General Assembly.

Ideally the members filling the appointed positions represent a mix of urban and rural populations. The board must also represent the diverse racial composition of the state. This September (2012) 6 commission members' terms end. With the newly designed Commission structure, and two Commission members resigning there are 4 positions for the Governor's appointment. (See Data Collection, 4-a)

Minority representation is also reflected in TCAD staff, the directors of the Planning Service Areas, employees of the AAADs, and the Area Advisory Councils. Specific statistical information may found in Appendix4-b. Partnering with minority owned businesses is a goal of the Commission. Currently, each AAAD has contracts with at least one minority owned businesses to provide service to consumers in their area. TCAD requires each AAAD to annually report their minority owned service providers and to identify the dollars contracted to each provider. The Commission tracks the number of providers and the contract dollars to ensure that each area recruits and has business agreements with minority service providers. Dollar expenditures to minority providers totaled 1,648, 750$ for fy 2011-2012. . (Appendix 4-b provides a list of all minority contractors and contract dollars statewide.)

TCAD staff is comprised of 2 part-time and 28 full-time employees. The racial breakdown, according to the TCAD Human Resource staff is as follows:

As of September, 2012
Full-time

White	20	71.43%

Black	8	28.57%

Temporary

White	2	100%
Black	0	0%

Total all staff

White	22	73.3%
Black	8	26.7 %

Complaints Received
There were no complaints received for this reporting period.

Lawsuits filled
None

5. Definitions of words often used in discussing disability and aging issues and programs:

1. **Abuse** - The willful--
   (A) infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish; or
   (B) deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness.
2. **Adult Child with a Disability** - A child who--
   (A) is 18 years of age or older;
   (B) is financially dependent on an older individual who is a parent of the child; and
   (C) has a disability.
3. **Aging Network** is described in the Older Americans Act and means the network of--
   (A) State Agencies, Area Agencies, title VI grantees, and the Administration; and
   (B) organizations that--

(i) are providers of direct services to older individuals; or
(ii) are institutions of higher education; and
(iii) receive funding under the Older Americans Act.

4. **Area Agency on Aging and Disability** - An Area Agency designated under section 305(a) (2) (A) of the Older Americans Act or a State Agency performing the functions of an Area Agency under section 305(b) (5) of the Older Americans Act.
5. **Assistive Technology** - Technology, engineering methodologies, or scientific principles appropriate to meet the needs of, and address the barriers confronted by, older individuals with functional limitations.
6. **Assurance** - A written statement or contractual agreement signed by the agency head in which a recipient agrees to administer federally assisted programs in accordance with civil rights laws and regulations.
7. **Beneficiaries** - Those persons to whom assistance, services, or benefits are ultimately provided.
8. **Board and Care Facility** - An institution regulated by a State pursuant to section 1616(e) of the Social Security Act (42 U.S.C. 1382e (e)).
9. **Caregiver** - An individual who has the responsibility for the care of an older individual, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law.
10. **Caretaker** - A family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) uncompensated care to an older individual who needs supportive services.
11. **Case Management Service**--
    (A) A service provided to an older individual, at the direction of the older individual or a family member of the individual—
        (i) by an individual who is trained or experienced in the case management skills that are required to deliver the services and coordination described in subparagraph (B); and
        (ii) to assess the needs, and to arrange, coordinate, and monitor an optimum package of services to meet the needs, of the older individual; and
    (B) includes services and coordination such as--
        (i) comprehensive assessment of the older individual (including the physical, psychological, and social needs of the individual);

(ii) development and implementation of a service plan with the older individual to mobilize the formal and informal resources and services identified in the assessment to meet the needs of the older individual, including coordination of the resources and services--

(I) with any other plans that exist for various formal services, such as hospital discharge plans; and

(II) with the information and assistance services provided under this Act;

(III) coordination and monitoring of formal and informal service delivery, including coordination and monitoring to ensure that services specified in the plan are being provided;

(IV) periodic reassessment and revision of the status of the older individual with--

(a) the older individual; or

(b) if necessary, a primary caregiver or family member of an older individual; and

(V) in accordance with the wishes of the older individual, advocacy on behalf of the older individual for needed services or resources.

12. **Civil Rights Compliance Reviews** - Regular systematic inspections of agency programs conducted to determine regulatory compliance with civil rights laws and regulations. Compliance reviews determine compliance and noncompliance in the delivery of benefits and services in federally-assisted programs. These reviews help to measure the effectiveness of agency civil rights programs. They identify problems, such as denial of full benefits, barriers to participation, disparate treatment, lack of representation on advisory boards and planning committees, lack of information, and denial of the right to file a civil rights complaint.
13. **Complaints** - A verbal or written allegation of discrimination which indicates that any federally assisted program is operated in such a manner that it results in disparate treatment of persons or groups of people because of race, color, or national origin.
14. **Compliance** - The fulfillment of a program, law or other regulatory requirement.
15. **Conciliatory Agreement** - A voluntary agreement between a federal agency and the state or between the state and a sub recipient that

provides for corrective action to be taken by a recipient to eliminate prohibited actions in any program receiving federal assistance.

16. **Contractor** - A person or entity that agrees to perform services at a specified price.
17. **Disability** - A disability attributable to mental or physical impairment, or a combination of mental and physical impairments, that results in substantial functional limitations in 1 or more of the following areas of major life activity:
    (A) self-care,
    (B) receptive and expressive language,
    (C) learning,
    (D) mobility,
    (E) self-direction,
    (F) capacity for independent living,
    (G) economic self-sufficiency,
    (H) cognitive functioning, and
    (I) emotional adjustment.
18. **Discrimination** - To make any distinction between one person or group of persons and others, either intentionally, by neglect, or by the effect of actions or lack of actions based on race, color, or national origin.
19. **Elder Abuse, Neglect and Exploitation** - The abuse, neglect, and exploitation, of an older individual.
20. **Elder Abuse** - Abuse of an older individual.
21. **Exploitation** - The illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit, or gain.
22. **Federal Assistance** - Any funding, property, or aid provided for the purpose of assisting a beneficiary.
23. **Focal Point** - A facility established to encourage the maximum collocation and coordination of services for older individuals.
24. **Frail** - With respect to an older individual in the State, that the older individual is determined to be functionally impaired because the individual--
    (A) (i) is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or
    (ii) at the option of the State, is unable to perform at least three such activities without such assistance; or (B) due to a cognitive or other mental impairment,

requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual.

25. **Greatest Economic Need** - A need resulting from an income level at or below the poverty line.
26. **Greatest Social Need** - A need caused by non-economic factors, which include--
    - (A) physical and mental disabilities;
    - (B) language barriers; and
    - (C) cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that:
        - (i) restricts the ability of an individual to perform normal daily tasks; or
        - (ii) threatens the capacity of the individual to live independently.
27. **Indian** - A person who is a member of an Indian tribe.
28. **Information and Assistance Service** - A service for older individuals that—
    - (A) provides the individuals with current information about opportunities and services available to the individuals within their communities, including information relating to assistive technology;
    - (B) assesses the problems and capacities of the individuals;
    - (C) links the individuals to the opportunities and services that are available;
    - (D) to the maximum extent practicable, ensures that the individuals receive the services needed by the individuals, and are aware of the opportunities available to the individuals, by establishing adequate follow-up procedures; and
    - (E) serves the entire community of older individuals, particularly--
        - (i) older individuals with greatest social need; and
        - (ii) older individuals with greatest economic need.
29. **Information and Referral** – Information that links the individual to the opportunities and services that are available within their community.
30. **Institution of Higher Education** - has the meaning given the term in section 1201(a) of the Higher Education Act of 1965 (20 U.S.C. 1141(a)).

31. **Legal Assistance** – Direct provision of legal advise and representation by an attorney; other appropriate assistance by a paralegal or law student under the direct supervision of an attorney; and, counseling and representation by a non-lawyer where permitted by law.
32. **Long-Term Care Facility** - means
    (A) any skilled nursing facility, as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i-3(a)); (B) any nursing facility, as defined in section 1919(a) of the Social Security Act (42 U.S.C. 1396r (a));
    (C) for purposes of sections 307(a) (12) and 712, a board and care facility; and
    (D) any other adult care home similar to a facility or institution described in subparagraphs (A) through (C).
33. **Minority** - A person or group of persons differing from others by race, color or national origin. Other legislation has defined minority status for other protected classes. Title VI focus is only on race, color and national origin.
34. **Multipurpose Senior Center** - A community facility for the organization and provision of a broad spectrum of services, which shall include provision of health (including mental health), social, nutritional, and educational services and the provision of facilities for recreational activities for older individuals.
35. **Neglect** - means
    (A) the failure to provide for oneself the goods or services that are necessary to avoid physical harm, mental anguish, or mental illness; or
    (B) the failure of a caregiver to provide the goods or services.
36. **Noncompliance** - Failure or refusal to comply with Title VI of the Civil Rights Act of 1964, other applicable civil rights laws, and implementing departmental regulations.
37. **Nonprofit** - As applied to any agency, institution, or organization means an agency, institution, or organization which is, or is owned and operated by, one or more corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.
38. **Older Individual** - An individual who is 60 years of age or older.
39. **Parity** - The proportion of minority participation to the minority eligible population of a service delivery point is the same as the

proportion of non-minority participation to the non-minority eligible population of the same delivery point.

40. **Physical Harm** - Bodily injury, impairment, or disease.
41. **Planning and Service Area** - An area designated by a State agency under section 305(a) (1) (E), including a single planning and service area described in section 305(b) (5) (A).
42. **Post-award Review** - A routine inspection of agency programs during and after federal assistance has been provided to the beneficiary or recipient. These reviews may be cyclical or based on a priority system contingent upon the potential for noncompliance in individual programs. Reviews are normally conducted through on-site visits; however, desk audits and other mechanisms may also be used to assess operation of federally assisted programs. A post-award review may result in a written report that shows the compliance status of agency program offices and recipients. When necessary, the report will contain recommendations for corrective action. If the program office or recipient is found to be in noncompliance, technical assistance and guidance must be provided to bring the recipient into voluntary compliance. If voluntary compliance cannot be secured, formal enforcement action is then initiated.
43. **Potential Beneficiaries** - Those persons who are eligible to receive federally assisted program benefits and services.
44. **Poverty Line** - The official poverty line (as defined by the Office of Management and Budget, and adjusted by the Secretary in accordance with section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)).
45. **Pre-award Review** - A desk audit of the proposed operations of a program applicant for federal assistance prior to the approval of the assistance. The department must determine that the program or facility will be operated such that program benefits will be equally available to all eligible persons without regard to race, color, or national origin. The applicant may provide methods of administering the program designed to ensure that the primary recipient and sub recipients under the program will comply with all applicable regulations, and correct any existing or developing instances of noncompliance. If the documentation provided by the applicant for the desk audit is inadequate to determine compliance, then an on-site evaluation may be necessary.
46. **Public Notification** - Process of publicizing information about the availability of programs, services and benefits to minorities and

statements of nondiscrimination. This is attained through use of newspapers, newsletters, periodicals, radio and television, community organizations, and grassroots and special needs directories, brochures, and pamphlets.

47. **Recipient** - Any state, political subdivision of any state, or instrumentality of any state or political subdivision, any public or private agency, institution, or organization, or other entity or any individual in any state to whom federal financial assistance is tended, directly or through another recipient, for any program, including any successor, assignee, or transferee thereof, but not including any ultimate beneficiary under such program.
48. **Registered Guardian** – Registered guardian certification is awarded upon successful completion of a two year course overseen by the National Guardianship Foundation. The certification is a means of demonstrating to the public, consumers and the courts that the guardian has sufficient skill, knowledge and understanding to be worthy of the responsibility entrusted to them.
49. **Representative Payee** - A person who is appointed by a governmental entity to receive, on behalf of an older individual who is unable to manage funds by reason of a physical or mental incapacity, any funds owed to such individual by such entity.
50. **Service Delivery Area** - The area served by a service delivery point in the administration of federally assisted programs.
51. **Service Delivery Point** - The place in which federally assisted program services or benefits are administered to the public.
52. **Severe Disability** - A severe, chronic disability attributable to mental or physical impairment, or a combination of mental and physical impairments, that--
    (A) is likely to continue indefinitely; and
    (B) results in substantial functional limitation in 3 or more of the major life activities specified in subparagraphs (A) through (G) of paragraph (8).
53. **State Agency** - The agency designated under section 305(a) (1) of the Older Americans Act.
54. **Supportive Service** - A service described in section 321(a) of the Older Americans Act.
55. **Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d-4 -** Federal law prohibiting discrimination based on race, color, or national origin. It covers all forms of federal aid except contracts of insurance and guaranty. It does not cover employment, except where

employment practices result in discrimination against program beneficiaries or where the purpose of the federal assistance is to provide employment.

6. Discriminatory Practices

It is the policy and intention of TCAD to comply fully with Title VI of the Civil Rights Act of 1964 and to require similar compliance from the aging and disability services network in Tennessee.

Prohibited practices include:

- Denying any individual any services, such as: Adult Day Care, Medication Management and Education, Case Management, Outreach, Chore Services, Personal Care, Congregate and Home Delivered Meals, Personal Emergency Response Systems, Homemaker Services, Respite Care, Legal Assistance, Support Groups for Caregivers, Long-Term Care Ombudsman, Transportation, Minor Home Modification / Repair based upon their race, color or national origin.

- Denying anyone the opportunity to serve as a volunteer, advisor, or member of a policy board, positions of leadership, or other benefit for which he/she is otherwise qualified based upon their race, color or national origin.

- Providing any individual with a service, or other benefit, which is different or is provided in a different manner from that which is provided to others, such as the selection of menu items, the mode or style of service, or the manner of conveyance in transportation based upon their race, color or national origin.

- Subjecting any individual to segregated or separate treatment in any manner related to his/her receipt of service, including congregate meals in separate sites or facilities, senior center services in separate sites or facilities, or employment services in separate sites or facilities based upon their race, color or national origin.

- Restricting an individual in any way in the enjoyment of services, facilities or any other advantage, privilege, or other benefit provided to others under the program based upon their race, color or national origin.

- Adoption of administrative methods which limit participation by any group of recipients based on their race, color or national origin.

- Adoption of administrative methods which limit participation in submitting bids for services and receiving contracts or subcontracts; and personnel practices such as hiring, firing, and granting raises due to race, color or national origin.

- Addressing any individual in a manner that denotes inferiority because of race, color, or national origin.

7. Limited English Proficiency

Participants enter programs funded through the TCAD via the nine AAADs. Each AAAD has a person or persons responsible for the Information and Assistance program. I&A Staff are certified through the Association of Information and Referral Services (AIRS certification) and are trained only in Title VI requirements and also in cultural diversity. The TCAD contracts with the State provider of interpretation services, Avaza, when interpreters are needed to gain access to services. Training included effective techniques in working with LEP persons and an interpreter.

The TCAD developed an LEP policy and has included it in the Handbook of Operating Procedures. (See 7.a, limited English proficiency Policy)

8. Complaint Procedures
Title VI Complaint Process

There have been no Title VI complaints filed in the last year with TCAD. The focus of the Title Implementation plan is to avoid the need for complaints by keeping an affirmative eye on access to services to all older Tennesseans.

A complaint alleging discrimination against a program or service funded through TCAD may be filed as an internal complaint or as an external complaint, i.e., the complaint may be filed at the (1) AAAD or other grantee agency level, (2) Commission level (3) the federal level (Regional Office for Civil Rights, U.S. Department of Health and Human Services). The first two avenues for complaint filing are internal and the third is external to the aging and disability services network.

Complaints must be filed in writing. The form can be filled out by the complainant or by his/her representative, or by the Title VI coordinator. A copy of the complaint must be sent to the Title VI coordinator at TCAD. A copy should also be retained by the AAAD or other grantee agency coordinator for the agency files. If the complainant is unwilling to complete the form, he/she may write, or have written, a letter stating the circumstances of the complaint. The form must then be filled out by the Title VI coordinator and should be attached to the complainant's letter. Any coordinator handling complaints must maintain a Title VI complaint log to show identifying information, type, and status of each complaint filed. The coordinator has the primary responsibility for receiving, acknowledging, investigating complaints and for reporting the findings. The coordinator must notify the Title VI coordinator at the Commission office when a complaint is filed.

Complaints which initially are received by the Title VI Coordinator at TCAD will be remanded to the appropriate or other grantee agency where the complaint originated for first level investigation.

When a complaint is received at the AAAD or other grantee agency level, the coordinator will complete a fact-finding investigation within 30 calendar days of receipt of the complaint and report the findings to the agency director. If the investigation does not find a Title VI violation, the AAAD reports, within five (5) days, the findings to the Commission and to the complainant. If the investigation confirms a violation of Title VI, the agency shall include any proposed remedial action in a complaint response. Within five (5) calendar days after the conclusion of the investigation, a written complaint findings response will be given to the complainant and TCAD. The complainant's rights to appeal (including instructions for filing) will also be provided at this time.

An appeal by a complainant regarding a complaint finding made at the AAAD or other grantee agency level is referred to TCAD for reconsideration. A copy of the complaint, the findings, the proposed action, and the request for appeal must be forwarded to the Commission Title VI Coordinator within 10 calendar days after the date of the appeal. The TCAD Title VI coordinator must conduct and complete fact-finding within thirty (30) calendar days after receipt of the appeal and convey the findings in writing, to the concerned parties. At this point, a complainant who wishes to pursue the complaint may choose to appeal the charges to the federal level,

i.e., the U.S. Department of Health and Human Services. Thus, these appeal rights should be explained to the complainant at this time. Adjudication of the appeal constitutes the last level in the TCAD's internal complaint system.

When an appeal is filed, the Title VI Coordinator shall review an appealed case and make a recommendation to the Executive Director of TCAD. Review may include, but is not limited to, discussing the complaint with the complainant, interviewing the alleged offender, discussion with the initial investigator and review of pertinent material. When an appeal is concluded, a copy of the findings will be sent to the AAAD or other grantee agency coordinator where the complaint originated and to the complainant.

A federal complaint (to the U.S. Department of Health and Human Services) must be filed no later than 180 calendar days after the alleged discrimination occurred. However, to allow a complainant time to file sequentially within the Aging and Disability network and external to the Department of Health and Human Services if he/she chooses, the complaint should be filed at the Area Agency or other grantee agency level no later than 30 calendar days after the alleged discrimination occurred. If it is filed beyond the 30 calendar day period, the Area Agency or other grantee agency shall investigate and process the complaint at that level if the filing is prompt enough to allow proceedings to be concluded and leave sufficient time for the complainant to file externally. If a complainant wishes to appeal a finding or the proposed remedial action by the agency, he/she should do so within the next 30 calendar days following receipt of the findings. If the appeal is filed beyond the 30 calendar day period, the Commission shall still proceed if the proceedings can be concluded and leave sufficient time for the complainant to file externally. If, after appealing to the Commission, a complainant remains unsatisfied with the findings or the proposed remedial action, then he/she still has time to file externally, with the U.S. Department of Health and Human Services, within their stated time limit of 180 calendar days.

If a complaint is filed simultaneously within the aging network and externally to the U. S. Department of Health and Human Services, the external complaint supersedes the internal complaint filing; accordingly, the aging network level complaint procedures will be suspended pending the outcome of the external (federal) investigation.

9. Compliance Reviews

A. Pre Award Procedures, Statement of Assurances
All contracts with the Area Agencies on Aging and Disability contain the same boiler plate requiring availability of reports and data for review.

1. Pre-Award Procedures
To assure Title VI compliance, all publications of TCAD shall include a formal statement of compliance to Title VI, thereby declaring TCAD's intention to render high quality service to all program participants without regard to race, color, or national origin.

The TCAD shall require in each contract a similar statement of compliance with the Civil Rights Act of 1964 from every contracting agency. AAADs document in their Area Plans that signed Assurances are available for review at the onsite monitoring visit and those assurances are reviewed annually.

The TCAD contracts with the following nine Area Agencies on Aging and Disability (AAADs) on an annual basis:

Contractors
First Tennessee Development District
East Tennessee Human Service Agency
Southeast Tennessee Development District
Upper Cumberland Development District
South Central Development District
Northwest Development District
Southwest Development District
Aging Commission of the Mid South (Memphis/Shelby County Government)

In addition the TCAD contracts with other agencies using Older Americans Act discretionary (grant funds).

Subecipients for Discretionary Funds include:

Alzheimer's Tennessee, Inc

The Benjamin Rose Foundation (Alzheimer's Evidence-Based program)

The Tennessee Respite Coalition

The University of Tennessee Social Work Office of Research and Policy

The University of Tennessee Extension Service

Mental Health America of Middle Tennessee

9.A.4.
Compliance and Assurances are a part of each AAAD Plan, prior to contracting.

Sample

Exhibit E
Assurances

PSA 08
PLAN PERIOD FY/06-09

(X) Original, Dated 3/12/08
() Revision, Dated_______

AVAILABILITY OF DOCUMENTS

*The **Sample Tennessee Area Agency on Aging & Disability*** hereby gives full assurance that the following documents are current and maintained in the administrative office of the AAAD and will be filed in such a manner as to ensure ready access for inspection by the TCAD or its designees at any time. The AAAD further understands that these documents are subject to review during quality assurance visits by TCAD.

1. Current policy making board member roster, including officers

2. Applicable current licenses

3. AAAD Advisory Council By-Laws and membership list

4. AAAD staffing plan
    (a) position descriptions (signed by staff member)
    (b) staff resumes and performance evaluations
    (c) documentation that staff meet the educational and experience requirements of the position and that appropriate background checks have been completed
    (d) equal opportunity hiring policies and practices

5. Personnel Policy Manual of grantee agency
6. Financial procedures manual in accordance with TCAD policies
7. Program procedures manual
8. Interagency agreements, if applicable
9. Insurance verification (general professional liability such as errors and omissions, officers and directors, etc.)
10. Bonding verification
11. Affirmative Action Plan
12. Civil Rights Compliance Plan
13. Conflict of Interest policy
14. Grievance Procedure and designated staff member
15. Documentation of public forums conducted in the development of the area plan, including attendance records and feedback from providers, consumer, and caregivers
16. Americans with Disabilities Act (ADA) policies
17. Documentation of match commitments for cash, voluntary contributions and building space, as applicable
18. Financial Reports or if applicable copy of audited copy of Financial Report of service providers
19. Emergency Preparedness/Disaster Plan
20. Drug-Free Workplace policies
21. Confidentiality and HIPAA policies.

ASSURANCE OF COMPLIANCE

Sample b Tennessee AAAD hereby gives full assurance that every effort will be made to comply with the regulations of the Older Americans Act with particular attention to the following areas:

1. Development and implementation of the Area Plan
2. Minimum Proportion of Expenditures of Title IIIB for Priority Services
3. Designation of Focal Points
4. Targeting services to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas
5. Planning and Coordination
6. Nutrition Services
7. Senior Center Acquisition and Construction
8. Legal Assistance
9. Affirmative steps to contract with small and minority businesses
10. Maintenance of Effort.

Certification by Authorized Agency Official:

I hereby certify that the documents identified above currently exist and are properly maintained in the administrative office of the Area Agency on Aging and Disability. Assurance is given that the TCAD or its designee will be given immediate access to these documents, upon request.

Signature:_________________________________ Date:____________________
Director, Area Agency

Signature:_________________________________ Date:____________________
(AAAD Grantee Board Chair
or other authorized official)

9.A. 5
There are no applications pending for federal funding at this time.

9. A. 6.

TCAD was instructed by the past THRC administration that self surveys were not acceptable. TCAD does ask for data for their Title VI review.

9.A.7.
The TCAD conducted reviewed of all AAADs for the purpose of the Tennessee Choices program, title VI is a part of that review

9.A.8
TCAD requires AAADs to provide title VI training in order for their providers to know and understand title VI and service provision. This is also a part of the boiler plate in all contracts that TCAD issues as a requirement of the Office of Contracts Review.

9. B. Post-Award Procedures Compliance Reviews

Each AAAD conducts annual Title VI compliance monitoring for all contractors providing services in their area. The scope of the review provides the Agency Director with sufficient information that he/she can ensure TCAD that all contractors are indeed operating within Title VI requirements. Any contractors that will not comply with Title VI provisions may not be used to provide Commission programs and/or services.

Annually TCAD's quality assurance staff conducts Title VI compliance monitoring on each AAAD. The quality assurance staff will:

- document that the AAAD has completed local level Title VI compliance monitoring for all contractors,
- ensure that the scope of the review was sufficient to determine that the contractors were operating within Title VI requirements,
- inspect the AAAD office for posting of the correct public notices
- review records, reports, complaint resolutions and other documents related to Title VI compliance,
- interview appropriate Area Agency staff on Title VI compliance efforts in their office, and
- report compliance review findings to the Area Agency as a section in their annual performance monitoring report.
- review Area Agency training records to assure that Title VI training had been accomplished. See Appendix E.

Public Notification

Materials designed to inform Aging and Disability services network employees, program participants, and prospective participants of their obligations and rights under Title VI, and of the availability of services, will be distributed periodically to all AAADs and other grantee agencies. The coordinator will be contacting appropriate agencies and referring to the internet for resource materials. The AAAD and other grantee agency coordinators are responsible for making these materials available to aging and disability service providers and participants, and for assuring that the materials are prominently displayed at service provider locations. All printed material issued from TCAD, the AAADs, or from provider agencies paid for with either state or federal funds will include the following statement:

> "No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Training will be provided to AAADs and provider agencies to assist personnel in presenting requirements under the civil rights act to the public and to apprising responsible staff of their responsibilities.

Area Plans and Plan Updates

The Older Americans Act requires AAADs to submit a four year plan (with annual plan updates) outlining needs, gaps, resources, objectives and strategies for serving older Tennesseans and adults with disabilities. The Area Plan format requires that Goals, Objectives and Strategies address the following: access to services, home and community based services, health promotion and disease prevention, Elder Rights and Improving Management practices. As a part of the charge of the Older American's Act, each AAAD submits a plan to target low income, rural, and minority populations. Since Title VI impacts all areas of service in the aging network, this year the TCAD made the Title VI plan a part of the annual planning process. When area plans are updated, a status report is made on the objectives from the previous year.

The Annual Area Plan Update also includes signed assurances for The Older Americans Act, Availability of Documents and Title VI of the 1964 Civil Rights Act. The area plan is referenced in the Area Agency Contract.

E. Procedures for Non-compliance

Any Area Agency or other grantee agency not in compliance with the provisions of Title VI shall be given a written notice. Failure to correct the non-compliance within thirty (30) working days of receipt of the notice will be considered a violation of the terms of the contract and a basis for contract suspension, termination, or rejection. The enforcement procedure by the Tennessee Commission on Aging and Disability for termination of the contract agency from participation as a recipient of federal financial assistance will be in accordance with Title VI enforcement procedures.

If an employee of the Commission on Aging and Disability is found guilty of violation of Title VI provisions, the employee shall receive progressive discipline. A verbal reprimand may be given for the first offense, a written reprimand may be placed in his/her personnel file for the second offense, and a suspension without pay (from one day to as many as thirty days, depending on the violation) may be issued for the third offense. A fourth offense may be considered as sufficient grounds for dismissal.

The Title VI Compliance (QA) staff reviews not only the AAAD contractors for compliance with Title VI, but also reviews the AAAD to assure that they are in compliance with Title VI.

10. Compliance/Non Compliance Reporting

There are no other federal or state entities with which TCAD provides or shares Title VI compliance reports. TCAD contracts with the Administration on Aging and the Center for Medicare/Medicaid Services.

11. Title VI Training Plan

On May 16, 2012 the TCAD conducted a training with Avaza to assure that in limited English proficiency and the use of Avaza services in interpretation, for clients or potential clients with limited proficiency in English. The training was conducted using a power point that was sent to all the area agencies, and with a conference line. Area Agencies will use the material to train Councils on Aging and Senior Centers in the use of the

Services. All appropriate TCAD staff and Area Agency staff attended the conference Training.

Area agency staff and their providers have contact directly with clients and potential clients; therefore, the AAADs provide Title VI training to all providers at a minimum of once a year during one of the quarterly trainings the hold with providers. The TCAD QA staff monitors this each time they audit the AAAD. The Title VI planning and compliance coordinators have developed a title VI power point for use by the Title VI coordinators in their training.

12. Public Notice and Outreach

As stated previously, the Administration on Aging requires that low income, rural, minority populations be a priority for services. The Title VI Implementation Plan (upon approval) will be placed on the Agency's website. All published educational brochures by TCAD and the Area Agencies have the Non discrimination policy on them, .Area Agencies, since they operate on a local level, are aware of community centers, churches and informal gathering places to outreach to those who may not be aware of the services offered.

Minority Input

Minority representation is also reflected in the staff of TCAD, the directors of the Planning Service Areas, employees of the AAAD, and the Area Advisory Councils. Partnering with minority owned businesses is a goal of the Commission. Currently, each AAAD has contracts with at least one minority owned businesses to provide service to consumers in their area. TCAD requires each AAAD to annually report their minority owned service providers and to identify the dollars contracted to each provider. The Commission tracks the number of providers and the contract dollars to ensure that each area recruits and has business agreements with minority providers.

TCAD solicits input in a variety of ways during planning and review processes. The aging network, which includes the AAADs also solicits inputs for their plans public hearings and community reviews of their area plans.

Process for Bidding

The TCAD goes through the state bidding process whenever bids are taken. Since the nine Area Agencies are the designated focal point for aging and disability services and programs, the bulk of TCAD contracts are with them.

13. Evaluation Procedures

The AAADs routinely conduct Title VI trainings in their quarterly provider training. The TCAD conducted LEP training in April of 2012 with the assistance of AVAZA. The training was conducted as a webinar, using TCAD's conference line, and power point provided by AVAZA. All appropriate TCAD staff as well as area agency staff participated in the training.

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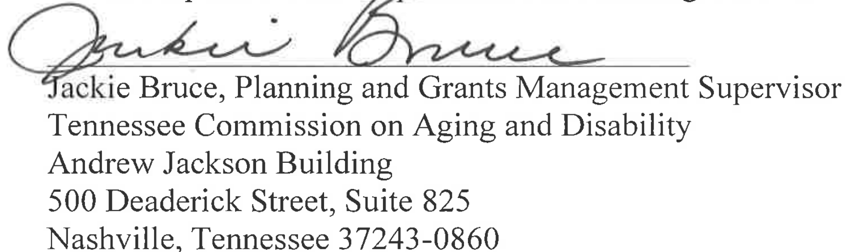
Responsible State Official ensuring that TCAD complies with Title VI

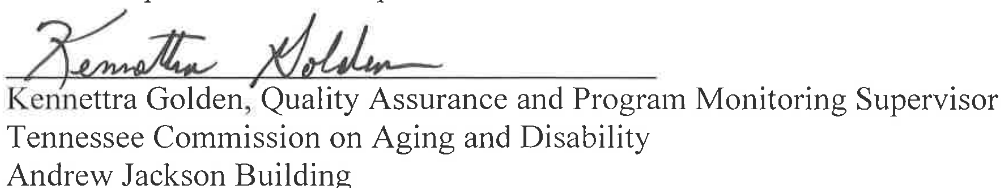
Jim Shulman, Executive Director
Tennessee Commission on Aging and Disability
Andrew Jackson Building
500 Deaderick Street, Suite 825
Nashville, Tennessee 37243-0860

Person responsible for implementation Planning Title VI



Jackie Bruce, Planning and Grants Management Supervisor
Tennessee Commission on Aging and Disability
Andrew Jackson Building
500 Deaderick Street, Suite 825
Nashville, Tennessee 37243-0860

Person responsible for Compliance with Title VI



Kennettra Golden, Quality Assurance and Program Monitoring Supervisor
Tennessee Commission on Aging and Disability
Andrew Jackson Building

500 Deaderick Street, Suite 825
Nashville, Tennessee 37243-0860

Attachments for sections 4 and 7

4. a. Commission members

TENNESSEE COMMISSION ON AGING AND DISABILITY (TCAD) **Jim Shulman, Executive Director** **Andrew Jackson Bldg., 500 Deaderick St., Ste 825** **Nashville, TN 37243** **Office: (615) 741-2056 – Website: www.tn.gov/comaging/** **COMMISSION MEMBER CENSUS DATA**			
COMMISSION MEMBER NAME	**AG E**	**SEX**	**ETHNICITY/ Affiliation**
Renee Bouchillon	40	F	**White/Caucasian - Department of Human Services**
Rep. Joe Carr	54	M	**White/Caucasian - House of Representatives**
Wendell Cheek	58	M	**White/Caucasian – Dept. of Veterans Affairs**
Ludell Coffey	78	F	**White/Caucasian - East Tennessee**
Mickey Eldridge	56	F	**White/Caucasian – Upper Cumberland**
Ken Kisiel	66	M	**White/Caucasian – First Tennessee**
Clint Lewis	44	M	**Black/African American – Greater Nashville**
Patricia Miller	64	F	**White/Caucasian – Southeast Tennessee**
Lynne O'Neal	63	F	**White/Caucasian – Department of Health**
Hannah Parker	26	F	**White/Caucasian – Governor's Office**
Richard Presler	60	M	**White/Caucasian- Dept. of Intel. and Devel. Disability**
Rose Rubin	73	F	**White/Caucasian – Aging Commission Mid-South**
Margot Seay	69	F	**White/Caucasian- AARP Advocate**
Dennis Temple	63	M	**White/Caucasian – Mental Health**
Wanda Willis	63 63	F	**White/Caucasian – Council of Dev. Disabilities**
Senator Ken Yager	65	M	**White/Caucasian-State Senator**
James York	66	M	**Black/African American- Disability Advocate**

Representatives to be appointed after October 1, 2012:

- Northwest Tennessee

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- South Central Tennessee
- Southwest Tennessee
- Chartered Statewide Organization – Tennessean Federation for Aging Minority Representation

First Tennessee Area Agency on Aging and Disability

Minority Service Providers with Expenditures
Fiscal Year 2011-2012

Service Provider Name	FY 2012 Total Expenditures Federal and State
Cornerstone Personal Care Services, LLC Vickie Stills, Administrator 808 Tusculum Blvd. Greeneville TN 37745	**$34,023**
Envision/Ind Living Solutions, LLC Marsha Daniels – Executive Director 125 E Jackson Blvd., Ste 15 Jonesborough TN 37659	**$35,007**
Heavenly Sonshine Senior Services Co April Gentry, President 750 #B Gray Station Rd Gray, TN 37615	**$93,932**
Home Instead Senior Care Sandra Smith - Chair 724-D W Center St Kingsport, TN 37660	**$63,494**
Legacy Home Care, LLC Pamela Lancaster, Administrator 112 E Myrtle Ave., Suite 300 Johnson City TN 37601	**$5,650**
Pro Careers, LLC Rose Thompson, Director 5051 Washington St. W. Cross Lanes, WV 25313	**$98,617**

TOTALS	**$330,723**

East Tennessee Area Agency on Aging and Disability

Minority Service Providers with Expenditures
Fiscal Year 2011-2012

Service Provider Name	**FY 2012 Total Expenditures Federal and State**
Helping Hands Home Assistance	$ 115,945.90
Brightstar Healthcare	$ 42,029.12
East Tennessee Personal Care	**$ 22,285.12**
Smoky Mountain Home Health & Hospice, Inc.	$ 964.44
TOTAL expenditures	**$ 181,224.58**

Southeast Area Agency on Aging and Disability
Minority Expenditures
FY 2011-2012

Service Provider Name	FY 2012 Total Expenditures Federal and State
Amazing Restorations	N/A
Caring Hearts Adult Day Care	$60.00
Coleman Personal Support Service	N/A
Complete Care Choice	$1,860.04
Good Neighbors, Inc	$94,672.97
Nurtured Living of Chattanooga	-$0-
On Demand Supportive Services	$0
Outreach Medical Supplies	$0
Paragon Home	$9,300.00

Public Guardian Only	
Quality Lifestyle Services, Inc. Adult Day Center	N/A
Rose of Sharon's Senior Villa	$0
Sharon's Adult Day Care	$0
Sharon's Adult Day Care Cleveland	$0
Sharon's Personal Care	$13,305.52
Sweetwater Home for Seniors	N/A
W R Community Services	$4,641.56
TOTALS	**$123,840.09**

SOUTH CENTRAL TENNESSEE Area Agency on Aging and Disability

Minority Service Providers with Expenditures
Fiscal Year 2011-2012

Service Provider Name	FY 2012 Total Expenditures Federal and State
Complete Care Choice 5226 Main Street, Suite 2 Spring Hill, TN 37174	$29,395
A Plus Medical Staffing 108 East McLean Street Manchester, TN 37355	$78,279
TOTAL EXPENDITURES	**$107,674**

Upper Cumberland Area Agency on Aging and Disability

Minority Service Providers with Expenditures
Fiscal Year 2011-2012

Service Provider Name	FY 2012 Total Expenditures Federal and State
Clark United Methodist Church	4,500.00

TOTAL expenditures	$4,500.00

Greater Nashville Regional Council Area Agency on Aging and Disability

Minority Service Providers with Expenditures
Fiscal Year 2011-2012

Service Provider Name	FY 2012 Total Expenditures Federal and State
A+ Medical Staffing **	$204
Albert Ross Tharpe Services ** ***	$5,667
Armor Valley Services ** ***	$15,022
Assurance Senior Care dba Home Instead Senior Care **	$30,000
B There Home Care ** ***	$68,508
Efficient Supports, Inc. ***	$00
Guardian Angel Healthcare Services **	$23,545
Health Angels Staffing Agency, LLC **	$572
Oasis In-Home Care **	$29,026
OCOF Family Services ***	$3,965
Quality Care Health Center **	$4,253

Quality Personal Care, Inc. ***	$44,923
Reliable Senior Care Inc. dba Home Instead Senior Care **	$28,375
Saving Grace Adult Day Care **	$00
Sitters and More, Inc. **	$49,493
Warren Family Services dba AtHome Care **	$43,910
Welcome Home, Inc. **	$8,213
WholeCare Connections **	$00
** Women Owned Business *** Ethnic Minority Owned	
TOTAL expenditures	**$ 355,676**

Southwest Area Agency on Aging and Disability

Minority Service Providers with Expenditures
Fiscal Year 2011-2012

Service Provider Name	FY 2012 Total Expenditures Federal and State
Albert Ross Tharpe Services	$20,471.37
West Madison Senior Center	$8,683
First Choice	**$14,780.38**
WR Community Services	$24,301.47
TOTAL expendi+tures	**$68,236.22**

Northwest TN Area Agency on Aging and Disability

Minority Service Providers with Expenditures

Fiscal Year 2011-2012

Service Provider Name	FY 2012 Total Expenditures Federal and State
Albert Ross Tharpe Services, LLC (ARTS) Paris, TN	$36,735.79
TOTAL expenditures	**$36,735.79**

Aging Commission of the Mid-South - Area Agency on Aging and Disability

Minority Service Providers with Expenditures

Fiscal Year 2011-2012

Service Provider Name	FY 2012 Total Expenditures Federal and State
1. Aldridge Pest Control	$315.00
2. Arc of the Mid-South	$49,049.00
3. Citizens Choice	$14,215.24
4. Companion Plus	$42,302.00
5. First Choice Community Services, Inc.	$43,462.70
6. Generations Community Services	$20,622.25
7. Goodwill Homes	$81,479.00
8. My Faith, Inc.	$22,649.63
9. Open Arms Healthcare	$29,221.56
10. Premier Health Care	$5,205.69
11. Ridgemont Manor	$8,171.56
12. W R Community Services, LLC	$123,448.55
TOTAL EXPENDITURES	**$ $440,142.18**

TOTAL EXPENDITURES
$1, 648,750

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7.a, Limited English Proficiency

Title VI Compliance

Limited English Proficiency Policy

Tennessee Commission on Aging and Disability

Policy:

The Tennessee Commission on Aging and Disability (TCAD) will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have access and an equal opportunity to participate in agency services and programs benefitting adults with disabilities and older Tennesseans. This policy provides for communication of information contained in vital documents including but not limited to:

Consent forms, service plans and release of information funds.

Interpreters, translators or other aids needed to comply with this policy shall be provided without cost to the person being serviced. The cost for such service will be billed through the state contracted entity (AVAZA) to provide this service.

All staff will be provided a copy of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective techniques, including the effective use of an interpreter.

TCAD will require Area Agencies to review language access needs of their service population in their Area Plans and plan updates.

Procedures:

1. The TCAD contracts with AVAZA Language Services to provide effective training to Area Agency Staff and TCAD staff in the use of competent interpreter services.

2. In order to assure contractor compliance, Area Agencies on Aging and Disability (sub-recipients) shall provide training in the LEP policy and the use of AVAZA services to reach people whose first language is not English as a part of the Area Agency's regular Title VI provider training.

3. Most inquiries regarding access to services are by phone, through the Information and Assistance staff at the Area Agencies on Aging and Disability, who are certified by the Alliance of Information and Referral Systems. Information and Assistance staff shall be trained in the use of AVAZA services.

AREA PLAN on AGING and DISABILITY

For Progress toward a Comprehensive, Coordinated Service System for Older Persons and Adults with Disabilities

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Designated Area Agency on Aging and Disability

for the

Planning and Service Area

in TENNESSEE for

July 1, 2010 – June 30, 2014

TABLE of CONTENTS

Older Americans Act
Section 306 *AREA PLANS*
Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1).

Section 307 *STATE PLANS*
(a) Except as provided in the succeeding sentence and section 309(a), each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan….
(a)(1) The plan shall—
(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and (B) be based on such area plans.

Link to OAA: http://www.aoa.gov/AoAroot/AoA_Programs/OAA/oaa_full.asp

Submittal Page

Part A: Area Profile

Part B: Area Service Plan

Part C: Status Report and Goals, Objectives & Strategies

Part D: Staffing and Organization

Part E: Documentation

Part F: Area Plan Public Hearings and Waivers

Part G: Financial Plan

SUBMITTAL PAGE

( ) 4-Year Plan for July 1, 2010 – June 30, 2014
( ) Plan Update for _____________
( ) Amendment (Date): _____________

This Area Plan for Programs on Aging and Disability is hereby submitted for the __________________________________ planning and service area. The _____________________________________ Area Agency on Aging and Disability assumes full responsibility for implementation of this plan in accordance with all requirements of the Older Americans Act and Regulations; laws and rules of the State of Tennessee; and policies and procedures of the Tennessee Commission on Aging and Disability.

This plan includes all information, goals and objectives, and assurances required under the Tennessee Area Plan on Aging format, and it is, to my best knowledge, complete and correct.

Signature: _______________________________ Date: _________
Area Agency Director

The Area Agency Advisory Council has participated in the development and final review of the Area Plan. Comments of the Advisory Council are included in Part F of the Plan.

Signature: _______________________________ Date: _________
Chair, Area Agency Advisory Council

The Board of Directors of the sponsoring agency has reviewed this plan and Submittal Page. It is understood that we are approving all sections of the Plan A-G. We are satisfied that the plan is complete, correct, and appropriately developed for our planning and service area.

Signature: ______________________________ Date: _________
Director, Grantee Agency

Signature: ______________________________ Date: _________
Chair, Grantee Agency Board

Part A: AREA PROFILE

Older Americans Act
Section 305(a) *ORGANIZATION*
(1) the State shall, in accordance with regulations of the Assistant Secretary, designate a State agency as the sole State agency to—

(E) divide the State into distinct planning and service areas…in accordance with guidelines issued by the Assistant Secretary, after considering the geographical distribution of older individuals in the State, the incidence of the need for supportive services, nutrition services, multipurpose senior centers, and legal assistance, the distribution of older individuals who have greatest economic need…residing in such areas, the distribution of older individuals who have greatest social need…residing in such areas, the distribution of older individuals who are Indians residing in such areas, the distribution of resources available to provide such services or centers, the boundaries of existing areas within the State which were drawn for the planning or administration of supportive services programs, the location of units of general purpose local government within the State, and any other relevant factors….

Section 306(a) *AREA PLAN*
(3)(A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point….

Exhibit Number	Title of Exhibit
A-1	Designated Planning and Service Area
A-2	Area Profile
A-3	2000 Census Data
A-4	Focal Points
A-5	Methods Used to Determine Service Needs
A-6	Summary of Service Needs

Exhibit A-1

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Designated Planning and Service Area

Area Agency:

Physical Address:

Mailing Address (if different):

All Phone #s and Fax #:

E-mail Address:

Website:

Director:

In Operation Since:

Mission:

Exhibit A-2

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Area Profile

1. Identification of counties within the planning and service area.

2. Identification of counties designated as rural in the planning and service area.

3. Identification of counties/communities designated as urban in the planning and statistical area.

4. Describe significant differences among counties/communities in the planning and service area.

Delete this blank page and insert PSA Census Data. Change exhibit # to Exhibit A-3.

Exhibit A-4

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Focal Points

1. For the purpose of assuring access to information and services for older persons, the area agency shall work with elected community officials in the planning and service area to designate one or more focal points on aging in each community, as appropriate. Define “community” for the purposes of focal point designation.

2. List community focal points within the Planning and Service Area.

Exhibit A-5

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Methods Used to Determine Service Needs

1. Describe below how the Area Agency assessed the needs of older persons and adults with disabilities residing in the planning and service area.

2. Which home and community based services have all slots filled and how many individuals are on wait lists as of October 1, 2009?

Exhibit A-6

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Service Needs

1. Based on the information reported in Exhibit A-5, Methods Used to Determine Service Needs, **list** the prevalent service needs of older persons and adults with disabilities in the planning and service area.

2. Based on the **list** of needs identified in question #1, briefly describe how the Area Agency will address the top 5 identified needs? This is an overview, details are more specific in Part C of this plan in the Goals, Objectives and Strategies section.

3. **List** the top 5 needs for the Grand Division that includes the planning and service area identified in the 2009 Statewide Needs Assessment.

4. Based on the list of needs in question #3, briefly describe how the Area Agency will address the top 5 needs identified. Do not repeat if the service was already addressed in question #2. This is an overview, details are more specific in Part C of this plan in the Goals, Objectives and Strategies section.

Part B: AREA SERVICE PLAN

Older Americans Act
Section 306 *AREA PLANS*
(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency**,** prepare and develop an area plan for a planning and service area…. Each such plan shall—
(a)(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, or construction of multipurpose senior centers, within the planning and service area covered by the plan,
(a)(7) provide that the area agency on aging shall, consistent with this section, facilitate the area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers

Exhibit Number	Title of Exhibit
B-1	System of Aging and Disability Services
B-2	Service Delivery in the Planning and Service Area
B-3	AAAD Budget Summary

Exhibit B-1

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Statewide Aging and Disability Programs

Introduction

The Area Agency uses funding from a number of programs to provide a comprehensive array of services for older persons and other adults with disabilities in the planning and service area (PSA). The following is a brief description of the public funding sources and a summary of how many individuals were served in each program.

Older Americans Act

Older Americans Act (OAA) funds provide, in addition to a comprehensive array of services, the administrative infrastructure to deliver all OAA programs. As the designated state unit on aging, the Tennessee Commission on Aging and Disability (TCAD) receives an annual allotment under Title III of the Older Americans Act as amended, from the Administration on Aging (AoA) in the U.S. Department of Health and Human Services. TCAD allocates OAA funds to nine Area Agencies on Aging and Disability (AAADs) based on an approved intrastate funding formula. The AAADs plan, develop, and implement a system of services for older persons age 60 and over in their respective Planning and Service Areas (PSA). OAA funds support home and community based programs and services such as information and assistance, case management, nutrition services, in-home services, multipurpose senior centers, health promotion, transportation, legal services, Long Term Care Ombudsman Program, and the National Family Caregiver Support Program.

Using Older Americans Act funding the Area Agency served approximately:

Persons Served	**2009**	**2010***	**2011***	**2012***	**2013***
Personal Care					
Homemaker					
Nutrition Services					
Case Management					
Transportation					
Legal Assistance					
Information & Assistance					
Family Caregiver					
Ombudsman					
Units of Service					
Personal Care					
Homemaker					
Nutrition Services					
Case Management					

Transportation					
Legal Assistance					
Information & Assistance					
Family Caregiver					
Ombudsman					

* 2010-2013 data will be completed in future Area Plan Updates.

Options for Community Living

On July 1, 2000, the Tennessee Commission on Aging and Disability received $5 million in state funds to support information and referral and to initiate a home and community based long term care services program for older persons and other adults with disabilities who do not qualify for Medicaid long term care services. The Options Program provides homemaker, personal care and home-delivered meals. Other services may be available on a case-by-case basis as funds allow.

Using Options for Community Living funding the Area Agency served approximately:

	2009	2010	2011	2012	2013
Persons Served					
Units of Service					

Statewide Medicaid Home and Community Based Waiver Services for Elderly and Disabled (Waiver)

Tennessee is in the process of implementing the Long Term Care Community Choices Act of 2008. The State Medicaid Agency, the Bureau of TennCare, is converting from a 1915(c) Statewide Home and Community Based Medicaid Waiver for Elderly and Disabled to a 1115 Waiver. The planned start date for the transition is expected to begin in 2010 and phased in over an eighteen month period. The State's nine Area Agencies on Aging and Disability will act as the single points of entry for the CHOICES Program.

The Statewide Home and Community Based Services Waiver is intended to provide a community-based, cost-effective alternative to institutional nursing facility care for eligible individuals. The program is administered by the Tennessee Department of Finance and Administration, Bureau of TennCare. This Medicaid Waiver program provides a variety of home and community-based services to low-income older persons and adults with disabilities who are frail, functionally impaired, and at-risk of nursing home placement. Funding for this program comes from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid.

Using Waiver funding the Area Agency served approximately:

	2009	2010	2011	2012	2013
Persons Served					
Units of Service					

State Health Insurance Assistance Program (SHIP)

SHIP is funded by the Centers for Medicare and Medicaid in the U.S. Department of Health and Human Services. The SHIP program is mandated by Congress to provide *free and objective* information, counseling and assistance to consumers, their adult children, caregivers, health care providers and other advocates about Medicare and all other related health insurance. Currently, an important aspect of the program is to provide information and assistance with enrollment in Medicare Part D and target outreach to low-income Medicare beneficiaries eligible for the Medicare Part D Low-Income Subsidy and Medicare Savings Programs. The Centers for Medicare and Medicaid Services (CMS) funds the nationwide program. The statewide Tennessee SHIP operates through a small, but highly trained, paid and volunteer staff. In addition to counseling, program staff performs community education and outreach on Medicare and current related issues.

Using SHIP funding the Area Agency served approximately:

	2009	2010	2011	2012	2013
Individuals Provided SHIP Counseling					

Public Guardianship for the Elderly Program

The Public Guardian Program is a state funded program designed to assist persons 60 years of age and older who are unable to manage their own affairs and have no family member, friend, bank or corporation willing or able to act on their behalf. Public Guardians (Conservators) assist clients in obtaining the basic necessities of life including making decisions regarding their finances or needed medical care. Legal proceedings (court order) are required prior to service delivery. The Tennessee legislature established a volunteer component to expand the guardianship program in 1996.

Using Public Guardianship funding the Area Agency served approximately:

	2009	2010	2011	2012	2013
Persons Served					

Other State Appropriations

The State of Tennessee also appropriates funds to distribute among the area agencies to support multipurpose senior citizen centers, home delivered meals and homemaker services. An intrastate funding formula is used to distribute the funds to each area agency. The funding formula is based on a number of factors such as the number of counties in the planning and service area, the proportion of elderly persons and proportion of low income elderly persons residing in the area.

Using State Appropriations the Area Agency served approximately:

Persons Served	2009	2010	2011	2012	2013
Senior Centers					
Meals					
Homemaker Services					

Units of Service					
Senior Centers					
Meals					
Homemaker Services					

Exhibit B-2

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Service Delivery in the Planning and Service Area

1. Describe how the following ACCESS SERVICES and related activities are coordinated and/or delivered in the planning and service area.

Information and Assistance:

Single Point of Entry:

Website and Resource Directory Development:

Marketing the Area Agency:

Outreach:

Transportation

Other:

2. Describe how the following HOME & COMMUNITY BASED SERVICES and related activities are coordinated and/or delivered in the planning and service area.

Service Coordination/Case Management:

Service Provider Network Support:

Family Caregiver Support:

Homemaker:

Personal Care:

Respite:

Chores/Home Modifications:

Personal Emergency Response Systems:

Assistive Technology:

Pest Control:

Adult Day Care:

*Other:

3. Describe how the following DISEASE PREVENTION and HEALTH PROMOTION services and related activities are coordinated and/or delivered in the planning and service area.

Health Promotion:

Health Education:

Medication Management:

*Other:

4. Describe how ELDER RIGHTS services and related activities are coordinated and/or delivered in the planning and service area.

Long Term Care Ombudsman:

Legal Assistance:

Public Guardian for the Elderly:

Elder Abuse Awareness:

*Other:

5. Describe how NUTRITION SERVICES are coordinated and/or delivered in the planning and service area.

6. Describe how SENIOR CENTER activities are coordinated and/or delivered in the planning and service area.

7. Describe how SHIP, SMP and MIPPA services are coordinated and/or delivered in the planning and service area.

8. Describe how Older Americans Act funding for coordination is used within the planning and service area.

9. Describe how the Area Agency coordinates with other public, non-profit or private partners to meet the service needs of older persons or adults with disabilities within the planning and service area. Include a summary of emergency/disaster preparedness coordination activities.

10. Describe other coordination activities related to advocacy or public education to meet the needs of older persons or adults with disabilities in the planning and service area.

11. Describe how the Area Agency provides volunteer opportunities or coordinates with volunteer organizations to meet the service needs of older persons or adults with disabilities within the planning and service area.

12. Describe any grant activities or pilot projects being conducted in the planning and service area to meet the needs of older persons, adults with disabilities and their caregivers.

13. How are consumers or their caregivers contributing to the cost of the services they receive—donations, cost-share and sponsored services.

14. *Other

Exhibit B-3

PSA:	( ) Original, Dated:
Plan Period:	( ) Update, Dated:

AAAD Budget Summary

Operating Budget for FY 2011*

A: Total Resources to Be Used for Area Agency Administration:

	Federal/State Funds	Minimum Match	Other Resources	Total Budget
OLDER AMERICANS ACT				
Area Plan Administration				
Coordination/Service Development				
STATE FUNDS				
Options for Community Living				
MEDICAID				
Elderly & Disabled Waiver				
LOCAL FUNDS				
TOTAL				

B: Total Resources to Be Used For Service Delivery:

	Federal/State Funds	Minimum Match	Other Resources	Total Budget
OLDER AMERICANS ACT				
Title IIIB Supportive Services				
Title IIIC1 Nutrition Services				
Title IIIC2 Nutrition Services				
Title IIID Disease Prevention & Health Promotion				
Title IIID Medication Management				
Title IIIE Family Caregiver				
Title VII Elder Rights				
STATE FUNDS				
Senior Centers				
Nutrition (Home Delivered)				
Homemaker				
Guardianship				
Title III Match				
Options for Community Living				
OTHER				
Elderly & Disabled Waiver				
NSIP				
SHIP				
TOTAL				

*Allocations are estimates. Funding allocations for FY 2011 have not yet been approved by the State Legislature.

Part C: GOALS, OBJECTIVES AND STRATEGIES

Older Americans Act
Section 306 *AREA PLANS*
(a)(4)(A)(i)(I) provide assurances that the area agency on aging will—
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I)

(a)(4)(B) provide assurances that the area agency on aging will use outreach efforts that will—
(i) identify individuals eligible for assistance under this Act, with special emphasis on—
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement

Exhibit Number	Title of Exhibit
C-1	Annual Status Report and Highlights
C-2	Access Services
C-3	Home and Community Based Services
C-4	Health Promotion and Disease Prevention
C-5	Elder Rights
C-6	Management Practices
C-7	Targeting Status Report
C-8	Targeting Plan

Exhibit C-1

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Annual Status Report and Highlights

For each of the goals listed in the FY 2010 Area Plan Update (July 1, 2009 – June 30, 2010), provide a status update that reflects the progress and accomplishments toward meeting the goals. Briefly describe any other agency highlights.

Goal 1: Access Services

Goal 2: Community Services / Health Promotion

Goal 3: Home and Community Based, Long-Term Care

Goal 4: Elder Rights

Goal 5: Management Practices

Other AAAD Highlights:

Exhibit C-2

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Access Services

AoA Goal: Empower older people, their families, and other consumers to make informed decisions about, and to be able to easily access, existing health and long-term care options.

TCAD Goal: Increase the number of individuals who access aging and disability services and benefits through a comprehensive, reliable, unbiased and easily accessible information, counseling and referral system.

AAAD GOAL

MEASURABLE Objective:

Strategy

Strategy

Performance Measure: Method for Measurement.

Exhibit C-3

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Home and Community Based Services

AoA Goal: Enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers.

TCAD Goal: Assist older individuals and adults with disabilities who are at risk of losing their independence the choice of remaining in their homes or communities thus delaying institutionalization in long term care facilities.

AAAD GOAL

MEASURABLE Objective:

Strategy

Strategy

Performance Measure: Method for Measurement.

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Health Promotion and Disease Prevention

AoA Goal: Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.

TCAD Goal: Provide community services and benefits counseling for older individuals that promote healthy aging through a variety of preventive services and enrollment in Medicare and other insurance options.

AAAD GOAL

MEASURABLE Objective:

Strategy

Strategy

Performance Measure: Method for Measurement.

Exhibit C-5

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Elder Rights

AoA Goal: Ensure the rights of older people and prevent their abuse, neglect and exploitation.

TCAD Goal: Develop, strengthen, and enhance elder rights services in the state that prevent elder abuse, neglect, and exploitation.

AAAD GOAL

MEASURABLE Objective:

Strategy

Strategy

Performance Measure: Method for Measurement.

Exhibit C-6

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Management Practices

AoA Goal: Maintain effective and responsive management.

TCAD Goal: Utilize practices that promote effective and responsible management of financial and human resources.

AAAD GOAL

MEASUREABLE Objective:

Strategy

Strategy

Performance Measure: Method for Measurement.

Exhibit C-7

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Targeting Status Report

Report on activities during the preceding year.

1. PSA Demographics and Individuals Served in Older Americans Act programs:

a. Number of low-income minority older individuals in the planning and service area (use 2000 Census population data)	
b. Number of older individuals residing in rural areas in the planning and service area (use 2000 Census population data)	
c. Number of older individuals who speak English less than very well (use 2000 Census population data)	
d. Number of low-income minority older individuals served (use State Reporting Tool data)	
e. Number of individuals residing in rural areas served (use State Reporting Tool data)	

2. Provide information on the extent to which the Area Agency met its Targeting objectives **for all programs** in the FY 2009 Area Plan Update.

2009* OBJECTIVE	ACTUAL ACCOMPLISHMENT

* Last complete 12-month period.

Exhibit C-8

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Targeting Plan

1. Civil Rights Act of 1964, Title VI Targeting Activities

a. Describe how the Area Agency plans and coordinates activities to disseminate information about services and programs to minority populations in the planning and service area?

b. How is diversity reflected in all aspects of area planning—programming, participants, personnel, service providers, governing/advisory entities?

c. What documentation or process is used by the Area Agency to document activities focused on increasing the representation and/or participation of minority populations in programs and services?

2. Older Americans Act Required Targeting Activities

Set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement; including specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and propose methods to achieve the objectives.

NOTE: Objectives and Tasks/Activities should cover Older Americans Act programs and may cover **all statewide programs** such as Single Point of Entry Marketing or SHIP.

OBJECTIVE	TASK / ACTIVITY	AREA AGENCY STAFF RESPONSIBLE

Part D: STAFFING AND ORGANIZATION

TCAD Policies and Procedures
5-4-.03 *AAAD STAFFING REQUIREMENTS*
(1) The AAAD must develop and implement a staffing plan consistent with federal and state requirements which sets forth the number and type of personnel employed and the timetable for hiring staff to carry out the functions of the AAAD. The AAAD is responsible for:
(a) recruiting and employing adequate numbers of staff members to develop and administer the area plan, and
(b) carrying out the functions and responsibilities prescribed by the OAA and other state and federally funded programs addressing the needs of older persons and other adults with disabilities, and its accompanying regulations and these policies.
(8) The AAAD shall submit in the area plan a Training and Staff Development Plan for staff and service providers. The plan should include conferences, meetings and in-service training organized for staff or service providers….

Older Americans Act Regulations
Section 1321.55 Organization and staffing of the area agency.
(b) The area agency, once designated, is responsible for providing for adequate and qualified staff to perform all of the functions prescribed in this part.

Older Americans Act
Section 306 *AREA PLANS*
(a)(6)(c)(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services….

Exhibit Number	**Title of Exhibit**
D-1	Staff Resources
D-2	Training and Staff Development Plan
D-3	Advisory Council

Exhibit D-1

PSA: ( ) Original, Dated:
PLAN PERIOD: ( ) Update, Dated:

AAAD STAFFING

TABLE 1.

Staff Positions & Name of AAAD Staff Person & Job Title	Minimum Full-Time Equivalent (FTE) & Responsibilities	Required Qualifications	AAAD Staff FTEs & Qualifications
Older Americans Act			
Director	1 FTE Oversight of AAAD operation; Planning and development of Area Plan; Management and operation of all program and fiscal aspects	Master's Degree and five years experience in supervision or management in field of gerontology, aging programs or related field of social work. Bachelor's Degree in a related field and seven years of related experience may be substituted for the Master's Degree	
Financial Specialist	1 FTE Fiscal functions of AAAD; Financial accounting; Budgeting; Technical assistance to service providers and Financial monitoring	B.S. Degree in Accounting or related degree in an area of financial management and minimum of 2 years experience requiring financial expertise	
Quality Assurance	1 FTE Provide technical assistance to service providers; Develop district Q&A Plan; Monitoring service providers, Approve Plans of Correction	RN, BSN or Bachelor's Degree in social work, gerontology, psychology, sociology, counseling or related field.	
Program Specialist/ Coordinator, Assistant Director	.05 – 1 FTE Duties as assigned by Director	Bachelor's Degree in social work or related field and minimum of 2 years experience in Social Service Program implementation	

Management Information Specialist	1 FTE Manage databases; Compile reports; Maintain resource directory; SRT; Analyze data	Proven familiarity with software and hardware installation and customization; Ability to provide help desk support on hardware, software, communications; Ability to develop and conduct training; Oral and written skills; Working knowledge of software packages; Programming experience; BS Degree, preferably in Computer Science, or other computer-related field with data-base experience, hardware experience, and/or 5 year's relative experience	
Family Caregiver Coordinator	A designated coordinator, full-time or part-time as deemed necessary Disseminate caregiver information; Organize support groups; Maintain records; Compile reports; Oversee caregiver needs assessments; Arrange for caregiver services; Assist with Area Agency functions as assigned by the AAAD Director	Bachelor's Degree in social work or related field, or RN	
Support Staff	Full-time or part-time as deemed necessary Assist AAAD program staff (Letters, faxes, documents, telephone, meeting coordinator, etc.)	Computer skills; Verbal and written skills; Ability to organize files; Correspondence; Faxing; Minimum of High School Education with emphasis in business, preferably post secondary clerical skills training	
Other Staff			
Adequate numbers of staff, qualified by	Full-time or part-time as deemed necessary	Qualifications will be developed in keeping with	

education and experience, assigned for the development and administration of the plan and to conduct other required AAAD functions	Based on the needs of the individual AAAD planning and service area	responsibilities assigned to the position	
SHIP			
SHIP Coordinator	1 dedicated FTE Cooperate with CMS requests to recruit/train volunteers; Maintain current knowledge of Medicare and Medicaid and other health insurance; Telephone counseling to beneficiaries; Compile reports; Communication skills; Work with media; computer skills	Preferably a Bachelor's Degree and 2 years experience in advocacy or information and assistance. A high school education and 4 years experience in advocacy or information and assistance may be substituted.	
Guardianship for the Elderly			
Guardian	1 dedicated FTE Manage Guardianship Program	See the Guardianship for the Elderly Chapter in this Policy Manual	
Statewide HCBS Waiver for the Elderly and Disabled			
Waiver Manager	1 FTE Financial & Program Oversight; Marketing; Policies and Procedures Compliance; Data Analysis of Performance; Reporting; Contact for Case Management Provider; Recruitment/Relations; Grievances/Appeals; Staff supervision as assigned by AAAD Director	Preferably Master's Degree in Social Work or a Registered Nurse (subject to Waiver requirements). Minimum of 2 years in management or supervision, preferably working with older adults and/or adults with disabilities.	

Information & Assistance Specialist	1 – 2 FTE As deemed necessary Telephone Information Assistance and Referral; Comprehensive telephone screening; Assist with appointments for in-home assessment visits; Assistance with case file development	AIRS Certified Information and Referral Specialist – Aging, according to AIRS Standards within 2 years of employment; Written/Verbal communications skills; Minimum of completion of grade 12, preferred at least 2 years college and minimum of 2 years employment in field of social work.	
Pre-Enrollment Specialist	2 – 4 FTE As deemed necessary Arrange and complete in-home assessments; Develop PAE; Develop initial Plan of Care; Compile information to submit to DHS for financial eligibility; Coordinate getting physician's orders; Submit paperwork to TCAD for enrollment	Preferably a Master's Degree in Social Work, Psychology, Sociology, or a related field from an accredited college or university and one year of supervised social services experience, with experience in geriatrics or service planning and delivery for the disabled. Bachelor's Degree in Social Work, Psychology, Sociology, or other field related to social work with 2 years of supervised work experience in a social services program, with experience in geriatric or service planning and delivery for the disabled preferred. The Bachelor's level Social Worker must work under the supervision of a Social Worker with a Master's Degree or an RN.	
Waiver QA	1 FTE Provider Recruitment; Training / Provider Meetings; Problem solving w/consumers and providers; Complaint Resolution; Missed Visits / Trends / QI; Plan of Correction;	Bachelor's Degree in social services or related field or nursing degree (RN or LPN)	

	HIPAA Responsibilities		
Data Entry	0.5 – 1 FTE As deemed necessary Waiver Client Data / Care Plan entered in SAMS 2000; Invoice / Billing Data entered in SAMS 2000; Develop and Run Rosters for Providers	Computer Skills; Minimum of High School education, preferably post-secondary training	
Assistant Fiscal Staff	0.5-1 FTE As deemed necessary Assist AAAD Financial Specialist with duties as assigned; Assist with Billing; TCAD contact for denials of payment; Provider Relations; Reconcile Care Plans to Provider Invoices; Provide financial monitoring	Minimum of high school education and 2 years training or experience in the field of Accounting	
Support Staff	1 – 2.5 FTE As deemed necessary Assist waiver staff with duties as assigned	Computer skills; Verbal and written communication skills; Ability to organize files; Correspondence; Faxing; Minimum of high school education with emphasis in business, preferably post secondary clerical skills training	
OPTIONS for Community Living			
I&A Specialist	1 dedicated FTE Disseminate information and make referrals; Telephone screening; Telephone counseling; Enter data into Beacon/SAMS database	AIRS Certified Information and Referral Specialist – Aging, according to AIRS Standards Written/Verbal communications skills. Minimum of completion of grade 12, prefer at least 2 years college and minimum of 2 years employment in field of social work.	

Service Coordinator	1 FTE Plus additional FTEs as deemed necessary by caseload In-home assessments; Development and management of Care Plans; Referral and arrange services; Re-assessment	BS Degree in social work, psychology, gerontology, sociology, counseling, nursing, or equivalent degree; or Licensed Practical Nurse/Registered Nurse or BS Degree with minimum of 2 years experience working with older persons and/or adults with disabilities; or Minimum of completion of 2 years of accredited college or university and 2 years experience in the field of social work or related field	

TABLE 2.

Name	Age 60+?	Female?	Minority?	Disability?
Total				

Supervision

The director of the Area Agency on Aging and Disability is directly supervised by:
____

Exhibit D-2

PSA: ( ) Original, Dated:

Plan Period: ( ) Update, Dated:

Training and Staff Development Plan

Title & Subject of Training	Category & Number of Persons to be Trained			Estimated Date of Training
	AAAD Staff	Providers or Partners	Volunteers	

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Advisory Council

Ask for copy of bylaws—see P&P manual 5-4-.04.

A. MEMBERSHIP and REPRESENTATION

Composition of Council: Choose among the following options to specify which category each Advisory Council member represents on the table below.

a. Age 60+ (50% Older persons)
b. Minority age 60+
c. Minority age <60
d. Resides in a Rural Area
e. Family Caregiver
f. Advocate for Older Persons
g. Service Provider for Older Persons
h. Advocate for Individuals with Disabilities
i. Service Provider for Individuals with Disabilities
j. Business Community
k. Local Elected Official
l. Provider of Veterans' Health Care
m. General Public (County Representative)
n. Has a Disability

Members	Represents

B. SCHEDULE OF ADVIORY COUNCIL MEETINGS

Give Dates and Times of Scheduled Meetings

C. OFFICERS & OFFICE

Name of Officer	Office	Date Term Expires

D. ADVISORY COUNSIL BYLAWS

Attach Bylaws that show date of last review.

Part E: DOCUMENTATION

Exhibit Number	Title of Exhibit
E-1	OAA Assurances of Compliance
E-2	Availability of Documents
E-3	Civil Rights Act Compliance

Exhibit E-1

PSA: ( ) Original, Dated:
PLAN PERIOD: ( ) Update, Dated:

Older Americans Act (2006) Assurances of Compliance

Section. 306. AREA PLANS

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency**,** prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, or construction of multipurpose senior centers, within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have greatest economic need with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals who have greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals at risk for institutional placement residing in such area, and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community, evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) **provide assurances** that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

(A) services associated with access to services (transportation, health services including mental health services) outreach, information and assistance, (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance; and **assurances** that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3) (A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers

(including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4) (A) (i) (I) **provide assurances** that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);

(ii) **provide assurances** that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(I) identify the number of low-income minority older individuals in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i);

(B) **provide assurances** that the area agency on aging will use outreach efforts that will—

(i) identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and
(C) **contain an assurance** that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas;
(5) **provide assurances** that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement with agencies that develop or provide services for individuals with disabilities;
(6) provide that the area agency on aging will—
(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;
(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;
(C) (i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;
(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that-
(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42 U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or
(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 676B of the Community Services Block Grant Act; and
(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the

Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations; (G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that—

(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) **provide assurances** that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

(11) **provide information and assurances** concerning services to older individuals who are Native Americans (referred to in this paragraph as ''older Native Americans''), including—

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, **an assurance** that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) **an assurance** that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) **an assurance** that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans; and

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) **provide assurances** that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency—

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and

(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

(14) **provide assurances** that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;

(15) **provide assurances** that funds received under this title will be used—

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the **assurances** specified in paragraph (13) and the limitations specified in section 212;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care; and

(17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery.

(b) (1) An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include—

(A) the projected change in the number of older individuals in the planning and service area;

(B) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(D) an analysis of how the change in the number of individuals age 85 and older in the planning and service area is expected to affect the need for supportive services.

(3) An area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service
area to meet the needs of older individuals for—

(A) health and human services;

(B) land use;

(C) housing;

(D) transportation;

(E) public safety;
(F) workforce and economic development;
(G) recreation;
(H) education;
(I) civic engagement;
(J) emergency preparedness; and
(K) any other service as determined by such agency.

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

(d) (1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for
older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f) (1) If the head of a State agency finds that an area agency on aging has failed to comply with Federal or State laws, including the area plan requirements of this section, regulations, or policies, the State may withhold a portion of the funds to the area agency on aging available under this title.

(2) (A) The head of a State agency shall not make a final determination withholding funds under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the State agency.

(B) At a minimum, such procedures shall include procedures for—
(i) providing notice of an action to withhold funds;
(ii) providing documentation of the need for such action; and
(iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

(3) (A) If a State agency withholds the funds, the State agency may use the funds withheld to directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

Section. 374. *MAINTENANCE OF EFFORT*

Funds made available under this subpart shall supplement, and not supplant, any Federal, State, or local funds expended by a State or unit of general purpose local government (including an area agency on aging) to provide services described in section 373.

Certification by Authorized Agency Official

(Insert name of AAAD) hereby gives full assurance that every effort will be made to comply with the regulations of the Older Americans Act.

SIGNATURES

______________________________ Date______________

AAAD Director

______________________________ Date ______________

Grantee Agency Director

Exhibit E-2

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Availability of Documents

(Insert name of AAAD) hereby gives full assurance that the following documents are current and maintained in the administrative office of the AAAD and will be filed in such a manner as to ensure ready access for inspection by TCAD or its designees at any time. The AAAD further understands that these documents are subject to review during quality assurance visits by TCAD.

1. Current policy making board member roster, including officers

2. Applicable current licenses

3. AAAD Advisory Council By-Laws and membership list

4. AAAD staffing plan
   a. position descriptions (signed by staff member)
   b. staff resumes and performance evaluations
   c. documentation that staff meet the educational and experience requirements of the position and that appropriate background checks have been completed
   d. equal opportunity hiring policies and practices

5. Personnel Policy Manual of grantee agency

6. Financial procedures manual in accordance with TCAD policies

7. Program procedures manual

8. Interagency agreements, if applicable

9. Insurance verification (general professional liability such as errors and omissions, officers and directors, etc.)

10. Bonding verification

11. Affirmative Action Plan

12. Civil Rights Compliance Plan

13. Conflict of Interest policy

14. Grievance Procedure and designated staff member

15. Documentation of public forums conducted in the development of the area plan, including attendance records and feedback from providers, consumer, and caregivers

16. Americans with Disabilities Act (ADA) policies, ADA Existing Facility Checklist and report on barrier removal

17. Documentation of match commitments for cash, voluntary contributions and building space, as applicable

18. Financial Reports or if applicable copy of audited copy of Financial Report of service providers

19. Emergency Preparedness/Disaster Plan

20. Drug-Free Workplace policies

21. Confidentiality and HIPAA policies

22. Individual background information for newly hired employees and volunteers who provide direct care for, have direct contact with, or have direct responsibility for the safety and care of older persons and adults with disabilities in their homes.

Certification by Authorized Agency Official

I hereby certify that the documents identified above currently exist and are properly maintained in the administrative office of the Area Agency on Aging and Disability. Assurance is given that TCAD or its designee will be given immediate access to these documents, upon request.

SIGNATURES

______________________________________ Date__________________

AAAD Director

______________________________________ Date __________________

Grantee Agency Director

Exhibit E-3

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Title VI of the Civil Rights Act of 1964 Compliance

The_____________________________Area Agency on Aging and Disability reaffirms its policies to afford all individuals the opportunity to participate in federal financially assisted programs and adopts the following provision:

> "No person in the United States, shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

This policy applies to all services and programs operated by, or through contracts or subcontracts from the ______________________ Area Agency on Aging and Disability.

Prohibited practices include:

1. Denying any individual any services such as: congregate meals, in-home services, and information and assistance; opportunity to serve as a volunteer, advisor, or member of a policy board, positions of leadership, or other benefit for which he/she is otherwise qualified.

2. Providing any individual with any service, or other benefit, which is different or is provided in a different manner from that which is provided to others under the program, such as the selection of menu items, the mode of style of service, or the manner of conveyance in transportation.

3. Subjecting any individual to segregated or separate treatment in any manner related to that individuals receipt of service, including congregate meals in separate sites or facilities, senior center services in separate sites or facilities, or employment services in separate sites or facilities.

4. Restricting an individual in any way in the enjoyment of services, facilities or any other advantage, privilege, or other benefit provided to others under the program.

5. Adopting methods of administration which would limit participation by any group of recipients or subject them to discrimination, including submitting bids for services and receiving contracts or subcontracts; and personnel practices such as hiring, firing, and granting raises.

6. Addressing an individual in a manner that denotes inferiority because or race, color, or national origin.

The________________________________Area Agency on Aging and Disability shall appoint a Title VI coordinator to ensure that the Area Agency on Aging and Disability and all service providers comply with the provision of Title VI. Whenever a planning or advisory body, such as a board or a committee is an integral part of the Area Agency on Aging and Disability or service provider program, the Area Agency on Aging and Disability will take such steps as are necessary to ensure that minorities are notified of the existence of such bodies and are provided equal opportunity to participate as members. Where members of a board or committee are appointed by the area agency or service provider agency, minorities shall be represented at least in proportion to their presence in the general population of the service area.

SIGNATURES

____ Date__________________

AAAD Director

____ Date __________________

Grantee Agency Director

Part F: PUBLIC HEARINGS ON AREA PLAN & WAIVERS

Older Americans Act
Section 306 *AREA PLANS*
(a)(6)(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

Exhibit Number	Title of Exhibit	
F-1	Public Hearing on Area Plan on Aging	
F-2	Advisory Council Participation in the Area Plan Process	
F-3	Requests for Waivers – Optional	
	F-3.1	Direct Provision of Service
	F-3.2	Required Minimum Services
	F-3.3	Provision of Priority Services
	F-3.4	Nutrition Site
	F-3.5	State Rule, Regulation, or Policy Requirement
	F-3.6	Cost Share Requirement
Attachment 1	Supporting Documentation for Public Hearing and Advisory Council Participation	

Exhibit F-1

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Public Hearings on Area Plan

A. PUBLIC HEARING INFORMATION

Date(s) of Public Hearing	
Time(s) when hearing was held	
Place(s) where hearing was held	
Was Place Accessible?	
Type of Notice(s) or Announcement(s)	
Date(s) of Notices or Announcements (attach copy)	

B. ATTENDANCE*

County	# of Advisory Council Members from County	Total from County**
Total # Advisory Council Members in column 2		
Total Attendance*		

* Do not include AAAD staff in Public Hearing attendance

** Include Advisory Council Members in column 3 so that the Total Attendance reflects everyone in attendance.

C. AGENDA & ANNOUNCEMENTS

Attach a copy of the agenda. See P&P manual for required agenda topics. Attach one example of each type of notice sent out and describe who notices were sent to. If the AAAD is requesting a waiver for any reason, the agenda and announcement must include a statement that a waiver is being requested.

D. DESCRIPTION

Include any other information about the Public Hearing. Mention any extenuating circumstances that affected attendance (weather, high proportion of sickness, etc.).

E. SUMMARY of PUBLIC COMMENTS

Opportunity must be provided for comments on goals, budgets, and waivers.

F. SUMMARY of CHANGES

List changes made in the plan as a result of comments made at public hearing(s).

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Advisory Council Participation in the Area Plan Process

Describe how the Area Agency Advisory Council was involved in the development of the area plan.

1. Date(s) when the Area Plan was reviewed by the Advisory Council.

2. Attach an agenda of the Area Plan review meeting or describe the review process.

3. List of Advisory Council members in attendance at the review meeting or who were actively involved in the review process.

4. Provide a summary of comments made by advisory council members about the completed plan.

5. Summary of Changes. List changes made in the plan as a result of comments made at Advisory Council review.

Exhibit F-3.1

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Request for Waiver for FY ____

DIRECT PROVISION OF SERVICE

1. AAAD: ____

2. Direct Service to be Provided by AAAD: (Please use a separate waiver request form for each service to be provided directly.

3. List all agencies in PSA now providing this service and the extent that each is providing service (funding level and area served).

   a.

   b.

   c.

4. Based on your responses in item 3, explain how the AAAD determined that the current level of service available is inadequate to meet the need.

5. Explain how this service is directly related to the AAAD's administrative function.

6. If service of comparable quality can be provided more economically by the AAAD, please document by providing an analysis which includes:

   a. costs comparison;

   b. quality comparison;

   c. method by which the analysis was conducted.

7. Explain the AAAD plan to phase out the direct provision of this service an to assure adequate service provision through a contracted provider agency in the PSA.

8. Attachments: At the end of Request for Waiver(s) attach the following items.

   a. List all agencies, providers, and individuals that received personal notice of public hearings (attach copy of letter sent).

   b. List all publications which carried public notice of public hearings and indicate circulation of each. (Attach a copy of notice).

   c. Record of public hearings. The record shall detail all written and oral testimony regarding the Area Agency on Aging and Disability's intention to request the waiver specified above.

SIGNATURES

______________________________ ________________
AAAD Director Date

______________________________ ________________
Chief Administrative Officer of Grantee Agency Date

______________________________ ________________
Advisory Council Chairperson Date

Exhibit F-3.2

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Request for Waiver for FY ____
REQUIRED MINIMUM EXPENDITURES FOR PRIORITY SERVICE

1. AAAD: ____
2. Service Category: ____
3. Required Minimum Percentage for this Service: ______%
4. Required minimum expenditure for this priority service using the required minimum percentage: $ __________________
5. Actual expenditure of Title III (federal funds only) for this service during the past fiscal year: $ __________________
6. Expenditure amount requested under this waiver $ __________________
7. Justify the request for waiver by explaining the:
    a. Projected impact on other services, using documented facts and figures (attach documentation);
    b. Projected impact on this service, using documented fact and figures (attach documentation), and
    c. Projected impact on level of service need and availability throughout the PSA.
8. Outline AAAD plan for achieving the required minimum funding level by the next fiscal year.
9. Attachments: At the end of Request for Waiver(s) attach the following items.
    a. List all agencies, providers, and individuals that received personal notice of public hearings (attach copy of letter sent).

b. List all publications which carried public notice of public hearings and indicate circulation of each (attach a copy of notice).

c. Record of public hearings. The record shall detail all written and oral testimony regarding the Area Agency on Aging and Disability's intention to request the waiver specified above.

SIGNATURES

______________________________	________________
AAAD Director	Date
______________________________	________________
Chief Administrative Officer of Grantee Agency	Date
______________________________	________________
Advisory Council Chairperson	Date

Exhibit F-3.3

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Request for Waiver for FY ____

PROVISION OF PRIORITY SERVICE

1. AAAD: ______________________________
2. Priority Service to be Waived: ____________________________________
3. List all agencies in PSA now providing this service and the extent that each is providing service (funding level and area served).
    a.
    b.
    c.
4. Explain how the need for this service by targeted population is being met throughout the PSA, and how the AAAD evaluated the ability of current provider agencies to meet that need.
5. Attachments: At the end of Request for Waiver(s) attach the following items.
    a. List all agencies, providers, and individuals that received personal notice of public hearings (attach copy of letter sent).
    b. List all publications which carried public notice of public hearings and indicate circulation of each. (Attach a copy of notice).
    c. Record of public hearings. The record shall detail all written and oral testimony regarding the Area Agency on Aging and Disability's intention to request the waiver specified above.

SIGNATURES

_________________________________ __________________
AAAD Director Date

Chief Administrative Officer of Grantee Agency | Date

Advisory Council Chairperson | Date

Exhibit F-3.4

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Request for Waiver for FY ____
NUTRITION SITE

AREA AGENCY:____________________ COUNTY:____________________

NAME AND ADDRESS OF
NUTRITION SITE: ____

____

____

1. Average Number of Congregate Meals Served Daily During Last Quarterly Reporting Period ____________

2. Average Number of Home-Delivered Meals Sent Daily from Site (Last Quarterly Reporting Period) ____________

3. Explain why the nutrition site's combined average of congregate and home-delivered meals is below 20.

4. Provide documentation of outreach and publicity activities undertaken to promote nutrition site attendance. Include in the documentation when the activity was conducted, who conducted the activity, and the number of potentially eligible persons contacted.

5. List all costs involved in keeping the site open, e.g. site manager's salary, rent, utilities, and insurance.

6. Discuss possibility of merging site with another nutrition site. How close is the nearest site? Do participants have their own transportation to the site or are they transported by other provider agencies?

Attach additional pages as necessary.

SIGNATURES

____________________________________ ________________
Area Agency Director Date

________________________________ __________________
Chief Administrative Officer of Grantee Agency Date

________________________________ __________________
Advisory Council Chairperson Date

Exhibit F-3.5

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Request for Waiver for FY ____

STATE RULE, REGULATION OR POLICY REQUIREMENT

1. AAAD: ____________________________
2. State Rule, Regulation and/or Policy for which waiver is requested:
3. Reference Location and Number of Specific Rule, Regulation or Policy:
4. Give full justification for this waiver request by documenting all efforts of the AAAD to meet the requirement and specific barriers to meeting the requirements.
5. Outline steps the AAAD will take to meet the requirements, giving specific dates of accomplishment for each step.

SIGNATURES:

____________________________________ _______________
AAAD Director Date

____________________________________ _______________
Chief Administrative Officer of Grantee Agency Date

____________________________________ _______________
Advisory Council Chairperson Date

PSA: ( ) Original, Dated:
Plan Period: ( ) Update, Dated:

Request for Waiver FY ______
COST SHARE REQUIREMENT

1. List Service(s) for which cost share waiver is requested.

2. Check below the basis for waiver request.

   ___ a. A significant proportion of persons receiving the Older Americans Act services listed above have incomes below 200% of the Federal Benefit Rate.

   ___ b. Cost sharing would be an unreasonable administrative or financial burden on the area agency.

3. Justify the request for waiver based on the proportion of low-income individuals participating in services affected by cost share.

4. Justify the request for waiver explaining the negative impact of cost share on area agency administration or financial responsibilities.

5. Attachments: At the end of Request for Waiver(s) attach the following items:

   a. List all agencies, providers, and individuals that received personal notice of public hearings (attach copy of letter sent).

   b. List all publications which carried public notice of public hearings and indicate circulation of each. (Attach a copy of notice.)

   c. Record of public hearings. The record shall detail all written and oral testimony regarding the area agency's intention to request the waiver specified above.

SIGNATURES

______________________________ ______________

AAAD Director Date

Chief Administrative Officer of Grantee Agency | Date

Advisory Council Chairperson | Date

ATTACHMENTS

1. Public Hearing Documents

2.

Part G: FINANCIAL PLAN

Older Americans Act
(NOTE: This summary does not include ALL financial or allotment references in the OAA)
Section 306 *AREA PLANS*
(a)(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—
(A) services associated with access to services (transportation, health services (including mental health services) outreach, information and assistance, (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);
(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded

Section 315 *CONSUMER CONTRIBUTIONS*
(a)(5) (Cost Sharing) REQUIREMENTS.—If a State permits the cost sharing described in paragraph (1), such State shall require each area agency on aging in the State to ensure that each service provider involved, and the area agency on aging, will—
(a)(5)(B) establish appropriate procedures to safeguard and account for cost share payments;
(a)(5)(C) use each collected cost share payment to expand the service for which such payment was given;
(b)(4) (Voluntary Contributions) REQUIRED ACTS.—The area agency on aging shall ensure that each service provider will—
(A) provide each recipient with an opportunity to voluntarily contribute to the cost of the service;
(B) clearly inform each recipient that there is no obligation to contribute and that the contribution is purely voluntary;
(C) protect the privacy and confidentiality of each recipient with respect to the recipient's contribution or lack of contribution;
(D) establish appropriate procedures to safeguard and account for all contributions; and
(E) use all collected contributions to expand the service for which the contributions were given and to supplement (not supplant) funds received under this Act.

Section. 721. *PREVENTION OF ELDER ABUSE, NEGLECT, AND EXPLOITATION*
(a) ESTABLISHMENT.—In order to be eligible to receive an allotment under section 703 from funds appropriated under section 702 and made available to carry out this chapter, a State agency shall, in accordance with this section, and in consultation with area agencies on aging, develop and enhance programs to address elder abuse, neglect, and exploitation.

Exhibit Number	**Title of Exhibit**
G-1	Financial Report File

DISASTER OPERATIONS GUIDE
Tennessee Commission on Aging and Disability

EMERGENCY SUPPORT FUNCTIONS

ESF 5: INFORMATION and PLANNING

Purpose

The purpose of the Tennessee Emergency Management Agency (TEMA) Emergency Support Function (ESF) 5, is to gather and analyze information to determine the extent of an emergency and implement Tennessee's Emergency Preparedness Plan for the Aging Services Network.

Concept of Operations

Tennessee has nine designated planning and service areas known as Area Agencies on Aging and Disability. Each Area Agency will gather information and report the extent of the emergency to the (TCAD) Emergency Services Coordinator (ESC). The ESC will relay information to TEMA.

Mission

The mission of TCAD is to identify and describe the availability of resources and services that can be accessed in an emergency and the location of persons over the age of 60 and those individuals age 18 and older with a disability.

ESF 5 Responsibilities

a. TCAD provides an ESC to the State Emergency Operations Center (SEOC).
b. The ESC shall comply with requirements of the ESF.

ESF 6: HUMAN SERVICES

Purpose

The purpose of this ESF 6 is to provide emergency shelter in senior centers, with the senior center director acting as coordinator for their center, their participants, and their contractors, in cooperation with TEMA, county mayors, Red Cross and other disaster agencies to the extent needed and within the limits of available resources. Focus of the assistance will be directed toward the elderly and persons age 18 or older with a disability.

Concept of Operations

The Tennessee Commission on Aging and Disability (TCAD) will utilize there resources across the state to assist with ESF 6 duties in a disaster.

ESF 6 services which may be employed, depending on the need, include the following:

a. Temporary shelter in Senior Centers
b. Helping with mass feedings
c. Helping with evacuation
d. Use of facilities as temporary morgues
e. Counseling and Advocacy
f. Information and Referral
g. Legal Services
h. Senior Volunteers
i. Transportation
j. Special Needs Transportation
k. Centralized nutrition sites
l. Home–delivered meals
m. Homemaker services

ESF 8: HEALTH

Purpose

The purpose of this Emergency Support Function 8 is to provide supplemental homemaker services and information and referral services to regional and local areas.

Concept of Operations

In the event of an emergency which requires the involvement of TCAD, the ESC coordinator and the Area Agency Directors will act as coordinator in the area where the emergency occurs. The Senior Center Director will act as coordinator for their center, their participants, and their contractors, in cooperation with TEMA, County Mayors, Red Cross and other disaster agencies to the extent needed and within the limits of available resources. The Tennessee Emergency Preparedness Plan for the Aging Services Network will be implemented.

ESF 8 Mission

a. The TCAD ESC will respond to the SEOC.
b. Area Agencies on Aging and Disability and Senior centers where the disaster occurs will report to TCAD ESC.
c. The TCAD ESC will support the mission of the State of Tennessee.

Note: Additional TCAD emergency management information may be found in the Tennessee Commission on Aging and Disability ***Continuity of Operations Plan (COOP)*** and Chapter 13 of the ***TCAD Policies and Procedures Manual***.

Tennessee Commission on Aging and Disability

CONTINUITY of OPERATIONS PLAN (COOP)

CONCEPT OF OPERATIONS

I. Objectives and Specifics
The objective of this plan is to ensure that a viable capability exists to continue essential agency functions across a wide range of potential emergencies, specifically when the primary facility is either threatened or inaccessible. The specifics of this objective include:

A. Protecting essential facilities, equipment, records, and other assets;
B. Reducing disruptions to operations;
C. Identifying and designating principals and support staff to be relocated;
D. Facilitating decision-making for execution of the Plan and the subsequent conduct of operations; and
E. Achieving a timely and orderly recovery from the emergency and resumption of full service to all older Tennesseans.

II. Planning Considerations and Assumptions
In accordance with Federal guidance and emergency management principles, a viable COOP capability must:

A. Be maintained at a high-level of readiness;
B. Be capable of implementation both with and without warning;
C. Be operational no later than three hours after notification; and
D. Maintain sustained operations in an alternate facility for up to 30 days, if necessary.

Tennessee's elder population is rapidly increasing and placing greater demands on the network of social service agencies. Following a disaster, the burden placed on the aging network becomes larger as older adults who ordinarily are self-sufficient, turn to local agencies for assistance and guidance.

The function of state, regional, and local agencies in disaster preparedness, response, recovery, and mitigation procedures is to address and meet the needs of older citizens through the coordination of mutual assistance. Cooperation and coordination in the aging network ensures all agencies will provide effective disaster relief services. The Continuity of Operations Plan encompasses agency responsibilities in the event of a disaster, natural or manmade, and its impact on older persons. **During times of disaster emergency preparedness procedures will take precedence over normal duties.**

The COOP will be reviewed and updated annually reflecting the changes in department and emergency management procedures.

Planning Considerations

In the event a major or catastrophic event, natural or manmade, such as earth quakes, tornadoes, floods, civil disturbances, contractual disputes, epidemics, massive migrations, fires, nuclear power plant accidents, train derailments, terrorism, bio-terrorism and hazardous materials have occurred:

A. The first 72 hours are the most critical for all Mass Care functions;
B. The Commission directs the Area Agencies on Aging to implement their Continuity of Operations Plan and, in turn, the AAAD directs the Local Service Providers to implement their Plans;
C. The ESC or alternate completes the call-down procedures to the Area Agencies on Aging and Disability and/or Local Service Providers in the potential impacted area;
D. Area Agencies on Aging and Disability and Local Service Providers will call down or home visit all at risk, in-home, community based, older consumers in the potential impacted area;
E. Area Agency on Aging and Disability and Local Service Provider personnel will ensure the services to their consumers will not be interrupted and will assist, if possible, at special needs shelters; and
F. Ensure delivery of shelf stable meals for consumers who remain in their homes.

Assumptions

This plan will be implemented when emergency conditions are apparent. This will allow response and recovery actions to be implemented quickly and efficiently. In the event of a major or catastrophic event, natural or manmade, the State Emergency Operations Center will be fully activated and the following will occur:

A. The Governor issues an Executive Order declaring a state of emergency. This order will direct Tennessee Emergency Management (TEMA) to implement Tennessee's Comprehensive Emergency Management Plan and, if necessary, the Continuity of Operations Plan;
B. The Governor requests activation of the Federal Response Plan. The Federal Emergency Management Agency (FEMA) coordinates and deploys federal resources to the State Emergency Operations Center; and
C. The Governor requests federal disaster assistance to supplement state and local emergency resources.

Agency's Capacity and Response Capability

A. Area Agencies and Local Service Providers have existing memorandums of agreement with neighboring counterparts to assist with providing services in the event they are overwhelmed;
B. There are a number of identified service provider personnel who are available for shelter management training;

C. Service provider personnel to assist with staffing of special needs shelters, if possible;
D. Area Agency on Aging and Disability Trained staff throughout the state available to staff Human Needs Assessment Teams, Community Relations teams and Disaster Recovery Centers;
E. Currently there are a number of volunteers throughout the state who can assist in recovery efforts on behalf of older Tennesseans disaster victims from the following programs: Adult Day Care, Advisory Council/Board membership, Clerical/administrative, Companionship, Congregate Meals, Consumer Education/counseling, Counseling, Education, TNVOCAD, Friendly visitation, Fundraising, Health promotion, Home delivered meals, Homemaker, Home repair/chore, Information and referral, Intergenerational, Legal assistance, Telephone reassurance, Transportation, TRA, Red Cross, Salvation Army, 211 (the 211 helpline system has the capability to accept calls for older Tennesseans who may need assistance).

Computer Network Systems Capability

A. Servers are backed fully on a daily basis.
B. The latest weekly copy of the full backup is stored offsite servers can be restored by using the full backup.
C. Restoration of operating environment would consist of simply reloading backups and restarting. If any equipment is destroyed, the equipment can be replaced, reloaded with backups and restarted.
D. Periodic testing has ensured the process works properly.

III. COOP Execution

Emergencies, or potential emergencies, may affect the ability of TCAD to perform its mission essential functions from the Headquarters. The following could mandate the activation of the TCAD Plan.

A. TCAD headquarters is closed to normal business activities as a result of an event (whether or not originating in the Headquarters office) or credible threats of action would preclude access or use of the office and the surrounding area.
B. The area is closed to normal business activities as a result of a widespread utility failure, natural disaster, significant hazardous material incident, civil disturbance, or terrorist or military attack(s). Under this scenario there could be uncertainty regarding whether additional events such as a secondary explosion or cascading utility failure could occur and TCAD will have to activate this plan.

In an event so severe that normal operations are interrupted, or if such an incident appears imminent and it would be prudent to evacuate the area as a precaution, the Emergency Service Coordinator Officer in consultation with the Executive Director will activate the TCAD COOP Plan. TCAD will be composed of selected essential staff members who possess the knowledge, skills and abilities to perform TCAD mission essential functions. This group will conduct operations remotely from the alternate

facility and will be responsible for continuing mission essential functions of TCAD for a period up to 30 days pending regaining access to the Agency's office.

The alternate facility will be a designated fixed site or a leased facility that will accommodate the Relocation Group. If the headquarters office is inaccessible the alternate facility will be utilized.

When the headquarters office is again ready for occupancy, the performance of the mission essential functions will be transitioned back to the headquarters office.

Such incidents could occur with or without warning and during duty or non-duty hours. Whatever the incident or threat, the TCAD COOP Plan will be executed in response to a full-range of disasters and emergencies, to include natural disasters, terrorist threats and incidents, and technological disruptions and failures.

It is expected that, in most cases, the Emergency Service Coordinator will receive a warning of at least a few hours prior to an incident. Under these circumstances, the process of activation would normally enable the partial, limited, or full activation of The TCAD COOP Plan with a complete and orderly alert, notification of all personnel, Area Agencies on Aging and Disability and Local Service Providers.

When an emergency occurs without warning, the process becomes less routine, and potentially more serious and difficult. The ability to execute the TCAD COOP Plan following an incident that occurs with little or no warning will depend on the severity of the incident's impact on the physical facilities and whether personnel are present in the TCAD office or in the surrounding area.

Positive personnel accountability throughout all phases of emergencies, to include the COOP, is of utmost concern, especially if the emergency occurs without warning, during duty hours. TCAD Evacuation Plans should include accountability of personnel.

IV. Emergency Procedures

When an emergency occurs within Tennessee affecting the health and safety of Tennessee's older persons, the Agency will enact the following procedures as support agency to the State's Comprehensive Emergency Management Plan and assists the impacted local AAAD. Each office within the Agency may be called upon to assist at the Agency, County Emergency Operations Center and in the field. A key component is the call down procedures to the Local Service Providers at risk in a disaster or emergency.

If the emergency is a tornado, notices of various levels are announced by the National Weather Service or additional information and/or actions are taken by the State Emergency Operations Center, the following describes the flow of action to be taken by Agency staff members. The Tennessee Emergency Management Agency (TEMA) monitors all state activities in the state 24 hours, 7 days a week. All Emergency Services Coordinators and alternates are on call 24 hours, 7 days a week.

If the emergency is a terrorism or bio-terrorism attack, there will possibly not be a warning prior to the attack. In this case the TEMA will go immediately to full activation. TEMA will be the lead agency in the case of an Earthquake, tornado, nuclear emergency, terrorism or bio-terrorism attack.

When an emergency is anticipated:

A. The (TEMA), State Emergency Operations Center, and State Emergency Response Team are activated.
B. The Aging Emergency Services Coordinator receives notification via pager System or other medium (cell phone, home phone and e-mail).
C. At each level of activation, the ESC notifies Tennessee Commission on Aging and Disability's Executive Director, who then informs the Area Agency on Aging and Disability Emergency Coordinating Officers.
D. In the event of headquarters having to relocate to an alternate facility, the relocation group will be activated.
E. In the event of the Area Agency on Aging and Disability having to relocate to an alternate facility, the Agency's relocations group will be activated.
F. Depending on the level of activation at the State Emergency Operations Center, the following may be required:

Level 3 Activation: Primarily informational; State Emergency Operations Center and ESC monitors situation. Division of Emergency Management makes notifications to key personnel in selected Emergency Support Functions via conference calls, pages, E-mails and phone calls.

Level 2 Activation: Partial activation; State Emergency Operations Center and all Emergency Support Functions are activated. The State Emergency Response Team members are requested to report to SEOC. Emergency Services Coordinator and/or Alternate Emergency Service Coordinator Officer will report to State Emergency Operations Center, as needed.

a. Formal message documentation begins.
b. The Emergency Service Coordinator begins call downs to Area Agency on Aging and Disability Emergency Coordinating Officers, who in turn will begin call downs to the Local Service Provider Emergency Coordinating Officer in potentially affected areas and updates on a regular basis.
c. The ESC, Alternate ESC will notify and update, TCAD headquarters, in order for them to notify field staff in potential impacted areas.

Level 1 Activation: Full activation; State Emergency Operations Center is operating 24 hours a day, 7 days a week. In the event of a major or catastrophic event, terrorist attack or bio-terrorism, the State Emergency Operations Center will immediately be activated at this level. The following will occur:

a. Response and recovery efforts begin.

b. Federal Emergency Management Agency (Federal Emergency Response Team) involvement is anticipated.
c. Selected ESC staff members will report, if requested, to State Emergency Operations Center and provide staffing as long as needed.
d. Normal Disaster Preparedness and Operations daily activities will cease during any emergency or disaster event.
e. The TCAD Emergency Service Coordinator or Alternate Emergency Services Coordinator completes or notifies a designee within the department to complete the Department's *Preparation to Implement Emergency Relief Measures* Once approved by the Executive Director, Assistant Director or designated the following occurs:

    1. Area Agency on Aging Emergency Services Coordinators contacts Local Service Providers.
    2. Local Service Providers implement their COOP Plan and call down to clients as required.
    3. After call downs have been completed, Local Service Providers call Area Agency on Aging Emergency Coordinating Officers with results of call downs of operational activities.
    4. Area Agency on Aging Emergency Coordinating Officers contact the Department's Emergency Coordinating Officer with results of call downs and operational activities.
    5. If the event occurs during business hours, staff will begin Agency shutdown and evacuation procedures. Special instructions will be given as required.
    6. If the event occurs outside of business hours, staff will be given instructions by their supervisor if and when they should report to the Agency to implement shutdown procedures. Staff should call the agency's main phone number and/or their voice mail for any messages regarding the closing and reopening of headquarters. Staff should also monitor local media for latest updates.
    7. In the event of a terrorist or bio-terrorism attack in the Nashville Tennessee area and has impacted the headquarters office and causes the immediate evacuation of headquarters, the Department will immediately activate its COOP Plan to relocate to an alternate site, if indicated.

Post-Disaster Response/Recovery

A. Area Agencies on Aging and Disability and Local Service Providers will call down or home visit all at risk, in-home, community based, older Tennessee clients in the potential impacted area;
B. Area Agency on Aging and Disability and Local Service Provider personnel will ensure the services to their clients will not be interrupted and will assist, if possible, at special needs shelters; and
C. Ensure delivery of shelf stable meals for clients who remain in their homes.

V. Area Agency on Aging and Disability Office Roles – Key Staff
The Area Agency on Aging and Disability provides staffing of the County Emergency Operations Center, as needed.

Note: Normal Disaster Preparedness and Operations daily activities will cease during any emergency or disaster event.

Area Agency on Aging and Disability or Local Service Provider's office may be advised to remain at or return home pending further instructions. A COOP activation will not, in most circumstances, result in a change of duty location affecting pay and benefits.

RESPONSIBILITIES OF KEY TCAD STAFF

A. Executive Director or Back-up to Emergency Services Coordinator shall:

1. Be fully aware of all the responsibilities of the ESC.
2. Be well versed in the Area Agency's Emergency's Plan.
3. Coordinating Component's Disaster Preparedness and Recovery Plans.
4. Keep Executive Director and/Commission members informed about Area Agency Disaster Preparedness and Recovery Plans.
5. Notify TCAD Executive Director of Agency's plans at time of impending disaster.
6. Execute responsibilities of Emergency Service Coordinator.
7. Ensure that the Area Agency property insurance is adequate and up-to-date.
8. Facilitate release of funds, on a yearly basis, for any needed emergency and recovery purchases/supplies.

B. MIS Director shall:

1. Establish procedures for the shut-down of system server.
2. Ensure that the designated staff is trained in all procedures.
3. Maintain and convey to the ESC any MIS emergency preparation and planning decisions reached by AAAD.
4. Protect all Area Plan documents and files.
5. Assist the ESC with the call-down of service providers.

C. Fiscal Staff shall:

1. Plan for all disk and hard copy back-up of fiscal operations, such as, fiscal records, accounting program data, and provider reports SAMS and Beacon reports, and monthly data and spreadsheets.
2. Prioritize which records, ledgers, etc. must be packed and/or removed from the premises. Maintain hard copy list of the same, to become an attachment to this plan.
3. Color code financial records to be packed/protected.
4. Protect provider contract records and documents.

D. Support Staff shall:

1. By June 1 of each year, check all boxes of recovery supplies to ensure contents are in working order and not outdated. Maintain an inventory of these supplies.
2. Procure any needed/replacement supplies by June 1 of each year, once the list has been approved by the ESC and the Chief Fiscal Officer.

E. Executive Assistant shall:

1. Review and update on a yearly basis, the list of all Commission documents/files to be safeguarded in the event of an emergency/disaster.
2. Protect all TCAD contracts.
3. Assist the ESC in updating the staff Telephone Tree.
4. Produce the Disaster I.D. Badges.

F. Floor Wardens shall:

Pack/protect file cabinets that include special program and special event materials, documents, contracts and computer disks.

G. Director of Human Resources (with the assistance of ESC) shall:

1. Include disaster preparation materials in each new staff person's orientation packet.
2. Require each staff person, to fill out the TCAD Agency Personal/Family Disaster Preparedness Plan". Update each plan yearly.
3. Develop a Telephone Tree, Utilize Experience Corps and ESC for disaster education outreach, prior to and during the Tornado Season.
4. Utilize Red Cross, RSVP and TNVOAD volunteers to assist with support after a disaster.
5. Staff members will compile a list of volunteers willing to assist in shelters, centers, etc.

VI. Alternate Facilities

The determination of an alternate facility will be based on the incident or threat. If TCAD headquarters only is inaccessible and there is no threat.

VII. Mission Essential Functions

It is important to establish priorities to ensure that the relocated staff can complete TCAD mission essential functions. All divisions and sections shall ensure that their essential functions can continue or resume as rapidly and efficiently as possible during relocation. Any function not considered essential will be deferred.

VIII. Delineation of Mission Essential Functions

It is important to establish priorities prior to an emergency to ensure that the relocated staff can complete TCAD mission essential functions. All Division/section heads shall ensure that their essential functions can continue or resume as rapidly and efficiently as possible during an emergency relocation. Any task not deemed essential must be deferred until additional personnel and resources become available essential functions.

IX. Overview of Disasters

This section provides a brief overview of common disasters anticipated and conditions expected during a disaster, natural or manmade, such as floods, tornadoes, civil disturbances, contractual disputes, epidemics, massive migrations, fires, nuclear power plant accidents, train derailments, terrorism, bio-terrorism and hazardous materials. In the event of a disaster, the local county office of emergency management will determine if evacuation is necessary and how to proceed with the evacuation.

Catastrophic disasters will require massive state and federal assistance, including immediate military involvement; **major disasters** will exceed local capabilities and require a broad range of state and federal assistance; and **minor disasters** will be within the response capabilities of local government and result in only a minimal need for state and federal assistance. **Catastrophic or major terrorism and/or bio-terrorism attacks** will require massive state and federal assistance, including immediate military involvement because of the nature of these attacks.

1. Catastrophic Emergency Conditions

The capabilities of state and political subdivisions to provide prompt and effective relief and recovery measures are overwhelmed by a catastrophic event; transportation is damaged and local transportation services are disrupted. There may be damage to commercial telecommunications and communication for government response and recovery will be impaired. Homes, public buildings, other facilities and equipment are destroyed or severely damaged.

Debris makes streets and highways impassable. The movement of emergency relief supplies and resources are impeded. Public utilities are damaged. Many state, regional, and local emergency personnel are victims of the disaster, prohibiting them from performing emergency duties. Fires in urban and rural areas should be anticipated.
After a disaster, numerous victims may be left homeless, injured and require social service assistance. Many victims will be in life-threatening situations requiring immediate rescue and medical care. There will be a shortage of supplies necessary for emergency survival. Hospitals, nursing homes, pharmacies and other health/medical facilities will be severely damaged or destroyed. Medical and health care facilities in operation will be overwhelmed with victims requiring medical attention and medical supplies and equipment will be in short supply.

Damage to facilities, which generate, produce, use, store or dispose of hazardous materials could result in the release of such materials into the environment. Food processing and distribution capabilities will be severely damaged or destroyed. There will be prolonged disruption of energy sources and electric power failure.

2. Types of Disasters

a. Tornados: Tornadoes are nature's most violent storms. Spawned from powerful thunderstorms, tornadoes can cause fatalities and devastate a neighborhood in seconds. A tornado appears as a rotating, funnel-shaped cloud that extends from a thunderstorm to the ground with whirling winds that can reach 300 miles per hour. Damage paths can be in excess of one mile.

b. Tornado Watch: Tornadoes are possible. Remain alert for approaching storms. Watch the sky and stay tuned to NOAA Weather Radio, commercial radio, or television for information.

c. Tornado Warnings: A tornado has been sighted or indicated by weather radar. Take shelter immediately.

d. Flooding: Floods are one of the most common hazards in the United States. Flood effects can be local, impacting a neighborhood or community, or very large, affecting entire river basins and multiple states.

However, all floods are not alike. Some floods develop slowly, sometimes over a period of days. But flash floods can develop quickly, sometimes in just a few minutes and without any visible signs of rain. Flash floods often have a dangerous wall of roaring water that carries rocks, mud, and other debris and can sweep away most things in its path. Overland flooding occurs outside a defined river or stream, such as when a levee is breached, but still can be destructive. Flooding can also occur when a dam breaks, producing effects similar to flash floods.

Be aware of flood hazards no matter where you live, but especially if you live in a low-lying area, near water or downstream from a dam. Even very small streams, gullies, creeks, culverts, dry streambeds, or low-lying ground that appears harmless in dry weather can flood. Every state is at risk from this hazard.

e. Terrorism and/or Bio-Terrorism Attacks: Terrorism or bio-terrorism attacks may occur without warning and can impact elders and services delivered to them.

f. Other Disasters: There are other disasters that may occur that are not weather related. Incidents such as train derailments, plane or major interstate car crashes, civil disturbances, contractual disputes, epidemics, massive migrations, fires, nuclear power plant accidents, and hazardous materials can impact elders and services delivered to them.

X. Warning Conditions

Upon receiving notification that a disaster has occurred or is about to occur, the Area Agency on Aging will respond in accordance with the Continuity of Operations Plan.
Activation Phase:

A. The notification procedure is facilitated for the aging network in the following manner:

1. State level notification comes from the Division of Emergency Management to via ESC pager. The Emergency Services Coordinator and Alternate Emergency Service Coordinator are available by pager. The Emergency Services Coordinator (ESC) pager number is 1-800-841-7243.
2. Regional level notification, depending on the nature and type of disaster, may come from TCAD to the Area Agency on Aging or from the Lead and Local Service Provider to the Area Agency on Aging, who in turn notifies TCAD. Local Service Providers may, in some instances, be the first to notify the aging network if the disaster originates in their county. Evacuation orders are issued at the local level by county emergency management requiring local coordination between the Area Agencies on Aging, Local Services and County Emergency Management.
3. If evacuation becomes necessary, the State ESC Officer will assist with any coordination that may be needed between counties or regions for the evaluation and registration process at shelters.

B. The alert phase requires two plans:

1. During normal working hours; and
2. After hours, weekends and holidays. Both plans include the following:

   a. The Emergency Service Coordinating Officer and Alternate Emergency Service Coordinating Officer maintain current listings of home addresses, home telephone numbers, work numbers, cell phone numbers, and pager numbers of key Area Agency on Aging staff.
   b. The Emergency Service Coordinating Officer or Alternate Emergency Service Coordinating Officer alerts TEMA and TCAD'S Executive Director on disaster status and begins preparation for potential mobilization.
   c. The Emergency Service Coordinating Officer or Alternate Emergency Service Coordinating Officer, in consultation with upper management, makes assessments as to the safety of the Agency's facilities, equipment and records.
   d. The Emergency Service Coordinating Officer in consultation with the AAAD Director will notify the Agency Relocation Group to activate and start preparation for relocation in an event so severe that normal operations are interrupted, or if such an incident appears

imminent and it would be prudent to evacuate the area as a precaution.

C. Upon receiving a memorandum for Preparation to Implement Emergency Relief Measures and/or the Implementation of Emergency Relief Measures, the Area Agency on Aging notifies the Local Service Providers of the actions to be taken in the event of a disaster.

XI. TCAD on Aging Support Activities

TCAD, will work with the local County Emergency Management Office in order to provide support under the appropriate Emergency Support Functions (ESFs). The ESF concept groups agencies, based on common functions and activities, in a coordinated approach for responding to disasters. The Area Agency provides support under the same ESFs that TCAD is named under in the state recovery plan. These are ESF 5 (Information and Planning), 6 (Human Services), 8 (Health).

XII. Direction and Control

TCAD will pre-delegate authorities for making policy determinations and decisions. All such pre-delegations will specify what the authority covers, what limits may be placed upon exercising it, which (by title) will have the authority, and under what circumstances. This list will be an attachment. The Relocation Group Members are:

Division/Office Position Title:

XIII. Hours of Operation for Alternate Facility

TCAD will operate Monday through Friday, 8:00 am to 5:00 pm. In the event of the need for 24-hour, 7-day coverage of Helpline and the Technical Assistance for Volunteers line at the alternate facility, a schedule will be established for this purpose.

XV. Alert and Notification

In case the area is affected by the event, the COOP Plan will be activated. Upper management will notify department staff members of the potential emergency.

1. If the event occurs during business hours, staff will begin Agency shutdown and evacuation procedures. Special instructions will be given as required.
2. If the event occurs outside of business hours, staff will be given instructions by their supervisor if and when they should report to the Agency to implement Shutdown procedures (Attachment I – Telephone Tree).

Staff should call the agency's main phone number and/or check their voice mail for any messages regarding the closing and reopening of headquarters. Staff should also monitor local media for latest updates. In the event of a terrorist or bio-terrorism attack in the Nashville TN area and has impacted The Agency's office and causes the immediate evacuation of the TCAD office the Agency will immediately activate its COOP Plan to relocate to an alternate site, if indicated.

Attachment 1

PHONE TREE for Managers and Supervisors

NAME	HOME PHONE NUMBER and/or CELL	HOME E-MAIL ADDRESS

Attachment C

Intrastate Funding Formula Requirements

Intrastate Funding Formula

Y=(.35*(%60))+(.3*(%LI))+(.1*(%LIM))+.15*(%RUR))+.1*(%80))

Factors	Weights
Population Age 60 and Over	35%
Low Income Elderly	30%
Low Income Minority Elderly	10%
Elderly Living in Rural Areas	15%
Population Age 80 and Above	10%

How changes in the 2010 census affected the funds distributed to the nine districts:

First Tennessee: +$20,900
East Tennessee: +$81,800
Southeast Tennessee: +$15,500
Upper Cumberland: +$89,100
Greater Nashville: -$105,500
South Central Tennessee: -$106,600
Northwest Tennessee: -$159,200
Southwest Tennessee: +$116,400
Memphis/Delta: +$47,600

RULES
OF
TENNESSEE COMMISSION ON AGING AND DISABILITY
CHAPTER 0030-1-10
FINANCIAL MANAGEMENT STANDARDS AND PROCEDURES

TABLE OF CONTENTS

0030-1-10-.01 Intrastate Funding Formula

0030-1-10-.01 INTRASTATE FUNDING FORMULA.

(1) Federal funds received under Title III of the Older Americans Act shall be allocated to each of the nine area agencies on aging using the following formula:

(a) Ten percent of the Title III funds for area agencies is designated for administration of area agencies on aging. From this amount each area agency is allocated an identical base sub-grant of $100,000 plus a pro rata share of the remaining funds. The pro rata share shall be equal to the percentage which reflects a given area agency's portion of total state funds allocated to all area agencies by the state agency for nutrition services and senior centers in the state fiscal year immediately preceding the distribution of funds.

(b) Ninety percent of the Title III funds for area agencies is allocated for services. This amount shall be distributed as follows:

1. Thirty-five percent of the services allocation shall be distributed among the area agencies in proportion to each planning and service area's share of the total number of elderly persons (aged 60 and over) in the state.

2. Thirty percent of the services allocation shall be distributed among the area agencies in proportion to each planning and service area's share of the total number of elderly persons with income below 100% of the poverty level established by the Office of Management and Budget.

3. Ten percent of the services allocation shall be distributed among the area agencies inproportion to each planning and service area's share of the total number of minority elderly persons with income at or below 100% of the poverty level established by the Office of Management and Budget.

4. Fifteen percent of the services allocation shall be distributed among the area agencies in proportion to each planning and service area's share of the total number of elderly living in rural areas (as defined by the Census Bureau).

5. Ten percent of the services allocation shall be distributed among the area agencies in proportion to each planning and service area's share of the total number of elderly persons who are age 80 and above.

(c) The Commission shall review and update the Title III formula as often as a new State Plan is submitted to the Administration on Aging.

(d) The source of data for all formula factors listed in sub-paragraph (1)(b) above shall be the most recent decennial federal census of population.

October, 2006 (Revised)

Attachment D

State of Tennessee Policy of Non-Discrimination

STATE OF TENNESSEE
POLICY OF NON-DISCRIMINATION

Pursuant to the State of Tennessee's policy of non-discrimination, the Tennessee Commission on Aging and Disability does not discriminate on the basis of race, sex, religion, color, national or ethnic origin, age, disability, or military service in its policies, or in the admission or access to, or treatment or employment in, its programs, services, or activities.

Equal Employment Opportunity/Affirmative Action inquiries or complaints should be directed to the Tennessee Commission on Aging and Disability EEO/AA Officer, Nashville, Tennessee 37243-0860, 615-741-2056. ADA inquiries or complaints should be directed to the Tennessee Commission on Aging and Disability ADA Coordinator at the same location.

Assistance for those with speech, hearing and visual impairments is available through the Tennessee Relay Center at 1-800-848-0299.

Tennessee Commission on Aging and Disability
161 Rosa Parks Blvd.
3rd Floor
Nashville, TN 37243
(615)741-2056 telephone
(615)741-3309 facsimile
www.tn.gov/comaging

Attachment E

Demographic Data

Demographics

According to the 2010 Census, Tennessee's population, 60 and over, increased 29.9% from the 2000 Census, from 942,620 to 1,224,186. At the same time the population 85 and over increased 22%, from 81,465 to 99,917. In the ensuing years since the 2000 census, while the total population of older Tennesseans (60+) has increased, the population has also shifted away from some of the more rural areas and toward metropolitan and micropolitan[i] areas of the state. According to the Office of Management and Budget, a micropolitan statistical area contains an urban core of at least 10,000, but less than 50,000, population.

The funding formula requires that federal funds be distributed based on the proportion (percentage) of the age 60 and over population represented by each district, for 35% of the funds. Low income (income below 100% of poverty level) elderly comprise a 30% portion of the formula. Ten percent of the services portion of the formula is based on the percentage of low income minority elderly persons. Ten percent is based on all low income elderly persons, and 15% is based on the proportion of elderly living in rural areas. Ten percent of the services allocation is based on the proportion in each planning area represented by frail elderly (80+).

The factors and weighting of the formula are based in the requirements of the Older American's Act. The goal of the formula is to target vulnerable populations while at the same time, providing needed services for those who are 60 and over.

PSA	Persons 60+ 2000	Percent 60+ 2000	Persons60+ 2010	Percent 60+ 2010
First Tennessee	95,130	10.10%	121,679	9.940%
East Tennessee	189,775	20.15%	255,617	20.811%
Southeast	101,585	10.78%	132,460	10.820%
Upper Cumberland	61,520	6.35%	81,974	6.69%
Greater Nashville	191,515	20.33%	264,717	21.624%
South Central	70,920	7.53%	89,883	7.234%
Northwest	52,920	5.62%	59,189	4.839%
Southwest	43,805	4.65%	53,244	4.349%
Aging Commission	134,875	14.32%	165,423	13.513%
Totals	942,045	100%	1,224,186	100%

PSA	Persons Age 60+ 2010 Census UT Data Center		Low Income Minority 65 + American Community Survey UT Data Center		Low Income 65+ American Community Survey UT Data Center		Estimated Rural TN. Dept. of Health, Bureau of Health Statistics		Persons Age 80+ 2010 Census UT Data Center	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
FIRST	121,679	9.940%	376	1.868%	10,289	11.017%	35,220	10.838%	21,520	10.157%
EAST	255,617	20.881%	1,211	6.015%	17,365	18.594%	70,400	21.664%	43,864	20.703%
SE	132,460	10.820%	1,999	9.929%	9,371	10.034%	32,510	10.004%	23,612	11.144%
UC	81,974	6.696%	191	0.949%	7,970	8.534%	40,470	12.454%	13,473	6.359%
GNRC	264,717	21.624%	4,064	20.187%	15,716	16.828%	42,620	13.115%	44,080	20.805%
SC	89,883	7.342%	767	3.810%	6,942	7.433%	42,050	12.940%	15,659	7.391%
NW	59,189	4.835%	922	4.580%	5,816	6.228%	26,870	8.269%	11,099	5.239%
SW	53,244	4.349%	1,661	8.251%	6,328	6.776%	21,930	6.749%	9,576	4.520
ACMS	165,423	13.513%	8,941	44.411%	13,594	14.556%	12,890	3.967%	28,988	13.682%
TOTALS	1,224,186	100%	20,132	100.00%	93,391	100.00%	324,960	100%	211,871	100.00%

Attachment F

Statewide Comprehensive Needs Assessment Data and Analysis

Regional Needs Assessment Reports

Needs Assessment

Content

Introduction
Purpose and Scope
Impact of Baby Boomers
Needs Assessment
- Aging and Disability Issues
- Impact of Baby Boomers
- What Works in the Community
- Small Focus Groups
- Conclusion
- Copies of the Survey Instruments

Stakeholders' Meeting
TCAD Commission Meeting
Regional Reports for the Area Agency on Aging and Disability
- First Tennessee Area Agency on Aging and Disability
- East Tennessee Area Agency on Aging and Disability
- Southeast Tennessee Area Agency on Aging and Disability
- South Central Tennessee Area Agency on Aging and Disability
- Upper Cumberland Area Agency on Aging and Disability
- Greater Nashville Area Agency on Aging and Disability
- Southwest Area Agency on Aging and Disability
- Northwest Area Agency on Aging and Disability
- Aging Council of the Mid-South Area Agency on Aging and Disability

Introduction

During February and March 2013, the Tennessee Commission on Aging and Disability (TCAD) conducted a Listening Tour across the Tennessee in each of the nine (9) regions served by the Area Agencies on Aging and Disability (AAAD). The Listening Tour was conducted

- to allow community members to discuss the challenges facing the aging and disability population;
- to gather suggestions about addressing these challenges; and
- to provide input on what can be done to make programs and services more accessible, efficient, and effective.

At each of the sites, attendees participated in the needs assessment by completing a survey focusing on:

- current aging and disability issues;
- issues faced by "baby boomers" as they age; and
- programs and services that are currently working in the community.

Attendees also participated in small focus groups. Additional input was provided from three (3) meetings held in Nashville: 1) Stakeholders' meeting held January 23, 2013; 2) the quarterly meeting of the Commission held February 5, 2013; and 3) public hearing held May, 2013.

The comprehensive needs assessment consisted of results of the surveys, the small focus groups, the stakeholders' meetings, review of literature regarding the differences between the current senior population and baby boomers, and a review of the previous data provided by the State Plan 2009-2013. The needs assessment was designed to aid in the development of the **Tennessee State Plan on Aging 2014-2018** and to give policy makers pertinent information about trends and themes expected to evolve with the increasing aging population, especially in regard to emerging growth of the baby boomer population.

Purpose and Scope

The Listening Tour and needs assessment was designed to aid in the development of the Tennessee State Plan on Aging 2014-2018, but it was also intended to provide community members the opportunity to provide input about their needs, to identify emerging needs as the baby boomer population ages, and to ensure that programs and services are efficient and effective to meet current and future needs. The needs assessment was used to identify the current and future challenges that will be faced in providing services and programs to the aging population. From the identified challenges, the goals, objective, strategies and performance measures were developed.

Tennessee Commission on Aging and Disability (TCAD) is celebrating its 50th anniversary. TCAD is taking the opportunity to use the data gathered from the needs assessment to review and assess its internal structure to ensure that the programs and services are cost effective and meet best practices. This effort will include identifying the competencies, knowledge, and skills needed for each position and to implement staffing patterns and job plans to match those

competencies, knowledge, and skills. Such a review might also include revisions to the Program and Policy Manual, monitoring tools, contract scope of service, and the data collection system.

Impact of Baby Boomers

The single largest factor impacting Tennessee's aging programs and services will be the growth of the aging population of "baby boomers". Baby boomers are defined as individuals who were born between 1947 and 1964. Currently, an estimated 75 million individuals are identified as baby boomers. In 2011, the first baby boomer reached the age of 65 and an estimated 10,000 individuals reach the age of 65 every day. The 2010 Census for Tennessee reports that the 65 & over population represents 13.7% of Tennessee's population as compared to the national rate of 13.3%. In the next 15 years, an additional 1,245,064 individuals or 20% of Tennessee's current population will reach the age of 65, representing a 65% increase.

According to "*10 Ways Baby Boomers Will Reinvent Retirement", **US News and World Report***, February 16, 2010, " baby boomers redefined each state of life as they passed through it."
Baby boomers:

- are living longer therefore retirement will last longer than their parents.
- will have to control their retirement funds by managing their investments.
- will continue to work as they need the income, the mental stimulation, and/or socialization.
- don't see retirement as a withdrawal from activity, but a new adventure.
- are the sandwich generation as they may be taking care of elderly parents, paying college tuition for the children, and/or taking care of their grandchildren.
- will have lower social security benefits.
- may retire with debt owing money on their mortgage, credit cards, and even college debt.

As baby boomers age and live longer, the sheer number of aging individuals will impact all systems, such as, but not limited to, health care; health and fitness; nutrition; mobility/ transportation; income, investments, and financial security; housing and community/ neighborhood development; socialization opportunities; work force; leisure and volunteer activities; mental health, people with disabilities, and family responsibilities/caregiving.

- "Baby boomers are healthier in some important ways. They are much less likely to smoke, have emphysema, or get heart attacks." (*Aging Poorly: Another Act of Baby Boomer Rebellion* Rob Stein, NPR, February 4, 2013) However, diabetes, high blood pressure and obesity are increasing. The number of individuals with disabilities is increasing.

- Disability Statistics: Online Resource for U.S. Disability Statistics reports that an estimated 36.8% of persons age 65 and over reported a disability. This includes non-institutionalized, males and females of all races regardless of ethnicity with all educational levels. For Tennessee, it is 40.8%.

- "There are currently 7,162 allopathic and osteopathic certified geriatricians in the US — one geriatrician for every 2,620 Americans 75 or older. Due to the projected increase in the number of older Americans, this ratio is expected to drop to one geriatrician for every 3,798

older Americans in 2030. There are far fewer geriatric psychiatrists. Currently there are 1,751 - one for every 10,865 older Americans. That ratio is projected to decrease by 2030 to one geropsychiatrist for every 12,557 Americans 75 and older." (The American Geriatrics Society, Advocacy Public Policy)

- "Persons aged 65 years and older comprise only 13 percent of the population, yet account for more than one-third of total outpatient spending on prescription medications in the US." (National Institute on Drug Abuse (NIDA) *Research Report Series: Prescription Drugs: Abuse and Addiction*, October 2011)

- "The major sources of income as reported by older persons in 2010 were Social Security (reported by 86% of older persons), income from assets (reported by 52%), private pensions (reported by 27%), government employee pensions (reported by 15%), and earnings (reported by 26%)." (The Administration on Aging, A Profile of Older Americans: 2012)

- According to the article *The Ripple Effect of Baby Boomer Retirement* by Dave Bernard, usnews.com August 3, 2012, baby boomers will not only challenge the health care system, but will also impact the nature of the work force, the amount of money going to charities, the nature of investments, and exercise and recreation.

"The baby boom in American was neither planned nor anticipated. It brought challenges and new ideas to many parts of our culture. It also brought problems. Fortunately, members of the baby boom generation will be around and working in order to be part of the solution." (The Administration on Aging, A Profile of Older Americans: 2012)

Needs Assessment

The Listening Tour was held at the following locations in each of the nine (9) regions served by the Area Agencies on Aging and Disability in the following order:

Area Agency	Date	Location
Northwest	February 12, 2013	Senior Center, Union City
Southwest	February 13, 2013	Southwest AAAD, Jackson
Aging Commission of the	February 14, 2013	Pink Palace, Memphis

Mid-South AAAD		
South Central	February 19, 2013	Henry Horton State Park, Chapel Hill
Upper Cumberland	February 21, 2013	Life Church, Cookeville
Greater Nashville Regional Council	February 26, 2013	Ajax Turner Senior Center, Clarksville
Southeast Tennessee	February 28, 2013	Jewish Cultural Center, Chattanooga
First Tennessee	March 6, 2013	Memorial Park Community Senior Center, Johnson City
East Tennessee	March 7, 2013	John T. O'Connor Senior Citizen's Center, Knoxville

Attendees represented adults age 60 and over, adults with disabilities, baby boomers under the age of 60, service providers, healthcare organizations, insurance providers, AAAD staff, TCAD staff, senior center staff, Veterans Affairs (VA), AARP, American Cancer Society, mental health facilities, area newspapers, businesses, housing authorities, offices on aging, churches and ministries, University of Tennessee Extension services, and public officials.

The survey focused on the current aging and disability issues, issues faced by "baby boomers" as they age, and the programs and services that are currently working in the community.

- Identify the ***aging and disability issues*** that are most important to you.
- ***What are the hard things that "baby boomers" face? How should the State of Tennessee help?***
- ***What is currently working well in your community? (like agencies that help, neighbors who help each other, van service, senior center, meal sites, food pantry, healthcare clinic, nursing home sidewalks, police presence, grocery stores that deliver)***

The major findings are included in this section.

The total number of questionnaires completed statewide was 555 with 812 individuals attending the Listening Tour meetings, a 68% response completion rate. The following identifies the number of individuals who attended the Listening Tour at each site and the number of questionnaires completed.

Area Agencies on Aging and Disability	# attending	# responding	% responding
Northwest	152	99	65%
Southwest	59	37	63%
Aging Council of the Mid-South	100	56	56%
South Central	32	23	72%
Upper Cumberland	103	81	80%
Greater Nashville	74	47	64%
Southeast	55	32	60%
First Tennessee	86	66	77%
East Tennessee	151	114	67%
Total	**812**	**555**	**68.3%**

Aging and Disability Issues

Each participant completing this survey question could identify 1 or more of 38 issues listed on the survey as being most important. Space was also provided to include other issues that were not on the list.

Issues	*# of responses*	*%*
1. Affordable dental care, hearing care and eye exams and glasses	388	69.9
2. Not having enough insurance or money to pay for doctors or medicine	386	69.5
3. Being able to get help when needed quickly and without hassle	385	69.4
4. Transportation for people who don't drive cars	384	69.2
5. Learning new things	384	69.2
6. Being able to get accessible transportation	382	68.8
7. Keeping healthy through exercise and eating healthy food	376	67.7
8. Getting care at home instead of in a nursing home	366	65.9
9. Respite services	340	61.3
10. Training for aid workers who help older adults and people with disabilities	333	60.0
11. Housing that people on a pension or Social Security can pay for	326	58.7
12. Learning how to live with a serious condition like heart disease, cancer arthritis	321	57.8
13. Learning about how to take care of yourself so that you don't get sick and tired	303	54.6
14. Protect people from abuse	302	54.4
15. Teaching volunteers to work with older adults and people with disabilities	298	53.7
16. Meals that are healthy and prevent hunger	289	52.0
17. Houses that are easy to get around in if you're on a walker or in a wheelchair	276	49.7
18. Knowing where to call for help and getting help without a big runaround	273	49.2
19. Help with memory loss	273	49.2
20. Learning about how to care for someone at home	271	48.8
21. Reasons people have to go into nursing homes	263	47.4
22. Teaching doctors, nurses, and other healthcare works to know the special needs of old adults and people with disabilities	260	46.8
23. Teaching police, firemen, emergency workers to know the special needs of older adults and people with disabilities	248	44.7
24. Meeting people and Making new friends	237	42.7
25. Being able to choose the workers who come into your home	233	42.0
26. Neighborhoods that are easy and safe to walk in	231	41.6
27. Making decision about health insurance, Medicare, and 0planning for the future without depending upon the government	230	41.4
28. Understanding how Medicare works	220	39.6
29. Easting out with friends	220	39.6
30. Learning how to prevent falls	218	39.3

31. Help with chores like lawn mowing and leaf raking	207	37.3
32. Places to volunteer	206	37.1
33. Reasons people have to go back to the hospital	200	36.0
34. Help with feeling sad or lonely	186	33.5
35. Neighborhoods that have grocery stores close by	178	32.1
36. Help with taking too much medicine	175	31.5
37. Being able to get accurate information from a website and being able to apply for services on-line	139	25.0
38. Help with drinking too much alcohol or taking drugs	89	16.0

All attendees were provided an opportunity to identify other aging and disability issues that were not identified in the above list of 38 items by listing their issues under the topic **Other.** Their responses to **Other** are contained in the AAAD Regional Reports.

Impact of Baby Boomers

A major issue impacting Tennessee's aging system will be the aging "baby boomer" generation. In response to the survey question ***What are the hard things that "baby boomers" face?,*** most of the respondents indicated that the current lack of accessible and affordable services and programs and the lack of funding will only increase as the retired population increases and lives longer than their parents.

The primary concerns faced by baby boomers are identified by category. Examples of the responses are included for clarification.

- Retirement: can't afford to retire; having enough money to retire; retirement benefits; saving for retirement; part-time job to supplement retirement
- Health Insurance: high cost of medical care; able to afford insurance; availability of insurance
- Economic Concerns: insecurity about the economy and/or shrinking economy; lack of assets; loss of saving from a bad economy; increasing costs of gas, utilities, food; hard to live on Social Security; fewer resources for middle income families; rising cost of living will outpace retirement benefits; reduced/fixed income; rising costs and declining income
- Social Security, Medicare, Medicaid: will they be there?; future of Social Security and the possibility of insolvency, raising the age eligibility requirements
- Caregiving: caring for aging parents while working; raising a family while caring for aging parents; shortage of caregivers; increase in Alzheimer's and dementia
- Maintaining Health: staying active physically and mentally; need more education and programs/facilities; health promotion; senior center hours not accessible for working adults age 60 and over; just now beginning to provide programs for baby boomers
- Transportation: affordable, accessible, and safe transportation; more city and rural transportation; more choices in transportation
- Healthcare: mentally challenged have limited resources; availability of health care; paying for medications; veterans exposed to Agent Orange; services for aging in place; services for the disabled and for low income; services for people living in rural counties, services are already lacking; not enough home and community based services; adult day care

- Technology: automated everything; quickening pace; keeping up/computer skills
- Housing: affordable, accessible, safe; affordable/available home repairs; livable and walkable communities; decreasing options for housing; investment friendly housing; housing to match abilities

All of these differences will significantly impact the aging services and programs to be designed in the next few years. In response to the second part of the question ***How should the State of Tennessee help?***, several responses reflect the lack of answers to this question: so many retiring at the same time, money and provision will run out; so many – gov't can't take care; and don't know.

What Works in the Community

The survey question "***What is currently working well in your community?*** asked participants to identify what programs and/or services they thought were working. Some of the programs and services identified may not be statewide. One participant had the following statement: "The services that are available are great, but so few can access."

The programs and services that are currently working included: meals (meal/nutrition sites, meals on wheels, mobile meals), van services, senior centers, grocery and pharmacies that deliver, Second Harvest Food Bank, food pantries, Elder Watch; Senior Citizen Awareness Network (SCAN), local church assistance, Project Live, Office on Aging, Alzheimer's Tennessee, United Way, Community Gardens, Area Agency on Aging and Disability (AAAD), police involvement with Seniors and Law Enforcement Together (S.A.L.T.) and the S.A.L.T. conference, networking, sidewalks, home and community based services, law enforcement and sheriff's office, Loaves and Fishes, dental care 3 days a week, Room in the Inn, Human Resource Agencies (HRA), SHIP, Senior Companion Program, Helping Hands, Ombudsman, Habitat for Humanity, legal aid services, homemaker services, Public Guardianship for the Elderly, CHOICES and Options, healthcare clinic, aquatics available, commodity distribution, Silver Sneakers, Matter of Balance, Cancer Society's Road to Recovery, and physical fitness programs.

Small Focus Group

The Small Group Focus Sessions were asked to expand upon the aging and disability issues facing Tennessee and to identify the factors impacting those issues. Since the sessions were open-ended, the responses from the multiple groups were overlapping and provided examples to re-enforce the identified issues:

- Not enough programs and services and lack of funding
- More affordable, accessible, and flexible transportation
- Tracking services provided by churches, the community, etc.
- Need for more education and training programs
- Lack of health insurance or money
- Financial assistance for food, heating, medications, utilities, etc.
- Limited computer skills and/or internet access

- Limited assisted living, retirement communities, especially in rural areas
- Solicitation calls, frauds and scammers
- More accessible services and user-friendly information
- Affordable, accessible, and safe housing and home repairs
- Lack of financial resources for dentures, hearing aids, glasses for adults age 60 and over and adults with disabilities
- Waiting lists for services and programs
- Depression and loneliness
- Lack of in-home services – home and community-based services
- Poor attitude toward adults age 60 and over
- High cost of medications
- Too many places to call for services and/or programs and how to qualify for services
- Decrease in people paying into system, benefits, and workers in the field
- Coordination of services
- Elder abuse
- Caregiving

Conclusion

The AARP survey seems to support the survey findings of this needs assessment. Baby boomers are concerned for financial security and improving their health. Aging in place is important to baby boomers. They do not plan to move like their parents.

Utilizing the data from the comprehensive needs assessment, the challenges that face TCAD and other state departments and agencies serving adults age 60 and over and adults with disabilities were identified and the **Tennessee State Plan on Aging 2014-2018** was developed. The **State Plan 2014-2018** provides policy makers, service providers, and the general population with appropriate data about trends and implications for the current population as well as the impact of the increase in the aging population due to the aging "baby boomer" population.

Tennessee Commission on Aging and Disability
Listening Tour
2013

I. What are the hard things that "baby boomers" face? How should the State of Tennessee help?

1. ____

____

2. ____

____

3. ____

____

4. ____

____

Tennessee Commission on Aging and Disability
Listening Tour
2013

II. Here are seven (7) aging and disability issues.
Under each, there is a list.
Mark the ones on the list that you think are most important.

Staying Healthy While Aging

- Keeping healthy through exercise and eating healthy foods
- Affordable dental care, hearing care, and eye exams and glasses
- Learning how to prevent falls
- Meals that are healthy and prevent hunger
- Learning how to live with a serious condition like heart disease, cancer, arthritis

Health and Wellness

- Reasons people have to go into nursing homes (*like falling down, breaking bones, medicine errors, lack of transportation, lack of healthy meals, lack of services in the home)*
- Reasons people have to go back to the hospital *(like not taking medication, not having someone to make meals, not asking the doctor questions)*
- Not having enough insurance or money to pay for doctors or medicine
- Getting care at home instead of in a nursing home
- Knowing where to call for help and getting help without a big runaround
- Understanding how Medicare works
- Making decisions about health insurance, Medicare, and planning for the future without depending upon the government
- Help with feeling sad or lonely *(like depression)*
- Help with drinking too much alcohol or taking drugs
- Help with taking too much medicine *(like prescription drugs, pain killers, tranquilizers)*
- Help with memory loss *(like dementia, Alzheimer's Disease)*
- Protect people from abuse *(like being hit, yelled at, forced to do things you don't want to do, others using your money)*

Continue choosing important issues

Caregiving (taking care of loved one at home)

- Respite services *(like getting someone else to look after loved one so you can have a short break and take care of errands)*
- Learning about how to care for someone at home
- Learning about how to take care of yourself so that you don't get sick and tired

Independence and Getting Services Easily

- Being able to get help when needed quickly and without hassle *(like being able to call and get the help you need without a runaround)*
- Being able to get accurate information from a website and being able to apply for services on-line
- Being able to choose the workers who come into your home
- Being able to get accessible transportation *(like rides that are there to pick you up when you need it; rides that can help people who use walkers or wheelchairs)*

Housing, Neighborhoods, and Safe Communities

- Help with chores like lawn mowing and leaf raking
- Housing that people on a pension or Social Security can pay for
- Neighborhoods that are easy and safe to walk in *(like sidewalks, low crime)*
- Neighborhoods that have grocery stores close by
- Transportation for people who don't drive cars
- Houses that are easy to get around in if you're on a walker or in a wheelchair

Continue choosing important issues

Staying Connected and Involved in the Community

- Places to volunteer
- Learning new things *(like ideas, skills, hobbies)*
- Meeting people and making new friends
- Eating out with friends *(like affordable, tasty, nutritious meals shared with friends)*

Working with Older Adults and People with Disabilities

- Training for paid workers who help older adults and people with disabilities *(like staff who go into homes, or who work in nursing homes)*
- Teaching police, firemen, emergency workers to know the special needs of older adults and people with disabilities
- Teaching doctors, nurses, and other healthcare workers to know the special needs of older adults and people with disabilities
- Teaching volunteers to work with older adults and people with disabilities *(like recruiting volunteers, training volunteers, and helping them do their best)*

Other *(Is there something else that you think is important?)*

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This survey may also be taken on-line at www.tn.gov/comaging/ or by mailing this form to the following address: TCAD, 161 Rosa L. Parks Blvd., Nashville, TN 37243. (Survey available until March 14, 2013.)

Tennessee Commission on Aging and Disability
Listening Tour
2013

III. What is currently working well in your community?
(like agencies that help, neighbors who help each other, van service, senior center, meal sites, food pantry, healthcare clinic, nursing home, sidewalks, police presence, grocery stores that deliver)

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Needs Assessment

Stakeholder Meeting
Nashville Public Library
Nashville, TN
January 23, 2013

Number of Attendees: 56

Statewide Needs Assessment Key Stakeholders' Meeting
January 23, 2013
Attendees

Lynette Porter	Council on Developmental Disabilities
Nancy Carr	Retired Citizen
Renee Bouchillon	Department of Human Services/Adult Protective Services
Holly Williams	Upper Cumberland Area Agency on Aging and Disability
Lanelle Godsey	Upper Cumberland Area Agency on Aging and Disability
Patty Ray	Upper Cumberland Area Agency on Aging and Disability
Elaine Graf	Aging Commission of the Mid-South
Jesse Samples	TN Health Care Association
Maribeth Farringer	Council on Aging (Middle Tennessee)
Norma Powell	Greater Nashville Regional Council
Cathy White	Greater Nashville Regional Council
Shani Abell	The Arc of TN
Wanda Simmons	Southwest Area Agency on Aging and Disability
Tom Cheetham	TN Department of Intellectual and Developmental Disabilities
Kathy Whitaker	First Tennessee Area Agency on Aging and Disability
Robin Rochelle	South Central Area Agency on Aging and Disability
Dottie Lyvers	East Tennessee Area Agency on Aging and Disability
Joe Evans	South Central Area Agency on Aging and Disability
Lisa Wright	Blue Cross Blue Shield
Simi Atolagbe	TN Department of Labor
Andrew Sandler	Abe's Garden
Vickie Trice	TN Department of Insurance
Carol Westlake	TN Disability Coalition
Valerie H. King	TN Commission on Aging and Disability
Lucy Utt	TN Commission on Aging and Disability
Janet Lamb	TN Commission on Aging and Disability
Jeanne Caudill	TN Commission on Aging and Disability
Cathy Taylor	Belmont University
Carol Wilson	Metro Social Services
Beverly Patnaik	Lipscomb University
Sherry Cummings	University of Tennessee School of Social Work
Dora Ivey	Aging Commission of the Mid-South
Tom Starling	Mental Health America
Carole Moore-Slater	TN Disability Pathfinders/Vanderbilt Kennedy Center
Aaron Bradley	East Tennessee Area Agency on Aging and Disability
Steve Witt	Southeast Tennessee Area Agency on Aging and Disability
Tommy Preston	Southeast Tennessee Area Agency on Aging and Disability
Julie Jones	Northwest Tennessee Area Agency on Aging and Disability
Susan Hill	Northwest Tennessee Area Agency on Aging and Disability
Barbara Acuna	Blue Cross Blue Shield
Adrienne Newman	Fifty Forward
Janice Wade-Whitehead	Alzheimer's Tennessee

Libby Cain	TN Department of Commerce and Insurance
Michelle Morse Jernigan	TennCare
LaVerdia McCullough	TN Commission on Aging and Disability
Shannon Jones	TN Commission on Aging and Disability
Carlie Cruse	Senator Corker's Office
Beth Zeitlin	Abe's Garden
Harriet Karro	The Gift Initiative
Angela Jefferson, Ph.D.	Vanderbilt Memory and Alzheimer's Center
Consuelo Wilkins	Vanderbilt University-Meharry College
Ruth Garrett	Vanderbilt University-Meharry College
Julian Sanborn	Fifty Forward
Robert Dittus	Vanderbilt
Rachel Henderson	Lakeshore Estates
Bonne Fertig	Citizen
Anna Lea Cothron	Vanderbilt University
Stephanie Mayers	Vanderbilt University

Stakeholder Meeting
Nashville Public Library
January 23, 2013

A Stakeholders' Meeting was held in Nashville on January 23, 2013 as the kick-off to the statewide Listening Tour regional meetings. The purpose of the meeting was to provide an overview of the Listening Tour agenda and the development of the State Plan on Aging for 2014-2018 in order to receive the federal funding, and have stakeholders participate in potential surveys to be used for the needs assessment and provide feedback. Attendees at each of regional meetings will be asked to complete the surveys for the needs assessment required for the State Plan. Stakeholders were also asked to encourage people to attend the Listening Tour in the Area Agency on Aging and Disability Regions.
The stakeholders' meeting consisted of an open discussion of the impact of the aging population on Tennessee's fiscal resources, programs, and services; the results of the surveys completed by attendees and feedback comments on the surveys; and concluding comments.

Fifty-six (56) individuals were in attendance at the meeting. Attendees including representatives from the Council on Developmental Disabilities, Area Agencies on Aging and Disability, Council on Aging, Tennessee Healthcare Association, ARC of Tennessee, Tennessee Department of Developmental and Intellectual Disabilities, Blue Cross/Blue Shield of Tennessee, Tennessee Department of Commerce and Labor, Abe's Garden, Tennessee Disability Coalition, Belmont University, Metro Social Services, Lipscomb University, University of Tennessee-Knoxville, Mental Health of America, Tennesse Pathfinders/Vanderbilt University/Kennedy Center, Fifty-Forward, Alzheimer's Tennessee, TennCare, Senator Corker's Office, The Gift Initiative, Vanderbilt Memory Center, Tennessee Department of Health-Division of Family Health and Wellness, Merry Hospital, and Lake Shore Estates.

The survey questions completed at the stakeholders' meeting included the following:

- Overall, what are the four (4) most pressing challenges facing the State of Tennessee in order to provide aging and disability services?

- The growing "baby boomer" population appears to have different wants and needs than the current aging population being served. Overall, what are the four (4) most pressing challenges facing the State of Tennessee in providing services to this "baby boomer" population?

- What works?
  From your area of expertise, what are the best practices, programs or services on which the State should focus? What would help Tennessee move forward to better serve our elders and people with disabilities?

Challenges

With the emerging baby boomer population, this question was designed to identify the challenges that Tennessee will be facing in the near future. The responses for Question #1 were divided into major categories for easier review; however, some of the responses may be overlapping.
Challenges facing Tennessee as the baby boomers age include providing healthcare (programs and services), building awareness of and access to information, resources and technology; addressing economic issues; coordinating, collaborating, and building partnerships; and addressing support services, including transportation, housing, nutrition and meals, caregiving, and advocacy. Repetitive responses, such as "transportation" or "funding", are included only once in this report.

Overall, what are the four (4) most pressing challenges facing the State of Tennessee in order to provide aging and disability services?

Healthcare/Programs and Services

- Home Health services
- Desire to live in their home as long as possible
- Mental services/support for those with Alzheimer's/memory loss diseases
- Identifying people in need
- Finding the right person or agency to assist the consumer
- Preparing for baby boomers – not enough services
- The aging baby boomers will be a large group needing multiple services. (from a volunteer)
- In-Home services
- Fragmentation of services (need aging department)
- Catching up to other states in service delivery options (promoting choice)
- Early identification of memory loss in older adults in the community
- Home health services for elders with cognitive impairment who need assistance with daily activities
- Services for the Alzheimer's community
- Single point of entry and return
- To include people with intellectual and development disabilities in existing services
- Service providers recommending appropriate resources and helping with connections
- Consistency of contact person at a given agency
- In-home services
- Healthcare (affordable & effective) including end of life care - Dementia related . . . .
- Healthy Aging
- Inconsistencies in assessments across the State
- Evaluating programs to assess efficacy
- Finding the target population
- Identifying their real vs. perceived needs
- Developing programs to meet needs

- Skilled providers
- Trained gerontology professionals/staff
- Providers in general
- Access to care
- Rural areas need access to services in a timely way
- Access in rural areas (funding)
- Easier access to in-home services
- Changes in TNCare criteria for CHOICES
- Affordable healthcare
- Shorten waiting lists for services – being able to get more people off waiting lists
- Increase in number of seniors for several more years (boomers)
- Growth of Alzheimer's population - increase in dementia
- Home and Community Based Services waiting list is causing many folks to be forced into facility LTC settings at more expense to government and taxpayers and it's not where consumers want to be
- Increase in ultra-elderly (85+) and having complex needs
- No emergency services available
- Aging mentally ill
- The rapidly aging general population which will increase demands for services
- Systems are too complicated to navigate for individuals and families
- Availability of services (waiting lists)

Awareness, Information, Education and Technology
- Awareness of programs and services available
- Many have no internet access
- Updating databases is time consuming and not always undated creating services no long available info that is not useful. Those same agencies could work together to share information about community services needed by county creating more comprehensive data. Tennessee, for too long, prefers to work in silo's or individually. This also creates duplication and wastes valuable state and federal dollars. We can do better.
- Lack of awareness from the consumer's level, of AAA services
- Raising public awareness of the challenges and opportunities presented by an aging population
- Getting folks who need resource the knowledge that it exists
- Health literacy
- Same as "boomers" – knowledge of available services in order to make informed choices
- Educating seniors about fraud and ways to avoid being financially taken advantage of
- Help educate seniors about medication & to be aware of all the meds they are taking. So many are taking meds that should not be taken together
- One stop shop/"first call"/well publicized statewide
- Education of primary care providers and staff for early identification and treatment

Economic Issues
- Static funding while need for services grows

- Health care affordability on fixed incomes
- More flexibility with funds (OAA) - OAA funding - flexibility between OAA programs
- Finding funding for persons who are uninsured
- Rising medical costs, low Medicare payments to physicians; medical subsidies
- Funding to provide or subsidize cost of HCBS
- Lack of funds available to provide services
- Funding has not grown with population
- Instability of Medicare and Social Security
- Budget/resources
- Will the State be prepared at the appropriate time regarding budgets? (from a volunteer)
- Funding for in-home care
- Competition with other populations in need for funding
- Threats to federal/state funding for services
- Possibly money/resources
- Need waivers or expansions (funding)
- Rigidity of current funding streams
- Need funding to encourage innovation
- Affordability of services
- Money
- Funding, Funding, Funding, Funding
- Fiscal Pressures as the demand increases so funding decreases
- Lack of State funding
- Sufficient funding
- Financial assistance for heat, prescription drugs, basic needs
- Funding for in-home assistance services
- Senior Centers provide a variety of social, educational & health related activities, but they are very limited to what programs they can provide due to very little funding and inability to expand with the growing population.
- Affordable health care
- Limited resources
- Income stability/economic self-sufficiency
- Economic/employment needs
- Medicare/coverage
- Reliable medical benefits/medication
- Resources available for Baby Boomer
- Adequate Medicare coverage
- Not enough resources for the # of people in need
- Planning for growth of aging population
- Aging issues as a priority

Coordination, Collaboration & Partnerships

- Effectively engaging faith communities in helping support of older adults and those with disabilities
- Partnering with stakeholders to fill gaps in service

- Coordination of services across departments/funding sources
- Centralized networking system (Tennessee)
- Coordination among key sectors – i.e., health, AoA programs, mental health, substance abuse
- Lack of coordination between State departments and private sector
- Better coordination of community resource information and referral to specific services is needed between disability, mental health, and aging agencies.
- Removing "silos" to maximize efficiency – resources/service delivery
- State giving State agencies the support necessary to do work (not shrinking workspace)
- Lack of leadership
- No comprehensive aging plan in TN
- Care coordination
- Will all agencies connected with State be prepared? (from a volunteer)
- Are agencies, volunteers, and the State planning now? (from a volunteer)
- Infrastructure needs to be in place in order for 21st century solutions be addressed

Support Services:

Transportation

- Public transportation for seniors
- Lack of public transportation for senior
- Transportation that meets the (needs?)
- Transportation especially in rural area
- Transportation/access to services must be available
- Transportation that is senior-friendly and disability-friendly while also being affordable
- Funding for rural transportation

Meals

- Congregate meals have a cap and the program is having to turn people away who really need a meal
- Meals program

Caregiver

- Caregiver Support
- Support services for caregivers
- (Alzheimer's) caregiver stress
- Workforce/caregiver development training - needs to be exercised
- Lack of natural support system

Nutrition

- Meals
- Food
- Nutrition (especially in Memphis)
- Hunger – home delivered meals/congregate meals

Housing

- Affordable housing
- Housing options
- Aging in place

Advocacy
- Legislative advocacy
- True advocacy for seniors
- External advocacy services

Other
- Pattern of doing same old same old

Impact of Baby Boomers

For the Needs Assessment, it was important to get input from the stakeholders as to the impact of the baby boomers on their programs and services to the aging and disability population. Baby boomers are defined as individuals who were born between 1947 and 1964. Currently, an estimated 75 million individuals are identified as baby boomers with an estimated 10,000 individual reaching the age of 65 every day. In Tennessee, the 65 & over population represents 13% of Tennessee's population (2010 Census). In the next 15 years, an additional 1,245,064 individuals or 20% of Tennessee's current population will reach the age of 65, representing a 65% increase.

The results of Question #2 have been divided into major categories concerning the challenges facing Tennessee as the baby boomers age. The categories are Awareness/Access to Information and Resources/Technology; Healthcare; Economic Issues; Housing; Need for Continued Employment and/or Postponing Retirement; Maintaining Health and Self-Sufficiency; Caregiving and Family Dynamics; Transportation; Meals; Expectations of Baby Boomers; Elder Care; and Other. The comments provided by the attendees are included in each category. Repetitive statements, such as "healthcare" or "funding", are included only once in this report.

The growing "baby boomer" population appears to have different wants and needs than the current aging population being served. Overall, what are the four (4) most pressing challenges facing the State of Tennessee in providing services to this "baby boomer" population?

Awareness/Access to Information and Resources/Technology
- Communicating relevant programs in aging – many seniors do not know about the services that are available to them or how you get these services
- Knowledge – starting early on – relating to navigating system/Social Security/Medicare
- Address those without internet access
- Systematic way to communicate services available for baby boomers and their parents
- Make the public aware thru media – internet, etc. of these responses so the children of the aged are more aware of resources and information
- Technology
- Digital (web) resource banks/ Info
- Boomers utilize computers more – need to have everything web base
- Become more web-based for a "computer-savvy generation
- Navigating a complicated system

- Education on what services are available in order to make informed choices
- Technology/innovative skills
- Information via website and mobile app
- Comprehensive Resource Database
- Where to find information about services – no wrong door approach
- One stop shop – first place to call
- Health literacy
- Developing more social media sites to help them access services

Healthcare

- The obesity epidemic and associated chronic illness
- Resources that are available when I need them
- Programs that have as proven outcome (best practices)
- Personal assistant/in-home assistance
- Find out what services they want and how they want them delivered
- Provide ways for boomers to participate in the delivery of services
- Use volunteers more
- Affordable home and community based services for aging in place
- Access to healthcare
- Demands for clinical services – locals services related to memory lost and dementia are going to exceed capacity
- In-home care availability
- Waiting lists and CAPS on most services – no APS $
- LTC – long term care, nursing home and skilled care – not enough preparation being taken now for when we are older
- Additional health care providers and caregivers are needed
- Control over healthcare
- Change in marketing strategy (do not call them "seniors" or "older adults")
- Need assistance but may miss eligibility criteria
- Educating service providers of changing needs
- Lack of mental health service
- Enjoyment in all areas of their care
- Build their own plan of care
- Finding what their needs and wants are – such as new programs
- HIV, AIDS, and LGBT issues in long term care
- Lack of knowledge of their needs/wants
- Substance abuse issues (carried over from the 1960's)
- Affordable health care
- Alzheimer's
- Chronic illnesses – diabetes, high blood pressure, etc.
- Mental health support/suicide prevention
- Increasing prevalence of Alzheimer's disease with aging "baby boomers"
- Planning for themselves (LTC) and how best to plan for and access services for an older family member

- Baby boomers will need more self-directed programs
- Home Health Care

Economic Issues
- Funding
- Income stability/economic self-sufficiency
- Serving more people with existing dollars
- Need a statewide system for regulated pay private services
- No emergency services – housing, financial assistance
- Put needs in budget far in advance
- Working with agencies and volunteers on budget items
- Demand/Need
- Financial Issues – do I have enough to retire?
- The # of people that fall into this category in Tennessee is huge.
- Finding insurance coverage
- Funding to transform senior centers into "booming" centers
- Financial instability during retirement years due to social security's insecurity
- Have some resources, but state may not have the infrastructure of services
- Money
- Funding to provide new programs
- $
- We need incentives to encourage more geriatric case managements and geriatric professionals
- Boomers have longer life expectancies and limited resources
- Impact of Obamacare
- # in population
- Health Insurance coverage
- Medical resources/benefits
- Lack of affordable health care insurance
- Handling the growth of aging population with services without an increase in funding

Housing (living arrangements and facilities)
- Affordable assisted living
- Housing
- Aging in Place
- Access to affordable housing and housing that meets ADA
- Living arrangements
- Independent living
- Desire to age in place
- Residences that are not existing/assisted living center
- Changing legislation to accommodate changing residential settings that don't look like traditional assisted living or SNF

Need for Continued Employment and/or Postponing Retirement

- Employment
- Volunteer and/or employment
- Employment opportunities/training opportunities
- Still working, decreases volunteers
- Currently, a large percentage is still employed so we will encounter bigger challenges in years to come. Due to so many still being employed, it increase challenges of recruiting volunteers
- Having to work longer to be able to retire
- Workforce opportunities
- This group will work longer by necessity
- Need for income beyond SS benefits – employment
- Lots of boomers still work and need flexibility
- Lack of employment or forced into early retirement without adequate financial planning
- Enough money to retire
- Many are still having to work

Maintaining Health and Self-Sufficiency

- Opportunities for productive aging
- More active – difficult to reach
- Transforming senior center
- They not only wasn't to remain at home, they want to remain active. They want and need preventative services and activities to stay as active as they want as long as they can
- Healthy aging
- Desire to be active physically and intellectually – meeting needs through programming
- Health reliability
- Redesigning to suit different lifestyles, i.e. they don't want to eat a congregate meal then head home
- Emphasis on healthy aging and need to promote fitness. Drawn by resort style amenities
- Exercise programs for prevention
- Developing programs at local focus points that will draw baby boomers and keep them active

Caregiving and Family Dynamics

- Caregiving responsibilities
- Care/service coordination
- Caregiver support services
- Trustworthy assistance for those with no children
- Caregiving issues
- Raising children or grandchildren later in life
- Maybe caring for parents and grandchildren
- Less enjoyment from their adult children – children live long assistance from their parents
- Respite/in-home services for caregivers

- Capitalize on the group’s talents – understanding the parameters around which we can tap them to help support older adults in need
- Being caretakers of “old Old parents” and opening their homes to adult kids
- Support services for their caregivers
- Adult daycare/senior center/programs
- Boomers are sandwiched as caregivers to young and older relatives

Transportation

- Transportation service low or no cost
- Improved public transportation
- Public transportation for seniors
- Provision of an effective and consumer friendly transportation system
- Rural and urban transportation
- Mobility options
- Simplify and streamline transportation support and service

Meals

- Lack of nutrition resources (both food and education)
- Revamp service delivery – congregate meals probably won’t work for booms

Expectations of Baby Boomers

- They want choices, options which are often unavailable
- They want to be heard, honor their preferences when possible which often not the case
- They tend to be more interested in health care, wellness or prevention – not enough resources spent on preventative health care
- Changing the name (aging) – the brand name needs to change
- Boomers want quick efficient service
- Boomers typically have researched what service they want and know the details of the services needed
- Expectation of more services than previous generations
- They don’t identify themselves as “old folks”

Elder Care

- No identified agencies to protect seniors from scams/frauds
- Lack of neutral advocacy services
- Planning for aging (advance directives)

Other:

- I don’t know enough about the validity of the statement (”The growing “baby boomer” population . . . .) to give an answer
- Changing direction from the old way
- Making sure there are open communications at all levels and all parties involve
- Innovation

What Works

The purpose of this question was to begin to identify some positive, proven practices that could be replicated and/or improved to address the issues and concerns of adults age 60 and over and adults with disabilities. Stakeholders are in an excellent position to provide this important data in order to build a better system of healthcare services and programs in Tennessee. This is especially important as the baby boomers age and require programs and services to meet the changing expectations and needs of this population.

The responses to this question are categorized by what is currently working; the focus areas identified by attendees that are categorized into programs and services; staff training; coordination, collaboration, and partnerships; information, education, and resources; support services; and funding, and ideas that would help move Tennessee forward. Repetitive responses, such as “transportation” or “funding”, are included only once in this report.

What works?
From your area of expertise, what are the best practices, programs, or services on which the State should focus?
What would help Tennessee move forward to better serve our elders and people with disabilities?

What works

- The State has a great delivery system for services in place, but the available services are full.
- SHIP is an excellent, much needed service for seniors
- Healthcare Mission orientation of Saint Thomas Health
- Palliative and end of live care by Alive Hospice (community based)
- Meals i.e. with Senior Citizens, Inc.
- Returning calls within 48 hours
- Working with related agencies and volunteers
- Encouragement of volunteerism by seniors and with seniors
- Focal points in the community
- Options, HCBS, & SHIP
- Communication
- Best practices – building on existing resources – don’t reinvent the wheel – i.e. Pathfinder – partner with it and build on it
- Emergency Assistance Program in our district provides a unique way to meet health and/or safety needs of an elderly or disabled adult that would not otherwise be provided due to lack of funding or a program directive.

Focus Areas

Programs and Services

- Guardianship services are needed for those with disabilities under the age of 60 years.
- SIVAP – food stamp program – needs adjusting to provide more benefits to seniors
- More services available to people under 60 who have disabilities

- There are more and more people under 60 who need help, but the options program is very limited in their funds
- HCBS for those not sick enough or poor enough to need CHOICES
- In-home assessment regarding needs
- SHIP and SMP are two programs that will continue to be the first “go to” programs for health care benefits and fraud/abuse information and assistance
- Continue to expand SHIP area
- Care management
- One-stop shop for services
- States should focus on home and community based services and further development of a single point of entry
- Seniors Centers have a great bricks and mortar presence, but need to be redesigned for greater appeal to ages 60+
- AAADs are pivotal to community services
- Emphasis on prevention of unhealthy behaviors
- Self directed service models
- One stop shop/First call!/single toll free #
- Public guardianship services for under 60
- Medical outreach (SHIP & SMP) *with boomers this becomes more detailed and involved, more choices
- Public Guardianship services for those under 60
- State should focus more on programs that are meeting the family from a holistic approach (housing, transportation, food, relative caregiver, respite care, etc.)
- Support programs for those with Alzheimer’s disease and memory loss
- More services to support driving evaluations for seniors
- Continuum of care
- Health promotion and healthy aging programs
- Inter-generational programs
- Aging in place options
- Have smaller focus areas to target specific issues in a community
- Better quality home and community based services that meet the needs of current old adults and boomers
- Peer counseling programs at senior centers to provide opportunity for seniors to share stressors
- Aging specific substance abuse programs – CBT, MI
- Depression treatment – psychosocial interventions as well as pharmacological. CBT, Interpersonal Psychotherapy
- Self direction (consumer direction)
- Adult Day Care programs/activities
- Integration with people of varying needs
- Programs that reflect activities participated in during other phases of adult life (not children’s programs)
- Single Point of Entry and Return

Staff Training

- Adequately trained/educated service providers
- Cross training of all staff at all levels of A&D network to ensure quality, uniform customer service
- Elevate volunteer programs to professional status, treat them like every other program – dedicated staff, standards, competency expectations, etc.
- Fortifying and educating lay and professional caregivers
- Trainings for workers – i.e. cooking, transferring, mental health, etc.
- Educational programs to train professionals re: agency services and resources – physicians, social workers, etc.

Coordination, Collaboration and Partnerships

- Program coordination/access
- Coordination under a Department of Aging
- Having a centralized network of services available statewide and local for senior and baby boomers
- Improved care coordination
- Partnerships with other government depts./non-profits/for-profits
- Identify neighborhood leaders
- Creative partnership to share funding burden for increasing needs
- Having like providers meet to share issues and concerns (i.e. senior center directors meet with each other regularly)
- Continue State being more focused and involved with agencies and volunteers
- Improved coordination of transit and home care providers

Information, Education and Resources

- Regarding adults with disabilities, under 60 years of age, work more collaboratively with Vanderbilt Kennedy Center for disability specific information and agency resources
- With Health Care Reform, individuals will seek knowledge . . . need resources
- Utilization of senior centers for providing information/education/outreach
- Health literacy
- Large scale public service announcement campaign for memory loss, screening and education about symptoms (i.e., memory loss is not normal)
- Additional resources to assist elders and people with disabilities in navigating the ever increasing complexities of our long-term care health system
- More information, easier flowing website - *consider creating a "meta" website of services by AAAD regions and then create collaborations – don't have duplication of services
- Navigating systems: "How to . . . ." manual
- Comprehensive Resource list statewide
- Better mental health resources & trainings
- Information on services available – needs to be local and up-to-date

Support Services

- Transportation vouchers/volunteer based transit

- More accessible transportation services
- Prepare better meals more in line with baby boomers wants such as salads, etc.
- Provide more transportation and make easier access
- Transportation
- Nutrition/food
- Residential based housing alternatives
- Residential setting
- Better more reliable transportation services
- Providing more resources for nutrition so more seniors can receive meals
- Caregiver support services (senior daycare services, etc.)
- One on one consultations about care giving techniques and how to delay/prevent institutionalization

Funding

- Moving forward, the State needs to develop a private pay system for those able to pay for services.
- Be sure to budget supports needs
- Senior Center Funding for best practices
- Helping seniors meet medical costs so they can receive medical care and medications
- Improved access and funding to care
- But, it's going to take some type of funding stream to be able to move forward in addressing issues of a growing population

What would help Tennessee move forward to better serve our elders and people with disabilities?

- TN should develop a statewide Policy on Aging services for the next 10 years.
- Provide examples from other areas of good programs for transportation, healthy aging, etc.
- Re-evaluate old solutions
- Agencies need to be more pro-active, more visual, more hands on. We need to identify people in need and know who to connect them to for assistance. Agencies need to network more and have contacts so when calls come in we know where to send the caller.
- An inclusive system that provides a wide array of services for those in poverty and those who can pay. This a regulated coordinated approach – everyone can request an assessment and can choose from a variety of services and receive them either free, reduced rate (gov't. subsidies) and for private pay.
- What should elderly be concern regarding global warming

Needs Assessment
Stakeholders Meeting
Comments from Attendees
January 23, 2013

Resources available to develop the Needs Assessment and State Plan

1. Use local information and information from Information and Assistance
2. Use Kennedy Resource Center data that's already been compiled (and other agencies' needs assessment data)
3. 211 may have needs assessment information
4. Blended experience is important—we want to hear from our constituents
5. Get in with mainstream media, public hearing
6. Identify segments of the community that don't get touched
7. Tell them what you are going to do with the information they give you
8. What about Walgreens and Walmart as locations for gathering information? Kroger has senior discount day every Wednesday.
9. Non-profit hospitals are doing a mandated needs assessment. Perhaps get that data. Tennessee Hospital Association may be helpful.
10. "Community Café" style meetings seem to work (round tables, neighborhoods, in the evening, provide meal, provide transportation, location is important, get someone in the community to be your champion/team leader, get interns to make calls)
11. Use United Way needs assessment data
12. The people (attendees) need to get something out of it (health screening, information)
13. Get non-traditional people involved (not in our network) like police, firemen
14. Get seniors in churches involved; put it in bulletins, in Electric Company bills
15. Ask researchers in Tennessee like at the universities such as Vanderbilt, University of Tennessee-Knoxville, Tennessee State University, Middle Tennessee State University, and

other pubic higher education institutions

16. Time of day is a challenge. Mid-afternoon meeting may be hard for those who work. Think beyond to the “sandwich generation.”
17. What about Facebook and Twitter?
18. Ask special interest groups to only bring 1-3 designated members of their constituency so that the results don’t get skewed
19. Let them know the “quality” of the people listening to their concerns
20. Provide food and door prizes or gift packets, gift cards
21. Ask key employers to allow their Human Resource Manager or other employees to take off work to attend and provide feedback from the retiree or family caregiver perspective
22. Let participants know that they are helping to craft the State Plan on Aging
23. Let participants know that decision makers will be in attendance – invite local and state elected officials to be there
24. What about virtual participation?
25. What about being able to watch the proceedings? Teleconference? Give input? Document it?
26. What about an Aging Cabinet?
27. Grassroots connections seem to be working, but there is less connection among the state offices and between the state offices and the grassroots

Verbal feedback on regional meeting survey:

- Add Alzheimer’s Disease/memory loss
- Add disability issues
- Make sure terms are clear (like access, medical training)
- Make the language plain
- Add employment for older adults or adults with disabilities
- Break into 2 half hour sessions so that participants can experience 2 different topics

- Let participants know that they will be moving around
- Write down what participants say
- Make it clear in the introduction that you want a broad range of ideas
- If you split into groups, make sure that the participants go to two different groups/topics
- Ask them to share opinion, then make sure they get feedback—thank you or a copy of what they said

Written feedback on regional meeting survey:

- Add senior/adult with disability employment support (to supplement social security income)
- Add budgeting help—ongoing support to best manage money
- Add screening for LIS, MSP, Medicaid, SSI, LIHEAP, telephone bill, SNAP
- Use term “older adult” rather than elderly
- Separate mental health and health.
- Mental health should include Alzheimer’s Disease, Depression, alcohol misuse, prescription drug misuse, severe mental illness
- Define terms/give examples
- Be careful/sensitive with language
- Suggest looking at health literacy information—commonly used terms
- Circled many terms that should have easier to understand language: chronic disease; geriatric; first responders; Medicare/Medicaid—what’s the difference; elderly; elder rights; respite; accessible; social engagement; congregate; livable and senior-friendly communities; walkable communities; non-driver; guardianship; universally designed housing; home and community based services; self-directed care; user-friendly
- Make the font bigger

Needs Assessment

Commission Meeting
Tennessee Commission on Aging and Disability
Doubletree Hotel, Downtown
Nashville, TN
February 5, 2013

Number of Commission Members Present: 15

Tennessee Commission on Aging and Disability
Quarterly Commission Meeting
February 5, 2013

At the quarterly meeting, Commission members were asked for their input or reaction to the Needs Assessment being done for the 4-year State Plan on Aging as required by the Administration on Aging (AoA). The AoA Program Instruction was distributed and reviewed. The State Plan must address the AoA core programs, discretionary grant initiatives, and document input from stakeholders and citizens. The Needs Assessment will be conducted in conjunction with the Regional Listening Tours to be held in February-March. Commission members provided feedback and competed the surveys to be used for the Listening Tour meetings.

Comments from Commission members included the following:

Communication:
- Contact Chamber of Commerce and get list of non-profits (and faith based) and businesses in aging community
- Special dates – make it "newsworthy"
- More than one date
- Senior watch the news
- Personally target people who need to be there
- E-mail, Facebook, Twitter – more and more seniors are on internet
- Tell them what you are going to ask ahead of time (preparation time)

How do we get them to come?
- Using technology to get information – not everyone needs to come
- Use survey wording – get away from term "needs assessment"
- 1-3:30 bad time of day for those who are working; 6-8 in some of the larger cities too
- Door prizes?
- What about locations? – left to the AAADs to find good, accessible location
- Go where people are
- Wellness complex – attract seniors – probably willing to sponsor

Jim Shulman discussed Process of Meeting:
- Is it better for moderators to move or people to move?
- Be specific on the questions – do concerns and solutions – Baby Boomers have solutions
- Are you going to have big note cards? If there is an opportunity to write, then they might take advantage of it.
- However you choose to circle back, it's important for you to let them know that they were heard and there will be follow-up.

Commission members present completed the three (3) surveys that were distributed at the Stakeholders Meeting on January 23, 2013. Each question is identified and the Commission

members' responses to each question are listed. The responses have been grouped under each survey question.

Overall, what are the four (4) most pressing challenges facing the State of Tennessee in order to provide aging and disability services.

- Actions to reduce obesity across all ages – to reduce diabetes, blood pressure issues and health costs
- Promote "visiting nurse" type programs and use of clinics
- Long waiting lists for various seniors
- Options program
- Providing adequate healthcare-higher risk of chronic health conditions
- Legislation surrounding long term care
- Expanding and improving the services to include unmet needs for veterans, healthcare (Alzheimer's), caregivers
- Having choice – an array of services for varied needs and lifestyles
- Need a comprehensive network for information
- Lack of knowledge of what already exists
- Awareness by families/individuals of all services/issues (not just those with financial need)
- Deeper and broader community awareness
- Providing better information of available services to families in crisis, hospitals, religious organizations, etc.
- A more educated and informed General Assembly
- No one seems to have a knowledge of all the available resources; free, for private pay or sliding scale
- Outreach – getting the word out
- Economy – limited resources to meet demands across the spectrum
- Funding opportunities/need to be increase and expanded
- Lack of allocation of funding for seniors for individuals with other developmental disabilities
- State funding for the "extra loads" on programs & services
- Successfully obtaining non-government to supplement government funding
- Selling the idea that aging and disabled persons should pay (if they can) for their services. Even partial payment (sliding scale) would enhance quality without additional paid staff.
- Need a state-level commission or what other organizations are doing to provide services for 50+
- Need to identify gaps and move collectively to fill them
- Shared vision and commitment
- Combined resources of ALL involved
- Fragmented Medicare/Medicaid delivery system and lack of coordination across benefits
- Caregiving (that allows aging in place) information
- Lack of community-based residential alternatives for people who cannot live alone
- Expand options or other support to promote community living (reduce institutionalization)
- Needed housing (different levels of care)
- Rebalancing initiatives that promote community living
- Community outreach for education and alternative funding - corporation – grants - churches

- Community outreach for partnering and volunteers
- Finding ways to enlist the aging and disabled community to be a part of the solution

Impact of Baby Boomers: The growing "baby boomer" population appears to have different wants and needs than the current aging population being served. Overall, what are the four (4) most pressing challenges facing the State of Tennessee in providing services to this "baby boomer" population?

- Communication their way!
- Information that is reliable and easy to access
- Keeping up with technology
- A strong network of information on what is currently available
- Community awareness of services
- Long waiting list
- Support aging services and providers
- LTC Assistance In-home and ACLF (how to fund so more affordable)
- The Sheer numbers!
- Adequate Medicare coverage/health insurance to meet LTC needs and maintenance of chronic diseases
- Broader options for all economic levels - $0 to full pay
- Expansion of services
- Funding for "quality" services
- Medical services
- Making certain that private companies fully fund retirement plans (define benefits) or provide some matching funds to motivate defined contribution plans
- Development of a variety of housing options to meet needs of vulnerable individuals with multiple issues
- More innovative long-term living options (new designs/ community)
- More focus on community design for future
- Ageless communities
- Long term care facilities
- Jobs
- Prolonging time before employment
- Belonging (participate/staying active)
- How to channel the energy of healthy "baby boomers" seniors to the joy of helping others.
- Caregiving challenges
- Knowledge of and support for caregiving
- Hunger
- Hunger – growing need not only for prepared food
- Resistance to label of "aging"
- Legal support/advanced directives/wills
- Integrated services (not management of individual pieces but combine services – food, household, transportation, shopping
- Promote educational development (at all levels) to assure adequate labor force participation

What works?

- Home meal delivery
- Transportation
- Health insurance (SHIP)
- Integrated care delivery systems especially for dual eligibles
- Sliding scale fee for service enables service providers to provide more services with limited funds. Consumers value what they pay for – don't try to have more services than they need
- From my personal observations – I believe that the Options program works. I am a big advocate of elderly and disabled individuals living within their homes for as long as possible!!
- Case Management – Re: hunger – innovative food pantries

From your area of expertise, what are the best practices, programs, or services on which the State should focus?
What would help Tennessee move forward to better serve our elders and people with disabilities?

- Focus on existing programs – transportation (rural areas), housing, hunger
- Telemedicine
- More outreach program
- Need expanded waivers
- Innovative partnerships for community gardens (hunger)
- Coordination of efforts and information
- Mobile Food Banks/commodity sharing
- Caregiving support – Ombudsman Program
- Additional transportation (public/rural)
- Housing
- Mobility options
- Hunger
- Ageless communities
- Nutrition – across all ages to reduce chronic illnesses (diabetes, blood pressure, etc.)
- Structured housing settings/funding for such programs
- Grant – sharing/collaborations
- Reward/assist programs which seek funding from foundations, corporations, United Way, local governments, etc.
- General funding to develop needed new programs
- Stronger funded caregiver programs
- I hate to say it – but more money – not likely
- Need a state level working group to address current programs and needs and/of plan for moving forward

Needs Assessment

First Tennessee Area Agency on Aging and Disability
Memorial Park Community Center Senior Center, Johnson City
March 6, 2013

First Tennessee AAAD
Memorial Park Community Center Senior Center, Johnson City, TN
March 6, 2013

What are the hard things that "baby boomers" face? How should the state of TN help?
(Number of Questionnaires containing 1 or more responses - 51)

This open-ended questionnaire was designed to elicit qualitative data from the attendees about how they thought aging would impact baby boomers. However, many attendees also identified issues that currently exist. Attendees were able to respond to the questions in any manner that included short, one-word answers, such as transportation, to very involved responses. In order to provide some order to the responses, major topic areas have been identified. In addition, some topics might include sub-topics for the purpose of reading the report more easily. Repetitive responses are included only once.

1. **Easier Access to Services Without Hassle** (including information and assistance; communication; and technology)
   - Aging education
   - Technology – education, education, education
   - Access to information on "Aging with Choices" that is easy to understand and navigate
   - Not knowing what all is available for them and how to find out
   - More available information for meals, transportation, doctor appointments
   - Getting information and assistance on services that can keep them safe and secure at home
   - Community meetings that can openly inform individuals of providers as well as benefits that may help them as they are needed

2. **Healthcare** (including in-home services; Home and Community Based Services; long term care; chronic disease; Alzheimer's disease and related dementia)
   - Lack of affordable, accessible alternative healthcare
   - Since coming to TN 3½ years ago – no one has been coming to my door offering the HELP – everyone has been looking for something: a donation, use my phone, sign up for something. Need door-to-door asking if they can HELP seniors
   - More doctors that will visit home bound patients
   - Finding assistance when different family members live out of the area (state)
   - Identify quality and recognized service providers
   - Better services for seniors – should not have to choose between food and treatment
   - Less family to help them
   - Medical knowledge
   - Shortage of any present programs
   - Help with meds, more discounts for lower income people taking multiple meds
   - Monthly set up of medications. There are no options once home health leaves
   - Qualifying for state benefits and learning various Options that they may have
   - Less of functioning ability – lack of mobility

- Receiving help at home
- In home care vs. nursing home, being able to stay home longer with in home care – homemaker services
- Education > home care
- Long-term care facilities; medical and dental care
- Health care, dental, vision, hearing
- Dealing with chronic illness or other health related issue
- Dementia – Alzheimer's – help caregiver with funding to keep in home
- Isolation from their very/very busy children/grandchildren

3. **Fiscal Concerns** (including health insurance; Medicare/Medicaid; employment; retirement; social security; cost of living)
   - Affordable healthcare/insurance
   - Health insurance access before Medicare eligibility
   - Affordable health insurance exchange
   - Medicare – will it be there?? – more out of pocket
   - Prescription coverage that is affordable and accessible
   - Medicare cuts – higher costs
   - Cash prices for doctor services are the most expensive way to pay. Allow payers who can't afford insurance to pay Medicare reimbursement rates for services
   - Good insurance too costly
   - Limited resources to stay healthy and well – doesn't cover all needed items (hearing aids), expensive medications
   - Unfair employment; little/no retirement
   - Employment opportunities
   - Working longer – help with training for jobs after retirement
   - Not enough work
   - Help get jobs for the elderly that still want to work
   - Social security becoming insolvent
   - Rising costs of living – groceries, home and care insurance
   - Securing money for retirement
   - Retiring as they originally planned
   - Folks having to put off retirement due to insurance/financial reasons
   - Part-time employment in retirement
   - Give help on retirement and how to apply – which insurance best suits retiree

4. **Support Services** (including transportation, meals/nutrition; elder abuse services; senior centers)

   a. **Transportation**
      - Transportation to and from doctor's appointments and etc., especially as driving abilities decline
      - Transportation issues – need more public transportation options for seniors who need service to and from home/living facility to and from doctor's offices, etc.

- Transportation for elderly parents to doctor appointments and other necessities
- Transportation – better bus service without having to pay – this is hard for seniors on a limited income to do
- Provide more bus routes in community
- Transportation issues – no able to drive – to/for shopping and doctor appointment - learning how to transport, and various provisions that are in place for needy individuals
- Government resources have waiting lists

b. Meals/Nutrition

- Meals and nutritional guidance for elderly parents (also spouses)

c. Elder Abuse

d. Senior Center

- Having senior centers to go to if you do not have family – friendships are built in senior centers
- Support senior centers and activities
- Have more senior facilities in rural area

5. Staying Healthy While Aging (including exercise, eating healthy foods, socialization, chronic disease, staying connected and involved in the community, volunteer opportunities)

- Fun things to do in the general public
- Maintaining/extending quality of life through various activities in the community
- Living longer – help with health education & preventative lifestyles
- Socialization, more Adult Day Care – senior organizations, for which they can socialize for their well being
- Physical activities that promote good mental and physical health
- Programs that are geared to fitness and maintaining health, balance, sound mind
- Access to social services

6. Adults with Disabilities

- Disability housing
- Transportation for disabled

7. Caregiving

- Caregiving for elder parents and children
- Elder care – transitions from caring for older parents to caring for self
- Caring for elderly parents while trying to work and maintain a household
- Caring for their parents and themselves – financial difficulty
- Caregivers that live out of state
- Good training for their caregivers

8. Housing, Neighborhoods, and Safe Communities (including home repairs and utilities)

- Being a part of a community when they are often isolated or shut-in due to physical conditions
- Senior housing – more senior living spaces
- Affordable housing
- Maintaining a sense of independence in their homes

9. Funding/Resources

10. Other:

- Holding onto our traditional values and habits in face of ID theft, rudeness, narcissism by younger generations
- More municipal support for senior services (Johnson City)
- Assist elderly in renewing driver's license on line to they can avoid the long wait and hassle of the DMV office
- Assist elderly in paying property taxes (same reason as above)
- No facilities for meeting with friends

First Tennessee Area Agency on Aging and Disability
Memorial Park Community Center Senior Center, Johnson City, TN
March 6, 2013

Question: **Here are seven (7) aging and disability issues.**
Under each, there is a list.
Mark the ones on the list that you think are most important.

Number of Questionnaires completed: 66

Response	# of responses	%
1. Getting care at home instead of in a nursing home	49	74.2
2. Meeting people and making new friends	47	71.2
3. Keeping healthy through exercise and eating healthy foods 4. Not having enough insurance or money to pay for doctors or medicine 5. Transportation for people who don't drive cars	46	69.7
6. Respite services	45	68.2
7. Affordable dental care, hearing care and eye exams and glasses 8. Being able to get help when needed quickly and without hassle 9. Being able to get accessible transportation	44	66.7
10. Housing that people on a pension or Social Security can pay for	42	63.6
11. Learning about how to take care of yourself so that you don't get sick and tired	39	59.1
12. Training for aid workers who help older adults and people with disabilities	38	57.6
13. Knowing where to call for help and getting help without a big runaround	37	56.1
14. Learning about how to care for someone at home	35	53.0
15. Learning how to live with a serious condition like heart disease, cancer, arthritis	34	51.5
16. Learning new things	33	50.0
17. Meals that are healthy and prevent hunger	31	47.0
18. Reasons people have to go into nursing homes 19. Protect people from abuse 20. Teaching doctors, nurses, and other healthcare workers to know the special needs of older adults and people with disabilities	30	45.5
21. Houses that are easy to get around in if you're on a walker or in a wheelchair	29	43.9
22. Neighborhoods that are easy and safe to walk in	28	42.4
23. Reasons people have to go back to the hospital 24. Help with memory loss 25. Teaching volunteers to work with older adults and people with disabilities	27	40.9

26. Teaching police, Firemen, emergency workers to know the special needs of older adults and people with disabilities	26	39.3
27. Understanding how Medicare works	24	36.4
28. Making decisions about health insurance, Medicare, and planning for the future without depending upon the government 29. Being able to choose the workers who come into your home	23	34.8
30. Learning how to prevent falls 31. Eating out with friends	21	31.8
32. Places to volunteer	19	28.8
33. Help with chores like lawn mowing and leaf raking	17	25.8
34. Help with feeling sad or lonely 35. Help with taking too much medicine	16	24.2
36. Neighborhoods that have grocery stores close by	15	22.7
37. Being able to get accurate information from a website and being able to apply for services on-line	14	21.2
38. Help with drinking too much alcohol or taking drugs	10	15.2

Other:

Free internet for low income seniors
Better ambulance service in rural areas
Improved medical access in rural areas
More doctors in rural counties/areas
Ambulance services in rural areas – faster response times – more stations or contracts to let services cross county line to pick up patients
Free internet for seniors (for low income seniors)
More ambulance services in rural areas
More physicians in rural counties
There are too many homebound needy people who are not eligible for current HBS, but they desperately need help!
Assisting elderly with making the best decisions on housing, insurance, etc.
Help for those that have no where to go or no one to care for them after being released from the hospital. There is a huge gap and those people need help.
Accessible food pantries
More involvement with government “pushing” issues with elderly concerns
Communal homes: like small care centers, i.e. 2 workers to 8 residents – these are all great - like a foster care, but the client stays in place and staff has 8-10 hour shifts
Provide pet care to people aging in place to frail or insufficient $ for pet care
public forums for information
Community endeavors to encourage participation
Make insurance companies actually consort with care providers on in home care before they make arbitrary changes

An easier path to getting employees in the home care industry put on the elder abuse list
Being able to apply for services via phone
People go into a nursing home due to lack of money
People go back into the hospital because doctors do not ask questions
Making it easier for seniors to sign up for programs that can provide services for them
I have some unusual health challenges like multiple chemical sensitivities celiac. Makes going to public places very difficult (perfume)
Meeting people that are not totally unavailable due to grandchild duties
Eating healthy foods especially in restaurants
Getting affordable care at home
Feeling sad and lonely, especially if family lives elsewhere
Need more small support groups for taking care of yourself
High grocery taxes – high gas taxes
Teaching self-management skills to seniors and caregivers
Understanding how seniors are going to be affected by Obama care
The above issues and lists are hard to find one or two important issues. All are good and all should be addressed masking it hard to accomplish much.

First Tennessee Area Agency on Aging and Disability
Memorial Park Community Center Senior Center, Johnson City, TN
March 6, 2013

Question: **What is currently working well in your community?**
(like agencies that help, neighbors who help each other, van service, senior center, meal sites, food pantry, healthcare clinic, nursing home, sidewalks, police presence, grocery stores that deliver)
(Number of Questionnaires containing 1 or more responses - 47)

This open-ended questionnaire was designed to allow attendees to identify the community programs and services that have worked for them and in their community. Evidence based and/or proven practices were not a consideration in the design of the questionnaire and no checklist was provided. The above items in parentheses were provided as examples. Attendees were asked to write in the programs and services that were working well in their community. The responses are individual and specific to the region served by the Area Agency on Aging and Disability. The number of attendees who indicated that the program is working well in the community is provided in parentheses ().

All of the above – need more community forums for soon to be seniors or caregivers of seniors
These are all very good services – we need more of them and need to have more in home visits and more watchful eyes
Agencies that help
Neighbors who help each other
• Van service (2) • Van service (to Wal-Mart) • KATS transportation (2) • Para transit • Transit • Bus service • Transportation • Net trans • Transport from FTHRA
Senior Center (10) • Wellness, provide activities of interest to seniors • Johnson City Senior Center • As Director of a Senior Center, our goal is to reach out to the aging population with services and activities of interest to seniors. We have grown so much in the past year with membership because of baby boomers and word of mouth about out programming. A new center is in our future within the year allowing for more opportunities.

Meal sites (3) • Salvation Army (meal sites) • Need more Meals on wheels (7) • Regional meals on wheels – calls come in almost daily for assistance – needs are growing • Meal assistance (delivery and preparations) • Schwann's home food delivery (but they are expensive)
Food pantry (4)
Healthcare clinic
Nursing home (2)
Sidewalks
Police presence (2) • Police involvement with SALT/SALT conference
• Grocery stores that deliver • Volunteer grocery delivery
Adult Protective Services
Assisted living
Aide and Assistance
First Tennessee Area Agency on Aging and Disability (FTAAAD) – handling all services of help in community (4)
Human Resource Center at the JC Mall sponsored by MHSA
Good Samaritan ministries
Downtown Clinic
Keystone Dental Clinic
Second Harvest (3)
Senior adult church meetings
Adult Day Care services
There is still a need for these service organizations to coordinate their services because there are people falling through the cracks that are hungry, hurting, etc. and with small children that are not being cared for appropriately
Church members who volunteer to go to peoples' homes and help
Active senior groups - advocacy
Great health care
Alzheimer's services
United Way
Community Gardens
Shepherd Center (drivers for doctors' appointments, medical equipment for loan)
A new website launched by Aging with Choices, Council of the United Way of Greater Kingsport
Senior Connectkpt.org – an easy-to-use portal that links seniors, their families/ caregivers, and concerned community members with information on local providers and resources

Unknown
Home health and hospice services
Education to seniors and their families about different services available
• First Tennessee Human Resource Agency (FTHRA) – the broad based agency that serves the community, always a standard for help and information (2) • The First Tennessee Human Resource Agency is offering a lot of assistance to the elderly and disabled in the community but there is always room for more help/funding
Clinics and volunteer agencies and program
In home care organizations that provide assistance with personal care, house keeping and errands. Services also provide companionship and foster meaningful relationships that will enhance quality of life.
Networking of agencies providing services in most cases
Jonesborough Public Safety/Jonesborough Senior Center
Gentiva
Amedysis
Volunteers
Community mental health
Home health hospice
Non-clinical in home care
Support groups that provide respite
Homemaker services
ETSU and church volunteers
Slater Center
Choices program
In home services
Kiwanis Towers of Kingsport
Contact ministries
Net-Vac
I think that the networks are in place, affordability is the issue.
Options other than nursing facilities are cheaper and would be, in most cases, more beneficial

First Tennessee Area Agency on Aging and Disability
Memorial Park Community Center Senior Center, Johnson City
March 6, 2013

Small Focus Group Responses

First Tennessee AAAD
Memorial Park Community Center Senior Center, Johnson City
March 6, 2013

Facilitator Notes for Small Focus Group 1

Keeping healthy for Baby Boomers
Not having enough insurance or money – being harassed by hospital – (Don't know how to get help) Programs and getting word out at senior centers
Knowing where to call for help – call senior center – and getting help without a big runaround - timely manner, get frustrated
Feeling sad or lonely not discussed or diagnosed
Volunteers
Staying busy keeps you young
Stepping out one door into another door
Protect people from abuse – seniors are afraid, embarrassed, or in denial
It's ok to ask for help
Parrish Nurse outreach can help you learn about taking care of someone at home
Education about available groups for learning to take care of yourself
Senior Connect – education and advertising on services
Net Trans is beneficial – in wheelchair hard to get anyone to take you
Will need more housing due to baby boomers
Feeling safe (drugs, theft)
Baby boomers better off than those in 80-90's now
Getting out – making new friends helps depression
Teaching and training for all who work with the elderly
Resistant doctors – not referring them to home health, hospice, etc.
Senior centers bringing services to them
Exercise – increased at centers

Facilitator Notes for Small Focus Group 2

Transportation: doctors, grocery store – NET Trans - evening transportation – social events
Maze of resources available – how confusing it can be to find the right resource
Confusion of consumers on how to use the resources that are available (schedule transportation, cancel van rides, etc.)
Handicap accessible/safe housing at affordable rates
Meeting basic needs first (food, shelter, etc.) then adding
Loneliness of elders/seniors – can lead to depression
Mental health issues that go untreated or unknown: cost of treatment, transportation to get there, patients don't want to be over medicated
Communication issues – no internet access or even cell phone services in many of our rural areas
Prescription drugs: costs even with insurance – food, medication, or shelter; people may not be aware of or have too much pride to ask for assistance that is available
Senior Employment training
Economic problems for seniors – if only income is Social Security – affording housing (rent,

upkeep on house if own house, etc.), utilities, insurance, etc.
Meals/Nutrition • Adequate, fresh locally grown food • Not just getting food to live on but that's healthy • Education on healthy food choices and having healthy options available • Deliveries from grocery stores – available in some metro areas but not our area
Maintaining house if own home • Lawn care – may be some church groups, but it's not well- known and people wouldn't • Know who to contact • Even if can afford it – finding someone who is reliable and honest and safe to trust
Safety – medications – being over-medicated and being able to follow instructions
Education for Doctors • What to look for – how seniors respond to meds • Only have one gerontologist in area that we're aware of • Recruit gerontologist and gerontology nurses for area • Women who take sleep aids 65% more likely to fall
Resistance of some seniors to participate in "Senior" activities or go to Senior Centers • Don't want to consider themselves old • Do education programs at places that reach beyond senior centers • Multi-generational community centers and events
Retirement homes – consumers who refuse to go into a nursing home, assisted living, etc., even those who need to be there for safety – who won't even address the issue – fears about going there to die, etc.
Caregiver issues • Not enough support for caregivers – not enough services to get them breaks and rest to care for themselves • The services that are available for caregivers often aren't aware that they are there or don't take advantage • Caregivers who live elsewhere and trying to get help for senior – where to go, what's available in the area, etc.
People who need help but don't know where to begin
Our area markets itself as a retirement destination/communities – as that population increases their families/support system is elsewhere and they are not aware of resources that are available and caregivers are dealing with issues from other states, etc.
Sitters or personal care companions who can be there all day – difficult to find trustworthy people and afford cost
More financial assistance as to in-home care
More adult day cares
Dental and vision care • Both of those affect the overall health and improve quality of life – if have poor dental care or poor teeth, can't eat healthy, etc. • Very limited resources in area for those services
Hearing – if you have poor hearing, it isolates seniors even if gets out/isn't homebound
Home safety • Unsafe homes – hoarders, burn trash close to home, other house hazards – electric,

heating - wood stoves, kerosene heaters, heating with cooking stoves • Large numbers of pets they can't care for • Limited resources not always used wisely – heating with cooking oven instead of other heating sources • Can't afford home repairs
Silver sneakers – good program
Hospital readmissions • No advocate from family for the discharge plan and make sure patient complies (meds, meals, therapy, etc.) • Need social support in hospital and on discharge • Patients being discharged too early
APS - being pushed to close cases earlier • Goes back to money pressures • Self-neglect – ss that most often in their APS cases that they provide services to • No longer have capacity to care for themselves, take care of finances, cook well/ eat healthy etc.
Suicide or threat of suicide – seen an increase in clients threatening suicide
On-line services • Computer training, adding more services that people can find about online (baby boomers) • Some services have increases – have personal contact, but many service applications could be started online • Do see many clients who are functionally illiterate – filling out paperwork
Choosing caregiver • Compensating family members as caregivers – much too complicated under CHOICES • Choice between staying home with parent or working – other family members who can't/won't help • If do send in professional caregiver thru service sometime the senior has conflict with caregiver or (vise versa) really like him/her and becomes upset if worker has to change • Family dynamics can create problems with caregiving or adds complications to delivering services
Available services for developmentally disabled DIDDs there to provide services but waiting list for community services make services basically unavailable unless the person is in crisis - no real preventive services – family fights to keep person out of institution – depending on behaviors can be difficult to get professional caregivers in the home

Facilitator Notes for Small Focus Group 3

Other - Budget cuts – will make increase in seniors that are homeless – some can't even get out of wheelchair on their own
Staying Health While Aging – need affordable dental – old enough to retire – not old enough for Medicare – service not available to them or can't afford

Hearing problems – cause change in personality and many other problems – won't participate in activities – creates isolation
Possible solutions • ETSU cleaning and exams – dental/still need dentures, extractions, etc. • RAM – available but older adults may be intimated by that places offering glasses and hearing aids didn't have takers need to make people more aware of where services are dental was long waiting list for extractions • work with Senior Center or FTHRA to take van
Need to get info out to rural areas – some people don't go to Center - Think about what you can do for people where they are
Learning how to manage chronic health problems • causing rise in health care – cost if not controlled • Alzheimer's recognition needed • Barrier – not wanting to know • Solution: educate, educate, educate
Health and Wellness – government wants to cut down on money being spent but aren't offering services to supplement need Barrier: lack of funding for support services and medical skilled care – can't get into facilities • more funding needed for HCBS and supports • new PAE requirements are too difficult to get approval • need to look at requirements for LTC in TN • no money for prevention – role of MCO – goal NP to go into home and do assessment -identify needs – and get help – growing and a real plus • need to access care
Health and Wellness
Need to better get the word out on where to call for help such as AAAD
Tap in church – establish info and resources – offer classes – assessments
Understanding Medicare, especially as relates to VA
Being charged for Part B even if they don't need it
Not aware of SHIP or certified counselors
Getting care at home vs. nursing home

Other: • Would love to have NP office in every HUD facility in each area • Once they qualify for HUD – never get kicked out base on income (ex. large money was inherited) • Medication management – huge problem – increase due to hospitalization – changes in meds memory problems • Use emergency room care due to lack of transportation or not knowing if emergency vs. management or not • APS needs to be better able to take action – APS needs more funding

Caregiving – must take care of caregiver to take care of person
Need education – Alzheimer's, how to provide care (physically), and how to manage- how to manage equipment – offer counseling
*Offer more respite - *not much to offer – can't afford private pay
Need more in home respite – funding ADC and a place without a waiting list
Independence and getting services easily
Takes too much time to get help
Need real person to answer the phone – not an automated machine
Facebook and twitter needed for baby boomers and social networks caregivers
New site called Senior Connect.com
*Ask each provider to put a link on it
Like big red button to talk
Need agency that provides grocery shopping
Barrier - handling money – would grocery store set up account, including contact # of person brining them
Contact Jr. League, HS, ETSU for volunteers tapping into service hours
Housing, neighborhoods
Neighborhood watch – needed but can't get it worked out – suggest group walks, walking buddies
Transportation
Transportation – huge need – not always transporting people, but also bring things to people
Barrier – liability, cost of gas
Staying Connected
Volunteer ideas: • Dorcas group at church - collect materials – for baby blankets to foreign country • Watauga Square now hosts to volunteer group and resident take part
Working with Older Adults
Dementia training is offered to EMS, police, etc., but not mandatory – often they don't participate
Need to get word out
Need to offer specialty training for top medical conditions
Other
Relax HIPAA law with caregivers, social workers, etc. – can't share very important things with health workers because HIPAA prevents it – prevents proper care
Difficult to plan ahead but don't know what you will need – sort of like state planning but we need aging planning
What to expect as we age
Get long term care insurance before it's needed
Re-evaluate/redistribute funding from prison to LTC

Facilitator Notes for Small Focus Group 4

Rick – training for CHOICES – managers – client – dementia Incontinent – horrible – took two weeks VA morning 7 X week – evening Case managers do not consult with sitter service
TN – geriatric – 50's stroke patient – did not meet criteria for CHOICES – AOL
Kim – MSHA – their case management – providing Health Pro – case managers – no thorough enough so patients care going home ill-equipped and are returning to the hospital – cannot financially afford care – raising children/grandchildren
Ed Jeffries – increased calls from folks whom cannot afford basic living expenses – economics is playing a huge part in problems
Case Managers CHOICES – problems
Need Case Managers – Medicare – early onset dementia
Safety – denied twice
AAA ER Plan – emergency plan – T. Sutphin
Daughter – 27 hours – CHOICES cuts – Lobby – Obama Care
Case Managers – caseload – AAAD 1 hr. 1 week bath 3 hrs. Who will make the call – on schedule Marilyn Turner - Payment – Rick 60,000
Regular meetings
Kim – Fink – caseloads – client chooses
6 different providers
MCOs
Terrie – lack of medical management – not utilized
1 hot meal
APS – can no longer
Baker's act
CHOICES – case managers – caseload size ? Case managers change client's schedules without notifying providers
Need training across the board for case managers – someone needs to monitor case managers more as they do not always make the proper med. Needs
Increase in calls from folks not able to meet basic living expenses
Loss of payment to providers of home health when changed from waiver to CHOICES
CHOICES not meeting needs of clients when they are no

Facilitator Notes for Small Focus Group 5

Housing: lack of affordable homes for those that do not already own their own home
Healthy food: • cannot afford fresh or nutritious food – all frozen and processed – just fills their belly but does not provide "good" nutrition • not getting the food that they need – may cause many of the health problems – if the could

get the fresh fruit and grains they need – this may cut down on disease and medication use
Someone to check on them and provide socialization
Individuals are getting sent out of state so they can get help paying for assisted living and nursing homes. TN is not providing this to these individuals so they must leave the State. We are dependent upon other states for . . .
Respite hours being available for those families that need it
The cost of hospital care is outrageous and there is not regulation on what the hospital charges you. There are not choices for people and hospitals are not up-front
Help dealing with hospitals and insurance companies. Who will help them appeal if the insurance company doesn't cover a cost or "bargain" over the billed price
Safe and affordable housing: multiple floors + no steps + can they get out if there is a fire? How is their mobility?
How long they wait when they use the transportation that is available. They may spend hours just traveling to their destination or waiting to be picked up
They need "door to door" rather than "curb to curb" with transportation
Assisted transportation: if you are bed bound you have to use the ambulance to go to the doctor so many end up going to the emergency room to avoid a huge fee since Medicare does not cover that
More meals on wheels delivery
More volunteers recruited, church involvement to help more people – if more churches were involved then there would be more help available to the community. The State should collaborate with these churches to initiate programs – informal support systems
The FTAAAD is really good about spreading information.
The government pays everything for those individuals with kids, but they neglect the elderly.
Community gardens to give access to more fresh nutrition to the elderly. We could utilize high schools for 4-H programs to grow gardens to feed the elderly.
They have to choose between medications and food.
Advocacy for individuals who seek help. No where to look for help and not give up.
Problems getting approved for CHOICES – people who need help are not getting it. They are scared of appealing and it is a hard process in an already difficulty time. Scared of the money that could be owed in the end.
Not enough funding for all the people and problems
Knowing where to go if you can't get help getting the medication prescribed if insurance won't pay. Who will help appeal?
More cohesive system for tracking what medications an individual is on so there are no drug interactions

Facilitator Notes for Small Focus Group 6

Activities for seniors in afternoons
Workshops/information for children of older persons that are in the evening, due to them working during the day
More residential housing for seniors
Residential hospice centers in this area
Help with being placed in the community after leaving a nursing home/retirement center/assisted living center

Better training of works caring for the elderly in the hospital
More help for grandparents caring for their grandchildren
Immediate access to what is available when help I needed. Where to go?
How to get the word out about services that are available to reach the most people.
Healthy eating – senior centers not serving unhealthy foods (cookies, etc.)
Limited resources for Baby Boomers due to financial instability
Not able to pay for needed medications
Older persons understanding what to do when being discharged from the hospital (new medications, --?-- with PCP)
More knowledge of home health on part of doctors and other healthcare providers – home health and resource
Resource in community to train people on how to care for an older person
Local agencies getting together to discuss resources that are available in the area
Medicare waste/too many not needed tests
More accessibility for services
Educating individuals on how to plan for the future
Less dependency on family for assistance
More training on how to deal with individuals with mental health issues
More awareness of mental health issues
Senior centers holding forums on mental health
After hour forums for working individuals

Facilitator Notes for Small Focus Group 7

Lack of planning – disaster plans – no one wants to talk about what would happen if disaster strikes
Resources for Seniors: - how to find them • How to find out what is available for seniors and disabled – make easier to find • Main desk # is not on brochures • Complaints about not getting through to area agency • Website is not correct with updated events
APS – needs to do something – • They call ahead of time to schedule appointment for visit but defeats the purpose of the visit • Frustration about APS not doing anything
Providers are not informed about issues with consumers re: drugs, theft, mental health issues – several agencies have been in the home – see situation but provider of services is not notified – This is problem with CHOICES and Options referrals.
*No cooperation with MCO's to providers of services – communication was much better when program was waiver with FTAAAD
FTAAAD website is difficult to find things, especially for seniors – needs to be more senior friendly
Have everyday places such grocery stores about services
Target adult children about what services are available
Vision care and dental care
Pet care – vet bills, pet food – seniors cannot afford vet bills and pet food – big problem for

seniors if someone has to go to senior housing and can't take their pet with them – pets enhance quality of life for seniors – flip side is that seniors have say "25(?)" cats and are unable to take care of them and caregivers spent most of their time taking care of the pets instead of the senior
Abuse of services in the system – providers see people that are getting services that do not need services – both in CHOICES and Options programs
Food Pantry: Angel food ministries – co-op food initiatives
Having someone to help with the shopping
Transportation is limited – no escort – all that is offered is drop-off and pick-up service
*Elder Abuse Registry – this needs to change: can't put a caregiver on the elder abuse registry – only medical professionals are the only people that can be place on registry
Affordable housing: people are taking advantage of the system and then the people that need affordable housing cannot get in – need checks and balances
Fall risks: make homes that are more accessible – washer and dryers need to be moved upstairs, loose carpet and they trip and fall, electrical not up to code
Difficult to get minor home modification contractors approved – use people that are in their 50's and that are hand and could do home repairs – employ them
Pest control is big issues – bed bugs and fleas – no money to help with these issues
Substance abuse
Getting paid by MCO's to the providers is a big problem
Overseeing services check on participants

Facilitator Notes for Small Focus Group 8

Staying healthy
• Free programs – like healthy lifestyles
• Free health fairs
• Education is #
• Age specific education
Health and Wellness
• Can't take help @ home
• Can't get the type of care they need at home
• Fear of bringing someone in your home – fear of uncertainty
• Dementia related forgetfulness – can't remember to take meds
• Open up Medicaid/Medicare/assisted living beds so that increases bed for those individuals
• 30-day not admit
• Better placement from the hospital upon discharge
• Reassessment during transitional care
Other
Medicare: Insurance companies are the client, not the individual
Get more churches on board – come together
Abuse – don't be afraid to make a referral. Fear of making APS referral
Having advocates in the community
Empower home delivered meal for safety checks

Empower parish nurses
Community centers
There was a time when you knew your neighbor. Go back to community to check on each other. > public service – building comes inside/out
respite care – too often funds are cut home delivered meals should not be cut
*Respite – families afraid that someone is stealing – afraid of being sued
How do seniors get info – should doctors?
Future is in technology: • Healthcare • Information on insurance • Being able to use all technology
*Have the State do something like the SeniorConnectkgt.com – like generation on line
*Social Security want to schedule computer lab on how to use SS line
Technology – seniors want and demand info – knowledge is power
Transportation: • bus lines – continue good working relationship with public transportation • how to get seniors to/from doctors – services for dialysis • put some transportation back on the providers, maybe healthcare provider or hospitals could do transportation bus • *clinics to pay or contract with a facility to transport patients like car dealerships • empower seniors for this
Training for seniors to enter the work place so they can enter the workplace – partner with businesses to train seniors on computers through senior centers – corporate business partnership with senior centers to train seniors to enter specific jobs
Neighborhood – get volunteers to help with home improvement
Disability – no place for programs for the disabled under age 50 to do social activities – open up community centers to younger than 50 - *possible grants for activities for disabled under 50

Facilitator Notes for Small Focus Group 9

People don’t have a lot of information, no contacts, don’t know the different companies, don’t know the AAAD (these are industry people talking) AAAD need signage, need more community presentations
People totally shut-in – don’t know, but people ask us as care agency (the ones who go in and do housekeeping and bathing) People complain that they call 6 places and get no answers Example: called 12 places to get help for father If people are at home, they can’t call and ask for help so they are “googling” Regardless of which company they choose to call, they need information, need to be re-answered
Question why there are a whole lot of programs to help people who have families (who can and should be helping); and then there are really needy people who can’t get on the program (and those are the people who seem to have the least # of hours of service)
Sometimes there are not enough home visits to see how people are doing – they are declining and case managers don’t know it (again, this is the perception of the service agency about the

case managers who decide how many hours of service someone receives)
It’s our responsibility to call care coordinator if person is getting progressively worse
People are falling through the cracks with care coordinators
ET/Upper East – more of a retirement destination, mobile socially, torn family = need for more services
Too many clients per MCO care coordinator
Companies need to keep calling up the line to TennCare
Some people need someone to help pay bills (help them write checks)
We’re the in-house agency so we are who the people ask (the clients are not calling their case managers)
Worried about PAE being done on Alzheimer’s patients in nursing home and nursing home turning them out because no longer meet new criteria – nursing home sending them to Salvation Army
Example – man lived in nursing home for 3 years and nursing home discharged; another example is when an equipment company left the lift they were delivering in the garage. The equipment was not set up or the family trained on how to use it.
Some of the legislators should make some home visit with us
Safety issues – skipping steps when nursing home discharges to home – not making home visits – houses not safe (discharges and care coordinator not making home visits)
Prior to discharge, they need to make sure everything is set up
For a lot of Baby Boomers, they’ve lost resources and retirement isn’t going to go as they expected - need some kind of intervention – need employment opportunities for seniors
Older people serving as respite workers – seems like a good fit
Dental issues
More educated seniors seem to be taking care of themselves better
Wellness messages – people seem to understand it now. If we don’t do wellness – the cost will be even more
Not enough $ for insurance – not enough $ for Medicare – eat rather than buy medicine
The length of time a person is in a chronic condition is bad
Income requirements – assessing that for government programs
Seeing a lot of depression but not as much substance abuse
Very lonely people
Over medication? Not as much – now those on oxycodone, etc. are referred to pain clinic
What do families need the most? Emergency respite, some families just need someone to sit with patient awhile – they have a few hours to take a hot bath and a nap
Families need help with lifting (back pain)
Transportation – Johnson City has Para-Transit - $4 each way – not affordable – 24 hours in advance – no easy – transit won’t come get you when appointment is over (waiting) – if you can ride bus for 50 cents why can’t you ride para-transit for 50 cents.
People need an advocate. People have had fraud calls over the phone.
Dementia/depression rampant – and patient refuses to go to doctor (lay on couch, hasn’t left house in 2 years) (mental health issue, but refuses to get help)
Good senior housing here, but there are waiting lists
Need laundry facilities in senior housing facilities
Programs may be available in community, but the people don’t know how to access it

Needs Assessment

East Tennessee Area Agency on Aging and Disability
John T. O'Connor Senior Citizen's Center, Knoxville, TN
March 7, 2013

Number of Attendees: 151

East Tennessee AAAD
John T. O'Connor Senior Citizen's Center, Knoxville, TN
March 7, 2013

What are the hard things that "baby boomers" face? How should the state of TN help?
(Number of Questionnaires containing 1 or more responses - 120)

This open-ended questionnaire was designed to elicit qualitative data from the attendees about how they thought aging would impact baby boomers. However, many attendees also identified issues that currently exist. Attendees were able to respond to the questions in any manner that included short, one-word answers, such as transportation, to very involved responses. In order to provide some order to the responses, major topic areas have been identified. In addition, some topics might include sub-topics for the purpose of reading the report more easily. Repetitive responses are included only once.

1. **Easier Access to Services Without Hassle** (including information and assistance; communication; and technology)
   - Better education about services available for seniors
   - Medical information/education – requirement and qualifications for assistance/education in medical insurance, medical equipment, and medicine
   - Technology – more training – the problem is businesses, doctors' offices, and any healthcare or government facility assuming everyone is up-to-date on technology
   - Information – making available and easy to access information available and pertinent to "BB"
   - Awareness – insure that "BB's" are made aware of all the services available
   - Centralized and up-to-date information about what resources are available for the elderly
   - Need for accurate and easily available information for services - understanding resources in the community
   - Adapting to changing technology – TN provide classes and workshops to learn skills
   - Central place for help in obtaining all these things – directories, websites, phone #s
   - Difficulty of finding answers to problems
   - Finding information and access to resources for seniors and disabled
   - One stop shop to access all services
   - Knowledge of assistive technology to help them or parents live more independently within their own home
   - Figuring out how to access programs and services
   - Good outreach/identification of service
   - Need for intergenerational education
   - Having sufficient information to plan our own retirement
   - Falls – need more education and exercise programs, specifically designed to prevent falls
   - Providing a system that will help to keep the 50+ informed in regard to services and programs available

- Knowing what services are available to them – advertise the AAAD more – advertise "211" more
- More volunteer to answer questions

2. **Healthcare** (including in-home services; Home and Community Based Services; long term care; chronic disease; Alzheimer's disease and related dementia)
   - Help establish program to help members who don't qualify for Choices-pre hospice PAE
   - Healthcare – increasing costs of medication and healthcare - cost of medical/Rx care
   - Medical monitoring in home – telemedicine
   - Being taken care of at end of life
   - Healthcare – assist financially with free clinics/provide free care
   - Medical doctors over medicating
   - Medication issues - *TN – monitor $ aspects and pharmaceutical co.
   - Affordable medications cost
   - Health care issues since they are getting older. The State of TN could make it easier for people to get insurance if they are not of age to get Medicare
   - Affordable medications
   - VA Veterans – Agent Orange
   - Fund programs that allow for home health care – make mental health assistance more available to seniors
   - Lack of Adult Day Homes for obese, brain injury, etc. who can't access nursing home care
   - Not enough doctors to handle # of retirees; increase # of clinics and NP, PE
   - Paying for medicines – extend GI 1 & 2 programs – expand
   - Dealing with aging and knowing what health problems they may have
   - Affordable and accessible healthcare services
   - Maintain independence – support organizations to promote this
   - How to deal with the medical community and how to connect with professionals that are in tune with aging issues
   - Low income services (sliding fee scale) – already need more transportation, mobile meals, homemaker
   - Mental health services including medical care and case management and assistance for those unable to care for themselves
   - Services when and how they are needed – flexibility
   - Lack of mobility
   - Loss of independence due to health and disability – promote and fund in home affordable services, including home-delivered meals
   - Accepting disabling conditions as they occur to themselves
   - If the become deaf, the will need a strobe light or vibrating smoke detector – cost $200
   - Lack of supportive services, cooking, cleaning, transportation
   - Medication management - prescription drug abuse - *bring in programs like "Home Meds" management system
   - Help with ADLs – Choices program – additional enrollment

- Lack of affordable case management to facilitate elders' health needs and transitioning needs
- Services for elderly who want to live at home as long as possible
- Case management
- More access and monies for programs
- Make sure ach caseworker is aware of social programs such as Adult Day Care in their community and promote above home care
- Promote village concept – one club services in Knox County
- Cost of prescriptions and health care – help with training for SHIP counselors
- Assistance with prescriptions if over income for the extra help – help with doctors' co-pays dental and vision
- Medical expenses – State provide assistance with costs of medications, dental care/ Medicaid expansion, respite
- More baby boomers will be faced with more health issues. Continuing support for senior centers and finding new free programs for baby boomers to live a healthy lifestyle is needed.
- Need for help with med administration and transportation
- Health concerns – coverage of routine health screenings and community education
- Finding in-home care that they care afford – extend $ to Options, NFCG programs
- Paying for assisted living and other alternative care. The State should expand its programs, etc. Home health and homemaker services (Choices, Options)
- May need assistance with ADL's but not ready for a nursing home
- In home service to keep seniors out of nursing home and in their own homes as long as possible
- More in home services for seniors and disabled – create more funding
- Services (home-based) that are easier to acquire and/or afford?
- Long term care – ease in application, quick response, affordable services
- Sharing nursing home facilities with younger residents – separate them
- Assistance with assisted living. It takes too long for the Choices process
- Paying for long term care; stable subsidized alternatives to nursing homes
- Possibility of having to live in nursing home
- More "in home" services – less focus on dollars to nursing homes
- Vouchers to help pay for a doctor visit co pay or a copy on denture, glasses, or hearing aid fitting - programs to help with dental, vision and hearing aids
- Health care is getting more expensive – very little access to much needed dental care and dentures - Assistance with dentures (dental care) and vision care and purchase of glasses
- Dental coverage/work – more dental clinics/encouraging more foundation or donations from dentists (RAM clinics especially)
- State partnerships with pharmaceutical companies to decrease drug costs for those with chronic conditions
- Living longer with chronic conditions – funding for programs that educate and teach people how to self-manage their health
- Assistance program to help manage medication (daily) Alzheimer's, dementia without Choices or family PAE

- Dementia – care facilities for behavior
- Need Alzheimer's support group that's accessible by bus and in daytime for Knoxville area
- One-stop centers for services – make access easy by either funding or better networks
- Continued difficulty transitioning from care settings – hospital – NF – home
- Poor quality of nursing homes – insufficient staffing, not enough facilities appropriate for Alzheimer's patients with behavioral issues or violent patients – creates problem keeping loved ones close enough to visit

3. **Fiscal Concerns** (including health insurance; Medicare/Medicaid; employment; retirement; social security; cost of living)

- Health insurance that is affordable and available - include dentures, glasses
- Rising cost and declining income
- Being prepared financially before retirement
- Limit on government funded programs
- Affordable services for the boomers in the middle-earning bracket
- Less money to live on. I'm not sure this is the State of Tennessee problem.
- Access to health care – make sure all groups can get insurance (affordable)
- Outliving resources
- Feeling confident in the future of Medicare, Health care, financial issues *More truth and less politics
- The future of our economy - *positive feedback from Washington with our representatives local and State
- Lack of opportunities for economic development – increase service funding for national service programs (i.e.: senior companion program)
- Medical care – regulate amounts doctors and hospitals can charge seniors, especially ones who can't afford insurance
- Assistance with paying for medication and basic needs, voting, assistive technology, more in-home doctor visits
- Having (feeling the need) to expend otherwise "nest egg" funds for their adult children's needs rather than for themselves
- Declining health and cost of health care
- Pay for medications as income is getting smaller - cost of medication
- Living on a fixed budget - surviving on a limited income – provide reasonable resources
- Distribute the dollars and cents equally and not just to a certain area of the city. Senior live all over Knoxville and dollars designated for seniors should be blind.
- Educating and assisting early preparation and financial info
- Increasing health costs
- Poor economy (loss of retirement funds meaning greater reliance on Social Security)
- More job training and self improvement classes for seniors
- Having a source of income big enough to live off of – income to meet needs
- Living longer, not financially prepared
- Medication plans and insurance plans that are affordable and have good coverage

- Medicare Choices are very challenging. The cost is very expensive - Medicare seminars to explain best plans - understanding Medicare – made simple - Medicare questions and concerns about what insurance will cover - more assistance for ongoing Medicare issues
- Cost of medical care and medications even with insurance is still very high
- Insurance coverage – open Medicaid categories
- Insurance coverage and how it could meet the needs of the individual
- Hire more people to work strictly with Medicare on a daily basis, not just Senior Center Directors or OOA Directors who are already overwhelmed with other senior problems
- Paying for in-home care and nursing home care
- Doctors who will take Medicare patients - drug costs – expand Medicaid
- What medical expenses and coverage will be – assist with low cost solutions
- How to navigate health insurance issues, specifically prescription drug plans
- Social Security and Medicare benefits – adjustment to these programs – TN programs to educate and explain
- Health care coverage for those with low income
- Affordable supplemental insurance for this age group
- What kind of insurance will there be for them and will it take care of their need
- Insurance – better screening services for government assistance to weed out truly ineligible individuals
- Medicare – will it be there for baby boomers? - possible lack of Social Security, Medicare, Medicaid
- Affordability of healthcare coverage – I am not sure how the state can help without possibly hurting another program or tax increases.
- Jobs – helping seniors get jobs – availability – job market
- Age discrimination in the work place and in employment
- Having to work longer
- Social Security – possibility that SS may not be available - I'm 60. Will I have Social Security by the time I retire?
- Navigating through Social Security system – when developmentally challenged
- Fewer people paying into Social Security and other government programs. There are lots of baby boomers to support.
- Cost of living increases - will income be enough to stay in their family home
- Out living funds for retirement -– lack of sufficient funds for retirement – TN provide budgeting fair, etc./education
- Training – adjusting to retirement through volunteer or other services in order that transition is less stressful
- Having to continue to work pass the retirement age of 65 due to finances are not available to continue to pay for their expenses of daily living
- Uncertainty of their retirement income
- Having sufficient funds to meet their retirement needs. The State should drop its tax policies on investments.
- Low retirement income realized afterward – increase funding for employment for programs for seniors

- Strong aging-in-place policies/legislation to keep people out of nursing homes (ex: Alabama's Geriatric Rehabilitation Services)
- Being prepared financially before retirement - preparing financially for their own retirement years - *education on how to finance retirement
- Adjusting to retirement – end of regular career – TN programs to help promote part-time work
- Earlier retirement age/inadequate pensions
- Not being able to retire as early as they had hoped due to a challenging economy
- Enough retirement centers (facilities for living when can no longer live at home)/facilities for us as we age and need those services/facilities.
- Less retirement funds due to Social Security issues, failed pensions, etc. – recruit industry and business to Tennessee for more job opportunities for everyone
- Adequate income after retirement – offer tax breaks or rebates to low income individuals

4. **Support Services** (including transportation, meals/nutrition; elder abuse services; senior centers)

   a. **Transportation**

   - Accessible, affordable, timely, senior-friendly, adequate, easy to use, and dependable transportation - cannot afford current service/not enough services
   - Transportation for more rural areas - establish more in city and rural transportation - need more rural/handicap transit services that are affordable
   - Being able to get affordable transportation to healthcare and shopping
   - Transportation – cost/availability - *TN – grants and funding for mass transit
   - Lots of seniors in my county do not have transportation
   - Transportation - $ for assisted transportation – hand-to-hand
   - More vans and/or small vehicles for transportation to appointments, grocery shopping, etc. on a more timely schedule than 3 days in advance
   - Transportation to and from appointment/diapers and ensure no longer covered by insurance
   - More transportation options - more choices - the State should work on expanding transportation options.
   - More funding to agencies providing transportation
   - Transportation for errands or appointments, etc. (vouchers?) - TN provide free busses, transportation, etc.
   - Transportation for shopping doctor appointments, therapy – volunteers willing to help with errands – picking up prescriptions
   - Transportation that provides an offset to isolation – from errands, from physicians, from senior centers, etc.
   - TN can help by exploring/funding initiatives for coordinated, well-advertised, user-friendly options in all communities (urban, suburban, and rural) to allow us all to remain in our homes of choice
   - Need bus service for a large area
   - Increase services with ETHRA/CAC – not just limited to MD visits
   - Lack of transportation that meets the needs of all

- Transportation, assisted and unassisted
- Develop and fund more transportation options
- More transportation options/more affordable options (Greeneville, Erwin and Elizabethton have not transportation but Net Trans)
- Lower costs/more transportation (Greeneville, Erwin, Elizabethton should have their own transportation)
- As baby boomers get older their health condition are preventing them from driving. Having more transportation services will help.
- Adequate transportation for those that are not longer able to drive
- Volunteers who can transport

b. Meals/Nutrition

- Meals – food and nutrition management, preparation, funding, volunteers, good tasting, nutritional meals, home delivered and congregate – food in general – assistance in obtaining
- Nutrition – nutrition education available to seniors including: mobile meals options and requirements, food pantries, nutrition in connection with physical, mental, emotional well-being - more options and affordable
- Food resources - *TN – expand subsidized food banks/pantries
- Securing food – low income
- Food security – delivery options for homebound seniors – food pantries
- More funding for senior meals
- Lack of nutritious meals for seniors – increase funding for meals on wheels
- How to provide food for themselves – fund more meals for homebound persons and food stamps
- Having access to proper nutritional resources: education and actual food promote healthy living and healthy eating statewide

c. Elder Abuse

- Protection/education about Elder Abuse and fraud
- Open to financial exploitation and physical abuse as they age – more freedom for Adult Protective Services
- Laws changed or made to better help vulnerable seniors
- Crimes, scams against seniors - * news reports to alert of new scams
- Help defending against abuse – physical and financial
- Avoiding financial exploitation – tougher penalties for criminals
- *Dire situation – huge lack of APS assistance
- Family members – exploitation by family members is an issue. Make eligible services available to elderly to screen for proper living arrangements and supportive circles
- Increased likelihood of being scammed by unscrupulous vendors

d. Senior Center

- Senior center funding
- Baby Boomers are active. I see the need for more funding for senior centers.

5. **Staying Healthy While Aging** (including exercise, eating healthy foods, socialization, chronic disease, staying connected and involved in the community, volunteer)

- Staying healthy, offer more educational programs and facilities - eliminate taxes on groceries
- Staying well – funding health promotion – screenings/physicals/mammograms
- Staying healthy to stay out of institutional care - intense health care support, fitness, diet, affordable/free
- More preventive health services – exercises at senior centers
- Limits on ability to socialize/"shut-ins"
- Isolation once a spouse dies - being alone – daily or weekly call checks – encourage volunteers - *reaching out to rural areas (forgotten area) - *trust issues
- Loneliness, no family members - lack of family – friends support- families not close by
- Under-diagnosed/treated depression, lack of socialization/physical & mental stimulation, complicated by care in the home only. Malnutrition often occurs not from lack of food but lack of motivation to eat!
- Depression, feelings of nothing to do/live for

6. **Adults with Disabilities**

- Mentally challenged have very limited resources for help with ADL's, hygiene, PAE
- Access to assistive technology to keep people with disabilities living independently - access to transportation – fund programs for assistive technology
- Affordable housing – handicapped accessible
- Increased accessible parking for seniors and people with disabilities. TN can help by passing statewide legislation requiring 2-3 times the number of accessible spaces provided by the American with Disabilities Act (ADA). Spaces should be close to accessible entrances to facilities and for those over the ADA-required number, the could be marked in a way to provide accessible parking restricted to use by seniors and people with disabilities that don't use wheelchairs
- Look @ our public (state, county, city-owned) facilities and programs and increase physical and programmatic access to people with disabilities. Accessible opportunities are available to all people, even if they don't have a disability but inaccessible opportunities exclude us – it will take money to make changes to buildings, but will drastically increase our (TN's) ability to welcome seniors and people with disabilities to our State so they can retire here, remain here, and keep their money here!!!
- Minimally-accessible (i.e., visitable) housing options in all parts of TN. TN can help by supporting proactive, creative ideas/initiative such as the one the City of Knoxville promotes (Statewide program was begun by TN Council on Developmental Disabilities and has proven hugely successful!)
- Assist DIDDS with accelerating waiting lists – ensure full utilization of Choices
- Taxi services – accessible for wheelchairs and service dogs

7. **Caregiving**

- Family support
- Trying to juggle caring for aging parents and their own families/obligations
- Raise the limit in assisted technologies to help families and caregivers. That would take a financial burden off of them while providing better home care.
- At-home care programs – family care pay programs: paying family caregivers
- Enough caregivers/younger folks to take care of us - lack of people to take care of them
- Teaching caregiver to learn how to give care at home
- Help with caregiving of older parents – respite services
- Being caught between kids in college and aging parents
- How to effectively take care of aging parents while working
- Having several generations in the home – raising grandchildren, taking care of parents
- Taking care of aging parents, still work, and remain sane – finding help for/with them
- Grandparents caring for grandchildren – social services @ school level
- Grown children in distant communities
- Caregiving older parents/spouses – *education and support for family caregivers
- Helping adult children who return home, often with children - *education/resources to help with children of grandchildren
- Caring for parents – in my case – from 850 miles away as primary caregiver
- Support/relief for caregivers – education – support through AAADs
- Children returning home – stay out of it
- Caregiving services (affordable) for those wishing to remain in their homes
- Support for caregivers/more respite programs and support groups, more trained aides and family members - more caregiver support and training in the community
- Many Baby Boomers are caring for older parents and are in need of respite. Would love to see funding for Adult Day Care so that caregivers can have the peace of mind
- Shortage of available care takers in facilities and homes due to large # becoming elderly/disabled – more training and staff are needed to provide adequate care.
- Quality trained caregivers
- Lack of family near by to assist with issues

8. **Housing, Neighborhoods, and Safe Communities** (including home repairs and utilities)

- Lack of federal funding – limit on availability of facilities = nursing home and assisted living
- Living with family members
- Decent affordable housing in neighborhoods they desire to be
- Baby boomers are living longer. More affordable assisted living facilities with the best care
- Affordable and accessible housing - *TN – provide more senior housing - community resources - safe housing - care options – availability
- Safely staying in their home as long as possible - having the resources to safely remain in their homes

- Safe, affordable subsidized housing with case management support - safe housing that is non-invasive and affordable
- Designated housing complexes for SENIORS ONLY!!! - more housing that meet the needs of our age group – housing for seniors/no one under 60
- Finding an affordable retirement option such as assisted living
- Housing problems because they may not be able to afford mortgage or rent and not eligible for low-income housing. Need vouchers for assisted living care that can be used like Section 8.
- Having somewhere to live
- Housing when we are unable to remain at home but not ready for the nursing home
- Housing information for this group that is safe, affordable, clean and run by people who care about older Americans
- Assisted living
- Lack of affordable housing
- Not enough affordable assisted living facilities or other alternatives to nursing homes
- Senior and disabled housing
- Assisted living facilities that are affordable and close to grocery store, physicians – assistance with rent
- People need help staying in their homes, safely. There are many technology devices/systems that can help. More assistance needs to be given to cover these items. Compared to the cost of facilities, the could result in a huge savings for the State – reduced hospital stays, better medication compliance, and reduced cost of care.
- Attempting to stay in their homes as long as possible – and avoid institutionalization. The State could work on expanding the definition of ACHs (Adult Care Homes) so more can be established across TN
- Enabling all seniors to remain in their home safely, regardless of income or resources - help with getting people in stable homes where they can remain
- Strong aging-in-place policies/legislation to keep people out of nursing homes (ex: Alabama's Geriatric Rehabilitation Services)
- Assistance with house repairs - house maintenance expenses without income to support – lawn care assistance
- Home repairs, roof repairs, etc. - home modifications- $ for home modifications – building ramps, widening doors, moving laundry facilities
- Utilities assistance for low income

9. Funding/Resources

10. Other:

- Laws concerning parenthood
- Help @HM
- Longevity or good health until end of life
- The need to still be heard and be a voice in society
- More of us of mentoring, elder internships or placement in corporate setting and service

- Society – in rural communities where exploitation of "entitlement" programs/funds is occurring, the hardship this creates trickles over to the elderly population. Suggest reform in government assistance
- Lifetime of unhealthy lifestyles choices

East Tennessee Area Agency on Aging and Disability
John T. O'Connor Senior Citizen's Center, Knoxville
March 7, 2013

Question: **Here are seven (7) aging and disability issues.**
Under each, there is a list.
Mark the ones on the list that you think are most important.

Number of Questionnaires completed: 114

Response	# of responses	%
1. Being able to get accessible transportation	88	77.2
2. Affordable dental care, hearing care and eye exams and glasses 3. Transportation for people who don't drive cars	82	71.9
4. Being able to get help when needed quickly and without hassle	81	71.1
5. Housing that people on a pension or Social Security can pay for	78	68.4
6. Not having enough insurance or money to pay for doctors or medicine	76	66.7
7. Teaching volunteers to work with older adults and people with disabilities	71	62.3
8. Protect people from abuse	69	60.5
9. Getting care at home instead of in a nursing home 10. Meeting people and making new friends	67	58.8
11. Meals that are healthy and prevent hunger	66	57.9
12. Keeping healthy through exercise and eating healthy foods	64	56.1
13. Knowing where to call for help and getting help without a big runaround 14. Training for aid workers who help older adults and people with disabilities	62	54.4
15. Respite services	60	52.6
16. Teaching doctors, nurses, and other healthcare workers to know the special needs of older adults and people with disabilities	58	50.9
17. Help with memory loss	57	50.0
18. Learning new things 19. Teaching police, Firemen, emergency workers to know the special needs of older adults and people with disabilities	55	48.2
20. Reasons people have to go into nursing homes	53	46.5
21. Learning about how to care for someone at home	52	45.6
22. Learning how to live with a serious condition like heart disease, cancer, arthritis 23. Understanding how Medicare works	51	44.7
24. Learning about how to take care of yourself so that you don't get sick and tired	48	42.1

25. Houses that are easy to get around in if you're on a walker or in a wheelchair	47	41.2
26. Making decisions about health insurance, Medicare, and planning for the future without depending upon the government 27. Neighborhoods that are easy and safe to walk in	45	39.5
28. Places to volunteer	42	36.8
29. Reasons people have to go back to the hospital 30. Being able to choose the workers who come into your home	41	36.0
31. Help with chores like lawn mowing and leaf raking	39	34.2
32. Help with feeling sad or lonely	38	33.3
33. Eating out with friends	37	32.5
34. Learning how to prevent falls	35	30.7
35. Help with taking too much medicine	32	28.0
36. Neighborhoods that have grocery stores close by	30	26.3
37. Being able to get accurate information from a website and being able to apply for services on-line	25	21.9
38. Help with drinking too much alcohol or taking drugs	13	11.4

Other:

Government assistance eligibility reform
Stretch TennCare dollars and reduce abuse of in-home caregivers being used for housekeeping for other family members by transitioning those who can receive service to an adult day care ($10 per hour instead of $22 per hour)
Also don't forget disabled adults 18-55
Those feeling sad or lonely need socialization – care in adult day care instead of home
Learning how to live with dementia/Alzheimer's
Being able to get accessible transportation for every day services also, not just healthcare
Assign one paid worker per county to do only Medicare – enrollment, problems, advice, etc.
Lessen the restrictions on fundraisers such as bingo or quilt raffles to help senior centers stay open
Meeting people and making new friends for socialization
Planned senior communities
Trolleys for getting to senior center and stores and other community activities
Adult day care
Support services for those caring for others
One call center
Senior communities
Have developers plan for access if the individual is on a walker or in a wheelchair
Transportation is huge – rural communities have no resources
Increased funding for Options/National Family Caregiver – -many people cannot get enough service time -HUGE waiting list (currently 450 on options & 100 on caregivers – up to a 3 year wait – many die before getting help

Most do not have access to internet

All are important
Outreach services for mental health crisis
Other rep. payee programs
Assistive technology
I could have checked every item. They are all important.
Increased national service opportunities for low income seniors
More adult day care is seriously needed. Assistance for paying for day-care services. Senior need for more low cost or free transportation
Transportation, transportation, and transportation all in rural counties is needed
Government and city officials need to be more accessible to homebound seniors – maybe be more involved in meal delivery
More nursing home access (and ALLF access) – expanded TennCare to pay for care. Lighten up PAE restrictions/requirements
Being sent to ER from ill equipped assist living facilities
Need more "house call" providers, geriatric physician's assistants and nurse practitioners
Better networking between existing services. Streamlining of information systems, referral networks
When a caregiver tries to stop person who is abusing illegal substances
Housing for developmental, behavioral persons who are low income and unable to live independently
In home non-medical assistance for individuals who fall between not qualified for Choices with medical conditions, but not yet ready for Hospice
Assistive technology in Options and coordinate with TennCare provide newer, more expensive devices than $900 in Choices
Mental health – keeping mentally active
Emotional health (family relationships –maybe feeling of worthlessness and dependency on family members)
Hearing care is so important to elderly
Family caregiver support groups can help individual with knowing where to call without run around
"Powerful tools for caregivers" is excellent education program
Denture coverage
Adult day care
Lack of housing that allows for "aging in place"
Grocery stores close by and ones that deliver
Being able to contact APS after house – follow through out the process from visit to court action
Trolley in Sevier Co. to serve Senior Center
More support for home-delivered meals – eliminate the waiting list
People who need APS but not being served
Shorten time for disability insurance
Adult day care as an option
Support services for caregiver
One call clubs
Need assisted transportation
Planned senior center in area that is easy and safe to walk in
As OOA, I think it would be great to have a qualified person, trained to only do insurance in my county once a month – paid worker

More funding for in home care
Tennessee is a growing state. As our urban areas grow – many of the federal programs whose funding is tied to urban area's population are not keeping up. In fact, Congress is cutting funding. This example is true for transportation funding. The Knoxville urban area grew by 33% over the last 10 years, but transit funding did not keep up. Many citizens in rural areas like Blount, Loudon, Anderson are losing transit services.
Feeling safe in their home or apartment
Providing housing for persons who do not need nursing home care, but still needs to have care and can not afford to be in assisted living
Teaching attitudes toward the elderly that are cheerful and accepting
Educational programs for caregivers of elderly family members
Printed info versus on-line/PDF's. Our area doesn't have full availability of internet access
More staff and more ability from our local APS offices
The State should give each county seed money to help with volunteer programs begun by each county – not just the region
Transportation, volunteer assisted transportation, Knox CAC
Funding for all in home services
There are waiting lists for all services
Mobile meals has a waiting list, this service is crucial to seniors
More services in rural counties
Safety checks on seniors more often and protection from scams/predators
Staying or getting involved with church life
Affordable transportation (preferably free)
Free opportunities for healthy life style and socialization
Provide persons to assist in home care
Affordable dementia housing
Emergency housing for special situations
Low cost – reliable transportation
Need more coordinated transportation services
Meals for under 60 population
Guardianship for those in need and with no one
Protection from exploitation when they can't protect self
Mental illness: supportive housing, intervention when they don't realize

East Tennessee Area Agency on Aging and Disability
John T. O'Connor Senior Citizen's Center, Knoxville, TN
March 7, 2013

Question: **What is currently working well in your community?**
(like agencies that help, neighbors who help each other, van service, senior center, meal sites, food pantry, healthcare clinic, nursing home, sidewalks, police presence, grocery stores that deliver)
(Number of Questionnaires containing 1 or more responses - 94)

This open-ended questionnaire was designed to allow attendees to identify the community programs and services that have worked for them and in their community. Evidence based and/or proven practices were not a consideration in the design of the questionnaire and no checklist was provided. The above items in parentheses were provided as examples. Attendees were asked to write in the programs and services that were working well in their community. The responses are individual and specific to the region served by the Area Agency on Aging and Disability. The number of attendees who indicated that the program is working well in the community is provided in parentheses ().

<table>
<tr><td>Second Harvest Food bank (3)</td></tr>
<tr><td>Van service (3)
East Tennessee Human Resource Agency (ETHRA) transportation (1)
ETHRA transportation service is a wonderful benefit.
CAC transportation, agency cooperation and help
Volunteer assisted transportation
Net Trans – transportation available but could be improved</td></tr>
<tr><td>Senior center (25)
Our senior centers work well with all other agencies in our community. We are lacking grocery store deliveries. We have access to ETHRA van service which works well.
Senior directors are very helpful in providing a central resource for senior services and other community sponsored agencies
*There is not a shortage of senior centers in the area.
Knoxville – Knox County senior centers (especially O'Connor)
Senior center is great
O'Connor and Strang Senior Centers
Senior Centers are a big help to older persons in the community. They provide companionship and also a healthy meal at lunch time.
This region is blessed with senior centers in our communities that strive to involve people in activities that benefit their health.</td></tr>
<tr><td>We have excellent city and county senior centers as well as SCAN (Senior Citizen Awareness Network) police department</td></tr>
</table>

<table>
<tr><td>Meal sites (4)
• Senior nutrition program works very well in our area (Cocke, Grainger, Hamblen, Jefferson, Monroe, Sevier); however, more funds are needed and volunteers needed for the services
• congregate meals
• Providing meals to low income residents
• Congregate mobile meals
Meals on wheels/mobile meals (19)
• Mobile meals for seniors – needs to funded. Nutrition is a basic need. Knox County has a waiting list. Food pantries provide for the same basic need. A safety net.
• Meals on wheels is vital service.
• We have mobile meals, FISH deliveries and KARM which deals with meals
• We have an active meals on wheels and congregate meal programs. There are several churches that have food pantry sites.
Meals on wheels and senior centers are very useful, but more people need to know about them and be able to utilize them.</td></tr>
<tr><td>Neighbors who help each other (3)</td></tr>
<tr><td>The Area Agency on Aging and Disability coordinates many programs and services available and works hard to make sure people know what is available for them.</td></tr>
<tr><td>Food pantry(9)
• Food pantry currently service 400 families per month</td></tr>
<tr><td>Honestly, I don’t know any that are working effectively. All are short staffed and inadequately funded.</td></tr>
<tr><td>Healthcare clinic (Helping Hands)</td></tr>
<tr><td>Nursing home (2)
• Adequate nursing home availability (need more affordable assisted living facilities)
• Nursing home advocacy – need more volunteers</td></tr>
<tr><td>Sidewalks</td></tr>
<tr><td>Police presence
• Knox County Sheriff’s Office (Project S.C.A.N.) – Senior Citizens Awareness Network. Volunteers that go out and check the well being of the senior community. We currently check on 240 recipients. Also make referrals to other agencies as needed. Eyes and ears of elderly community.</td></tr>
<tr><td>Grocery stores that deliver
• Food City – grocery store that pull orders</td></tr>
<tr><td>Pharmacy/drug store that delivers (4)
• Pharmacies that provide financial assistance with Rx through grants, foundations (need more pharmacies that do help with med costs.</td></tr>
<tr><td>Volunteers (3)</td></tr>
<tr><td>Elder Watch</td></tr>
<tr><td>Douglas Cherokee Economic Authority</td></tr>
</table>

Local churches – assisting residents with home mods/doctor appointments, etc.

• Office on Aging programs • Excellent Office on Aging programs – transportation services, mobile meals, senior centers. Unfortunately, there are insufficient funds which create waiting lists for important programs like mobile meals, transportation services, legal assistance for the elderly. • Office on Aging – Senior Services Directory • CAC – Office on Aging/Case Management – Project LIVE • Office on Aging programs • Office on Aging (including mobile meals) • CAC services – Office on Aging • Office on Aging – some food banks – outreach/community outreach events, volunteers • Office on Aging is a good concept as it strives to create a way to help seniors. • The Knox County Office on Aging provides many contacts and resources in relation to question packets I & II. Recently my neighborhood they have reconstructed all sidewalks so they are wheelchair accessible, which has assisted in many “neighbors” getting outside and around the neighborhood with ease. • Office on Aging – Chearie Phillips has an individual doing (homebound) calling from Anderson County; OOA
Project Live – case management for low income seniors
Free in home services for seniors through senior companion program
Church assistance
Options for Community Living, NRCS, Choices, Operation Backyard, The Love Kitchen, CAC
Operation Backyard, Moms Meals, MRDD
Senior citizens home assistance service
Food City, Belew, MAC’s pharmacy
Smokey Mountain Hospice
CAC transportation/Senior Companion Program
O’Connor Center
Choices and Options programs
Volunteers, local agencies, churches which supply clothing, food and meals, free dental clinics, Sheriff’s Office having volunteers who call on elderly and disabled individuals
Legal assistance for the elderly is a great service, but needs for funding so they can serve more people.
TennCare to pay for nursing home, ALF, and at-home care is a vital service, but needs to cover more people and not be as restrictive.
Meal delivery, church groups assisting homebound with tasks, commodity distribution, fuel assistance, central services agency, home health services
Volunteer groups such as local churches
*Elder Watch has been very successful in East TN.
KCDC
Alzheimer’s Tennessee

TennCare Choices
Professional networking and resource groups
Senior services – non-profit/church/United Way collaboration
Blount Co. Community Action Agency
Blount Memorial Senior Care Services
Blount Co. Public Library – senior programs and presentations regarding services and information
Choices, ETHRA transportation
CADES church sponsored daycare for disabled seniors – needs duplication – makeup of Farragut community means fewer services
Partnerships with other agencies
Case management offered to connect seniors to community services
Low income health clinic for indigent care
Ecumenical partnerships and agencies (such as Compassion Coalition, church volunteer groups, etc.
Case managers in KCDC housing to provide support
All of the above are present on a limited basis. A lot of the senior population do not know of services they can access
Choices Home Care, SCAN, Garbage pick up, rural Metro
Community Action Connect programs
Large volunteer base, extra programs, volunteer assisted transportation
Knox County Office on Aging Programs, CAC Transit, Volunteer Assisted Transportation (VAT), RSVP, Senior Companion program, etc.
Ladies of Charity – food pantry and thrift store; KARM – rescue mission; Volunteer Ministry Center; Interfaith Health Clinic
Central point of entry
Knox Office on Aging, particularly transportation programs; AMOS (affordable medical options); Senior Citizens information and referral service, and mobile meals
FISH Hospitality, KASM, VMC, Salvation Army and other food programs
Good Samaritan, Family Promise and other disrupted family support
ETAAAD, ETHRA vans, Knox CAA mobile meals, KCDC housing
We are fortunate in Knoxville to have a Disability Resource Center, a Mayor's Council on Disability Issues, an active Council on Aging, a great Office on Aging and public transportation. Other counties are not as fortunate to have these organizations and services.
Getting information out to the elderly community
Home health care/transportation
Serenity House – hospice care; dental care; Helping Hands – medical clinic
ALPS, ETHRA – transportation, volunteers, Senior Connect, home health
ALPS Adult Day Care; Hospitals senior network; Helping Hands clinic; ETHRA
Transportation services; Neighborhood Watch; networking

Senior center – has activities – information – exercise – transportation – 2 nursing homes – volunteers are good – churches and centralized services @ Central Services – 2 free health clinics – police active with Elder Watch
CAC – case management project/services/mobile meals/transportation; food pantries/churches assist well
Partnerships with State, Federal, local and private funding to provide in-home services, meals, food pantries, learning, exercise, and socialization; FISH pantry
What's not working: We attack each problem in isolation from all the other problems – dividing people by diagnosis – not addressing all the issues and how they interact with each other.
Knox County CAC; Options through ETHRA; Choices/TennCare; food pantries throughout Knoxville; KARM
ETHRA transportation; great senior centers
The small community of Lake City has a wonderful lady running the congregate meal site. She uses her talents of hospitality to bring this community together in a celebration type environment daily. If all of the congregate meal sites we would never have to worry about attendance at the sites. She uses her personality and passion to enlist volunteers to transport folks who need it. These volunteers included several public servants. The Lake City police officers are great helpers as well.
Volunteer assisted transportation; O'Connor Senior Center; Disability Resource Center; CAC; Office on Aging
Choices
Knoxville's Project Live program which assists low income homebound seniors by providing free in-home case management to link vulnerable seniors to community resources and volunteers to assist with home repairs, housekeeping services
CAC, Choices Program, Love Kitchen
ETHRA; MLB Building; Elder Watch
Lots of volunteers to assist with programs
Volunteer assisted transportation; CAC Transit; One Call Club; Daily Living Center – Adult Day Program free for low income
CAC but need more and quick availability
Congregate and home delivered meals, sliding scale services; pharmacies that allow fixed income consumers to make payments on their meds as they are able
More police presence in East Knoxville; Rights For Caregivers; shorter waiting periods for minor home repairs for seniors
Collaboration with disability and seniors groups; existence of CODI "Mayor's Council on Disability Issues" that advises city on disability (and senior) issues; commitment to visitable housing; team effort toward transportation options that work for seniors and people with disabilities; person with a disability is in charge of disability issues, policy, etc. @ City of Knoxville
Having a relationship (partnership) with CSBG funding to provide senior services
Innovative nutrition partnerships with local hospital, assisted living facilities

Roane county is beginning a clearinghouse starting with 8 local churches beginning with utility and crisis services. This may be widened to include these senior issues.
Loudon Co. has a very successful clearinghouse through Love, inc.
Neighborhood Service Center (LIHEAP)
ETAAAD – good source of information
AAA; home delivered meals; SHIP; service centers; fuel assistance through CSBE; VA Hospital
AAAD; SHIP/SMP; home-delivered meals; VA
ETAAAD; SHIP; SMP; fuel assistance through CSBG; neighborhood service centers; adult day care centers; VS's; Mooney's West Towne Pharmacy and Princeton Pharmacy deliver
Churches with food panties and clothes closets; also provide monthly senior adult activities

East Tennessee Area Agency on Aging and Disability
John T. O'Connor Senior Citizen's Center, Knoxville, TN
March 7, 2013

Small Focus Group Responses

East Tennessee Area Agency on Aging and Disability
John T. O'Connor Senior Citizen's Center, Knoxville, TN
March 7, 2013

Facilitator Notes for Small Focus Group 1

Facilitator Notes for Small Focus Group 1
Options program is frozen – 2 year wait list.
State is hoping people will just die and let them off the hook.
New TennCare PAE requirements are far too restrictive.
People with mental problems don't know how to find help.
CHOICES is denying people who need care desperately.
People are actually dying from lack of care.
Hospitals are sending people home when they are in desperate need of continuing medical care.
Hospitals are limited as to what they can do. They have to send them home – CHOICES does in-home assessment and says, "they don't qualify for care".
There needs to be programs in place to see that all elderly in need have help at home, adequate meals, medication help.
Big gap between CHOICES and Hospice that needs to be filled. There are non-medical help services that will go in for $10/hr. but may elderly cannot even afford that.
We all see people starving to death – literally – from lack of food.
Need more hot meal programs. People starving. Family members are often not helpful. People tend to eat undercooked food, rotten, expired good when they are mentally challenged.
In some counties a route can be 90 miles/day. Lack of volunteers because they have to donate their own gas as well as time. In rural counties, the volunteers don't even have enough money for the gas.
Transportation is a big issue. • People can't sit and wait for van for medical appointments. • Issues with no one to help people on and off vans or to help them get inside medical offices.
Demand is so great, transport so many people, that they often sit and wait for hours to be picked up and sometimes never get picked up.

Facilitator Notes for Small Focus Group 2

Facilitator Notes for Small Focus Group 2
More volunteers
More education for volunteers
Centralized volunteer line for all counties for people to connect to volunteer opportunities
Limitations of Adult Protective Services law for older adults who live alone and have no support system: • APS say "not in imminent danger" so can't help • APS be more aggressive
Socialization and other programs that don't require money to participate
Transportation – free for those who can't afford • education to public on opportunity (getting the word out) • for those not eligible for publicly-funded programs
Affordable medical care for those not on TennCare, etc.

Home repairs – more funds for (currently only wait lists)
Affordable assisted living
Quality and affordable and decent residential housing
Affordable services for middle-income (those just over limit for publicly-funded programs)
Neighborhood watch for older adults who live alone
Education for businesses and back tellers
Way to connect churches to get volunteers to assist older adults
Have programs that benefit all counties, especially rural
SCAN program or outreach program in each county
For CHOICES members transitioning out of SNF – vital to have socialization and transportation to keep engaged
More funds for works in assisted living, SNF, APS – better salary
Dental care indigent – more dentists offering free or low cost dental
Get churches engaged in watching our seniors
More regulation for gov't., county, etc. – seniors need a break for access to services, transportation
Advocate (volunteer based) for those going to doctor, in hospital, etc. (for those who don't have anybody) – have government have advocates in each area (vase # of advocates on population of seniors in area)
Emergency housing for individuals coming out of hospitals
Support for individuals transition out of hospitals (to reduce hospital readmissions)

Facilitator Notes for Small Focus Group 3

Caregiving and taking care of loved ones at home. Not know what resources are out there for families and caregivers. Navigating care and services
Transportation issues because the pick-up/drop-times. Waiting on the ETHRA buses. Run out of oxygen, while waiting on buses
Being able to get accessible transportation
Education current generation about NH, assisted living and/or care @ home for their family members
Affordable dental, hearing care, eye exams and glasses
Learning healthy foods and amount exercise that is really needed to sustain brain health
Making sure all materials are printed for the home-bound people
Making sure the resources are very easy to access, especially to those who are not out in the community
Food stamp amounts for elderly people
Not enough adequate housing. Why not use some of the homes that are taken by the State of CHOICES or NH care and put seniors or disabled clients into them so that they have "safe" places to live
Getting information out to home-bound clients

Facilitator Notes for Small Focus Group 4

Lack of affordable hearing and dental services
More SNAP benefits for our seniors - $16.00 is the average benefit
Affordable, accessible, senor friendly transportation (through organized church groups, grant

funding) (liability issues?)
Additional adult day care facilities. Partnerships with churches and financial/stipend assistance
Respite care
Looking at the senior nutrition program, looking at a way that eligible seniors pay a portion of their meal. Seniors will have more a stake in the program and feel better that they are contributing.
More flexibility with Senior Nutrition Congregate meal sites. Partnerships with local restaurants, hospitals as voucher system, etc.
Part D Medicare very difficult for our seniors to understand. More educational opportunities by trained, paid staff into the community. Needs dedicated staff in the communities
Medication management, higher incidents of hospital re-admissions. Providing funding for telehealth when released form hospital and beyond
More funding through CHOICES for in-home monitoring systems (PERS, TeleHealth, emergency buttons, bed sensors, bp monitors, etc.)
Addressing the high occurrence of depression in the elderly, leading to suicide in some cases, and poor quality of life
Need for more affordable, reliable creditable minor home repair for seniors. Also help with lawn mowing, leaf blowing, raking and garbage pick-up. Vouchers for garbage pick up
Area Agencies across the State to unify OOAs, SCs, Nutrition programs by assisting with fundraising, advertising that benefits each county in the specific region'
Utilize community colleges for volunteers

Facilitator Notes for Small Focus Group 5

Aging in Place after coming to DC to work – Baby Boomer resources eaten up in economy decline
Moved away from family ties and ties don't bind as in the past
Churches and traditional network has faded away as a result of the mobility of the BB generation as traditional aspect of supports faded away
Who's going to take up the slack
Thinning the herd – where is the parachute/net
Reaping repercussions of longer life
Younger retirees not wanting to see yourself as senior or attend senior centers/resources
Senior discounts are "embarrassing"
See the handwriting on the wall – forced to look for resources which increase demand for service providers
Not building group of friends/network to help one another
Has become exclusive "book group" that is dying away/shrinking
Volunteerism
Peace corp generation
Special volunteer opportunities in focused health (cancer group)
Gov't. is not best resource - people are
XY generation not so willing to give $/small wonder to give (don't waste my time)
Insurance issues
Different set of values around volunteerism

Get different generation in perspective – same priorities but different perspective of solving
We're in for it for the next 5 years.
We're not prepared for the next 5 years
Decreasing people paying into the system
Decreasing benefits
Decreasing in new workers in aging field
Stigma
Invisible generation/put away in nursing home
Aging marginalized
Life expectancy has increased and definition of old has change
Concept of retirement
Family experience with multi-generation has changed
Sandwich generation overwhelmed
Baby Boomers may change definition of aging
Baby Boomer had small families
Information though available but not user friendly
Young old more tech savvy, but older old
Perception of being on Medicare/Medicaid –
Intelligent folks struggle with understanding the process
Preventive services more critical of Betty Crocker generation
Is chronic disease increasing because of transplants?
Other states (Florida) offer increasing senior benefits
No emissions control = increase health issues in the valley
Worried about who is going to take care when desire to be independent
Children "take over" when parents decrease health
Don't understand legal issues
People with no children have decreasing choices
Communication styles different among generation
U.S. Cellular training program
Safety issues without computer
Senior network for profession is ineffective and would benefit from a data base/clearinghouse
Frustration level of sorting out resources and give up
Income issues for meeting needs
Inpatient is prevalent
Trust issues and avg. people don't always know right questions to ask
Long distance care is a totally different world
Navigating health resources state to state issues
Transportation/driving a care must be monitored and a strong willed independent person is a challenge
Get the white coat involved
Topography is not conducive to independence
Crosswalks are unsafe
Tele-medicine may be on the horizon
May need to provide bridge to make connection
If no need for face-to-face exam, tech may decrease office visits

Primary care docs are over schedule and don't have time to assess
Flash drive must be updated
HIPPA is limiting and goes way beyond common sense
Document/fear and liability oriented
Crisis reaction and crisis management
TN has good POA on line but legal issues still hard
Get out the power of attorney (documents available)
Making sure accurate information is promoted
How can you be sure you have accurate information?
What supersedes will? POA, bank account vs. financial POA
Auto immune disease increasing due to stress of BB, sandwich between 2 generations and fixers
Caregiver mentality

Facilitator Notes for Small Focus Group 6

More funding for in-home care for aging and disabled people, make eligibility less stringent
Affordable health care – people can't afford their medicines or insurance – • supplement the physicians to take Medicare • Medicare rules need to be adapted to Real Life Situation – elderly and disable are discharged too soon and when they need to be readmitted hospital keeps them in ER so they won't get fined
More funding for mobile meals – they all have waiting lists
More respite services for caregivers
More accessible transportation – frail elderly or disabled people need an attendant to escort them in and out of care and in and out of doctor's office – vans leave them too long – aren't very easy for frail people

Facilitator Notes for Small Focus Group 7

Affordable housing: Case manager - There is an increase of seniors without family support, housing that we currently have right now. There is a mix of seniors and under 60, senior housing is not safe (more senior housing). Same i.e., nursing homes – younger generation mixed in with seniors
@ Home care: Family members who want or who are caring for a family member. But family member can't afford to quit job and care for senior (need program that can help family stay @ home to care for senior)
Energy Help: Seniors living in older homes that in turn has abnormally high energy bills - $400 and up bills with incomes $600 to $1,000 per month
Foster Care: foster care for seniors – group homes for seniors – adopting a senior (good ideas!)
Community churches: partnering with local agencies to help care for seniors in church communities, with home visits, assurance calling
Nutrition: not enough of food! Even seniors that get mobile meals, too many seniors are doing without food. Seniors not able to get the food – no way to food banks – need a program that gives food to seniors that are not able to get to a food bank or other food distribution
Back Packs for Seniors!!: Maybe piggy back with senior nutrition to deliver easy open foods,

micro meals, etc. – work with the senior nutrition programs in each county – partner up with food banks, second harvest, churches, agencies – deliver pack once per week
Transportation: affordable, easy access, money for transportation – hand on hand transportation – assisted transportation – transportation can also prevent depression, can promote health nutrition
Mental health: more in home mental health care, more mental health – prevent depression – how can we prevent
Loneliness of Seniors: more contact for seniors
Most Important! - Transportation, Extended Nutrition

Facilitator Notes for Small Focus Group 8

Sign language instruction
Staying Healthy while Aging
Mobile meals – healthy and tasty, specialized meals
Affordable dental, hearing, eye exams and glasses and medical care
Health and Wellness
More D/C assistance
Decreased availability of housing
Availability of funding for meds
Independence
Outlive driving abilities about 8 years
Cut D/T without tx
$ for tx divided more evenly
Access when and where
Funding and coordination of services
Caregiving
Pre-planning for recoup from surgery or illness – meals, meds - transportation to and from appointments
Personal responsibility – for care
Education on condition and providing programs at various sites
Independence and Getting Services Easily
More networking between agencies and thinking outside the box – possibly sacrificing agencies' individual programs for a better outcome
Housing, Neighborhoods, Safe Communities
ID agencies in each community to recruit providers for services – maintain referral list with central group
Staying Connected and Involved
*Senior centers – branch out into areas that target local community needs and adding programs

that will meet a real need – set up satellite offices
Working with Older Adults and People with Disabilities
Add education regarding aging and respect
Abuse issues – especially drug abuse
Teaching police, etc. to know special needs and those with disabilities

Facilitator Notes for Small Focus Group 9

More truth and less politics
Unsure about the future – need "plain talk" to understand changes in Medicare and/or health care or any issues affecting elderly
CHOICES • Affordable housing issues – someone who would need assisted living but cannot afford it. The person that is in the "gap" needs help. • Not enough options for disabled people who cannot afford to refurbish their hone to make it accessible and needs to more into an accessible apartment/room
Working people in a gap between TennCare need financial help
Need housing opportunity to share duties to help the disable. There are some places, but very few in this area
Program that would allow someone to monitor those who need monitoring – maybe all live in the same house
Transportation mileage that is unaffordable for those who need transportation
Agencies need to work together to help people in need – especially in small rural counties
Since the inception of CHOICES there has not been a raise to the provider and the gas prices, etc. have continued to increase
CHOICES is a big savings to the State by keeping the elderly out of nursing homes
Seniors are being scammed more often
Seniors need to be checked on more often. Visits needed from dependable persons
Need help to find a doctor or other healthcare – Doctors are not taking Medicare/primary care and some doctors are dropping TennCare
Clients need to be able to go to dentist and get other care, but they need insurance before they are accepted.
Transportation from this area to Johnson City is an all day trip with transfers of vans and the cost increases for each county line crossed
FISH and KARM is visible in our area and have volunteers to help
Good dental health is needed for seniors who cannot afford it,
Need accessible and affordable transportations in rural counties – everywhere – need to partner with disability agencies and senior citizens agencies
Needy people who are disabled need to be able to be transported. Volunteer Assisted Transportation in Knoxville is good, but service needs to be in all counties
Some disabled need equipment donated or affordable for their vehicle. Sometimes they need to find a provider to do maintenance also.
Compassion Coalition – over 2,000 to 7,000 churches – group of churches that help with needs of people in the community (i.e., elderly man needs roof on home in Anderson Co. – church in Anderson county does project) (i.e.; disabled needs a lift for vehicle - $500
Mobile meals program – there is a waiting list in our area. Need additional funds to provide

more meals
Need to develop a foster care program for the elderly
Lack of education and knowledge of programs is common with the elderly
Better integration of services that cross county lines – elderly and disabled
Need additional guardians for those who do not have anyone to be a guardian, especially in rural counties

Facilitator Notes for Small Focus Group 10

Some co-pays should be required if customer can pay – sliding fees too
More services should be available in outlying counties
More in-home services – in-home services should include meal preparation
Services for elderly homeless
Need congregate meals on weekends too
Bedbug and other pests in complexes
Housing options for those who don't qualify for Medicaid – from Medicare standpoint, more affordable assisted living
Partner with church groups like Family Promise to meet needs in community – increase efforts of Circle of Support and FISH program – good models for nutrition and even housing
Boost volunteer – assisted transportation particularly in rural areas
Transportation in general, especially wheelchair accessible
Need care settings – adult care homes for hard to place patients, traumatic brain injury, mental illness, and obese patients
Assistive technology and adaptive equipment
Mental illness – more training for police, etc. – better treatment – more long term counseling and medication stabilization – more services/case management in home to reduce hospitalization of chronically mentally ill (like PACT with Helen Ross McNabb) ("do more on front end to prevent crises" like hospitalization, jails, homelessness)
More defined ADA parking enforcement – more "cut out" in sidewalks for wheelchairs
More ramps, etc. to promote handicap accessibility

Facilitator Notes for Small Focus Group 11

Elderly outlive everyone who can help them, then it's a crisis. Example: person with disability (DD) and parent dies. Families not preparing but also resources are limited. Need system that builds resources. These resources are overwhelmed. Some how reach out to elderly family member and help them make a plan for the adult child with disability (education and resources needed) – all disabilities need this – MH/DD/etc. Need to navigate easier through the system we already have
Help to navigate through the system – forms; unable to read/hard for those who are trying to live independently
Barriers to helping people
Outlying counties – issue is transportation for folks that don't have family or friends to help especially to go to Dr.
Need housing in rural counties - affordable
By the time they pay basics, there is little money left for housing like assisted living
People live in less than desirable living situations, don't want to go to nursing home, challenge

to get them safe housing
When person wants to go home from nursing home, some don't have a home to go to and the nursing home has only 30 days to find a place – Discharge to shelter
Real issue with people discharged from nursing home to community but no "in between" place
Harder to get approved medically for Medicaid
Some people need to be in nursing homes – also need supportive homes for vulnerable mentally ill, etc
As a caregiver, what are my rights as the person who take care of younger sister who has dementia, stroke, drug, alcohol use – I have no help. The sister refuses to get any help. I'm afraid to leave home. What are the resources to help me?
Homes for aged/assisted living qualify, but just barely and people are living in less than desirable situation, they need somebody to watch over them – home is clean, well lit, cares about them as a resident – needs things to do – go to park
Need for more training for people who run homes for aged
To eat healthy, it costs $, so they are going for convenient and cheap. People have a hard time standing up to cook.
Even staff who work in the field have a hard time keeping up with all the resources (Resource Directory very helpful.)
Need to have more places that people could call up and get help. It's all word of mouth.
By word of mouth, information about what faith-based organizations are doing – need for coordination and info – need more coordination
Need help with people who need to move
Needed help for someone who lived in Nashville, didn't know how to get help for someone in another town
Hard to get information on services. Time is limited for staff people, get the run around – wasted time (hassle and run around)
More finances for aging in place
More networking of the agencies
More affordable housing
More transportation in rural counties
Just because you're older, you may not be disabled, and you need employment (3-4 hours per day)
Need affordable dental care
Issues discussed on the larger group (Jim Shulman facilitating)
People are being let out of hospital in as cab and no help at home (no transitions)
HUD Housing – seniors feel unsafe because of the younger people using drugs – need complexes for just seniors. This also happens in nursing homes.
APS – hands are tied – waste of our time to call them – we need to know what they are allowed to do or not (they can only help if "imminent danger")
Need better oversight of MCOs – in response when families have issues
More funding for CHOICES and Options

Facilitator Notes for Small Focus Group 12

Needs of Seniors:
Awareness of day care agencies that are available
Takes as long to get senior approved for CHOICES
Too many seniors falling through cracks because they are above monetary guidelines
Transportation is often a problem for seniors in rural counties. Senior Center attendance would thrive - Upper East TN has voucher system for free transportation to senior centers
Research volunteers to help with all programs
ATTAC is providing computers – State surplus is trying to distribute used computers
Caregiver training before the need arises
Brain games – competition between senior centers from county to county and resulting in a statewide contest. 3 championship teams competing in the final contest in Nashville, possibly at Belmont.

Facilitator Notes for Small Focus Group 13

Increase in the # of home meals needed – funding cuts probable to affect
Title 3 programs funding – cuts expected but current funding is already insufficient • Transportation • Homemakers • Sr. Companions
Dental and hearing needs – education of benefits and services available
Proper assessment of need
NF care – activity
Ratio of care providers to residents in NF
Take more action & put more funding toward HCBS
Mental health needs continue increasing for elderly and disabled with little or not resources available • Depression affecting physical well being • Need a holistic approach
Rural areas affected by lack of resources
Lack of knowledge about Medicare/Medicaid/insurance
Opening up lines of communication about planning for LTC (families) • Proactive action become common practice
Elder Abuse = APS (need improvements in process outcome)
Organize resources
Housing, housing, housing!

Facilitator Notes for Small Focus Group 14

Transportation, especially assisted
Transportation for low income seniors
Road condition issues
Funding for dental/eye/hearing
Increase OCL in-home services
Eliminated donut hole – penalties
More stipend opportunities

Resources to get meds to seniors
Dual diagnosis Alz./MR issues – how to get the resources
Increase respite care
Better hospital discharge coordination
Way to get resources
Increase APS resources
Home repair services – develop community resource responses – UAW/old Dominion Trucking
More for mobile meals
Develop partnerships with colleges, schools – intergenerational
Raise awareness of aging issues for medical community, police, etc.
Medication management assistance – in-home (reminders)
Case management in home for seniors
Utilities assistance for seniors – help with insulation, caulking
Affordable assisted living
Affordable health insurance (subsidies, other)
Awareness (aging) training for volunteers, anyone working with seniors
Solutions for elderly homeless

Facilitator Notes for Small Focus Group 15

Staying Healthy While Aging – NEED:
Healthy food, help preparing food, enough food (so does not need to worry about getting next meal)
Education to prevent falls since one fall can begin the demise of a senior adult (cited 40% of hospitalizations are from hip fractures and that most will never regain their independence)
More education about how to stay safe (Senior Safety Task Force, Sheriff's Department, Knox County – promotes prevention – exercise, home safety, medication management and good vision)
More opportunities to participate in "Stay Active and Independent for Life" (SAIL, CDC-funded) program
Brain fitness programs
Health and Wellness – NEED:
Greater focus on socialization to prevent depression and resultant physical decline
Much easier process for making application for Social Security and Medicare (current system is too complicated for older persons; many inadvertent mistakes are made and seniors suffer consequences)
More access to programs like Senior Companions (participant said she works through Knox CAC in a stipend Senior Companion role, feels she makes a positive difference for the consumers she serves)
Education and support for older persons when they are discharged from hospitals with a "bag of medications" and don't know what to do with them when they get home because they are weak, confused and still sick (said hospitals, doctors, pharmacies need to pay more attention to the issues that ensue when elderly patients don't take their meds as prescribed post-discharge; noted penalties to hospitals for readmissions under the new health care law as motivation for

change; suggested a chart be sent home with patient to clearly show meds and schedule for taking them - hospitals/doctors/pharmacies would use same chart)
Teach seniors to ask questions about their medications (of their doctors and pharmacists)
Teach older adults the importance of throwing old/outdated medications away (cited her parents were born during The Depression and refuse to throw anything away)
Teach older adults about the dangers of taking tranquilizers and pain medications on an ongoing basis and restrict doctors from prescribing them for long-term use (said when her parents were younger tranquilizers and pain meds were frequently prescribed and that parents expect pills to be "like magic")
Fewer medications for older adults (said sister changed to new doctor who reduced the number of meds she was taking and that she feels much better, is more active, etc.) Advocates for older persons to interface with doctors and pharmacies around medication management
"HomeMeds" program (developed in Tarrant County, TX; evidence-based; reduces medication errors through patient support; suggested could use AmeriCorps workers to implement)
Focus medication management efforts on homebound seniors and adults with disabilities
Develop training for persons who work with seniors and adults with disabilities to learn how to motivate them to focus on what they can do, instead of what they cannot
Educate older adults about the dangers of smoking and offer more opportunities for smoking cessation learning (said sees many older caregivers who still smoke and make the statement that smoking is the only bad thing they do)
More focus on brain fitness
Caregiving – NEED:
Education on being a caregiver, as well as being a care recipient (said most adults will be either a giver or getter of care at some point; AARP is focusing on caregiving this year)
Much more help/support for caregivers (husband/wife team have non-profit that trains caregivers – individuals and providers – offering free, evidence-based education to unpaid caregivers; cited stat that indicates persons caring for loved one with dementia often die first; 655,000+ caregivers in TN suffer from depression and financial distress)
Mental health support (60% of caregivers have moderate to severe depression, are raising grandchildren in addition to caring for spouse or parent)
Financial support to caregivers who must retire early or give up jobs to provide care (average hourly rate lost by caregivers is $25)
Utilize AARP NC model for education and facilitated support groups for caregivers
Independence and Getting Services Easily – NEED:
Understanding that as we get older, we will probably not be able to do what we always did (e.g., repair the roof) and that being less able is okay; said the belief that we should maintain all of our physical abilities causes depression (suggested educating on appropriate aging and slowing down some)
Housing, Neighborhoods and Safe Communities – NEED:
Neighborhoods for seniors and older adults that foster "loosely-knit support" among residents (stated his father lives in a retirement community where he has observed that fellow residents care about and for each other on an informal basis)

Protection from grandchildren and adult children stealing and selling/using narcotics prescribed for a legitimate issue for the older adult (mentioned medication collection and disposal programs)
More transportation access (said no public transportation available in Blount County)
Help getting groceries (shopping, getting them home and into the house and put away)
Staying Connected and Involved in the Community – NEED:
To live in communities, rather than alone
To have opportunities to develop new friendships as spouses and friends die
Help to be able to go places (assisted transportation options)
More income to be able to afford to participate in activities (movies, church, senior centers, etc.)
Working with Older Adults and People with Disabilities – NEED:
Teach those who work with seniors to develop substantive relationships with their clients (said good program, "Emotional Isolation and How to Deal with It," teaches that superficial relationships do not bolster the sense of self-worth for older persons, but have a devaluing effect on them; said it is possible to maintain healthy boundaries and still have meaningful relationships)
Teach health care providers to address elderly patients appropriately, rather than addressing questions or discussion to the adult children who accompany the older person to appointments (said with "Silver Tsunami," health care system will be overwhelmed and Boomers will not tolerate being ignored)
Other
This group was comprised of a county AARP representative, a Second Harvest employee, a Health Department Injury Prevention Coordinator, an Alzheimer's Tennessee representative, a Senior Companions worker, a BCBST representative, a librarian and a couple who operates a non-profit to train consumers and providers about caregiving. Most group members were engaged in the conversation, had ideas for improving existing service access and delivery and expressed interest in learning the outcomes of the statewide needs' assessment initiative.

Needs Assessment

Upper Cumberland Area Agency on Aging and Disability
Life Church, Cookeville
February 21, 2013

Number of Attendees: 103

Upper Cumberland Area Agency on Aging and Disability
Life Way Church, Cookeville
February 21, 2013

What are the hard things that "baby boomers" face? How should the state of TN help?
(Number of Questionnaires containing 1 or more responses - 33)

This open-ended questionnaire was designed to elicit qualitative data from the attendees about how they thought aging would impact baby boomers. However, many attendees also identified issues that currently exist. Attendees were able to respond to the questions in any manner that included short, one-word answers, such as transportation, to very involved responses. In order to provide some order to the responses, major topic areas have been identified. In addition, some topics might include sub-topics for the purpose of reading the report more easily. Repetitive responses are included only once.

1. **Easier Access to Services Without Hassle** (including information and assistance; communication; and technology)
    - Better access to services
    - Create a better means to access services – the processes should be more accessible and easier to understand
    - The need for increased computer skills to gain services
    - Learn more about hospice and what they do
    - Not knowing what assistance is available
    - Finding relevant information covering insurance, housing, etc.
    - Everything appears to be going to self-service due to computers
    - Making baby boomers be informed about health
    - Cancer awareness
    - Computer issues and phone issues – training
    - Getting info pertinent for insurance (SHIP)
    - Need a "master list" of available services – in church offices
    - Easily understood information about services offered via the State. Getting such to non-email recipients
    - Some baby comers don't know what their choices are out there, I think after a certain ---DOB should send information out – do they know they can help
    - Caregiver information and support awareness – advertise/website

2. **Healthcare** (including in-home services; Home and Community Based Services; long term care; chronic disease; Alzheimer's disease and related dementia)
    - Affordable health care and medication cost
    - Being able to stay at home when ill or hurt
    - Increase day care would decrease the need for institutional care
    - Money for medicines and being able to live on fixed income
    - Medical care – we need standardized care for standardized costs and readily available
    - Provide more benefits and services, meals
    - Many are grieving – fund counselors for every other week or more

- Affordable health care with healthy lifestyles
- Large number of baby boomers that will soon be entering the health care system
- If medicine funds will be available for all, the people that will be needing it.
- Available community resource that aren't affordable
- Not being able, medically, to make their own decision. Have support groups to let them know its OK.
- Medication Assistance – "donut hole issues!"
- They need the help of SHIP and their volunteers. The State can help by not cutting funding.
- Offering programs for individuals who are not in poverty
- Some programs that are designed to help are income/asset based – too much income
- TennCare – replace it with a more user friendly programs
- Not being able to care for myself
- More service for them – more info for the services
- Affordable prescriptions for them
- Aging – age 65 and onward – "Quality of life" for physical, emotional and overall wellbeing – be able to afford care for themselves as they move in life from independence to dependence
- More real, direct help and service at grassroots level where needed
  -Cost of medical supplies
- Medical care – TennCare
- Health disabilities
- Needed assistance that is unavailable
- Health/mobility issues and how to pay for services. Carefully screen these people to provide appropriate/available services
- More assistance for in-home care
- Access to needed home and community based services such as home delivered meals, homemaker, personal care services
- Assistance in-home with activities such as cooking and cleaning
- Giving up their independence – having to have someone come in and help them do daily activities in their home
- In-home caregiver assistance to ensure their safety
- Loss of abilities – provide caregivers
- Long waiting to receive in home care – should be as quicker process
- Option for low income elderly to live in affordable assisted living – or stay at home with caregiving at affordable levels or provided by TennCare
- Getting long term care
- More option 2 approval on Choices program
- Cost effective alternatives to LTC facilities and other LTC services
- Free dental and hearing exams and help with treatment - eyeglass assistance– free testing at centers. Need for regular dental and vision testing and payment of these services
- Chronic illness – COPD, diabetes – many disabled at a young age
- Care of dementia residents

- Increase dementia-related disease and shortage of providers and funds

3. **Fiscal Concerns** (including health insurance; Medicare/Medicaid; employment; retirement; social security; cost of living)

- Being stuck in the middle of having too much money, but not enough to pay for needed services
- Need more assistance/tax cuts for middle age, middle-income people
- Financial concerns from living longer
- So many that need help that the gov't will not be able to take care of
- National debt
- Putting in place a plan for loved ones to that they are not a burden on their loved ones
- Not enough income
- Collapse of value of investments
- Assistance with banking, business
- If we bankrupt State, all seniors and other citizens will suffer more.
- Excessive amount of individuals applying for assistance
- Fewer pension plans
- Affording health care – insurance becoming so expensive –raising deductibles in order to afford insurance and then avoiding care due to falling in the deductible range and insurance won't cover
- Due to housing loans being difficult to obtain – renting/lease expenses are high – really taking advantage of those that may not be able to get a lesser expensive home loan
- Need more crackdown on insurance companies – raising premiums even if client in good health – need insurance options
- Planning for their care and future needs affording health care/insurance cost – spend down
- Health coverage – not sure
- Paying for healthcare and paying for the cost of insurance
- Affordable insurance supplements
- Insurance costing too much – provide cheaper insurance
- Not being educated on Medicare/Medicaid – have training/meetings/more documentation how what it pays for and how it is paid
- Medicare – too many plans/info
- High costs of prescription drugs and medical services (insurance costs)
- With Medicare related issues as that continues to be more complex
- Fraudulent Medicare providers; lack of Medicare-accepting physicians
- Access to employment
- Transcending to possible part-time employment
- Finding meaningful thought provoking employment after retirement
- Work because to many will have to work past retirement age
- New technology in jobs –training
- Insolvent Social Security in 2025

- Social Security stability – lobby government representatives to limit social security disability, and place social security funds separate from general funds to preserve this program for seniors (for which the program was originally intended).
- Social Security being available
- Increased cost of living. Increasing costs of medicines, healthcare, long term care. Aggressive promotion is needed to advise adults as early as possible to save for retirement and their senior years.
- Rising cost of living and continued cuts in healthcare cuts – re-evaluate the increasing cost of living
- Cost of living increases outpace retirement benefits
- Enough money to get through the retirement years
- They can't afford to retire
- No or limited part-time work available
- There are so many that will hit retirement age at the same time – money and provision will run out
- Planning for retirement and long term care when needed
- Financially preparing for the aging years, i.e. having financial nest egg that provides for their health and welfare
- Lack of retirement planning and knowledge of healthcare laws and services available

4. **Support Services** (including transportation, meals/nutrition; elder abuse services; senior centers)

a. **Transportation**

- Affordable and accessible transportation
- Money for more services
- Transportation for evening and weekend events – increase u-carts routes and hours - step risers on vans
- Resources for transportation, non-covered services in the home
- Adequate, accessible transportation for both medical and non-medical assistance
- Transportation for elderly that is timely and easy to obtain
- Recognizable rail transportation service
- U-carts or other etc. or having better way to get to appointments, shopping, picking, exams

b. **Meals/Nutrition**

- Adequate healthy foods
- Lunch every day
- Commodities delivered to the Senior Centers
- Stipend to deliver meals
- Provide food from Second Harvest or other food distribution
- Nutrition
- Food programs could deliver bulk food monthly to those who can't travel to food pantries
- Grocery delivery

- Ability to get food – prep and/or pay for these. Services provided for persons as needed by person accountable when able

c. **Elder Abuse**

- Protecting elders from financial exploitation
- Free legal advice available for many daily life issues, not simply wills, deeds, etc.

d. **Senior Center**

- Staying active – support financially our senior centers so programs can be provided
- Senior centers will need to change to adapt to baby boomers. The State could help with a marketing campaign.

5. **Staying Healthy While Aging** (including exercise, eating healthy foods, socialization, chronic disease, staying connected and involved in the community, volunteer opportunities)

- Staying healthy and in shape
- Keeping healthy and exercise programs
- Isolation/lonely – promote community/provide companionship

6. **Adults with Disabilities**

- Develop training programs to help those with disabilities and adding adults gain new skills

7. **Caregiving**

- Multi-family care responsibility – children in home longer (can't afford to live out on their own) and parents – they need assist with care from all levels – housing –ADLs – financially
- Must take care of both parents and grand-children while still working
- Maintaining employment – caring for parents
- Balancing care of parents and care of children
- Baby boomers are now facing the task of taking care of the elderly parents while taking care of their children and grandchildren. They need support with finding resources and community
- Sitter services/respite – state approved funded attendant services
- Taking care of aging parents
- Loss of abilities – provide caregivers

8. **Housing, Neighborhoods, and Safe Communities** (including home repairs and utilities)

- Able to find affordable housing
- Suitable housing for individual's physical/mental needs
- Broader options available for home loans – subsidized loan options, etc.
- Not enough assisted living places
- Community involvement, seminars

- Assistance with staying connected to their community, i.e. volunteering, meeting new friends, staying busy with their idle time
- Affordable assisted living – offset costs
- Home - property less due to rising costs associated with increased taxes
- Advocate for 202 housing (HUD)
- Staying in home – money for more services
- Aging in place – need more options for care in the home, continuous care, retirement
- Living longer . . . assist with finding appropriate housing for persons in needs. Still give people some responsibility when able.
- Ramps – member have to be on a waiting list and usually is up to 2 years waiting list
- More help for members to get help on furniture or help around the house to fix floors or actually have good, they may have Choices and have good stand, and still have to pay bills and meds and can't get or pay for their house to fix the Big Safety problems on their home
- Supplemental payments for electricity for low income

9. Funding/Resources

- Conservatorship funding for adults 50 and up – mental health services – none available
- Money

10. Other:

- Maintaining employment while taking care of patients
- Undo new PAE guidelines
- The turmoil without our gov't. – don't make it worse with absurd laws and threatening legislation
- Government should stay out of doing welfare – welfare belongs in the hands of the churches!
- Churches must step up!!
- Help/learning to make decision with declining "smarts" – classes and resources
- State of TN should not do more than facilitate help

Upper Cumberland Area Agency on Aging and Disability
Life Way Church, Cookeville
February 21, 2013

Question: **Here are seven (7) aging and disability issues.**
Under each, there is a list.
Mark the ones on the list that you think are most important.

Number of Questionnaires completed: 81

Response	# of responses	%
1. Not having enough insurance or money to pay for doctors or medicine 2. Being able to get accessible transportation	59	72.8
3. Getting care at home instead of in a nursing home	57	70.3
4. Affordable dental care, hearing care and eye exams and glasses	56	69.1
5. Respite services 6. Being able to get help when needed quickly and without hassle 7. Training for aid workers who help older adults and people with disabilities	55	67.9
8. Transportation for people who don't drive cars	53	65.4
9. Housing that people on a pension or Social Security can pay for	52	64.2
10. Keeping healthy through exercise and eating healthy foods	51	63.0
11. Teaching volunteers to work with older adults and people with disabilities	48	59.3
12. Meals that are healthy and prevent hunger 13. Learning how to live with a serious condition like heart disease, cancer, arthritis	47	58.0
14. Meeting people and making new friends	44	54.3
15. Knowing where to call for help and getting help without a big runaround 16. Houses that are easy to get around in if you're on a walker or in a wheelchair	41	50.6
17. Help with memory loss	40	49.4
18. Protect people from abuse 19. Learning about how to care for someone at home	39	48.1
20. Making decisions about health insurance, Medicare, and planning for the future without depending upon the government	37	45.7

21. Reasons people have to go into nursing homes 22. Learning about how to take care of yourself so that you don’t get sick and tired 23. Learning new things	36	44.4
24. Understanding how Medicare works	35	43.2
25. Teaching doctors, nurses, and other healthcare workers to know the special needs of older adults and people with disabilities	33	40.7
26. Being able to choose the workers who come into your home	32	39.5
27. Teaching police, Firemen, emergency workers to know the special needs of older adults and people with disabilities	31	38.3
28. Help with taking too much medicine 29. Eating out with friends	30	37.0
30. Learning how to prevent falls	29	35.8
31. Help with chores like lawn mowing and leaf raking	27	33.3
32. Reasons people have to go back to the hospital 33. Neighborhoods that are easy and safe to walk in 34. Places to volunteer	26	32.1
35. Help with feeling sad or lonely	24	29.6
36. Being able to get accurate information from a website and being able to apply for services on-line	20	24.7
37. Neighborhoods that have grocery stores close by	17	21.0
38. Help with drinking too much alcohol or taking drugs	12	14.8

Other:

Meaningful activities, spiritual and otherwise
Some medical personnel available periodically to answer question and address concerns when people cannot afford or cannot get to a doctor
Create yellow dot program (AARP) or the Vial of Life on house
Understand how Medicaid works
Having the member get money that are on a fixed income to help the aide with enans.(?) Members that don’t have a care, we should have a special transportation for members that are on these services.
Providers should have more info on all the options there is out there. A lot providers don’t have enough one their snap card to last the whole month.
Being able to get accessible transportation - Members bend the aide ride and have problems with meals for diabetic and bathroom breaks for UI and can’t go so they go in their depends.
Need more options for transportation
Houses that are easy to get around in if you’re on a walker or in a wheelchair - Member have problems trying or not having money to make ramps or insurance won’t pay.
Family support, Community support
Education concerning legal information such as living will, healthcare, POA, etc.
Public education (e.g. TV spot ads) on respect and helping elderly
Understanding how Medicare works – no one knows!!

Help with taking too much medicine – most seniors take <u>too</u> many meds because Dr’s. keep prescribing to

avoid liability
Being able to get accessible transportation – UCART tries
To get better meals at the Overton Co. Senior Center instead of warm over from Gainesboro. Get it from nursing home.
Suggest workshop for physicians and staff to learn about programs offered
Classes offered to families educating them on the value of the seniors in their family
More funding for help!! State and federal
Home delivered meals program
I'm a nurse director of CHOICES for NOTO – my patients are my #1 thing to keep them safe in home. Transportation I think is the worse thing with this program.
Employment opportunities for people with disabilities or older adults; job coaching; life skills training; teaching business about hiring these individuals.
Greater emphasis from UCDD & TCAD for services for people with disabilities (seems there is a greater emphasis on the aging population)
People in nursing homes are often not receiving adequate care by physicians, routine checkups, etc. I think that people in nursing homes should be visited by doctors and receive routine exams to ensure their healthcare needs are met.
Workers that are available that can assist in the home with the elderly
Money for more services – 370+ on home delivered meal waiting list – needs to be reduced

Upper Cumberland Area Agency on Aging and Disability
Life Way Church, Cookeville
February 21, 2012

Question: **What is currently working well in your community?**
(like agencies that help, neighbors who help each other, van service, senior center, meal sites, food pantry, healthcare clinic, nursing home, sidewalks, police presence, grocery stores that deliver)
(Number of Questionnaires containing 1 or more responses - 66)

This open-ended questionnaire was designed to allow attendees to identify the community programs and services that have worked for them and in their community. Evidence based and/or proven practices were not a consideration in the design of the questionnaire and no checklist was provided. The above items in parentheses were provided as examples. Attendees were asked to write in the programs and services that were working well in their community. The responses are individual and specific to the region served by the Area Agency on Aging and Disability. The number of attendees who indicated that the program is working well in the community is provided in parentheses ().

<table>
<tr><td>Food pantry (7)
• Senior center and Welchland Baptist – food pantry</td></tr>
<tr><td>Police presence (5)</td></tr>
<tr><td>Several opportunities for volunteers – library, nursing home</td></tr>
<tr><td>Upper Cumberland Development District (UCDD) (4)</td></tr>
<tr><td>• Upper Cumberland Human Resource Agency (UCHRA) (7)
• UCHRA/White Co.,</td></tr>
<tr><td>Area Agency on Aging and Disability (AAAD) (4)</td></tr>
<tr><td>• Meal sites (4)
• Congregate meals (5)
• Home delivered meals (3)
• Meals on wheels (6)
• UCHRA nutrition
• Senior meals
• Meals delivered – great need since less are qualifying for nursing homes – but very difficult to get access to – long waiting lists
• Commodities
• Home delivered meals from nursing home</td></tr>
<tr><td>• Churches (2)
• Church in area that distributes food
• Life Church helps the DAV and many others
• Several of our patients receive assistance from churches in the form of food items, financial services, and home health care
• Churches: Help Hands</td></tr>
<tr><td>Unaware of any grocery stores that deliver</td></tr>
<tr><td>CRMC (Cumberland Regional Medical Center)</td></tr>
</table>

Community agencies that help
Agencies that help
Neighbors who help each other Family members and friend, neighbors that are always willing to go that extra mile
• Grocery store that delivers/Clay County • Need more groceries that could deliver • Floyds Grocery/Sparta
• Transportation/Public transportation (7) • Transportation for senior and persons with disabilities • Public transportation = is about the best but they still have work that can be done • Van services/UCHRA van (8) • U-carts (6) • No personal experience (yet) but I think UCHRA transportation might be
Alzheimer's TN Regional Office Services: • Alzheimer's TN for support/direction
Rescue Mission
Pharmacy • There are pharmacies that will deliver • Pharmacy delivers • There are a few pharmacies in the area that deliver meds
Senior centers (18) • Allgood Senior Center is great resource site • Seniors centers offer opportunity to make new friends & stay socially active • Senior center only thing working in community • Services provided by area senior centers • Senior center and healthcare clinic in Baxter • Senior center – Putnam – YES – Maxine Frazier • Need funding for UCADD and for senior centers/please provide additional funding • Senior citizen center/Sparta • Senior centers with meals • Senior centers are good in some places, but others are too "clicky" • Senior center is helping a lot, they need more info for the seniors. More info on the food pantry so more seniors know what's out there. A lot of seniors don't know what they can get.
• Nursing home (2) • Nursing homes present but are much harder to meet LTC criteria
Geri-Psych Units readily available but none to deal with alcohol and detox except Ten Brook Tennessee at CRMC but that is more adult structured
There are a lot of providers in our area but the problems are hard to get around. We need more funding Respite care with dealing with Alzheimer's, etc.
Have health agencies able to offer help to seniors wanting to stay independent and at home

SMP/SHIP SHIP is very helpful (Meghan Moore)
Public awareness has increased in recent years. Doctors, nurses have a better understand of people's needs. Food Pantries in area have become increasingly important as the costs of food increase and government payments stay the same
Cleaning project started by Clare Farless at UCDD/AAAD
Volunteerism: • Ministerial programs that provide volunteer assistance • Volunteer programs from churches
Service providers – non-medical and medical
Senior expos
Community support
Help program
• Options and CHOICES Programs (2) • Screening for Choices LTC • Choices program – YES • Options – NOT – waiting list
Emergency – 911 services
Life line – YES – but $ for some
Health department
SHIP & Choices
Adult day care
Senior companion program
I work with State of TN Services for Blind & Visually Impaired. We show people that are physically able, but have vision impairment to be more independent in doings things around their home by showing alternative way or assistive devices.
Senior center; food pantry – multiple options throughout the community; day habilitation programs; vocational rehab (could be enhanced but is a valuable resource); networking opportunities for agencies/providers to collaborate; employment options like Goodwill (need more opportunities)
Second harvest food bank
Local agencies working together to provide assistance – donate money and fund local programs
Helping hands
Elder Abuse agency – need more; delivery services
Home and community based services
Community center
We have no delivery grocery in Tansi; no sidewalks in Tansi, little police; we have good neighbors; Crossville has 2 good senior centers/Tansi has none of the other services. We need van service, meal sites, food pantry, healthcare clinic, nursing home, SIDEWALKS, delivery grocery.
Cookeville Housing Authority – Elderly housing is clean & safe NHC Nursing Home – great staff & director Public Conservator Office very helpful & professional CRMC Rehab Facility is great – CRMC ER – NOT great

Ombudsman Marie Ferran – smart and cooperative
Apartments for elderly
Networking amongst healthcare providers, State, county and gov't. agencies; DHS-APS; senior centers and local health department; homecare services (various); nursing home care (need more dementia/Alzheimer's units)
The White Co. Senior Citizen Center – excellent job!; unaware of a grocery store that delivers in White Co.; police presence could be more prevalent
Habitat for Humanity; LBJC; Food pantry at White Co. Agricultural Center
CRUC – low income housing

Upper Cumberland Area Agency on Aging and Disability
Life Church, Cookeville
February 21, 2013

Small Focus Group Responses

Upper Cumberland Area Agency on Aging and Disability
Life Church, Cookeville
February 21, 2013

Facilitator Notes for Small Focus Group 1

Staying Health While Aging
Keeping healthy through exercise & eating healthy foods – more funding for meals as many don't have food
Affordable dental care, hearing care and eye exams and glasses – insurance should cover
Learning how to prevent falls – continue prevention education
Include cognitive impairments, treatment for mental illness at home treatment
Health and Wellness
Reasons people have to go into nursing homes – spouse may not be able to care for person at home – early prevention could prevent nursing home need
Reasons people have to go back to the hospital – Proactive Discharge Planning and good referral sources
Not have enough insurance or money – affordable insurance Medicaid expansion needed
Getting care at home – expand Choices $ for more services – Choices not enough currently
Understanding how Medicare works – education, education (SHIP)
Making decisions about health insurance, Medicare, and planning for the future – limited resources – income still a problem
Help with feeling said or lonely – more mental health oversight – need better insurance coverage
Help with drinking too much alcohol or taking drugs – will become a bigger problem in future – need to be more proactive now
Help with taking too much medicine – electronic system for MD's would help prevent or catch
Help with memory loss – more respite care/adult day care
Protect people from abuse – should be very high on the list – see lots of these problems more and more – regionalize abuse hot line – direct access to case workers
Caregiving
Respite services – need increased hours
Learning about how to take care of yourself – caregivers must have breaks as they will wear down quickly and most are not also caring for grandchildren
Independence and Getting Services Easily
Being able to get help when needed quickly and without hassle – increased funding so people can answer live
Being able to get accurate information from a website and being able to apply for services on-line – Baby Boomers will use computers so this could be useful
Being able to choose the workers who come into your home – people like to have people in their home they know
Being able to get accessible transportation – work on transportation that can meet all needs, mot has restrictions (wheelchairs, etc.)

Housing, Neighborhoods, and Safe Communities
Help with chores – more community outreach (Churches, etc.)
Neighborhoods that are easy and safe to walk in – more HUD/202 developments – more affordable
Neighborhoods with grocery stores close by – Dollar store concept with delivery services
Staying Connected and Involved in the Community
Places to volunteer – not lack of places but volunteers
Learning new things – are plenty out there just encourage them to participate
Meeting people and making new friends – making senior centers more safe
Working with Older Adults and People with Disabilities
Training for paid workers – continue training
Teaching police, firemen, emergency workers – could save problems – use something like yellow dot program
Other
Working with underserved groups that may not feel comfortable talk to their family, etc.

Facilitator Notes for Small Focus Group 2

Food for hungry seniors is a big need. Not just dropping some frozen food at the door. People need a warm meal that is already prepared. So often those who can't make it to a meal at the nutrition site, also feed isolated.
I think it is a shame that people are on the waiting list for 2 years to get home delivered meals. Before we try to fix anything else we need to make sure that seniors aren't starving or having their health compromised by poor nutrition.
There is a need to coordinate all the food providers in the area so we are able to tell where the needs are greatest. There are churches and civic groups that provide meals or are willing to provide meals if the effort is coordinated so that there is no duplication or leaving people out of the loop.
Meals need to move closer to the people so that they are hot when delivered, and cost is reduced.
Baby Boomers are going to want a lot more choices in meals.
Overton County, poor county, the wait is 3-4 months for a home delivered meal, but the wait is forever 3-4 months, no one ever seems to get off the list and onto the meals.
Lack of a place and opportunity to exercise. Tied to isolation, transportation motivation.
Not a lot of resources that are known of for older folks who are feeling depressed as the losses begin to pile up, decrease in sight, loss of significant other all at once or one day at a time with dementia, loss of mobility, Mental Health as treatment and prevention.
Emotional health needs a lot of attention. Often people are willing to help out by raking leaves and changing light bulbs, what might be needed is a kind ear to listen.
All of it seems to tie together, emotional health, nutrition, exercise and a place to be connected to others.
Caregivers, especially for Alzheimer's and other dementias need a lot of support either through

respite or information and education or both.
There are speakers and health fairs but what is needed is something like the diabetes support groups for other chronic issues.
Often it is hard to get people to ask for help, example caregivers feel like they need to do it themselves, don't want to admit that they need help.
There is a need for a trained group of volunteers that are screened and trained to do small things around the house , but mainly to check on and listen to people.
U-cards (U- carts?), uchra transportation is terrible, pick folks up early drop them off at home very late with a medical apt in the middle. Some felt all the time and coordination was being used on TennCare pts. Need access to affordable transportation without long waits.
Someone needs to monitor how transportation is done, too many ways to take advantage of vulnerable seniors.
Need to make the homes safer, help clear clutter, repair flooring and wiring.
Need more and better coverage for eyeglasses and dental.
Suggested coordinating with VR, who runs workshops to train staff, to train and background check personal care and homemaker workers.
What is working:
The SHIP program great, non-biased information at no cost to the consumer.
*Legal Assistance is not working.

Facilitator Notes for Small Focus Group 3

Meals are not good – "feed them to dog"
Specialty meals are same one (HRA)
nutritional risk assessment not being completed on all clients – Choices (AoA)
Should be transportation just for Choices
12 hour van ride – transportation
Need more education about what services available
More Options hours
More training for the elderly about issues that affect them
Employment opportunities for seniors who needs
Train how to hire those with disabilities and elderly people
Enhanced training for those with disabilities
Medications 4 or 500 dollars
Education of doctors about programs
Too many meds being prescribed
Not enough doctors who understand disabilities
First responders need to be more educated in elderly and disabled
More network opportunities
More outreach to doctors and hospitals
Teeth – dental
Eye glasses
Home care equipment
More home modifications
More outreach to dentists to figure out how to better get dental work done for seniors

Partner with DHS
Dinged up halls due to wheel chairs in Senior Housing , Seniors being charged 4-5 hundred dollars for damage.
Training on how to use equipment
Training on individuals on abuse

Facilitator Notes for Small Focus Group 4

Staying Healthy While Aging – NEED:
Increase funds to reduce long waiting list for home-delivered meals
Increase access to food (great need for food in this region)
Help with cost of food
Commodities dropped off at senior centers in every county (rather than consumers, many of whom lack transportation, having to go to another location to get them)
Increase congregate meals to five per week from current four
Reinstate hospital discharge priority status for home-delivered meals (persons just discharged from inpatient hospital settings no longer eligible for meals)
Encourage health plans to provide more comprehensive availability of Silver Sneakers Program (some said would like to participate, but would have to travel a distance to do so)
Educate about benefits of eating properly and exercising regularly (15 of 20 senior centers have exercise equipment)
Increase funds for transportation vouchers (region supplies vouchers to consumers to use for any type of ride they wish, but supplies are limited, funds will run out and voucher program may end)
Teach seniors how to use, care for (clean) and change batteries in hearing aids (schedule regular sessions at senior centers for this and other similar activities)
Get information on services out to more consumers (many are unaware of what's available)
Health and Wellness – NEED: **As above,**
Increase funds to reduce long waiting list for home-delivered meals
Increase access to food (great need for food in this region)
Help with cost of food
Commodities dropped off at senior centers in every county (rather than consumers, many of whom lack transportation, having to go to another location to get them)
Increase congregate meals from four per week to five
Reinstate hospital discharge priority status for home-delivered meals (persons just discharged from inpatient hospital settings no longer eligible for meals)
Encourage health plans to provide more Silver Sneakers Program (at present, only four UC counties have the program; consumer said would like to participate, but would have to travel a distance to do so)
Educate about benefits of eating properly and exercising regularly (15 of 20 senior centers have exercise equipment)
Increase funds for transportation vouchers (region supplies vouchers to consumers to use for any type of ride they wish, but supplies are limited, funds will run out and voucher program may end)

Teach seniors how to use, care for (clean) and change batteries in hearing aids (schedule regular sessions at senior centers for this and other similar activities)
Develop collaboration between dental, vision and hearing care providers in each county wherein each practice takes a turn giving free care on an annual schedule (some dental practices in area already offer periodic free care days; good PR for providers and for meeting needs of consumers; TCAD and AAADs would maintain online calendar of these events and work to inform public about them)
Help with cost of utilities
More education and information on health issues (White County Senior Center offers a monthly program "Breakfast with the Doctor" where doctor comes in to speak)
Help/tools to identify depression in seniors (one center director said it is hard to tell when a senior is feeling down because they usually perk up when with others)
More holistic approach to seniors' issues, like Choices MCO takes (MCO staff present indicated their program observes for mental health and substance abuse issues and refers people for help)
Better transportation system for getting consumers to Nashville for specialized medical care (long days, bumpy rides, uncomfortable conditions not good for sick people trying to get well)
Access to chore services (one senior center offers these to consumers – separately from Options Program)
Access to SHIP staff for more seniors (senior center director commented SHIP is very helpful to consumers)
Caregiving – NEED:
Volunteer programs like Senior Companions to provide support to consumer and caregivers (could serve to slow decline and forestall need for greater level of care; UCDD staff member said people who are sick, but not sick enough for Choices, decline when they are no longer being able to drive, become isolated and depressed – Senior Companions would keep this group able longer)
Better matching of caregivers to care recipients (Choices)
Independence and Getting Services Easily – NEED:
Transportation designated for seniors (Choices consumers take priority on vans)NOT SURE HOW THIS FITS WITH FREE RIDES VIA VOUCHERS, BUT SOMEONE SAID IT: Keep cost to ride down (currently $1/ride in Putnam County; has schedule of fees based on distance, e.g., to/from Nashville and other out of county locations)
Maintain funding for HRA Transportation Voucher Program (provides no charge, door to door rides; consumer must call 24-48 hours in advance to reserve, but county coordinators work to accommodate persons who do not call to reserve within required time frame)
Getting information about services out in non-computer-based formats (most older adults do not use computers)
Housing, Neighborhoods and Safe Communities – NEED:
Modifications of older houses to be accessible for ambulances
Senior housing facilities unsafe (younger residents using and selling drugs, being rowdy)
Affordable residential facilities where persons with mental illnesses (depression, schizophrenia and others) could live and receive supervision for taking their meds as prescribed; those whose

illnesses would be controlled could then become reliable workers (this population is underserved, there will be more among Boomers)
Staying Connected and Involved in the Community – NEED:
Identify ways to motivate seniors to volunteer (senior center director stated it is very hard to get seniors to volunteer)
Develop programs to help retirees cope with sudden loss of identity (when they are no longer participating in the work world where most had more responsibility than they have once they retire - UC staff member and MCO representatives – big issue)
Develop volunteer programs geared toward Boomers and seniors (model after local hospital where over 100 volunteers are very active, raising $50,000/year for the hospital's pet therapy program; volunteers are provided free meals while volunteering)
Working with Older Adults and People with Disabilities – NEED:
Help persons with mental illnesses become reliable workers by creating residential environments where they may live and have the help of supervision to take their medications as prescribed.
Other
This group was composed of a hospital social worker, three MCO representatives, an UC staff member, three senior center directors and one consumer.
Noteworthy comments from different members of the group were, as follows:
A local National Guard group periodically provides medical and dental treatment at no or low-cost; it was suggested that TCAD could partner with the National Guard at the state level to make this service available statewide.
An old Cookeville family of dentists (the Johns family) holds an annual event where free dental services are provided.
Bethesda Health Care sends a nurse to one senior center on a monthly basis to provide a different health-oriented presentation each month.
Suggestion that a senior center do a pilot project where high school students help seniors make and tend a community garden and/or teach seniors computer skills and seniors teach the students a skill like knitting or canning. THIS MAY BE IN PLACE NOW, NOT SURE.

Facilitator Notes for Small Focus Group 5

Staying Health While Aging
To expand on last bullet (Learning how to live with a serious condition like heart disease, cancer, arthritis) – education about their condition
Health and Wellness
Medical Resource Director and one location for all entities to contact for updating this directory. Also, in other areas such as respite.
Consider county site offices for AAAD

Caregiving
Flexibility within the employment industry to allow caregivers to care for loved ones
Certification process for staff to stay with care recipients; could be available on YouTube
Independence and Getting Services Easily
The requirement of 72 hours for reservations
Training on how to use internet and other computer-based technology
Horsing, Neighborhoods, and Safe Communities
Livable communities – bring stakeholders together
Resources for home meds such as wheelchair ramps
Staying Connected
Senior centers and ADCs are not utilized enough
To build on 2nd bullet (Learning new things) – learning computer/internet skills
Employment opportunities
Intergenerational activities
Working with Older Adults and People with Disabilities
Training on utilizing public transportation
Training curriculum for staff that is held in the home with caregivers present. Each situation is unique and varies home to home
Other
Elder law is so valuable and needed by everyone

Facilitator Notes for Small Focus Group 6

Staying Healthy While Aging
Exercise – seniors will not exercise for 1 hour – helping by breaking it up (senior centers)
Overton County meals coming from Jackson Co. Meals are cold and need re-heating. Should use local providers. Re-heating is ruining the food.
Need affordable clinics to help with dental, hearing; more money into health departments; maybe they can help with these services; preventative services very important – need access
Health and Wellness
Most people want to stay home, but caregivers do not have respite and they burn out – leads to burnout and abuse- respite funding is needed
Not a lot of people getting enrolled in group 2 TennCare; this is cheaper than group 1; why is this group so limited?
Need low-income assisted living based on income; we are hurting our middle class and making them low income
Socialization is very important
Widows are lonely, depression
Dementia patients falling through cracks; not ready for NH but can't stay at home safely

Like the vial of life program, but things change – how to keep seniors updating the information. Where is best place to keep information for easy access.
Caregiving
Respite funding
Need more $ - one day a month is not enough
Training for caregivers in the home – utilize home health
Some are forced to be caregivers
How do we know that caregivers are not hurting
Worry about retaliation to senior if report abuse
APS only get snapshots – they need more funding
Independence and Getting Services Easily
Respite
Caregiver training
Need assistance for short term help. People who are recovering from surgeries (HDM, HMK, PCS)
There is a waiting list need more funding
Need sitters they need training
Seniors are afraid to let people in home Getting worse every day
Transportation: not enough for non-medical trips – takes so long that peoples' food spoils – heard people had to wait 4 hours at the Drs. Office after her appointment
ER transportation for seniors – rural counties
More money for Options
Do needs assessment at senior centers couple of times a year – then link to services
Need assistance with yard work
Need a "pot of money" for volunteers – risk involved – they need to reimburse for some things (gas)
Easy access to county resources that everyone can use
Housing, Neighborhoods and Safe Communities
Trailers and low income apartments – drug use
Not enough housing for middle income seniors – would love for there to be assisted living facilities based on income
Lots of door-to-door crimes in the counties – need education for seniors
Need more weather alerts – Van Buren does not have any alert system for severe weather
Staying Connected and Involved in the Community
Need more transportation so they can get out – transportation has changed over the years – seniors are getting pushed out by medical trips and younger people using
More vans with ramps, etc. What about a volunteer helping people one and off – some people need a little assistance on and off van, but could navigate fine in town
Wait time

Working with Older Adults and People with Disabilities
Police, fire department, mail man, hair dresser: educate them so they can keep their eyes open for problems
Wellness checks by police department
Churches could also do wellness checks
Some people go for days without contact
Keep information in purse, etc. with medical, etc.
Teach about living wills

Facilitator Notes for Small Focus Group 7

Emphasis Health How much do you have to make? To get help? Make a little, too much to qualify Health & Exercise
Amount you make affects the kind of help you can get
Living with serious conditions – Taking care of husband with Alzheimer's but I also have a serious condition
Getting divorce so spouse can get care – shouldn't have come to that
Facing fact that help might not be available for Baby Boomers
Glasses/dentist – some can't afford the insurance
Do without food to pay for medicine Church has pantry – feed 200+ per week (gone up from 150) (city)
Cancer – unhealthy things that get put in food Food and Drug Admin. & Dept. of Ag have been bought off
Another persons says – well, we are living longer
Concerned about sugar, corn syrup, additives, etc. – known carcinogens
Cost of prescriptions monopoly on it, not going generic/issue with pharmaceutical company
Issue with doctors and pharmaceuticals/making huge profits
Doctors give too much medicine that Medicare won't pay for
People become disabled and in home doctor never referred – perhaps doctor's office doesn't know how to refer
Need more education of doctor's office about services
People who are newly disabled should be told of all the services that are available
Issues with substance abuse/medication abuse but they may not know they need help
Frustrating when you want to help people, but it may take months to them help (waiting list, estate recovery)
Thoughts of losing her little house, legacy, estate recovery
Thought of losing everything is biggest fear
Perhaps we need legal advocates for elderly
Stress and worry that you might lose your home
Churches helping caregivers – need more advertising of help/website available
DHS care workers should help people find services (like when the frail go in to recertify for food stamps – they should be more helpful)
Social worker's job should be to tell people what's available
Church staff should be observing and socials director should be referring – need training for

church staff and volunteers
Newspaper ads/facebook with information
The State of Tennessee has no business doing this for people, we are bankrupting the gov. – State should make sure that churches and charities that are taking in money and not helping people
If churches are not providing services, then they should lose their tax exemption
Churches need to do more community outreach and put sign out
Need to make better choices of how government money is spent
Prosecution of fraud
Gov. does a lot of good and there is a lot of shenanigans – we are taking notice
Balance budget
Training of caregiver – for at home caregiving
People don't know what's available Need a list of services We use SHIP, but many people have never heard of SHIP
Transportation – frustrating – 3 days in advance, what if something happens and need to go next day
What about U-Cart – works well if in advance
Need transportation to banks, etc.
U-Cart seems to work
State should make a list of the needs in the community & contact churches and let churches step and provide the service (like chores, etc.)
Perception is that neighborhoods are fairly safe
Some bootlegging in public housing
U-Cart will take you to grocery store
Courses to audit in community colleges – computer literate – senior centers
Need programs to get "life alerts" – some people need this, but doesn't have a land line
No transportation from outside city to congregate meal site
Congregate meals seem to be OK
Good word to postal service – fell at mailbox – letter carrier got him up
U-Cart has someone to ride with you if you need help
Background checks/certification need to be made for all who work with elderly & disabled Need professional training Need to be well-monitored (like child day care centers)
Need to be careful of abuse of elderly and disabled – it's rampant
Choices – family members get paid – ripping off patient – State doesn't govern this enough
Need to drop in on family in nursing homes because staff is not taking good care
Nursing homes are understaffed
Senior Expos – need to get people there – get churches to help

Needs Assessment

Greater Nashville Agency on Aging and Disability
Ajax Turner Senior Center, Clarksville
February 26, 2013

Number of Attendees: 74

Greater Nashville Area Agency on Aging and Disability
Ajax Turner Senior Center, Clarksville, TN
February 26, 2013

What are the hard things that "baby boomers" face? How should the state of TN help?
(Number of Questionnaires containing 1 or more responses – 41)

This open-ended questionnaire was designed to elicit qualitative data from the attendees about how they thought aging would impact baby boomers. However, many attendees also identified issues that currently exist. Attendees were able to respond to the questions in any manner that included short, one-word answers, such as transportation, to very involved responses. In order to provide some order to the responses, major topic areas have been identified. In addition, some topics might include sub-topics for the purpose of reading the report more easily. Repetitive responses are included only once.

1. **Easier Access to Services Without Hassle** (including information and assistance; communication; and technology)
   - Understanding modern technology – e.g. Email, etc.
   - Low income and public assistance info available in terms one can understand
   - How to get emergency assistance if necessary (especial those living alone)
   - Better information on what programs are out there for seniors
   - Caring for grandchildren – understanding school system and technology
   - Asking for help rather than going it alone or guessing what to do
   - The ability to get services right away, instead of always going to the hospital first
   - Be able to help when needed
   - Do they understand resources available whether disability or retirement

2. **Healthcare** (including in-home services; Home and Community Based Services; long term care; chronic disease; Alzheimer's disease and related dementia)
   - Support groups/senior education
   - Interpreters for non-English speakers
   - Doctor – general
   - Afford medical care
   - Better help with drugs and doctors
   - Help for the low income
   - Health workshops and support groups in evening or weekends
   - Medicine help
   - Continue to have available resources that are in close areas
   - Health care after retirement, education, nutrition
   - Fall prevention
   - Housing upkeep – house keeping – clean-up
   - Middle class people need to be eligible for some type on in-home care
   - Alzheimer's
   - Drug and alcohol abuse
   - Have to get off of drugs and alcohol

3. **Fiscal Concerns** (including health insurance; Medicare/Medicaid; employment; retirement; social security; cost of living)

- Rising gas and food prices
- Increased cost of prescription drugs
- Still working but need help illnesses and insurance
- Health care and insurance
- Medicare insurance –promote TN SHIP
- Long-term care insurance/facilities
- Doctor and hospitals not taking certain insurance
- Insurance not covering hearing aids completely or as needed
- Insurance covering in home care as needed
- Cuts in Medicare
- Lack of assets/savings
- Understanding disability and Medicare
- Help with city and county taxes
- Employment with accommodation
- Better wages
- Competitive edge in workplace
- More and better jobs
- Raising limits for Social Security
- Working longer ? retirement – health care after retirement
- Do they have enough to retire on?
- Thinking about retirement (have more TN and radio ads)
- Work longer because the retirement age has been raised
- Adequate finances past work retirement – help with more advise, continued promotion of savings plans and public education on "what I can do now"

4. **Support Services** (including transportation, meals/nutrition; elder abuse services; senior centers)

   a. **Transportation**
      - Access to safe, reliable transportation
      - Provide transportation and make this info known
      - Right to drive
      - Mobility issues (bus, stores, homes, etc.)

   b. **Meals/Nutrition**
      - Access to adequate and appropriate food
      - Meal services - food assistance
      - Food – store having carts
      - Improve on the type of meals that are served to seniors at the centers
      - Some seniors cannot cook for themselves – some go without on weekends because centers are closed. One good meal, per day at affordable prices – buy

meal tickets like the school kids do.

c. Elder Abuse

- Avoiding misdirection by commercial vendors (i.e. Reverse Mortgage) and scammers – help – continued public education

d. Senior Center

- By funding these interested in 50+ senior center
- The Senior" Centers are just now providing programs for the Baby Boomers
- Some are still working – center hours are not helpful
- More weekend programs or evening programs
- Extended centers for seniors
- Place to socialize on evening and weekends/more hours at Senior Center/utilize volunteers for opening on weekends
- Better facilities for the senior centers
- Senior Centers in Tennessee are not able to meet the needs of Baby Boomers as they currently are operating. Baby Boomers demand or expect more than playing Bingo, cards, etc. Senior Centers need more money from the State of Tennessee to expand their space, programs, and fill needs of Baby Boomers. More needs to be done to get "seniors" who think they are young maybe too young to be seniors. They are old and I'm not old. Recommend we put the word community in the name of all Tennessee Senior Centers. The Ajax senior center does a great job for seniors but are about to run out of money. The State should look at the way senior centers are funded. Some States use a different method of funding. We seem to be caught up in the sixties (60's) – wake up before we have to close doors – 400 Baby Boomers every minute – Wow! 1946-1964 the We Generation – Right.

5. **Staying Healthy While Aging** (including exercise, eating healthy foods, socialization, chronic disease, staying connected and involved in the community, volunteer)
   - Have places to go
   - Getting up when being seated
   - Promote things they are interested in, such as diet, exercise, and staying healthy.
   - Playing their type of music at the dances

6. **Adults with Disabilities** Ramps in public places
   - Dealing with disabilities and reduction in income
   - Wheelchair accessibility in housing – lower sinks in homes, etc.

7. **Caregiving**
   - Taking care of parents and grandchildren
   - Raising family – help more if they help themselves

8. **Housing, Neighborhoods, and Safe Communities** (including home repairs and utilities)
   - Affordable housing

- Housing for their abilities
- There is no low rent housing except in slum area
- 2/3's of the people at age 65 only have Social Security to live on which is fine if they can find cheap rent
- More police protection
- Stay home as long as possible

9. Funding/Resources

- Fundraisers
- Funding for all of these: reduction in health care – price increases in all areas – funding for all college schooling from childhood
- More resources for rural counties

10. Other:

- No fireworks in city
- Want term limits for politicians
- Clothes
- Myrtle Colman
- Info for VA benefits, arthritis, cancer, and heart attack

Greater Nashville Area Agency on Aging and Disability
Ajax Turner Senior Center, Clarksville, TN
February 26, 2013

Question: **Here are seven (7) aging and disability issues.**
Under each, there is a list.
Mark the ones on the list that you think are most important.

Number of Questionnaires completed: 47

Response	# of responses	%
1. Not having enough insurance or money to pay for doctors or medicine	40	85.1
2. Affordable dental care, hearing care and eye exams and glasses	37	78.7
3. Keeping healthy through exercise and eating healthy foods 4. Being able to get accessible transportation	35	74.5
5. Transportation for people who don't drive cars	33	70.2
6. Housing that people on a pension or Social Security can pay for	32	68.1
7. Learning how to live with a serious condition like heart disease, cancer, arthritis	31	65.9
8. Houses that are easy to get around in if you're on a walker or in a wheelchair	30	63.8
9. Respite services	29	61.7
10. Making decisions about health insurance, Medicare, and planning for the future without depending upon the government 11. Learning about how to take care of yourself so that you don't get sick and tired 12. Being able to get help when needed quickly and without hassle	28	59.6
13. Help with memory loss 14. Protect people from abuse 15. Meeting people and making new friends	27	57.4
16. Getting care at home instead of in a nursing home 17. Teaching police, Firemen, emergency workers to know the special needs of older adults and people with disabilities	26	55.3
18. Being able to choose the workers who come into your home 19. Teaching doctors, nurses, and other healthcare workers to know the special needs of older adults and people with disabilities	25	53.2
20. Learning how to prevent falls 21. Meals that are healthy and prevent hunger	23	48.9
22. Reasons people have to go into nursing homes 23. Training for aid workers who help older adults and people with disabilities	22	46.8
24. Neighborhoods that have grocery stores close by 25. Learning new things	21	44.7

26. Learning about how to care for someone at home 27. Teaching volunteers to work with older adults and people with disabilities	20	42.3
28. Neighborhoods that are easy and safe to walk in 29. Places to volunteer	18	38.3
30. Reasons people have to go back to the hospital 31. Knowing where to call for help and getting help without a big runaround 32. Understanding how Medicare works	17	36.2
33. Help with feeling sad or lonely 34. Help with chores like lawn mowing and leaf raking	16	34.0
35. Help with taking too much medicine 36. Eating out with friends	14	29.8
37. Being able to get accurate information from a website and being able to apply for services on-line	13	27.7
38. Help with drinking too much alcohol or taking drugs	12	25.5

Other:

Not have enough insurance or money to pay for dentists. Dental car is an important issue. Everyone seems concerned about health in seniors and healthy eating. Having affordable dental care is a huge issue. If a person cannot consume healthy foods because they do not have the teeth to chew; this is the first step to unhealthy eating which is the next step to failing health.
If there is a special list for geriatrics, I have not seen it. There is a very big difference in regular M.D.'s and General M.D.'s
Grocery stores close by that provide highest quality of food.
Clarksville is void of sidewalks – put unemployed to work putting in sidewalks in neighborhoods. Paid for by city and county tax funds
Most take care of dental care, hearing care and eye exams and glasses themselves
Learn to prevent fall – just got to be careful
Most don't have enough $ to pay for doctors or medicine – insurance is high
Hate the thought of going to a nursing home
In some cases don't know where to call for help
Most who are on Medicare understand it
Too many dependent on the government – too expensive
Don't know if people need help with taking too much medicine – I take it if prescribed
Protect from abuse in nursing homes
Respite services, especially for those who don't have enough $
Accessible transportation is a problem for people who can't see
Help with chores – generally have to pay for it yourself
Would love to volunteer, but that's hard when blind

Not enough places to meet real friends

Most important are learning how to live with a serious condition, not having enough insurance or money, and being able to get help when needed
Respecting seniors and utilizing their skills
Sidewalks in TN
We try to fulfill all of the above through our senior center here in Clarksville. I have read the newsletters from the surround counties and they do not offer as many of the above programs.
Knowing where to get the information to get help when needed
Accessible and affordable transportation
Finding housing for those with disabilities and live on SSA alone
Programs which help disabled and seniors find employment with accommodations
Affordable low cost housing for seniors
Housing that people on a pension or Social Security can pay for that are safe

Greater Nashville Area Agency on Aging and Disability
Ajax Turner Senior Center
February 26, 2012

Question: **What is currently working well in your community?**
(like agencies that help, neighbors who help each other, van service, senior center, meal sites, food pantry, healthcare clinic, nursing home, sidewalks, police presence, grocery stores that deliver)
(Number of Questionnaires containing 1 or more responses - 34)

This open-ended questionnaire was designed to allow attendees to identify the community programs and services that have worked for them and in their community. Evidence based and/or proven practices were not a consideration in the design of the questionnaire and no checklist was provided. The above items in parentheses were provided as examples. Attendees were asked to write in the programs and services that were working well in their community. The responses are individual and specific to the region served by the Area Agency on Aging and Disability. The number of attendees who indicated that the program is working well in the community is provided in parentheses ().

Agencies that help (1)
Neighbors who help each other (2)
Van services (7)
Senior center (15) • With more money from gov. • Things to do – like trips – I'm stuck – this is the only place I go • Need more funding • Ajax Center is great • Ajax Center
Meal sites (6)
Food pantry (2)
Healthcare clinic (5)
Nursing home (3) • Signature HC Erin
Sidewalks (2) • There are no sidewalks in the subdivision I live in. It would be great to have them.
Police presence (5)
Grocery stores that deliver (2)
Meals on wheels (4)
Not sure at this point – new to the situation
Manna Cafe
Council on Aging
Greater Nashville Regional Council (GNRC)
United way
The people, neighbors in the community

Good emergency response system
Good lighting in public areas
Loaves and Fishes (2)
There is a clinic the Baptist Church on Madison Street that provides dental care and has a Dr. 3 days a week
Room at the Inn that the churches sponsor during cold weather (a place to eat, socialize, take a bath and spend the night for the homeless)
Transportation: • Transportation for elders • Bus route • Need of van service outside city limits • No transportation
There is increased awareness of places offering assistance to seniors.
Need more senior housing at affordable prices
Second Harvest
Everybody working with the senior citizens
Working for the seniors
Hand in hand together
Still being able to work, drive self, having close knit family members, all of the above
The Mayor's city and county
I do believe we have a good working establishment of the above agencies. I feel there is a serious downfall in the publication. The agencies work well for the people who know them. As, "The Montgomery Sr. Center – the best kept secret in Clarksville." We are improving. Now open on Sat. and Fri. night for other than dancing. Knitting, crochet, ceramics, etc.
People being able to get services in their home, but need more than 2 hours a day sometimes.

Greater Nashville Agency on Aging and Disability
Ajax Turner Senior Center, Clarksville
February 26, 2013

Small Focus Group Responses

Greater Nashville Area Agency on Aging and Disability
Ajax Turner Senior Center, Clarksville
February 26, 2013

Facilitator Notes for Small Focus Group 1

There is a lack of resources in rural counties (Houston and Stewart). Seniors have to come into Clarksville for services and sometimes transportation is an issue.
What does a person going into retirement or past 65 do next? There should be an avenue or county seat or somewhere where someone can go talk with someone face to face about what do they do next. They should be able to explain about what steps does a senior citizen need to take to get the help they need. A suggestion would be to develop a packet for retirees and persons over the age of 65 that would include this information as well as information about affordable health insurance.
Health Insurance – People have no idea of what is available and they are overpaying for things they don't need.
Education to seniors on how to live comfortably with the income they have. Education from utility companies about what they provide to senior citizens in the way of help especially for those with limited income.
Transportation is sad. Needs to be more accessible. You have to call and get on their schedule and it doesn't always work with the appointments you have. They limit where you can go. The wait time after you appointment is done is too long, it takes the transportation people too long to come back and pick you up.
Nutrition, the quality of the food is not good. They want to know who evaluates the food. Sometimes the food taste like sandpaper and the meat is unrecognizable.
It is hard to find transportation when needed. She would like to come to the senior center but has asked and they always say they don't provide transportation from her retirement community to the senior center. She want to be involved in the activities and being around other people but unless she can drive which her children don't want her too or she can get her children to bring her and they have to work she is not able to get to the center.
She mentioned that she works at a senior center and they have transportation that is designated for the seniors who are members of the center but the transportation is often taken away for other uses. She is at the Senior Center at Ashland City. She says seniors are often turned away for rides or has to be picked up by 12:30 which doesn't allow them to enjoy the day. Transportation is a big issue.
The quality of food at congregate meal sites is bad. The meals are not well balanced. Sometimes the meals have all this starch and no green foods. The food is overcooked to the point you can't tell what it is and loses its nutritional value.
There is not enough senior housing for low income seniors.
Baby Boomers – What happens to people who are not a retirement age but they have lost their jobs? There are people who have lost their jobs at 50 years old and they are unable to get employment but don't have the money to not work. Workforce protection is needed. Eligibility for meals on wheels. Some seniors have too much money to get a meal through meals on wheels but can't afford to pay for them.
The frozen meals are sent to seniors who live in rural counties but when they get the frozen meal they are still going hungry because of health reasons they are not able to physically get up and prepare the frozen meal.

More places are needed for seniors especially boomers who have addiction issues. There is not anywhere for them to go for help.
Transportation is sometimes available to go to the doctors at a cost but not able to financially pay to get to the transportation to take to them to the doctors and not on Medicaid for them to pay the cost.
Advocacy for seniors in nursing facilities is needed. Seniors are not aware of the ombudsman.
State Internal Advocate for seniors without any political boundaries and not appointed by governor or legislatures.
Something should be done about when places such as doctors' offices give seniors packets of papers to fill out and people need assistance. Also too many things have to be done online and seniors don't have access to internet.
Rights/Access – No matter what income you have when you are sick you should be able to get help.
More doctors and specialist in rural counties.

Facilitator Notes for Small Focus Group 2

Training for police officers in dealing with seniors or adults on meds or disabilities
More senior housing
Can't eat the food they serve here
They are smarter
Going to need more services – Baby boomers caught between generations needing help - now they are aging to need more services
Most siblings don't share genetics – a lot of difference in health of people
Medical – complicated – too many doctors – do they talk to each other – learn how to talk to doctors
Lack of training for Baby Boomers
Insurance companies – hard to understand
Meds – you have to get meds through your insurance – drug plans hard to understand
Solicitation from insurance – scammers
Don't answer phone calls
Live independently – some need to know about Veterans benefits
Programs – are there programs out there for people
There is a screening for Option program
Transportation – Mid-Cumberland HRA. $4 a day for dialysis curb to curb not door to door
He is in a wheelchair – needs assistance
You can't call – the week – 2 weeks in advance
Scooter limited to Walmart and Kroger
Does the Senior Center give out this information
Affordable – lifts. Tennessee Mobility finding private funding sources
Gaps between funding sources and agencies
YMCA – does some transportation
Need has to be demonstrated – of mobility
Disabilities and obesity are increasing - Disabled baby boomers
People losing mobility between the ages 40-60

How can we solve the problem – immediately – Kroger needs to be made available
Need – home modifications and repairs
Insurance – Part B – need more and fresher information on premiums
Employment is a need for healthy people - need jobs to supplement their income
Jobs not there – age
There is a lot of wasted money government

Facilitator Notes for Small Focus Group 3

Bill at the table ID 3 different senior center participants that took wrong meds in the last 2 weeks from their senior center that have been hospitalized
Senior Center takes eyeglasses from members who have passed and recycle them for current members because eye exams and glasses are too expensive. I gave them name of Lion's Club contact as potential partner.
3 expressed worry about workers coming into their homes – wanted choice
Safety issues – yes, both Jerry and Bill expressed decrease in their neighborhoods; Worked: increased lighting, better sidewalks, closer grocery stores that are accessible
*Connectedness – "That's why we all come here" – Bill and all nodded heads – last 4 years without wife – huge issue here
Began expressing their worries about worries that Center will close . . . I turned it around to "help think of some new ides to fund raise" – Zumba bands, cooking classes, dances

Facilitator Notes for Small Focus Group 4

Reasons for not going into a nursing home – depressing and don't like going there
Reasons people go back to the hospitals – concerned won't have help
Not having enough insurance – not for people @ my table
Knowing where to call – don't know, need help
Understanding Medicare – confusing – need help
Making decisions about health insurance, etc. – not sure who to trust – afraid someone will hurt us
Help with memory loss – big problem
Abuse – not a problem for my group, but could be
Respite services – definitely for some activities
Need help learning about how to care for someone at home
Big need learning about how to take care of yourself
Big problem being able to get help quickly and without hassle
Don't use computer
Didn't know you could choose workers
Accessible transportation very limited – takes too much getting it when needed
Not sure that housing on a pension or Social Security is available
Too many neighborhoods are not easy and safe – small or some big
Don't have grocery stores close to senior citizens
Houses that easy to get around in – It's very hard. Don't know where to go. It is a problem.
Places to volunteer – don't know of any
Don't know where to go to learn new thing
Meeting people – just started @ senior center and go to church

Eating out with friends – can't afford to – don't know where to go
Training for paid workers – needed but not knowing its accessibility
Teaching policeman, firemen, etc. – needed but not a priority
Teaching doctors, nurses, etc. – don't know how to fix or what to do
Teaching volunteers – very needed
VA benefits help. Benches @ business to sit on waiting for bus. Worried about falling in tub, etc. Accessibility to info (brochures) about heart attack, stroke, and arthritis. Affordable housing. Sidewalk problems.

Facilitator Notes for Small Focus Group 5

For the first part of the discussion, a senior center employee reviewed all of the programs that the senior center offered that are good
• Matter of Balance and nutrition – it would help to follow up once a month
• Tai chi is starting. This will be a full class
• Tuesday line dance is exercise
• Water Aerobics is on base. Have transportation to it. If want, van can do it and take it on post (they can go to water aerobics in the van)
• Fall prevention – Master your body exercise with sister. Fell after class and credits class for survival. Broke back and knew how to get up. There is a waiting list for this class.
Have discount lunch based on income. 61 people on the discounted lunch list where they pay $1-$3. Full price is $4 that anyone can buy.
One person at the table has $140/month income. Said if did not have children would be under a bridge.
Ladies have a problem with income. The average of the senior center is 78 and going up to 80. That age women did not work. Also a lot of farmers and they don't have income.
Won't find men asking for help because men won't tell that they are down and out. One man comes and gets bread.
Address food issues with Food Bingo. Prized include peanut butter, popcorn, coffee, cereal, green beans. 15-20 play each day.
Congestive heart failure support group
Living with chronic disease support group
Support group for the blind
Alzheimer's
They have the only adult day care. Have 19 on the list. Five that come every day from 7-6. It is income based, but they have to be continent. The program is maxed out but there is a bigger need for either here or a nursing home.
Exercise classes
The reason people go to the nursing home is falls. Once go to a nursing home never see them after. Lack of services in home. Nursing home. Caregiving a hardship on one person. Couldn't take husband to the car. Took all three to help.
She'd got down on the floor and couldn't get her up. Got down where they couldn't get her.
Put John in the nursing home and could not pick her up. Need an on call organization to pick up people. Pick up the phone (ambulance) would charge $600. Sheriff and fire department call. Some simple thing. People in the neighborhood are all in the same age group or working.
Mature medical. No insurance on dental for 55-65

Need affordable dental care. Depend on people to take care of self and spend money on other things. Son gave $400. Priority in need.
Hearing care. People need hearing aids. Cannot afford them. Send people to the Lions donation to see if there are any glasses that work.
Mostly homeless. Four or five come in every day. Class on Alzheimer's. Most staff alert regarding dementia.
Participants transition to adult day care.
So many in age group do not have computer. Do not want to. Most government sites have more problems or government sites are confusing even with technical skills. People are impatient. Arrogant. All of them top list Social Security. For more paper and more paper. Then how dare you ask a question
Medicaid waiver. Got to sign property
Accessible transportation:
• Montgomery County has the Lift. Call the Lift 24 hours in advance. Only within city limits. Outside call 72 hours and lucky if them come. Some one couldn't get transportation because of service animal.
• 72 hours – not reliable – Selective about who can pick. Couldn't find place. Depends
• Some drivers hateful to consumers. Have had people sit and wait. Can't handle – things no accessible transportation outside of city limits
• Two vans not active. Have to buy gas. Cannot buy gas
• Cannot afford gas. If city would furnish gas, could serve more.
Senior housing:
• Do not have enough
• Apartment complex
• Reserved one building. Assisted living. Have cooking facility to have to buzz door. Had to sign in and out.
• More secured senior living facilities. Independent and assisted living. South Central village. Fieldstone – have to be a millionaire to live there
153,000 military and dependents – lost of military – VA hospital – Veteran home – half senior community is retired military
BB retirees attracted here. Loosen rules to make money – Casino night – want to break
50/50
People struggle to make most subsidize housing. Lincoln homes made
Summit Heights based on income. People have to lock equipment
Dental and medicine. No one can eat good food if do not have good teeth. Medicare needs Part Something for dental

Facilitator Notes for Small Focus Group 6

Opening Comments for attendees
TCAD – no one had heard of TCAD
Is there anyone who knows how to teach police to treat seniors? Linda – survivor of traumatic brain injury – uneven gate – policemen with years of service are nice – new ones not so much (may think the person is an alcoholic)
Need more senior housing in Clarksville

Issues
Teach policemen – train them to treat seniors correctly
Do not take medicine properly - Linda talking about her experiences
Mary Ann – hospital setting – people react quickly – deaf in left ear - Young people think every one is like themselves, the don't understand – might take lessons
Staying Health While Aging
*Learn how to prevention falls – balance class – helps people who have had strokes, etc. Footwear, hand rails, objects in the way
Medicine
Respite care - Linda's husband works 4:30 p.m. – 1:00 a.m. Her husband prepares her medicine
*Affordable dental care is a problem.
Hearing aids – insurance will not pay for it – receive hearing aid through United Way (half the price
Health and Wellness
Not having enough insurance or money to pay for doctors or medicine Laverdia talked about addition (over medicate, alcohol, smoke) – one person said she stopped drinking
Need homemaking services (clean house) Laverdia asked about abuse (no one admitted to being abused)
Feeling sad or lonely – depression – no one admitted to being depressed, sad or lonely (not a problem
*communication for seniors – everyone needs a buddy system in case they get sick, fall or need help – last to know if the person is OK – if single, person may need more help Life alert/medical alert
*Boomers don't stop.

Caregiving (taking care of love one at home)
*Respite services are needed. Caregiving is such that people cannot retire. Seniors keep working in order to pay for caregiving services. People want to go in TennCare because they don't want to lose their home
*Employers need family care as a benefit. Sandwich generation (children taking care of their parents, children, and grandchildren
Independence and Getting Services Easily
Choose your own caregiver
*Transportation
The need to be independent
Question – how does the State handle a situation when a senior person does not need to be driving. Car Fit

Housing, Neighborhoods and Safe Communities
Safe neighborhoods, housing
Wheelchair – accessible
*Older houses are not wheelchair accessible
Staying Connected and Involved in the Community
50 Forward senior centers
recommended a membership at the YMCA (Laverdia)
Working with Older Adults and People with Disabilities
*They would be willing to help older adults and people with disability

Facilitator Notes for Small Focus Group 7

Staying Healthy While Aging – NEED:
Transportation to support staying in society and maintaining well-being (this was of great concern to this group; one 81 year old lady said she is not supposed to drive at night, but says a prayer first, then drives on Friday nights in order to go to the center's dance – said won't miss one)
Restore the $5 evening meal that was stopped for the Friday night dances due to funding cuts (group said some seniors have stated they depended on that meal and that dance night participation has dropped since the meal is no longer available)
Better engage the over 3,000 members of the Ajax Turner Center to raise more funds
Affordable dental, vision and hearing care (some thought Medicare would cover, did not realize it would not)
Create programs to help persons whose incomes and savings are above eligibility for getting help so that more people can participate (suggested sliding fee scale based on income)
Offer more accessible opportunities for socialization
More donations of food to center (said no food pantry at center, but churches, Loaves & Fishes, Manna do provide food to those in need; also, that Ft. Campbell, Walmart, Publix and Kroger's donates bread and some other food items to the center daily for the lunch meal – everyone in group said the food was good and they appreciated it)
Reviews/repetition of Matter of Balance training they received several years ago (one lady shared technique she had learned in that training, says she tells everyone she meets who is older – when arising from a sitting position, move slowly and stand in place for 4 – 5 seconds before trying to walk)
Health and Wellness – NEED:
More income to pay co-pays for medicines, doctor visits and tests
Nursing home care without spouse losing "everything," including the house
Information on what's available to help (didn't know about services, programs, etc.)
Visitors or companions to check on persons who live alone or who spend days by themselves
Meds that are easy to tell apart (many same approximate size, shape and color; confusing)
Independence (if lose this, get depressed, downward spiral)
Education about free "Wellness Checks" performed by Clarksville's 911 Service for older

adults who may be questioning whether or not to go to the ER for an issue or feel they need something like their blood pressure checked (several consumers in the group said they use the service whenever they need it)
Communities to develop programs for people to take care of one another in times of need (mentioned training)
Caregiving – NEED:
Money to pay for home modifications to make caring for someone at home more manageable
More respite care (one man repeated several times how much the two hours/day of respite he received when his wife was terminally ill meant to him; knowing that she was well-cared for while he was out gave him great relief)
More volunteers, as in neighbors and friends, to help family member provide care to loved one at home (several said they had provided long-term volunteer help to neighbors and good friends who were working hard to keep someone at home; one woman said she cared for both of her neighbors until their deaths and now there is no one left to help her should she need help)
Independence and Getting Services Easily – NEED:
Transportation to doctor and other health care appointments, to shop and just to get out (said important to have contact with other humans)
Assisted transportation so frail individuals and those with disabilities are able to go out
Programs to help prevent depression (social groups, activities, healthy diet)
Sheltered areas at all bus stops (weather – rain, wind, snow, ice, heat – real threats for older adults and people with disabilities)
More bus stops in neighborhoods comprised mostly of older persons
Better coordination between doctors' offices and transportation providers (cited incidents where transportation is late, so consumer is late for doctor appointments and when consumer arrives s/he is told it's too late and will have to make another appointment)
Housing, Neighborhoods and Safe Communities – NEED:
More sidewalks in neighborhoods (one lady said the City of Clarksville promised her sidewalks when she built her house in 1965 and there are none yet)
Sidewalks in, especially, areas surrounding stores like WalMart where people in wheelchairs could go safely to shop for food and other items (cited woman in motorized wheelchair they see going down the side of a busy highway – if there was a sidewalk, she could make the trip in relative safety)
Bus stops covered to protect the elderly and adults with disabilities from the weather, especially extreme heat and cold, wind, rain, snow (group mentioned risk of dehydration, hypothermia for older adults)
More senior-friendly police presence (most said feel "fairly safe," but some talked about incidents where police were not as helpful as they might have been)
Affordable/subsidized senior housing (said have only two assisted living facilities in town – one based on income – one couple and a single woman said they would move to a facility if cost wasn't so high)

Staying Connected and Involved in the Community – NEED:
More funding for senior center (to avoid participants feeling shortchanged when there are budget cuts and to attract more participants)
Charge a fee to those who are able to pay to attend senior center (help with costs, maybe add new programs)
Program to support and acknowledge neighbors, friends and relatives as they work to help elderly persons and adults with disabilities (to increase commitment to the "work")
Working with Older Adults and People with Disabilities – NEED:
There were no comments on this topic.
Other
This group was comprised of six older adult consumers, all of whom are active at the senior center (all Clarksville residents) and two TCAD staff members. Group members seemed well-bonded with one another and protective about others who did not have the ability or resources they had and how those persons manage their day to day lives. None of the group's members had a physical disability.

Facilitator Notes for Small Focus Group 8

Need to teach people how to eat (fruits and veg) – it's gotten sky high – can't afford to eat healthy
Move – do something – even if it's not exercise - boredom = inactivity
Sometimes you have to drive to get somewhere to exercise – transportation has a lot to do with it – cost has a lot to do with it
Discount to ride the bus – this is good- $30 for 30 rides, but what if you don't have $30
Lift rides aren't available on Sundays – Rides aren't available at the time you need it (example: 1 and 1/2 hours early to get to church on Friday night and then they come back before program is over)
Living in city is better than in county when it comes to getting transportation
Depend on friends for rides
Chronic conditions – classes; but it's up to the person to change (buddy system is also good)
Medicare booklet very complicated to understand – can also go on-line, but hard to understand
Low income – AFDC – act like it's their money – sometime make $20 too much
Don't take into consideration all you have to pay out of Social Security
The way benefits are calculated seems wrong – worker said "You don't look like you need it." (talking about TennCare) (even before I touched a paper)
About food stamps "Prove it" . . . . . in terms of who is on it
Some people sell food stamps – need to drug test all who are on it (example: got a phone call from someone selling food stamps - $50 for $100 worth)
People who put Medicare together don't understand how it works!
Confusing about Health Springs and still have to pay for some things
How do you help someone from losing their memory? "I don't have Alzheimer's, I have half-heimer's"
Affordable Housing – only have one in Clarksville – run by 7th Day Adventist – we need more senior housing – need for medium income people- need independent living housing

Friends and neighbors help with respite for caregivers
Family members need to learn how to take care of loved ones
Important to get out of each other's hair
People don't help handicapped – like sidewalks for wheelchairs
Affordable dental – available at church, but it's at night – need more affordable dental care
Where do you go for help? – phone book, internet, ads, friends (need to ask staff, not volunteer on phone
Need to set people up to volunteer
Work 20 hours and get minimum wage – good program
Chores – depend on family – need volunteers to help – perhaps could pay organization a little and volunteer could do it – would help people stay independent
Clarksville is void of sidewalks – unsafe - no one walks – no one knows neighbors (It's OK in particular neighborhoods)
Need to make neighborhoods safer (drugs . . .) not safe to walk – never see kids outside because of it 9 near homeless shelter – and they ask people for cigarettes, etc.
With all the money going overseas, keep it at home and help us
Making information that seniors should have easy to understand

Needs Assessment

South Central Area Agency on Aging and Disability
Henry Horton State Park, Chapel Hill
February 19, 2013

Number of Attendees: 32

South Central AAAD
Henry Horton State Park, Chapel Hill, TN
February 19, 2013

What are the hard things that "baby boomers" face? How should the state of TN help?
(Number of Questionnaires containing 1 or more responses - 22)

This open-ended questionnaire was designed to elicit qualitative data from the attendees about how they thought aging would impact baby boomers. However, many attendees also identified issues that currently exist. Attendees were able to respond to the questions in any manner that included short, one-word answers, such as transportation, to very involved responses. In order to provide some order to the responses, major topic areas have been identified. In addition, some topics might include sub-topics for the purpose of reading the report more easily. Repetitive responses are included only once.

1. **Easier Access to Services Without Hassle** (including information and assistance; communication; and technology)
   - Place to get information and assistance
   - Factual information on issues such as Medicare, nursing homes, assisted living, Social Security
   - Awareness of help available
   - Awareness of help with insurance
   - Awareness of help available – educate about assistance for help available

2. **Healthcare** (including in-home services; Home and Community Based Services; long term care; chronic disease; Alzheimer's disease and related dementia)
   - Affordable adult day care programs are needed
   - Healthcare – in facilities and at home – what is out there for them?
   - Less waiting list like options
   - Cost of healthcare
   - Not enough money to purchase medication
   - Health problems and aging
   - Preventing falls
   - Health benefits
   - Programs – offer light housekeeping for the people who don't funding for Choices or Options
   - Medical issues – hearing, vision, dental (not covered by Medicare) – is there any way to help with these items?
   - Healthcare – affordable care that covers dental, optical, and hearing for those unable to afford
   - Lonely – miss friends/family
   - Stress

3. **Fiscal Concerns** (including health insurance; Medicare/Medicaid; employment; retirement; social security; cost of living)

- Saving of money instead of spending
- Fewer resources for middle income families
- Lack of funds/wellness
- Rise in overall living expenses on fixed incomes
- Gas prices on a fixed income
- Baby Boomers – fresh start on credit history
- Health insurance cost and availability – more competition in State market
- Fraud and financial abuse
- Health insurance – for those unable to pay – something like TennCare
- Rising medical costs, insurance premiums
- Medicare deductibles
- No insurance or can't afford it
- Workforce – more jobs
- Employment/security and availability
- Training
- Part time jobs – occupy time
- Many will need to work past retirement age to be able to maintain an acceptable lifestyle or to keep insurance.
- They need continued supports to help them stay active in the workforce in the way of training or accommodations as they age.
- Social Security cuts
- Social Security – will the age for retirement change from 62 to 65
- Rising cost of living – with threat of the limited resource of Medicare being taken away
- Cost of living out weighs the average retirement costs
- Enough money to retire
- Retirement benefits – being able to work for a company long enough to get retirement

4. **Support Services** (including transportation, meals/nutrition; elder abuse services; senior centers)

   a. **Transportation**
   - Transportation issues – can't see or hear! You need dependable transportation systems that work
   - Availability of transportation services if there is a change – make it affordable
   - Transportation – assist with planning to provide transportation for those they need transportation to get to important appts. That affect their healthcare
   - Offer rides to Dr's. /hospital at low or reasonable rates
   - Gas prices
   - Transportation – programs – for things like stores/outings

   b. **Meals/Nutrition**
   - Meals – offer meals at Senior Centers and to home bound for reasonable prices

c. **Elder Abuse**
- Work on legislation to protect seniors who have assigned Power of Attorney

d. **Senior Center**

5. **Staying Healthy While Aging** (including exercise, eating healthy foods, socialization, chronic disease, staying connected and involved in the community, volunteer opportunities)
   - Volunteer opportunities to maintain sense of worth
   - Social Activities – trips to library, movies, senior centers, shopping

6. **Adults with Disabilities**

7. **Caregiving**
   - Caring for elderly parents and spouses
   - Sitter – programs – that are affordable

8. **Housing, Neighborhoods, and Safe Communities** (including home repairs and utilities)
   - Affordable safe housing – make good neighborhoods available and investment friendly for housing
   - Housing (affordable) for the Baby Boomers who don't have retirement
   - Housing – community – that resemble retirement community – that are affordable

9. **Funding/Resources**
   - Community resources

10. **Other:**

South Central Area Agency on Aging and Disability
Henry Horton State Park, Chapel Hill
February 19, 2013

Question: **Here are seven (7) aging and disability issues.**
Under each, there is a list.
Mark the ones on the list that you think are most important.

Number of Questionnaires completed: 23

Response	# of responses	%
1. Being able to get accessible transportation	19	82.6
2. Protect people from abuse 3. Transportation for people who don't drive cars	17	73.9
4. Getting care at home instead of in a nursing home	16	69.6
5. Keeping healthy through exercise and eating healthy foods 6. Respite services 7. Housing that people on a pension or Social Security can pay for 8. Teaching volunteers to work with older adults and people with disabilities	15	65.2
9. Affordable dental care, hearing care and eye exams and glasses 10. Meals that are healthy and prevent hunger 11. Not having enough insurance or money to pay for doctors or medicine 12. Learning about how to care for someone at home 13. Being able to get help when needed quickly and without hassle 14. Training for aid workers who help older adults and people with disabilities	14	60.9
15. Learning how to prevent falls 16. Learning new things 17. Meeting people and making new friends	13	56.5
18. Learning how to live with a serious condition like heart disease, cancer, arthritis 19. Making decisions about health insurance, Medicare, and planning for the future without depending upon the government 20. Learning about how to take care of yourself so that you don't get sick and tired	12	52.2
21. Houses that are easy to get around in if you're on a walker or in a wheelchair	11	47.8
22. Reasons people have to go back to the hospital 23. Knowing where to call for help and getting help without a big runaround 24. Understanding how Medicare works 25. Neighborhoods that are easy and safe to walk in 26. Eating out with friends	10	43.5

27. Reasons people have to go into nursing homes 28. Help with feeling sad or lonely 29. Help with memory loss 30. Being able to choose the workers who come into your home 31. Places to volunteer	9	39.1
32. Teaching police, Firemen, emergency workers to know the special needs of older adults and people with disabilities	8	34.8
33. Being able to get accurate information from a website and being able to apply for services on-line 34. Neighborhoods that have grocery stores close by	7	30.4
35. Help with taking too much medicine 36. Help with chores like lawn mowing and leaf raking	6	26.1
37. Teaching doctors, nurses, and other healthcare workers to know the special needs of older adults and people with disabilities	5	21.7
38. Help with drinking too much alcohol or taking drugs	3	13.0

Other:

Handicapped Public Restrooms need to be improved for enough room for the motorized wheel chairs
Showing these people love!
Change some of the menus

South Central Area Agency on Aging and Disability
Meeting at the Henry Horton State Park, Chapel Hill
February 19, 2013

Question: **What is currently working well in your community?**
(like agencies that help, neighbors who help each other, van service, senior center, meal sites, food pantry, healthcare clinic, nursing home, sidewalks, police presence, grocery stores that deliver)
(Number of Questionnaires containing 1 or more responses - 14)

This open-ended questionnaire was designed to allow attendees to identify the community programs and services that have worked for them and in their community. Evidence based and/or proven practices were not a consideration in the design of the questionnaire and no checklist was provided. The above items in parentheses were provided as examples. Attendees were asked to write in the programs and services that were working well in their community. The responses are individual and specific to the region served by the Area Agency on Aging and Disability. The number of attendees who indicated that the program is working well in the community is provided in parentheses ().

Response
Meal sites (2) • Congregate needs additional funding • Nutrition (congregate and home delivered)
Meals on wheels (2) • More meals on wheels
Senior center (5) • Meals and activities • Senior centers are a great place to obtain information and get services, but only reaching a small number of the elderly and disabled population
Van services (2)
Legal aid services
Churches that help with odd jobs for seniors
Nursing home
To some degree, transportation, but as a whole
Not sure – some are not publicly advertised
Police presence
Meals for the elderly
Homemaker services
Affordable housing in some counties
Health fairs (2)
Food banks
Churches
Mifa – companion program
CHOICES
AARP sponsored bringing medical canisters to collect old medications
Nursing homes

Visiting with the sick
Homemaker services
Volunteerism
Food pantry - At the churches
Facility for mentally challenged has gone up in price until it is not affordable/was $25.00 daily now - $65.00 daily
Vita

South Central Area Agency on Aging and Disability
Henry Horton State Park, Chapel Hill
February 19, 2013

Small Focus Group Responses

South Central Area Agency on Aging and Disability
Henry Horton State Park, Chapel Hill
February 19, 2013

Facilitator Notes for Small Focus Group 1

Staying Healthy While Aging
Exercise and eating healthy - diet and exercise (do what doctor says)
Concerned about poverty level and concerned about diet (fats and carbs) • is healthy food available? • seniors get fewer food stamps ($16 not enough)
Physical fitness in senior centers important, but need more equipment to attract seniors
Difficulty accessing services – more and more people (despicable state) • understanding mail • people on their own with no one to help • families less likely to help financially *Seniors are having trouble accessing services because they don't know how (example – accessing social security – system has gotten too sophisticated
Need for social workers to help them navigate system
Ones that call us don't know about other services they could get
Families don't always get information from facilities (like hospitals)
Senior centers could be place where people could ask resources
HRA has offices in all counties
Some people don't know that senior center is a place to get information
Fraud and financial abuse of seniors (children taking checks and bills not getting paid)
Even people working in agencies don't know about how Social Security works – need for education
SHIP works to help understand Medicare
People who really need that help may not be the people who read the paper, etc. to know that help is available
Need publicity of what's available
We advertise, do health fairs, and people don't take advantage
Need billboards, PSA's, radio PSA's
How open are providers (like pharmacies, doctors) to helping to publicize
How would you see a carrier, like BCBS, helping with message? • Best is give I&A # (toll free #)
BCBS – we could do more to customize out message by region
Health and Wellness
Care at home instead of institutionalized
Seniors worried about losing home
Many physicians affiliated with nursing homes to they don't want to tell patient that home care is a choice (conflict of interest)
Seeing more mental health issues – depression, bi-polar perhaps not addressed when younger, or not taking medication (not counting Alzheimer's and dementia

More Alzheimer's and dementia
More people aging well yet others are not (perhaps life style)
Still concerned about people in poverty "just don't know" how to do things
Seeing more substance abuse among elderly – street value of medications and selling half of meds
Substance abuse rampant in elderly
Public information needs to be on Facebook and Twitter
Need to change image of senior centers as more than quilting/cards/recreation
Senior centers – word of mouth that you can get help there
Tricky to talk to seniors so that are not stigmatized by going to senior center or place for help
Caregiving
Computer illiterate issue, phones untouched
There are programs in place for low income and high income can go to assisted living or hire someone in; problem is middle income because their families are working. Need adult daycare while families work.
Independence and Getting Services Easily
Need more adult day programs. Need to be covered by insurance
Had to get adult care started because of licensure requirements
Rural counties – logistics for adult day care is a problem – driving long ways, etc.
If a nursing home could have adult day care – but recruitment is problem
Transportation – Maury Co. Senior Center looking at purchasing van because undependable transportation from rural transportation. Looking at buying rides from church vans – thinking outside the box
Issue with liability of using church vans, etc. – this is the key to figuring out
Issue with Medicaid medical trips taking priority for rides
Easier to buy a ride than buy vans
Runaround – calling many places to get help
If everyone is being taken care of in-home, how do you keep them from being lonely and sad? Need a visitation program. Perhaps "Health Occupation" in high schools to check on them, special time, adopt them
Affordable and Safe housing – hard to get both at the same time
Chores – like cleaning gutters Example: churches doing odd jobs around the house needs to get formalized volunteer programs
How to find those people who are isolated
Break up families causes elderly to have to help raise grandchildren
Need coordination of intergenerational help – identification of an organization to spear head – one organization to pull it all together
Working with Older Adults and People with Disabilities
Need teaching volunteers to work with people with disabilities

Need training for nursing home personnel
All providers need to do training out in the community (also a good way to do marketing)
When people retire, educate prior to retirement and also have volunteer opportunities
Issue with reaching out/marketing and then there's a waiting list
Really frustrating to publicize toll free # and services and then having to say there is a waiting list
Need marketing professional to help us to find people

Facilitator Notes for Small Focus Group 2

Transportation is limited other than going to the doctor's office. Seniors would like to be able to get the Senior Centers and to shops but the local transportation never has space to take them to those places.
The senior centers have cut back on congregate meals. One site went from having 35 meals to 12 meals. They charge a $1.25 for members and $7 for non-members. Some seniors have stop getting a meal so that others who they feel need a meal more can get a meal.
Seniors would like education provided to families on Alzheimer's disease. This education is rarely if ever available in their community. They would like education on the disease process.
Work with churches about providing resources such as the Aging and Caring book provided through Council on Aging of Greater Nashville. If the churches have the information then they can share with seniors in their church.
Renaming the senior centers. Offer a contest to see who can come with the most creative name for a senior center. They feel maybe the name is outdated.
Transportation of Seniors who are not on TennCare is an issue, not necessarily transport to the dr or other medical appointments, but going to the store for example.
Ahead of time scheduling has increased from one day to some times 3 or 4 days to call ahead to schedule an appointment to be picked up. Passengers pay 1$ one way within the city limits and 2$ each way for destination in the county limits. Passengers have noticed a drop in service sing the agency s started providing transportation for TennCare.
Murray county meal site has cut back to 12 meals per day. Say they can't afford to do more???
Alzheimer's Disease is an issue for baby boomers on two fronts, one taking care of aging parents or a spouse with dementia and two worrying about dementia for themselves in later years.
Participants agreed that they need more information about all aspects of aging, healthy aging, Alzheimer's, not getting ripped off by home repair or insurance sales agents, what services are out there.
One participant spoke about the book that fifty forward put together for caregivers as a part of the Innovative Alzheimer's grant.
There is a need to know a lot of stuff about aging and resources and what to expect and where to turn for in depth information .
Need more resources on mental health/depression as people age.
Caregivers need more support and help

Facilitator Notes for Small Focus Group 3

Staying Healthy While Aging – NEED:
More meals served at senior centers (number of recipients recently reduced due to funding cuts, so fewer seniors are able to receive meals – big problem, consumers say has created

concern about future access to meals at senior centers)
Help for persons with visual impairments to manage at home (someone to manage meds, write checks, provide some personal care, shop)
Dependable transportation for people who use wheelchairs in Centerville (Hickman County)
Make lifestyle changes to eat right and exercise both body and brain regularly (said can walk at senior center, but need more help to make real changes)
More food access for unemployed Boomers
Build and maintain an active lifestyle
Access to health care
Education and information on available services
Health and Wellness – NEED:
Transportation to be able to go anywhere (some can't get to doctor, pharmacy, grocery store, senior center)
Use transportation money more efficiently by stopping current practice of “zig-zagging" from the North to South side of town and back picking people up or traveling with one person on board”)
Door-to-Door transportation
Not to be dropped off in the middle of the street by van (one consumer reported this, said confusing and dangerous to stand in the middle of a busy street with vehicles moving in front and behind older person)
Dependable transportation for people who use wheelchairs in Centerville (Hickman County)
Improved transportation for Columbia (“SC DOT;” consumers said provider often late, so that they miss programs at the senior center – supposed to be there by 8, but get there at 10, eat lunch at 11 and then van comes to take them home at noon – discouraging)
More “free” transportation “like Marshall County offers” (per Ms. Vernell – may be free to her because she taught school there for 32 years and knows the drivers)
Sidewalks (Centerville, wheelchair cannot navigate gravel on side of road; if had paved sidewalks, consumer could go independently to grocery store one block away from home)
Wheelchair accessible public bathrooms (while ADA requires compliance, many restaurants and other businesses' public bathrooms do not accommodate wheelchairs, walkers, etc. - big problem)
Increase funding for senior centers for activities and programs, meals and transportation (food pantry operated by one center often runs out of food and cannot help consumers before the consumers' next check comes)
Access to health care in the home (a doctor in Centerville makes house calls, but only to patients he has recently seen – suggested nurse practitioners could do this)
Behavioral health services (to help seniors who are isolated, depressed, etc.)
Caregiving – NEED:
Training for informal caregivers (neighbors, friends, family members) for helping older people who live alone and need some help (example, one man helps blind neighbor put eyedrops into her eyes x4/day and he and his wife prepare and deliver all of her meals to her – would do more, but feels he would need training in some areas)

Independence and Getting Services Easily – NEED:
Transportation to be able to go anywhere ("just get out," some can't get to doctor, pharmacy, grocery store, senior center)
Dependable transportation for people who use wheelchairs in Centerville
Improved transportation for Columbia (said provider often late, so that they miss programs at the senior center – supposed to be there by 8, but get there at 10, eat lunch at 11 and then it's time to go home at noon - discouraging)
Sidewalks (Centerville, wheelchair cannot navigate gravel on side of road; if had paved sidewalks, could go independently to grocery store one block away)
Transportation to be able to go anywhere (some can't get to doctor, pharmacy, grocery store, senior center)
Dependable transportation for people who use wheelchairs in Centerville
Improved transportation for Columbia (said provider often late, so that they miss programs at the senior center – supposed to be there by 8, but get there at 10, eat lunch at 11 and then it's time to go home at noon - discouraging)
Help for persons with visual impairments/who are blind to manage at home (someone to manage meds, write checks, provide some personal care, shop)
Large format telephones for persons with visual impairments
Someone to walk with persons who are unsteady on their feet, whose balance is a little off or whose meds affect vision (consumers reluctant to walk alone for these reasons)
Housing, Neighborhoods and Safe Communities – NEED:
Sidewalks, but, also, someone to walk with persons who are unsteady on their feet, whose balance is a little off or whose meds affect vision (consumers reluctant to walk alone for these reasons)
Higher commodes for older people and for those with disabilities
Large format telephones for people with visual impairments
Program to make contact with people who do not show up for regular activities or appointments to make sure they are okay (said they informally watch over each other, but know there are older adults and people with disabilities who live alone and have no one to check on them)
Transportation that does not require older adults to stand outside for long periods of time, especially in unsafe neighborhoods or business districts
Grass cutting (so house does not look abandoned)
Staying Connected and Involved in the Community – NEED:
More transportation options that are readily available so people can go where they need and want to go (to avoid isolation and greater dependence on others)
Working with Older Adults and People with Disabilities – NEED:
There were no comments on this topic.
Other
This group included three MCO case managers, a Franklin County Mayor's assistant, six consumers (a woman who uses a wheelchair and her husband, plus four elderly women) and a

senior center director.
An innovative practice used by the senior center director is participation in the “Pet Pals” program where donations of cat and dog food are made to seniors to allow them to use their limited dollars on food, medicines, etc.

Needs Assessment

Southeast Area Agency on Aging and Disability
Jewish Cultural Center, Chattanooga
February 28, 2013

Number of Attendees: 55

Southeast Area Agency on Aging and Disability
Jewish Cultural Center, Chattanooga, TN
February 28, 2013

What are the hard things that "baby boomers" face? How should the state of TN help?
(Number of Questionnaires containing 1 or more responses - 33)

This open-ended questionnaire was designed to elicit qualitative data from the attendees about how they thought aging would impact baby boomers. However, many attendees also identified issues that currently exist. Attendees were able to respond to the questions in any manner that included short, one-word answers, such as transportation, to very involved responses. In order to provide some order to the responses, major topic areas have been identified. In addition, some topics might include sub-topics for the purpose of reading the report more easily. Repetitive responses are included only once.

1. **Easier Access to Services Without Hassle** (including information and assistance; communication; and technology)
   - Information – have information available to them on what might be resources for them
   - Keeping up with technology – training sessions
   - Lacking awareness of communication access
   - Making sure the programs are made known in homes, church, the senior centers and the YMCA and such
   - Don't know what's available to them. Inform them more by taking more time to explain in detail to them.

2. **Healthcare** (including in-home services; Home and Community Based Services; long term care; chronic disease; Alzheimer's disease and related dementia)
   - More slots available for assistance
   - Education on how to cope with aging, depression, how to prevent falls
   - Not enough services or money available
   - Some are as agile and able to move about as others or have the appropriate resources or family members to assist
   - Develop trusting relations with service providers
   - Simple health service – easy access – locations – low cost
   - Nursing home care for elderly and those with disabilities
   - Nursing home or retirement homes – HH or late deafened – need exposure of resources available to be captions, etc.
   - Inadequate funds for health care
   - Main concern because of the changes
   - Palliative care options
   - Affordable and practical health care that's accessible and beneficial – better choices in healthcare systems
   - Help with medication costs
   - More home and community based services

- Getting home care instead of a nursing home even if it means paying a family member
- Cost share programs to help supplement cost for home care
- Knowing and understanding homemaker services and how to obtain Homecare, chores, outside work
- Long term care for middle-income parents and for self
- Basic needs taken care of to assist ADL's – dental care – glasses
- No funds available to help late deafened adults with assistive devices and ASL classes
- Affordable dental care
- Help managing chronic conditions like CHF, COPD, etc.
- Dementia care for those who need long term care (nursing homes)
- Being alone – medically

3. **Fiscal Concerns** (including health insurance; Medicare/Medicaid; employment; retirement; social security; cost of living)
   - Adult child living with aging senior parent earring limited income – prevent parents from receiving benefit for home repair grant – reconsider not counting or having that family income included their income
   - Gas prices – set cap on gas prices/low income families
   - Grocery, utilities, and phone services – create lower price scales for low income families
   - Less benefits in other areas
   - Financial guidance – need someone to teach and/or handle finances to prevent others from taking money
   - Health insurance – Medicare/Medicaid
   - Inflation; create jobs to supplement Social Security
   - Rising property tax – give tax break by setting the bar lower
   - Being able to afford health insurance
   - Insurance coverage
   - Understanding insurance and assistance with obtaining insurance
   - Financial fear – job loss – job bank for seniors still able to work
   - Social security benefits, increase in medical care, and increase of long term care
   - Social Security retirement – do more to protect Social Security
   - Lack of Medicare and/or SSA when we retire
   - Difficulty with saving for retirement due to rising gas and grocery prices
   - The anger over the theft of their retirement funds by corporations to whom these funds were entrusted.
   - Retirement and employment - part-time employment options
   - Having enough money to retire
   - Building or rebuilding retirement plans that are sound investments – offer retirement planning at no to low cost

4. **Support Services** (including transportation, meals/nutrition; elder abuse services; senior centers)

a. **Transportation**
- Transportation for the "old, old" who need "door to door" transportation alternatives (destination on demand too) as opposed to group, curbside transportation
- Transportation – provide funding for the less fortunate in order to keep their independence
- Safe, reliable transportation
- Transportation – public transportation – transports in groups – having to arrive too early for appointments and having to set and wait for public transportation to take them home
- Better transportation public/private
- Let PSSA transport

b. **Meals/Nutrition**
- Elderly couple cannot receive meals on wheels in Tiftonia – why?
- Food, prescriptions, delivery to homes at a reasonable price
- Need home cooked meals – don't like frozen meals – caretaker cook for them

c. **Elder Abuse**
- Bricks/mortar emergency shelter for elder abuse victims who need to be separated from their caregiving perpetrators

d. **Senior Center**

5. **Staying Healthy While Aging** (including exercise, eating healthy foods, socialization, chronic disease, staying connected and involved in the community, volunteer opportunities)
- Help with providing means for activities to exercise and healthy nutrition
- Keeping lines of communication with relative and friends – create community centers that assist with reconnecting individuals
- Not losing identify or self-worth as aging occurs – behavioral services that focuses on self-esteem
- Keeping healthy through exercise and healthy foods
- Isolated socially
- Prices for admission to events are too high for those on limited incomes

6. **Adults with Disabilities**
- Mobility for access to buildings and venues

7. **Caregiving**
- Some are faced with caring for elderly parents and need assistance themselves
- Employee retention for providers who provide services and lack of good caregivers
- The Baby Boomer generation now have children that they are currently taking care of
- Being caregivers

8. **Housing, Neighborhoods, and Safe Communities** (including home repairs and utilities)

- Livable communities with mixed use zoning, high density housing, sidewalks, sidewalk setbacks and grid-system roadways
- Affordable housing and affordable repairs
- Being able to maintain – upkeep of a home (home repairs)
- No affordable housing either independent or assisted
- Affordable assisted living rather than nursing home placement
- Program to help them stay in their homes longer
- Affordable assisted living/in home care for middle income individual
- Safety in home – being able to stay in your own home
- Housing assistance – emergency housing solutions
- Shared housing
- Aging in place – provide services that will allow them to do just that
- Help stay in homes!

9. **Funding/Resources**

10. **Other:**

- State: coordination of services and volunteers – reverse adoption: adoption/foster elders
- Better education, better paying job, removal of gang problems, and health education
- Ongoing advocate
- There are more single parents coming from that age group
- Funeral assistance/planning

Southeast Area Agency on Aging and Disability
Jewish Cultural Center, Chattanooga, TN
February 28, 2013

Question: **Here are seven (7) aging and disability issues.**
Under each, there is a list.
Mark the ones on the list that you think are most important.

Number of Questionnaires completed: 32

Response	# of responses	%
1. Affordable dental care, hearing care and eye exams and glasses 2. Learning how to live with a serious condition like heart disease, cancer, arthritis 3. Learning about how to take care of yourself so that you don't get sick and tired	26	81.3
4. Getting care at home instead of in a nursing home 5. Being able to get accessible transportation 6. Transportation for people who don't drive cars	25	78.1
7. Not having enough insurance or money to pay for doctors or medicine 8. Being able to get help when needed quickly and without hassle	24	75.0
9. Protect people from abuse	23	72.9
10. Respite services 11. Training for aid workers who help older adults and people with disabilities	22	68.8
12. Keeping healthy through exercise and eating healthy foods 13. Meals that are healthy and prevent hunger 14. Teaching doctors, nurses, and other healthcare workers to know the special needs of older adults and people with disabilities	21	65.6
15. Understanding how Medicare works 16. Help with memory loss 17. Housing that people on a pension or Social Security can pay for 18. Houses that are easy to get around in if you're on a walker or in a wheelchair	20	62.5
19. Meeting people and making new friends	19	59.4
20. Reasons people have to go into nursing homes 21. Neighborhoods that are easy and safe to walk in 22. Teaching volunteers to work with older adults and people with disabilities	18	56.3
23. Learning how to prevent falls 24. Learning about how to care for someone at home 25. Neighborhoods that have grocery stores close by	17	53.1

26. Places to volunteer 27. Learning new things	16	50.0

28. Reasons people have to go back to the hospital 29. Teaching police, Firemen, emergency workers to know the special needs of older adults and people with disabilities	15	46.9
30. Knowing where to call for help and getting help without a big runaround 31. Making decisions about health insurance, Medicare, and planning for the future without depending upon the government 32. Help with feeling sad or lonely 33. Help with chores like lawn mowing and leaf raking	14	43.8
34. Being able to choose the workers who come into your home 35. Eating out with friends	13	40.6
36. Help with taking too much medicine	12	37.5
37. Help with drinking too much alcohol or taking drugs 38. Being able to get accurate information from a website and being able to apply for services on-line	8	25.0

Other:

Building trust relationship with client/caregivers and other family
Just love them!
Help with food, housing and health care needs.
Retirement funds cannot keep up with inflation
Help for car for Alzheimer's patients that are not ready for nursing home

Southeast Area Agency on Aging and Disability
Jewish Cultural Center, Chattanooga, TN
February 28, 2012

Question: What is currently working well in your community?
(like agencies that help, neighbors who help each other, van service, senior center, meal sites, food pantry, healthcare clinic, nursing home, sidewalks, police presence, grocery stores that deliver)
(Number of Questionnaires containing 1 or more responses - 22)

This open-ended questionnaire was designed to allow attendees to identify the community programs and services that have worked for them and in their community. Evidence based and/or proven practices were not a consideration in the design of the questionnaire and no checklist was provided. The above items in parentheses were provided as examples. Attendees were asked to write in the programs and services that were working well in their community. The responses are individual and specific to the region served by the Area Agency on Aging and Disability. The number of attendees who indicated that the program is working well in the community is provided in parentheses ().

Neighbors who help each other
Van service • SETHRA bus Transportation/public (3)
Senior center (5)
Meal sites (3) • Food services
Food pantry (3)
Healthcare clinic
Nursing home
Sidewalks • Sidewalks have been placed – good
Police presence (3) • Probably would like more police presence • Law enforcement
Grocery stores that deliver (and Pharmacy) (2) • Cook's grocery
Meals on wheels (4)
Health Department (3)
Human services (food stamps)
The Partnership
All work well

Partnership Elderly Services (2)
Samaritan Center
Hamilton Human Services
Southeast Tennessee Human Resource Agency (SETHRA) (2)
Housing authority
Jewish Federation/services (2)
Area Agency on Aging and Disability (2)
Alzheimer’s Association
Community services
Networking to have someone to check on elders that live alone
Homemaking
Diversity of residential housing options and alternative
Networking of aging service provider/agencies
Chattanooga “can do” attitude
Willingness/determination to solve aging issue problems
Attracting retirees to region
Availability of adult day centers
Having senior centers where meals are available
Senior nutrition centers
Home and community based services
Suggestion: wrapped care – think of as neighborhood school model – most working because its not multi-faceted – think specialist instead of generalist
The agencies are too under funded to really do more than help people subsist. If older and disabled people are helped to thrive they can contribute much to the community. Too many are homeless or nearly so.

Southeast Area Agency on Aging and Disability
Jewish Cultural Center, Chattanooga
February 28, 2013

Small Focus Group Responses

Southeast Area Agency on Aging and Disability
Jewish Cultural Center, Chattanooga
February 28, 2013

Facilitator Notes for Small Focus Group 1

Transportation/Assisted Transportation
One speaker has elderly parents in West Tennessee (Brownsville) but lives in Chattanooga herself. Things like trips to the doctor cannot be taken for granted. A sibling is closer, but she has difficulty physically helping the parents into and out of the car—they both do. They share the responsibility and try to help one another, but the commute back and forth from Chattanooga is also challenging, tiring, and problematic.
*And I contributed to this topic myself, noting that my mother is the only one of three children in the state close enough to provide immediate care to my grandparents, and immediate is still a relative term in that she travels roughly three hours each way between Murfreesboro and Paris, Tennessee. She typically takes a weekend "shift," which means additional arrangements—more trips—have to be made for things like appointments with doctors, which are often in places like Nashville or Memphis.
Even when public transportation is available, it's often accompanied by extended delays—typically forced waits when a group of patients is taken together and some complete their visits earlier than others.
There are people willing to help or looking at alternatives to existing transportation programs, but it's cost prohibitive, particularly with commercial insurance in mind, and there is concern for liability. In the case of volunteers willing to waive reimbursement, there is also perhaps some confusion over what is and isn't legal, or what is and isn't possible. *There is crossover here with a feeling shared later that existing rules and regulations often prevent or hamper solutions to problems.
Who (or what) authority regulates transportation? Where would one ask for approval to try new things? Clarification is needed as to who can legally do what. Is the issue one of the exchange (or not) of money alone?
SETHRA was mentioned as a source of assistance with transportation needs. (There is a website at www.sethra.us which I identified after the fact.)
Several people agreed that it's better sometimes to forge ahead, asking forgiveness rather than permission when in conflict with a regulation.
Healthcare and Medical Needs
There needs to be recognition for the need for "familiar faces." There is a rotation of care providers that is upsetting to the elderly, who respond much better to care when they receive it regularly from the same people.

Rather than addressing problems separately, health care needs to be addressed in a way that looks at the entirety of a person. In other words, there is a need for a role in which a care provider examines and analyzes a person's holistic needs: what they're eating, what medicines they're taking, their injuries, their diseases, their transportation requirements. Rather than identifying and treating a single need or ailment, the need is for an entity who will look inclusively and who will examine the ways in which many factors contribute to an individual patient's quality of life.
Nursing homes should be a last resort, a medical necessity
What will be the impact of the Affordable Healthcare Act on Tennesseans?
Access to Services (Communicating Resources)
He messages need to speak to the average person. What good is a directory if a senior never opens it? *Older Adults . . . the Resource Guide* was the example on hand. The point was not that the guide is without value, just that it doesn't reach everyone and, more importantly, it's not necessarily accessible to everyone—even people who can get their hands on it. The belief stated was that there has to be a alternate delivery method for the information, particularly in communities where there may not even be a senior center. *TV was highlighted. "Older people watch TV."
It's heard regularly and too often: "I didn't know that service was available!"
There is a need to better utilize relationships with associations and organizations to spread information. Contact needs to be made with administrators and directors, and a strong effort must be made to "engage them in the vision."
The path to answers, to reliable and easily accessed sources of information, remains convoluted. It's too often still too difficult for seniors to get the information they need, and they give up.
Housing
Why not provide shared homes for compatible people—people with similar conditions or circumstances—who can live together and help each other? The state would provide the house, the physical structure, and the people living in it would help care for each other. This could also address homelessness and social isolation. It's an idea in common with integrated community services.
Title 3: "CHORE" was referenced. How can assistance for home maintenance be provided while fighting to keep seniors in those same homes—their homes? Where is the funding? And there is a need for a resource: a list of trusted sources of both work and for legitimate donations. It's not just an issue of yard care, although that's a major problem, but also structural repairs such as roofing, flooring, plumbing, etc. This has not been addressed in an organized way, and seniors (and their support) need help in locating reliable and trustworthy, as well as affordable or free, sources of labor.
Could estate recovery be modified to allow for reclamation of empty or abandoned homes for use as shared or group homes?
Everything Else: Statements I Wasn't Sure How to Categorize
CHOICES and OPTIONS are limited in their ability to intervene and assist. *Made in reference to transportation, but I took the meaning as also a generalization of their overall capacity for affecting change.

More hours are needed—more money for at-home care (CHOICES).
Partnerships was brought up more than once as a resource, with the VOCA, VOCARE, and SARAH programs each invoked by name as possible providers of solutions to various problems. Each program deals with its own target issues, as well as separate age groups.
There was an assertion that more collaboration and coordination of resources, like churches and faith based groups, was needed. “They’re ready to help but . . . they’re scattered and without direction.” And in some cases they only give to coordinated organizations. The sentiment was that they are an underutilized and untapped resource.
“Stop penalizing people for doing the right thing.” Medicare restrictions on taking a loved one, someone receiving institutional care or living in a facility, home for the weekend was offered as an example. The sentiment among more than one person is that the federal government, as well as state agencies, create roadblocks to practical, good-hearted, well-intentioned solutions at times.
Tennessee does not pay/reimburse family members who provide care to other family members. This can contribute to a number of problems, not least of which is creating the conditions for a cycle of dependency when caregivers must leave the workforce to provide care, with the result that they then eventually need financial help themselves.
More needs to be done to address the exploitation of finances by family and “friends.” Victims of theft or misappropriation need more attention, someone—a counselor—who can work with them over an extended period of time to address both the exploitation and the associated fears. (Fear of abandonment, for example, by reporting the crime.)

Facilitator Notes for Small Focus Group 2

Funding – needs are great than funds
Aging population – want to stay home
Information for those that need more programs – to help stay at home
Assistance with errands
Chronic disease self management needed
Huge gaps in dental care
Meals that are healthy needed – can’t make nutritional meals
Medication management
People go back to hospital – being able to afford cost of medication
More family involvement, training, etc.
Need people to visit with people who are feeling said and lonely
Isolation – need ways to bridge gap from those who don’t have access to information/services
Problem: reaching home bound
Need home modifications to stay at home but can’t afford
Need for more community/social/religious organizations to do more
Definitely more education on Alzheimer’s and how to deal with people who suffer with disease
Gap in services between people with cognitive disability vs. physical disability
Current provider is providing non-reimbursed services – how long ban agencies due this and survive?

Help with chores – living in homes that are in poor shape – in need of repairs/can't afford
Transportation
If major life changes, like moving – assistance with doing so
Being a victim of exploitation
Depressing that people/elderly are living in poor conditions
Education on health condition – in relation to behaviors (eating, smoking)
Places to volunteer – giving them purpose
Family needs to be more involved
Training for paid workers, especially with Alzheimer's, and training especially to deal with frequent illness
Pest control is a huge need
They want to feel loved
Need for federal assistance/food stamps
Caregiver education/training
Volunteer programs – use high schoolers to assist seniors
Education of caregivers on dementia/Alzheimer's
Basic needs should be considered based on person and not program
If someone is on meals and needs a lifeline, should be covered
Access to assistive devices
Streamlining application process for most services
Need for more case management services and assist seniors with accessing services
Transportation – huge problem – seniors driving power wheelchairs on main road due to lack of transportation especially rural/outlying counties
Funding is issue but knowledge is half battle of that
All the points on this sheet are important

Facilitator Notes for Small Focus Group 3

Affordable living for middle-income families, persons – too much $ for TennCare – not enough to maintain living at home with HCBS
After hours care – adult evening care
Need to promote phone #s 1+A – SHIP
People who need the information don't know who to call
Caregivers of Alzheimer's are s isolated – info needs to be on TV
Dental care a big issue – without it other body systems
For eye glasses not covered in some supplement policies
Consumers need to have input in how TennCare designs its programs
Caregivers need respite – time to run errands go to the grocery store
Need to begin to engage in developing livable communities and homes so folks don't have to drive everywhere
MCO's for TennCare – need to do better assessments – they don't even consider the caregiver
More community awareness of the problems
Wait list on meals – inexcusable
Need to involve more Senior Center and churches in disease prevention healthy life choices
With more boomers staying in the work force – healthy living courses could be taught there
Expand relative caregiver program (grandparents caring for grandkids)

Do away with automated phone message and answering – also language is an issue for some consumer lines - Ex. VA help line: "If you are considering suicide, call --- --- ---."!
Need to do a better job of end of life/palliative care – more services more education
Need to change dr. culture so they are more compassionate and listen
EMS needs training in dementia
Not knowing enough to make the right decisions
Why is insurance getting higher? Older people have financial fear – will they have enough?
More and better MH services - seniors are depressed/lonely/isolated have a lot of loss to deal with
What works: Those in the field know about services/resource – everybody else should

Facilitator Notes for Small Focus Group 4

Ombudsman program – need help with volunteers Need support of State; need more funding; getting Baby Boomers in nursing home; BB's have a different mind set – more meetings, advocating for rights – they want to be heard – want socialization – not satisfied with just setting by the nurses station
Alzheimer's – Baby Boomers are caregivers and their expectations are more demanding – glaring problem is that they expect Medicare/Medicaid to pay, but it doesn't • sometimes those who have funds, don't have enough • opposite ends of the spectrum – either have $ or no $ • need cost-share program that is less restrictive than the current
Tighten up on eligibility requirement and people who are very ill aren't able to get on Choices or in home service -- there is a group of people who can't get services at home and get sicker and sicker and end up in nursing home
General lack of funding for any program you can name, don't know remedy • Social Security income less that $1,000 a month and if need to go into assisted living, it's more then income • also regular rent is more than SS income • have to decide between loneliness and eating
Nothing to help people who become deaf in old age – where can you get free devices; what if you don't know computer skills Baby Boomers – factory workers; rock music – loss of hearing and no funds to help these people thrive in the community (just subsisting not thriving and contributing to community)
People would volunteer and contribute if they didn't have to worry about subsistence
Need to look at innovative ways to use funding (no one wants increase in taxes). We have some good programs that need to be expanded – would like to see more of a mind set where community takes care of community Example: teaching about elder care/dementia care; physician's awareness about the lives of patients (example – medicine bottles) There are some simple things that could be done to help (we all need to fix it; awareness; mindset)
People don't want to think about elderly until absolutely have to
Do more PSA's about safety issues/elder issues (solutions that won't burden to the system)
Americans have moved away from intergenerational living and more people living alone

Problem moving out to suburbs and not conducive to community living – no sidewalks, easy access; transportation (need better planning for urban living
Multi-cultural/diverse community make-up needed
Example: Walmart comes in 12 miles out and small accessible downtown area died – Walmart parking lots/dangerous to navigate
Do more with less (funding) is ok concept until you can't do it How do we creatively solve problems
Volunteers – how do we recruit effective volunteers and train them? Teaching young people to care about aging. Hard to get volunteers out of families who are working 2 jobs; at some point, you have to have more resources
Cultural Awareness of Aging (Agism exists)
Use of media to raise awareness
Transportation – Hunger – Healthcare/Medication – Housing
Communication for disabilities – hearing – lack of awareness of culture – need more interpreters – people they have to deal with on a regular basis and no communication (example: where deaf person had no interpreters; no schooling, etc.)
Issue about awareness of all disability issues (deafness, diabetes, etc.) – needs to start in the schools
Need experiential learning
Shelter – victims of abuse – no bricks and mortar place for them to go when abuser is taken off to jail – shelters not accessible
700+ homeless in Chattanooga
Concerned about transportation – church has community service program
Partnership has program for women over 60; network between non-profits and gov. – for women who don't have family support – hiring a case manager – education is the key
Faith-based organization also lost $ during recession so they have fewer resources
Education of faith-based organization
Need for adult day care centers – co-located with senior centers (need new names for it) Policy change – make cost effective changes Like a "hub" Somewhere people can mingle Also attractive Help to families and sandwich generation/concept change – resources to families Intergeneration/accessible, etc. Make it easy Incentive
Deaf couple were not able to get meals on wheels in Tiftonia (Hamilton Cty.)
If I retire to take care of mother in her home, she would lose benefits because too much income (if both are in same house), but my retirement wouldn't be enough (rules aren't logical)

Facilitator Notes for Small Focus Group 5

The number 1 issue from the group centered on healthcare, home care, the bureaucracy,

accessible housing, and senior transportation.
Concerns were raised about the fact that people don’t know who to call and where to got to get their questions answered
Discussion the focused on the lack of case management services in Tennessee and the fact that there is really no follow up after initial help is provided by agencies. No one is out there checking on folks; no one is out there.
Right now, people use referrals or education to figure out how to manage and operate within the system. Need for more PSA’s to let people know about what services are available.
On senior transportation, discussion focused on para-transit in Chattanooga (door-to-door service) and SETHRA. Catholic Charities also does work in the senior transportation area in the Chattanooga area.
On senior housing, one of the group participants commented on the concept of Purpose-built Communities which is being led by former Mayor of Atlanta, Shirley Franklin.

Needs Assessment

Southwest Area Agency on Aging and Disability
Southwest Tennessee Development District, Jackson
February 13, 2013

Number of Attendees: 59

Southwest Area Agency on Aging and Disability
Southwest Tennessee Development District
February 13, 2013

What are the hard things that "baby boomers" face? How should the state of TN help?
(Number of Questionnaires containing 1 or more responses – 29)

This open-ended questionnaire was designed to elicit qualitative data from the attendees about how they thought aging would impact baby boomers. However, many attendees also identified issues that currently exist. Attendees were able to respond to the questions in any manner that included short, one-word answers, such as transportation, to very involved responses. In order to provide some order to the responses, major topic areas have been identified. In addition, some topics might include sub-topics for the purpose of reading the report more easily. Repetitive responses are included only once.

1. **Easier Access to Services Without Hassle** (including information and assistance; communication; and technology)
   - Computer on-line applications – designate folks @ AAAD to help
   - Knowing what resources are available and how to access those
   - Home base for low-income who do not have access to computers
   - Provide assistance with understanding and completing forms
   - Educate public on viable options for in-home care

2. **Healthcare** (including in-home services; Home and Community Based Services; long term care; chronic disease; Alzheimer's disease and related dementia)
   - Uncertainty of the future of healthcare as a result of legislative action
   - Affordable and available healthcare
   - Rising health care costs
   - Cancer patients need lodging resources as well to help them complete their treatment. Across the state these are the largest reasons cancer patients call the American Cancer Society
   - Security of healthcare
   - Baby boomers face medical issues
   - Physicians that understand the elderly
   - Friendly OHS workers
   - Greater needs – fewer services; greater need for more services
   - Help with housekeeping, bills, personal care when not ready for Choices – provide more funding for services under Title III and options
   - People in prison get all their meals and healthcare taken care of but the nursing homes have to pay to get services. When aging adults go to nursing homes, don't take everything they got.
   - Dental and eye benefits
   - Mental health issues – provide more education for seniors on mental health (other than Alzheimer's)

3. **Fiscal Concerns** (including health insurance; Medicare/Medicaid; employment; retirement; social security; cost of living)

- The high cost of healthcare and insurance
- Affordable and available health insurance
- Rising cost of living
- Continuing decline of our purchasing power – inflation - $15 increase in SSA benefits & $7 loss of food stamp assistance (2 yrs. in a row)
- Finance – assist & provide programs on savings
- The price of health insurance, even if it is possible to get it
- Different "levels" of Medicaid and TennCare and No One who can explain what or why
- Explain insurance and what insurance pays for better
- Security of Medicare and Social Security
- Tax relief for buying a long-term care insurance
- Have funds for retirement when they reach retirement age
- Not certain of retirement/SS benefits after paying in for entire working life – 40+ years
- Not prepared for retirement financially/less money to live on

4. **Support Services** (including transportation, meals/nutrition; elder abuse services; senior centers)

   a. **Transportation**
   - Inability to drive distances to doctors (financial/physical & dependable transportation)
   - Cancer patients are having transportation issues that are causing them not to complete their treatment - we need help in funding more transportation resources for cancer patients
   - Provide affordable & reliable transportation

   b. **Meals/Nutrition**
   - Cost of food which continues to rise
   - Keep providing good healthy meals

5. **Staying Healthy While Aging** (including exercise, eating healthy foods, socialization, chronic disease, staying connected and involved in the community, volunteer)

- Continue games etc. to keep minds active
- Elderly – isolation

6. **Adults with Disabilities**

7. **Caregiving**

- Advancing age while still care taking either parents or disabled children
- Raising grandchildren
- Taking care of parents – children and grandchildren

- Who will take care of them as they get older?
- Caregiver program
- Being able to take care aging

8. Housing, Neighborhoods, and Safe Communities (including home repairs and utilities)
- Affordable independent living facilities
- Financial assistance with home repair and maintenance (& other emergency assistance)
- Payment for overvalued homes – government lending institutions
- Senior housing – aging in place for independent assisted and memory care patients on one campus

9. Funding/Resources
- Make more resources available in health care
- Food stamp funding
- Keep funding centers

10. Other:
- Education of their children – teaching more on how important education is
- Reasons that minorities are left still at an educational disadvantage
- The Great Recession that seems to have no end

Southwest Area Agency on Aging and Disability
Southwest Tennessee Development District
February 13, 2013

Question: **Here are seven (7) aging and disability issues.**
Under each, there is a list.
Mark the ones on the list that you think are most important.

Number of Questionnaires completed: 37

Response	# of responses	%
1. Being able to get help when needed quickly and without hassle	26	70.3
2. Keeping healthy through exercise and eating healthy 3. Affordable dental care, hearing care and eye exams and glasses	25	67.6
4. Learning about how to take care of yourself so that you don't get sick and tired 5. Getting care at home instead of in a nursing home	24	64.9
6. Not having enough insurance or money to pay for doctors or medicine	23	62.2
7. Learning new things	21	56.8
8.. Learning how to live with a serious condition like heart disease, cancer, arthritis 9. Respite services 10. Being able to get accessible transportation 11. Training for aid workers who help older adults and people with disabilities	20	54.1
12. Transportation for people who don't drive cars	19	51.4
13. Housing that people on a pension or Social Security can pay for	18	48.6
14. Teaching police, Firemen, emergency workers to know the special needs of older adults and people with disabilities 15. Meals that are healthy and prevent hunger	17	45.9
16. Being able to choose the workers who come into your home 17. Knowing where to call for help and getting help without a big runaround	16	43.2
18. Learning about how to care for someone at home 19. Understanding how Medicare works 20. Help with memory loss	15	40.5
21. Teaching volunteers to work with older adults and people with disabilities 22. Help with chores like lawn mowing and leaf raking 23. Reasons people have to go into nursing homes	14	37.8

24. Eating out with friends 25. Neighborhoods that are easy and safe to walk in 26. Learning how to prevent falls	13	35.1
27. Teaching doctors, nurses, and other healthcare workers to know the special needs of older adults and people with disabilities 28. Houses that are easy to get around in if you're on a walker or in a wheelchair 29. Protect people from abuse	12	32.4
30. Help with feeling sad or lonely	11	29.7
31. Places to volunteer 32. Meeting people and making new friends	9	24.3
33. Being able to get accurate information from a website and being able to apply for services on-line 34. Neighborhoods that have grocery stores close by 35. Making decisions about health insurance, Medicare, and planning for the future without depending upon the government 36. Help with taking too much medicine	8	21.6
37. Reasons people have to go back to the hospital	7	18.9
38. Help with drinking too much alcohol or taking drugs	4	10.8

Other:

Hospital admissions are getting too complicated for some seniors.
Support for caregivers, more education.
More communication between systems of care.
Drug tests for anyone under 50 drawing SSI
Assistive Technology to help increase quality of life, independence and decrease the level of daily care
CPR – first aid certs – low cost training
CHOICES: members in McNairy and Hardeman Cos. Are highly upset about 27 AC (Attendant Care State Mandate) our UHC MCO is not giving us opportunity to gradually decrease those with high AC hours and it is causing them to request Group 1 placement!!
Huge issue: Being able to get accessible transportation – they will not help folks on and off bus (SW)
Transportation for people who don't drive cares or whose cars can't go distances
Not being "forced" into public housing because of financial (lack of) assistance for repairs
Teaching emergency workers, teaching doctors
Not enough services and funding
Too long of waiting list

Southwest Area Agency on Aging and Disability
Southwest Tennessee Development District
February 13, 2013

Question: What is currently working well in your community?
(like agencies that help, neighbors who help each other, van service, senior center, meal sites, food pantry, healthcare clinic, nursing home, sidewalks, police presence, grocery stores that deliver)
(Number of Questionnaires containing 1 or more responses - 25)

This open-ended questionnaire was designed to allow attendees to identify the community programs and services that have worked for them and in their community. Evidence based and/or proven practices were not a consideration in the design of the questionnaire and no checklist was provided. The above items in parentheses were provided as examples. Attendees were asked to write in the programs and services that were working well in their community. The responses are individual and specific to the region served by the Area Agency on Aging and Disability. v The number of attendees who indicated that the program is working well in the community is provided in parentheses ().

We have none in Scotts Hill
Senior center (13) • Scotts Hill Senior Center works well drawing senior to potluck and activity. We pack commodities for Southwest • Senior center – provides transportation, meals, volunteer opportunities, educational classes and socialization • Senior center is very active • The Selmer Senior Center • Senior Center transportation program
Meal sites (3) • Commodity distribution
Nursing home (4)
Van for seniors (4) • Transportation • Southwest van (2) • Transportation is important to some of our people • Transportation program
• Agencies • Agencies that help
Food pantry (3) • McNairy and Hardeman
No opinion here as I have not given much thought to this until just right now!
Grocery stores that deliver (1)
Neighbors who help each other (2)
• Healthcare clinics (2) • McNairy and Hardeman

• Clinics
Police presence/McNairy and Hardeman
AARP contributing to food banks
Choices, Rx delivery
Physical fitness programs – counseling!
information and assistance programs
Most things
CHOICES program
Southwest Tennessee Development District (SWTDD) (very helpful resource)
Assisted living facilities
Church organizations
Not the weatherization assistance, nor the winter utility assistance
Don’t know what works
Disparity between disabled/elderly to get State assistance vs. irresponsible youth (or illegals) who get “rewarded” for fertility
Partners with Southwest Human Resource Agency (SWHRA) with meals and transportation
Local churches contributing to food pantry
Not sure!
Resource assistance programs
The services that are available are great, but so few people can access

Southwest Area Agency on Aging and Disability
Southwest Tennessee Development District, Jackson
February 13, 2013

Small Focus Group Responses

Southwest Area Agency on Aging and Disability
Southwest Tennessee Development District, Jackson
February 13, 2013

Facilitator Notes for Small Focus Group 1

Nutrition
Home delivered & congregate are bad
Over/under cooked Frozen
No seasoning Not good
Serve a lot of greens but people on blood thinner no eat
Cooking themselves would work
Some items are raw & some could be better
Better participation when make own foods
Vouchers would work @ a restaurant
Ashamed of what meal they got today
Staying Healthy
People not afford meds
One participant passed away
Some meds not covered
Borrow $ from kids to pay for meds
No dental care is huge
Eye care needed
Keep same glasses for years
Lions Club will help w/ glasses
Resources are limited to what they can do
Young people getting all benefits
Even w/ meds @ $5 each pt. D = people take so many they can't afford
Changes year to year
Can afford generic some but not as good
Not help if it goes to garbage
Health and Wellness
Clinics not see you without insurance
Hospital taking pay up front before service
Fed like others (minorities) getting services ¬ majority
Depression not talked about
Some ready to give up & go to NH
Because they have no support or interaction
Lonely at home
Family believes senior center is meeting all his social needs

Senior centers being used by families as adult day care
Using as respite
Directors worry about the people and they worry
Financial abuse: children taking parents $
Seniors not realize or want to do anything about it
Caregiving
Most have family to do CG
Family needs a break
Not afford to have a sitter
Sons & daughters moving mom out of home that leads to depression
Best thing to do is commit a crime & go to prison to get services
Some depression starts because losing ability to drive
Depression due to decreasing health & no hope of getting better
Senior centers save lives because it gives purpose & provides interaction
Senior centers need more money
Want more arthritis exercise
Enjoy the NH coming to senior centers. They bring cakes and play games
Independence
Not get information they need
Vans miss appts. = consumer miss surgery
Families are paying individuals to provide transportation
Not like automated voice on calls for help
Housing
Yard work needed by many
Home repairs needed
Not one to come bale hay on farm = even for free
Many churches build ramps out of their benevolent fund in small community
Crime not as much of a problem
Most places accessible > can pay utilities at the bank
Utility help is available & most elderly are very conservative
Staying Connected
Everyone likes shopping – Dollar Tree, Dairy Queen
Some come to senior center because just need transport to go shopping
Most that go are independent & no need help with their shopping – only transportation
The HRA bus is too expensive
HRA only allows the passenger to have 2 bags – some shop most than that
Some want trips to Tunica to gamble

Not much want to volunteer
Would like to volunteer at NH if there was enough people
Really like to go out to eat but about $6-$& is the limit
Enjoy going at night – if back by dark (4-6 p.m.)
Socialization is the biggest draw of the center
Not like speaker because can't hear
Working w/ Older Adults
Companies change in-home workers & that unsets the elder
Most elders cannot afford $15/hr.
If personal care doctor doesn't listen to concerns, elder is changing doctor
Many problems getting diabetic shoes – doctors think they are scams
These shoes cost $300 to $500 - Medicaid is supposed to provide 1 pair a year
Biggest Need
1. yard work
2. medications & insurance (can't afford)
3. medication
4. medication
5. medication & lawn care

Facilitator Notes for Small Focus Group 2

Staying Healthy While Aging – NEED:
Focus on preventive services for Boomers
Access to exercise facilities in rural areas (distance and lack of transportation)
Free "card" to access exercise facilities (for Boomers and seniors)
Partner with senior centers for exercise equipment/class access (Boomers)
Education about what's available (Boomers and seniors)
More marketing/networking/partnering to get info out to seniors
Resource guide in two parts – first part to address how to stay healthy; second part is information about types of resources and resource directory
Some way to motivate seniors to be more active (Wanda Simmons said they are getting more calls from children concerned about their parents' "slowing down," or showing decreased interest in being active)
Affordable access to dental, hearing, vision care resources (lots of need)
More education about serious and chronic illnesses before leaving hospital and accessible support groups post-discharge; more involvement of families, friends; volunteer program to visit in home post-discharge
Food pantries designated for older persons (younger people who "don't care to find jobs" exhaust supplies)
Health and Wellness – NEED:
In-home help, especially for those living alone (cooking, bathing, shopping, cleaning)
Help for raising grandchildren (said if raising grandchildren, often go to nursing home sooner)

Support for taking meds correctly after hospital discharge
More income/lower cost to be able to afford doctor visits and meds
Stay at home with help, rather than go to nursing home
Less bureaucratic process when trying to get help (big response on this, said many give up)
Help to navigate Medicare (think we understand, but then find out later we didn't)
More human contact for people living alone to prevent or help with loneliness or depression (said see problems, but don't want to butt in, especially in small communities where everyone knows each other)
More education on alcohol and drug abuse for older persons; more AA groups in region (mental health provider said there is a problem, but that families usually approach the matter with caution and consumer doesn't get help)
Law enforcement to stop doctors who prescribe tranquilizers for elderly so that "doctor shopping" options are fewer and to stop children and grandchildren from stealing their meds

More programs like Selmer's "Jesus Cares" which provides food, financial assistance and other help to eligible consumers of all ages – sees many seniors (UMC collaboration with churches in McNairy County to pool funds for buying in bulk, uses common application and tracks distribution to individuals to prevent consumers going from church to church.)
Doctors to tell patient and pharmacist to use generics (elderly don't know this is possible)
Help for newly discharged and often confused persons to manage meds
Avoid going back to hospital by not discharging too soon (DRG system cited as cause of early discharges)
Doctors dispense 2-3 day supply of meds at discharge, but should then fax prescriptions to pharmacy since patients are unable to go to pharmacy to have prescriptions filled
More pharmacies that deliver (if using public transportation, often unable to stop to get meds on way home from doctor)
Less costly meds (many delay getting refills due to cost, many cut pills in half, many don't take
Pharmacists should always tell consumer about potential negative drug interactions (product inserts are done in small font and use language that most are unable to understand)
Teach consumers to be alert and informed about medication safety and to always ask questions of doctors and pharmacists (media campaign, booklets, pamphlets at doctors' offices, pharmacies, senior centers, etc.)
Caregiving – NEED:
More "Caregivers' Day Out" programs
Education on the relevant disease(s) for both caregiver and care recipient, especially regarding Alzheimer's; awareness of resources to help
An easy-to-read guide for caregivers (from man who cares for mother)
Expand the reach of caregiver support programs
Independence and Getting Services Easily – NEED:
More education to consumers about help to maintain independence
Acknowledgment to older persons that their independence matters
Reduce stigma felt by older persons about asking for help (they do not want to be a burden for

anyone)
More readily available and more affordable transportation options ($6/trip for shopping in one county; must call three days ahead to reserve)
Standardized appearance of transportation provider vehicles (one consumer afraid to go to big, dark colored car with darkly tinted windows – thought wasn't legitimate provider – turned out it was, but she was traumatized)
Transportation from Jackson area to Memphis for medical treatment (said this is often needed, but unavailable)
Raise awareness among Choices recipients about transportation availability
Easier way to get benefits (less runaround, fewer barriers to getting information and making application)
More respectful workers at DHS, particularly (bad experiences made seniors unwilling to go back)
Education on advance care directives (most do not know about them)
Housing, Neighborhoods and Safe Communities – NEED:
More safe and affordable senior housing (mental health worker cited sliding fee scale independent living facility in McNairy County sponsored by UMC)
Senior apartments without drug deals
Staying Connected and Involved in the Community – NEED:
More attention from families
Transportation to get to senior center, places of worship, visit families and friends
Opportunities to help others, as in children, grandchildren (no transportation, cost of gas cited as barriers)
Working with Older Adults and People with Disabilities – NEED:
There were no comments on this topic.
Other
This group was small and included two seniors from the NW district (Carroll County) who were unable to attend the NW Listening Tour event, one mental health provider, two MCO representatives and a VA representative.
The two men from NW serve as AARP representatives for their county and are actively involved in helping others through their church's food pantry and whatever initiatives AARP asks them to work. One of the men is recently retired and provides care for his mother, as well.

Facilitator Notes for Small Focus Group 3

Staying Healthy While Aging
Exercise is very important but not enough facilities for older folks
The lack of affordable dental care, vision blocks
Accessing info to learn how to stay healthy
Health and Wellness
Outreach in accessing

Clear concise info on where to access help with medicine "face to face"
"Unknown" service with names not reflective of "Choices" service
Rural setting blocks much info access
Caregiving
Not enough hours available to realistically give you a rest
More family members want to taske care of loved one but don't know how and they want compensation
Ruler makes it hard for family members to caregivers
Independence & Getting Service Easily
Need for workers not to rotate so that people can establish a relationship with worker
Still not receptive of technology and want a live person
Current services limit "Independence"
Staying Connected and Involved
Meeting people should be encouraged
Redefine senior center
Working with Older Adults & People with Disabilities
Not enough service
Access is limited
Not clearly defined what is available
Stop warehousing people, take closer look
Streamline service

Facilitator Notes for Small Focus Group 4

Bethel Springs has no local services and no transportation.
Affordable care for in-home services.
Some of the "help" lines for providers are located in other counties where language maybe a barrier for some customers.
There was lots of conversation around DHS and attitude toward older folks. Example of eye rolling, rude words, etc. When clients go for help – food stamps for the first time in these lines – then treated poorly.
DHS is confusing and compassion is missing. They need to use simple language and listen to the customer.
DHS and others (MCOs, transportation, doctors practice) need to learn how to better coordinate services.
Missouri has self-directed care, does Tennessee? No – discussed what self-directed was - & possibility of VA using
Baby boomers are caught in between plus they didn't have as many children.
Need more and better support for the caregiver
Couple of suggestions grew out of this: 1. At the persons home – need a place where a list of all meds are kept & everyone knows where it is. Home Instead gives folks a magnetic white board 5X7 or so to put of the refrigerator and list drugs

2. This led to a discussion of first responders police, for EMS to receive training in dementia - also have to deal with mental health issues - *training is done, but not in a coordinated effort rural areas probably left out of the loop 3. Senior Emergency Kit – one provider gives customer a Senior Emergency Kit with they Sign up – with a place to list meds and controls; and the need to have an emergency plan
Training – Training – Training Customer training for <60 Tech Schools, Community Colleges – working with older adults Education about LTC insurance and advanced directives
There needs to be better outreach to seniors to let them know there is a safe, comfortable place to go for information.
There needs to be a hospital ombudsman – after poor and not easily understood instruction and sent home pt's – which ends in a return – discussed concept of Care Transition
Also mentioned that DHS needed a separate ombudsman
Pastime aspect – Baby Boomers will not stand a lot of this
Need to channel that energy to be volunteers - advocates

Facilitator Notes for Small Focus Group 5

Staying Healthy
Preventative care is important
Keeping healthy
Dental health – glasses
Serious illness – 2 conditions (heart and arthritis)
Health and Wellness
Depression – a lot of seniors deal with depression
Abuse – spouse, children, nursing home, verbal or physical
Knowing where to get help w/o runaround
Keeping you on hold for extended periods
Feel like get runaround mostly with insurance
Insurance workers intimidate elderly & insurance can't answer your questions (private health insurance)
Feel same about Medicare in some instances
Caregiving
Learn how to take care of yourself
Accepting help from others with caregiving
Independence
Being able to depend on walker/other assistance after surgery or falls
Transportation – when you need it
Getting help without hassle
Internet doesn't apply right now – most elderly will not use computers and don't want one – should be other ways for service info and applying – elderly senior just don't use computers

Staying Connected
Senior centers cover all things in this sector
Seniors would take a trip to Jackson to eat out every wee if center could take them
Love going, but not having to drive
Working with Older Adults and People with Disabilities
Better pay and better training for staff

Facilitator Notes for Small Focus Group 6

There are too many places to try and find out of they are eligible – too many hoops Also concern about too many services (through homemaker services, et.) being provided. Some get more than they need. We could actually save more money.
Healthy aging: Program through MAC – Jackson County – a whole program of activities
How do you get people more involved. Finding people who need to get out and get services – churches, talk to the communities – promote interesting events
Also coordination of programs would help
A Retirement Guide – everything to do with aging – softball, sports, religion A clearinghouse – one phone number for folks to call
Home Instead is a foundation that might be worth look into
More children calling about how to get parents involved after retirement
Lack of transportation services for individual with cancer or a cancer diagnosis – led to American Cancer Society's Road to Recovery program in Madison City (to get people to their treatment) – Road to Recovery is a volunteer-let program – volunteers pick them up and take them home. 459 trips in the past year – runs on American Cancer Society donations - Road to Recovery – calls them 24 hours in advance –
In further discussions about transportation, Madison City buses don't go as far as the Star Center facility – is located in Jackson so people have to find their own way
Volunteers going into certain area has been a problem in some areas - *not* a problem going into certain areas with the program here
A provider said that he continues to have problems understanding who qualified for what programs including TennCare
There needs to be a "landing pad" for people looking for services
"The community is responsible for the community."

Facilitator Notes for Small Focus Group 7

People don't know how to get services like meals – education about programs
Can't afford to buy food because of buying medication
Lack of resources under 60 Don't know who to call or ask I've been disabled for 15 years
Use the senior center as point of contact to ask questions Before went to center, asked the county mayor because call 5 different places – "circled around" and nobody know about helping anybody with anything, then just went to senior center – senior center was advocate

Senior center has classes Older people don’t get on-line to learn and computer sites send you around also
Caregiver for 10 years House not wheelchair accessible Ambulance had to carry out bodily Agency got motorized wheelchair and ramp and that made a huge difference (thru agriculture dept.) Always stayed with him (don’t know anybody in McNairy Co. that would do that)
People don’t understand the disease they have and they don’t ask questions, so they don’t try to do better
People don’t understand directions doctor gives them
Important to have someone with me during a doctor visit to help me listen (have it put on your record that doctor can talk)
Health and Wellness
Understand Medicare and TennCare - unwieldy
I have Medicare and TennCare – I get all these bills and I was told not to pay the bill – why do they send me a bill
Different levels –QMB– what is all that?
Waste of money for Pink Cards (TennCare)
Some doctors not taking Medicare and TennCare (some have signs up that doctor is not taking any more Medicare or TennCare patients
Hard for family members who have someone with dementia/Alz.
Nice to know ahead of time – information about what we face – or doctor refer to class (example: Hospice told me what to do for wife)
Would have liked to have someone come in so I could go to grocery or go get medicine
I took a home health aid course so I could learn to take care of husband and now neighbors call me
Doctor in Franklin – vehicle won’t make it – you’ve got QMB so you don’t qualify $150 to get ride to Franklin when you go to a doctor out of town and often, then you can’t afford transportation How do they figure those benefits? Then issue about doctor no longer being in network Missing appointments because of transportation issues
Have to get on at 8:00 and don’t get back on to 2:00 (one van gets 6 or 7 people and everyone has to wait on each other – no food, can’t take meds)
Often have to go to Nashville or Memphis to get treatment – issues about child care when Bus rides rough – pain after long ride
Wife taking husband for a ride – so she didn’t get help until he was bedridden
Have a good neighbor who helps and calls everyday to see what I need
Needed home repairs – so was told to move to public housing – house payment is less than public housing – can’t get help with roof (could get a low interest loan but don/t have income to pay
For < 60 with disabilities hard to get a little help
Agencies run out of $ (like run out of energy assistance)
State does not do a good job to telling people where to go for help

People getting in line at 4:00 a.m. to get food
Are there checks and balances in the system – are we serving most needy?
Families with children get all the food boxes, free food and seniors (who get $44 in food stamps) don't get the free food Boxes ought to go to people who only get a little in food stamps
Volunteerism – opportunities at senior center Pooled volunteerism "Jesus Cares" coordinates it
Need training for people who work with seniors and adults with disabilities, but not sure State needs to be doing it (example: 1st responders)
More $ for senior center You can have I&A lines, but there is nothing better than having face-to-face at senior center Who is advocacy
Legalize strip poker at senior center

Facilitator Notes for Small Focus Group 8

More HDM meal sites necessary
Food stamps being cut out
TennCare HDM assessment
Need more extended hours
Need for dental, eye wear, and hearing aids
Home health
Fire alert
Doctors need to a better job at educating their patients
Lack of services in home – not enough services
TennCare clients getting readmitted to hospital because they are not afforded Medicare
No support results in readmission
Transportation issue for all things
Bus driver will not assist clients on and off bus
TennCare only allowed 5 prescriptions a month
Depends on county by county basis – nw/sw are different
Lack of advertisers
Too much advertisements around Medicare especially evaluating eligibilities
Mental health education outside of Alzheimer's both on client and doctor level
Need more resources the community for chores
Errands no one to run errands
Affordable safe housing (waiting list) for senior and those with disabilities
Drs. are referring seniors to pain clinics aging issues
More senior centers in the community
Need for free SPR and first aid certified
Self directed programs cumbersome
ppl drug testing

Needs Assessment

Northwest Area Agency on Aging and Disability
Senior Center, Union City
February 12, 2013

Number of Attendees: 152

Northwest Area Agency on Aging and Disability
Southwest Tennessee Development District
February 13, 2013

What are the hard things that "baby boomers" face? How should the state of TN help?
(Number of Questionnaires containing 1 or more responses – 91)

This open-ended questionnaire was designed to elicit qualitative data from the attendees about how they thought aging would impact baby boomers. However, many attendees also identified issues that currently exist. Attendees were able to respond to the questions in any manner that included short, one-word answers, such as transportation, to very involved responses. In order to provide some order to the responses, major topic areas have been identified. In addition, some topics might include sub-topics for the purpose of reading the report more easily. Repetitive responses are included only once.

1. **Easier Access to Services Without Hassle** (including information and assistance; communication; and technology)
   - Technology - making it easier for them to reach their resources
   - Able to get their services easier without having to push a bunch of buttons
   - Having service available when needed

2. **Healthcare** (including in-home services; Home and Community Based Services; long term care; chronic disease; Alzheimer's disease and related dementia; loneliness; alcohol and drugs)
   - How to stay out of nursing
   - Adapting to having to leave their home for temporary services (nursing home)
   - Too many trips to doctor to get to the final lab test and results – skip worthless test and go right to the good test/change from 3 months to one-year prescriptions
   - Get the people off tenncare, free food, free everything else and help the baby boomers to afford meds, drs.
   - Losing your home because of nursing home care
   - Being able to afford services
   - Fewer care providers, thus increased waiting time in clinics
   - Rising health care charges
   - Learn to shop more frugally – certain to need more doctors' visits and prescription medicine and remember to take meds on time
   - Need more agencies to provide help within the home
   - Getting healthcare at home
   - More needing LTC – lengthy wait list for services
   - Long term places for us to be taken care of it there is not family members to take of me.
   - Hearing aids – medication
   - Stop the selling of drugs and alcoholic parents

3. **Fiscal Concerns** (including the economy, health insurance; Medicare/Medicaid; employment; retirement; social security; cost of living)

- Financial changes when there confronted with lost savings from bad economy and high cost of medical care
- Hard to live on social security - if fortunate not to have what's put aside for medical expenses
- More money needed for services
- Rising prices in food and gas
- Save more money for their golden years
- Hope social Security and Medicare will be available for them when they become of age
- Helping financially with parents at same time as helping children with college
- Adjust to a lower pay check
- Paying for some of our meds and that makes it hard to pay for food and bills
- Help with insurance
- Health problems and enough money to meet expenses
- Provide accurate and affordable insurance.
- Understanding insurance questions
- How to afford healthcare
- Paying for medications
- Affordable long-term healthcare
- Planning and help about Medicare and legal matters
- We need health care
- Help with medical bills
- Changes in medical (Medicare) insurance due to affordable care act – repeal it
- Rise in cost of Medicare and supplemental insurance – every time a COLA is given cost
  of insurance goes up
- Medical benefits
- Buying food or healthcare, but not both
- Expenses for healthcare and med. Should be a consideration for financial assistance not
  just income and assets alone
- Medicine/Insurance
- Need to lower insurance
- Getting old! Will there still be Medicare and Social security
- Supplemental insurance to cover more for low-income people
- (Insurance gap)/too young not old enough
- Insurance prices
- Help prevent insurance fraud
- Less taxes out of my check - anything to keep taxes as low as possible
- Take some young people off welfare and put them to work
- Job opportunities, programs, finding jobs, loss of jobs, no security
- Employment for elderly

- Lack of pensions
- No paid insurance with jobs
- Keeping job
- Change in social security information
- Increase in social security checks
- Baby boomers are expecting to get social security so hopefully there will be funds available for them - possibility of social security not being there for them
- High cost of living
- Live according to their income
- Having enough income in their later years - saving for retirement

Plan a way of security so that they can help them self
By financing away to let them know how to help them self

- Possible loss or decreased social security benefits/concerns re: retirement and how to fund it
- They are still working more retirement benefits
- Can I afford retirement?
- Estate planning
- Possible loss of retirement
- No retirement in sight
- The 60-65 year Old baby boomers seem to have issues finding jobs to supplement their
  retirement and SSI
- We should not be supporting all those on welfare that should not be on it - better screening

4. Support Services

a. Transportation

- Transportation For Sick to Nashville and Memphis
- Better transportation - transportation availability
- Transportation to doctors, groceries, and center activities
- Gas prices/ sit on congress and president to stop gas prices from jumping up – older people are starving/no money left to buy essentials
- Transportation in Union City – no taxi or public transportation

b. Meals/Nutrition

- Meals for the elderly
- Help with food
- Good hot nutritious meals
- Food costs - groceries
- Help in feeding the low-income seniors more!
- Nutrition services, more choices for meals on wheels
- Better meal sites with choices
- Food stamps going down and good going up

c. Elder Abuse

- Being victimized by telephone solicitation when the "Do not call" is ignored and no action taken by government to stop this practice

- Protecting elderly parents from opportunist
- Protection against fraud and identify theft
- Exploitation from others who take advantage of the elderly
- Affordable legal assistance

d. Senior Centers

5. **Staying Healthy While Aging** (including exercise, eating healthy foods, socialization, chronic disease, staying connected and involved in the community, volunteer)
   - Activities for grandparents that have grandkids living with them
   - Maintaining a healthy profile
   - Staying active physically and mentally
   - Being able and try to stay independence
   - Accepting that they are seniors – more positive image of 60+
   - Age appropriate activities and social events
   - Staying healthy and able to work until their age requirement
   - Senior trips
   - Need larger buildings for senior centers
   - Making friends in safe settings

6. **Adults with Disabilities**

7. **Caregiving**
   - Being caregivers for elderly parents
   - More funding to aid caregivers to help keep their parents at home
   - Care for aging parents – home care assistance
   - Taking time to keep others and be unselfish with older adults
   - Taking care of aging parents while trying to work fulltime
   - Caregiver burnout

8. **Housing, Neighborhoods, and Safe Communities** (including home repairs and utilities)
   - Crime
   - Safety in the home - also personal safety education for outside home
   - Low-income housing – (quality) for single seniors
   - Assistance with home repairs
   - All utilities
   - More help in order to stay in our homes
   - Making friends and enjoying activities at safe locations in their community
   - Several seniors come to us needing help with repairs on their homes, needing air conditioning/heating and no $ to do so. We need programs to assist.

9. **Funding/Resources**
   - More funding for activities and to rent space to have activities
   - Make sure resources for benefits are very accessible to the public
   - Put some money in programs to help these people

10. Other:

- "David Reynolds" Tenn. is doing, it best, to
- "Helping all of the people of the state" We thank you very much
- Tell them about God - And that he died for their sins
- I believe the State of Tennessee is going a pretty good job right now.

Northwest Area Agency on Aging and Disability
Senior Center, Union City
February 12, 2013

Question: **Here are seven (7) aging and disability issues.**
Under each, there is a list.
<u>Mark the ones on the list that you think are most important.</u>

Number of Questionnaires completed: 99

Response	# of responses	%
1. Being able to get help when needed quickly and without hassle	80	80.8
2. Keeping healthy through exercise and eating healthy	79	79.8
3. Affordable dental care, hearing care and eye exams and glasses	73	73.7
4. Transportation for people who don't drive cars	71	71.7
5. Not having enough insurance or money to pay for doctors or medicine	68	68.7
6. Learning how to live with a serious condition like heart disease, cancer, arthritis 7. Training for aid workers who help older adults and people with disabilities	67	67.7
9. Getting care at home instead of in a nursing home	66	66.7
10. Meeting people and making new friends 11. Respite services	65	65.7
12. Reasons people have to go into nursing homes	64	64.6
13. Housing that people on a pension or Social Security can pay for	63	63.6
14. Teaching volunteers to work with older adults and people with disabilities 15. Being able to get accessible transportation	60	60.6
16. Houses that are easy to get around in if you're on a walker or in a wheelchair	58	58.6
17. Help with memory loss 18. Protect people from abuse	56	56.6
19. Learning new things	55	55.6
20. Knowing where to call for help and getting help without a big runaround 21. Help with chores like lawn mowing and leaf raking	54	54.5

23. Learning about how to take care of yourself so that you	52	52.5

don't get sick and tired 24. Understanding how Medicare works		
25. Eating out with friends	50	50.5
26. Being able to choose the workers who come into your home	49	49.5
27. Making decisions about health insurance, Medicare, and planning for the future without depending upon the government	48	48.5
28. Meals that are healthy and prevent hunger	48	48.5
29. Neighborhoods that are easy and safe to walk in	47	47.5
30. Learning how to prevent falls 31. Teaching police, Firemen, emergency workers to know the special needs of older adults and people with disabilities 32. Teaching doctors, nurses, and other healthcare workers to know the special needs of older adults and people with disabilities	46	46.5
33. Places to volunteer 34. Help with taking too much medicine	44	44.4
35. Help with feeling sad or lonely 36. Neighborhoods that have grocery stores close by	40	40.4
37. Being able to get accurate information from a website and being able to	27	27.2
38. Help with drinking too much alcohol or taking drugs	18	18.1

Other:

Recycling opportunities and more local sites that are available for items
Recycling opportunities – need more coordination between recycling sites and the city/county & also phasing out Styrofoam containers by state and local agencies
Meeting people and make new friends
All is important – everyone would like help
All of these non-medical agencies that are sent to care for seriously medically ill patients that are not qualified
We keep hearing volunteer, no one can afford volunteer anymore
We need a place to turn to when we hear of an individual who is in a bad way, starving, house keeping – lists are too long when added to these list.
Teach senior computers
Strengthening federal laws to provide residents on long term care facilities a voice and better, consistent care.
More support for senior centers. You want to get Baby Boomers in our centers, but Baby Boomers want modern building, topnotch equipment and well informed instructors. These things cost money. Many thins in this survey can be accomplished thru senior centers with more support.
Educate children on importance of "time spent" with elder parents and proper understanding of medication's usage and side effects.
In-home service is very important. It's a service to keep the elderly at their homes and out of the nursing homes.
Love – Peace – Happiness – Forever – Togetherness

Love – Peace – Honesty – Sharing – Caring – Fellowship
Checking in on more people that are on Medicaid, that are selling their meds.
Plenty more need to be helped

Northwest Area Agency on Aging and Disability
Senior Center, Union City, TN
February 12, 2012

Question: What is currently working well in your community?
(like agencies that help, neighbors who help each other, van service, senior center, meal sites, food pantry, healthcare clinic, nursing home, sidewalks, police presence, grocery stores that deliver)
(Number of Questionnaires containing 1 or more responses - 80)

This open-ended questionnaire was designed to allow attendees to identify the community programs and services that have worked for them and in their community. Evidence based and/or proven practices were not a consideration in the design of the questionnaire and no checklist was provided. The above items in parentheses were provided as examples. Attendees were asked to write in the programs and services that were working well in their community. The responses are individual and specific to the region served by the Area Agency on Aging and Disability. The number of attendees who indicated that the program is working well in the community is provided in parentheses ().

In my community all the things above are near my home.
All of this/All of the above (3)
All good
All of these are very important and work well in our community.
All of the above/senior centers most important
Senior Center (42) • Senior Center Milan • Thank God for our senior center • Our senior center provides a place for older adults to get together five days a week playing games, meals, exercise, health clinics, information, problems. • Our senior center is aware of other monies that become available for use with citizens through the Senior Center. • Senior center activities at Union City, Obion County • Our Senior Center is doing good, but could have more participants if transportation could more in getting them there. • Senior centers are a great place. They need more funding for activities. • The Dresden Senior Center is a great place. It really helped me when I was left alone. It was great to make new friends. • The senior center in Dresden is helpful in our little town. They offer help in giving information on Medicare and insurance supplements and also in delivering daily hot meals and frozen meals. And, several activities are provided for entertainment and socializing. • Center is going strong but need additional space. • Madison Senior Center • Having senior centers for us to enjoy, meeting new people and enjoying day trips • Senior Centers – older adults can go for companionship, congregate meals – just to

be with others and learn different things

Police Presence (20) • Sheriff's Dept. extremely active in support (meals, etc.) • Sheriff's department • Police are always available to help when needed
Nursing home (20)
Van service (19) • Transportation vans help individuals in our community. Also WeCare helps provide volunteer opportunities, clothes, furniture and other items at an affordable rate/price. • Northwest Transportation Service • Van service is helpful • Some time they schedule one person to be picked up by two drivers at different times in the a.m. Some times not enough time. • Transportation services • Local transportation (Center operated) for trips to gro. Local drs. And clinics (need a new van). • Living in country, I have to get my own transportation to grocery store and to drs.
The Bridge at Ridgely is a nursing facility in Lake County that now offers home modifications to those that prefer to stay home, but need their home to be accessible to them.
• Waiting too long • It is sad that when you sign up that you will have to wait so long to get some help. Most of the time when they get to you, you are dead.
Senior meals and having places for senior to go
Meal sites (19) • Meals on wheels • United Way and all programs for meals is hurting so it would help to have sponsors for meals on wheels • Meals are delivered to older and sick people
Food pantry/mobile (16) • Food bank services
Neighbors who help each other (5)
• Cut away sidewalks (need to be more though) • Sidewalks
T.A.R.P.
• Going to grocery store • Grocery stores that deliver (4) • E W James delivers groceries
Healthcare clinic (12)
• Healthmart Pharmacy (has delivery service in town) • Pharmacy from neighboring town delivers to center since we do not have a pharmacy.

Programs/Rehab services for information
Good volunteers to help with activities (2)

Agencies that help (3)
We have all of the above but many of the things are for already on SSI or other services – many don’t know of the services or are to proud to ask for help
AARP
Church, church, church
Partnering with TN Extension Service for certified instructors for teachers on Chronic Disease.
In my community, van service and center for seniors are working very well. Most seniors don’t have transportation or family to transport them to different areas, i.e. supermarket, bank, post office, etc. and the Center gives seniors a place to come and make new friends, great old friends and to just commune and have fun.
Agencies with knowledgeable people
Our Senior Citizen Center very good, my church, my friends, my family
• Food assistance through Ministerial Alliance in Benton Co. • Food assistance through partnership with First United Methodist Church and Second Harvest Food Bank
CHOICES program with TNCare
Food drives, commodities
Aquatics available
Service for seniors
In-home service from the local OOA
Dresden office on aging helped me with all of my problems – liked helped me with my insurance – and keeps us active

Northwest Area Agency on Aging and Disability
Senior Center, Union City
February 12, 2013

Small Focus Group Responses

Northwest AAAD
Senior Center, Union City, TN
February 12, 2013

Facilitator Notes for Small Focus Group 1

Staying Healthy While Aging
What works:
• Silver sneakers *
• Need more exercise equipment
• Matter of Balance
Problem of attracting Baby Boomer's to services:
• Choices are more important to baby boomers
• They want more choices in food and activities
• One newly retired BB wanted to know why he hasn't seen more people of his age at the senior center
Health eating, Healthy aging/Nutrition provider
Meals provider suggested that they are concerned with hunger and that there are meals that are provided by churches, pot lucks, other sponsors and they are not counted or reported for Title IV meals
There should be a way to count as match
Eating alone – one participant talked about eating alone – food not as tasty as it used to be and then eating alone on top of that. Likes congregate meals.
How do we attract younger BB to food program
Food desert - from Paris, TN – have to drive to Jackson for low fat, low carb foods
Back to BB's and good program: they want more choices
What works:
Senior Circle: hospital-based education program – monthly lunch and an education program on Healthy Living and Choices
Exercise:
Enjoys walking inside with a few friends
Facilities (community centers) usually don't have a pool and UT Martin has a pool, but it's not heated
Gardening mentioned as a favorite hobby (exercise) by several
Transportation:
Mentioned several times not just to Dr. appointments, but other activities
Nutrition
Mentioned on two levels: 1) quality of food 2) some seniors going hungry

Facilitator Notes for Small Focus Group 2

Windows – money for repairs, heating and air conditioning – only programs are for veterans – no general programs for seniors
Home modification programs through TennCare was suggested and Reel Foot Rural Ministries
Limited Assisted Living and Retirement communities in rural areas
High utilities and limited assistance
Statewide Community/Neighborhood watch geared toward seniors
Solicitors/callers not honoring do not call list – seniors being taken advantage of - Do Not Call being violated
Up Police Presence in rural areas
Requirements for someone being sent home from facility to home that is in poor condition that would put client and caregiver at risk
Turnaround time on getting services
Marketing of services for housing modifications and other things available
Internet not good marketing tool – most seniors don't have access
Housing for seniors and disabled with younger disabled sometimes becomes unsafe for seniors
More affordable housing
Guidelines for housing (who qualifies) – more strict on behavior (Ex. Drug Abuse)
More information about more efficient housing (ex. Handicap accessible)
Funding for modifications
Training local departments on responding to those with disabilities
Better marketing of services available in area
More neighborhood watch in communities
Failing Life Alerts (Life Alerts for Seniors would help with safety for seniors)
Lighting and sidewalks (better to accommodate wheelchairs)
Safe places to go in bad weather (in home or community)
Educate more on Emergency Preparedness and Safety

Facilitator Notes for Small Focus Group 3

Staying Connected
Playing rook in senior center /Luncheon events dominoes keep people connected
Doctor said keep your heart ticking-they more you do the better your emotional and physical health.
Seniors go to Churches and nursing homes sing and visits - positively/religiously healthy
Find friends to do the same thing you like and do it together.
Join AARP –
Go through churches to get names of homebound people, civic organizations share list of homebound going to their home on holidays bring gifts-inviting them to senior center functions
Bring in new activities to senior centers- Basket weaving/knitting, quilting, exercise
More Nursing home volunteers.
Problem: Most people who come to centers are repeats…it hard to keep new people committed to coming.
Barriers: People having problems getting to Senior Center for Activities - handicapped

accessible travel < room in the centers-Transportation schedule medical first then recreational.
Mentality of older people are changing < few changing younger mind
No resources for vehicles to take people to and from recreational activities
For seniors who are Homebound/telephone reassurance programs need to be used more
More Nursing home visits
Staying healthy – exercise/project list
Most Seniors cannot afford healthcare if they don't have Medicare and tend to neglect their health
No financial resources for Dentures/Hearing Aids/Glasses
Staying active is very important to Seniors
Educating in the Centers makes a huge impact on health
Health & Wellness
Prevent repeat injuries many fall in nursing homes - do not have appropriate care when they come home—taking meds, dr visits, etc.
There is a Role for education in senior centers-educating them on finances, health, and other important things that are not discussed.
Protecting our seniors

Facilitator Notes for Small Focus Group 4

Consumer Direction – have own workers
CPR - training
Resources for free training
Volunteers for more help for the seniors – home maintenance - _____home repairs – air conditioners
Volunteers to check on them on people out of hospitals and nursing
Educating community/people for volunteer communities – registry of people willing to help

Facilitator Notes for Small Focus Group 5

Staying Healthy While Aging – NEED:
Information on our programs and other help (don't know what's available)
Food assistance (vehicle counts toward eligibility, so most get small benefit (county is rural, so having car is essential – need to change rules to allow vehicle without penalty)
Heating assistance
More money for home-delivered meals to reduce long waiting list (per center director)
Transportation to be able to apply for benefits, get healthy food, see doctors, go to senior center, visit others, go to church, etc.
More money (get less income when retired than when working)
Somewhere nearby to walk/exercise
Someone to walk with (afraid might fall or be robbed)
Health and Wellness – NEED:
More visits and help from family (loneliness)
Medicare to cover dental care, OTC vitamins

Medicare (better coverage of meds - high cost)
Help with cost of Medicare premiums and co-pays
COLA increases to be greater than Medicare premium increases
Transportation to get to senior center or “Y” (Silver Sneakers Program) to exercise
Help with utility bills
More services when needed, no waiting lists (“hard to get services”)
Caregiving – NEED:
“Companions” (need more than are available)
More funding for program
Independence and Getting Services Easily – NEED:
Transportation – more options, less expensive than current $5 each way, more vans, more volunteer drivers, help getting from house to van/van to destination, separate programs for TennCare clients and elderly clients – “TennCare has taken over” transportation for one person even if no one else is scheduled to ride (HRA will not transport just one)
“One-Stop Shop” to get “benefits” (food stamps, heating assistance, “Extra Help”) – now must go to different place to sign up for each
Easier access to services (“hard to get services,” want more marketing of our and other services and easier way to apply, help in filling out applications)
Housing, Neighborhoods and Safe Communities – NEED:
Property tax break for elderly
Homeless shelter (there is none in county)
Better help from police (police not helpful, too busy talking to each other, focused on drug problems, community unsafe)
Police department to protect names of those calling to report suspicious activity (people afraid to call because their names are broadcast on police scanners – everyone in small towns know each other – too risky to become known as one who alerted police)
Subsidized housing for seniors separated from subsidized housing for younger people (too much drug activity and other crime, seniors do not feel safe)
Staying Connected and Involved in the Community – NEED:
More funding for senior centers (center director said too many cuts to services)
Transportation to get to senior centers
More family involvement in lives (visits and other expressions of caring)
Working with Older Adults and People with Disabilities – NEED:
There were no comments on this topic.
Other
The greatest needs expressed by this group (all from Lake County Senior Center) were more, more affordable and more accommodating transportation options and ssafety in their community.
There was much frustration expressed about the lack of transportation for individuals who happened to be the only person needing a ride on a particular day, since the HRA

Transportation will not provide the service for just one person. Several cited 92 year old woman with cancer who is refused transportation to chemo appointments if she is the only person scheduled to ride.
Lots of discussion about the concern for police protection in the community due to police seeming to regard drug violations as very important and the needs of older adults as much less important. Many said they had stopped believing the police department was there to help a long time ago.

Facilitator Notes for Small Focus Group 6

Caregiving
More qualified workers
More clients/more $
Caregiver training and support group
Unable to research/limited computer skills
Education the family to take care of elderly!
Educate on Alzheimer's or dementia
Support for caregivers – someone to talk to
Adult day care – socialization – motor skills
More hours
Transportation
Lower price or discounted prices
Less hassle w/ appointments
Is not helping the community
False advertising
Scheduling difficulties
Misinformation given
Why are different districts operated differently?
More accessible services and info
Volunteering
Not enough training
Recruitment
Where are the needs?
Adopt a Grandparent Day
More ppl. Involved – not enough volunteers
Staying Healthy
Exercise class/dance class/table tennis > lots of participation
More $ for equipment/health promotion $
Ease of Info
• Limited computer skills
• Phonebooks – small
• Referrals from community/Dr.'s to AAAD – do Dr.'s know to refer?

Facilitator Notes for Small Focus Group 7

Facilitator Notes for Small Focus Group 7
Residents in home and nursing home need more education and supports for seniors to process medication and alcohol interaction
Too many doctor visits
Once a year instead of every three months
Long waits at office visits
Doctor visit process too long and tedious
Lack of interest in exercise program
Healthy aging what to expect
Lack of consistent transportation
More funds for transportation
Need for senior companion programs
More money for in-home services
More training for personal care services
More home delivered meals
More affordable meds
Encourage more education with sheriff's department
More intergenerational
Easy to understand electronics
Better meds
More meds
Expand program in churches
More in home services
Respite for caregivers, especially for those with dementia
Surrogate program to help make health care decision
Options waiting list
Protection against fraud and abuse
Recycle programs into senior center and community education
$20 of food stamps for seniors/have to hire someone to take them to set – signed up – not worth it
Alternate exercises that are low impact
Silver sneakers have been for 5 years – make people have for socialize and exercise for all ages 2 times a week
More in community supports to avoid readmission
Limits on pa pain clinics – too much pain
Primary care
No med list like no call list for solicitation
Use of pill dispenser
TRA program advertise and don't work
A lot of seniors don't have money for insurance – insurance does not cover hearing aides/or glasses – can see or hear or removed
Seniors can't afford supplemental plans in the 20192 up but premiums go up
Not understanding how insurance or socials security works – long waits at social services and Medicare
Social Security unapproachable

Not talks to person re electronic voice mail to reach me
Consistency in the people who they talk to
It's important that seniors keep healthy exercise
Need funds to hire well trained instructors

Facilitator Notes for Small Focus Group 8

Health and Wellness
Seniors over 60 – not enough income for hearing aide, eyeglasses, can't afford (hearing aides $2,000) people discounted
Runaround – when you call, it takes forever and put on hold, back with you, never get back – people wind up getting really rich
Money not handled at the lowest level
Concern about where $ goes - - too much at administrative level and not at local level (pyramid on the point - - drive pyramid into ground)
Need more help – not enough Need more help in home (ended up in nursing home)
Don't want estate recover – families leaving themselves to death so family farm won't be lost, but still want mom to have good care
On waiting list for homemaker – don't get when you need it
Nursing – don't have enough help – not enough staff and patients don't get help – friends and family helping to feed patients
When in nursing home/rehab – nobody (staff came to help)
CSBG (Corrine Welch grant $) program – now have to go through ABS
Family caregiver – no help so I can leave (more falls/can't cook)
End up in nursing home because they didn't take medicine right (forget Sometimes doctor doesn't tell you right Doctor's don't listen when medications make you feel bad or funny
Medicare? Don't know half the time what I'm reading
High poverty rates
Care coordinators fall behind on visits and fall behind on re-certification and person ends up getting sicker/falling (CHOICES)
Care coordinators/not doing job/services combine/service provider doesn't get paid
Need more home health
Need to communicate more with patients about medicines/what their supposed to be doing
Some people can't take medicine on their own – taking wrong pill (need to use trays to put them in
People with memory loss – not understanding how to take medicine
Staying Healthy While Aging
Activity/exercise at senior center – need $
More classes/dietitian/diabetic classes
Recreation/not being home alone
Have to be able to afford food, etc., when they need to change diet – expensive
One store in Taylorville

Need Dr. Oz
Chronic Disease – on diagnosis have to watch what eat/fluid intake/use less salt
New Group
Transportation
• People are weak – need to have 3 or 4 chairs on as van to set on a trip to Nashville
• Example: cancer patient needing new medication stranded for an hour or more at hospital - $25 to go to Nashville (private pay)
• Appointment – month ahead of time with specialty doctor; no transportation; if it's public transportation, then they need to be on a schedule (false advertisement)
• How do you qualify to ride on the vans? (someone answers – anyone can qualify – supposedly)
• In Crockett Co. – no problems with vans taking around the county (beauty ________)
• Supportive Living – need accessible vans to wheelchairs (pulling on him) (dangerous) It shouldn't come to that – shouldn't take an act of congress to get what you need in terms of accessible transportation
Volunteers –
• want to hear volunteer ideas
• guardianship training – new to it – lots of hands on
• volunteers at senior centers
• recruitment of volunteers
• need list of where volunteers are needed
Most can't work computer
Surprising
Not know what's available/not knowing what they are eligible for
Private companies – level of care – come in to do house making, but citizen needs more – like taking medicine
Waiting lists – needs and can't help people
Nursing home > then home > home not livable when they get back
Central registry for volunteers who help people get home repair assistance

Needs Assessment

Aging Commission of the Mid-South
Area Agency on Aging and Disability
Pink Palace, Memphis
February 14, 2013

Number of Attendees: 100

Aging Commission of the Mid-South Area Agency on Aging and Disability
Pink Palace, Memphis
February 14, 2013

What are the hard things that "baby boomers" face? How should the state of TN help?
(Number of Questionnaires containing 1 or more responses – 56)

This open-ended questionnaire was designed to elicit qualitative data from the attendees about how they thought aging would impact baby boomers. However, many attendees also identified issues that currently exist. Attendees were able to respond to the questions in any manner that included short, one-word answers, such as transportation, to very involved responses. In order to provide some order to the responses, major topic areas have been identified. In addition, some topics might include sub-topics for the purpose of reading the report more easily. Repetitive responses are included only once.

1. **Easier Access to Services Without Hassle** (including information and assistance; communication; and technology)
    - Communicating program (we are not talking to each other)/funds available
      Help! Partner and go to McDonald's at breakfast! Target group is there.
    - Not up to date with technology – provide tutoring workshops
    - Give discounts – affordable internet & cable TV for those who cannot get out of the house due to disability or transportation. We want to stay connected to information.
    - Build awareness in general public and among key stakeholders
    - Provide a list of comprehensive guidelines to agencies and service
    - More public information about the TN Choices program – infomercials would help
    - Use methods other than the internet to provide information
    - How to function IT age
    - Guidance, people need to be taught how to care for themselves, what to do, where to do and who to talk with
    - Continue to provide training on know how, prevention
    - Provide health ads
    - Knowledge of programs about care services – public information – *media attention
    - Clear info on services for elderly
    - Knowing where to go to for assistance with love ones
    - Limited knowledge base – teach the basic applications for living

2. **Healthcare** (including in-home services; Home and Community Based Services; long term care; chronic disease; Alzheimer's disease and related dementia; assisted living)
    - Health care issues > decreasing coverage?/ co-payments – transportation to and from appointments
    - Health issues aging with grace – make it affordable – doctors who liberally use the pen and pad for prescriptions
    - Medical care/finance
    - Independence - assistance to remain independent
    - Affordable health care

- Because there are so many baby boomers, there is a ratio where boomers out number providers and not enough opportunities for them all to participate in the programs.
- Some do not have family support. Provide home based services and supports that are not income based.
- Medicine compliance
- There will be so many of them requiring services at the same time. There will be a need for partnerships with various agencies.
- They have a hard time paying for medication
- Health changing with the aging peers
- Need for medical clinic access to avoid ER
- Lack of adequate healthcare – where to seek healthcare
- Guidance – classes on how to function during the time of need
- By accepting the Obamacare insurance program
- Mental health for the homebound and also at senior high rises, communities and centers. This is also important for people with disabilities.
- The self-directed waiver should NOT include dental along with funds for the caregiver
- Support services for "boomers" with and without disabilities, such as CHOICES program
- Better communication between service providers
- Co-ordination of communication regarding care
- The need for programs to be available to assist older clients with their finances and personal needs
- More health clinics - More non-medical in home services
- HCBS (getting services in home – NOT nursing home) without going broke
- They would like to stay in their homes but have no one to help them with little things around the house.
- In-home assistance to age in place
- Lack of family support particularly as it affects how income older adults
- Lack of in-home services (homemaker services)
- Expand Medicaid (Choices – Expand Choices 3
- Confine/increase support to CHOICES program
- Affordable medical and dental care
- Drug and alcohol use – free counseling services
- Access to assisted living which is now totally ***not*** subsidized – i.e. fill the "gap" between independent living and nursing home

3. **Fiscal Concerns** (including health insurance; Medicare/Medicaid; employment; retirement; social security; cost of living)
   - Rising health care costs
   - Poor health care insurance
   - Insurance concerns; make sure they have great medical insurance after retirement
   - Financial concerns (decreasing income > expenses >/= income; increasing medical cost; Food/housing/general expenses

- Financial stability
- Finance restrictions for State cost reduction
- Lack of financial resources – prepare financial assistance that will provide stability
- Reality of living on fixed income
- Income not meeting the demand of increasing cost
- Enough money for shelter, food, and clothing
- Getting reverse mortgage without the equity
- Paying for non-prescription drugs
- Medical bills – lower the prices
- Medication costs – not eligible for Medicare yet
- Lack of knowledge about products marketed to seniors/older adults
- Non-medical home health costs
- Drug cost
- Affordable insurance/dental care/medicines
- The difference between what is Medicaid and Medicare? – give a better explanation on the program
- Medicare/healthcare access; working towards adapting the "Obamacare" Act vs. what is currently being done
- People living longer – will Medicare be enough
- Jobs – incentives for employers to retain aging workers
- Discrimination of the aged in jobs.
- Loss of Social Security
- They are in need of an increase in SSI and SS income
- Questions about Social Security
- Guarantee of Social Security benefits
- Retirement issues with issues with health and finance
- Retirement with lifestyle they are used to
- Financial security – many adults have not saved enough for retirement. State could provide financial planning, etc.
- Not enough in savings to support retirement
- Money – incentives to save for retirement
- How to live on retirement income
- For younger boomers – planning financially for retirement needs; appropriate counseling for retirees – adjusting to retirement living
- Part-time job (retirement) – raise the retirement allowance
- Inability to retire because of increasing cost of living
- Guarantee of a true retirement
- Betters opportunities to work for the ones that choose to work

4. **Support Services** (including transportation, meals/nutrition; elder abuse services;)

   a. **Transportation**

      - Help! Expand transportation coverage/vendors/availability – MATA vouchers, etc.
      - Accessible transportation

- Public transportation when no longer able to drive – Help: more vans for senior centers
- Options that realistically connect people in older neighborhoods with medical centers where doctors offices are
- Lack of transportation services
- Transportation affordable and on schedule
- Access to transportation; having more transportation services available in a timely manner
- Spread out community – when mobility is limited – services too spread out
- Provide more support public transit – loss for roads

b. Meals/Nutrition

- State partner with big chain grocery stores to deliver groceries to those who can no longer drive to grocery store, but who still cook their meals
- Restaurants that serve low sodium or special dietary foods – Piccadilly has fantastic dietary meals at affordable price. Perhaps State could partner with restaurant associations.
- Help with food insecurities
- Healthy veg food

c. Elder Abuse

- Elder abuse from those who guide us in "wrong direction" for Commission
- Elder maltreatment is a huge issue. ASPS not appropriately managed or responsive. Needs to be supported in same manner as children's courts
- Legal services

d. Senior Centers

- Not having enough activities to catch their interest; ensure that the "senior centers" have age appropriate activities that fun and not boring

5. **Staying Healthy While Aging** (including exercise, eating healthy foods, socialization, chronic disease, staying connected and involved in the community, volunteer opportunities)

- Not enough senior related activities
- Getting old with nothing to do (daily)
- Community involvement driven activities
- Being left alone

6. **Adults with Disabilities**

- More programs to do for disable people at home – more hours too
- Provide assistance in reducing the cost of public transportation for people with disabilities
- Transportation for all disabled
- Day programs for seniors and mentally ill adults with disabilities
- Programs and services for the blind

- The State needs to try to extend TennCare for the adult who is disabled
- Increase support for Center for Independent Living

7. **Caregiving**
   - Caregiver support > caregivers die before boomer; not willing/capable/available CGs Help! Like with advance directives – add space for caregiver support/people/contacts
   - Caregivers not supported. Work with businesses to offer caregiver support through worksite wellness/benefits
   - Caring for aging parents and spouse while still working
   - Resources to taking care of aging parents, especially when grandchildren don't live near parent
   - Caring for aging parents – Help: more in-home services
   - I am a 70-year-old caregiver. I take care of my daughter. State of Tennessee won't give me help because they say my situation is not critical. I have hypertension and I am diabetic. It gets very hard for me at times. I don't have time for myself.
   - Caring for elderly parents and children while saving/trying to retire
   - Working longer while caring for aging parents

8. **Housing, Neighborhoods, and Safe Communities** (including home repairs and utilities)
   - Decreasing number of options; income not sufficient to cover
     Help! Build . . . they will come
   - Housing (accessible, affordable)
   - Safety
   - Affordable living communities
   - Help keep up the community with tree cutting and street repair
   - Retirement communities with access to shopping, activities, no maintenance=safe environment
   - Some of them face housing problems.
   - Downsizing to livable communities – ordinances that promote mixed use/size housing
   - Reasonable housing
   - Explain the State of TN Housing Recovery Act. How will this affect their home if services are given.
   - By allowing home owners tax exemptions once they reach 65 years. Of age
   - Apply for next round of 811 housing vouchers
   - Crime (drugs, guns) protection
   - Existing housing stock not accessible or able to promote "aging in place" – fund home repair/modification efforts, use volunteers.

9. **Funding/Resources**
   - Few resources
   - There may be limited resources and the State must be ready to aid in supplying the short fall
   - The state can help with funding & create new problems
   - Funding for housing and develop start up services for elderly
   - They need help in paying bills

- Shelby County has lost funding to service seniors – increase budget
- Financial assistance

10. Other:

- A prevailing attitude of RESPECT for elders/treatment of dignity
- Several emotional barriers – address the barriers for actual healing
- Recognizing that patience is a work in progress. As helping professionals this point we certainly want to convey the importance.
- Public services
- Engage lower income seniors in the advocacy movement
- Engage the corporate world
- The demands of the baby boomers will demand different things than seniors today – TN will needs to balance the needs of the aging.
- Need someone to advocate for them since many are unable to do it themselves
- Better coordination of services
- Not really coming to grips with getting older
- Need people focused government vs. corporate health

Aging Commission of the Mid-South Area Agency on Aging and Disability
Pink Palace, Memphis
February 14, 2013

Question: **Here are seven (7) aging and disability issues.**
Under each, there is a list.
Mark the ones on the list that you think are most important.

Number of Questionnaires completed: 56

Response	# of responses	%
1 Transportation for people who don't drive cars	38	67.9
2. Keeping healthy through exercise and eating healthy	37	66.1
3. Not having enough insurance or money to pay for doctors or medicine 4. Getting care at home instead of in a nursing home 5. Housing that people on a pension or Social Security can pay for	36	64.3
6. Learning new things	34	60.7
7. Learning how to live with a serious condition like heart disease, cancer, arthritis 8. Being able to get help when needed quickly and without hassle 9. Training for aid workers who help older adults and people with disabilities	33	58.9
10. Being able to get accessible transportation	32	57.1
11. Affordable dental care, hearing care and eye exams and glasses	31	55.3
12. Learning about how to take care of yourself so that you don't get sick and tired 13. Teaching doctors, nurses, and other healthcare workers to know the special needs of older adults and people with disabilities	30	53.6
14. Protect people from abuse 15. Respite services	29	51.8
16. Houses that are easy to get around in if you're on a walker or in a wheelchair	28	50.0
17. Learning about how to care for someone at home	27	48.2
18. Neighborhoods that are easy and safe to walk in	26	46.2
19. Being able to choose the workers who come into your home 20. Teaching volunteers to work with older adults and people with disabilities	25	44.6
21. Eating out with friends 22. Teaching police, Firemen, emergency workers to know the special needs of older adults and people with disabilities	24	43.9
23. Neighborhoods that have grocery stores close by 24. Places to volunteer 25. Meeting people and making new friends	23	41.1

26. Meals that are healthy and prevent hunger 27. Knowing where to call for help and getting help without a big runaround 28. Understanding how Medicare works 29. Help with memory loss	22	39.3
30. Learning how to prevent falls	21	37.5
31. Help with chores like lawn mowing and leaf raking	20	35.7
32. Help with feeling sad or lonely	18	32.1
33. Reasons people have to go into nursing homes 34. Being able to get accurate information from a website and being able to apply for services on-line	17	30.4
35. Reasons people have to go back to the hospital	16	28.6
36. Making decisions about health insurance, Medicare, and planning for the future without depending upon the government	15	26.8
37. Help with taking too much medicine	13	23.2
38. Help with drinking too much alcohol or taking drugs	9	16.1

Aging Commission of the Mid-South Area Agency on Aging and Disability
Pink Palace, Memphis TN
February 12, 2013

Question: What is currently working well in your community?
(like agencies that help, neighbors who help each other, van service, senior center, meal sites, food pantry, healthcare clinic, nursing home, sidewalks, police presence, grocery stores that deliver)
(Number of Questionnaires containing 1 or more responses - 30)

This open-ended questionnaire was designed to allow attendees to identify the community programs and services that have worked for them and in their community. Evidence based and/or proven practices were not a consideration in the design of the questionnaire and no checklist was provided. The above items in parentheses were provided as examples. Attendees were asked to write in the programs and services that were working well in their community. The responses are individual and specific to the region served by the Area Agency on Aging and Disability. The number of attendees who indicated that the program is working well in the community is provided in parentheses ().

All of the above serve a fraction of purpose
• There are services in my neighborhood who also provide van service and assist with grocery store delivery • Grocery stores that deliver
• Meal sites (3) • Meals on wheels • MIFA – meals on wheels – congregate meals • Commodities
Senior center (6) • In my community the senior center works well. We have a place to go and learn or refresh what we know, like knitting, the computer, the movies and getting to be around people to laugh, dance and enjoy • Senior center activities and educational meetings • Great senior center facilities – under utilized, but available • Senior center activities and educational meetings
Healthcare clinic (4)
Police presence (6) • Law Enforcement Agencies provide some education • Senior crime stoppers/Senior B Safe programs
The aging commission in the Mid-South does a wonderful job at accessing the needs of the aging.
Van services (3)
There needs to be MUCH, MUCH more services for medical services for the disabled.
MCIL; I do not see a lot that is working well.
MIFA – ombudsman program to provide advocates for nursing home residents
Lauderdale Commission on Aging (many programs)

Faith Based Organizations – food, meals
Deltas Human Resource Agency – food and van service
Arnold’s Drug Co. in Hale – delivers medicines
Sidewalks (2)
I don’t know of any
Neighbors who help each other (4)
A company called Top Priority Homemaker Services. This company was introduced to me from a good friend of mine. She is getting a home services through the Choices program. The other came out and met with me and after about 2 months I’ve got the service started for me. If not for the information from my friend, I would not have know about this program. Thank you.
• Free community senior expo’s that have vendors who serve seniors available to provide education what is available to the. • Free senior expo’s to give out information
Services that are affordable to seniors – need more
Agencies that help (3)
Nursing home (2)
• Public Guardianship for the Elderly • Although extremely under funded and busting at the seams, the Public Guardianship program provides URGENT SERVICES for person who can no longer help themselves. Sometimes it happens – we don’t wish it or want it to happen – but it does and we need to admit this need and provide for it!
Fire Department comes into our homes to install detectors
Choices waiver is great, but needs expansion to include housekeeping and maybe yard work for seniors and people with disabilities who can’t pay for these services.
• Food pantry • We have a good pantry and get food from Memphis food bank who often runs short of food – they need donations.

Aging Commission of the Mid-South
Area Agency on Aging and Disability
Pink Palace, Memphis
February 14, 2013

Small Focus Group Responses

Aging Commission of the Mid-South Area Agency on Aging and Disability
Pink Palace, Memphis
February 14, 2013

Facilitator Notes for Small Focus Group 1

Housing does not allow for aging in place
Heating, cooling, pest control
Waiting list
Easy assistance
Better access to services
Falling between the cracks
Work better with physicians to sent out information
Make greater effort to stay in community
Expand community support
Transportation to go back to work
Are seniors being provided the opportunity to stay informed
Seniors and technology – how do we get senior acquainted with technology?
Elder abuse
Formula how we allocate dollars to programs
Abuse in nursing homes

Facilitator Notes for Small Focus Group 2

There is a need for more contact with/ oversight for older people who live in facilities, nursing homes and have no children, family or friends who watch out for and advocate for them.
Difficulty with transportation to dr appointments with adults on disability Medicare. Medicare does not pay for transportation. Transportation costs are expensive and inconvenient.
There is a big hole in services for non-elderly adults with disabilities. Options wait list goes on for years.
It seems like all services are cutting back.
Income restrictions on Choices, makes folks become almost destitute before they can receive services.
It's a struggle to keep houses safe and livable, energy efficient, well insulated, painted not falling apart.
Things that work: VA has some self directed care and also offers a foster family program for veterans who have no one. Families are screened before placement and are paid a foster family monthly fee.

Facilitator Notes for Small Focus Group 3

Health care in the suburbs – hard to get to – transportation
Hearing, seeing, eating
Physicians who will accept Medicare
Evidence-based programs – Matter of Balance
In-home services
Victims of fraud and scams
Long-distance caregiving – consider bringing in outside help – emotional, financial

Transportation – huge issue
Computer information not so important
CHOICE of caregiver very important
Safe, accessible housing
How to prioritize which neighborhoods for curb cuts (?)
Home mods. – bathrooms
TN Housing Dept, - problem – won't help renters

Facilitator Notes for Small Focus Group 4

Staying Healthy While Aging
Learning how to live with a serious condition such as dementia/memory loss
38104, 38109, etc. needs local med. home in the community
Health and Wellness
Getting care at home instead of a nursing home – simplify, streamline & centralize approval to 7-10 days of less
Understanding how Medicare works – Dept. of Commerce & Insurance – regulate/guidelines for marketing Medicare – stop (all phone) solicitation
Caregiving
More affordable options for respite services
Housing
Help with companion care for light errands
Transportation for people who don't drive cars 1) decrease wait (from phone to action) from TennCare < 3 days to written 24 hours 2) more reliable transportation 3) more affordable transportation 4) expand geographic limits (to Drs. East)
Increase private/public partnerships to improve/develop affordable healthy habits(?) (reduces blight/crime)
Staying Connected and Involved in the Community
Affordable internet services (seniors, kids, grandkids' school work, etc.)
Communication between service providers, ideally electronically
Working with Older Adults and People with Disabilities
Dementia training for all works, professionals, and volunteers who help older adults and people with disabilities
Other
The Alzheimer's Association offers family caregiver training at no cost. Professional training for a fee.

Facilitator Notes for Small Focus Group 5

Issues and Possible Solutions
Health Financing:
Medicare D – existed 7 years – need more information SHIP program – 7 workshops – for new Medicare beneficiaries – 4 in Shelby, +1 per other county = pilot program 140,000 in Delta AAAD area (4 county)
Medicaid – people need information
Social Security:
People need more information on SSI
Big issue of Education people – communicating
Suggest: Rural TN vs. Urban TN? Communication needed
Transportation:
Need to get elder driving skills assessed at TN-DOT. Need to be able to request the elder parent, etc. come in for assessment – need to be based on traffic area and on individual basis, for ex. on prior accident
Senior Centers:
Cuts in funding – need more funding for transportation in rural areas
Choices program:
To keep people out of nursing home
Concern for caregivers –
Need TEAM decision on nursing home admits
Facilitate Sr. Volunteering:
R.S.V.P. not currently through AAAD
Increased retirement age:
How does it impact employers and how do they react?
Need workplace incentives (tax wise?) to retain older workers
Technology/ computers & Literacy issue – adults:
Use RSVP volunteers and Teach for America
Medical records:
Need to follow individuals and allow necessary access
Food needs
Awareness of elder abuse – need more adult protective services – only 1 in our AAAD
End of Life Care – Major Luttrell

Facilitator Notes for Small Focus Group 6

Staying Healthy While Aging – NEED:
Information and education about benefits of proper diet and exercise
Access to medical care and medications (undesirable transportation options and unaffordable for some)
Preventive health care screenings
More accommodating transportation options (some must wait 2-3 hours for buses and never get to medical appointments; no help for getting to/from appointments; Memphis Area Transit Authority charges $1.50/trip, but is unreliable)
Ramps on homes in order to be able to get out to go anywhere
Leaders to collaborate to place focus on transportation from quality of life perspective
Health and Wellness – NEED:
Transportation options that are more accommodating (long waits; may never get to appointments)
Lower gas costs (if own vehicle or if taking ride from friend/family and want to help pay for gas)
Benefits' eligibility to be less rigid, based on need, rather than on “numbers” (“Look at person and not at numbers.”)
Lower cost of “private insurance” (reference to Medicare Supplement Plan by consumer with high enough income that her Part B premium was $140/month – she didn't know why, but another member of the group explained the income-based fee scale to her)
Campaign to lessen distrust of government and ensure confidentiality so more people enroll in benefits (make information on complex topics simple, inasmuch as possible)
Campaign to increase awareness of young people about the achievements and value of older people (lack of respect from young people evident; treated badly at DHS and other offices)
Government to reach out to people in zip codes where low-income persons live to enroll them in benefits (no excuse for people to miss out if government would act)
Family members to be more involved in care of elders
Restructure system to eliminate the flood of marketing mail and phone calls to people new to Medicare and during Open Enrollment periods (very confusing and misleading)
Insurance companies penalized for lying to consumers
Better communication between agencies/health and drug plans and government departments to help and protect consumers
Classes/training for all persons about to go on Medicare
Require Congress to have the same benefits as regular citizens
Distribute information about Medicare, programs and other services at places people commonly frequent (suggested WalMarts, McDonald's, groceries, pharmacies, places of worship)
Caregiving – NEED:
There were no comments on this topic.
Independence and Getting Services Easily – NEED:
Eliminate automated phone systems and have real people answer phones at agencies older

persons need to contact about benefits or services (very confusing, unless computer-savvy, can't navigate)
Foster respect for older adults and those with disabilities among young people
Transportation options that are more accommodating (long waits; may never get to appointments)
Lower gas costs (if own vehicle or if taking ride from friend/family and want to help pay for gas)
Benefits' eligibility to be less rigid, based on need, rather than on “numbers” (“Look at person and not at numbers.”)
Family members to help more to preserve and extend consumer's independence
Government to reach out to people in zip codes where low-income persons live to enroll them in benefits (no excuse for people to miss out if government would act)
Better communication between agencies/health and drug plans and government departments to help and protect consumers
Classes/training for all persons about to go on Medicare
Distribute information about Medicare, programs and other services at places people commonly frequent (suggested WalMarts, McDonald's, groceries, pharmacies, places of worship)
Ramps on homes (said only people who get ramps are those on Choices)
Housing, Neighborhoods and Safe Communities – NEED:
Affordable retirement communities (suggested income-based sliding fee)
Break on property taxes (woman cited $1,000 city tax, plus $900 county tax, saying she didn't know where she would get money to cover those)
Eliminate wheel taxes for seniors and persons with disabilities
Give seniors and those with disabilities a “fresh start” on credit
More shelters for homeless persons, especially for those who have disabilities
Staying Connected and Involved in the Community – NEED:
Transportation options more readily available than three-day advance registration, at minimal or no cost to consumer, and willing/able to take on necessary and elective trips
Working with Older Adults and People with Disabilities – NEED:
There were no comments on this topic.
Other
This group was comprised of three MCO representatives, one younger person with a disability (uses a wheelchair), two human service agency professionals and three consumers. The woman with a disability was largely quiet, but did echo her agreement with the needs identified by others in the group.

Facilitator Notes for Small Focus Group 7

Staying Healthy
Prevention is priority to prevent other issues – if they eat right
Resources to purchase healthy foods
Access and economic means to buy food

Should make better choices – education is needed early on with children to sustain healthier eating habits for long term
Genetic factors should be considered as well – holistic perspective
More community involvement
Health and Wellness
Live in home main concern – independence in homes with some resources – some have strong desire to be independent
Stressed – don't want to go in nursing home
Not have insurance, co-pays – resources
Have age restrictions Medicare
Large population not informed about Medicare
Reach limit for services – major concern
Lack of communication between doctors and hospitals - * all providers
Education at early age to save so they can prepare for future
When you recognize (not deny) symptoms for dementia/Alzheimer's – seek assistance from family
Abuse happens in nursing homes
Caregiving
Self-preservation is important for caregiver
Family may abuse other family members as well
Tighter control over home care agencies – minimum for approval – which translates
to workers – just doing a job – not really taking care of client
Independence and Getting Services Easily
#3 and #4 definitely (Being able to choose the workers who come into your home; Being able to get accessible transportation)
Housing, Neighbor and Self Control
Need to develop Safe communities
Need walkable areas
Need for healthcare providers within the community
Staying Connected
Learning new things
Seniors have no where to go – senior centers are important for socialization
Working with Older Adults and People with Disabilities
Never get enough training
Continuing education for police, firemen, etc. and doctors is important
Other
Seniors and those with disabilities need motivation and encouragement!
Nursing Homes – pretty on outside with nice amenities – but care is unacceptable – needs improvement, especially on 3rd shift

Facilitator Notes for Small Focus Group 8

Increase of cost to eating healthier
Baby Boomers don't have resources to support self in retirement
Need to learn to grow vegetables
Gardens – community gardens
Pick your own (Shelby farms)
Farmer's Markets are expensive – need volunteer gardens for low-income
How can limited seniors access gardens? Transportation; disabilities – this might be "pie in the sky" – maybe need to share with others
Need delivery services – shop for seniors
Mid-America goods
There's a meals on wheels waiting list now – need better way to reach everybody
Need more programs on TV designed for seniors and people with disabilities (make sure it's not same time as their "stories")
Older adults need socialization and others to exercise
If you don't get out and socialize – transportation is the key
Aging in place is good and in the community is good – not enough independent senior living facility
Need to work on an article that living in own home is not the only option – stigma against not living in own home
Are there other alternatives to living in original home? It could be OK.
Need to start partnering with businesses when they start talking about retirement counseling – llo at alternative living – start figuring it out when you're 60 – look at options
"Partnership Program" "Own Your Future" – 2008 State incentives people who plan ahead – nothing on State website about it – Gov. Haslam needs to revisit it
Change perspective that your assets are paying for your care – it's not that you are "losing" your assets or home
Estate recovery – older person going without the care they need because they want to leave it to kids.
Not having enough income to pay for insurance – we don't talk about the high cost of medicine – everybody has to take a cut
Medicare doesn't cover hearing or vision which is a major issue in aging
More funding for in-home services – waiting list too long – just a little help
Hardeman program (MIFA) would help people stay in homes
More funding for in-home services – Waiting list too long – just a little help
Hardeman program (MIFA) would help people stay in homes
Cities and rural areas need to be more involved & coordinated – need to work together
Cities and counties need to address transportation and make it accessible and affordable to older people. (It seems to work for disabled, but it's late, etc. – hours short) Seems to work better for "working disabled" than it does for "older disabled"
Sidewalks seem to be more accessible than it used to, but we need to make scooter accessibility like we did bike lanes
ACMS as focal point – it's improved and people aren't getting the runaround, but not all people know about it

Call, intake, then find out there's no help or waiting list – hard to give over the phone what they need to hear
Seniors get taken advantage of the complicated Medicare/advantage plans need better regulation
Safety net and focus for those who cannot make decisions on their own. This population is growing as fast as the aging population. Vulnerable populations
Surprising:
Automated phones a problem
Government waste in TN – why wasn't this money spent on elderly? (UCDD, corporate welfare to General Motors)
Wrong to stick things in bills
Vulnerable adult population growing

Facilitator Notes for Small Focus Group 9

Stay Healthy While Aging
Not exercising and eating healthy foods can cause illness
Affordable dental care, hearing care, and eye exams and glasses important
Learning how to prevent falls – huge problem requiring rehab can cause so many problems
Preventive care
Health and Wellness
Concern about not having enough insurance
Elderly individuals feel more comfortable at home
Concern about making health insurance decisions and planning for the future without government
Help with feeling sad and lonely – spouse passing, empty nest
Help with drinking too much alcohol or taking drugs – baby boomers
Protecting people from abuse
Caregiving
The table agreed all three very important – respite care, learning how to care for someone at home, and learning how to take care of yourself
Independence and Getting Services Easily
Being able to choose workers – personal space
Being able to get accessible transportation – proper training to transport people with walkers or wheelchairs
Housing, Neighborhoods, and Safe Communities
One person said all issues in this category were important
Transportation to dr. appts., errands
Life changes but house doesn't without making renovations – wheelchair ramps

Staying Connected and Involved in the Community
Places to volunteer
Learning new things – keeping up with technology – cell phones and computers
Eating out with friends – interaction, socialization
Working with Older Adults and People with Disabilities
Geriatric training very important (paid workers, police, firemen, emergency workers, doctors, nurses, healthcare workers, and volunteers) – older adults will not be intimidated to go places thing people will not know how to care for them if they fall
Other
Legal services – government funded free advocacy for people in nursing homes and assisted living

Attachment G

Description of TennCare CHOICES And Money Follows the Person

CHOICES

The TennCare CHOICES in Long-Term Services and Supports Program (or CHOICES), serves persons who are age 65 and older and adults age 21 and older with physical disabilities. CHOICES is an integrated Medicaid Managed Long-Term Services and Supports (MLTSS) program. At-risk MCOs accredited by the National Committee on Quality Assurance and selected via a competitive bid process are responsible for coordinating the full array of physical and behavioral health and long-term care services that eligible members need. A global budget strategy is achieved for long-term care services via a fully blended capitation payment that encompasses all of the long-term care services—Nursing Facility (NF) or HCBS—needed by the member, as well as services for physical and behavioral health needs. Members who qualify for NF care have freedom of choice of the setting in which care will be received, so long as their needs can be safely met in the community at a cost that does not exceed institutional care. Thus, "money follows the person" into the most integrated care setting of their choice.

Because MCOs operate at full risk for institutional as well as community-based care, financial incentives are appropriately aligned for MCOs to assist members in receiving more cost-effective care in the community for as long as it can be safely provided. A comprehensive risk assessment and planning process serves to identify potential risks of community living, to develop strategies to help mitigate those risks, and to help ensure each participant's health, safety, and welfare.

Since the implementation of the CHOICES program in 2010, the percentage of persons enrolled in HCBS (versus NF services) has increased by more than 120% (from 17% at the program's inception to 38% as of April 2013). During the same period, the number of persons enrolled in HCBS has increased by 150% (from 4,861 to 12,200) and the number of persons enrolled in NF services has declined by almost 15%.

The CHOICES program is the result of comprehensive long-term care reform legislation passed unanimously by both houses of the Tennessee General Assembly in 2008: the Long-Term Care Community Choices Act of 2008 (LTC CCA). Key to its passage was overwhelming support from a diverse stakeholder community, including the AARP, the State's Aging network and numerous disability advocacy groups, who helped to inform the legislation and how the LTSS reforms would be structured.

The LTSS CCA specifically called for the State to expand access to HCBS and to rebalance long-term care expenditures for the elderly and disabled populations, in addition to numerous other structural reforms—including a single point of entry, streamlined enrollment processes, consumer directed options, and the development of additional community-based residential alternatives (CBRAs) to NF placement.

Tennessee's Area Agencies on Aging and Disability (which served as the day-to-day operating agencies for the Section 1915(c) waiver that existed prior to the implementation of the MLTSS program) have transitioned to a new, but critical role in CHOICES, based on their self-assessment of core strengths as well as the needs of the new program. In CHOICES, they serve as the single point of entry for non-Medicaid eligible individuals seeking LTSS. (MCOs assist their current members who need LTSS.) Non-Medicaid eligible persons seeking HCBS must go through the SPOE in order to enroll in CHOICES; persons in a NF may go through the SPOE, but are not required to do so.

The AAADs provide counseling and assistance, screening and intake, and facilitated enrollment for Medicaid financial as well as medical (or level of care) eligibility. In addition, they are the designated

Local Contact Agency (LCA) for Minimum Data Set (MDS) Section Q referrals for non-Medicaid eligible persons. (Here too, MCOs are the LCA for their current members.)

As a critical partner in the delivery of LTSS, the AAADs have become a resource for other advocacy-related functions as well. The State Unit on Aging contracts with the AAADs to operate the State's LTC Ombudsmen Program—for nursing facilities as well as community-based residential alternatives. In addition, TennCare contracts with AAADs to conduct face-to-face Quality of Life Surveys for the State's Money Follows the Person Rebalancing Demonstration (described below), and more recently, for an expanded CHOICES Quality of Life Survey which is part of the State's Quality Improvement Strategy. At various points, MCOs have also opted to contract with various AAADs to perform specific Quality Assurance functions for HCBS providers.

MFP

After being denied an MFP rebalancing demonstration twice, Tennessee's MFP rebalancing demonstration proposal was finally approved and the program implemented in October 2011. Tennessee's award was $119 million to transition 2,225 individuals over five (5) years—primarily persons in Nursing Facilities (NFs), but also including 50 persons in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).

Tennessee's MFP rebalancing demonstration is aligned with the goals of and "layered onto" the existing Managed Long-Term Services and Supports (MLTSS) program, CHOICES (implemented in 2010), as well as the existing 1915(c) HCBS waivers for persons with intellectual disabilities. The benefits that members in MFP receive are the benefits offered under the applicable HCBS program in which the person is enrolled, and upon conclusion of the 365-day MFP participation period, the person's benefits seamlessly continue.

By the time the State received approval to implement an MFP rebalancing demonstration, the MFP processes set forth in the Operational Protocol were already well-established under the CHOICES program (for persons transitioning from a NF) and the State's Section 1915(c) waivers (for persons transitioning from an ICF/IID). Well over 500 persons who had previously received services in a NF were enrolled in CHOICES HCBS during the first year of the program's operation (*prior to* MFP), and one of the State's large public ICFs/IID was already closed, and the remaining two significantly down-sized before the rebalancing demonstration commenced.

In CHOICES (where one of the primary objectives is rebalancing), Managed Care Organizations (MCOs) must have in place a NF Diversion and a NF-to-Community Transition program. At least annually, Care Coordinators are required to assess the member's potential for and interest in transitioning to the community, and must facilitate transition assessments, and develop and implement transition plans within specified timeframes.

MCOs are permitted to offer members transitioning in MFP (as well as members transitioning out of a NF who do not qualify for MFP) an up to $2,000 transition allowance for rent and/or utility deposits, kitchen appliances, basic furniture, and basic household items (such as towels, linens, and dishes) that are essential in order to establish a community residence and facilitate the member's safe and timely transition.

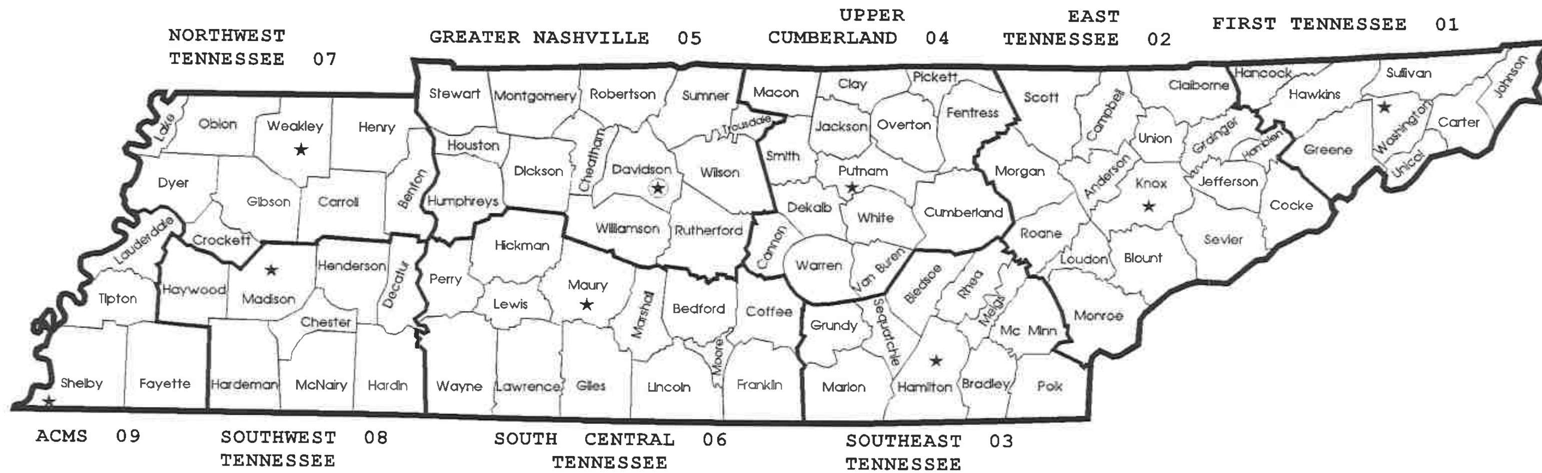
Further, pursuant to State Medicaid Director Letter, Olmstead Update No. 3, July 25, 2000, the State's Contractor Risk Agreements with MCOs permit that any CHOICES HCBS that must be completed prior to a member's transition from a NF to the community (in MFP or in CHOICES broadly) in order to ensure the member's health and safety upon transition (e.g., minor home modifications, adaptive equipment, or PERS installation) may be completed while the member is still receiving NF services, and billed as HCBS once the member is transitioned to the community, with the date of service the effective date of enrollment in CHOICES HCBS.

As of March 2013, the State has transitioned 536 people under MFP, including 279 Seniors, 234 adults with physical disabilities, and 23 adults with intellectual disabilities. The oldest person at the time of transition was 98, and the youngest 22. The longest institutionalized prior to transition was a person who had resided in an ICF/IID for more than 60 years. The longest institutionalized in a nursing home had been in the facility for 20 years. Additional transitions also continue to occur (outside of MFP) program for persons who do not qualify for MFP.

Attachment H

Map of Area Agencies on Aging and Disability

TENNESSEE AREA AGENCIES ON AGING AND DISABILITY



01 FIRST TN AAAD
Kathy T. Whitaker, Director
First TN Development District
3211 North Roan Street
Johnson City, TN 37601-1213
423-928-0224 fax 928-5209
kwhitaker@ftaaad.org

02 EAST TN AAAD
Aaron Bradley, Director
East TN Human Resource Agency
9111 Cross Park Drive
Suite D100
Knoxville, TN 37923-4517
865-691-2551 ext. 4216
fax 531-7216
abradley@ethra.org

revised 03/08/2013
g:\support\lists\
aaad directors with state map.doc

03 SOUTHEAST TN AAAD
Steve Witt, Director
Southeast TN Development District
1000 Riverfront Parkway (37402-2103)
PO Box 4757
Chattanooga, TN 37405-0757
423-266-5781 fax 424-4225
stevew@sedev.org

04 UPPER CUMBERLAND AAAD
Patty Ray, Director
Upper Cumberland Development District
1225 South Willow Avenue
Cookeville, TN 38506-4194
931-432-4111 fax 432-8112
pray@ucdd.org

05 GREATER NASHVILLE AAAD
Norma Powell, Interim Director
Greater Nashville Regional Council
501 Union Street, 6th Floor
Nashville, TN 37219-1705
615-862-8828 fax 862-8840
npowell@gnrc.org

06 SOUTH CENTRAL TN AAAD
Joe Evans, Aging Program Director
South Central TN Development District
101 Sam Watkins Boulevard
Mount Pleasant, TN 38474-4024
931-379-2929 fax 379-2685
jevans@sctdd.org

07 NORTHWEST TN AAAD
Susan C. Hill, Director
Northwest TN Development District
124 Weldon Drive (38237-1308)
PO Box 963
Martin, TN 38237-0963
731-587-4213 fax 588-5833
susan.hill@nwtdd.org

08 SOUTHWEST TN AAAD
Wanda C. Simmons, Director
Southwest TN Development District
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09 ACMS
Dora Ivey, Executive Director
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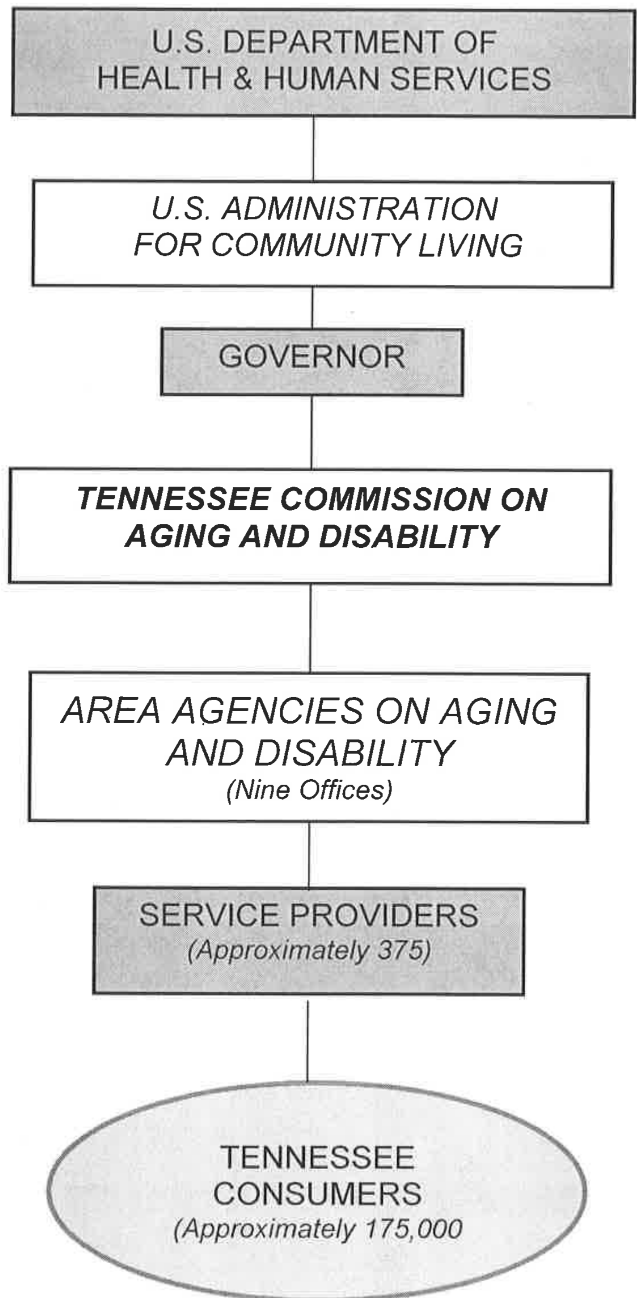
2670 Union Avenue Extended
Suite 1000
Memphis, TN 38112-4416
901-222-4100 fax 222-4199
divey@agingcommission.org

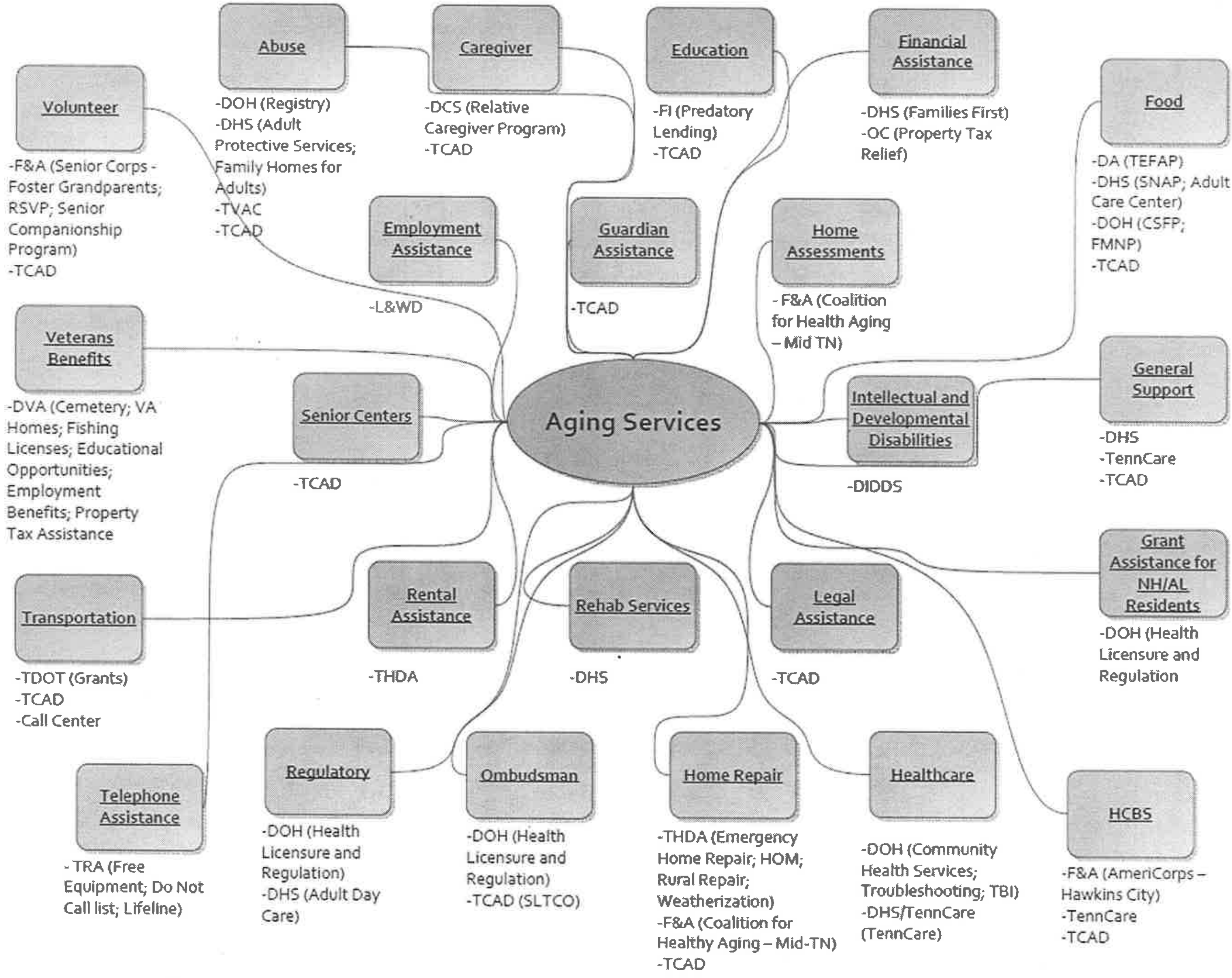
Attachment I

Aging Network


U.S. DEPARTMENT OF
HEALTH & HUMAN SERVICES
U.S. ADMINISTRATION
FOR COMMUNITY LIVING
GOVERNOR
TENNESSEE COMMISSION ON
AGING AND DISABILITY
AREA AGENCIES ON AGING
AND DISABILITY
(Nine Offices)
SERVICE PROVIDERS
(Approximately 375)
TENNESSEE
CONSUMERS
(Approximately 175,000

Attachment J

Map of State Agency Services


Aging Services
Volunteer
-F&A (Senior Corps - Foster Grandparents; RSVP; Senior Companionship Program)
-TCAD
Abuse
-DOH (Registry)
-DHS (Adult Protective Services; Family Homes for Adults)
-TVAC
-TCAD
Caregiver
-DCS (Relative Caregiver Program)
-TCAD
Education
-FI (Predatory Lending)
-TCAD
Financial Assistance
-DHS (Families First)
-OC (Property Tax Relief)
Food
-DA (TEFAP)
-DHS (SNAP; Adult Care Center)
-DOH (CSFP; FMNP)
-TCAD
Employment Assistance
-L&WD
Guardian Assistance
-TCAD
Home Assessments
- F&A (Coalition for Health Aging – Mid TN)
Veterans Benefits
-DVA (Cemetery; VA Homes; Fishing Licenses; Educational Opportunities; Employment Benefits; Property Tax Assistance
Senior Centers
-TCAD
Intellectual and Developmental Disabilities
-DIDDS
General Support
-DHS
-TennCare
-TCAD
Grant Assistance for NH/AL Residents
-DOH (Health Licensure and Regulation
Transportation
-TDOT (Grants)
-TCAD
-Call Center
Rental Assistance
-THDA
Rehab Services
-DHS
Legal Assistance
-TCAD
Telephone Assistance
- TRA (Free Equipment; Do Not Call list; Lifeline)
Regulatory
-DOH (Health Licensure and Regulation)
-DHS (Adult Day Care)
Ombudsman
-DOH (Health Licensure and Regulation)
-TCAD (SLTCO)
Home Repair
-THDA (Emergency Home Repair; HOM; Rural Repair; Weatherization)
-F&A (Coalition for Healthy Aging – Mid-TN)
-TCAD
Healthcare
-DOH (Community Health Services; Troubleshooting; TBI)
-DHS/TennCare (TennCare)
HCBS
-F&A (AmeriCorps – Hawkins City)
-TennCare
-TCAD

Aging Services by State Department/Agency

Department/Agency	*Services/Programs*
Finance and Administration	Senior Corps is proud of the more than half a million volunteers ages 55 and older who serve through the Foster Grandparents, RSVP and Senior Companion Programs throughout the country
	Foster Grandparents Program (FGP): Serving Children Foster Grandparents devote their volunteer service to one population: children with special or exceptional needs. Across the country, Foster Grandparents are offering emotional support to child victims of abuse and neglect, tutoring children who lag behind in reading, mentoring troubled teenagers and young mothers, and caring for premature infants and children with physical disabilities and severe illnesses.
	Retired and Senior Volunteer Program (RSVP): Serving the Community RSVP offers maximum flexibility and choice to its volunteers. RSVP matches the personal interests and skills of older Americans with opportunities to help solve community problems.
	Senior Companion Program (SCP): Senior Companions reach out to adults, who need extra assistance to live independently in their own homes or communities; assist their adult clients with in basic but essential ways; they provide companionship and friendship to isolated frail seniors; assist with simple chores, provide transportation, and add richness to their clients' lives; and serve frail older adults and their caregivers, adults with disabilities, and those with terminal illnesses.
	AmeriCorps – Hawkins City: The mission of AmeriCorps is to strengthen communities by bringing together individuals from a variety of backgrounds in the common effort to improve America. The full and proactive inclusion of individuals with disabilities in AmeriCorps programs is therefore a key component of the goals of AmeriCorps.
	Coalition for Healthy Aging – Mid TN: Members provide fitness screenings for senior citizens in Middle Tennessee and improve the daily living environment for seniors by doing minor home repairs, home assessments and wheel-chair ramp construction.
Department of Children Services	Relative Caregiver Program (RCP): Relative Caregiver Program (RCP) is a public/private collaboration designed to support children who are not able to be raised by their parents, and are being cared for by grandparents, aunts, uncles and other extended family members. DCS contracts with community based agencies to provide services in each of the 12 regions.
Office of the Attorney General and Reporter	Predatory Lending includes the making of unethical or abusive loans that include excessive and often disguised fees, inflated rates, and various practices used in making loans the borrowers cannot repay. The most common type of predatory loans involves home mortgages.

Department/Agency	*Services/Programs*
Department of Health	Registry: While searching for information on a particular health care professional, consumers should be aware that there are several locations available to aid them with their research. (Licensure Verification, Abuse Registry, Monthly Disciplinary Actions, and Recently Suspended Licenses For Failure to Pay Child Support) Links to various Internet sites are available from the Department of Health Website home page and from the Health Related Boards Website
	Commodity Supplemental Food Program (CSFP): The program is designed provide nutritious supplemental foods to low-income men and women age 60 or over who have an inadequate diet.
	Senior Farmers Market Nutrition Program (FMNP): Senior citizens in Davidson, Dyer and Shelby Counties who get Commodity Supplemental Food Program (CSFP) foods also get SFMNP checks. Hamblen and Warren County seniors only get SFMNP checks. Seniors must be a resident of the county and 60 years of age or older. They must have an income at or below 130% of the federal income poverty guidelines. The SFMNP gives eight $5 checks to about 15,000 seniors each year.
	Health Licensure and Regulation: The Division of Health Related Boards provides administrative support to the boards, committees, councils and one registry that are charged with the licensure and regulation of their respective health care professionals, as well as the Office of Consumer Right to Know. The mission of each board is to safeguard the health, safety and welfare of Tennesseans by requiring those who practice health care professions within this state to be qualified.
	Community Health Services: The mission of the Community Services section is to reduce premature death, disease, and disability through a combination of preventive programs, wellness initiatives, and chronic disease interventions.
Department of Veterans Affairs	Cemetery: The Tennessee Department of Veterans Affairs maintains and manages four Veterans Cemeteries in the state.
	VA Homes: Tennessee State Veterans' Homes provide skilled nursing care for veterans at our three locations in Tennessee. The Tennessee Department of Veterans Affairs is a liaison between the state and the Tennessee State Veterans' Homes and the Tennessee State Veterans' Homes Board.
	Fishing Licenses
	Educational Opportunities: Training and Job openings
	Employment Benefits
	Property Tax Assistance: Property Tax Relief For Disabled Veterans
Department of Labor and Workforce Development	Employment assistance: Visit the state's premier job resource with an average of 90,000 Tennessee jobs. Jobs4TN Online also creates and posts resumes, searches for qualified employees in your city, and gives valuable labor market information.
	Veteran's Assistance: All U.S. military veterans are eligible for job referral and referral to training programs through the Tennessee Department of Labor and Workforce Development offices (TDLWD). TDLWD offices serve as an outreach to veterans and insure veterans' preference in referral to jobs and other services. Employment-related testing, training information, skills assessment, referral, and case management are among the services provided.

Department/Agency	Services/Programs
Department of Human Services	Tennessee Supplemental Nutrition Assistance Program (SNAP): SNAP provides nutritional assistance benefits to children and families. Food stamp benefits are issued and accessed electronically using a Benefit Security Card or EBT Card.
	Adult Protective Services unit is partnering with the Tennessee Department of Commerce and Insurance and the Tennessee Vulnerable Adult Coalition (TVAC) to help raise awareness and stop elder abuse. APS staff investigate reports of abuse, neglect (including self-neglect) or financial exploitation of adults who are unable to protect themselves due to a physical or mental limitation. APS staff assess the need for protective services and provide services to reduce the identified risk to the adult.
	Family Homes for Adults: All over Tennessee there are men and women who are frail or living with a disability who cannot live alone, but do not need to be in a nursing home or institution. They have no relatives or their relatives are unable to look after them. These individuals need homes with "new families" who will provide safety, needed care and protection from abuse and neglect.
	Families First, Tennessee's welfare reform program, began in September 1996, under a federal waiver and replaced the Aid to Families with Dependent Children (AFDC) program. The federal waiver expired June 30, 2007. We currently operate our program in compliance with the Federal Temporary Assistance for Needy Families (TANF) program.
	Adult Care Center: Many vulnerable adults do not need the services of institutional care such as nursing homes, but they still need services that will help them function to their fullest potential. They also need a place that will help them avoid feeling isolated or lonely, and one that will help their caregivers (such as family members) take some time to rest and care for themselves.
	TennCare: The Medicaid program provides medical benefits to eligible individuals who may have no medical insurance or inadequate medical insurance.
	Vocational Rehabilitation Services: Vocational Rehabilitation (VR) is a federal and state-funded program providing services to help individuals with disabilities enter or return to employment. It is designed to assist individuals of work age with physical and/or mental disabilities compete successfully with others in earning a livelihood.
Tennessee Vulnerable Adult Coalition (TVAC)	To bring Tennessee public and private entities together to promote collaboration necessary to prevent the abuse, neglect, and exploitation of vulnerable adults. Older persons, or persons with disabilities, who are in danger of being mistreated or neglected, are unable to protect themselves, and have no one to assist them.
Tennessee Comptroller of the Treasury	Property Tax Relief: Elderly or Disabled Homeowner or Disabled Veteran Brochures available
Department of Agriculture	The Emergency Food Assistance Program (TEFAP) is a Federal program that helps supplement the diets of low-income Americans, including elderly people, by providing them with emergency food and nutrition assistance at no cost. Under TEFAP, USDA makes commodity foods available to State Distributing Agencies.

Department/Agency	***Services/Programs***
Tennessee Commission on Aging and Disability	Senior Centers
	Transportation
	Volunteer
	Elder abuse
	National Family Caregiver Support Program (NFCSP): The purpose of the program is to help families sustain their efforts to care for older relatives with chronic illness or disability in their homes. This program is available through the Commission and local Area Agencies on Aging and Disability.
	Education
	Food
	General support
	Home and Community Based Services: OPTIONS for Community Living is a state-funded program. The program was created to provide the elderly, as well as adults with disabilities, home- and community-based service choices. This program is available through the local Area Agencies on Aging and Disability.
	Home Repair
	State Long-Term Care Ombudsman Program: This program provides assistance to elderly residing in nursing homes, homes for the aged, assisted care living facilities, and adult care homes. The Ombudsman is available to help residents and their families resolve questions or problems and will advocate for solutions to problems for qualified residents of long-term care facilities.
	Guardian for the Elderly Program: The primary purpose of the program is to provide conservatorship services to persons 60 years of age and older who are unable to manage their own affairs and who have no family member, friend, bank, or corporation willing and able to act on their behalf.
	Legal assistance
	The Tennessee State Health Insurance Assistance Program is a statewide program that provides free and objective counseling and assistance to persons with questions or problems regarding Medicare and other related health insurances. In Tennessee, SHIP operates through the state's nine Area Agencies on Aging & Disability (AAADs).
Department of Revenue: Tennessee Housing Development Agency (THDA)	Emergency home repair
	HOMe
	Rural Repair
	Weatherization
	Rental assistance

Department/Agency	***Services/Programs***
Tennessee Bureau of Investigation	Medicaid Fraud control unity, drug investigation, information systems- background checks
Tennessee Department of Transportation	Elderly and Persons with Disabilities Grants – provides transit capital assistance, through the state, to private non-profit organizations and public bodies that provide specialized transportation services to elderly and/or disabled persons.
	Call Center – Route HRA vans
Bureau of TennCare	TennCare is the State of Tennessee's Medicaid program that provides health care for 1.2 million Tennesseans and operates with an annual budget of approximately 8 billion dollars.
	Implement the Medicaid waiver long-term care home and community based services program intended to serve low income nursing home eligible individuals in HCBS settings who have been approved by the TennCare and certified eligible for Medicaid services by the Department of Human Services.
Tennessee Regulatory Authority	Free Equipment: Telecommunications Devices Access Program (TDAP) is designed to distribute appropriate telecommunications devices so that persons who have a disability may effectively use basic telephone service. Devices are issued on a first-come, first-served basis. However, there are certain qualifiers that might enable individuals to receive devices on a priority basis
	Do not call list: The Tennessee Do Not Call Telephone Sales Solicitation law T.C.A. Section 65-4-401 et seq., directs the Tennessee Regulatory Authority to promulgate regulations and to compile and maintain a Do Not Call register.
	Lifeline: To ensure that telephone service is available and affordable for low income telephone subscribers, the Federal Communications Commission established the Lifeline Telephone Assistance Program. Administered by the Tennessee Regulatory Authority, the Lifeline program reduces the monthly local service portion of your telephone bill, but does not assist with long distance portion.
Department of Intellectual and Developmental Disabilities	The state agency responsible for providing services and supports to Tennesseans with intellectual disabilities. DIDD provides services directly or through contracts with community providers in a variety of settings. These settings range from institutional care to individual supported living in the community.

Attachment K

Tennessee Commission on Aging and Disability Members

TCAD COMMISSION MEMBERS
2013-2014

Rene Bouchillon – Representative for the Tennessee Department of Human Services

Representative Joe Carr – Member of the Tennessee State House of Representatives

Wendell Cheek – Representative for the Tennessee Department of Veterans Affairs

Ludell Coffey – Representative for the East Tennessee Region (Knox County)

Mickey Eldridge – Representative for the Upper Cumberland Region

Patti Killingsworth – Representative for the Bureau of TennCare

Ken Kisiel – Representative for the Upper East Tennessee Region (Tri-City: Bristol, Kingsport, Johnson City)

Clint Lewis – Representative for the Greater Nashville Region (Davidson County)

Patricia Miller – Representative for the Southeast Tennessee Region (Hamilton County)

Lynne O'Neal – Representative for the Tennessee Department of Health

Joyce Paggeot – Representative for a Chartered Statewide Organization who advocates exclusively for older persons (Tennessee Federation for the Aging)

Richard Presler – Representative for the Tennessee Department of Intellectual and Developmental Disabilities

Rose Rubin – Representative for the Delta District (Shelby County)

Margot Seay – Representative for a Federally Chartered Organization (AARP)

Dennis Temple – Representative for the Tennessee Department of Mental Health and Substance Abuse Services

Beth Tipps – Representative for Governor Haslam's Staff

Wanda Willis – Tennessee Council on Developmental Disabilities

Senator Ken Yager – Member of the Tennessee State Senate

James York – Representative who advocates exclusively for disabled persons

Attachment L

Cost Sharing Rule

RULES
OF
TENNESSEE COMMISSION ON AGING AND DISABILITY

CHAPTER 0030-1-7

COST SHARING FOR SERVICES FOR THE ELDERLY PROVIDED THROUGH TITLE III OF THE OLDER AMERICANS ACT

TABLE OF CONTENTS

0030-1-7-.01 Purpose
0030-1-7-.02 Services Exempt from Cost Sharing
0030-1-7-.03 Cost Sharing and Participant Contribution Requirement
0030-1-7-.04 Waiver

0030-1-7-.01 PURPOSE.

The purpose of this rule is to establish cost sharing requirements for services funded by the Older Americans Act as authorized by 42 U.S.C. § 3030c-2.

Authority: *T.C.A. § 71-2-105 (b)(1) and 42 U.S.C.A. § 3030 c-2.* ***Administrative History:*** *Original rule filed May 24, 2005; effective August 7, 2005.*

0030-1-7-.02 SERVICES EXEMPT FROM COST SHARING.

(1) The following services are exempt from cost sharing:

(a) Information and referral, outreach, benefits counseling, or case management services.

(b) Ombudsman, elder abuse prevention, legal assistance, or other consumer protection services.

(c) Congregate and home delivered meals.

Authority: *T.C.A. § 71-2-105 (b)(1) and 42 U.S.C.A. § 3030 c-2.* ***Administrative History:*** *Original rule filed May 24, 2005; effective August 7, 2005.*

0030-1-7-.03 COST SHARING AND PARTICIPANT CONTRIBUTION REQUIREMENTS.

(1) Each Area Agency on Aging and Disability, and each service provider involved, shall adhere to these cost sharing requirements for recipients of services funded in whole or in part through the Older Americans Act funded through the Commission on Aging and Disability who can pay all or a portion of the cost of the services rendered.

(2) Each Area Agency on Aging and Disability shall utilize a sliding fee scale developed by the Commission to determine the amount a consumer of service will be asked to pay toward the cost of services he receives.

(3) Except as otherwise provided, each Area Agency on Aging and Disability shall utilize the following sliding fee scale:

(a) Consumers with income less than 200% of the Federal Benefit Rate shall not be subject to cost sharing for services they receive.

(b) Consumers with income at or above 200% of the Federal Benefit Rate shall be asked to pay a percentage of the cost of the services they receive, but the cost share shall not exceed 45% of their income.

(Rule 0030-1-7-.03, continued)

(c) Recipients with incomes greater than 600% of the Federal Benefit Rate may receive information and assistance and other services exempted from cost share listed in 0030-1-7-.02, but shall be asked to contribute 100% of the cost of any additional services they receive.

(4) These cost sharing rules shall ensure that each Area Agency on Aging and Disability and each service provider involved will:

(a) Provide applicants for services with a written description of the cost sharing guidelines prior to the commencement of any services;

(b) Determine the cost share amount based solely on the self-declaration of income with no consideration of assets;

(c) Collect consumers' cost share obligations utilizing an invoice format at least quarterly;

(d) Issue a receipt of payment to any consumer of service making a payment pursuant to these policies;

(e) Safeguard all funds collected through the cost sharing process including a record of accounts receivable for each consumer;

(f) Use methods for receiving cost share payments and contributions that protect the privacy and confidentiality of each older individual with respect to the declaration or non-declaration of income and to any share of costs paid or unpaid by an individual;

(g) Make a good faith effort to collect cost sharing obligations from consumers of service where feasible and cost effective. If the Area Agency on Aging and Disability finds that collecting a given amount is not cost effective, the Area Agency may waive this amount;

(h) Not deny any service for which funds are received under the Act for an older individual due to income or failure to make a cost share payment;

(i) Ensure that consumers of services who are not subject to cost sharing be given an opportunity to make a voluntary contribution toward the cost of the service being provided.

(5) All income collected in accordance with these rules shall be utilized by Area Agencies on Aging and Disability and each service provider involved to expand the service for which such payment was given.

Authority: *T.C.A. § 71-2-105 (b)(1) and 42 U.S.C.A. § 3030 c-2.* ***Administrative History:*** *Original rule filed May 24, 2005; effective August 7, 2005.*

0030-1-7-.04 WAIVER.

(1) An Area Agency may request a waiver to the Commission's cost sharing policies, and the Commission will approve such a waiver, if the area agency can adequately demonstrate that—

(a) A significant proportion of persons receiving services under the Act subject to cost sharing in the planning and service area have incomes below the poverty level; or

(b) Cost sharing would be an unreasonable administrative or financial burden upon the Area Agency on Aging and Disability.

(Rule 0030-1-7-.04, continued)

Authority: *T.C.A. § 71-2-105 (b)(1) and 42 U.S.C.A. § 3030 c-2.* ***Administrative History:*** *Original rule filed May 24, 2005; effective August 7, 2005.*

Attachment M

Financial Plan
Operating Budget for FY 2014

FINANCIAL PLAN
OPERATING BUDGET FOR FY 2014

A. Total Resources to be used for State Agency Administration

	TITLE III AND TITLE VI	OTHER RESOURCES	TOTAL BUDGET
OLDER AMERICANS ACT –III&VII			
State Administration	$1,097,964	$1,364,136	$2,462,100
Elder Abuse	25,000		25,000
OTHER.FUNDING SOURCES			
ALZ DISEASE & ADRC		13,500	13,500
INSURANCE COUNSELING		208,700	208,700
TOTAL	$1,122,964	$1,586,336	$2,709,300

B. Total Resources Awarded for Substate Planning and Service Delivery

Area agencies on Aging and Contract Service Providers			
FEDERAL FUNDS			
FEDERAL, TITLE III		$20,861,100	
FEDERAL, TITLE VI		$ 389,500	
NSIP Reimbursement		$1,515,700	
Insurance Counseling		$778,000	
SUB-TOTAL FEDERAL FUNDS			$23,544,300
STATE FUNDS			
Senior Citizen Centers		$1,250,100	
State In-Home Services		$1,500,600	
Guardianship		$1,010,000	
Home & Community Based Services		$8,569,800	
SUB TOTAL STATE FUNDS			$12,330,500
TOTAL AREA AGENCIES ON AGING			$35,874,800
TOTAL			$38,584,100

Allocation of Title III Funds

For Development and Administration of Area Plans by Planning Service Area

PSA	III-C	III-E	TOTAL192
First Tennessee	$192,200	$29,500	$221,700
East Tennessee	$271,500	$54,900	$326,400
Southeast Tennessee	$196,800	$31,000	$227,800
Upper Cumberland	$182,300	$26,400	$208,700
Greater Nashville	$252,400	$48,800	$301,200
South Central	$182,900	$26,600	$209,500
Northwest Tennessee	$160,800	$19,500	$180,300
Southwest Tennessee	$153,300	$17,100	$170,400
ACMS	$206,100	$34,000	$240,100
Totals	$1,798,300	$287,800	$2,086,100

Attachment N

Public Hearing

Public Hearing
Tennessee State Plan on Aging 2014-2018
May 7, 2013

Fifty Forward
Patricia Hart Building
174 Rains Avenue
Nashville, Tennessee

Number of Attendees: 48

Public Hearing
Tennessee State Plan on Aging 2014-2018
Fifty Forward
Nashville, Tennessee
May 7, 2013

Number of Attendees: 48

Name	Organization
Tracy Beard	Tennessee Disability Pathfinder
William Von Schipmann	Tennessee Commission on Aging and Disability volunteer
Jo Evans	South Central Tennessee Area Agency on Aging and Disability
Dennis Temple	Tennessee Department of Mental Health and Substance Abuse Services
Wanda Willis	Tennessee Developmental Disability Coalition; Tennessee Commission on Aging and Disability member
Alice Kirby	Tennessee Federation on Aging
Cheryl Mingle	Tennessee Association of Senior Centers
Kathy Whitaker	First Tennessee Area Agency on Aging and Disability
Deborah Lively	Tennessee Health Care Association
Wanda Simmons	Southwest Tennessee Area Agency on Aging and Disability
Patricia Miller	Tennessee Commission on Aging and Disability member
Rob McRae	citizen (Hamilton County
Carrie Hobbs Guiden	The Arc of Tennessee
Robin Rochelle	South Central Tennessee Area Agency on Aging and Disability
Aaron Bradley	East Tennessee Area Agency on Aging and Disability
Elaine Graf	Aging Commission of the Mid-South
Rachel Henderson	Tennessee Health Care Association/Tennessee Center for Assisted Living
Tommy Preston	Southeast Tennessee Area Agency on Aging and Disability
Maribeth Farringer	Council on Aging
Normal Powell	Greater Nashville Regional Council
Ken Kisiel	Tennessee Commission on Aging and Disability Chairman
Lucy Utt	Tennessee Commission on Aging and Disability staff
Ludell Coffey	Tennessee Commission on Aging and Disability member
Carol Moore Slater	Tennessee Disability Pathfinder
Ruth Garrett	Consultant
Carol White	Benton County Office on Aging/Tennessee Federation on Aging
Rebecca Kelly	AARP
Donna DeStafano	Tennessee Disability Coalition

Dora Ivey	Aging Commission of the Mid-South
Grace Smith	Meharry Geriatric Center
Patty Ray	Upper Cumberland Area Agency on Aging and Disability
Ryan Ellis	Tennessee Commission on Aging and Disability staff
Jim Shulman	Tennessee Commission on Aging and Disability staff
Diane Gramann	Mental Health America of Middle Tennessee
Connie Rigsby	Tennessee Association of Senior Centers
Lynne O'Neal	Tennessee Department of Health/Tennessee Commission on Aging and Disability member
Susan Hill	Northwest Tennessee Area Agency on Aging and Disability
James York	Tennessee Commission on Aging and Disability member
Holly Williams	Upper Cumberland Area Agency on Aging and Disability
Rose Rubin	Tennessee Commission on Aging and Disability member
Joyce Paggeot	Tennessee Commission on Aging and Disability member
Anna Lea Cothron	Vanderbilt University
Carol Westlake	Tennessee Disability Coalition
Janice Wade	Alzheimer's Tennessee
Jean Renfro	Tennessee Commission on Aging and Disability staff
Cindy Warf	Tennessee Commission on Aging and Disability staff
Kathy Zamata	Tennessee Commission on Aging and Disability staff
Jackie Bruce	Tennessee Commission on Aging and Disability staff

Public Hearing
Tennessee State Plan on Aging 2014-2018
May 7, 2013
1:30 p.m.

Introduction and Overview of the State Plan on Aging

Kathy Zamata, Deputy Director, Tennessee Commission on Aging and Disability opened the Public Hearing by announcing that this is an official meeting and that the meeting is being recorded. Please use the microphone when making comments and begin with your name. Kathy introduced Jim Shulman, Director; Ryan Ellis, Cindy Warf, and Jean Renfro. Commission members in attendance were asked to raise their hands. Staff members from the Area Agencies on Aging and Disability were also asked to raise their hands. Copies of the draft State Plan and the funding formula were distributed.

Kathy reported to attendees that there are two methods to provide input into the State Plan – verbal comments and/or written comments. A form to provide written comments was distributed. Following Kathy's overview of the Administration on Community Living's Program Instructions, the State Plan narrative, goals and objectives, and the funding formula, the meeting will be open for comments. State Plan narrative and appendices will be posted on the website. Kathy reminded the audience that this plan was written for both the State and the Administration on Community Living.

Kathy reviewed the Program Instructions that identified the required elements of the State Plan and then presented an overview of each chapter in the current draft of the State Plan, especially Chapter 2 that identified and described each of the ACL required Focus Areas (federally funded programs). Chapter 2 also included a description of the available State funded programs. Chapter 3 focused on the needs assessment and the baby boomers impact on the aging and disability system of services. The current system of services has 9,000 on a wait list without the impact of sequestration. The goals and objectives incorporated the Commission's Strategic Plan, the information from the Governor's Summit on Aging, and the Administration on Community who contracts with the Lewin Group's Assessment of Tennessee's Aging and Disability Resource Centers (ADRCs).

The intrastate funding formula has not changed. The funding formula uses a weighted system. The Older Americans Act provides the funding and the funding is distributed to the nine (9) regions based on a weighed system. TCAD must make certain that the required target population (rural, low income, minority) receive services as specified in the Older Americans Act.

Comments from Attendees

Diane Gramann, Manager of Program Services for Mental Health America of Middle Tennessee: Is your SHIP unit going to work with the Navigators across the state to include the health care market information?

Jim Shulman, Executive Director, Tennessee Commission on Aging and Disability: That keeps coming up in terms of discussions that the federal government is sending down through SHIP to talk about it. Because of where the state is right now in terms of how this … we're not exactly sure where we're going to end up. We've been kind of holding that, trying to get a chance to talk with the Administration to figure out where we're going to be or what we can do. I think that Shannon Jones has done a good job of accumulating all of this information and saying "they're pushing us to do it". But, before we… because it's kind of a minefield right now within the State, we are trying to figure out what is the proper role for us to do? So the answer to your question? I don't know. I know that Shannon is feeling pressure from the federal government to say SHIP people are supposed to do this. We're not sure where we are supposed to be and we're trying to figure that out. Then you have the federal government coming in with the Navigators and all of the other things. But, we're hoping to figure that out, probably soon. We don't know who will pick up the ball and move on this. We're not sure if it's going to be us. We're willing to help.

The speaker announced that on June 10, the Mental Health American of Middle Tennessee will hold the First Annual Aging and Behavioral Health Symposium. This program is the result of the Policy Academy. It is free of charge with on-line registration.

Kathy Zamata, Deputy Director, Tennessee Commission on Aging and Disability: The interesting part, I thought, the things that came out on the top 10, substance abuse was low. The interesting part to me was when we were sitting in listening groups and if I had a group of providers, it was way up. But if I had a group of seniors, it was like not an issue. So, I think that it has a lot to do with perspective and who actually was answering the questionnaire. As the baby boomer population hits us, our baby boomer drug use and alcohol abuse is moving on up. I think it's going to be an issue.

Rebecca Kelly, State Director of AARP: Thanks for this. Thanks for the Listening Tours across the State. I'll also say that I think that's it's going to take all of us … educational information, but we also need to lean on the SHIP folks, providers will also need to do that as well. Curious, as I look at these, and actually, Aaron and I were talking earlier it looks like we are reorganizing the priorities. I see it here again … in terms of how…. we can access information. One of the things that may be missing, but may be included, is financial security, in general, and jobs. Any thoughts on why those might not have shown up? Then, I would comment on the 5th goal, the sooner we can do that the better. It's critical that we have that type of conversation.

Jim Shulman, Executive Director, Tennessee Commission on Aging and Disability: I will say the #1 issue was concern on not having enough money to pay for vision, dental and hearing, and #2 was not having enough money, so financial security was showing up in different places. If it's "I'm scared of estate planning", or whatever, I think that's out there. It's showing up in some specific things depending on the issues. What, I think we heard when we went out, was that we are very worried about money, and not having enough money. We hear that when we go out to visit Senior Centers, and when the SHIP people go out to talk about Medicare. They're spending all of their resources down. That's one of the concerns, regardless of this, they worry about, and I'm sure you all do, too, is how do you

protect people's assets? How do you make sure that when you're getting older that their assets are protected? One of the things that we've talked about, as you turn age 40 or age 50, or whatever, to give people advice so that they don't … you know when they turn 60's and 70's. I'm not sure why jobs didn't show up. I've heard that before, I'm not sure the reason for it. When we were sitting around during the talk, I don't remember that coming up as an issue.

Kathy Zamata, Deputy Director, Tennessee Commission on Aging and Disability: The only place I remember it was in Clarksville where they said that they wished they had part-time jobs.

Dr. Ruth Garrett, Geriatrics Education Consultant, Vanderbilt University Center for Quality Aging: First of all, you have all done a great job and the plan is very well done. I think that we should give them a big hand for doing such a good job. In any other State Plan, I've looked at the Virginia State Plan and I see some solutions which are mentioned in here. One of them is volunteerism and I think that is a big resource to tap, and I think it should be that locally every Senior Center could take charge of a volunteer program. I think that's how it should happen. I think you're off to a great start. I offer the solution that … the aging in place. When I looked at the Virginian plan, it first focused on aging in place, and the second major focus was on volunteerism and how they were able to manage. I'm wondering about the cutbacks on Medicare/Medicaid. I'm trying to look at the entire plan to see where we have to go to accomplish it; it's very complex and it's there in writing. It is the first time that it's been there.

Maribeth Farringer, Executive Director, Council on Aging of Greater Nashville: One thing it talks about to me was about cross training staff, I'd love to see it go beyond that. At our agency, we get calls all the time from hospice and hospitals that don't know what services are out there. Perhaps, once the area agencies and the Commission on Aging are trained, they could then train providers to get a more direct line of what services are available.

Patty Ray, Director, Upper Cumberland Area Agency on Aging and Disability: Ok, in looking at the Senior Center section, it says 50% of senior centers will have a minimum of two AIRS certified staff, my question is will that be accomplished by a contract requirement or how will that be implemented? The second part of my question is AIRS certification is expensive, and since the AAADs already have to be AIRS certified, why would they have to have two AIRS certified staff in the Senior Centers?

Dr. Ruth Garrett, Geriatrics Education Consultant, Vanderbilt University Center for Quality Aging: What does AIRS stand for?

Kathy Zamata, Deputy Director, Tennessee Commission on Aging and Disability: I can't remember what the acronym stands for.

Carole Moore-Slater, Program Director, Vanderbilt Kennedy Center, Tennessee Disability Pathfinder, UCEDD: It stands for Alliance of Information and Referral Systems (AIRS) and it's kind of the mother ship for information and referral whether its 211, area agency on

aging, etc. The purpose is so that people who need information and referral are kind of on the same page, that when you're talking about family support groups, for example, which is a service, that you know what family support is. The problem with many sources in a state like Tennessee, there's not many places out there so you have to be really sharp about how to access databases and how to find services. Because of this, I cannot see why our senior centers may need to be AIRS certified. It seems that training could be done without having to go through a national test that certifies you. You could have a training manual, and if you've got good staff who are certified then it seems that would be helpful. The other part of that is I'm more concerned about finding resources. I'm with the Tennessee Disability Pathfinders and we are an information and referral system statewide program for all ages, all disabilities and all nationalities. The thing that I'm more concerned about is finding resources because that's my passion. I would suggest that part of that would be even more important than folks being certified are whether or not the information is accurate and current. The databases on the AAA's websites, they know what's going on in their area/districts. You need a good database, and from the disability perspective, our agency's database is user friendly… we've helped people across the state. We're committed to that particular population and I call AAADs to back us up. I am more concerned about the resources than I am the AIRS certification. In Tennessee, something about services because of the way that funding is organized in the grant, and something pops up … if you … you're not going to find it. I trust the AAADs.

Kathy Zamata, Deputy Director, Tennessee Commission on Aging and Disability: My response to the senior centers and the AIRS certification is it appears to us that many people go to the senior centers for information, and they go to the senior center director because they are the trusted person in the community. A lot of people are more likely to start there instead of the area agency. So when we put that in there it was a matter of trying to encompass the "no wrong door" concept and the people who were getting out the information at the senior center were certified. That's where we were going with that and helping them provide … I mean, from our state level helping them to provide training for them on that.

Carole Moore-Slater, Program Director, Vanderbilt Kennedy Center, Tennessee Disability Pathfinder, UCEDD: You know TNAIR has more than training … In that organization ….

Janice Wade Whitehead, Executive Director, Alzheimer's Tennessee, Inc.: Thank you for putting emphasis on Alzheimer's. I was pleased to see the possibility of the development of a good healthy Tennessee plan. We get a lot of questions from folks on brain health and their specialties that we have developed. I would hope that cognitive health would also be included. What we encourage is keeping folks socially engaged. As you have been talking about harvesting that resource in our communities, I think it would be great to put an infrastructure in place.

Connie Rigsby, President, Tennessee Association Senior Center: One of the comments that I wanted to make, is where you were talking about having the requirement of the certification. But, also the accreditation, I know that a lot of senior centers are always working toward that. They've had a hard time in getting senior centers to do this, and they still have not accomplished it. My encouragement in putting it in is that there needs to be some

encouragement for those centers to go through that process. We need to have some incentive to do this because we do have some directors who don't stay longer than two years and aren't thinking about the certification because two years later she's gone. Yes, we would, as directors, like to be accredited centers across the state but there does need to be some incentive for us to do that.

Alice Kirby, Director, Fentress County Senior Citizens Center, and President for the Tennessee Federation for the Aging: I want to say thank you, this has been a great day of learning experiences. I got to see some people, hopefully, are making very good acquaintances and friends today. I wanted to say that when I read on page 6 about the description of senior centers, you're right on with, you know, of what you're doing. I'm not questioning any of you in here. I just want you to know that senior centers are viable. I call Patty (Ray) because she's my boss in the Upper Cumberland. She talks all the time about the partnerships with senior centers. We like to call it the grassroots of where it's happening because we interact with the people every day. We see it. I reach out to the AAADs. When somebody calls me, the great thing about being the senior center director, you don't have to know everything. You can fudge a little bit, but you can place a telephone call and call Ms. Patty for answers. I've learned a lot in the last 3 years. Please know that everything that you do here is for one reason and it's for those people. Think about the impact of the decisions you make here today and how it's going to filter back to the people at the senior centers. All of the area agency directors who I know, I want to commend you for helping your senior centers and being a resource for us to help us in all we do. I want to thank you for all you do. Please remember if you doubt how viable a senior center is, call up and give … it's about the size of this room. Come visit Jamestown.

Jim Shulman, Executive Director, Tennessee Commission on Aging and Disability: I've been to Jamestown twice and you all have it going on; it's a really good place to go. The last time I was there, you had about 100 people and you had a lot of good things to do. So this may be a really bad question. I haven't been through this process before but I think that the plan is very, very good. Here's my question, we've got a list of about 10 items that are concerns for seniors across the board, and then we have a lot of goals and objectives to try to deal with that it. I guess my question is how we make sure that we stick to our guns and we deal with these issues. It's kind of a weird question, because we're the ones doing the report, but, what I don't want to do is do the report, send it to Washington, have it approved and then it sits on my desk for 4 years, and then we do another 4-year report. What did we do about the last 4-year report? Very little. The question to me is would be, ok, we're going to get this report done, and it's going to go up to Washington, and hopefully, it's going to be approved. But then, how do we make sure we're dealing with this in following our goals and objectives? I guess the question is do we need to meet back here? All I know is that transportation did not get addressed and it's sitting there in front of everybody and we left it alone. So, how do we take this document and make sure that we take care of the issues and actually follow our goals and objectives? What I don't want to do is to do all this work and it just sits there.

Maribeth Farringer, Executive Director, Council on Aging of Greater Nashville: There were two things. When our agency did a Strategic Plan, we appointed one person to keep on

everyone else. So at the monthly board meeting, there was a monthly report on where they were in their strategic plan. So it never got lost because it was their job to look at that plan. The second thing is that we always try to be ambitious in strategic plans such as this, and it's probably doubtful that everyone on the plan will get accomplished by TCAD. But if the plan can be widely distributed to other agencies or even businesses that could perhaps take some part of that, such as the Council on Aging might do or AARP could do. But, we need to go to our boards and say that this has been identified as a priority and need and I think that more could be accomplished.

Jim Shulman, Executive Director, Tennessee Commission on Aging and Disability: Maribeth, I like both of those and I like the idea of forcing the issue. So the second thing here is the question would be… so this is the TCAD plan, but, one of the goals that we are trying to do is partner out and to reach out without over stepping and getting in anybody's way. If we start working on goals and start pulling together teams, would you all be willing to serve?

Maribeth Farringer, Executive Director, Council on Aging of Greater Nashville: Our agency does that. We're not a direct service provider so we might have some responsibilities to do that; I realize some other agencies that are service providers might not.

Jim Shulman, Executive Director, Tennessee Commission on Aging and Disability: We would rather work with everyone rather than work quietly, or separately, or against from everyone. We don't want any of that. So we want to pull people in so we can go ahead and give you Goal #1? Depending on who's willing, I just don't want to see it sit on the desk and not do anything. I will tell you this, we've got a strategic plan that our Commission set up, we have information from the Governor's summit that they had in 2011, and then we have this (Tennessee State Plan on Aging). So, we're trying to figure out how to put everything together into one, so that we're not driving ourselves crazy trying to follow three different plans. So we're working on that. But, once we get that and once we get the approval back, hopefully, in July that this has been approved, then I think it's our responsibility to follow our own plan and your responsibility, as stakeholders in this, to make sure we follow the plan. The only way that I can think of to do that is probably bring everybody back in together and give everyone some time to provide feedback. We're also responsible so you all should hold us accountable. We told people when we were going through the nine city tour; we said we're listening to you because what your concerns are should be our concerns. We have to listen to people so that we can deal with this. If everyone is willing, I think that we ought to try to do that.

Dr. Ruth Garrett, Geriatrics Education Consultant, Vanderbilt University Center for Quality Aging: I agree with you, we are the stakeholders. But I must say that the senior center directors are the first contact for seniors. I'm still concerned about going to a senior center site and the books from the Council on Aging are still in boxes stacked up against the wall. I think that our senior center directors are singularly responsible for disseminating information. In reading through this last night, I didn't see how information would be disseminated to all of us. How will those people be contacted and how will information be disseminated? I didn't see that in there. Also, thank you for the AIRS explanation. Also, I

would like to comment on the cognitive suggestion. All the plans I have read focused first on physical exercise because without it…. With everything I read on the Tennessee Diabetes and Obesity, I think the emphasis needs to be on exercising. The World Health Organization mentioned it… so I think we have to get people in shape first before we can get their brain in shape.

Jim Shulman, Executive Director, Tennessee Commission on Aging and Disability: Well, you and I have had this conversation. I think that as much as the physical part is there that cognitive part is there, too.

Dr. Ruth Garrett, Geriatrics Education Consultant, Vanderbilt University Center for Quality Aging: It's really important that we're going to get too far into that without saying … I think that Maribeth's suggestion is good, people have to take responsibility.

Jim Shulman, Executive Director, Tennessee Commission on Aging and Disability: We're just going to keep fighting over that and I'm going to have Janice on my team and we're going to take you on.

Carole Moore-Slater, Program Director, Vanderbilt Kennedy Center, Tennessee Disability Pathfinder, UCEDD: I just wanted to ask, the meetings that we've had … where the Commission on Aging could partner with our Commission to select one of the goals that they're passionate about, that they could agree to chair that particular committee. Then all of the people across the state, you could get the information out asking if you have a passion about an objective then you have something to add to this group, then partner up with that committee for that particular goal. Then you are organizing people who are interested in that particular goal and volunteering to help out. Then those committees meet on their own and they can organize together whether they do it by conference call or face-to-face meetings. They can develop a plan of how to do that goal and that might be a way to organize the objectives. This is an overwhelming document with lots of different objectives. But, if there are people working on individual things…

Jim Shulman, Executive Director, Tennessee Commission on Aging and Disability: Sure. I think that's a great idea.

Grace Smith, Meharry Geriatric Education Center: One thing that I would love to see enhanced in this report is a stronger vision of what we want to see in terms of aging services in Tennessee. We go from having all this feedback from the seniors from around the state. There needs to be some guiding principles that flow through all of the objectives and goals. Dr. Garrett shared with me the Virginia State Plan on Aging. And very early in their plan they articulate some guiding principles that flow through everything; healthy aging, exercise, disease prevention, etc. There are guiding principles that form all of the objectives and I don't see that here. I see a flow into all of the existing services that are out there and they should be evaluated to make sure they're following best practices. What are we striving for? What can we get people excited about? Keeping senior's mobile, keeping them healthy, helping them stay active. I just feel that is a piece that could be injected and is missing right now.

Jim Shulman, Executive Director, Tennessee Commission on Aging and Disability: I think that's right, but, I want to add this thought, too. The question would be that we're looking to the creation of the healthy aging plan, and we're trying to pull in the right people initially, and then we'll have discussions. But, there is no Healthy Aging Plan in the State of Tennessee. The only one that we've seen is the one from Virginia. If you remember, we called looking nationally for a state for a health aging plan and we couldn't find one. Why wouldn't you have the basic parameters of how to do this? Once you do it, which is what drives the state plan. I think what I'm asking is can we put it into the state plan without having the healthy aging plan? Or does the healthy aging plan really have to be developed first and then onto the next step? I'm not sure. We're talking about really good things that you're talking about, but, we haven't sat down and actually developed that plan yet.

Kathy Zamata, Deputy Director, Tennessee Commission on Aging and Disability: I think that you're right, the guiding principal thing, I understand the concept and we can do that.

Grace Smith, Meharry Geriatric Education Center: I will send that information to you (Kathy Zamata).

Patricia Miller, TCAD Commission Member: There are so many things here; it would be nice to have a structure because we do have guiding principles. We almost need a checklist up on the board of what to do and should be cross checked. Then you have all of these mechanisms and structures in place such as a strong volunteer system. Then you take everything on your to do list, and then you check off those things. So you have to have a plan just to mobilize volunteers, for example. So there is a lot more thinking in the room that I'm hearing. There's a way of getting a mental picture of all of that into play and organized to make sure that anytime you're working on this piece here, it's in line to support that piece. I think that's what I'm hearing and I'm seeing a way for other organizations to kind of keep that in place. Then another thought I had, how are we going to get everyone involved? How are we going to keep on track? How are we going to make sure that we're monitoring? You've talked about having a project manager or somebody that's a director familiar with the plan. Another concept that we use in organizations is we have people actually assigned responsibilities to do certain things. You've got a team working on it. We've got a concept called a sponsor; and, what the sponsor's role is … a sponsor may not even be in the direct line of anybody working there, but, they're the go to person if they need something, such as if they need counseling or advise. So when someone needs something, then the sponsor can then talk to whomever they need to talk with to get problems resolved. So there are all types of structural layers you can put into place, but, I like the ideas of developing guiding principles. Simply, lay that out sort of like a matrix, to keep those ideas in mind. I'm looking at you because of your comments, is that all what you're thinking about?

Grace Smith, Meharry Geriatric Education Center: Yes, because I think that the guiding principles will flow through all of the goals, objectives and program that already exist.

Patricia Miller, TCAD Commission Member: It's just a way to have checks and balance.

Dr. Ruth Garrett, Geriatrics Education Consultant, Vanderbilt University Center for Quality Aging: I will e-mail three slides to Kathy Zamata.

Aaron Bradley, Director, East Tennessee Area Agency on Aging and Disability: I love the idea of the guiding principles because really and truly you ask yourself the question does this lead me towards the guiding principles or away from the guiding principles. Regardless of the goals and objectives, I love that concept. The other thing that I want to say, we can try to do 100 things well, we won't do any of them well. My hats off to the group that pulled this together; it's about as comprehensive of a state plan as I've ever seen. Someone said a while ago, it is phenomenal the work that this plan represents. I'm a proponent of lets decide on the top 3-4 things that we want to try to accomplish and focus all that energy on those until we get it done. There is no comprehensive aging support plan in the State of Tennessee and it's not going to happen unless we hold hands and make it happen. Healthy aging, that's a huge, huge goal in and of itself that's part of the bigger plan and comprehensive answer to this. I think that is what we have to try to hold hands and have a blueprint to get it done.

Rose Rubin, TCAD Commission Member: I want to thank Kathy and staff for all their hard work. I want to thank all of you for being here for your contribution. I would like to build on two concepts which are the vision by attributes and really targeted objectives. I would like to add a third leg and that is to have some timelines somewhere and attach them to specific objectives, such as three months, etc. You need to have timelines which is the order to work on achieving those.

Patty Ray, Director, Upper Cumberland Area Agency on Aging and Disability: Kathy, may I make a comment? When you talk about how do we stay on task? We could use conference calls to focus on our shared state plan. At our quarterly review, as the AAADs and with the TCAD staff, they could develop an outline.

Kathy Zamata, Deputy Director, Tennessee Commission on Aging and Disability: I want to thank you all so much for coming. You are all very precious. We especially want to thank FiftyForward for providing the location. Anything else? Thank you very much.

Meeting concluded at 3:15 P.M.

State Plan on Aging
Public Hearing
May 7, 2010

Written Comments Submitted During the Public Hearing

1. Carrie Hobbs Guiden, representing the Arc of Tennessee
    - Please include The Arch of TN in initiatives related to transportation, conservatorship, abuse prevention, self-directed services, training workers to support adults with disabilities
    - Page 11-"mentally challenged" is not person first
    - Page 16—need collaboration with the Department of Intellectual and Developmental Disabilities, as well
    - An Ombudsman is needed for HCBS programs (i.e. CHOICES); there are many issues and few ways to advocate for people in the program
    - Objective #7—need to include people with disabilities in any abuse prevention efforts for vulnerable populations—this population has the highest rate of abuse
    - Consider using term "conservator" over "guardian" to be consistent with other related programs and laws around this topic
2. Elaine Graf, representing Aging Commission of the Mid-South
    - Several areas include a review and potential revision to contract scopes of services. Will these changes be clarified prior to Jan. 2014 to enable the ACMS RFP and contracts to meet the SCG timelines?
    - Goal 1-Evaluate and modify internal structure of SUA. Will this goal be included for AAADs in the new Area Plans for FY15?
    - Objective 9—Senior Centers—will there be funding to support training and the goal of AIRS certification for senior center staff? Accreditation?
3. Dora Ivey, representing Aging Commission of the Mid-South
    - Focus Areas and Programs--Give SHIP to AARP. Better fit as AARP has a bigger volunteer program.
    - Statewide Needs Assessment--800+ participants is excellent #. Great job TCAD!
    - Challenges—p. 22 Outcomes—"increases" are not possible with stagnant and or decreased funding. Maintaining is our best chance, but decreases are likely
    - Goals and Objectives—page 29. We have no luck with VAMC partnerships; page 32 will the intrastate funding formula be reviewed in State Rule? 35% 60+; 30 % low income elderly; 10% low income minority; 15% rural' 10% 80+; page 21 senior centers may not have capacity to achieve accreditation; p 21. AIRS certification not realistic for senior centers; p. 25 volunteer coordinator not funded
4. Alice Kirby, representing Tennessee Federation on Aging and Fentress County Senior Center
    - Focus Areas and Programs—p. 22 #8 this is not fundable for most senior centers—working with the AAAD—will—would and could work closer together to accomplish the same result—senior centers do not have staff or funding to get accreditation

- Goals and Objectives—Hey-just get it done!; You have the plan; Assign a dependable human to each area—get it done—They Report to?; Seniors report to the AAAD—we are held accountable—Set your Goals—Get it done.

5. Ludell Coffey, representing Commission—member
   - I'm pleased to see private pay and cost sharing addressed. Many seniors can afford to pay at least part of the cost. Since unity cost is impacted positively by increased numbers of people and unit of services/meals, etc., private pay could increase (dramatically) the number of people served and the amount of service provided.
6. Kathy Whitaker, representing First Tennessee Area Agency on Aging and Disability
   - Page 22-Performance Measures—it will be impossible to increase number of consumers receiving services with decreases in funding
7. James York, representing Commission (member)
   - Executive Summary—provided a realistic view of the future needs
   - Focus Areas and Programs—focuses on the basic areas that govern senior needs
   - Statewide Needs Assessment—the plan makes realistic use of the needs assessment
   - Challenges—adequately addresses the future challenges facing the State of TN
   - Goals and Objectives—plan does an excellent job in forming the future of TCAD
   - Note: Encourage each citizen to engage in senior living activities !!
8. Donna DeStefano
   - Challenges—Learning New Things—coordinate with community arts programs—TN Arts Commission funds many exciting programs; Community gardens—some exist in communities (i.e. Metro Nashville Schools have program)—need to coordinate with them
   - Goals and Objectives—Aging in Place—need to get realtors involved—as well as developers/builders so more accessible homes are built—lots and lots of new homes being built and very few are accessible for people with mobility issues; Respite—critical need for caregivers—good to see the focus on this as well as Alzheimer's needs
9. Carole Moore Slater
   - Goals and Objectives—Objective 2. Strategy 6. Update resource database regularly—Comments: Remove database <Services, Find organizations> on tnaaad.org website. This database is not user-friendly, and the organization of the info is dated and not useful at all. Replace this database with links to AAAD agencies in each developmental district—(info may not be as current but organization of info is better, although I have not worked directly w/AAAD databases in several years. On this page should be a link to TN Disability Pathfinder for access to this statewide database and community, disability, and social services agencies>is updated annually. www.familypathfinder.org

COMMISSIONER
Jon Weizenbaum

November 13, 2014

ACTION

MEMORANDUM FOR THE COMMISSIONER

THROUGH: Elisa J. Garza
Assistant Commissioner, Access and Intake

FROM: Sue Fielder
Director, Area Agencies on Aging

SUBJECT: Senate Bill 271 - A Profile of Informal Caregiving in Texas

Purpose

Staff request your approval and signature on the attached letters to submit the attached report, A Profile of Informal Caregiving, to the Governor and the Legislative Budget Board, which is required by Senate Bill (S.B.) 271, 81st Legislature, Regular Session, 2009. Your approval and signatures are requested by November 19, 2014.

Background/Summary

S.B. 271, 81st Legislature, Regular Session, 2009, requires the Department of Aging and Disability Services (DADS) to submit a report on strategies to raise awareness of support services available for informal caregivers and DADS recommendations to strengthen the delivery of informal caregiver support services.

Discussion

This report discusses the progress DADS has made in implementing informal caregiver support strategies during fiscal years 2013 and 2014, including the implementation of key legislation and grant activity. A previous report was submitted December 1, 2012, for the period of October 5, 2010, to March 1, 2012. A report is due no later than December 1 of each even-numbered year to the governor and the Legislative Budget Board. The report deadline is December 1, 2014.

Recommendation

The Access & Intake division recommends your approval of the attached report and signature on the attached letters.

701 W. 51st St. ★ P.O. Box 149030 ★ Austin, Texas 78714-9030 ★ (512) 438-3011 ★ www.dads.state.tx.us
An Equal Opportunity Employer and Provider

Commissioner's Decision

Approve JW 12-10-14 Disapprove ______
Modify ______ Schedule Briefing ______
Comments/Acknowledgement ______

Attachments

COMMISSIONER
Jon Weizenbaum

December 11, 2014

Ursula Parks, Director
Legislative Budget Board
P.O. Box 12666
Capitol Station
Austin, Texas 78711

Dear Ms. Parks:

It is my pleasure to submit the attached report, "A Profile of Informal Caregiving in Texas," as required by Senate Bill (S.B.) 271, 81st Legislature, Regular Session, 2009. The Department of Aging and Disability Services (DADS) developed this report on the strategies DADS implemented after September 1, 2009, to collect and analyze data related to informal caregiver support services in Texas.

In September 2010, DADS filed a report as required by the 2010-11 General Appropriations Act (Article II, Department of Aging and Disability Services, Rider 38, S.B. 1, 81st Legislature, Regular Session, 2009), entitled "Rider 38: Delivery of Caregiver Support Services," detailing strategies to strengthen the delivery of informal caregiver support services in Texas. In 2012, DADS submitted "A Profile of Informal Caregiving in Texas," which continued beyond the September 2010 report and further detailed its efforts to assist informal caregivers in long-term care situations to prepare for, and sustain, their caregiving roles.

Today's report provides updated statistics, activities, and recommendation for the future support of caregivers in Texas. Please let me know if you have any questions or need any additional information. Elisa J. Garza, assistant commissioner for Access and Intake, serves as the lead staff on this matter and can be reached by phone at (512) 438-4245 or by email at elisa.garza@dads.state.tx.us.

Sincerely,

Jon Weizenbaum

JW:ejg

Attachment

701 W. 51st St. ★ P.O. Box 149030 ★ Austin, Texas 78714-9030 ★ (512) 438-3011 ★ www.dads.state.tx.us
An Equal Opportunity Employer and Provider

COMMISSIONER
Jon Weizenbaum

December 11, 2014

The Honorable Rick Perry
Governor
State Capitol, Room 2S.1
Austin, Texas 78701

Dear Governor Perry:

It is my pleasure to submit the attached report, "A Profile of Informal Caregiving in Texas," as required by Senate Bill (S.B.) 271, 81st Legislature, Regular Session, 2009. The Texas Department of Aging and Disability Services (DADS) developed this report on the strategies DADS implemented after September 1, 2009, to collect and analyze data related to informal caregiver support services in Texas.

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Today's report provides updated statistics, activities, and recommendation for the future support of caregivers in Texas. Please let me know if you have any questions or need any additional information. Elisa J. Garza, assistant commissioner for Access and Intake, serves as the lead staff on this matter and can be reached by phone at (512) 438-4245 or by email at elisa.garza@dads.state.tx.us.

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An Equal Opportunity Employer and Provider

A PROFILE OF INFORMAL CAREGIVING IN TEXAS

Report to the Texas Legislature

As Required by
Senate Bill 271, 81st Legislature, Regular Session, 2009

Submitted to the
Office of the Governor
and
Legislative Budget Board

Texas Department of Aging and Disability Services

December 1, 2014

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Executive Summary

Informal caregivers, those relatives and friends who provide unpaid care to older individuals and persons with disabilities, are considered the backbone of the long-term care system.[1] Identifying and meeting the needs of the estimated 3.4 million caregivers in Texas[2] who care for older persons and persons with disabilities often determines whether the individuals needing care can remain at home or must enter an institutional care setting.

As is common throughout the United States, many Texans are unprepared to assume the role of caregiver when the time comes. Assisting Texans in preparing for and sustaining their roles as caregivers has a positive impact not only on the individuals receiving care, but also helps the state avoid long-term services and supports costs, which might otherwise be shifted to Medicaid. The economic value of caregiving by informal caregivers in Texas is estimated to be $34 billion annually, with caregivers contributing over 3.2 billion hours of care.[3]

Between February 2012 and March 2014, the Texas Department of Aging and Disability Services (DADS) interviewed 27,503 informal caregivers providing care to individuals seeking or receiving long-term services and supports in Texas. The data collected by DADS provides further evidence relatives (primarily spouses and children) are the basis for informal caregiving in Texas. Although the vast majority of caregivers identified are women, the ratio of female to male caregivers appears to decrease as age increases. This declining ratio may be attributed in part to a shift in the focus of caregiving from a child/parent-care relationship to a spousal-care situation. About one-half of women reported they are caring for a parent or parent-in-law, compared to one-fourth of males who report they are providing care for their spouse.

DADS also found caregivers who are relatives of older individuals or persons with disabilities are more likely to live with their care recipient. Those living in the same household reported higher stress levels than those who do not live with their care recipient, with 8 percent of caregivers reporting no effective way to relieve their stress. Data also revealed the percentage of individuals living in the same household is higher for caregivers residing in urban areas than for those residing in rural areas. Only about 3 percent of caregivers reported living 11 or more miles away from the individual for whom they provide care.

Less than one-third of informal caregivers were employed. Those who were employed full-time or part-time were asked a variety of questions about the effects of caregiving on employment. Most reported caregiving had no negative impacts on their employment, although those with full-time jobs reported higher stress levels than those who were employed part-time or not employed at all. A very small percent report having to quit a job in order to continue providing care. Three percent fear they could lose their jobs.

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[1] Texas Department of Aging and Disability Services, *Informal Care in Texas: Aging Family Caregivers and their Need for Services and Support*, October 2009.
[2] AARP Public Policy Institute, *Valuing the Invaluable: 2011 Update*, 2011.
[3] AARP Public Policy Institute, *Valuing the Invaluable: 2011 Update*, 2011.

Through a statewide coordinated system involving 28 area agencies on aging (AAAs) and 14 aging and disability resource centers (ADRCs) operating in 10 of 11 health and human services (HHS) regions, DADS is working to deliver services and supports to enable and encourage informal caregivers in long-term care situations to prepare for and sustain their caregiving roles. This report reflects the progress DADS and the State of Texas have made toward achieving the goals outlined in Senate Bill (S.B.) 271 (81st Legislature, Regular Session, 2009). These include identifying caregivers of individuals interested in accessing Medicaid programs operated by DADS; establishing a standardized assessment to be used by AAAs to evaluate the needs of caregivers of individuals eligible to receive OAA services; and supporting the tools through which the collection and analysis of data will allow one to formulate a profile or portrait of caregivers in this state. These also include coordinating and expanding outreach and public awareness of the services and supports available to assist informal caregivers statewide in preparing for and sustaining their caregiving roles; and, through the coordination with other state programs, establishing a mechanism to collect and create an inventory of respite services available statewide and developing resources to assist caregivers in locating the services and supports available within their respective communities.

A Profile of Informal Caregiving in Texas

Introduction

As required by Senate Bill (S.B.) 271, 81st Legislature, Regular Session, 2009, the Department of Aging and Disability Services (DADS) has developed this report on the strategies implemented by DADS after September 1, 2009, to collect and analyze data related to informal caregiver support services in Texas. This report to the Governor and Legislative Budget Board (LBB) is required to be submitted by December 1, 2014.

In September 2010, DADS filed a report with the Governor and LBB as required by the 2010-11 General Appropriations Act (Article II, Department of Aging and Disability Services, Rider 38, S.B. 1, 81st Legislature, Regular Session 2009) entitled Rider 38: Delivery of Caregiver Support Services. This earlier report detailed the strategies implemented by DADS to strengthen the delivery of informal caregiver support services in Texas, as of the date of its publication.

DADS 2012 report, *A Profile of Informal Caregiving in Texas*, continued beyond Rider 38: Delivery of Caregiver Support Services and further detailed its efforts to assist informal caregivers in long-term care situations to prepare for, and sustain, their caregiving roles. This report focuses on the analysis of collected data related to informal caregivers in Texas from February 1, 2012, through March 31, 2014,[4] and provides updated statistics, activities, and recommendations for the future support of caregivers in Texas.

Background

In June 2009, Governor Rick Perry signed two pieces of legislation directed toward identifying caregivers and improving the delivery of caregiver support services in Texas: S.B. 271 relating to informal caregiver support services, and House Bill 802, 81st Legislature, Regular Session, 2009, relating to the creation of the lifespan respite care program. S.B. 271 incorporates the 2009 recommendations[5] of the LBB relating to strengthening the delivery of informal caregiver support services including:

- raising public awareness about caregiving and available support services;
- implementing a caregiver status form into the existing Medicaid functional eligibility determination process;
- standardizing a caregiver assessment and protocol for caregivers accessing services through an area agency on aging (AAA); and
- analyzing the quantitative data collected from the caregiver status form and caregiver assessment form.

[4] Date range differs from 2012 report of October 5, 2010 through March 1, 2012. All future date ranges will be consistent to allow better data comparison.
[5] Texas Legislative Budget Board, *Texas State Government Effectiveness and Efficiency*, January 2009.

DADS began activities in September 2009, with an initial focus on developing the required forms which have become known as the Caregiver Status Questionnaire (CSQ) and the Caregiver Assessment Questionnaire (CAQ). Appendix A-1 and B-1 include a copy of each.

In October 2009, DADS met with community services regional directors to discuss and solicit input on a draft of the CSQ and its use during the community services intake process. The CSQ was later released for review by regional community care intake workers and screeners. Comments and concerns resulting from the review process were considered and incorporated, if appropriate, into the final version of the CSQ.

DADS shared information about S.B. 271 throughout the fall of 2009 with AAA directors and councils of governments and met with the Texas Association of Area Agencies on Aging and the Texas Association of Regional Councils to discuss the project. In January 2010, a teleconference was held with AAA directors statewide, followed by the release of a draft of the CAQ to AAAs for review and comment. The comments and concerns resulting from the review were considered and incorporated, if appropriate, into the CAQ.

Pilots of the CSQ and the CAQ were held in both rural and urban areas of Texas. A two-week pilot of the CSQ in hard-copy was performed in January 2010, in selected regional intake offices across the state (regions 2, 6, 7, 8, 9). A total of 134 caregivers participated in the pilot. The CAQ was tested in selected local AAA pilot sites across the state between February and March 2010. The AAAs of the Concho Valley, Coastal Bend, Deep East Texas, Permian Basin, North Texas, Harris County, Dallas, Panhandle, and West Central Texas participated in the pilot. A total of 110 caregivers were assessed during the pilot.

The results of both pilots were reviewed and discussed with regional directors and AAA directors. Modifications resulting from comments received during pilot projects were incorporated into the CAQ and the CSQ. Over the ensuing months, staff worked to incorporate the approved versions of the CSQ and the CAQ into DADS respective automated data systems. These efforts led to the successful deployment of the CSQ on August 2, 2010, and the successful deployment of the CAQ on August 9, 2010.

The CSQ is applied to informal (unpaid) caregivers of new interest list consumers as their names are entered into the automated intake (NTK) system for the following programs: Community Care for the Aged and Disabled (CCAD), Community Based Alternatives (CBA) until September 1, 2014,[6] Medically Dependent Children Program (MDCP) and the In-Home and Family Support (IHFS) program. The NTK system is used to register persons interested in receiving these Medicaid, Title XX, and state general revenue funded services provided through DADS programs. The CSQ attempts to identify and collect information pertaining to the primary informal caregiver of an individual whose name is placed on a program interest list.

Completion of the CAQ occurs for all caregivers receiving AAA Caregiver Support Coordination funded through Title III-E of the OAA, also known as the National Family

[6] The CBA waiver was terminated as a result of S.B. 7, 83rd Legislature, Regular Session 2013. CBA consumers transitioned to managed care on September 1, 2014.

Caregiver Support Program. When an individual seeks help through a AAA, an information and referral specialist provides a variety of options for assistance based on regional community resources or resources offered directly by the AAA. When an eligible caregiver chooses to receive services offered directly by the AAA, the individual is referred to staff specializing in caregiver supports authorized by the OAA. The CAQ is administered to identify specific areas of need for the caregiver based on the caregiver's unique circumstances. Because the CAQ includes questions beyond those included in the CSQ, it helps direct the discussion between the caregiver and the AAA staff in developing a care plan based on documented need and consumer choice.

Because the CSQ and the CAQ share demographic questions vital to developing a profile of caregivers, any modification to either form requires the same modification be made to the other form to ensure consistency of data. Some duplication of data is expected for consumers who completed the CSQ and are referred to a AAA for caregiver supports, as it is possible caregivers referred by regional intake are not asked, or may not choose to disclose, the source of their referral when accessing services through the AAA.

Discussion

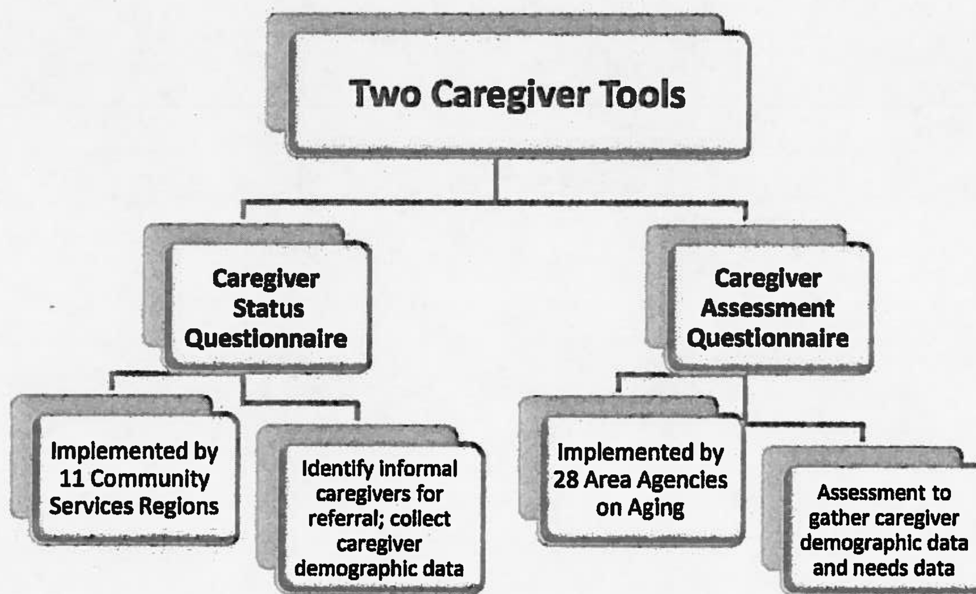
When services are requested to enable an individual to maintain their independence in the community, the caregiver often plays a crucial role. The caregiver can be a main point of contact for physicians, home health providers and others to gain information about the individual, to assist in developing a service plan to meet the individual's needs, and to help coordinate health care and support services. The caregiver is an invaluable asset, and oftentimes, the availability of a caregiver is the link that enables the individual needing care to continue living in their own home and remain part of their community. Sustaining and supporting informal caregivers should continue to be a primary topic for future policy and practice directions.

It is the expectation of S.B. 271 that the data collected and analyzed as a result of this initiative be used by DADS to evaluate the needs of assessed informal caregivers; measure the effectiveness of certain informal caregiver support interventions; improve existing caregiver support programs; develop new services for caregivers; and determine the effect of informal caregiving on employment and employers.

Development of Tools to Profile and Assess Informal Caregivers

The CSQ is used during the intake process for DADS community services and Medicaid programs, including CCAD, CBA (until September 1, 2014), MDCP, and IHFS. The CSQ activity occurs at intake telephone contact and attempts to identify and collect information pertaining to the primary informal caregiver of the individual whose name is placed on a program interest list. Staff is not required to complete a CSQ for anyone other than the primary informal caregiver. The questions from the CSQ allow DADS to gain a demographic profile of the caregiver without assessing the needs of the caregiver. It is also used to refer people who may qualify for services provided through the OAA to AAAs.

Completion of the CAQ occurs for all caregivers receiving Caregiver Support Coordination funded through Title III-E of the OAA. The CAQ is designed to assist in identifying needs and appropriate services for the caregiver and may be completed in person or by phone. AAAs use the CAQ to develop an individual plan of care based upon results from each individual assessment, as determined to be appropriate and based on the preferences of the caregiver and the care recipient.



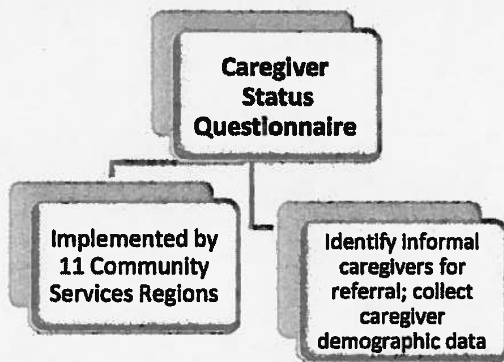
While some AAAs had previously developed and were using assessments for services under the National Family Caregiver Support Program of the OAA, no single assessment of needs for caregivers had been developed for consistent use across the state. Neither the CSQ nor the CAQ

has the capability of assigning level of risk; however, AAAs may use the CAQ, along with the Caregiver Intake and other risk assessment tools,[7] to target services to eligible caregivers.

DADS staff extensively studied and reviewed assessment tools from a wide variety of sources prior to drafting a recommended document. Resources included existing Texas AAA assessments, national caregiver information clearinghouses, other states' documents, evidence-based caregiver interventions, university caregiver research studies and other data. The review focused on common data elements across assessments, questions relevant to the legislative requirements, common caregiver identification questions, employment issues and stress/burden measurement tools.

Stakeholder groups were engaged for response to the final draft of the CAQ and the CSQ. Each question for each tool was reviewed for clarity, content, language and format. The protocol for administering each tool and the quality of each question to produce good analytical data was also evaluated. In August 2010, the project was launched.

In response to the S.B. 271 requirement to implement a caregiver status form into the existing Medicaid process, the CSQ was developed to identify and collect information pertaining to primary informal caregivers. The CSQ was developed as a survey for the caregivers of individuals requesting long-term services and supports through the DADS intake system. The questions are designed to provide DADS with a demographic profile of the caregiver and are not intended to assess the full range of needs of the caregiver. The purpose of the questionnaire is to identify informal caregivers for referrals to appropriate support services and to develop a profile of caregivers.



The CSQ is used to gather information about informal, unpaid caregivers of individuals seeking DADS services who are entered into the automated intake system for community-based long-term services and supports, including CCAD, CBA (until September 1, 2014), MDCP, and IHFS. The intake system is used to register persons interested in receiving Medicaid services provided through DADS programs.

In addition to developing a profile of caregivers in Texas, the CSQ provides an opportunity to identify issues which may impact the caregiver's ability to assist the individual. Appropriate referrals by intake staff are based on the caregiver's needs. By design, intake staff refer caregivers to the AAA if it is determined the caregiver meets eligibility screening criteria. Individuals are also referred to other local resources.

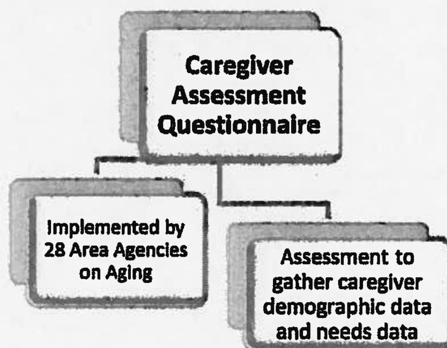
[7] Caregiver risk assessment tools measure the risk for institutionalization for the care receiver that can result from challenges of caregiving.

Eligibility screening criteria for AAA services included in the CSQ are:

- 60 years of age or older and is caring for an individual of any age;
- 55 years of age or older and:
  - is caring for a grandchild under the age of 18 in his/her home because the biological or adoptive parents are unable or unwilling; or
  - has legal custody or guardianship or is raising the child informally; or is caring for a recipient age 19-59 with severe disabilities; or
- a caregiver for an individual of any age with Alzheimer's disease or dementia.

An individual may request DADS services by telephone, mail, fax or in person. Other agencies, organizations, friends, and family may also contact DADS to request information on behalf of the individual. Individuals in need of services can be of any age, and caregivers comprise a wide range of age groups. When a request for DADS services is received, DADS staff provides general information about DADS, determines the type of service being requested, refers the individual to the appropriate DADS program, and makes referrals to other state or community agencies, if applicable. At this point, the information gathered by DADS staff is entered in the NTK system to begin the assessment process for services or to be placed on an interest list.

The CSQ is completed by DADS staff at the time of intake contact. If a caregiver to the individual requesting services is identified, and the caregiver is available to speak with DADS staff, DADS staff asks the questions on the CSQ and enters this information in the NTK system. When the identified caregiver is not available, one additional contact with the caregiver is attempted. Identification of the caregiver is voluntary by the person who makes contact with intake staff.



In response to the S.B. 271 requirement to standardize a caregiver assessment and protocol for caregivers accessing services through AAAs, the CAQ was developed to assist in identifying needs and appropriate services for caregivers accessing services through AAAs statewide. The CAQ incorporates the identical questions used in the CSQ to develop a profile of Texas caregivers.

A CAQ is completed for all caregivers receiving Caregiver Support Coordination funded through Title III-E of the OAA. Results of the CAQ are used to develop an individual plan of care, as appropriate, taking into consideration the preferences of the caregiver and care recipient.

The OAA defines a caregiver as "an adult family member, or another individual, who is an informal provider of in-home and community care to an older individual…"[8] A grandparent or older individual who is a relative caregiver is defined as "a grandparent or step-grandparent of a child, or a relative of a child by blood, marriage, or adoption who is 55 years of age or older and lives with the child; is the primary caregiver; and has a legal relationship to the child, or is raising the child informally."[9]

Effective in 2010, and as a result of S.B. 271, caregiver needs are consistently assessed by each of the 28 AAAs in Texas using the CAQ. Developed as an assessment tool for caregivers seeking help through AAAs, and who meet the eligibility criteria as defined by the OAA, it assists AAA staff in identifying needs and appropriate services for caregivers accessing services. When appropriate, the AAA develops an individual plan of care based on needs identified through the assessment.

While the CAQ identifies the major roles of the caregiver, it also identifies areas in which a caregiver may need education or training to enhance the knowledge and skills needed for an individual's circumstances. It guides the professional conducting the assessment to help the caregiver identify how a more family-centered approach to caregiving can be achieved, and addresses the physical and mental health status of the caregiver.

Following the initial implementation phase, five AAAs were randomly selected and asked if the assessment had resulted in any positive, unexpected outcomes. Some AAAs reported the process greatly assisted in care planning, but more importantly, it helped caregivers identify their own needs – even the fact they are, indeed, a caregiver. According to one AAA, "caregivers feel empowered to do more, or something different, with their loved one and they experience for the first time interest in them as a consumer themselves."

The CAQ data collected are entered into the statewide-automated data system. This data is used to identify caregivers meeting the OAA priority populations and to identify target populations for outreach and public awareness efforts. Resulting data may be individually analyzed by the AAA for service planning purposes. The caregiver seeking service through the AAA may choose to not identify the source of referral; therefore, some duplication of data can be expected for consumers completing the CSQ and referred to a AAA for caregiver supports by the regional intake office.

An individual, or another person or agency contacting the AAA on behalf of an individual, may request caregiver support services by telephone, mail, email, fax, or in person. When a request is received, the AAA determines the type of assistance required, which may range from brief information to in-depth caregiver service supports.

Services specifically for caregivers include education, information, care coordination, support groups, respite, and supplemental services.

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[8] Older Americans Act, as amended in 2006, 42 U.S.C. §3022.
[9] Older Americans Act, as amended in 2006, 42 U.S.C. §3030.

The CAQ is completed by AAA staff when a caregiver is provided care coordination, the protocol established by DADS when this mandate was initiated. Information gathered is entered into the State Unit on Aging Programs Uniform Reporting System (SPURS) using a specialized data entry format.

Data Analysis

The data analysis section profiles the characteristics of caregivers responding to the CSQ and CAQ. Respondents to the CSQ were informal caregivers of new interest list consumers for CCAD, CBA, MDCP and IHFS. Respondents to the CAQ were caregivers receiving care coordination or caregiver support coordination funded through Title III-E of the OAA. The following sections profile caregivers and their experiences with caregiving.

Caregiver Respondents by County and Health and Human Services Region

Of the 20,279 caregivers who responded to the CSQ between February 2012 and March 2014, 233 of the 254 Texas counties were represented. The following counties experienced the highest number of caregiver calls:

- 2,223 callers – Harris County;
- 1,703 callers – Dallas County;
- 1,230 callers – Tarrant County; and
- 474 callers – Lubbock County.

The U.S. Office of Management and Budget[10] groups counties into the different metropolitan areas across the nation. Those counties designated as part of a metropolitan area are considered urban, while those counties not part of a metropolitan area are considered rural. Of those who responded to the CSQ, more caregivers were residing in urban counties than in rural counties across the state.

Of those caregivers who spoke with DADS, 11,423 lived in 79 urban counties while 3,280 lived in 154 rural counties.

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[10] Office of Management and Budget definition: The White House's Office of Management and Budget (OMB) designates counties as Metropolitan, Micropolitan, or Neither. A Metro area contains a core urban area of 50,000 or more population, and a Micro area contains an urban core of at least 10,000 (but less than 50,000) population. All counties which are not part of a Metropolitan Statistical Area (MSA) are considered rural. Micropolitan counties are considered non-Metropolitan or rural along with all counties which are not classified as either Metro or Micro. The OMB definition is easy to use since it designates all the land and population inside a county as either Metro or Non-Metro. For more information on Metro areas, see: *http://www.census.gov/population/metro/*.

In regards to health and human services (HHS) regions, caregivers resided in all 11 HHS regions. Regions 3, 4, and 6 accounted for 63 percent of all calls. Regions with over 1,000 callers each (1, 3, 4, 6, and 7) accounted for 83 percent of callers, while regions 2, 5, 8, 9, 10, and 11 accounted for 17 percent of callers.

The 7,224 caregivers who completed the CAQ represented 212 Texas counties and 646 towns/cities across the state. The top six counties to have caregivers complete the assessment were Harris, Dallas, Tarrant, Bexar, Cameron, and El Paso. These counties represented the highest number of caregiver assessments completed. The number of caregivers assessed by county included:

- 618 residing in Harris County (Harris County AAA);
- 514 residing in Dallas County (Dallas County AAA);
- 437 residing in Tarrant County (Tarrant County AAA);
- 300 residing in Bexar County (Bexar County AAA);
- 274 residing in Cameron County (Lower Rio Grande AAA); and
- 249 residing in El Paso County (Rio Grande AAA).

The CAQ is required only when the caregiver receives support coordination. Caregivers are assessed as identified by the local AAA, rather than being assessed when contacting the state for a broad range of services. The number of assessments for each area was not representative of the ratio of the older (age 60 and older) population living in metropolitan or rural areas of the state.

The majority of caregivers assessed (67 percent) were not aware of caregiver support services prior to contacting the AAA for assistance.

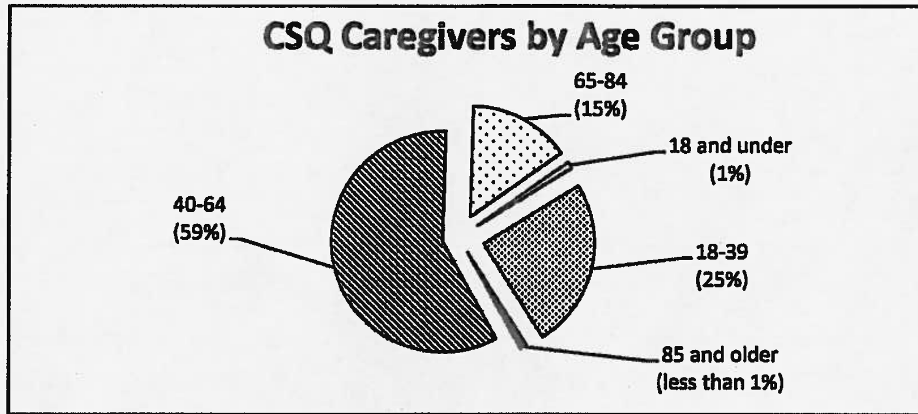
Demographic Characteristics of Caregivers

Whites were the predominant group of caregivers (42 percent) among CSQ respondents; in 2012, Hispanics were predominant. The next largest group consisted of Blacks/African Americans (30 percent) followed by Hispanics (26 percent). American Indian/Alaskan Native and Native Hawaiian/Other Pacific Islander made up one percent of respondents while Asians made up less than 1 percent of the respondents.

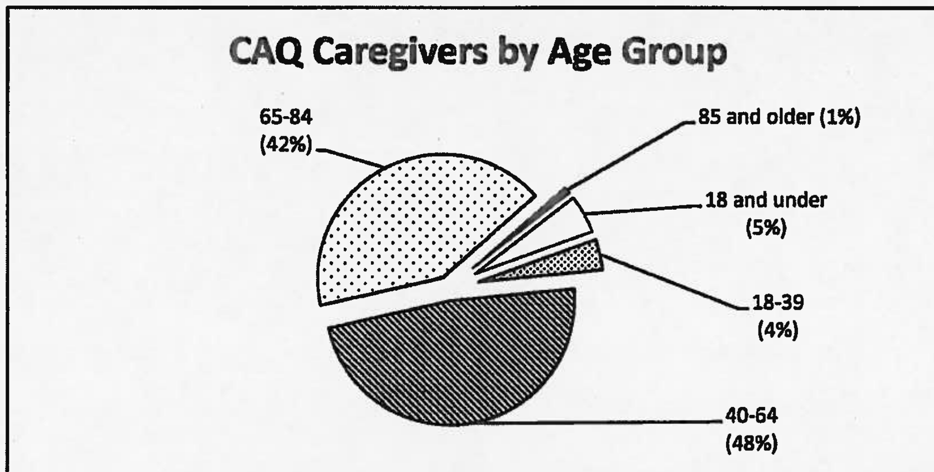
The majority of caregivers assessed by AAAs using the CAQ were White (45 percent), with the next largest group reporting to be of Hispanic origin (32 percent), followed by Black/African American (20 percent). Asians represented 1 percent of caregivers assessed, with American Indian/Alaskan Native and Native Hawaiian/Other Pacific Islander each comprising less than 1 percent. As the following chart[11] shows, the majority of caregivers were between the ages of 40 and 64, making up 59 percent of CSQ respondents. Caregivers between the ages of 18 and 39 made up the next largest group at 25 percent, followed by caregivers between 65 and 84 years of

[11] Age ranges for this report differ slightly from the 2012 report to follow the standard across the Health and Human Services Commission for reporting data.

age (15 percent). One percent of caregivers were 18 and under and less than 1 percent were 85 and older.



As was the case with the CSQ, the majority of caregivers assessed through the CAQ were between the ages of 40 and 64, making up 48 percent. Caregivers between the ages of 65 and 84 made up the next largest group at 42 percent, followed by caregivers under age 18 (5 percent) and those between 18 and 39 years of age (4 percent). The remaining 1 percent was age 85 or older.



The CAQ also includes questions about level of poverty. The younger the caregiver, the more likely the caregiver was to be in poverty. Thirty-seven percent of caregivers age 18-39 reported being in poverty. For caregivers who are age 40-64, there is a significant drop in the rate of poverty at 27 percent, and for those who are age 65-84, 20 percent reported being in poverty. Eighteen percent of the caregivers age 85 and older reported living in poverty. Women were

slightly more likely to report living in poverty than men, 26 percent versus 22 percent. Although the percentage of women and men in poverty is lower than the 2012 results of 34 percent versus 29 percent respectively, the ratio between women living in poverty to the number of men living in poverty remains similar in 2014 to 2012.

Similar to the 2012 results, seventy-two percent of caregivers assessed through the CAQ were female, with females being the majority in all age groups. This figure is lower than the 81 percent of female caregivers responding to the CSQ. The ratio of female to male caregivers decreased as the age group increased. For caregivers who were 18-39 years of age, 76 percent were female; for the 40-64 age group, 78 percent were female; for the 65-84 age group, 66 percent were female; and for those 85 years and older, 51 percent were female.

Caregivers and Relationship to Care Recipient

Relatives of care recipients primarily served as the informal caregiver. The majority of caregivers were children or spouses of the care recipients. The data reflects 25 percent of men were more likely to be the spouse of their care recipient, while 48 percent of women were more likely to be caring for a parent. However, differences existed between questions for percentages of children and spouses providing care. Spouses represented 33 percent of caregivers responding to the CAQ and 16 percent of CSQ respondents; in 2012 spouses represented 49 percent of CSQ respondents, which may indicate the state is reaching broader cohorts of caregivers. Children of the care recipient represented 37 percent of the CAQ data and 47 percent of the CSQ data.

On the CAQ, other relatives, including son/daughter-in-law, grandchild, grandparent, other relative, and sibling accounted for 22 percent of all caregivers. Friends, neighbors, and other non-relatives accounted for fewer than 4 percent of caregivers. On the CSQ, 11 percent were other relatives to the care recipient, while grandchildren, grandparents, life partners, or siblings made up 13 percent of caregivers who responded. Non-family members, such as friends, neighbors, and other non-relatives, made up fewer than 4 percent of caregivers according to the CAQ. More non-family members (12 percent) served as caregivers as reported in the CSQ.

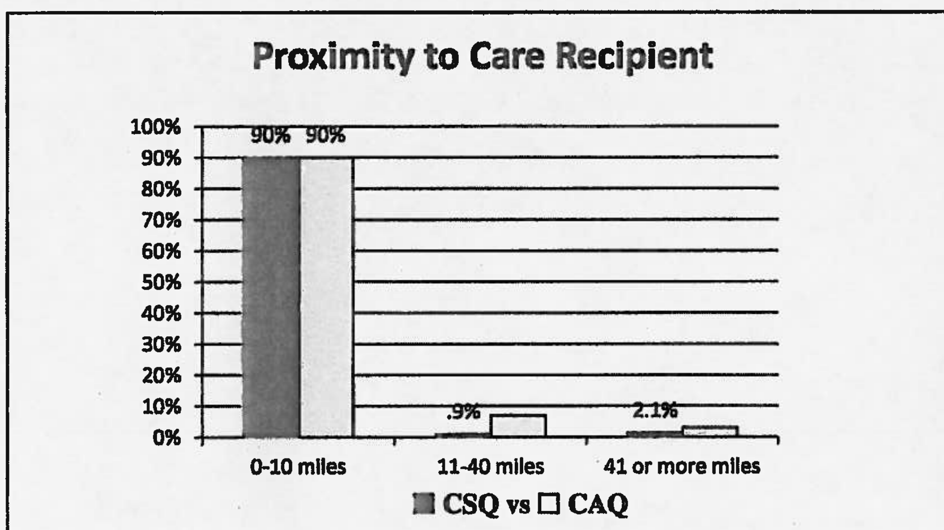
Caregivers' Family Composition

Most respondents to the CAQ reported being married, at 66 percent, and 81 percent indicated they did not have children under the age of 18. This is similar to the composition of caregivers responding to the CSQ, with 48 percent married and 75 percent reporting no children under the age of 18.

The percent by race/ethnicity who reported having children under the age of 18 was relatively dissimilar among this reporting group. Of the CAQ respondents, 22 percent of Asians, 20 percent of Hispanics, 16 percent of Black/African Americans, and 11 percent of Whites reporting this information had children under the age of 18. The CSQ data indicated Hispanics (30 percent) and other racial/ethnic groups (29 percent) were more likely to report having children under the age of 18. Twenty-eight percent of Blacks/African Americans, 22 percent of Whites, and 19 percent of Asians reported having children under the age of 18.

Proximity of the Caregiver to the Care Recipient

Most caregivers, regardless of race/ethnicity, lived with their care recipient, with 70 percent (CSQ) and 71 percent (CAQ). On the CSQ, a higher proportion of urban caregivers, 71 percent, as compared to rural caregivers, 68 percent, reported living with the care recipient. The majority, 90 percent of caregivers regardless of age or race/ethnicity lived within 10 miles of the care recipient, as reported on the CSQ and CAQ.



Paid vs. Non-Paid Caregivers

The majority of caregivers (94 percent), regardless of race/ethnicity, were not paid to provide care to the recipient, according to CSQ data. In addition, many caregivers, 77 percent, indicated they were the only non-paid caregiver for the care recipient.

CAQ data reports 96 percent of the caregivers as being non-paid caregivers.[12] Of the total caregivers assessed, 60 percent reported being the only non-paid person providing care to the care recipient, compared to 77 percent of CSQ respondents.

Caregiver Time Dedicated to Assist Care Recipient

Time dedicated to caregiving was examined by frequency and length of time. On the CAQ, the overwhelming majority, 95 percent, provided care at least once per week, regardless of race or

[12] The Older Americans Act does not allow funding for services to paid caregivers.

ethnicity. Slightly less than 2 percent assisted the care recipient monthly. On the CSQ, 94 percent of caregivers reported providing care every day. About 5 percent provided care weekly, and less than 1 percent provided care monthly or less. Most caregivers had someone to call on in an emergency, as reported on the CAQ (78 percent) and CSQ (64 percent). As a result, almost one-fourth, or 18 percent, of CAQ respondents reported having no other person to call to fill in as caregiver as needed, such as in an emergency. Thirty-six percent of CSQ respondents also did not have someone to call on to fill in.

In addition, the CSQ focused on length of time a caregiver had provided care. Twenty-one percent of caregivers had been providing care between one month and one year at the time of their interview. Caregivers who had been providing care between 1 and 2 years made up 29 percent. Some caregivers had been providing care between 2 and 5 years (29 percent) and some had been providing care between 5 and 10 years (11 percent). Another 7 percent had been providing care for 10 years or more. Two percent had only been providing care for less than one month. Caregivers are also performing many more complex medical or skilled nursing tasks. A recent AARP Public Policy Institute study, ***HOME ALONE: Family Caregivers Providing Complex Chronic Care*** notes, "Almost half (46 percent) of family caregivers performed medical/nursing tasks for care recipients with multiple chronic physical and cognitive conditions. These tasks include managing multiple medications, helping with assistive devices for mobility, preparing food for special diets, providing wound care, using monitors, managing incontinence, and operating specialized medical equipment."[13]

Of employed caregivers:

- 1 percent reported they had quit work
- 8 percent reported they had changed work schedules
- Less than .5 percent reported taking a second job
- 18 percent reported they take leave frequently
- 1 percent reported they had exceeded Family Medical Leave Act limits
- About 3 percent reported they feared losing their job

Effects of Caregiving on Employment

Similarly, over one-half of the caregivers indicated they were not employed on both the CSQ (69 percent) and CAQ (61 percent). Approximately 20 percent of CSQ respondents and 27 percent of CAQ respondents were employed full-time. Those employed part-time accounted for 11 percent of CSQ respondents and 9 percent of CAQ respondents.

Those caregivers who were employed full-time or part-time were asked a variety of questions about the effects of caregiving on employment. According to the CSQ findings, caregivers reported few negative impacts on their employment as a result of providing care to another person.

[13] Susan C. Reinhard, RN, PhD, FAAN,Carol Levine, MA, Sarah Samis, MPA, *Home Alone: Family Caregivers Providing Complex Chronic Care* (United Hospital Fund, AARP Public Policy Institute, October, 2012)

The Families and Work Institute reports in *The Eldercare Study: Everyday Realities and Wishes for Change*, "Forty-two percent of U.S. workers have provided care for an aging relative or friend in the past five years. About half (49 percent) of the workforce expects to be providing eldercare in the coming years."[14]

Among CAQ respondents, 28 percent of caregivers with employment reported caregiving responsibilities have affected their work. Effects included decreasing work hours or going part-time, losing wages or having extended leave without pay, and difficultly focusing or concentrating at work.

With regard to race and ethnicity from the CSQ findings, 9 percent of Asians and other racial/ethnic groups, 6 percent of Whites, 5 percent of Hispanics, and 4 percent of Blacks/African Americans reported to have lost wages or to have had periods with no income due to caregiving responsibilities. Hispanics (25 percent), Whites (20 percent), and Asians (13 percent) were more likely to take leave frequently because of caregiving responsibilities than Blacks/African Americans (12 percent) or people in other racial/ethnic groups (9 percent) were.

By race or ethnicity from the CAQ findings, Native Hawaiian/Other Pacific Islander were more likely to report being employed full-time, at 66 percent. Thirty-one percent of Black/African Americans, 28 percent of Hispanics, and 23 percent of Whites worked full-time. Sixty-one percent of caregivers reported they currently do not work. Sixty-seven percent of Whites, 60 percent of Hispanics, and 54 percent of Blacks/African Americans assessed do not work either full-time or part-time.

Any discussion of caregivers and employment must begin with the understanding employed caregivers who work in less flexible work environments may not have an option to provide care, so they would not be captured in the CSQ or CAQ data. In addition, some caregivers may have had to reluctantly leave a job to care for a loved one, so although they are identified as not employed, their caregiving has affected their employment. National statistics indicate, "Once caregiving has started, more than 6 out of 10 caregivers (62 percent) say they make some sort of workplace accommodation, such as going in late or leaving early, taking a leave of absence, or dropping back to part-time."[15] DADS CSQ and CAQ data on employment may, in part, reflect these caregivers who chose to leave the workforce to provide care.

In addition to the personal costs for the caregiver, there is a cost to employers with absenteeism, workplace disruptions, and reduced work status. Nationally, businesses lose between $17.1 and $33.6 billion per year in decreased productivity of their workforce due to caregiving pressures.[16]

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[14] K. Aumann, E. Galinsky, K. Sakai, M. Brown, and J. T. Bond, *The Eldercare Study: Everyday Realities and Wishes for Change* (New York, NY: Families and Work Institute, October 2010)
[15] National Alliance for Caregiving and MetLife Mature Market Institute. (2010) *Working Caregivers and Employer Health Care Costs.*. https://www.metlife.com/assets/cao/mmi/publications/studies/2010/mmi-working-caregivers-employers-health-care-costs.pdf
[16] *The MetLife Caregiving Cost Study: Productivity Losses to U.S. Business* (2006)

Impact of Caregivers' Health Issues on Caregiving

Care for others impacts the health of caregivers regardless of race or ethnicity. Fewer caregivers (22 percent) reported on the CSQ as having had a chronic health condition or having experienced a recent health crisis, as compared to 42 percent of caregivers responding to the CAQ. More than half (52 percent) of those who had a chronic health condition or a recent health crisis indicated their health condition affected their ability to provide care. Of the CAQ respondents, 30 percent stated their health has affected their ability to provide care for the care recipient.

In fact, the Caregiver Health Effects Study cites, "Elderly spousal caregivers (aged 66-96) who experience caregiving-related stress have a 63 percent higher mortality rate than non-caregivers of the same age."[17]

Stress Level of Caregivers

The majority of caregivers responding to both the CSQ and CAQ reported caregiving as stressful. Fifty-one percent of caregivers reporting on the CSQ found caregiving to be stressful. Of those who found caregiving to be stressful, 48 percent rated their stress level as moderate. Thirty-one percent said their stress level was high, and 22 percent of respondents indicated their stress level was low.

CAQ data tells us 75 percent of caregivers find caregiving to be stressful, with 28 percent reporting their stress level as high. Somewhat lower than the CSQ, 40 percent of caregivers reported moderate stress levels, and 27 percent reported low stress levels.

According to CAQ findings, caregivers were responsive to questions about the impact of caregiving on their stress levels. Eighty-eight percent of caregivers reported they agreed or strongly agreed with feeling a sense of satisfaction helping the care recipient and 84 percent reported feeling confident about providing care. Sixty-three percent of caregivers agreed or strongly agreed providing care while meeting other family and work responsibilities was stressful, and 84 percent of caregivers felt they had an obligation to provide care to the care recipient. In addition, 31 percent of caregivers reported they could do a better job of providing care than someone else could.

Thirty-nine percent reported agreeing or strongly agreeing their finances are strained due to providing care. Overall, Whites most frequently reported their finances were strained because of caregiving. Financial strain was reported by 44 percent of Whites, 41 percent of Asians, 37 percent of Hispanics, and 35 percent of Blacks/African Americans.

According to the CAQ findings, regardless of race, the majority of caregivers feel some sense of satisfaction in providing care for another person. While 59 percent reported engaging in activities

[17] Schulz, R. & Beach, S. (1999). Caregiving as a risk factor for mortality: The Caregiver Health Effects Study, *JAMA*, 282: 2215-2219.

which effectively relieve stress, 26 percent reported activities "somewhat" relieve stress and a full 8 percent reported finding no effective ways to relieve stress. Thirteen percent indicated they would like information, education, and/or training about caring for oneself while caring for others.

Stress and Proximity to Care Recipient

Caregivers who reported living with the care recipient reported slightly higher stress levels than those who reported not living with the care recipient, as reported on both the CSQ and CAQ. Among CSQ caregiver respondents who live with the care recipient, 32 percent reported high stress levels, 47 percent reported moderate, and 21 percent reported low levels of stress. Among those who did not live with the care recipient, 25 percent reported high levels of stress, while 53 percent reported moderate, and 23 percent reported low levels of stress. Similar to the CSQ finding, 30 percent of caregivers responding to the CAQ who reported living with the care recipient rated their stress level as high, versus 23 percent of those who did not live with the care recipient.

Stress levels increase the closer a caregiver lives to the care receiver as CAQ data revealed. High stress levels were reported by 29 percent of caregivers living within 10 miles of the recipient, 24 percent of those living 11 to 40 miles, and 21 percent living 41 to 100 miles away.

Stress Level of Employed Caregivers

Caregivers reported various stressors in concert with working full-time. On the CSQ, caregivers with full-time jobs were more likely to report higher stress levels than those who were employed part-time or not employed at all. Of those caregivers employed full-time, 35 percent reported high stress levels, and 47 percent reported moderate stress levels. Of those employed part-time, 26 percent reported high stress levels, and 48 percent reported moderate stress levels. Of those caregivers who were not employed, 29 percent reported high stress levels and 48 percent reported moderate stress levels.

Twenty-six percent of caregivers reported working full-time on the CAQ. Of those, 33 percent reported feeling they could do a better job of caring for the care recipient than someone else could. Of the 8 percent of caregivers working part-time, 32 percent reported feeling they could do a better job of caring for the care recipient. Variances in stress levels for employed versus non-employed caregivers were not significant. The majority of caregivers assessed using the CAQ were not employed.

Impact on Stress Level when Providing Care to More than One Person

Similarly, the majority of caregivers reported on the CSQ and CQA were not providing care to more than one recipient. On the CSQ, 81 percent of caregivers indicated they were not providing care to anyone other than the care recipient. Of those caregivers providing care to more than one person, 36 percent reported higher stress levels, as compared to 29 percent of those who provide care to only one care recipient.

Of all caregivers surveyed through the CAQ, 70 percent reported they were not caring for more than one person, significantly lower than those responding to the CSQ. Of those who are providing care for more than one person, 32 percent reported high stress. Twenty-seven percent reported high stress when caring for only one person. Data revealed a significant variance in stress when providing care to either one or more than one person.

Caregiver Assessment Questionnaire Support Tasks Performed by Caregivers

A high percentage of caregivers provide significant assistance when taking care of another person. Eighty-five percent reported helping the care recipient with homemaker chores and 72 percent of caregivers reported helping the care recipient with personal care tasks. Ninety percent reported helping the care recipient with health care (doctor visits, medication monitoring), 85 percent reported helping the care recipient with transportation, and 73 percent reported helping the care recipient with managing finances. Eighty-five percent reported helping the care recipient by providing emotional support, and 80 percent reported the need to provide supervision to the care recipient.

Support Tasks Provided

Percent of Caregivers Providing Support Tasks	Support Task
90	Health care (e.g., doctor visits, medications monitoring)
85	Emotional support
85	Homemaker chores
85	Transportation
80	Supervision
73	Managing finances
72	Personal care tasks (e.g., bathing, grooming, etc.)

Caregivers assessed reported a high level of responsibility in taking care of the recipient. Eighty-one percent reported the care recipient requires assistance with three or more personal care tasks. Three percent reported being a grandparent or older relative, age 55 and older, providing care for children with severe disabilities. Over a third, 35 percent, reported the care recipient has Alzheimer's disease or related dementia. With 39 percent of care recipients having been hospitalized recently, and 9 percent of caregivers reporting a recent hospitalization for themselves, it is not surprising 28 percent of caregivers reported the care recipient is at risk of institutionalization.

Caregiver Assessment Questionnaire Caregiver Knowledge and Acceptance of Support Services

Most caregivers (67 percent) were not aware of support services prior to contacting the AAA, and 57 percent had not received caregiver support services in the past. Eleven percent of caregivers reported reluctance to accepting outside help. This reluctance to accept outside help was based on a lack of trust of service providers in the home as expressed by 6 percent of caregivers, or the feeling no one else can provide care as well as they do (12 percent). Almost one-third, or 29 percent, had other concerns about receiving caregiver support, regardless of the fact 85 percent reported their caregiving is likely to continue indefinitely.

Caregiver Assessment Questionnaire Caregiver Knowledge of Care Recipient's Condition

More than one-half of caregivers, 64 percent of those responding to this question, indicated they felt "very" knowledgeable about the care recipient's disease or condition. Thirty-two percent reported feeling "somewhat" and four percent reported feeling "not at all" knowledgeable about the care recipient's disease or condition. Percentages below indicate caregivers who reported they would like information, education, and/or training for the following:

Information, Education, and/or Training

Percentage of Caregivers Wanting More Information	Topics
25	In-home support services
13	Home safety and/or home modifications or equipment
11	How to provide care to an aging individual
11	Care recipient's disease or condition
10	Support groups
9	How to get other family members to help
8	Long-term care options (e.g., insurance and/or other benefits)
6	Short-term respite care in a facility
5	Legal and financial issues, powers of attorney, living will
4	Individual counseling options
4	Hands-on skills training for personal care tasks (e.g., bathing, grooming, etc.)
4	On-line information and supports
3	How to choose a long-term care facility

Approximately two-thirds (64 percent) of those with "no knowledge" or "some knowledge" of the care recipient's condition reported a high stress level. Those with a lot of knowledge of the care recipient's condition (30 percent) were the least likely to report high stress.

Sixty percent of caregivers reported engaging in activities which effectively relieve stress; however, 26 percent reported their activities were "somewhat" effective at relieving stress, and 8 percent reported finding no effective ways to relieve their stress.

Conclusions

- Of all caregivers assessed using the CSQ and CAQ, majority were age 40 to 64.
- Compared to the 2012 report, there was a significant drop in the CSQ data for the percentage of caregivers who reported caring for spouses. This may indicate the state is reaching broader cohorts of caregivers.
- The majority of caregivers were female, but the relation of female to male caregivers decreases as age increases.
- The majority of caregivers were children or spouses of the care recipient.
- Married relatives had primary responsibility for caregiving to care recipients with whom they reside. A slight majority of caregivers assessed using the CSQ were not married.
- A majority of caregivers lives with the care recipient and is the only non-paid caregiver.
- Caregiving required a long-term commitment with frequent dedication of time to caregiving.
- Most caregivers found caregiving stressful, with a significant number reporting high stress. Caregivers living with the care recipient reported slightly higher stress levels than those who reported not living with the care recipient.
- Eight percent of caregivers found no effective way to relieve stress.
- Caregiver knowledge about a care recipient's condition appeared to reduce stress.
- Caregiving responsibilities negatively affected the work of employed caregivers. An average of sixty-four percent of respondents said their caregiver responsibilities had not affected their employment. For those whose employment was affected, a small percentage reported taking leave frequently due to caregiving responsibilities.
- Most caregivers felt caregiving will continue indefinitely, with almost one-half believing the care recipient is at risk of institutionalization. Only 3 percent requested information about choosing a long term care facility.
- Most caregivers were willing to accept help from others, and a majority of caregivers could call on someone to help in an emergency.
- Caregivers were highly likely to assist a care recipient in a multitude of essential life activities.
- Caregivers most frequently requested information about in-home support services, home safety and home modification, and caring for an aging individual. In 2012, support groups were among the top three, rather than home safety and home modification.
- Almost one-half of caregivers assessed by AAAs were caring for an individual with Alzheimer's disease.

DADS will continue to analyze data collected from the CSQ and CAQ to better understand the needs of caregivers in Texas. The S.B. 271 workgroup identified what changes will be made to

DADS current intake processes to ensure sustained, ongoing data collection and analysis of the profile of caregivers across Texas. DADS will identify regional differences in service availability; variances in need based on gender, age, care recipient conditions, and relationship; as well as the impacts of informal caregiving on employment and employers. Regularly updated data analysis of the profile of Texas caregivers will help to inform future policy and program decisions at DADS.

Procedures have been established for referring caregivers, identified through the CSQ process, to their respective local AAA. Beginning in fiscal year 2013, DADS regional intake staff began sending follow-up resource letters to caregivers identified during the intake process who provide contact information in response to the CSQ. The resource letter includes a link to the Take Time Texas website, where they will have access to a searchable database of respite care providers across the state.

DADS formally launched the Take Time Texas website in May 2012. TakeTimeTexas.org, a result of S.B. 271 and H.B. 802, as well as a grant from the U.S. Administration on Aging, contains the Texas inventory of respite services, a searchable database of more than 900 respite care providers across the state. Although similar databases exist on a national level, the inventory is the first to create a comprehensive listing of Texas respite providers. Caregivers can search for providers in their area by name, county served, type of respite provided, age group served, or the type of provider. TakeTimeTexas.org was created in partnership with the Texas Respite Coordination Center.

This website also provides a wide range of caregiver education and training materials, including self-assessment tools, information on identifying and managing stress related to caregiving, disease-specific information, and educational programs. For service providers, the website offers an array of training and outreach materials.

From May through August 2012, the Texas Health and Human Services Commission conducted a survey of caregivers as part of the grant requirements under the current Lifespan Respite Grant provided by the U.S. Administration on Aging. Data was collected with respect to caregiver demographics, care receiver relationship, caregiver tasks performed, and awareness and use of respite and other caregiver support services. Caregivers across the state completed the survey on-line, through the Take Time Texas website, or in paper form, through surveys distributed by mail and by ADRCs and AAAs. A total of 2,649 responses were received from all parts of the state, representing caregivers from a broader community base and not just those who were seeking services through DADS intake processes or AAAs.

- Preliminary data revealed one-half of respondents were female, and the majority was between the ages of 40 and 70. The racial and ethnic distribution of caregivers approximated the state population, with 49 percent White, 24 percent Hispanic, 11 percent Black/African American, and 4 percent other (13 percent did not identify their race or ethnicity). Approximately 30 percent of caregivers were caring for an adult child, 23 percent were caring for a spouse or partner, 18.5 percent were caring for a parent and 11.8 percent were caring for a family member. Nearly one-half of the care recipients were age 70 or older.

- Caregivers perform an important role in helping older adults and persons with disabilities remain living at home by providing them with care and support. This was reflected in the survey responses, in which the primary tasks of caregivers were listed as transportation (82 percent), homemaking (82 percent), companionship or supervision (81 percent), healthcare assistance (74 percent), financial assistance (70 percent), and personal care assistance (63 percent).

- One important note is one-half of all respondents stated they spent 40 hours a week or more providing care. Research indicates "family caregivers who provide care 36 hours or more weekly are more likely than non-caregivers to experience symptoms of depression or anxiety. For spouses, the rate is six times higher; for those caring for a parent the rate is twice as high."[18] One quarter (25 percent) had been providing care for more than 10 years, 27 percent for 4-10, years, and 28 percent for 1-3 years. The remainder had been providing care for less than one year.

- The majority of caregivers (63 percent) responding to the survey knew what respite care was, and two-thirds agreed respite care services reduced their stress level. Despite this, less than half (40 percent) had used respite services. One-half of respondents stated they did not know what type of respite care was available in their community, and 67 percent did not know how to find a licensed and reputable provider. Only 37 percent had received help finding respite care services, with the majority of those (36 percent) obtaining help from a social service agency or AAA (33 percent). Caregivers also received help finding respite care from medical providers (24 percent), friends or family (23 percent), and ADRCs (15 percent).

These survey outcomes reveal that even though the majority of caregivers (63 percent) knew what respite care was, less than half (40 percent) had used respite services and 67 percent did not know how to find a licensed, reputable provider. DADS Access and Intake staff have taken measures to address these outcomes by launching an outreach effort to increase awareness of the Take Time Texas website. Staff is also working to expand the inventory of respite services, allowing more caregivers to find services in their community.

Currently DADS is conducting an extensive project to enhance the Take Time Texas website, which is the online central hub for respite resources in Texas. DADS staff, including several members of the internal web and marketing team, have developed a communications plan outlining the goals, objectives, and strategies of the website and have received feedback from the Respite Coalition on these activities. The goal of this project is to increase user interaction, awareness of the Take Time Texas website, average time spent on the website, the information provided on the respite locator database, and to make the site more user friendly overall.

The DADS media team utilized Google analytics, website user surveys, market analysis and research on other similar websites to guide the redesign process. The inventory of respite

[18] Cannuscio, C.C., C Jones, C., Kawachi, I., G. A., Berkman, l., & Rimm, E. (2002). *Reverberation of Family Illness: A longitudinal assessment of informal caregiver and mental health status in the nurses' health study.* American Journal of Public Health, 922 305-1311.

services is also being redesigned to increase the accuracy and availability of provider information and increase ease of navigation.

DADS Access and Intake division will regularly coordinate with program information technology (IT) staff to collect data from the DADS NTK system and SPURS. Regional needs will then be compared to resources available in the inventory of respite services. This will allow DADS to identify gaps in services by region and/or zip code to better inform policy decisions, program focus, outreach activities, and future infrastructure design.

Recommendations

1. Continue support for programs and services providing education, training, and awareness for caregivers, including the Take Time Texas website and the Texas Inventory of Respite Services.

2. Continue support for respite services provided under the Texas Lifespan Respite Care (TLRC) program. Family caregivers play a key role in providing support services, which allow individuals to remain at home in their communities. In 2009, throughout the United States about 42.1 million family caregivers provided care to an adult with limitations in daily activities. It is estimated the value of the unpaid care provided by these caregivers was approximately $450 billion. Texas caregivers provided 3,270,000 hours of care for an estimated value of $34 billion.[19]

3. Promote expansion of consumer-directed and/or voucher models of service delivery. This allows caregivers to choose an individual provider that best meets their needs. This may also assist caregivers in rural counties where there are limited provider agency options. As reported in the *Health Affairs* Journal, "A shortage of well qualified, reliable, and affordable healthcare workers has a direct impact on the health and safety of persons with chronic conditions or disabilities. It also has a direct impact on the health and well-being of family caregivers who must pick up the extra workload, which requires training and support they do not have, and which adds to their caregiving burden."[20]

4. Continue support of services for caregivers and care recipients offered by DADS long-term services and supports and through AAAs, including caregiver information, education, training, and support services, such as home modifications and short-term respite.

5. Expand access to supportive services and educational opportunities for caregivers through ADRCs. Examples of supportive services include evidence-based care transitions support, options counseling, and evidence-based disease prevention and health promotion

[19] L. Feinbert, S. C. Reinhard, and R. Choula, *Valuing the Invaluable: 2011 Update, the Growing Contributions and Costs of Family Caregiving,* AARP Public Policy Institute Insight on the Issues 51 (Washington, DC: AARP, June 2011

[20] Donelan, K., et al. (2002) Challenged To Care: Informal Caregivers in a Changing Health System. Health Affairs, July/August 2002, 222-231.

interventions. Some ADRCs also provide caregiver specific education and training with respect to personal care skills, caring for individuals with dementia, and/or stress reduction.

6. Continue to provide a wide array of caregiver support services through the AAAs and TLRC program community partner organizations to address the broad range of assistance with tasks identified by caregivers. These include respite, help with personal care tasks, homemaker chores, transportation, medication management, durable medical equipment, benefits counseling, emotional support, and basic needs assistance (e.g., housing, meals, and utility assistance).

7. Promote increased caregiver access to "hands-on" practical training opportunities. This training should include enhanced communication, training, and curricula which support caregivers who provide complex care such as medication management and wound care for adults with multiple chronic conditions.

8. Implement a targeted outreach plan to identify and partner with faith-based and volunteer organizations to expand the number of free respite programs available in the state.

9. Implement a targeted outreach plan to educate "critical healthcare pathways" partners including physician groups, hospital discharge planners, home health agencies, and community-based organizations providing personal assistance services. Provide printed and on-line information about caregiver needs in addition to processes for referral to better coordinate medical and long-term care systems.

10. Disseminate findings of data analyses to stakeholders to support the development of effective local plans to serve caregivers.

Appendix A-1

Caregiver Assessment

Date:

1. Caregiver's first name: 2. Caregiver's last name: 3. Care recipient's first name: 4. Care recipient's last name:	5. Caregiver's relationship to care recipient: ☐ Child ☐ Friend ☐ Grandchild ☐ Grandparent ☐ Life Partner ☐ Neighbor ☐ Other Relative ☐ Other Non-Relative ☐ Sibling ☐ Son/Daughter-in-Law ☐ Spouse ☐ Refused to Answer
6. Caregiver Demographics and Living Arrangement a. Marital Status: ☐ Married ☐ Not Married ☐ Refused b. Hispanic Origin: ☐ Yes ☐ No ☐ Refused c. Race: ☐ Asian ☐ Black ☐ Native Hawaiian Other Pacific ☐ White ☐ Refused d. Lives with care recipient: ☐ Yes ☐ No ☐ Refused	7. Assessment Time Start: 8. Assessment Time End: 9. Total Time:

Caregiver Needs

10. Were you aware of the caregiver support resources prior to making this contact? ☐ Yes ☐ No
11. If YES, have you received caregiver support services in the past? ☐ Yes ☐ No
12. If NO, what prompted you to seek help now?
13. Do you have concerns about receiving the caregiver support? (Check all that apply)
    - ☐ Care recipient reluctant to accept outside help
    - ☐ No one else can provide care as well as I do
    - ☐ Do not trust service providers in the home
    - ☐ Other
14. If "Other" was indicated above, please describe:

Caregiver Profile

Question		
15. Are you paid to provide care for [care recipient's name]?	☐ Yes ☐ No	(If Yes, stop here)
16. Are you the only non-paid person providing care to [care recipient's name]?		☐ Yes ☐ No ☐ Refused to Answer
17. How long have you provided care for [care recipient's name]?	☐ year(s)	☐ month(s)
18. How often do you provide care to [care recipient's name]? ☐ Weekly ☐ Monthly ☐ Less than Once per Month ☐ Refused to Answer		
19. Do you have children under the age of 18?		☐ Yes ☐ No ☐ Refused to Answer
20. Are you also providing care to any other individuals?		☐ Yes ☐ No ☐ Refused to Answer
21. Is there anyone you can call on in an emergency to fill in for you as a caregiver?		☐ Yes ☐ No ☐ Refused to Answer
22. Distance to care recipient's home: (Select one)	☐ 0 – 10 miles ☐ 11 – 40 miles ☐ 41 – 100 miles ☐ Over 100 miles	☐ Refused to Answer
23. Do you have a chronic health condition or have you experienced a recent health crisis? (If No, go to question 25)	Caregiver's health condition/crisis:	☐ Yes ☐ No ☐ Refused to Answer
24. Has this health condition affected your ability to care for [care recipient's name]?		☐ Yes ☐ No ☐ Refused to Answer

Revised 10/8/2014 1

Caregiver's Name:	Date:
Care Recipient's Name:	

25. Are you employed? ☐ Full-time ☐ Part-time ☐ Not Employed ☐ Refused to Answer

26. Have your caregiver responsibilities ever affected your employment? ☐ Yes ☐ No ☐ Refused to Answer (If No, go to question 28)

27. How has your employment been affected? (Select all that apply)

Schedule	Pay	Leave	Work Relationships	Performance
☐ Changed jobs	☐ Has taken a second job	☐ Takes leave frequently	☐ Feeling of isolation	☐ Decreased confidence in own ability
☐ Decreased hours or went part-time	☐ Has lost wages or periods with no income	☐ Used all paid leave; no leave remaining	☐ Less co-worker interaction	☐ Decrease in productivity
☐ Has taken extended leave with pay	☐ Has taken leave without pay (LWOP)	☐ Exceeded Family Medical Leave Act (FMLA)	☐ Tension or problem with co-worker	☐ Difficulty with concentration or focus
☐ Quit job	☐ Missed promotion opportunity		☐ Tension or problem with supervisor	☐ Fear of losing job
	☐ Received pay cut or pay decreased			☐ Perform or manage caregiver tasks at work

Caregiver Skills and Training Assessment

28. Which of the following tasks do you assist the care recipient with? (Check all that apply)

- ☐ Personal care tasks (ADLs)
- ☐ Homemaker chores (IADLs)
- ☐ Transportation
- ☐ Managing finances
- ☐ Health care (doctor visits, medication monitoring)
- ☐ Supervision
- ☐ Emotional support
- ☐ 29. Other (describe):

30. If [care recipient's name] has a chronic disease or condition, how knowledgeable do you feel about this disease or condition? ☐ Very ☐ Somewhat ☐ Not at all
Care recipient's disease/condition:

31. Do you need information, education and/or training about the following? (Check all that apply)

- ☐ How to care for yourself while caring for others
- ☐ How to provide care to an aging individual
- ☐ More information about care recipient's disease/condition
- ☐ How to get other family members to help
- ☐ Home safety and/or home modifications, or equipment
- ☐ Legal and financial issues, powers of attorney, living will
- ☐ Long-term care options (insurance and/or other benefits)
- ☐ In-home support services
- ☐ Short-term respite care in a facility
- ☐ Choosing a long-term care facility
- ☐ Support groups
- ☐ Individual counseling options
- ☐ On-line information and supports
- ☐ Hands on skills training for personal care tasks (bathing, grooming, toileting)

32. ☐ Other, please describe:

Caregiver's Name:	Date:
Care Recipient's Name:	

Caregiver Stress Interview

33. Do you find caring for [care recipient's name] to be stressful?	☐ Yes ☐ No ☐ Refused to Answer
34. Would you rate your stress level as	☐ Low ☐ Moderate ☐ High ☐ Refused to Answer

Check the response that best describes how you feel:	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Refused to Answer
35. I feel a sense of satisfaction helping [care recipient's name].	☐	☐	☐	☐	☐	☐
36. I am confident about providing care to [care recipient's name].	☐	☐	☐	☐	☐	☐
37. Caring for [care recipient's name] while trying to meet other responsibilities for my family or work is causing increased stress.	☐	☐	☐	☐	☐	☐
38. I feel a sense of obligation to provide care.	☐	☐	☐	☐	☐	☐
39. My health has suffered because of my involvement with providing care.	☐	☐	☐	☐	☐	☐
40. My finances are strained because I provide care.	☐	☐	☐	☐	☐	☐
41. I could do a better job of caring for [care recipient's name].	☐	☐	☐	☐	☐	☐

42. What do you do to cope with the stress related to the challenges of caregiving? Describe:

43. Is this working to help relieve stress?	☐ Yes ☐ Somewhat ☐ Not at all

Caregiver Priority Status (check all that apply)

☐	Providing care to a person with Alzheimer's disease or related dementia	☐	Grandparents or older relative caregivers who are 55+, who are providing care for children with severe disabilities

Optional targeting categories (check all that apply)

☐	Caregiver recently hospitalized	☐	Care recipient requires assistance with three or more ADLs
☐	Care recipient recently hospitalized	☐	Caregiver's income is at or below federal poverty level
☐	Caregiving is likely to continue indefinitely	☐	Caregiver is caring for more than one person
☐	Care recipient is at risk for institutionalization	☐	Other:
☐	Caregiver has chronic health condition or has had a recent health crisis		Notes:

Care Coordinator's Name

Revised 10/8/2014 3

Appendix B-1

Form 1027
February 2011-E

Caregiver Status Questionnaire

Caregiver declined to answer: ☐ Yes ☐ No
Date of follow up (mm/dd/yyyy): ________
Attempt to contact failed: ☐ Yes ☐ No

Caregiver Demographics

DADS Staff			Date
Caregiver Name			Telephone
Address			
City	State	ZIP Code	County

Hispanic Origin? ☐ Yes ☐ No ☐ Refused to answer

What is your race?
☐ American Indian/Alaskan Native ☐ Black/African American ☐ White ☐ Refused to answer
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ None of the above

Age ____ ☐ Refused to answer Gender: ☐ Male ☐ Female ☐ Refused to answer

What is your relationship to [care recipient's name]?
☐ Child ☐ Grandparent ☐ Other – Non-relative ☐ Son/Daughter-in-law
☐ Friend ☐ Life Partner ☐ Other – Relative ☐ Spouse
☐ Grandchild ☐ Neighbor ☐ Sibling ☐ Refused to answer

Marital Status: ☐ Married ☐ Not Married ☐ Refused to answer

Lives with [care recipient's name]: ☐ Yes ☐ No ☐ Refused to answer

Distance to care recipient's home (select one):
☐ 0 – 10 miles ☐ 11 – 40 miles ☐ 41 – 100 miles ☐ Over 100 miles ☐ Refused to answer

Caregiver Profile

1. *Are you paid to provide care for [care recipient's name]?* ☐ Yes ☐ No ☐ Refused to answer
   - If Yes:

     I'd like to thank you for taking the time to respond to our survey. The information you've provided will be very useful. The focus on the remainder of the questionnaire is on unpaid caregivers.

     Stop the interview.
   - If No or Refused to Answer, continue.
2. *Are you the only non-paid caregiver providing care to [care recipient's name]?* ☐ Yes ☐ No ☐ Refused to answer
3. *How long have you been providing care for [care recipient's name]?* Year(s) Month(s)
4. *How often do you provide care to [care recipient's name]?*
   ☐ Daily ☐ Weekly ☐ Monthly ☐ Less than once per month ☐ Refused to answer
5. *Do you have children under the age of 18?* ☐ Yes ☐ No ☐ Refused to answer
6. *Are you also providing care to any other individuals?* ☐ Yes ☐ No ☐ Refused to answer
7. *Is there anyone you can call on in an emergency to fill in for you as caregiver?* ☐ Yes ☐ No ☐ Refused to answer
8. *Are you employed?* ☐ Full-time ☐ Part-time ☐ Not employed ☐ Refused to answer

   If No or Refused to Answer, skip to question 10.

Form 1027
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Caregiver Profile (continued)

9a. *Have your caregiver responsibilities ever affected your employment?* ☐ Yes ☐ No ☐ Refused to answer

- If No or Refused to Answer, skip to question 10a.
- If Yes:

9b. *Can you tell me a little bit about how this is affecting your employment? For example, has your pay been affected due to having to take off work, have you had to change your work schedule, or had to take frequent leave? Have your work performance or work relationships suffered due to caregiving demands?*

Use the examples below to prompt the caregiver if, based on his/her responses, he/she is having difficulties in responding to the question.

Schedule	Pay	Leave	Relationships	Performance
☐ Changed Jobs	☐ Has taken a second job	☐ Exceeded Family Medical Leave Act (FMLA)	☐ Feeling of isolation	☐ Decrease in productivity
☐ Changed Work Schedule	☐ Has taken leave without pay (LWOP)	☐ Takes leave frequently	☐ Less co-worker interaction	☐ Decreased confidence in own ability
☐ Decreased hours or went part-time	☐ Lost wages or periods with no income	☐ Used all paid leave/no leave remaining	☐ Tension or problem with co-worker	☐ Difficulty with concentration or focus
☐ Has taken extended leave with pay	☐ Missed promotion opportunity		☐ Tension or problem with supervisor	☐ Fear of losing job
☐ Quit job	☐ Received pay cut or pay decreased			☐ Perform or manage caregiver tasks at work

10a. *Do you have a chronic health condition or have you experienced a recent health crisis?*

☐ Yes ☐ No ☐ Refused to answer

- If Yes, ask question 10b.
- If No or Refused to Answer, go to question 11a.

10b. *Has your health condition affected your ability to care for [care recipient's name]?*

☐ Yes ☐ No ☐ Refused to answer

11a. *Do you find caring for [care recipient's name] to be stressful?* ☐ Yes ☐ No ☐ Refused to answer

- If Yes, ask question 11b.
- If No or Refused to Answer, stop.

11b. *Would you rate your stress level as:* ☐ Low ☐ Moderate ☐ High ☐ Refused to answer

Referral to the Area Agency on Aging (AAA)

If the individual meets one of the following criteria, s/he may qualify for services from AAA. If so, and if the individual indicates s/he would like assistance, make the referral according to regional procedures.

AAA Eligibility Screening Criteria: The individual may qualify for services from AAA if he or she is:

- 60 years of age or older and is caring for an individual of any age;
- 55 years of age or older and is caring for a grandchild under the age of 18 in his/her home because the biological or adoptive parents are unable or unwilling; or has legal custody or guardianship or is raising the child informally; or is caring for a recipient age 19-59 with severe disabilities; or
- a caregiver for an individual of any age who has Alzheimer's or dementia.

I'd like to thank you for taking the time to respond to our survey. The information you've provided will be very useful in improving current services and developing additional resources and supports for caregivers throughout the state.

If the caregiver status form is only partially completed, please explain why:

ANNUAL REPORT 2013–2014

UTAH COMMISSION ON AGING

INSIDE THIS REPORT

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Director's Message

No longer do we signal the warning for an oncoming Silver Tsunami. The aging of our Utah population, with dramatic peaks of retirees in the Baby Boomer cohort counterbalancing our young families, is now more predictable. We have had time to prepare for the aging wave in Utah and through coordinated efforts show signs that we are developing some policies to prepare for the surge of older, frailer people needing more medical and social care. Impending crisis, it seems, can precipitate change. This greater appreciation for the policy implications of aging in Utah shines through strains of a legislatively-coordinated planning effort during 2014.

State Representative Rebecca Edwards called an aging-focused Utah Intergovernmental Roundtable in May and throughout the summer, her house colleague, Rep. Rebecca Chavez-Houck orchestrated a multi-agency presentation coinciding with the long-term planning agenda of the legislature's Health and Human Services Interim Committee in September. Among the predictable gaps that were identified between needs and services was an unsustainable reliance on family caregivers making-do in providing the lion's share for loved ones living with dementia and other types of chronic disease.

Commission on Aging Chair Becky Kapp, whose primary hat is directing Salt Lake County Aging and Adult Services, pointed out the need for $350,000 in ongoing funding for statewide Meals on Wheels, and $250,000 to provide respite care at local centers for Utahns who need temporary relief from caregiving duties. Commission member and Senator Dr. Brian Shiozawa convened three times with leaders of the Utah Geriatrics Society, who impressed upon him the dire shortage of physicians, nurses, and nurse practitioners, who specialize in seeing older adult patients. Together they are discussing how to better prepare our healthcare workforce.

The Commission has focused significant efforts on the implementation of programs to help those caring for an aging loved one such as:

- **Revising the forms healthcare providers use to document conversations about patients' End-of-Life care preferences**
- **Bringing personalized, iPod based music to nursing home residents with cognitive impairment**
- **Disseminating our research on proximity of age-designated housing to community amenities that enhance livability and enable aging-in-place**
- **Hosted the Institute for Health Metrics and Evaluation as prospective analysts of Utahns' life-expectancy**
- **Analyzed Utah health information systems' capabilities to host the electronic Physician Orders for Life-Sustaining Treatment medical registry.**

We can and we are preparing government for drastic changes in our state's makeup. New champions for coordinated care of the vulnerable elderly are emerging in this state. This will not be a cataclysmic flood of older people if we seize the opportunity to be prepared. Success means economic stability and programs to support optimal aging, not succumbing to an unanticipated tidal wave.

Anne Elizabeth Palmer Ed.D., M.P.A.
Executive Director

THE COMMISSION'S STATUTORY PURPOSE:

1. Increase public and government understanding of the current and future needs of the state's aging population and how those needs may be most effectively and efficiently met;

2. Study, evaluate, and report on the projected impact that the state's increasing aging population will have on, and identify and recommend implementation of specific policies, procedures, and programs to respond to the needs and impact of the aging population relating to government services, health services, social services, the economy, and society in general;

3. Facilitate coordination of the functions of public and private entities concerned with the aging population; and

4. Accomplish the following duties:
   a. study, evaluate, and report on the status and effectiveness of policies, procedures, and programs that provide services to the aging population;
   b. study and evaluate the policies, procedures, and programs implement-ed by other states that address the needs of the aging population;
   c. facilitate and conduct the research and study of issues related to aging;
   d. provide a forum for public comment on issues related to aging;
   e. provide public information on the aging population and the services available to the aging population;
   f. facilitate the provision of services to the aging population from the public and private sectors; and
   g. encourage state and local governments to analyze, plan, and prepare for the impacts of the aging population on services and operations.

SIX ASSIGNED REPRESENTATIVES

NAME	ORGANIZATION | REPRESENTING
Senator Brian Shiozawa, M.D.	Utah Senate
Rep. Stewart Barlow, M.D.	Utah House of Representatives
David Patton (proxy Angie Stefaniak)	Executive Director, Utah Department of Health
Ann Silverberg Williamson (proxy Nels Holmgren)	Executive Director, Utah Department of Human Services
Val Hale (proxy Patty Conner)	Executive Director, Governor's Office of Economic Development
Jon Pierpont (proxy Karla Aguirre)	Executive Director, Utah Department of Workforce Services

15 VOTING MEMBERS

Approved By The Governor for a 2-year Term

Mayor Ron Bigelow	West Valley City, Utah | UT League of Cities and Towns
Barry Burton	Davis County | Utah Association of Counties
Michael Cupello	Peace Officers Training | Public Safety Sector
Becky Kapp	SL County Aging Services | UT Area Agencies on Aging
Gary Kelso	Mission Health Services | Long-term Care for the Elderly
William (Bill) Knowles	Public Transportation
Tracey Larsen	Bank of American Fork | Financial Institutions
Alan Ormsby, J.D.	AARP | Aging Advocacy Organizations
Fahina Pasi	Utah Tongan Society | Ethnic Minorities
Mary Street	Commerce Real Estate | Business Community
Mark Supiano, M.D.	The University of Utah | Higher Education in Utah
Elizabeth (Bette) Vierra	General Public
Frances Wilby	Goodwill Initiatives on Aging | Charitable Organizations
Troy Wilson, J.D.	Wilson Estate Elder Law | Legal Profession
Elizabeth (Bette) Vierra	General Public

Representative Stewart Barlow, MD

Utah House of Representatives

Dave Gessel

Representing Utah Health Care Providers

Becky Kapp, Chair

Utah Area Agencies on Aging

Mayor Ron Bigelow

Utah League of Cities and Towns

Val Hale

Executive Director of Economic Development

Gary Kelso

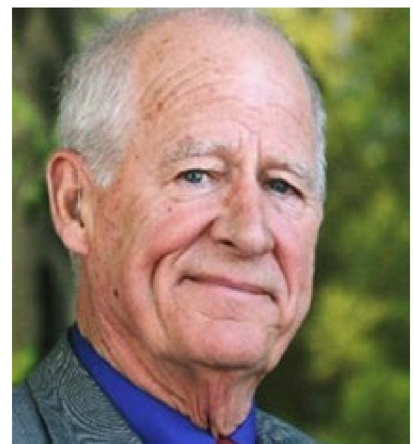
Long-term Care for the Elderly

Barry Burton

Utah Association of Counties

Nels Holmgren

Representing UT Dept. of Human Services



William (Bill) Knowles

Public Transportation

Tracey Larsen
Bank of American Fork

David Patton
Executive Director of Health

Mary Street
Business Community

Alan Ormsby, J.D.
Advocacy Organizations - AARP

Jon Pierpont
Executive Director, Dept. of Workforce Services

Mark Supiano, MD
Higher Education in Utah

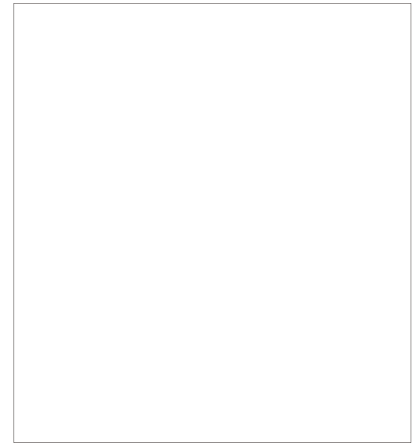
O. Fahina Tavake-Pasi
Ethnic Minorities

Senator Brian Shiozawa, MD
Utah Senate

Nate Talley
Governor's Office of Economic Development

Elizabeth (Bette) Vierra
General Public

Troy Wilson, J.D.
Legal Profession

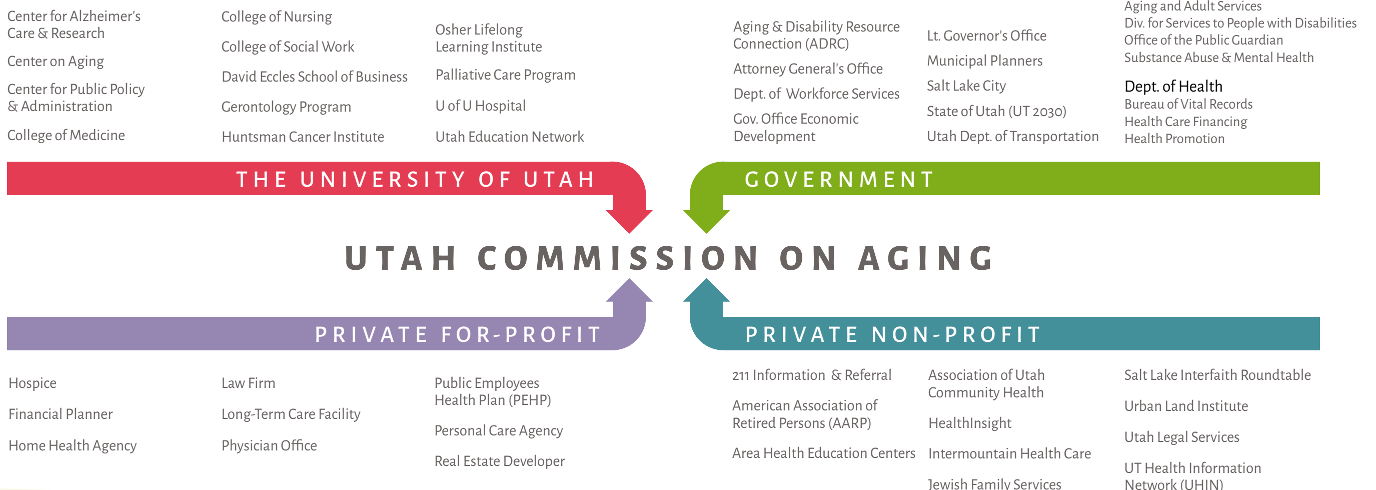


Not Pictured: **Michael Cupello**
Public Safety Sector

Fran Wilby
Charitable Organizations

Ann Silverberg Williamson
Executive Director of Human Services

UCOA RELATIONSHIP CHART

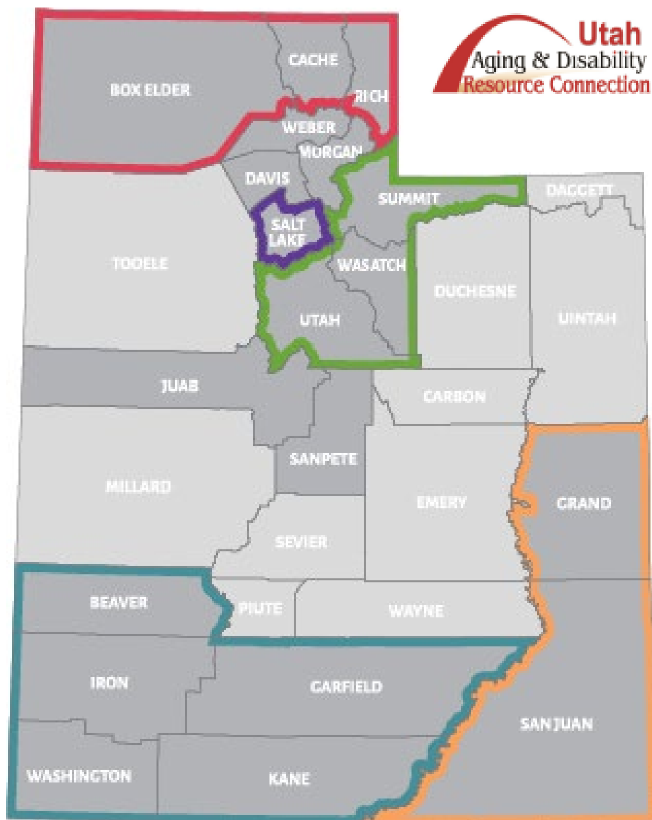


AGING, DISABILITY AND VETERAN'S PROGRAMS

Utah's Aging and Disability Resource Connection has been working to provide a No Wrong Door experience for older adults and people with disabilities, needing current or future long-term services and supports.

Image © Alamy

Utah Aging and Disability Resource Connection



In 2009 the Utah Commission on Aging first received Administration on Aging funds to create the Aging and Disability Connection in Utah. The Aging and Disability Resource Connection Program (ADRC) supports state efforts to streamline access to long-term services and support options for older adults, people with disabilities, and their caregivers.

- Active Re-Entry - Center for Independent Living
- Bear River - Area Agency on Aging
- Five County - Area Agency on Aging
- Mountainland - Area Agency on Aging
- Salt Lake County Aging and Adult Services Area Agency on Aging

ADRC's CORE PHILOSOPHY

What is Options Counseling?

The ADRC's Options Counseling concept is based on person-centered planning. This one-on-one approach allows clients to share what they desire in their long term care needs and with guidance of an ADRC Options Counselor, can create a plan to achieve the client's goals. It supports the broader system goals of rebalancing Long-Term Services and Supports (LTSS) and helps to prevent or delay premature institutionalization by offering options to help individuals spend resources wisely in the community.

In 2010, the ADRC Steering Committee selected four pilot sites to implement the ADRC philosophy and Options Counseling services. Utah's strategy was to have a balance of Area Agencies on Aging (AAA) and Centers for Independent Living (CIL) represented.

In 2010, four pilot sites kicked off the ADRC:

- **Ability First (CIL):** Utah, Wasatch, Juab, Sanpete Counties
- **Active Re-Entry (CIL):** Grand, San Juan Counties
- **Bear River (AAA):** Cache, Box Elder, Rich Counties
- **Mountainland (AAA):** Utah, Summit, Wasatch Counties

Three additional sites were added in the ensuing years:

- **Roads to Independence (CIL):** Davis, Morgan, Weber Counties (April 2012)
- **Salt Lake County Aging and Adult Services (AAA):** Salt Lake County (April 2012)
- **Five County (AAA):** Washington, Beaver, Iron, Kane, Garfield Counties (April 2013)

The Utah ADRC has been fully supported by federal funds covering the ADRC Program Office, Director and Coordinator, site subcontracts, evaluation, training, and operational supplies. The University of Utah waived all indirect costs, providing the program office space without cost. The ADRC sites received between $10,000-$14,000 to function as an ADRC; trainings, options counseling with clients, and data reporting are provided.

State Level Impact

ADRC initiatives have made a significant difference in our state.

DEDICATED MEDICAID WORKER

In FY13 the Utah Commission on Aging committed $25,000 which allowed the ADRC to draw down a 50% Medicaid Federal Match to support an ADRC dedicated Medicaid Outreach Worker.

Strengthening Single Point of Entry

In March 2013, Josie Martinez set up her office at Salt Lake County Aging and Adult Services and her door was opened to all ADRC staff. With direct-line access, staff could immediately assist their clients with Medicaid applications, policy clarifications, waiver questions, and time saving troubleshooting.

MDS SECTION Q

The ADRC was instrumental in establishing procedures for more effective follow-up of the responses of nursing home residents to the Minimum Data Set Section Q (MDS Section Q) which asks, "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?" This November a pilot project with the State Medicaid Agency and Active Re-Entry will be launched. Active Re-Entry will provide an in-person visit with Nursing Home residents who are interested in transitioning backing into the community to discuss their options.

"Our agency adopted the philosophy and vision of an ADRC and changed our staffing and structure to address LTC options. The ADRC was the catalyst for these changes."

Expanding service to veterans

In 2012, the Utah ADRC and the Veterans Rural Health Resource Center-Western Region sent an electronic survey to ADRC sites in the US to identify challenges in serving veterans in their areas. "Do you regularly assess a caller's veteran status?". The survey showed that agency staff had a lack of basic information on VA benefits and information resources about VA services viewed as unhelpful and/or unreliable. Staff also viewed having a personal VA contact was valuable and these agencies want training about VA services and benefits.

The survey results led to a collaborative pilot project between the VA and Utah Aging and Disability Resource Connection (ADRC).

Project Goals included:

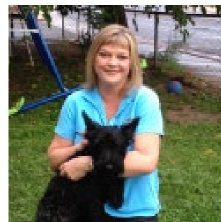
- **Create access point for rural Veterans**
- **Provide options counselors extensive training in VA Benefits**
- **Build relationships with the VA and ADRC**
- **Disseminate to ADRC programs nationwide**

SERVING RURAL VETERANS

In March 2013, "Connecting Rural Veterans to Aging and Disability Resource Centers for Options Counseling" received funding from the VA Office of Rural Health with five ADRC sites to receive VA Benefits training and provide outreach to rural veterans.

Veteran Benefits trainings have reached more than 100 staff statewide for a total of 1182 received training hours. Five designated veteran client options counselors have acquired over 70 hours of VA Benefits training including completion of a 19 module on-line VA TRIP training acquiring an exam certification, and two options counselors have passed the Veteran Service Officer (VSO) Accreditation exam.

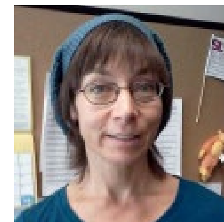
Deborah Crowther
Bear River Association of Governments



Joey Allred
Active Re-Entry, Center for Independent Living

Melanie Haws
Mountainland Association of Governments

Rachel Stoddard
Salt Lake County AAA



Stephanie Herrig
Salt Lake County AAA

APRIL 1, 2013 – SEPTEMBER 30, 2014

ADRC Veteran Clients Served **585**

TYPES OF REFERRALS MADE*

VHA Healthcare	280
Aid & Attendance	269
Pension	164
VA Nursing Home	107
Disability Compensation	85
Burial Benefits	80
VHA In-Home Services	57
Other Public Programs	228
Other Private Programs	63

*Clients referred to multiple VA Programs

Gulf War/Afghanistan: 0.5%
Other Service time: 7.2%

Age 70+	67%
Age 60 -70	19%
Age 59 -	2%
Deceased	12%

VETERAN DIRECTED HOME AND COMMUNITY BASED SERVICES (VD-HCBS)

In June 2014, the Salt Lake City Veteran Affairs Medical Center (SLC VAMC) contracted with Mountainland Aging and Family Services/ADRC to begin the first VD-HCBS program in Utah. The VD-HCBS program provides Veterans the opportunity to self-direct their long-term supports and services to enable them to avoid institutionalization and continue living independently at home. Veterans enrolled in VD-HCBS have the opportunity to manage their own flexible budgets, decide for themselves what mix of services best meet their needs, and to hire and supervise their own workers.

Currently, Mountainland has 20 veterans participating in the program. Salt Lake County Aging and Adult Services will be the next ADRC site to participate in the VD-HCBS program.

"For AAAs, the vision of participant-directed services has been game changing. ADRC has changed the way the AAAs do business."

ADRC'S UPCOMING YEAR

The ADRC received an additional year of funding from the Veterans Affairs Office of Rural Health to continue expanding the five ADRC site's capacity to serve rural veterans. The Veteran Directed Home and Community Based Services (VD-HCBS) will continue to expand statewide providing veterans the opportunity to self-direct their own long term care. And the ADRC Program Office will continue the critical discussions to improve Utah's citizens access to planning for long term services and support.

ADRC STEERING COMMITTEE MEMBERS 2014

Name	Organization
Andy Curry	Roads to Independence
Anne Smith	Representative of Older Adults
Becky Kapp	Salt Lake County Aging and Adult Services
Carrie Schonlaw	Five County Area Agency on Aging
Chiara Cameron	2-1-1
Gary Kelso	Mission Health Services
Jeremy Christensen	Division of Substance Abuse and Mental Health
Les Carter	Division of Services for People with Disabilities
Michelle Benson	Bear River Area Agency on Aging
Michelle Carlson	HealthInsight
Nancy Bentley	Active Re-Entry Center for Independent Living
Nate Palmer	Department of Workforce Services
Nels Holgrem	Division of Aging and Adult Service
Sandra Curcio	Ability First Center for Independent Living
Scott McBeth	Mountainland Area Agency on Aging
Trecia Carpenter	Utah Department of Health (State Medicaid Agency)

Non-voting member

Name	Organization
Daniel Musto	State Long Term Care Ombudsman

Staff:

Jennifer Morgan	Program Director
Rhonda Hypio	Program Coordinator

Evaluator:

Judith Holt	Utah State University

END OF LIFE CARE Planning and recommendations

Like most states, Utah is developing a program to improve communications between patients with advanced illness, their families, and health providers – a means that allows frail patients to request or refuse certain measures such as CPR. Unlike most states, Utah's will be an electronic system, rapidly accessible by authorized emergency medical providers.

The Utah Commission on Aging has accepted responsibility to help implement the electronic Physician Order for Life Sustaining Treatment, or *ePOLST*.

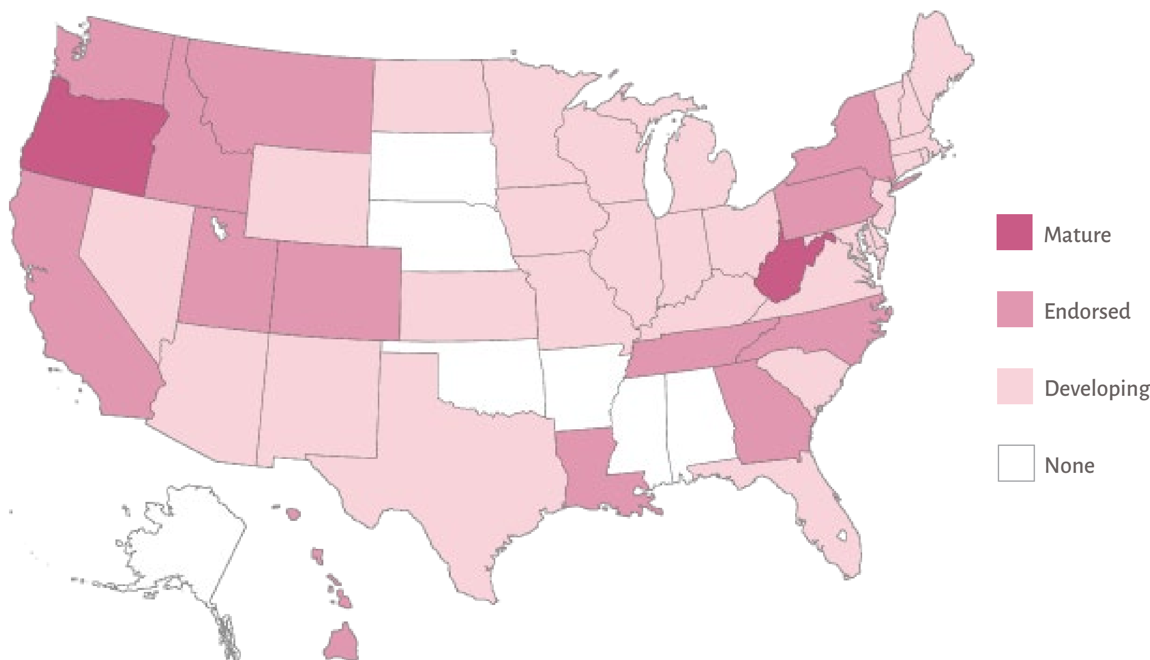
Utah's ePOLST will help to increase rapid access to POLST orders. These orders come from the preferences patients express to their primary physicians through end of life planning conversations.

The Utah Department of Health's Information Technologists were the creators of Utah's pilot ePOLST system. The private, nonprofit organization HealthInsight provided initial guidance and over-sight. Pilot funding came from the federal Beacon Community Cooperative Agreement Program. The aim was to show how health IT investments and meaningful use of electronic health records advance the vision of patient-centered care, while achieving better health and better care at lower cost.

As one of 17 Beacon Communities nationwide, coordinated efforts are assisting Utah's health care organizations to find ways to reduce costs and improve health care using innovative technology and best practices in treating patients nearing the end of their lives.

In October, 2013, the Commission on Aging received funding to steer the ePOLST system from pilot to functional status and toward stability. With the Department of Health, the Commission helped stakeholders weigh key factors in determining where to permanently house and how to fund the system. The Commission was also involved in arranging training for healthcare professionals who will use this system to enter and access physician orders.

Sustainable funding for registry operations is vital to its long-term success, as Utah joins 43 other states in POLST program outreach. This engagement has enabled Commission members representing our public, senior advocacy organizations, nurses, and of course, the public, to contribute their expertise to a 12-month project.



As Utahns age, three housing concerns consistently top the list—the ability to age-in-place, housing affordability, and the availability of housing options, with a strong relationship between the three.

The Livability Index

The number of adults aging up into a 65-and-older category is growing rapidly, thanks in large part to the 'baby boom' generation. Earlier demand by this generation for large-lot homes in suburban style neighborhoods is giving way to a need for more walkable, mixed-use neighborhoods with a range of housing options.

The Metropolitan Research Center at the University of Utah uses several quantitative measures to determine neighborhood livability. Four of these measures were factored into a geographic model presented at the Center on Aging Research Retreat in March.

Markets

Number of Supermarkets and Farmer's Markets within one half mile of census block centroids

Parks

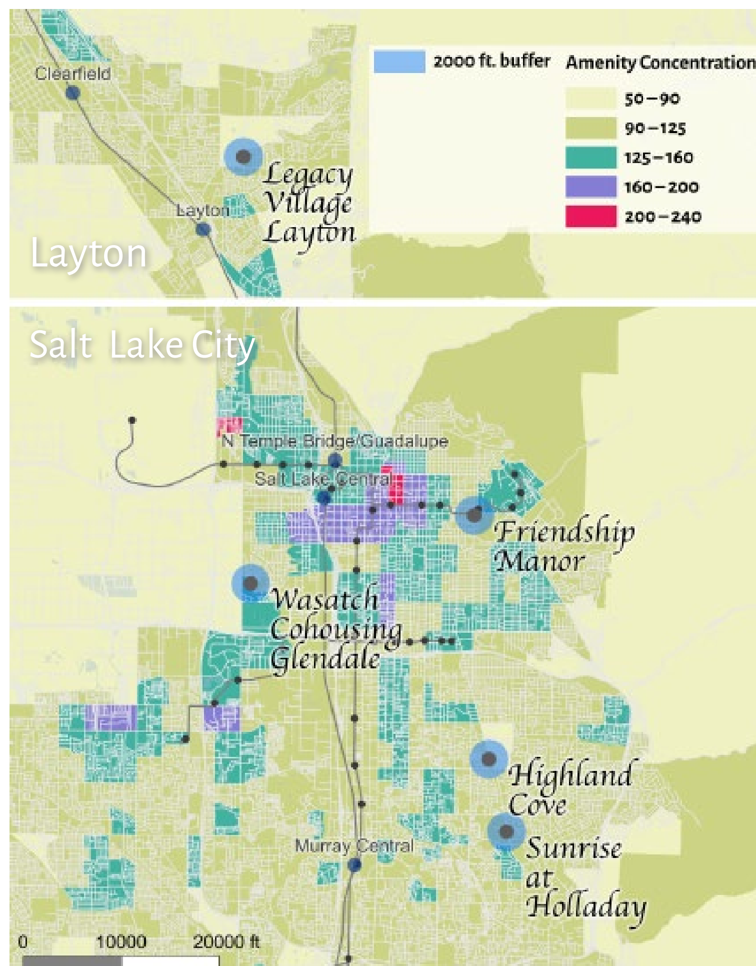
Number of Parks and Farmer's Markets within one half mile of census block centroids

Activity Density

Resident and Job density within census blocks

Mixed Use

Diversity of job sectors within census blocks



ECONOMIC BENEFITS:

- Creating a range of housing opportunities in proximity to jobs saves households money.
- Improving neighborhood "walkability" tends to enhance property values.
- Walkability also enhances health.
- Fostering a sense of place
- Preserving critical environmental areas

Wasatch Front Senior Housing

A CONTINUUM OF OPTIONS

Wasatch Cohousing

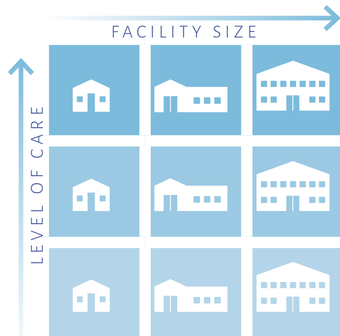
Friendship Manor

Highland Cove

Sunrise at Holladay

In addition to creating new policies, communities require support for breaking down barriers to a wider range of housing options. Understanding these housing options begins a dialog upon which to build inclusive, universally accessible communities. This brochure identifies, defines, and organizes older adult housing options.

This brochure was presented at the 2013 Utah American Planning Association Conference.



The brochure cross-references facility size with levels of care.

UTAH'S CHANGING DEMOGRAPHICS

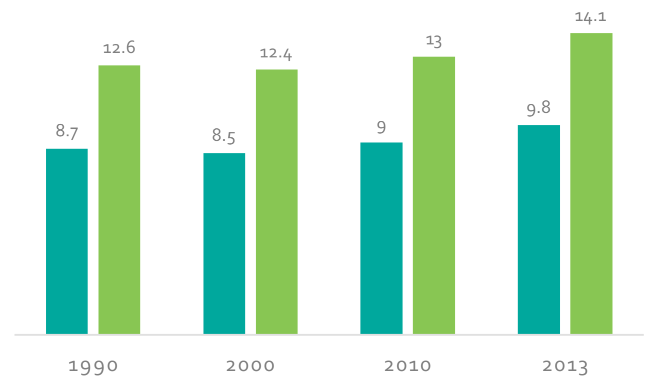
The following graphs were created by Mallory Bateman at the Utah Foundation and were presented to the Utah Health and Human Services Interim Committee in September.

Image © Deseret News

An Aging Population in Utah

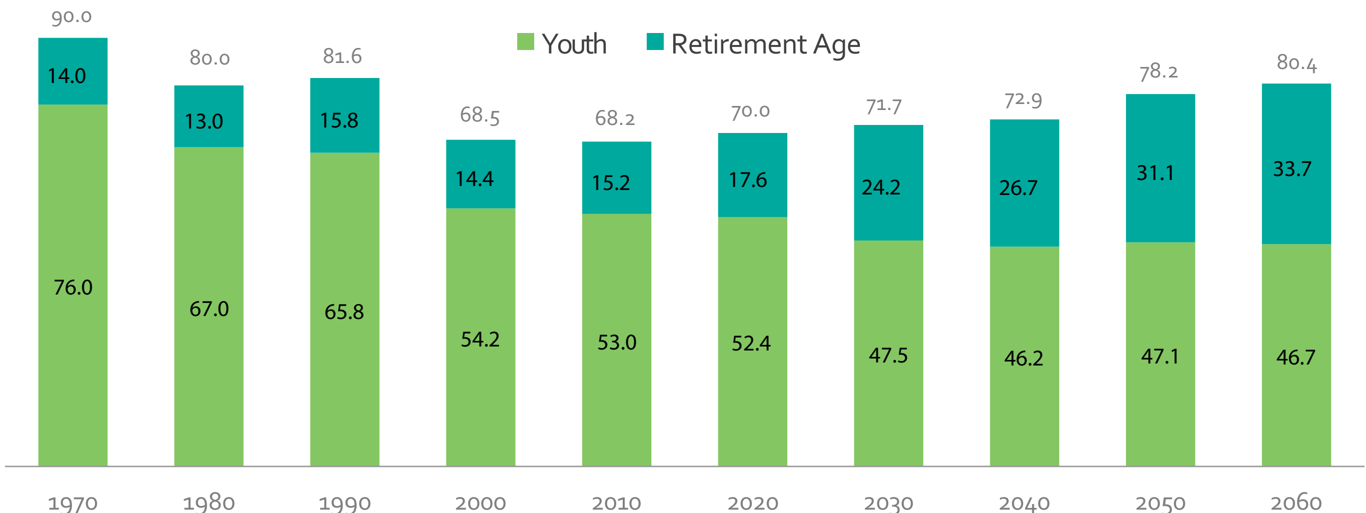
PERCENT OF POPULATION 65 YEARS OR OLDER

An aging Baby-Boom generation is contributing to the demographic transformation in progress in Utah. The 65+ demographic is growing as a share of the overall population. And Utah's Youth population share more closely resembles US numbers, so planning now for a quickly-growing demographic is increasingly important.



DEPENDENCY RATIO | 1990–2060

The Dependency Ratio is the percentage of the population that is dependant on the working population based on working age. The 65+ share of the dependency ratio is projected to grow toward near-parity with the Youth share by 2060.



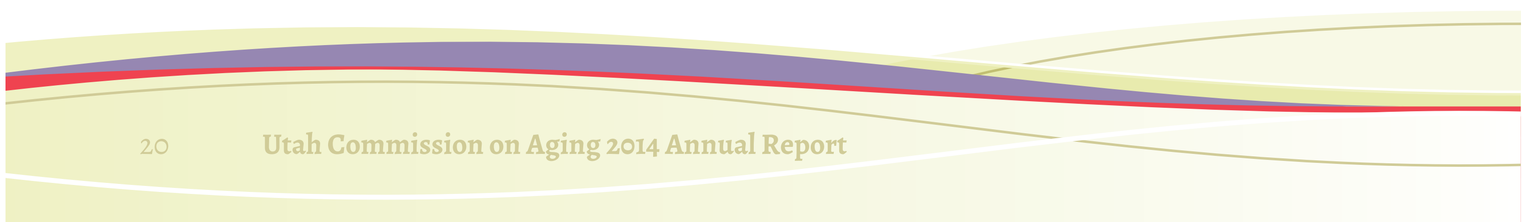
Source: BEBR analysis of Governor's Office of Management and Budget, 2012 Projections. Note: Dependency Ratios are computed as the number of nonworking age persons per 100 working age (18 – 64 years old) persons in the population.

GENERATIONAL PROPORTIONS

	Source: U.S. Census Bureau	UT	US	
1946–1964	Boomer	18.7	24.9	%
1965–1980	Gen X	20.9	21.2	%
1981–1995	Millennial	26.0	27.7	%

MEDIAN AGE

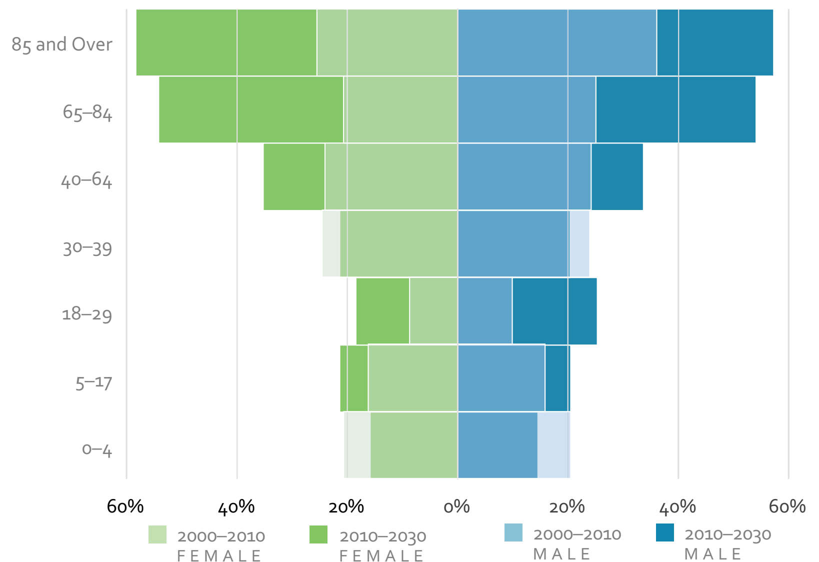
Source: U.S. Census Bureau	1990	2000	2010	2013
UT	26.3	27.1	29.2	30.2
US	32.9	35.3	37.2	37.6



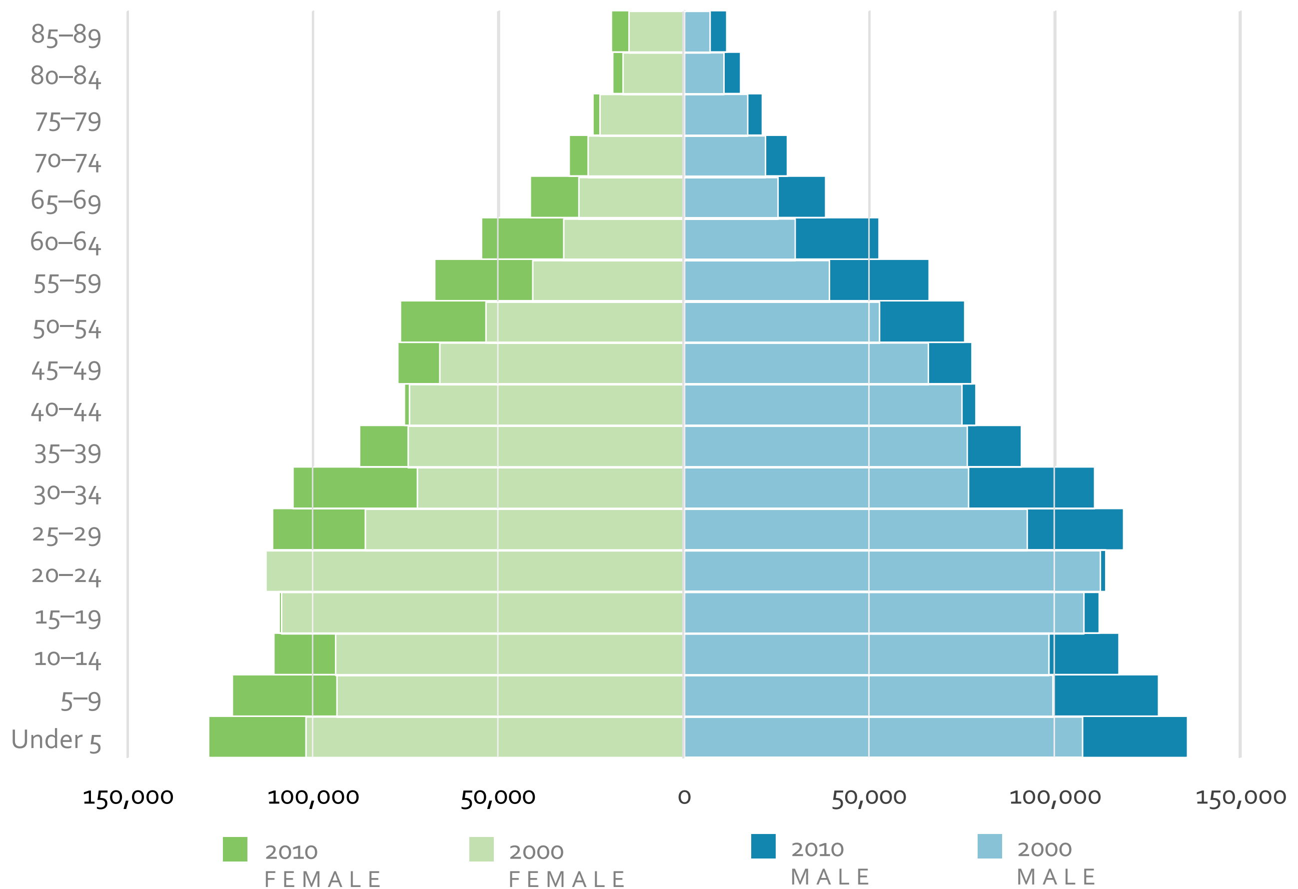
POPULATION CHANGE
2000–2010 actual and 2010–2030 Projected

(Right) The demographics seeing the highest growth rates in Utah are the 65–85 and 85+ populations.

(Below) This population pyramid shows the overall structure of Utah's population by age and the growth of those age groups in the decade between 2000 and 2010. The aging Baby Boom and 'Echo Boom' are shown as two major waves.



UTAH POPULATION BY AGE AND SEX
2000 and 2010



Source: U.S. Census Bureau. 2000 and 2010 Censuses. Bureau of Economic and Business Research

MUSIC AND MEMORY

MUSIC & MEMORY[SM] is a non-profit organization that brings personalized music into the lives of the elderly or infirm through digital music technology, vastly improving quality of life.

Image courtesy Michael Rossato-Bennett, 2012

Photo Credit: BOND360

“We Will Do This”

In January 2014, when Alive Inside was winning over Sundance audiences, at a post-screening Q&A, Deb Burcombe, Deputy Director of the Utah Health Care Association, stood up and announced, **“I represent all of the nursing homes in Utah, and we will do this!”**

In a few short months (with generous guidance from the State of Wisconsin's Department of Health Services, which has just announced expansion of their program to 275 nursing homes), a group of Utah leaders secured the funds, purchased 1,500 iPods and lined up 100 nursing homes to initiate the Music and Memory program, which brings personalized, iPod-based music to people living with dementia.

According to Dan Cohen, Executive Director of the Music and Memory Foundation, based in New York, something extraordinary happened in Utah. Not only did Ms. Burcombe see the film, but so did many of the state's healthcare, business, arts, and educational leaders. This is in no small part due to Scott Anderson's leadership and generosity and that the Executive Producer, Geralyn Dreyfous lives here and negotiated the right to have the film shown throughout the state with Zions Bank's philanthropic support. She worked with the University of Utah College of Nursing and Utah Commission on Aging to provide a free screening of the film for Careers in Aging Week in April, 2014. What resulted was establishment of the Music & Memory Coalition of Utah, spearheaded by the Commission on Aging. The group meets monthly to forge a unified, coordinated approach to implementing personalized music statewide.

Skullcandy is donating headphones, Intermountain Homecare and Hospice is rolling out a statewide hospice

Image courtesy Michael Rossato-Bennett, 2012

personalized music program, Zions Bank is funding strategic research and the Alzheimer's Association provided booths at its fall Memory Walks. The Commissioner on Aging is group convener, and Jewish Family Service, the state's first to be M&M certified, is serving as a resource for others. Their goal: permeate the state's care centers with personalized music and do it with one voice—one voice to gather donated iPods, to get students and teachers involved, to raise funds to build the program.

We are gratified to be a leader among statewide initiatives focused on improving the quality of life of elders in need with this inexpensive, practical and often powerful approach. We look forward to working with other states, regions and cities to bring the benefits of personalized music to those they serve.

Photo Credit: BOND360

The Utah Division of Aging and Adult Services is tasked with overseeing the Medicaid Aging Waiver and Alternatives Program which are carried out at the local level by county based Area Agencies on Aging.

© PhotoAlto/Alamy

Medicaid Aging Waiver and the Alternatives Program

The goal of the Medicaid Aging Waiver and Alternatives Program is to provide services for low-income, medically frail seniors that would otherwise be placed in a nursing home or care facilities enabling them to be cared for safely, independently, and cost effectively in their homes. On average, these individuals can be served at home for about one fifth the cost of nursing home placement.

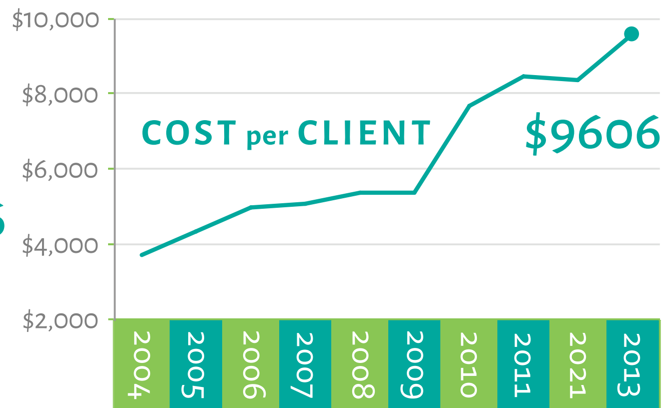
MEDICAID AGING WAIVER 1915 (c)

The bulk of the funding is overseen by the Department of Healthcare Financing. The Waiver is tasked with providing services statewide to help older adults who are nursing home eligible remain in their homes and live as independently as possible, provided it is cost effective to do so.

Eligibility Requirements

- Be 65 years of age or older
- Require nursing facility level of care approval (LOC)
- ADLs and IADLs score
- Meet financial eligibility requirements for Medicaid

	Unduplicated Clients	Average Annual Cost
Nursing Home Stay	1	**$67,343** or $184 per day
	499 (current enrollment)	**$33,604,157**
Medicaid Aging Waiver 1915(c)	1	**$9,315**
	499	**$4,648,815**



With a current waiting list averaging around 165, an increase of ongoing funding of $250,000 for the Medicaid Aging Waiver Program could serve an additional 111 Clients throughout the state.

ALTERNATIVES PROGRAM

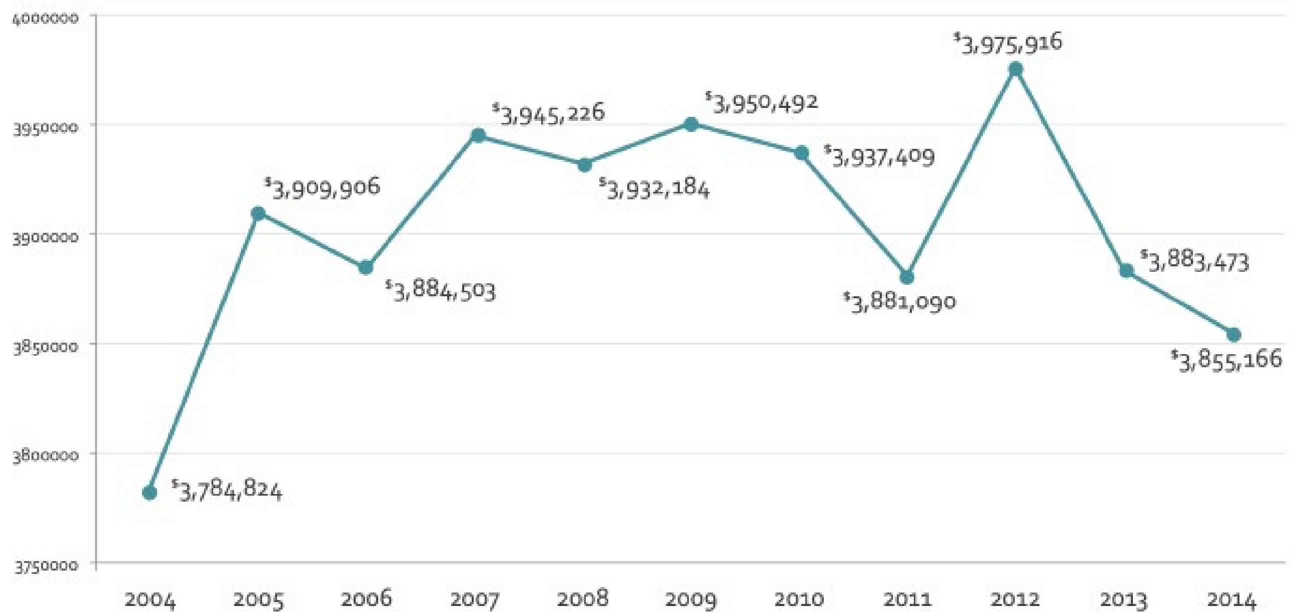
In 1977 the Older American Act allowed states to develop programs for Home Community Based Services/Supportive Services. The Alternatives Program is a state-funded, non-Medicaid assistance program. It's goal is to provide services to help older adults who are not nursing home eligible, but who are at risk for facility based care, remain in their homes and as independent as possible.

Eligibility Requirements

- 60 years of age or older, or
- 18 – 59 years of age with a disability
- Utilizes Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) score
- Meets financial eligibility based on the federal poverty level.
- Means tested—Sliding Scale

	Unduplicated Clients	Average Annual Cost
Nursing Home Stay	1	**$30,000** Cost varies
	645 (current enrollment)	**$19,350,000**
Alternatives Program	1	**$5,000**
	645	**$3,225,000**

In-Home Alternatives Expenditures FY 2004 through FY 2014



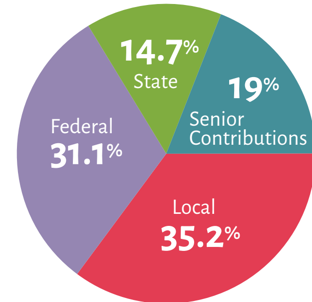
HEALTH & HUMAN SERVICES Presentation Highlights

On September 17, 2014, Utah Representative Rebecca Chavez-Houck convened a group of Aging and Adult Services stakeholders to present findings. Two major topics were nutrition and caregiver programs.

Nutrition

PROVIDING THE BASIC BUILDING BLOCKS FOR INDEPENDENT LIVING

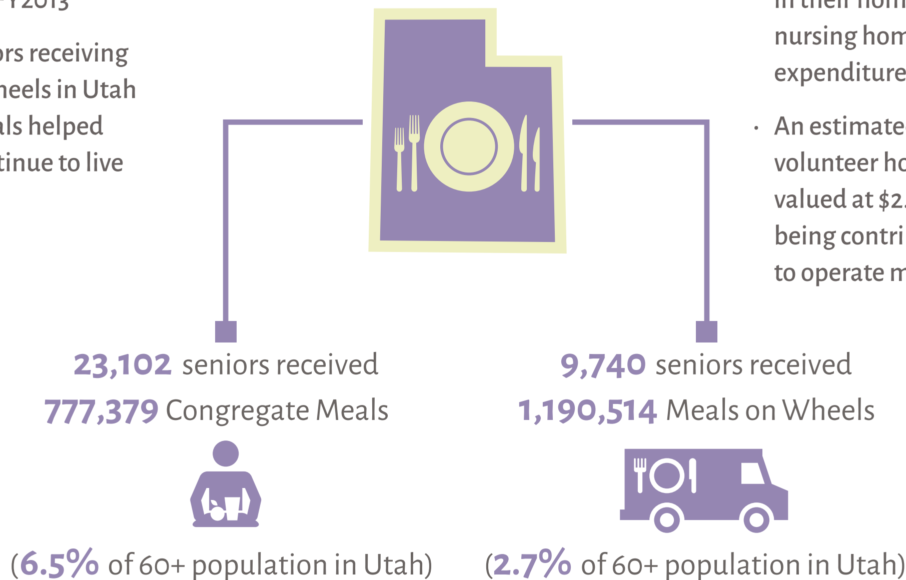
Good nutrition is the foundation upon which independent living is built. Helping seniors remain healthy and independent by providing nutrition programs, both home delivered and in senior centers, remains the highest service priority for Counties and Area Agencies on Aging.



UTAH BY THE NUMBERS

- 1,967,893 total meals provided in FY2013
- 83% of seniors receiving Meals on Wheels in Utah said the meals helped them to continue to live at home.

- Helping seniors remain in their homes saves nursing home Medicaid expenditures.
- An estimated 112,000 volunteer hours (54.0 F.T.E.s) valued at $2.5 million are being contributed each year to operate meal programs.



23,102 seniors received **777,379** Congregate Meals

(**6.5%** of 60+ population in Utah)

9,740 seniors received **1,190,514** Meals on Wheels

(**2.7%** of 60+ population in Utah)

LEGISLATIVE FUNDING REQUESTED:

$350,000 in ongoing funding for 12 local Area Agencies on Aging for Meals-on-Wheels & senior center meals for Utah's senior population.

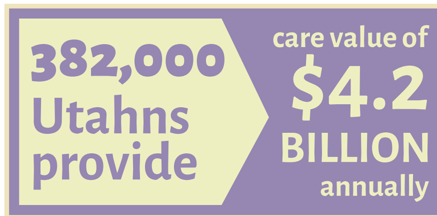
$300,000 one-time funding is in the current budget. (Without ongoing funding, 42857 meals will not be provided to approximately 285 seniors currently within the program.

Caregiving

SUPPORTING CAREGIVERS HELPS US ALL

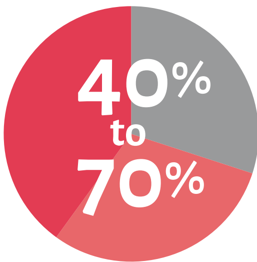
Support provided to caregivers helps them continue to act in their role of meeting the long-term care needs of their loved ones, at home, reducing taxpayer expenses today and in the future.

Unpaid caregivers are meeting 90% of long-term care needs. The typical caregiver is a 46-year-old female providing more than 20 hours of care each week.

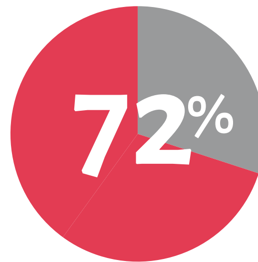


Local survey of Caregiver needs:

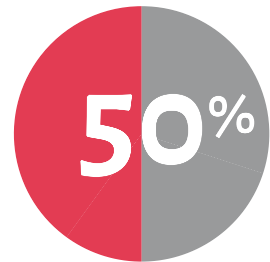
- **65%** had been a caregiver for 3–10 years.
- **53.7%** listed respite care as the most needed service.
- **60.3%** requested education and information on caregiving.
- **82.5%** are caring for their spouse or parent.



of caregivers have clinically-significant **SYMPTOMS OF DEPRESSION**.



of caregivers said they **DO NOT GO TO THE DOCTOR** because they put their family's needs first.



of caregivers said they were **TOO TIRED TO TAKE CARE OF THEMSELVES.**

LEGISLATIVE FUNDING REQUESTED:

$250,000 for 12 local Area Agencies on Aging to provide respite care, information, and support activities to caregivers.

(Add to Base Budget of Aging & Adult Services—Human Services Department)

CoA Management and Leadership

ANNE ELIZABETH PALMER, ED.D., M.P.A.

Executive Director - Utah Commission on Aging

Anne Elizabeth Palmer, Ed.D., M.P.A., serves as the Executive Director of the Utah Commission on Aging. She is the founding director of the Osher Lifelong Learning Institute, which provides education to citizens age 50 and older. She was appointed to the Utah Commission on Aging in 2005. Needs identified through her committee laid the groundwork for establishing the Utah Aging & Disability Resource Connection. Anne completed her Doctorate in Education in 2009 at the University of London Institute of Education, studying international dimensions of lifelong learning. Her masters degree is in Public Administration, and her bachelor degree is from the University of California, Berkeley.

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HOLLY ABEL, B.A.

Program Coordinator - Utah Commission on Aging

The Commission on Aging welcomed Holly Abel as Administrative Program Coordinator in 2013. Holly has over eight years administrative experience at the University of Utah. She has worked previously in the departments of Biomedical informatics and Pharmacotherapy. Holly holds a bachelor degree in Music with Vocal Performance emphasis from The University of Utah School of Music. She coordinates the administrative needs of the Commission.

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JENNIFER MORGAN, B.S.

Director - Utah Aging & Disability Resource Connection

As Director for the Utah Aging and Disability Resource Connection, Jennifer Morgan works closely with the seven ADRC sites for data collection, data reporting protocols, and on-going options counseling training. She serves on multiple community partner steering councils. In this past grant year she implemented an Options Counselor Coordinator program, organized an ADRC dedicated Medicaid Outreach Worker, coordinated with ADRC Program Evaluators, evaluated the readiness assessment for Five County AAA, and collaborated on the ADRC VA Office of Rural Health proposal and pilot project.

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RHONDA HYPIO, B.S.

Program Coordinator - Utah Aging & Disability Resource Connection

Rhonda Hypio is the new Program Coordinator, working closely with the Director, assisting with all the daily functions at the ADRC program office. She has over 10 years of experience working with state and federal programs, constituent affairs, and the aging population. Rhonda holds a Bachelor of Science in Business Administration, with emphasis in Information Systems and Technologies from Weber State University.

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