



2018 **AGING**



Innovations &
Achievement
AWARDS



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National Association of Area Agencies on Aging



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About n4a

The National Association of Area Agencies on Aging (n4a) is a 501(c)(3) membership association representing America's national network of 622 Area Agencies on Aging (AAAs) and providing a voice in the nation's capital for the more than 250 Title VI Native American aging programs. n4a's primary mission is to build the capacity of our members so they can help older adults and people with disabilities live with dignity and choices in their homes and communities for as long as possible.

For more information about n4a, AAAs or Title VI programs, visit www.n4a.org.

n4a's Aging Innovations and Achievement Awards staff:

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About WellCare

Headquartered in Tampa, FL, WellCare Health Plans, Inc. (NYSE: WCG) focuses exclusively on providing government-sponsored managed care services, primarily through Medicaid, Medicare Advantage and Medicare Prescription Drug Plans, to families, children, seniors and individuals with complex medical needs. WellCare has served approximately 4.3 million members nationwide as of March 31, 2018.

WellCare has developed a full complement of expertise in three major areas of government-sponsored health care: Medicaid, Medicare Advantage and Medicare Prescription Drug Plans. Leveraging our expertise is a key part of the value we bring to our members. We are committed to continually improving the quality of care and service we provide to our members, helping them access the right care at the right time in the appropriate setting.

WellCare Leadership:

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Cindy Hatcher, Vice President, Product

Audrey Haynes, Vice President, Market Government Affairs

INTRODUCTION



A handwritten signature in black ink that reads "Kathryn C. Boles".

Kathryn C. Boles
n4a President, 2016-2018



A handwritten signature in black ink that reads "Sandy Markwood".

Sandy Markwood
n4a CEO

Every year, the National Association of Area Agencies on Aging (n4a) proudly recognizes the innovative programs and best practices of our members through the *n4a Aging Innovations and Achievement (AIA) Awards* program. This publication is a comprehensive listing of the 45 programs earning Awards in 2018.

It is thanks to our partnership with WellCare that we have this opportunity to honor and showcase the initiatives of Area Agencies on Aging (AAAs) and Title VI Native American aging programs across the country.

We salute all those who have enhanced the prestige of this awards program by sharing their initiatives with their peers in the Aging Network. This sharing of cutting-edge concepts, best practices and innovative ideas helps inspire others, seed replication and ultimately, boost the capacity and success of all agencies.

The awards highlight leading-edge and successful programs that demonstrate sound management practices that are replicable by others in the Aging Network. They exemplify both traditional and new strategies in a range of categories including Advocacy, Agency Operations, Care Transitions, Caregiving, Community Planning & Livable Communities, Diversity & Cultural Competency, Elder Abuse Prevention, Health-LTSS Integration, Healthy Aging, Home & Community-Based Services, Information & Referral/Access to Services, Intergenerational Programs, Nutrition, Social Engagement, Technology, Transportation & Mobility and Workforce Development.

Aging Innovations Awards honor the most innovative programs among all nominations received and **Aging Achievement Awards** recognize programs that meet all of the award eligibility criteria as a contemporary, effective and replicable program.

Annually, the awards are presented at a luncheon held during the n4a Conference & Tradeshow. This year in Chicago, IL, 16 programs were honored with engraved Aging Innovations Awards and 29 received Aging Achievement Awards with a certificate of recognition. In addition, through the generous support of WellCare, the top-ranking programs received monetary awards.

To qualify for an award, programs must have been in operation for between one and five years, receive minimal assistance from outside experts and demonstrate effective approaches in either offering new services or improving existing services. Awards criteria include demonstration of measurable results, e.g., cost savings, improved client service and enhanced staff productivity. The AIA awards are open to n4a members only.

Highlights of all past Aging Innovations Award recipients are available in the n4a member-only clearinghouse of best practices at www.n4a.org/bestpractices.

We hope that these award-winning programs will inspire your efforts as you address current challenges, seize opportunities and implement solutions in your community. And remember, plan to share your innovations with us next year!

“ WellCare is pleased to support n4a’s Aging Innovations and Achievement Awards program, which recognizes the work Area Agencies on Aging do to serve older adults, people with disabilities and caregivers with innovative, successful programs designed to fill gaps in services and meet the critical needs of consumers in communities across the country. We salute this year’s winners for sharing their secrets to success with their peers, helping grow the AAA network’s capacity and responding to the incredible demographic changes ahead.”

*Pamme Taylor
Vice President, Center for Community Impact
WellCare*

n4a Aging Innovations Award Winners

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2018 Aging INNOVATIONS Awards

CAREGIVING

CareAware: Help and Hope for Family Caregivers

CICOA Aging & In-Home Solutions

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The six-part video series “CareAware: Help and Hope for Family Caregivers” features interviews with local subject matter experts and real-life caregivers who provide insights and practical advice on how to take care of yourself while also caring for loved ones. Topics covered in the series include: the journey of caregiving; key legal documents and advance directives for end-of-life care; dealing with negative emotions; preventing caregiver burnout; physical, emotional and financial abuse; and available community resources.

The series was produced in 2016 by CICOA Aging & In-Home Solutions to increase support for the growing population of family caregivers in Central Indiana. The video series is accompanied by a workbook and promotional resources for support group leaders, all of which are available at careawarejourney.org.

Budget:

The series cost roughly \$70,000 to produce, including costs for filming, editing, graphic design, DVD duplication, mailing and distribution. In 2017, CICOA received an additional \$5,000 from the Alzheimer’s Foundation of America to reprint materials and develop a standalone website. Costs do not include in-kind support from subject matter experts or support group volunteers.

Accomplishments:

To date, 982 individuals have registered to view the series online, and it has been shared with the other 15 Area Agencies on Aging in Indiana as well as many community groups, faith partners, businesses, libraries, hospitals and senior centers. CICOA also was awarded a Google grant to promote the series for free.

Replicability:

The videos are available for free for private, non-commercial use. Caregivers and caregiver support groups can access the resources online.



COMMUNITY PLANNING & LIVABLE COMMUNITIES

Appalachian Agency Senior Living Community Appalachian Agency for Senior Citizens

Appalachian Agency Senior Living Community provides safe and affordable housing to help reduce the isolation experienced by senior citizens and adults with disabilities living in rural areas. Renovated, accessible homes owned by the agency in a local mobile home park are reserved for low-income seniors with risk criteria such as health issues, homelessness or extreme isolation.

The main office complex houses an adult day care center, a childcare center, County Transit offices, AllCARE for Seniors (a Program of All-Inclusive Care for Seniors, or PACE program) with an onsite medical and physical therapy clinic, and administrative and program offices. Services that help meet residents' needs onsite and enrich their lives include housekeeping and personal care, medication management, assistance in enrolling in Medicare, emergency services, educational services, nutrition assistance, guardianship services, PACE services, a community garden and accessible transportation.

Budget:

Up-front costs involved the purchase and renovation of units to make them accessible. Repair and maintenance costs vary. Last fiscal year operational costs were \$50,000 and income was \$70,000.

Accomplishments:

Currently the agency owns 11 homes in the 32-spot mobile home park. Two-thirds of the residents in the park are age 55 and older. Future plans include constructing a community center onsite.

Replicability:

Replication may be easy for agencies that operate PACE programs and own or are in close proximity to housing complexes. Otherwise, developing partnerships with housing and other service providers is essential. Transportation, medical and nutrition services, and opportunities for community activities need to be incorporated into the design of the senior living community.

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COMMUNITY PLANNING & LIVABLE COMMUNITIES

Lifelong Housing Project

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Lifelong Housing Project (LLH Project) makes it possible for seniors in Southern Oregon to live in their own homes and communities for the rest of their lives by increasing the supply of and demand for housing that meets residents' needs.

The project offers a Lifelong Housing checklist of features for remodeled and new homes, provides targeted education to homeowners and professionals, and offers a certification program so accessible homes can be identified as such when they are being sold. Exhibits at the annual Home Show, seminars and presentations to civic groups further expand awareness of the LLH Project.

Budget:

The development of the LLH Project cost about \$4,500 a year in staff time. Implementation costs are about \$3,000 per year. Agencies seeking to replicate the project should figure a base monthly cost of at least four hours to facilitate meetings, plus additional time for community research and outreach in the first year.

Accomplishments:

Each year, more families who are preparing for relatives with disabilities to live with them request the checklist at the Home Show. To date, 55 homes in Oregon and one in Arkansas have been certified. AARP regularly features the LLH Project in its national Livable Communities publications. The Real Estate Standards Organization has adopted LLH Project descriptions of accessible features into its Data Directory.

Replicability:

This project was created with replicability in mind. A toolkit is available for community organizations that wish to create an LLH Project. Soon a toolkit will be available for professional inspectors who want to add LLH certification to their business offerings.

ECONOMIC SECURITY

Older Workers Employment Program

City of Los Angeles Department of Aging

As the number of homeless people age 55 and older increases, the City of Los Angeles Department of Aging developed the Older Workers Employment Program (OWEP). The new paid, on-the-job training program is designed to meet the unique needs of homeless older adults. Clients earn a paycheck, acquire new job skills, including state-of-the-art training in the growing digital print media industry, gain access to temporary and permanent housing, and are connected with supportive services. Participants are trained and supervised by policy staff in the Mayor's Office of Economic Opportunity, Homeless Services.

Budget:

The total annual budget for OWEP is \$450,000, all of which is directed to participant wages. The City of Los Angeles has leveraged existing staff to build the program thus far, though additional funds for staff will be necessary as the program grows.

Accomplishments:

In 20 months, OWEP has served 103 older adults. Nine participants have secured unsubsidized employment, 12 have secured permanent housing, 11 participants with disabilities secured transportation and clothing vouchers worth \$650, four OWEP participants now work at the Homeless Help Desk at City Hall, and all participants have received AAA supportive social services.

Replicability:

To replicate this program, it is necessary to have staff dedicated to "doing what is needed" and the funding to cover participant wages. The City of Los Angeles is willing to provide support for those who wish to replicate this program.

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ELDER ABUSE PREVENTION

Awakenings Victim Outreach

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Awakenings Victim Outreach is a unique program designed to offer supportive services to older adults and individuals with disabilities younger than the age of 60 who have been victims of crime or who self-neglect. The program meets individuals where they are in their victimization/trauma by holistically addressing their needs and assisting them to the point where they feel empowered and in control of their lives again.

Supportive services include temporary food assistance, short-term crisis counseling, temporary emergency housing, transportation, and information and referral services. Additionally, through a collaboration with Adult Protective Services, Awakenings assists in removing barriers (such as bed bugs) that prevent elders from receiving in-home services. Community education assists people who work with these populations in identifying potential red flags of abuse and guiding victims to resources.

Budget:

Primary funding is provided by a federal Victims of Crime Act grant. Support is provided through the local United Way and state foundations. Older Americans Act and state Community Services funds assist with direct services and staffing costs.

Accomplishments:

The number of program participants increased from 82 in 2015 to 195 in 2016. Since 2016, 1,297 individuals in the community including elders, banking professionals, nursing home staff and church leaders have been educated. Recently the agency rolled out a sister program, Stages Behavioral Health, for individuals age 60 and older who are in need of short-term counseling.

Replicability:

This program is highly replicable through collaboration between Area Agencies on Aging, Adult Protective Services and other agencies. Creativity with sources of funding is critical. Victims of Crime Act funding may be available from state Attorneys General.

HEALTH-LTSS INTEGRATION

Dementia Care Coordination Program

Jefferson Area Board for Aging (JABA)

The Dementia Care Coordination Program is an innovative integrated and coordinated care system for individuals living with dementia, their families and caregivers. This model was created by the Jefferson Area Board for Aging (JABA) in association with the University of Virginia's Memory and Aging Care Clinic and Virginia's Department for Aging and Rehabilitative Services.

The three-year pilot program will result in a replicable best practice for dementia care coordination. Care Coordinators (CCs) with backgrounds in health/social work and aging undergo a specialized 30-hour training before working intensively with caseloads of 50 families each. CCs provide long-term coordinated care including options counseling, education on dementia, behavioral symptom management training and eligibility assistance.

Budget:

Total operating costs for FY 2017 of \$156,980 include salary and fringe benefits for two care coordinators (\$98,000), salary and fringe benefits for one half-time supervisor (\$29,400), supplies/materials/printing costs (\$3,000), postage (\$300), training (\$500), equipment/computer (\$2,000), mileage reimbursement (\$6,000), and administration and support costs (\$15,000).

Accomplishments:

Outcome measures will be analyzed at the conclusion of the pilot in August 2018. Outcomes are measured by a 20-item satisfaction survey completed by individuals and primary caregivers. In addition, care coordination participants are asked to complete measures of hospital utilization, depression, behavior and neurological symptoms, functioning and quality of life when they join the program and at annual follow-ups.

Replicability:

The goal of this pilot is to produce a replicable best practice for care coordination for individuals with dementia and their caregivers. A replication manual will be publicly available at the conclusion of the pilot.

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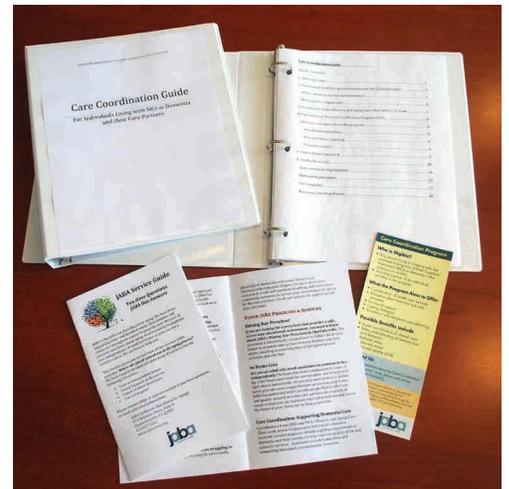
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HEALTHY AGING

Geriatric Mental Health (DGMH)

New York City Department for the Aging

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Many barriers prevent seniors from seeking, accessing and utilizing mental health services, particularly among culturally diverse elders. Access to quality mental health care requires bilingual/bicultural clinicians who first can provide effective engagement, outreach and education to introduce and destigmatize mental health. This innovative program breaks down silos of care, embedding mental health in communities where seniors are most comfortable.

This onsite mental health model, provided at 25 senior centers across all New York City boroughs, includes individual, group, family, couples therapy as well as medication management with bilingual/bicultural clinicians (English, Cantonese, Mandarin, Polish, Spanish, Russian). Clinicians become part of the fabric of the center, decreasing stigma and promoting mental health assistance.

Budget:

This program has \$1.4 million in annual baseline funding. Funds are used to contract with four mental health organizations that recruit, hire and supervise onsite clinicians. A blended funding model draws down dollars from Medicaid, Medicare and other insurances for the services.

Accomplishments:

More than 46,420 seniors have been reached in 25 centers. Of 1,145 people screened, more than 45 percent scored positively for mental health problems, with 250 receiving clinical services, indicating a need beyond what is normally seen in community seniors. Center directors indicate the positive impact of having onsite services.

Replicability:

The program can be replicated by other Area Agencies on Aging seeking to meet the health needs of older adults from diverse cultures. Breaking down silos of care requires collaboration with community mental health partners. Financial support for engagement programs/activities that destigmatize mental health treatment is essential.



Sustainability Through Medicare Billing for the Living Well DSMP

Prince George's County Area Agency on Aging

The evidence-based Living Well Diabetes Self-Management Program offers workshops that incorporate the needs, goals and life experiences of the individuals with diabetes and their caregivers. The workshops focus on techniques for dealing with diabetes, appropriate exercise, healthful eating and appropriate medication use. They complement existing programs and treatments to support informed decision-making, self-care behaviors, problem-solving and active collaboration with the patient's health care team.

The program has been funded periodically by federal and state grants but has not had a sustainable funding source. To address this issue, Prince George's County became the first Area Agency on Aging in Maryland to undergo the accreditation process through the American Association of Diabetes Educators, which allows the AAA to seek reimbursement from Medicare. The ability to bill for services ensures sustainability of the program.

Budget:

The AAA's budgeted expenses are \$79,000 before Medicare reimbursement. Program income is available after approved budgeted expenses are paid; distribution of revenue is 75 percent to the AAA and 25 percent to the Medicare biller.

Accomplishments:

A primary accomplishment to date is the completion of the accreditation process that results in Medicare reimbursement. Program-wise, the AAA collects and evaluates two clinical measures (A1C and BMI), both of which improved in participants as a result of the program.

Replicability:

The AAA wrote a "How To" manual for Diabetes Self-Management Program Medicare Billing and a policy and procedures manual for program administration. Both manuals are available for other AAAs to use when seeking Medicare reimbursement. Two recorded webinars are also available.

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HEALTHY AGING

PAWS (Pets Are Wonderful Support), a Shanti Program

San Francisco Department of Aging and Adult Services

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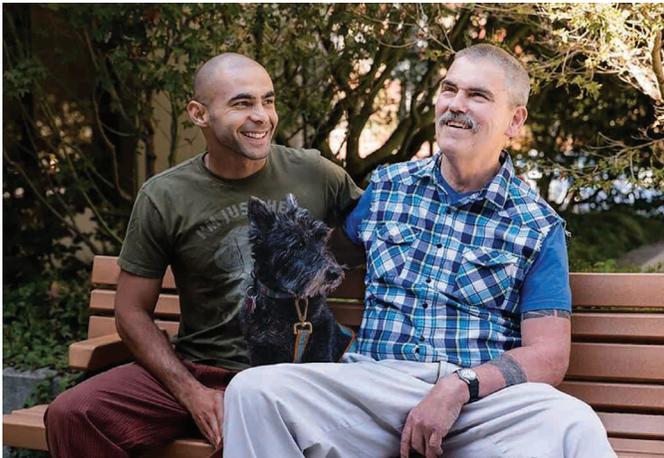
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Medical evidence demonstrates the link between pet ownership and improved or stabilized health, particularly for seniors who are ill, frail, isolated or face discrimination and prejudice. The Pets Are Wonderful Support (PAWS) program was designed to alleviate the heightened risks faced by the LGBT aging and disability community in San Francisco.

The program uses a combination of care navigation, peer/volunteer support and pet care services to assist clients and their pets. The pet is often an entry point for a relationship between the PAWS program and clients, which results in a level of trust that enables the Care Navigator to offer additional case management services to pet owners.



Budget:

For FY 2016/2017, program costs of \$275,000 included staffing for supervision, Care Navigator staff, peer recruitment and the purchase of pet care services. Additional costs for pet food and supplies were covered by donations from the public, pet-related businesses and other organizations.

Accomplishments:

The program provided services to 56 clients and 798 hours of care navigation in FY 2016/2017. The 35 volunteers who were recruited and trained provided 3,477 hours of peer support. According to annual survey responses, participants reported a high satisfaction with the program and that they are more socially engaged, less isolated and more able to live independently due to program interventions.

Replicability:

Existing case management and volunteer programs can be used to replicate PAWS. Some dedicated funding and staff resources are needed to develop veterinary relationships, obtain pet supply donations, and recruit and train volunteers.

Stepping Up Your Nutrition: A Malnutrition Risk Workshop

Maryland Living Well Center of Excellence, Maintaining Active Citizens (MAC), Inc.

Stepping Up Your Nutrition (SUYN) is an innovative, interactive workshop to help older adults remain independent and prevent malnutrition and falls risks. Topics addressed through role-playing, problem-solving activities and planning tools include how nutrition and muscle strength impact falls risks, the use of fluids and protein to maintain strong muscles and ways to reduce falls risks.

The workshop is delivered by peers trained in evidence-based programs and is designed as a “session zero” before falls prevention or disease self-management programs. Participants follow a patient named Mary’s nutrition risk assessment and identify what she is doing right and what makes her at risk for malnutrition, before completing their own nutrition assessment and tasting protein-rich foods and drinks.

Budget:

Total costs for FY 2017 of \$10,263 include curriculum/leader training development for pilot workshops (\$2,720), leader training (\$925) per training, workshop costs including handouts and manuals (\$1,200 for 10 workshops), protein snacks for workshops (\$300 for 10 workshops) two leaders/workshop implementation (\$1,000 for 10 workshops), printing (\$2,100), overhead (\$768), data setup/entry (\$1,000) and data entry/reporting (\$250 for 10 workshops).

Accomplishments:

Five pilot session workshops with 75 attendees have been held in three counties. In an evaluation of 48 participants, 96–100 percent strongly agreed that they understand how nutrition and muscle strength are linked to falls risk; how to improve their nutritional status; and how to achieve their protein and fluid goals.

Replicability:

An interactive online leader training is being developed over the next year based on leader training/program implementation interviews and participant survey outcomes. Participating agencies need to ensure they identify and link to resources such as food banks, farmers markets, home-delivered meals and nutrition counseling. The workshops are more effective when Area Agencies on Aging establish referral relationships with health care providers.

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HOME & COMMUNITY-BASED SERVICES

Linkages to Senior Housing

Sonoma County Area Agency on Aging

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The Senior Homeless Prevention Program was developed to address a housing crisis facing older adults in Sonoma County. This pilot project focuses on stabilizing housing for vulnerable seniors through a comprehensive case management model. The program includes two social workers, a housing needs fund, money management services, two beds at an assisted living/residential care facility, shared housing services, rental assistance and housing vouchers.

Individuals referred for these services have intensive case management needs and require a high number of home visits and telephone contacts. The focused care manager and community resources assist in addressing each older adult's unique housing needs.

Budget:

Annual program costs of approximately \$1,000,000 include personnel (social worker and money manager, \$200,000 total), contracts for assisted living beds (\$108,000), rental subsidies (\$20,000), the SHARE Program for shared housing (\$45,000), purchase of services (\$50,000) and 10 in-kind housing vouchers from the Community Development Commission (approximately \$500,000).

Accomplishments:

In the program's first year, 71 percent of clients served had their homelessness risk reduced. Ten evictions were rescinded or avoided, nine clients received vouchers for permanent affordable housing, four clients were placed in SHARE rentals and three clients were sheltered at an assisted living facility. Additionally, 17 clients received Legal Aid advocacy and 26 clients received money management services to secure existing or new housing.

Replicability:

Case management services are built on Linkages, the Older Americans Act (Title III B) case management program in Sonoma County. Other communities can replicate a similar program by partnering with their local Community Development Commission, Legal Aid, money management programs, shared housing agency and other partners.

Peer Mentor Program

AgeOptions

The AgeOptions Transition Engagement Program assists people who are living in nursing homes to relocate to a community-based living setting of their choice. An essential component of the program's success is the Peer Mentor Program, which enlists former nursing home residents who have successfully transitioned to independent community living to serve as ambassadors and motivators to the nursing home population.

The Peer Mentors' own experiences in nursing home settings inspire them to share with current nursing home residents who have the potential to thrive in the community. The Peer Mentors believe that although the nursing home is where they started, it does not have to be where they stay. AgeOptions Transition Engagement Specialists collaborate with the trained Peer Mentors to help residents meet their goals to transition.

Budget:

The annual budget of \$4,000 includes a \$50 Peer Mentor stipend for each outreach activity, transportation, background checks and monthly focus groups with lunch. Personnel and overhead are included in another program budget.

Accomplishments:

As a result of the Peer Mentor Program, more nursing home residents have been motivated to seek housing outside of a nursing home setting and an increased number of nursing home residents have successfully transitioned to living in the community. The Peer Mentors also are thriving by living independently and giving back to their community.

Replicability:

Replicating this program involves recruiting individuals who have been successful in the program to serve as Peer Mentors. Resources needed include training manuals for Peer Mentors and supporting staff, transportation services and training on public speaking for Peer Mentors.

CONTACT:

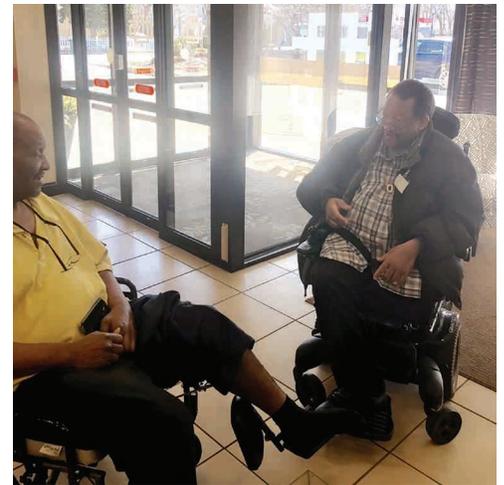
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HOME & COMMUNITY-BASED SERVICES

Rise & Shine for Mini Grants and Crisis Funds

Senior Connection Center, Inc.

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Rise & Shine Awards Breakfast combines a celebration of the accomplishments and contributions of local seniors with education on the unmet needs of elders in the community and the services offered by Senior Connection Center. Funds collected at the event are used for two newly created initiatives.

The first, Mini Grants, are awarded to organizations to leverage their existing resources to help vulnerable seniors. The second, a Crisis Fund, provides one-time assistance to seniors or adults with disabilities who have encountered an emergency or crisis for which there are no other community resources available. Elder Helpline staff are trained to identify and refer clients for grant funding.

Budget:

Costs to host Rise & Shine are approximately \$11,000. Approximately 200 staff hours are devoted to planning and hosting. Staff time to process Crisis Fund applications is approximately two hours. For Mini-Grant applications it is approximately 20 hours. No salaries for staff time are taken from funds raised.

Accomplishments:

Through the four Mini-Grants, local nonprofits have leveraged volunteer support and donations to build 26 wheelchair ramps and seven sets of half-height stairs. In addition, 85 clients received emergency food supplies, 336 were given emergency food boxes, 500 received home-delivered meals after Hurricane Irma, 38 received utility bill payment assistance and 248 received SNAP application assistance. The Crisis Fund provided 20 seniors or adults with disabilities with one-time assistance for transportation, utility payments, pest control services and appliance repairs.

Replicability:

The first step is creating an event to showcase the agency and raise funds. Costs can be offset with ticket sales and corporate sponsorships. The creation of videos to show attendees the impact of the donations can inspire further giving.

INFORMATION & REFERRAL/ACCESS TO SERVICES

EmPowerment: Emergency Readiness for Older Adults

Arlington Agency on Aging

The EmPowerment program was developed to hear from older adults about their needs and concerns related to emergency preparedness and to assist them in planning for the unexpected. In September 2017, the program was held at an affordable senior independent residence in conjunction with Emergency Preparedness Month.

Through a collaboration with the Office of Emergency Management, local fire departments, the American Red Cross and the Animal Welfare League, residents met with representatives from their local fire department, participated in interactive activities and received a Red Cross ready kit with emergency drinking water, flashlight, poncho, food rations, whistle, blanket and other supplies. An onsite interpreter translated information to Spanish for non-English speaking residents.

Budget:

Costs include Area Agency on Aging staff time. Approximately \$200 was spent on printing materials and light refreshments. A grant from the local Red Cross was used to purchase ready kits for each resident.

Accomplishments:

Hosting the event at an affordable senior residence increased the number of attendees. Nearly all attendees described the event as excellent in a follow-up survey. Many responded that they would use the materials to help them plan for an emergency and that they would create or update their emergency plan. Partners at the event were able to gain feedback from older adults.

Replicability:

Any AAA can replicate these efforts with public and private partnerships. Most local emergency information management offices and fire departments are seeking opportunities to engage with the community. Resources are also available from the U.S. Administration for Community Living, U.S. Department of Health and Human Services and www.ready.gov.

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Arlington Agency on Aging

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TRANSPORTATION & MOBILITY

Mountain Empire Older Citizens Mobility Vision

Mountain Empire Older Citizens, Inc.

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Mountain Empire Older Citizens, Inc. (MEOC) offers an innovative approach to transportation assistance specifically aimed at the needs of older adults, people with disabilities and veterans who must attend frequent health appointments. Through the organization's Mobility Manager, Care Coordination staff and transportation aides, MEOC identifies patients who have special needs and provides extra attention to riders requiring additional assistance or who have weak or non-existent support systems.



Transportation assistance offers door-to-door, door-through-door and on-board assistance, thanks to volunteers or paid aides. Such a service is particularly important, for instance, for dialysis patients who are exhausted after more than four hours of treatments or patients who have lengthy travel to and from rural areas.

Budget:

The National Aging and Disability Transportation Center (a partnership of n4a, Easterseals and the Federal Transit Administration) provided a \$47,215 one-year grant for operating expenses, of which 81 percent was for personnel. This allowed MEOC to lay the groundwork for a successful program.

Accomplishments:

The program has provided 750 one-way trips to medical appointments for individuals with chronic conditions. Of those trips, 150 were for individuals needing assistance from an aide. One hundred of the riders were identified as having little or no supports at home. Also during the year, 3,600 one-way dialysis trips were also provided, an increase of 20 percent over the year before. These rides enabled some individuals to maintain their quality of life by remaining in their homes while attending necessary medical appointments.

Replicability:

This process can be duplicated in any community that develops a volunteer system. Organizations must make their case to the community and elected officials and promote the concept of neighbors helping neighbors.

WORKFORCE DEVELOPMENT

Primary Care Liaison: Bridging Clinical and Community Environments

Area Agency on Aging and Disabilities of Southwest Washington

With an increasing population of older adults comes an increased need for geriatrics expertise from primary care providers and their teams. The Area Agency on Aging and Disabilities of Southwest Washington (AAADSW) collaborated with the Northwest Geriatrics Workforce Enhancement Center and Aging and Disability Services to design and implement a new Primary Care Liaison (PCL) role.

The PCL provides targeted outreach and ongoing support to health care providers in AAADSW's service area. The PCL also coordinates a AAA-based practicum, educating family medicine residency trainees on the Aging Network and best practices for connecting their patients to community resources.

Budget:

Primary costs for this initiative involve staff time for program development and coordination. The approximate annual budget of \$91,670 for the PCL role includes salary (\$46,643), fringe benefits (\$31,228), travel (\$1,242), supplies (\$600) and indirect administrative costs (\$11,957).

Accomplishments:

The PCL developed and implemented a referral form and standardized process that led to more than 3,000 referrals from health care providers. A AAA-based practicum has offered 48 four-hour mini internships enabling 29 physician trainees to shadow AAA staff. One family medicine residency clinic made more than 500 referrals as a result of the practicum.

Replicability:

Implementing the PCL role requires a staff member trained in Aging Network services as the single point of contact, six to nine months for program development, \$100,000 for PCL wages and related costs, partnerships with AAAs with established PCLs for technical assistance, and a commitment to a minimum of three years to establish and embed the PCL role in the AAA.

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2018 Aging **ACHIEVEMENT** Awards

ADVOCACY

Your Vote Counts!

Aging Ahead

Your Vote Counts! mobilized Silver Haired Legislature (SHL) volunteers to provide accurate and up-to-date voting information to homebound older adults who were receiving home-delivered meals. SHL volunteers provided specifics on how to register and vote absentee through a collaboration with local government offices and the League of Women Voters.

Budget:

Costs are minimal for this volunteer-driven program. The inaugural session cost (\$3,504.50) included about 60 hours of in-kind SHL volunteer time (worth \$2,640), printing costs (\$555.70) and postage (\$308.80).

Accomplishments:

Of the 2,700 flyers distributed to clients receiving home-delivered meals, 193 (seven percent) returned the tear-off portion of the flyer requesting information on additional services. Half of the seniors requesting assistance were already registered to vote. Approximately 50 percent more successfully registered to vote through the project and 88 percent successfully voted by absentee ballot. Of the 68 clients who completed a survey, 98 percent found the information easy to understand and 64 percent were able to share the information they learned with others.

Replicability:

The project is easily replicable because it uses existing relationships with homebound individuals who are already receiving services.

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AGENCY OPERATIONS

Electronic Performance Appraisal Tool

Senior Services of Southeastern Virginia

The Electronic Performance Appraisal Tool (EPAT) uses a familiar, user-friendly platform—Survey Monkey—to simplify the employee evaluation process for staff and supervisors at Senior Services of Southeastern Virginia, while simultaneously enhancing performance measurement through customized questions for each department, position and employee. EPAT provides a logical and fair basis for allocating salary increases; reduces employee/supervisor anxiety during evaluation interviews; and promotes job satisfaction.

Budget:

Implementation and operating costs of \$818.60 include a Survey Monkey subscription (\$288 per year) and personnel time for building the system (\$530.60). This breaks down to a cost of only \$7.72 per employee.

Accomplishments:

The EPAT's effectiveness is measured through satisfaction surveys, which found that 35 percent of respondents strongly agreed and 41 percent agreed that EPAT measured their job performance more accurately than the previous system, and 41 percent strongly agreed and 37 percent agreed that overall EPAT is more effective than the previous system.

Replicability:

This tool is easily replicated, with minimal expense beyond the initial setup of 20 hours for one employee. Technical support is available for other agencies interested in adopting EPAT.

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CAREGIVING

Loudoun County Caring for the Caregiver Program

Loudoun County Area Agency on Aging

The Loudoun County Caring for the Caregiver Program is a holistic, high-impact, multifaceted, person-centered approach to improving caregivers' emotional, physical and social well-being through sessions that caregivers and their loved ones attend together. Through education, support groups, disease self-management programs and a companionship-promoting book club, caregiver attendance has increased by 336 percent.

Budget:

The program is funded by the Area Agency on Aging and Older Americans Act Title III E. Startup costs are primarily an investment of time. Ongoing support is approximately 10 hours per program. Donations, sponsorships and local funds are also used. Actual costs for lunch and marketing are budgeted at \$300 per month.

Accomplishments:

More than 1,300 caregivers have been served and 64 caregiver sessions have been held since the program began in 2014. Eighteen people now regularly attend the support group. Survey results indicate high satisfaction levels.

Replicability:

The program is easily replicated and highly sustainable. Materials (marketing, curriculum, evaluations) can be replicated by other AAAs, which may wish to partner and share resources with local senior and adult day centers.

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Relative Caregiver Support Group Thrive Alliance

Thrive Alliance developed a support group for relatives raising family members' children to ensure they focus on their own health and can connect with others who are experiencing similar challenges. The monthly meetings include an educational seminar, therapist-facilitated conversation, evening meal and childcare. Older children who attend also have the opportunity to participate in a therapist-facilitated conversation.

Budget:

Total costs of \$11,800 include meeting space rental (\$1,800), a licensed counselor (\$1,200), food (\$1,800), gift cards for guest presenters (\$204), staff resources (\$6,336), paper and printing (\$240), and incentives for caregivers (\$300). In-kind support is provided.

Accomplishments:

A 2017 Family Strengths Scale Assessment indicated that 71 percent of grandparents reported an improvement in knowledge about community resources and 57 percent saw an improvement in their ability to understand and better manage their emotions. Eleven families used the Thrive Alliance Caregiver Library to check out books about grief, grandfamilies and more.

Replicability:

To replicate, develop new and nontraditional partnerships early, involve elected officials in the process, and start with a focus group. Offering childcare and a meal helps ensure families can attend.

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DIVERSITY & CULTURAL COMPETENCY

LGBT Senior Social Connection Elder Services of the Merrimack Valley

The LGBT Senior Social Connection is a group of like-minded lesbian, gay, bisexual and transgender seniors who want to meet and support one another. This group, a first of its kind in northeast Massachusetts, seeks to support the unique needs and experiences of LGBT seniors as they age. Monthly meetings provide older LGBT adults with a positive, collegial and safe setting to share meals and speak openly.

Budget:

The main cost associated with the program is renting a venue to host the monthly gatherings. Space is donated through the Merrimack Council on Aging. Funding through Friends of the Merrimack Senior Center covers meals (\$150 per month). Elder Services purchases ice, water and soda each month (\$25 per month). Staff time of approximately five hours per month is donated.

Accomplishments:

About 22 participants attend each month. Many seniors who participate say it is the only time during the month they get to spend with peers.

Replicability:

Replication is easiest if donations can be secured for the venue, monthly meal and staff time.

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Moving from Diversity to Inclusion ElderSource

Although ElderSource staff discussed valuing diversity and being diverse, they weren't sure if their organization was truly inclusive. After conducting a self-assessment, the organization took steps to implement changes to spark inclusion, including writing an inclusion statement, conducting staff training, changing staff and volunteer recruitment, making accessibility upgrades and revamping outreach and partnerships development/engagement to become authentically inclusive.

Budget:

Costs include training materials (\$1,500), training delivery (\$5,300 annually for staff and provider training) and installation of automatic door openers (\$3,240). There were no costs associated with the self-assessment or development of the inclusion statement.

Accomplishments:

Changes to advertising and hiring practices have resulted in more applicants with diverse backgrounds. The organization has also increased outreach and partnerships with more diverse groups, including members of disability, LGBT and faith-based communities. Staff say they are more aware and sensitive of issues affecting these communities and are able to provide more responsive services.

Replicability:

This process begins with staff and board leadership. Complete a self-assessment to determine where to focus attention. Ongoing staff training is key.

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ELDER ABUSE PREVENTION

Safe Haven

Region 2 Area Agency on Aging

To protect vulnerable adults from abuse, exploitation and neglect, Region 2 Area Agency on Aging developed the Safe Haven Project. The AAA works with Adult Protective Services from the Michigan Department of Health and Human Services in nearby counties to offer immediate, safe, temporary housing and care coordination and to address other needs to ensure the safety of at-risk adults in the community.

Budget:

Total operating costs for the program's first year were \$63,798, with \$61,200 in grant revenue received. The majority of operating costs include wages for staff involved in care coordination; remaining costs cover actual services delivered.

Accomplishments:

Safe Haven served six participants in its initial year. This year the program is on track to increase participants served by 50 percent. The ultimate outcome of this program, which is the successful development of an immediate elder abuse response system, has already been achieved.

Replicability:

This project can be replicated annually through coordination with local Adult Protective Services agencies, care coordination services and other temporary service need providers. The AAA is willing to share best practices and procedures with those interested in replicating the project.

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Statewide Elder Abuse Awareness and Prevention Training

Florida Association of Area Agencies on Aging

The members of the Florida Association of Area Agencies on Aging collaborated on the development of an elder abuse awareness and prevention training. A train-the-trainer program ensures training is delivered consistently throughout the state. The training is now also available online through an Area Agency on Aging that has a learning management system.

Budget:

Costs include curriculum development (\$900), travel for collaboration meetings (varies by agency), staff time (varies by agency), printing the train-the-trainer manual (\$341 for 11 copies) and purchase of a learning management system to make the training available online (\$5,300).

Accomplishments:

Staff trainers say they feel more comfortable with the quality of this training and their ability to deliver this training, as well as the consistency of the training being delivered statewide.

Replicability:

Replication requires a staff of experts on the subject willing to collaborate. A curriculum developer can provide additional assistance.

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HEALTH-LTSS INTEGRATION

Caring Beyond Healthcare

Area Agency on Aging and Disabilities
of Southwest Washington

Access to quality medical care does not ensure an individual's ability to maintain their health if they do not have safe and stable housing, healthy food and transportation. Caring Beyond Healthcare screens admitted patients at a local hospital who are eligible for both Medicare and Medicaid benefits for social determinants of health and refers them to the Area Agency on Aging and Disabilities of Southwest Washington for needed services.

Budget:

Staff time for program development, supplies, printing and travel during the initial implementation cost approximately \$5,000. Ongoing costs for staff time (data entry, participation in feedback huddles and follow-ups with patients) cost approximately \$11,000 per year.

Accomplishments:

Initial data shows a significant reduction in healthcare utilization, including readmissions and emergency department usage, among the pilot population.

Replicability:

Replication necessitates engaging existing stakeholders to identify a vulnerable population. Development or implementation of an existing comprehensive screening tool is also necessary. Funding for staff time, training, planning and coordination is essential.

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Flourish

KIPDA Area Agency on Aging
and Independent Living

The Flourish model of coordinated care seeks to decrease chronic disease burden and increase supportive environments by connecting primary care and community-based services for rural older adults in Kentucky. Community Health Navigators work directly with clients to connect them to services, communicate with health care providers and improve health behaviors. An interdisciplinary team conducts Weekly Case Conceptualizations to develop a patient care plan that addresses all social determinants of health.

Budget:

FY 2018 operating costs for KIPDA Area Agency on Aging and Independent Living (AAAIL) for development and implementation of the program are \$77,322. This includes personnel/staff (\$74,019), travel (\$2,878) and copying (\$425).

Accomplishments:

In the program's first year of implementation, there have been measurable outcomes for the 70 clients served. Based on an analysis of 25 clients whose data was collected before and after their participation in the program, clients have shown a significant improvement in environmental, biological and social determinants of health.

Replicability:

This program can be replicated by agencies with the time and resources to establish a care coordination partnership. The University of Louisville Institute for Sustainable Health and Optimal Aging, which partnered with KIPDA AAAIL to develop the program, has educational modules available on their website.

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HEALTHY AGING

Hospital2Home

Area Agency on Aging District 7, Inc.

Hospital2Home incorporates service vouchers and short-term telephone assistance from options counselors to create an affordable care transitions program for individuals age 60 and older who are transitioning from hospital to home and who are not currently on Medicaid. The initial assessment looks at medication discrepancies, access to medical care/transportation, understanding of discharge instructions and current care at home. Vouchers can be used to purchase short-term personal care and/or home-delivered meals.

Budget:

The total operating cost for year one was \$95,000. This breaks down to \$1,000 per person, which includes services, personnel and overhead. This cost should decrease in year two due to program efficiencies.

Accomplishments:

For the first year, 81 individuals (85 percent) did not readmit after discharge. The program received a 93 percent customer satisfaction rating, with 78 percent reporting the service helped their recovery.

Replicability:

Organizations using state-funded dollars and existing staff can implement this program at no cost. Partnerships with hospitals, provider contracts and a documentation database are needed. Materials from Area Agency on Aging District 7, Inc. are available for sharing.

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Seniors Fit & Fun

Care Connection for Aging Services

Seniors Fit & Fun is an interactive event designed to educate seniors about programs available to help them stay healthy and active. At the event, traditional health fair tables are replaced with activities that feature health and wellness information. Stations include cooking demonstrations with recipes emphasizing good nutrition, hula hoops with preventive benefit information, a beach ball toss with exercises, Wheel of Benefits with assistance program information and a memory game with brain health tips.

Budget:

A \$5,000 grant funded staff time, advertising and supplies to initially set up the events. Ongoing costs remain low because events are held at senior centers, which provide supplies for cooking demonstrations (\$30 per event). Aging Network partners contribute activities and prizes.

Accomplishments:

Consistently, 99 percent of attendees surveyed indicate an increased awareness of preventative benefits and say they intend to speak with their health care providers about receiving services.

Replicability:

Area Agencies on Aging can replicate this project by collaborating with local Aging Network providers and focusing on fun and interactive methods for engaging seniors.

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HOME & COMMUNITY-BASED SERVICES

Sandbags for Homebound Seniors

Los Angeles County Workforce Development, Aging and Community Services, Area Agency on Aging

The Sandbags for Homebound Seniors Program was designed and implemented in winter 2015 to prepare vulnerable adults for El Niño storms. The program identified impacted homebound seniors, conducted preemptive onsite property flooding assessments and delivered and installed filled sandbags at no cost. The pilot was successful and well-received so it was replicated again during the next storm season.

Budget:

This program was provided at no additional cost to the department through the leveraging of existing resources and reliance on a task force to carry out the services.

Accomplishments:

In the first year of implementation, 21 at-risk homes were identified. The second year, 96 at-risk homes were identified. Fire personnel delivered and placed sandbags at targeted residences and also conducted comprehensive follow-up inspections. In its two years of existence, the program has provided 150 individual home visits to seniors.

Replicability:

This program is replicable if buy-in is received from various agencies. Success of the program relied on bringing together a skilled group of experts to intervene before disaster strikes.

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Veteran-Directed Home & Community-Based Services

Aging Ahead

The Veteran-Directed Home & Community Based Services (VD-HCBS) program operates in 34 states to assist veterans in need of long-term supports. Aging Ahead and St. Louis Veterans Affairs Medical Center (StLVAMC) have been recognized nationally for their collaborative decision-making model and enhanced reporting tools and processes that clearly demonstrate the value-add that an AAA partnership provides veterans and medical centers.

Budget:

VD-HCBS is funded through the Veterans Health Administration. The StLVAMC purchases services from Aging Ahead on a fee-for-service basis, fully reimbursing staff time and contracted services.

Accomplishments:

According to a survey of veterans enrolled in the program through 2017, 100 percent of respondents stated they are living their life the way they want, 91 percent are receiving services they think they need and 38 percent were linked to other community services. Quarterly reviews of 291 veterans enrolled in the local program revealed a 100 percent satisfaction rate.

Replicability:

VD-HCBS was intended to be implemented nationwide so replication is strongly encouraged. The model implemented by Aging Ahead, now considered a promising practice, has led the agency to serve as a consultant for other AAAs in Missouri.

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INFORMATION & REFERRAL/ACCESS TO SERVICES

Veteran-Directed Home & Community-Based Services Program, Hub & Spoke Model

Bay Aging

The Veteran-Directed Home & Community-Based Services (VD-HCBS) program is open to all veterans at risk of nursing home placement. Currently, Bay Aging partners with numerous medical centers and Area Agencies on Aging to provide this service to veterans throughout Virginia and eastern North Carolina using the Hub & Spoke model of service, where Bay Aging acts as the hub overseeing program and financial management services while partnering with AAAs that act as the spokes, providing options counseling services to enrolled veterans. Options counselors work with veterans to develop spending plans, conduct monthly well-check calls and provide yearly reassessments.

Budget:

The AAA is reimbursed by the U.S. Department of Veterans Affairs for direct services provided to veterans; however, the reimbursement is typically received 90 to 120 days after the funds have been dispersed for payroll. Bay Aging provides the advance funding for all spoke agencies. Operating costs for FY 2017 totaled \$445,000.

Accomplishments:

This model has provided assistance to more than 200 veterans. Patient satisfaction results over the last four quarters average 97 percent.

Replicability:

Bay Aging can provide assistance to ease access to VD-HCBS service delivery and expedite the U.S. Department of Veterans Affairs Readiness Review process using the Hub & Spoke model of service delivery.

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Bay Aging

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Connect Me to a Human, Please!

Alliance for Aging, Inc.

Clients and staff in Florida's State Medicaid Managed Care Long-Term Care Program (SMMCLTC) grew frustrated with the program when a lack of staff made it difficult for Medicaid Benefits Counselors to respond to the large number of client calls in a timely manner. To remedy the situation, the Alliance for Aging established a secondary queue system. The queue system is modeled after the AAA's I&R hotline, which allows a caller to remain on hold until a specialist can take their call. Staff are trained to answer the calls in the queue and work on each other's cases to ensure clients' needs are addressed promptly.

Budget:

There were no costs for setting up a secondary queue. Time was invested in creating a protocol and training staff to handle calls.

Accomplishments:

The secondary queue system helped increase client access to services in a timely manner. Answered calls pertaining to SMMCLTC increased from 9,460 in 2014 to 17,471 in 2017. The number of complaints due to lack of response decreased tremendously.

Replicability:

The queue system can be replicated by any agency, particularly those with an established queue system in place for their I&R hotline.

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INFORMATION & REFERRAL/ACCESS TO SERVICES

Kansas Statewide ADRC Call Center: Promoting Collaboration, Partnerships and Quality Service Central Plains Area Agency on Aging

The Kansas Aging and Disability Resource Center (KADRC) Call Center is a statewide call center housed at Central Plains Area Agency on Aging that offers a single point of contact for all residents seeking long-term care and support services. The Call Center provides information, referrals and assistance and transfers residents' calls to local Area Agencies on Aging (AAA)/Aging and Disability Resource Centers (ADRC). A comprehensive training plan ensures the call center provides quality customer service and accurate information to all callers.

Budget:

Funding was accessed through a statewide ADRC grant. Costs include salary and benefits for three call center specialists and one supervisor (\$222,650) and a management information system (\$36,000).

Accomplishments:

Contact/call volume has increased from 13,000 in 2013 to more than 42,000 in 2017, with continued growth expected due to new partnerships and statewide marketing. In 2017, 97 percent of callers stated they were satisfied or extremely satisfied with the service they received.

Replicability:

Replication will be most successful if AAAs jointly plan a statewide call center. A management information system is essential to manage call volume and collect data.

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Targeted Options Counseling The Heritage Area Agency on Aging

The Heritage Area Agency on Aging established a partnership with a senior housing facility to fund onsite targeted options counseling. The Targeted Options Counseling program connects low-income older adults and people with disabilities to housing and supportive services. The funding covers part of a full-time staff position, which enables the AAA to allocate additional funds for home services for targeted populations.

Budget:

This project secured 53 percent (\$37,653) of funding for a full-time options counseling position through a Housing Finance Agency grant. Total cost to sustain the position is \$70,316. The money previously used to support the position is now being used to fund supportive services.

Accomplishments:

Through this program 49 residents (70 percent) in the 70-unit facility have received options counseling services including a home visit, needs assessment, benefits eligibility review, care planning and follow-up services. Of those 49 residents, 100 percent have been connected with supportive services.

Replicability:

Strong relationships with Housing Finance Agencies and regional housing developers increase the chances of obtaining lead agency status and securing additional funding.

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INTERGENERATIONAL PROGRAMS

Generations Intergenerational Day Care Center

Appalachian Agency for Senior Citizens

Generations Intergenerational Day Care Center serves people ranging from babies to seniors. Children and seniors have the opportunity to participate together in select, supervised activities in a safe, home-like setting while family members and caregivers work or take a break from caring for loved ones. The Adult Day Care offers individuals 18 years and older a safe daytime environment that includes recreation, socialization, meals and health monitoring. The fully licensed childcare facility provides year-round care for children ages six weeks to 12 years.

Budget:

The annual operating budget is \$553,650. Most funds are received from adult day care private pay (\$315,000) and childcare (\$80,000) fees. Current enrollment is 53 children and 73 adults.

Accomplishments:

The intergenerational day care program was so successful that a separate child development center was constructed in 2014. This enabled the expansion of the adult physical therapy, art and activities areas, and led to the enrollment of 28 more children.

Replicability:

Area Agencies on Aging are well suited to replicate the intergenerational day care concept because of their local connections to providers, funders and older consumers.

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NUTRITION

Brenda's Casamia Restaurant and Catering

Ventura County Area Agency on Aging

The Ventura County Area Agency on Aging (VCAAA) partnered with Brenda's Casamia Restaurant and Catering to better identify and serve isolated seniors living in the rural, low-income, predominantly Hispanic community of Piru, California. The local Mexican restaurant offers strong community ties and nutritious, culturally appropriate food options and was willing to provide congregate and home-delivered meal services to eligible Senior Nutrition Program clients.

Budget:

Brenda's Casamia is reimbursed at a rate of \$6.75 per meal from Older Americans Act Title III C1 and C2 funds for providing program-approved meals to eligible clients. VCAAA's associated annual costs are \$7,375 for arranging the meal deliveries, mileage reimbursement, client assessments, meals rosters, meal vouchers, program reporting and donation collection.

Accomplishments:

Since Brenda's Casamia began providing meals, home-delivered meal services have increased by 65 percent and congregate meal services have increased by 55 percent. Feedback has shown the services have reduced participants' feelings of isolation and loneliness.

Replicability:

This program can be replicated by identifying the unmet needs of an existing Senior Nutrition Program and establishing partnerships with vendors that provide superior customer service and quality, culturally appropriate food.

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NUTRITION

MealsPlus

Salt Lake County Aging and Adult Services

MealsPlus is an innovative partnership between a AAA and local food growers started in 2014 to address many homebound seniors' minimal access to fresh produce due to financial limitations and lack of transportation. The program provides fresh, locally grown produce to seniors who receive home-delivered meals. In 2016, the program was expanded to include a Pop Up Farmers Market component, which enables participants at senior centers to receive fresh produce.

Budget:

Community partnerships and leveraged resources have resulted in minimal program costs. MealsPlus was awarded a \$2,500 grant for startup costs and four years of operations. Produce is donated and food is sorted and distributed primarily by volunteers.

Accomplishments:

Last year, 78 MealsPlus clients received a home-delivered bag of produce, and 84 markets distributed 8,017 pounds of produce to 3,170 seniors. Participants say the program saves them money and contributes to a healthier diet.

Replicability:

MealsPlus and Pop Up Farmers Markets are highly replicable initiatives for agencies with existing meal delivery programs and senior centers. Partnerships with local food organizations, suppliers and growers are key.

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Mitigating Malnutrition with Farm Fresh Delivery for Kinship Families

Area Office on Aging of Northwestern Ohio, Inc.

Studies show that older adults are 16 times more likely to experience food insecurity when children reside with them. Through the Fresh Fruits and Vegetable Program for Kinship Families, local farmers provide a large box of produce to participants monthly, substantially alleviating food insecurity and mitigating malnutrition in grandparents and grandchildren. Cooking demonstrations and nutrition education are also provided.

Budget:

The \$71,558 total cost of the program includes compensation for a nutrition and wellness specialist (\$4,758), chef cooking demonstrations (\$100), fruit and vegetable produce boxes (\$64,000), printing of recipes and educational items (\$500), food for cooking demonstrations (\$1,400) and produce package deliveries (\$800).

Accomplishments:

One hundred percent of participants reported the produce packages enabled them to expand their food budget, serve more nutritious food and have more time to spend caring for their grandchildren.

Replicability:

Coordination is key for successful implementation. Farmers must be identified, drop-off sites secured and delivery of produce scheduled. Produce may be purchased from fruit and vegetable purveyors rather than local farmers.

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SOCIAL ENGAGEMENT

Pantry-on-the-Go Davis County Senior Services

The Pantry-on-the-Go program is a unique partnership between Davis County Senior Services and the Bountiful Food Pantry that helps address food insecurity in older adults at risk for malnutrition and who have limited transportation options. Twice monthly, the mobile pantry delivers food to the county's three senior centers, increasing access to perishable items including produce, deli, dairy and frozen meat items.

Budget:

There are no additional costs to run this program. Senior Services senior center employees and volunteers distribute food as part of their weekly routines. The Bountiful Food Pantry combines the senior center food delivery with regularly scheduled pickups and deliveries.

Accomplishments:

In each of the last two years, approximately 95,000 pounds of food were distributed to 2,375 (duplicated) people during 88 Pantry-on-the-Go days.

Replicability:

Most Area Agencies on Aging and community food pantries have access to similar facilities and resources to replicate this increased access to food distribution. This model is cost-efficient and replicable.

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Care Connections In-Home Personalized Companion Care Senior Resources of West Michigan

Care Connections In-Home Personalized Companion Care program provides participants with the activities, support and companionship needed to maintain independence in the comfort of their own homes. Companions are matched with participants based on interests, personalities and potential compatibility. Most companions are retirees looking for something fulfilling to do. Some of the many activities based on participant interests include scrapbooking, gardening, cooking, assisting with home computer and Internet use, assisting with hair dressing and other grooming, walking, caring for pets and performing light housekeeping tasks.

Budget:

Costs for FY 2017 (\$140,000) include staff wages and payroll taxes, travel, training, supplies, equipment and administrative costs.

Accomplishments:

The program has averted nursing home placement due to participants' improved physical health and cognitive function. Many anecdotal stories of positive impacts on participants' lives have been reported.

Replicability:

Senior Resources of West Michigan created a separate department, Care Connections, for direct-to-consumer/private pay programs including this one. Such an approach is highly recommended. To begin, develop a business plan and obtain board support and a financial commitment.

Contact:

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SOCIAL ENGAGEMENT

Reimagine Aging Initiative for 2017 Baltimore County Department of Aging

In 2017, the Baltimore County Department of Aging launched a six-month social media and educational campaign to raise awareness of ageism and promote aging in a positive manner. The agency used the hashtag #ReimagineAging2017 as it initiated conversations about aging stereotypes on Instagram and Facebook, at professional conferences, in a featured area at the Power of Age Expo and at senior programs and events. Baltimore County residents also nominated individuals age 60 or older to be the campaign's "Faces of Reimagine Aging."

Budget:

Due to the establishment of private/public partnerships with various local providers, the only cost was staff time.

Accomplishments:

Program participation included 4,889 participants in 152 intergenerational programs, 774 participants in 79 video learning programs, 4,849 attendees at 591 health screenings, and 4,234 attendees at 367 health education classes. Total daily reach on Facebook was 82,760, with 880 engagements on Instagram. Additionally, 92 essays/poems were submitted to the writing contest and 600 people discussed ageism at the Power of Age Expo.

Replicability:

Replication requires the development of a committee to identify a slogan, logo, marketing materials and public education plan.

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TECHNOLOGY

System for Efficient and Accessible Learning (SEAL) ElderSource

ElderSource adopted a learning management system to provide an alternative to in-person training for staff, providers, board and advisory council members and professionals in the community. The system enables ElderSource to add topics and keep trainings updated and current.

Budget:

Costs include the learning management system (\$5,300) and software for developing trainings (\$360).

Accomplishments:

Training is provided more frequently and consistently, with a greater number of topics covered. ElderSource has delivered almost 400 hours of training to more than 200 users, with 91 percent of participants saying the trainings are well organized, easy to follow and relevant, and 90 percent saying they would encourage a coworker or others to complete a training.

Replicability:

Having a champion willing to take on training development is key, as is the right platform and tools for developing and hosting the training. Although trainings can be done with PowerPoint presentations, additional training software may be used to make the trainings more interactive and engaging.

Contact:

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TRANSPORTATION & MOBILITY

myride2 Travel Training Area Agency on Aging 1-B

The myride2 Travel Training program provides education and instruction for seniors and adults with disabilities. The service teaches participants how to access and use the Suburban Mobility for Regional Transportation and Detroit Department of Transportation bus systems. This service is in addition to the Area Agency on Aging 1-B's one-call, one-click myride2 mobility management service.

Budget:

Implementation costs of \$51,900 annually consisted of \$50,900 in operating and \$1,000 in capital costs. The majority of the budget was allocated to personnel with the remaining allocated to other general operational costs. Total operating cost for the most recent fiscal year was \$34,914, with anticipated operating costs for the current fiscal year at \$31,000.

Accomplishments:

Two staff members completed the Easterseals Project Action Consulting Certified Travel Training Instructor course and led seven classroom training sessions attended by 97 people. Staff also conducted one-on-one and small-group field training sessions. Participants stated they had a newfound freedom and felt comfortable using the system even with language barriers.

Replicability:

This project is replicable at different levels depending on available funding. Substantial information is available from the Easterseals Project Action Consulting website.

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Rides for Health LifePath

Rides for Health volunteer drivers offer door-through-door transportation to and from medical appointments and other health care-related venues for home care clients. Each client is matched with a volunteer who uses their own vehicle to provide individualized transportation services and even assists with carrying equipment and packages. Rides for Health drivers are vetted and trained in the provision of sensitive and safe services. Clients arrange for rides directly with their volunteers, which eliminates the need for a centralized dispatch.

Budget:

Total program costs including contributed staff time, benefits and indirect costs were \$17,702 for calendar year 2017. Waiver income increased dramatically during the past year, offsetting a greater share of fixed costs.

Accomplishments:

In 2017, seven volunteers provided service to 18 clients, logging 3,543 miles of travel, 176 hours of service and a total of 83 trips to medical and health care-related venues.

Replicability:

Rides for Health is an easily replicable assisted transportation initiative, particularly for programs operating within the Aging Network. The training curriculum and programmatic resources, documents and forms can be easily adapted to other locations. Once the client referral source and volunteer base has been established, the Rides for Health program can be implemented quickly.

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WORKFORCE DEVELOPMENT

The Adult Protective Services Training Academy

County of San Diego Health and Human Services Agency,
Aging & Independence Services

A combination of training, support group and strengths-based coaching, the County of San Diego Adult Protective Services (APS) Training Academy is a yearlong program designed to support new APS Specialists. The program includes monthly in-person meetings with expert community professionals, and attendees are expected to complete the San Diego State University Academy of Excellence MASTER core curriculum and be eligible for the nationally recognized National Adult Protective Services Association (NAPSA) Certificate 12 months after graduation.

Budget:

A new APS Trainer Supervisor position costs an estimated \$75,234 yearly. Having training materials available online and expert professionals on hand to donate their time helps minimize administrative costs.

Accomplishments:

Currently, APS has more NAPSA Certificate candidates than any other county in California. Ninety-five percent of participants pass probation successfully and are eligible to obtain the Certificate. Additionally, 98 percent of attendees report having learned practical skills at every training session.

Replicability:

This program can be replicated easily. The program manual, transfer of learning tools and resources can be tailored to any schedule.

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