SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

506A

FROM: Office on Aging

SUBMITTAL DATE:
April 23, 2014

SUBJECT: Approval of the Office on Aging's 2014 - 2015 Update of the 2012 - 2016 Strategic Plan; "Focusing on a Healthy Tomorrow". [Districts – All] [Total Cost: $0]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Approve the attached 2014 - 2015 Strategic Plan Update of the 2012 - 2016 Strategic Plan, "Focusing on a Healthy Tomorrow";
2. Authorize the Chairman of the Board of Supervisors to sign three (3) copies (must be original signatures) of the attached Transmittal Letter; and
3. Return two (2) copies of the Transmittal Letter to the Office on Aging after approval by the Board of Supervisors. One (1) copy will be retained by the Clerk of the Board for filing.

BACKGROUND:

Summary

Every four years the Office on Aging, in coordination with the Advisory Council on Aging and the community, is mandated by the Older Americans Act and the Older Californians Act to develop a strategic plan that is updated annually. On April 10, 2012 (Agenda #2.09), the Board of Supervisors approved the 2012 - 2016 Strategic Plan, "Focusing on a Healthy Tomorrow" and on April 30, 2013, approved the first Plan Update (Agenda #2.6).

(Continued on next page)

Michele Haddock
Director

Departmental Concurrence

FORM APPROVED COUNTY COUNSEL
BY: NEAL R. KIPNIS DATE 4/23/14

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:	POLICY/CONSENT (per Exec. Office)
COST	$ 0	$ 0	$ 0	$ 0	Consent ☒ Policy ☐
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0	

SOURCE OF FUNDS: N/A

Budget Adjustment: N/A

For Fiscal Year: 2014/2015

C.E.O. RECOMMENDATION:

APPROVE
BY: Lani Sioson
Lani Sioson

County Executive Office Signature

MINUTES OF THE BOARD OF SUPERVISORS

☐ Positions Added ☐ Change Order
☐ A-30 ☐ 4/5 Vote

Prev. Agn. Ref.: 04/30/13 (#2.6) | **District: ALL** | **Agenda Number:** 2-6

BACKGROUND:
Summary (continued)

This is the second annual update of the 2012 – 2016 Strategic Plan. The California Department of Aging requires that each update reflect a history of the original 2012 – 2016 Strategic Plan. On March 12, 2014, a Public Hearing was held and changes to the Strategic Plan were discussed and approved by the Riverside County Advisory Council on Aging on April 9, 2014. Primary changes include slight modifications to goal statements and timelines and alterations to service plans units based on ongoing sequestration projections.

Impact on Citizens and Businesses

This strategic plan establishes the rationale, development and delivery of community based services in Riverside County and ensures compliance with the Older Americans Act set forth by the Area Plan.

ATTACHMENTS:

A. 2012-2016 STRATEGIC PLAN ON AGING: *Focusing on a Healthy Tomorrow*
2014-2015 PLAN UPDATE

TRANSMITTAL LETTER
Four-Year Area Plan
2012-2016

AAA Name: Riverside County Office on Aging **PSA** 21

This Area Plan is hereby submitted to the California Department of Aging for approval. The Governing Board and the Advisory Council have each had the opportunity to participate in the planning process and to review and comment on the Area Plan. The Governing Board, Advisory Council, and Area Agency Director actively support the planning and development of community-based systems of care and will ensure compliance with the assurances set forth in this Area Plan. The undersigned recognize the responsibility within each community to establish systems in order to address the care needs of older individuals and their family caregivers in this planning and service area.

1. (Type Name) ~~John J. Benoit~~ Jeff Stone

Signature: Governing Board Chair [1] Date

2. (Type Name) Gloria Sanchez

Signature: Advisory Council Chair 4/10/14 Date

3. (Type Name) Michele ~~Wilham~~ Haddock

Signature: Area Agency Director 4-10-14 Date

FORM APPROVED COUNTY COUNSEL
BY: NEAL R. KIPNIS DATE 4/3/14

1 Original signatures or official signature stamps are required.

Revised 4.3.2014

RIVERSIDE COUNTY
OFFICE ON AGING

Aging & Disability Resource Connection
ADRC of RIVERSIDE COUNTY

Riverside County Office on Aging
Aging and Disability Resource Connection

2012-2016 Strategic Plan on Aging
2014-2015 Plan Update

Focusing on a Healthy Tomorrow

TABLE OF CONTENTS

Overview

Purpose

Part II includes all forms referenced in Part I: Instructions & References.

Regulation

In accordance with the Older Americans Act (OAA) 2006 Section 306(a) and 307(a)(1), Area Plans shall be submitted in a uniform format specified by the State Agency. The forms and templates contained in this Guidance constitute the required Area Plan format.

In the event of an amendment to the OAA during the 2012-2016 Area Plan cycle, CDA will issue a Program Memo (PM) outlining the changes, provide relevant guidance, and any necessary form and template changes pertaining to the Area Plan.

Content

The following components comprise the Area Plan:

- Area Plan Required Components Checklist – found in Part II.
- Transmittal Letter – found in Part II.
- Sections 1 – 22 (The Area Plan) as delineated in Part II.
- Additional Instructions, Information and Logistics are at the end of Part I.

AREA PLAN REQUIRED COMPONENTS CHECKLIST

To ensure all required components are included, "X" mark the far-right column boxes. Enclose a copy of the checklist with your Area Plan

Section	Four-Year Area Plan Components	4-Year Plan
	Transmittal Letter – must have original signatures or official signature stamps	☐
1	Mission Statement	☒
2	Description of the Planning and Service Area (PSA)	☒
3	Description of the Area Agency on Aging (AAA)	☒
4	Planning Process / Establishing Priorities	☒
5	Needs Assessment	☒
6	Targeting	☒
7	Public Hearings	☒
8	Identification of Priorities	☒
9	Area Plan Narrative Goals and Objectives:	
	Title III B Funded Program Development (PD) Objectives	☒
	Title III B Funded Coordination (C) Objectives	☒
	System-Building and Administrative Goals & Objectives	☒
	Title III B/VII A Long-Term Care Ombudsman Objectives	☒
	Title VII B Elder Abuse Prevention Objectives	☒
10	Service Unit Plan (SUP) Objectives	☒
11	Focal Points	☒
12	Disaster Preparedness	☒
13	Priority Services	☒
14	Notice of Intent to Provide Direct Services	☒
15	Request for Approval to Provide Direct Services	☒
16	Governing Board	☒
17	Advisory Council	☒
18	Legal Assistance	☒
19	Multipurpose Senior Center Acquisition or Construction Compliance Review	☒
20	Title III E Family Caregiver Support Program	☒
21	Organization Chart	☒
22	Assurances	☒

TRANSMITTAL LETTER
Four-Year Area Plan
2012-2016

AAA Name: Riverside County Office on Aging **PSA** 21

This Area Plan is hereby submitted to the California Department of Aging for approval. The Governing Board and the Advisory Council have each had the opportunity to participate in the planning process and to review and comment on the Area Plan. The Governing Board, Advisory Council, and Area Agency Director actively support the planning and development of community-based systems of care and will ensure compliance with the assurances set forth in this Area Plan. The undersigned recognize the responsibility within each community to establish systems in order to address the care needs of older individuals and their family caregivers in this planning and service area.

1. (Type Name) ~~John J. Benoit~~ Jeff Stone

_____ _____
Signature: Governing Board Chair [1] Date

2. (Type Name) Gloria Sanchez

_____ _____
Signature: Advisory Council Chair Date

3. (Type Name) Michele ~~Wilham~~ Haddock

_____ _____
Signature: Area Agency Director Date

1 Original signatures or official signature stamps are required.

SECTION 1. MISSION STATEMENT

To provide leadership in addressing issues that relate to older Californians; to develop community-based systems of care that provide services which support independence within California's interdependent society, and which protect the quality of life of older persons and persons with functional impairments; and to promote citizen involvement in the planning and delivery of services.

Riverside County Office on Aging's Philosophy

Our Vision

Hope for today with expanded possibilities and choices for tomorrow.

Our Core Value

The right to age with dignity.

Our Purpose

To enhance quality of life across generations through innovation and partnerships.

Our Promise

To listen with respect, to foster trust, and to serve with compassion and commitment in a timely manner.

SECTION 2. DESCRIPTION OF THE PLANNING AND SERVICE AREA (PSA) 21

Physical Characteristics

Riverside County, one of 58 counties in the state of California, covers 7,296 square miles in the southern part of the state stretching from Orange County to the Colorado River, which forms the state border with Arizona. Riverside County lies inland of Los Angeles County and is bordered by Orange County to the West, San Bernardino County to the north, and San Diego and Imperial Counties to the south.

The County forms a unique shape similar to a long rectangle (see map on right). It is approximately 180 miles from the east to the west side of the County and 40 miles north to south, roughly the size of the state of New Jersey in total area. Due to its unique shape and total area size, the Colorado River town of Blythe is a three-hour drive from the county seat of Riverside. The County's landscape features everything from lush, irrigated farms to desert sand dunes and has altitudes ranging from 200 feet below sea level, at the Salton Sea, to 10,084 feet above sea level at the top of Mt. San Jacinto.

The County is home to diverse geographical features, including deserts, forests, mountains, and biological resources. Additionally, there are growing industrial and urban/suburban population centers and productive agricultural lands.

Riverside County was founded in 1893, and is currently comprised of 28 incorporated cities, unincorporated communities and neighborhoods, and 12 federally recognized Indian reservations. Over 87% of the county is unincorporated land.

http://www.californiacountymaps.com/riverside_county.shtml

TOTAL POPULATION

According to the 2010 United States Census, the population of Riverside County was 2,189,641, which represents 5.88% of the total population of California. As of January, 20112, the total Riverside County population was 2,268,78317,778[2] with approximately 23.1% of the county's residents living in unincorporated areas. Of the 58 counties within the State of California, Riverside County is the fourth largest county in the state with only the counties of Los Angeles, Orange, and San Diego having a larger population. Additionally, Riverside County is the eleventh largest county in the nation, with more residents than 15 of the country's states.[3] With regards to the total population within cities of Riverside County, the city of Riverside has the highest population with 303,871 and the city of Indian Wells has the lowest population with 4,958. The following table (Table 1) from the Demographic Research Unit of the Department of Finance provides the total population by incorporated cities and census designated places (CDP) as of April, 2010 shows the wide variance in population per square mile between different regions of Riverside County.

Table 1: Land Area, Population and Population Density, April 1, 2010
Incorporated Cities and Census Designated Places (CDP) For Riverside County

Geography	Total Population	Land Area in Square Miles	Population Per Square Mile (Land Area)
California	37,253,956	155,779.2	239
Riverside County	2,189,641	7,206.5	304
Aguanga CDP	1,128	13.6	83
Anza CDP	3,014	27.6	109
Banning city	29,603	23.1	1,282
Beaumont city	36,877	30.9	1,193
Bermuda Dunes CDP	7,282	2.9	2,472
Blythe city	20,817	26.2	795
Cabazon CDP	2,535	4.9	521
Calimesa city	7,879	14.8	531
Canyon Lake city	10,561	3.9	2,689
Cathedral City	51,200	21.5	2,381
Cherry Valley CDP	6,362	8.1	787
Coachella city	40,704	29.0	1,406
Corona city	152,374	38.8	3,925
Coronita CDP	2,608	0.7	3,754
Crestmore Heights CDP	384	0.3	1,335
Desert Center CDP	204	30.4	7
Desert Edge CDP	3,822	2.3	1,686
Desert Hot Springs city	25,938	23.6	1,098
Desert Palms CDP	6,957	2.7	2,605

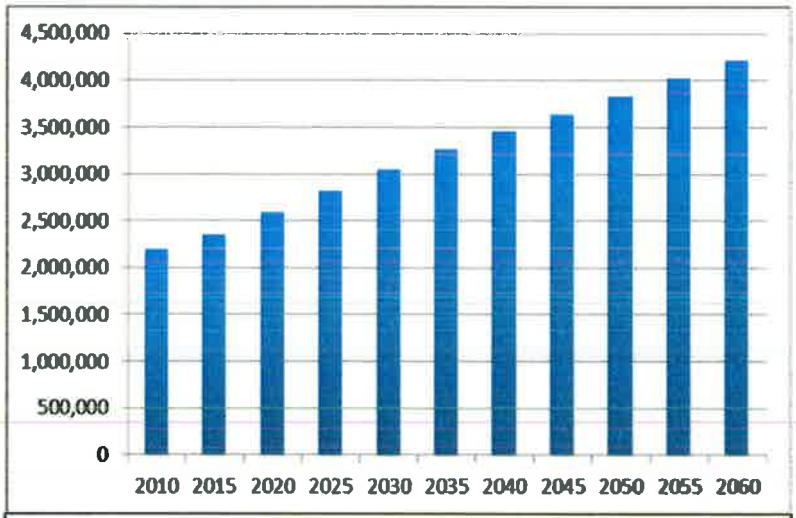
[2] Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2012; 2012 Population Estimates
[3] U.S. Census Bureau, Preliminary Annual Estimates of the Resident Population for Counties: April 1, 2000 to July 1, 2010, CO-PEST2010-TOTALS

Geography	Total Population	Land Area in Square Miles	Population Per Square Mile (Land Area)
East Hemet CDP	17,418	5.2	3,341
Eastvale CDP	53,668	11.4	4,706
El Cerrito CDP	5,100	2.6	1,998
El Sobrante CDP	12,723	7.2	1,764
French Valley CDP	23,067	10.9	2,123
Garnet CDP	7,543	11.3	668
Glen Avon CDP	20,199	8.1	2,494
Good Hope CDP	9,192	11.2	818
Green Acres CDP	1,805	1.4	1,289
Hemet city	78,657	27.8	2,825
Highgrove CDP	3,988	3.2	1,239
Home Gardens CDP	11,570	1.6	7,436
Homeland CDP	5,969	4.3	1,398
Idyllwild-Pine Cove CDP	3,874	13.7	282
Indian Wells city	4,958	14.3	346
Indio city	76,036	29.2	2,606
Indio Hills CDP	972	21.5	45
Lake Elsinore city	51,821	36.2	1,431
Lakeland Village CDP	11,541	8.7	1,330
Lake Mathews CDP	5,890	15.9	370
Lake Riverside CDP	1,173	7.2	163
Lakeview CDP	2,104	3.3	645
La Quinta city	37,467	35.1	1,067
March ARB CDP	1,159	12.0	97
Meadowbrook CDP	3,185	6.9	465
Mead Valley CDP	18,510	19.2	966
Mecca CDP	8,577	7.0	1,233
Menifee city	77,519	46.5	1,668
Mesa Verde CDP	1,023	4.3	236
Mira Loma CDP	21,930	8.0	2,742
Moreno Valley city	193,365	51.3	3,771
Mountain Center CDP	63	1.9	33
Murrieta city	103,466	33.6	3,081
Norco city	27,063	14.0	1,938
North Shore CDP	3,477	11.2	311
Nuevo CDP	6,447	6.8	952
Oasis CDP	6,890	19.6	351
Palm Desert city	48,445	26.8	1,807
Palm Springs city	44,552	94.1	473
Pedley CDP	12,672	5.1	2,495
Perris city	68,386	31.4	2,178
Rancho Mirage city	17,218	24.4	704

Geography	Total Population	Land Area in Square Miles	Population Per Square Mile (Land Area)
Rancho Mirage city	17,218	24.4	704
Ripley CDP	692	1.7	407
Riverside city	303,871	81.1	3,745
Romoland CDP	1,684	2.6	637
Rubidoux CDP	34,280	9.7	3,549
San Jacinto city	44,199	25.7	1,719
Sky Valley CDP	2,406	24.3	99
Sunnyslope CDP	5,153	1.5	3,497
Temecula city	100,097	30.2	3,320
Temescal Valley CDP	22,535	19.3	1,167
Thermal CDP	2,865	9.5	303
Thousand Palms CDP	7,715	23.6	326
Valle Vista CDP	14,578	6.9	2,123
Vista Santa Rosa CDP	2,926	16.1	182
Warm Springs CDP	2,676	2.0	1,321
Whitewater CDP	859	9.9	87
Wildomar city	32,176	23.7	1,358
Winchester CDP	2,534	7.7	328
Woodcrest CDP	14,347	11.4	1,257

Source: Center for Demographic Research, Department of Finance, April, 2010

California's population grew by 0.7% between July 1, 2010 and July 1, 2011 to total more than 37.5 million persons, according to the official population estimates released by the Department of Finance. [4] ~~This represents 260,000 new residents within state during the fiscal year and continues the pattern of modest growth rates over the past few years. However, Riverside County has the largest percentage increase in population with a 1.59 percent increase, which is more than double the percentage of increase as compared to the entire state within the same time period. This is in sharp contrast of the growth b~~Between the years 2000 to 2010, ~~in which~~ Riverside County grew 41.7%. New



Source Table: Total Population Projections for California and Counties: July 1, 2015 to 2060 in 5 Year Increments Demographic Research Unit, California Department of Finance, January 2013

[4] State of California, Department of Finance, California County Population Estimates and Components of Change by Year, July 1, 2010-2011. Sacramento, California, December 2011.

studies show that Riverside County's population will continue to grow, reaching 4.2 million by 2060.[5] This growth will make Riverside County the second largest county in California, surpassed only by Los Angeles County.[3]

ELDER POPULATION

The aging of the Boomer generation (those born between 1946 and 1964) means that the oldest of the Boomers turned 60 in 2006, which equates to 330 people turning 60 every hour. The state of California as well as Riverside County has to anticipate this growth and take this into account in its planning efforts. According to the 2010 U.S. Census figures, the population by age category for both California and Riverside County are shown in Table 2 below[6].

TABLE 2. 2010 U.S. Census by Age Group (Ages 50 and Above)

AGE	CALIFORNIA	RIVERSIDE COUNTY
50 to 54 years	2,562,552	140,016
55 to 59 years	2,204,296	114,765
60 to 64 years	1,832,197	98,974
65 to 69 years	1,303,558	78,495
70 to 74 years	971,778	62,103
75 to 79 years	766,971	49,003
80 to 84 years	603,239	36,793
85 years and over	600,968	32,192
Total 60 years and over	6,078,711	357,560

For Riverside County, the population projections according to the Department of Finance 2007 demographic information for the years 2000-2050 for older adults are shown in Table 3.[7]

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[5] State of California, Department of Finance, New Population Projections: California to Surpass 50 Million in 2049

[6] U.S. Census Bureau, 2010 Census Demographic Profile Summary File. Table prepared by Demographic Research Unit, California Department of Finance.

[7] State of California, Department of Finance, *Population Projections for California and Its Counties 2000-2050,* Sacramento, California, July 2007.

TABLE 3. Riverside County Population Projections 2000-2050

Age Group	2000	2010	2020	2030	2040	2050
ALL Age Group (Total Population)	1,559,039	2,239,053	2,904,848	3,507,498	4,103,182	4,730,922
60-69	106,508	151,469	250,274	316,322	333,125	456,228
70-79	95,156	96,608	133,969	217,406	276,315	297,163
80+	49,463	69,734	80,483	114,772	194,135	282,504
ALL 60+	251,127	317,811	464,726	648,500	803,575	1,035,895

Clearly the projections in the above table (Table 3) underestimated the impact of the boomers in the 2007 Department of Finance projections as compared to the actual 2010 census figures. The 60+ age group was projected to be 317,811 in 2010 from the 2007 data. However, the actual 2010 population was 357,560! By the year 2040, the age 65+ group will exceed half a million in Riverside County, and will be approaching 1 million by 2060! The fastest growing cohort proportionately is the age 80+, which is projected to grow between 255% (75-84 years of age) and 531% (85+) by 2060. [8] The unprecedented growth in older adult population will mean a demographic change that will necessitate infrastructure changes to meet the needs of the growing population. The boomers are living longer but not necessarily healthier. In addition, Californa boasts the highest number of Centurians, persons aged 100 or older, than any othe state. This population, which makes up less than 1% of the total population both in the state and nationwide, is expected to increase as the overal population of the state increases.[9]

[8] State of California, Department of Finance, New Population Projections: California to Surpass 50 Million in 2049, Sacramento, California, January 2013.

[9] US Census Bureau, 2010 Census Special Reports, Centurions: 2010, C2010SR-0, U.S. Government Office, Washington D.C., 2012.

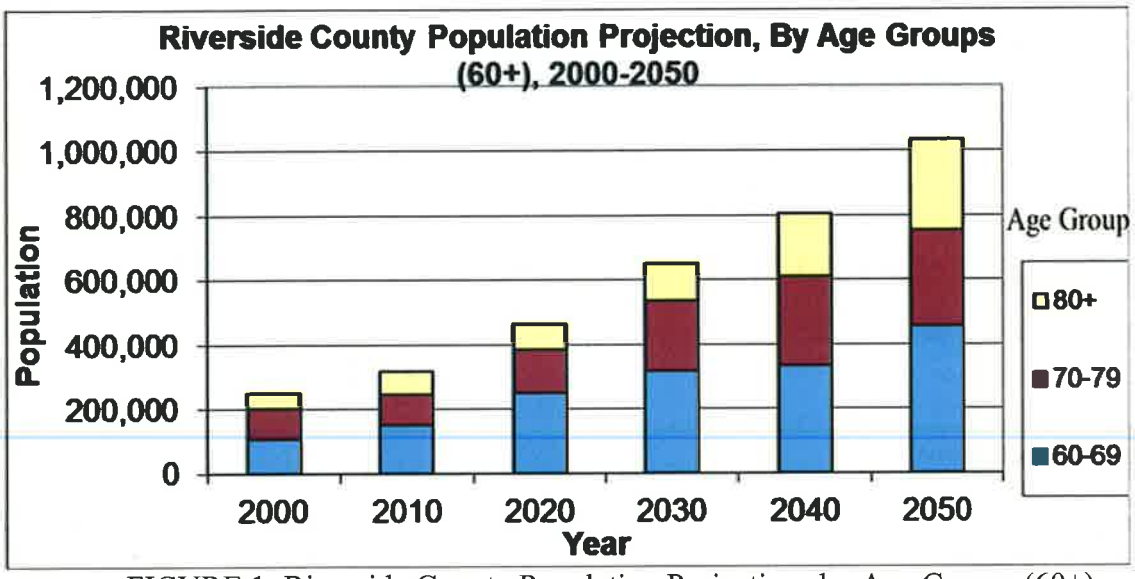
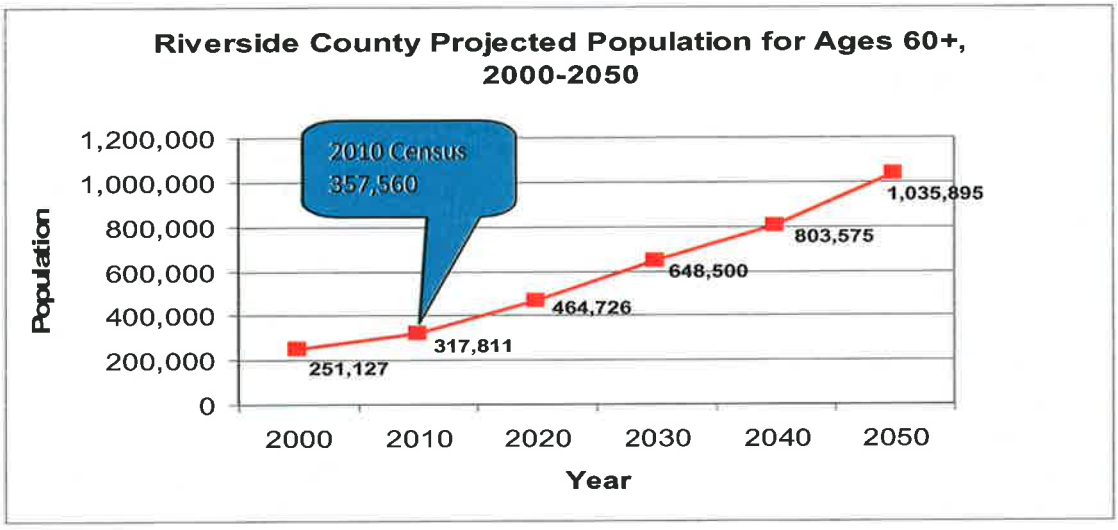


FIGURE 1: Riverside County Population Projections by Age Groups (60+)

Source: Department of Finance, *Population Projections for California and Its Counties 2000-2050*



Source: Department of Finance, *Population Projections for California and Its Counties 2000-2050*

DISABLED POPULATION

The 2010 U.S. Census estimated that the total civilian, non-institutionalized population within Riverside County with a disability is 220,121 persons, which represents about 10.1% of the total population, which is slightly higher than the State of California (9.910%).[10] The 2008-2010 American Community Survey 3-Year Estimates of Riverside County shows that the percentage of people with disability remains fairly constant at about 10.3%. Table 4 is a brief summary of disability statistics by age grouping as well as by type of disability.

TABLE 4: DISABILITY CHARACTERISTICS FOR RIVERSIDE COUNTY [11]
2010 American Community Survey

Subject	Total Population	Estimated With Disability	Percent with Disability
Total Civilian, Non-Institutionalized	2,180,857	220,121	10.1%
Population under 5 years	163,258	1,062	0.7%
With a hearing difficulty		764	0.5%
With a vision difficulty		406	0.2%
Population 5 to 17 years	460,038	16,468	3.6%
With a hearing difficulty		2,528	0.5%
With a vision difficulty		2,158	0.5%
With a cognitive difficulty		11,632	2.5%
With an ambulatory difficulty		2,974	0.6%
With a self-care difficulty		4,695	1.0%
Population 18 to 64 years	1,299,857	105,412	8.1%
With a hearing difficulty		20,593	1.6%
With a vision difficulty		18,603	1.4%
With a cognitive difficulty		40,598	3.1%
With an ambulatory difficulty		54,477	4.2%
With a self-care difficulty		21,129	1.6%
With an independent living difficulty		40,476	3.1%
Population 65 years and over	257,704	97,179	37.7%
With a hearing difficulty		42,457	16.5%
With a vision difficulty		16,286	6.3%
With a cognitive difficulty		23,667	9.2%
With an ambulatory difficulty		64,548	25.0%
With a self-care difficulty		24,956	9.7%
With an independent living difficulty		43,954	17.1%

As expected, the older adults have a significantly higher percentage with disabilities. Among the 353,900 civilian non-institutionalized population 60 and older, 32.9%, or 116,433 have a disability and 67.1% (N=237,467) do not have a disability. [12] Thus, the 60 and older population has more than 3 times

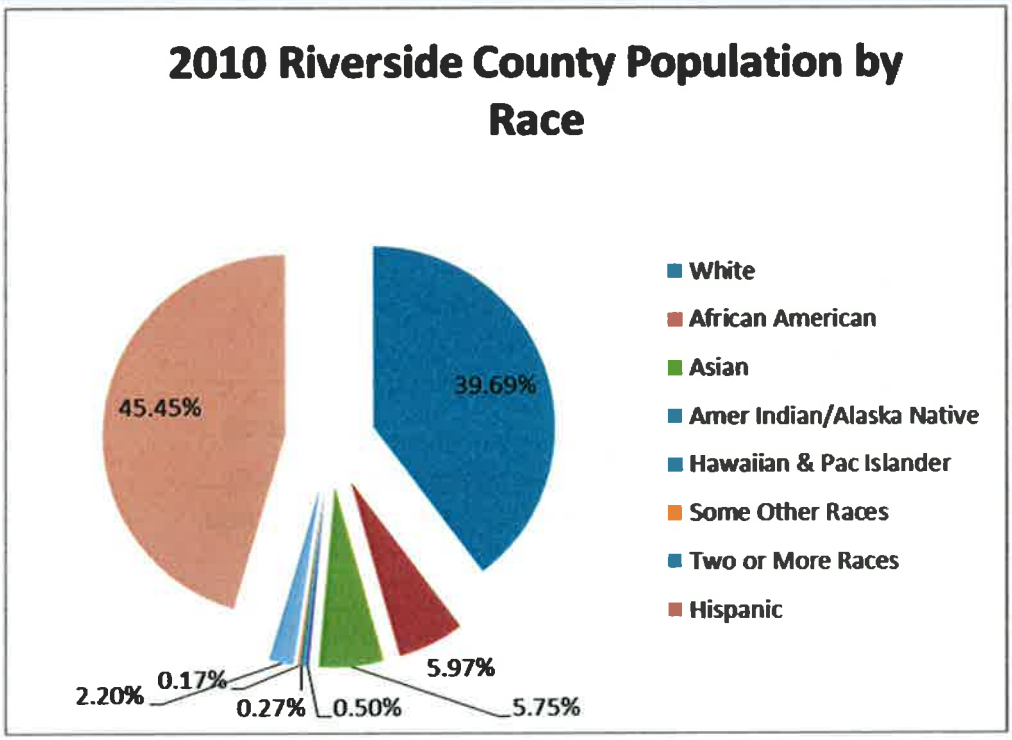
[10] U.S. Census Bureau, 2010 American Community Survey
[11] Ibid.
[12] 2010 American Community Survey 1-Year Estimates Population 60+ in U.S.

the disability rates than their younger cohorts in the County. With greater longevity coupled with greater rates of disabilities, the cost and need of healthcare should be anticipated.

RACE AND ETHNICITY

The 2010 United States Census reported that Riverside County had a population of 2,189,641. The racial makeup of Riverside County was 39.7% Wwhite ~~persons not~~ non-Hispanic, 45.5% persons of Hispanic or Latino origin, 6.4% African American ~~black persons~~, 6.0% Asians, 1.1% Native American ~~American Indian~~ and Alaska Native persons, 0.3% Native Hawaiian and Other Pacific Islander, and 4.8% persons reporting two or more races. [13] The racial and ethnic population of the County is shown on Figure 3.

FIGURE 3. 2010 Riverside County Population by Race



As shown above, the Riverside County population is becoming more ~~a lot more~~ racially and ethnically diverse, which will have an ~~enormous~~ impact on the delivery of social services, mental health services, and health care. D~~The d~~iverse ethnicities will require delivery systems, professionals, providers, and caregivers to be highly sensitive to cultural differences and how those differences impact care. The growing diversity is fueled by a steady flow of immigrants into the County. As a result, ~~the~~ Non-Hispanic Whites are no longer the "majority" group.

[13] U.S. Census Bureau, 2010 Decennial Census

The projected population trend of Riverside County by racial/ethnic groups is shown in Figure 4 for the years 2000-2050 from the Department of Finance[14]:

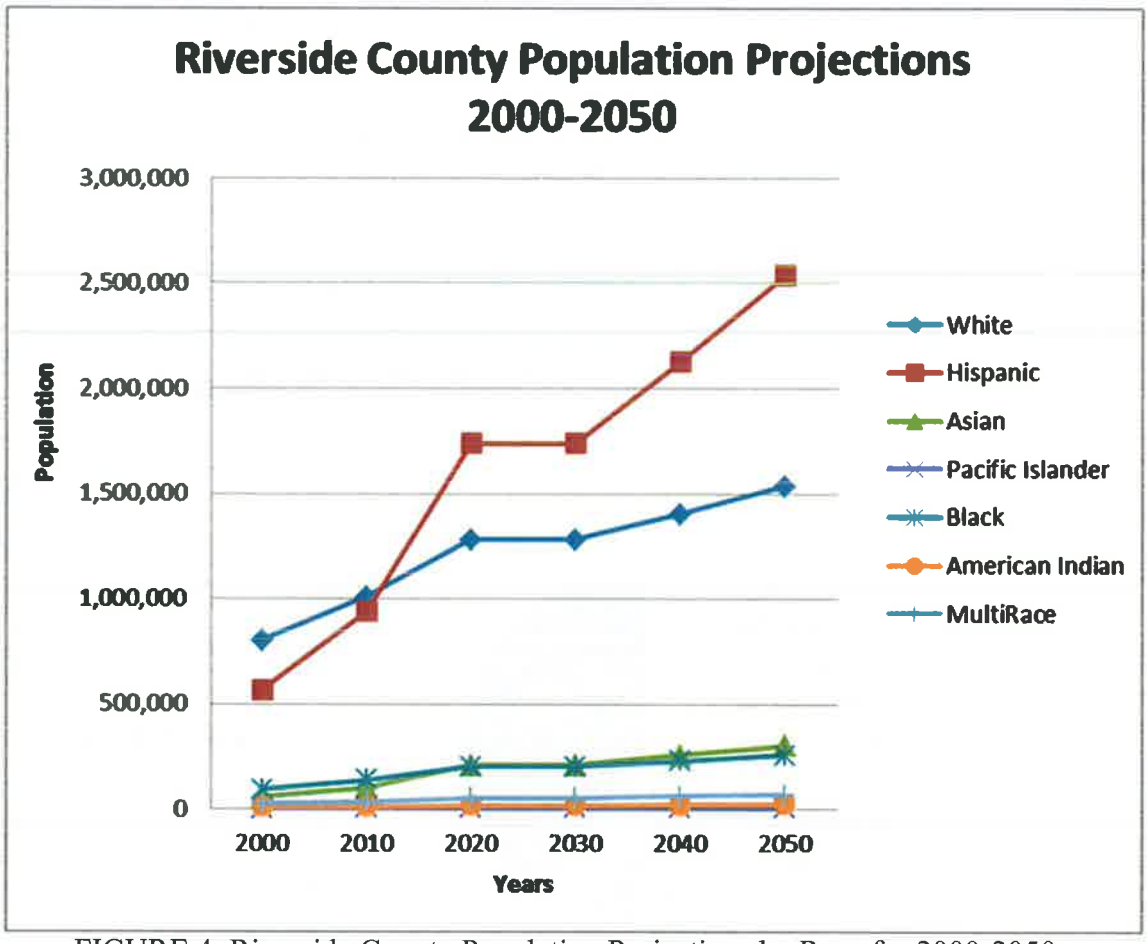


FIGURE 4: Riverside County Population Projections by Race for 2000-2050

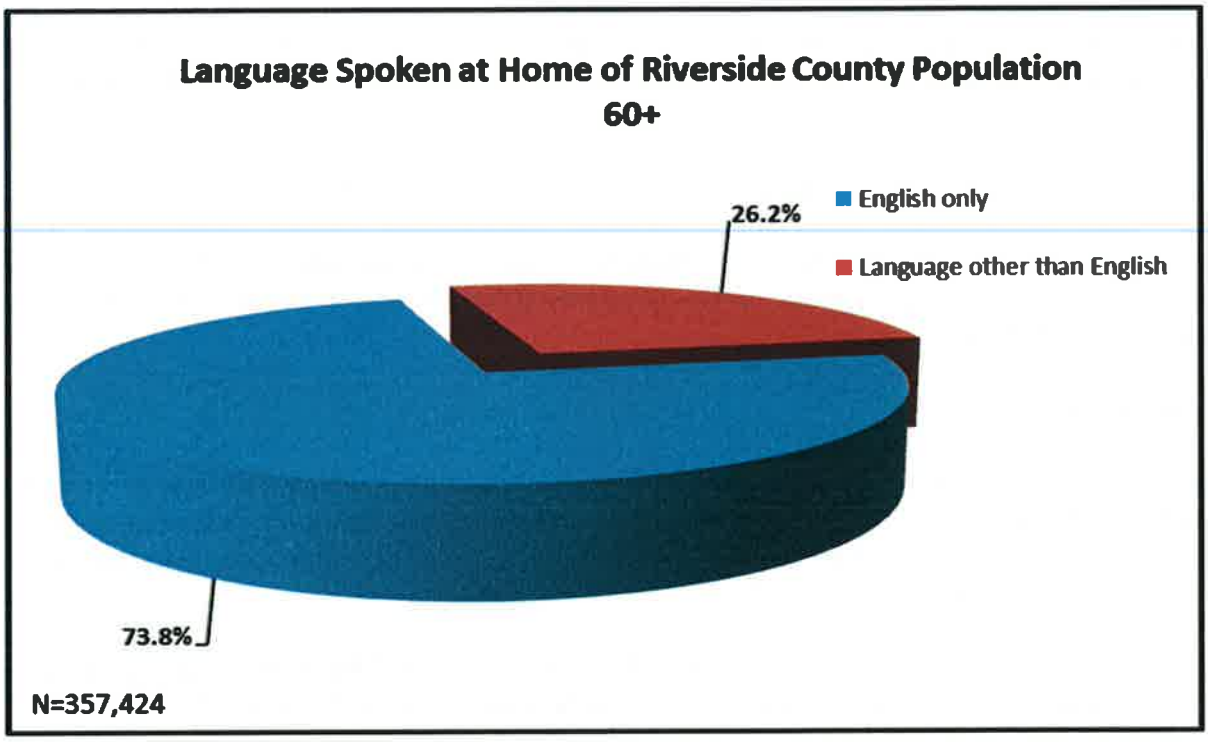
"The longer I live the more beautiful life becomes."
~Frank Lloyd Wright

[14] State of California, Department of Finance, Population Projections for California and Its Counties 2000-2050, by Age, Gender and Race/Ethnicity, Sacramento, California, July 2007

Language Spoken at Home and English Language Ability

As shown in the figure below, three quarters (73.8%) of residents 60 years of age and older speak only English at home. Of the 26.2% that speak a language other than English, 15.0% (about 14,000 residents) reported that they speak English less than "very well."

Figure 5. Language Spoken at Home of Riverside County Population 60+



Source: 2010 American Community Survey 1-Year Estimates Population 60+ in U.S.

UNIQUE CHALLENGES

Governmental Structure

The Planning and Service Area (PSA) designated as PSA 21 is comprised of Riverside County exclusively. The Area Agency on Aging (AAA) is a stand-alone agency that is responsible to the County Board of Supervisor on the local level. The Board of Supervisors is made up of 5 members each representing different areas/districts within the County. As one of the largest counties in the country, Riverside County has a mix of urban, suburban and rural qualities that presents very unique challenges and constraints in the development and sustainability of the service delivery systems required of all AAA.

There are 28 cities in the County, large areas of unincorporated land, and several Native American tribal entities. Two governmental associations facilitate coordination among jurisdictions that seek cooperation on issues of mutual interest and which are broader in scope than a single community. They are the Coachella Valley Association of Governments (CVAG) and Western Riverside Council of Governments (WRCOG). [15]

Rural Population

Despite high population growth during the last decade, the overall population density remains low, estimated at 301.6 persons per square mile. [16] Servicing the entire county presents a unique challenge due to the distance and rural nature of the land. Land uses underscore the rural characteristics of the 7,296 square mile County:

- After residential uses, which make up 58% of the county's land, 28% of the county is open space.
- Agricultural use comprises 5% of the land and industrial/commercial uses make up 2%.
- Mining/recreation and public uses each comprise 1% of total land area.
- The remaining 5% of land includes development, water, freeways, and other uses.[17]

Employment Status

Like the unemployment trends nationwide, Riverside County's unemployment rates have risen dramatically in the last decade. The unemployment rate in the County in 2001 was 5.5%, and then dropped to a low of 5.0% in 2006, to a high of 14.7% in 2010.[18] In fact, in some cities, such as Perris, about 1 in 5 workers are currently without a job. As for the employment status of adults 60 and older, 74.8% are not in the labor force and 25.2% are in the labor force. Of those in the labor force, 21.8% are

[15] Riverside County Transportation and Land Management Agency
[16] California Department of Finance 2010 Census Data and Riverside County Transportation and Land Management Agency GIS
[17] Riverside County Transportation and Land Management Agency, August 2011
[18] California Employment Development Department Historical Annual Average Labor Force for the United States

employed and 3.5% are unemployed. Riverside County adults 60+ comprise 13.8% of the civilian labor force. [19]

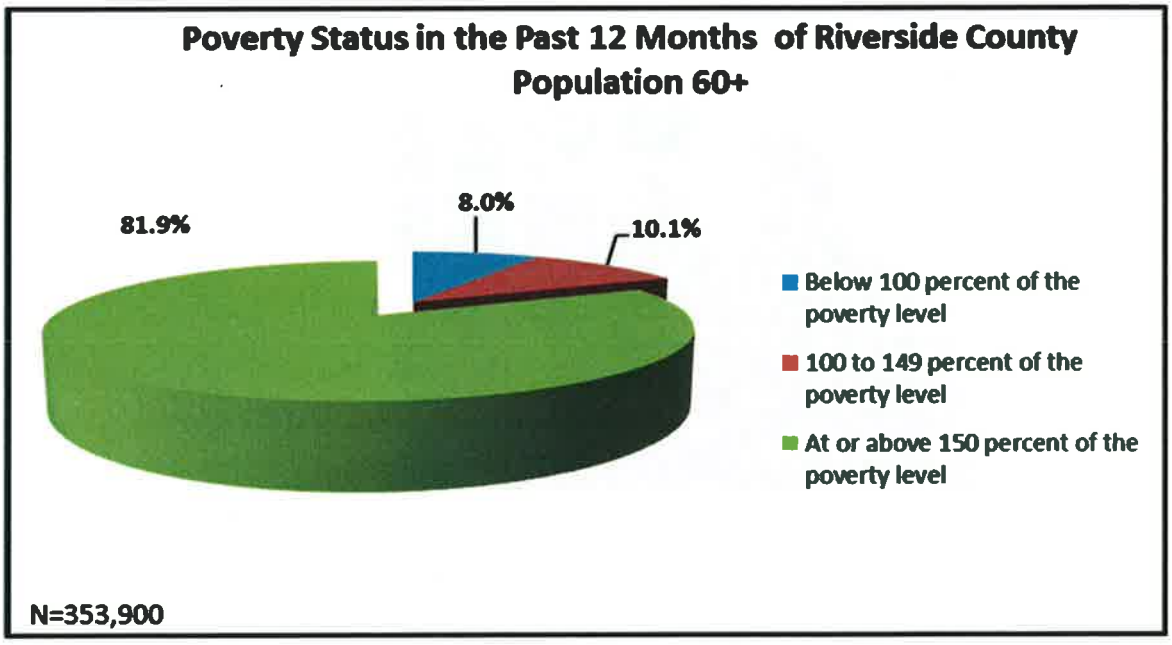
After several years of steady increase, the Riverside County labor force peaked in 2007 at 849,400 and then began to decline. By June of 2011, the total number of people employed declined to 770,800, a decrease of 9.25%. Agricultural employment declined 27% between 2000 and 2010, whereas non-farm employment increased 17% in the same time period. [20] In December 2013, the unemployment rate in Riverside County was down to 9%. [21]

The decline in available employment and concomitant increase in unemployment with the increase in population resulted in Riverside County's unemployment rate being higher than California's during the last five years. And as indicated above, the unemployment rate of elders (age 60 and above) who are in the labor force are greater than that of the general population.

Poverty Level

The majority (8281.9%) of residents 60+ for whom poverty status could be determined haves incomes at or above 150% of poverty. The remaining residents (18.1%) are either between 100-149% of poverty (10.1%) or below 100% of the federal poverty level (8.0%). These data are shown in figure below:

Figure 6. Poverty Level of Population 60+



[19] 2010 American Community Survey 1-Year Estimates Population 60+ in U.S.
[20] California Employment Development Department, Employment by Industry Data for Riverside County.
[21] State of California Employment Development Department Labor Market Information Division; Riverside-San Bernardino-Ontario Metropolitan Statistical Area (MSA) (Riverside and San bernardino Counties) January 24, 2014

Source: 2010 American Community Survey 1-Year Estimates Population 60+ in U.S.

Housing/Household

Most homes in Riverside County are single-family, detached homes. A majority of the housing units are owner occupied (68%) compared to renter occupied (32%). [22] Riverside County has the eleventh largest household size in California as of 2010, with an average household size of 3.1 persons, higher than California (2.9) and the U.S. (2.6). In fact, 77% of Riverside County's cities and unincorporated areas have average household sizes larger than the national average.[23]

For the population 60 years of age or older, there are 203,777 occupied housing units in Riverside County. Of these, 81.4% are owner-occupied (average household size is 2.14) and 18.6% are renter-occupied (average household size is 1.94).

In addition to the larger household size, Riverside County remains high on ~~at the top of~~ national lists for ~~having some of the worst~~ foreclosure rates. In October of 2011, 1 in 157 houses in Riverside County were in foreclosure, according to RealtyTrac, an Irvine company that monitors U.S. foreclosures. In spite of these economic setbacks, in Riverside County, unlike most places in California, about half of the growth is the result of people moving into the area.~~, which is three times the next highest county in California.~~

[22] U.S. Census Bureau, 2009 American Community Survey
[23] California Department of Finance, Demographic Research Unit, State Census Data Center, Demographic Program Summary File, Table 1: Population, Age, and Sex Characteristics, April 1, 2010.

Health and Chronic Disease

According to the National Council on Aging, nearly 92% of older adults have at least one chronic condition, and 77% have at least two; four chronic conditions—heart disease, cancer, stroke, and diabetes—cause almost two thirds of all deaths each year. Diabetes affects 12.2 million Americans aged 60+, or 23% of the older population and 90% of Americans aged 55+ are at risk for hypertension, or high blood pressure. 77% of women aged 75+ have this condition, as do 64% of men aged 75+. Chronic diseases account for 75% of the money our nation spends on health care, yet only 1% of health dollars are spent on public efforts to improve overall health. In 2009 alone, direct health care expenditures for chronic conditions in the United States totaled more than $262 billion.[24]

New research from the Alzheimer's Association of America[25] states that Alzheimer's disease (AD) is the most common form of dementia, making up between 60-80 percent of all cases. One in nine older Americans or approximately 5 million adults over the age of 65 has AD. About one-third of people age 85 and older (32%) have AD and of those with the disease, approximately 82% are age 75 or older. California is home to roughly 10% of the people with AD in the US. By 2030, the number of people living with AD in California will double to over 1.1 million. The total monetary cost of providing care for someone with dementia is $159-$215 billion. It is the most costly disease in America at this time; more than heart disease and direct spending for cancer. [26]

According to a recent study by the Riverside County Department of Public Health, in 2011, there were 3,247 people reported living with AIDS and 1,521 people living with HIV in Riverside County. Eastern Riverside County has almost 2.5 times the number of cases of AIDS and HIV than any other county region. Approximately 60% of people living with AIDS and 45% of people living with HIV in Riverside County are 50 years old or older and between 2009 and 2011, 27% of all new HIV cases were in people 50 years old or older.[27]

Receipt of Income and Benefits

As shown in the table below, the majority (77.4%) of 60+ households receives social security income; the mean (or average) amount received annually is $17,469. About two in five (43.4%) households report earnings—on average of $56,399 annually. About the same proportion (40.9%) report retirement income—on average of $26,041 per year. About one in twelve (8.5%) households receives supplemental security income (an average of $9,409 annually). Just 2.4% of households receive food stamp/SNAP (Supplemental Nutrition Assistance Program) benefits and 1.4% receives cash public assistance.

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[24] National Council on Aging, Healthy Aging Fact Sheet, October 2012

[25] Alzheimer's Association, 2014 Alzheimer's Disease Facts and Figures, Alzheimer's & Dementia, Volume 10, Issue 2.

[26] Falconi, April and Dow, William H. *"Will Boomers Bust the Budget?"* University of California, Berkley's Division of Health and Policy Management, November 2013.

[27] County of Riverside Department of Public Health, Epidemiology of HIV/AIDS in Riverside County, 2011, Epidemiology & Program Evaluation, Presented in 2012 at "Think Tank" for Desert Aids Project

Table 5. Income and Benefit Earnings of Riverside County Population 60+

Occupied Households Units With…	Percent Estimate	Mean Income/ Benefits Percent
Social Security Income	77.4%	$17,469
Earnings	43.4%	$56,399
Retirement Income	40.9%	$26,041
Supplemental Security Income	8.5%	$9,409
Food Stamp/SNAP Benefits	2.6%	--
Cash Public Assistance Income	1.4%	$6,915

Source: 2010 American Community Survey 1-Year Estimates Population 60+ in U.S.

Elder Economic Security Standard™ Index

Older adults who rent need more than twice the amount established by the Federal Poverty Level (FPL) Guideline to meet basic living expenses.[28] Housing and health care are the primary drivers of the high costs. The Elder Index takes into account the actual cost of living within a county, such as the housing, food, transportation, and health care. In contrast, the FPL is a "one size fits all" approach that is the same dollar amount across the country and is based on the cost of food alone. California's high cost of living makes the FPL inadequate as a measure of poverty. However, the FPL is utilized to determine income eligibility for many public programs, to allocate funding for other programs, and is used as an evaluation measure when determining program effectiveness. The 2010 comparison of the FPL versus the Elder Index for Riverside County is shown in the table below (Table 6).

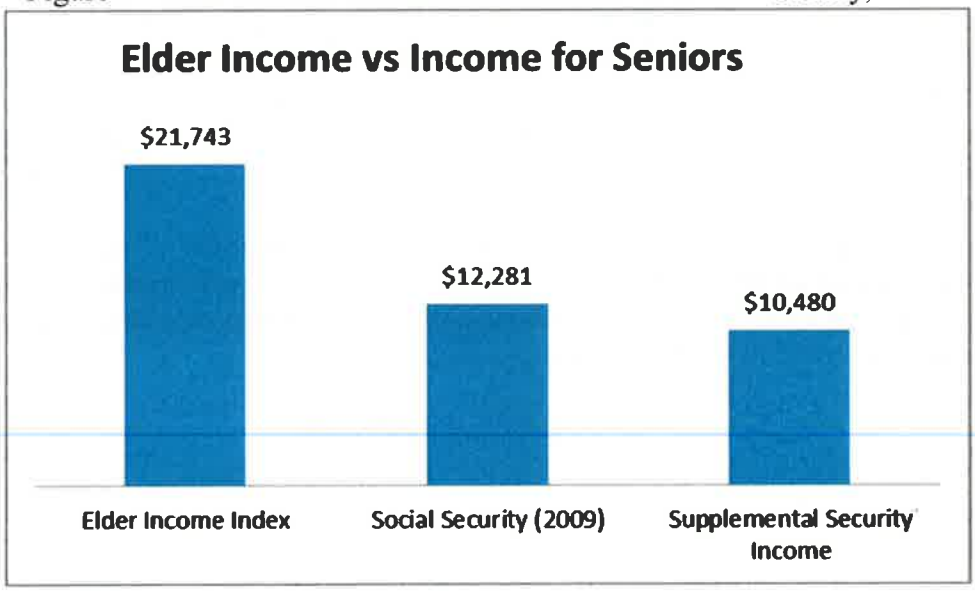
TABLE 6. Elder Income Index Comparison to FPL (Per Person) 2010

	Owner w/o Mortgage	Owner w/ mortgage	Renter, 1 Bdrm
Elder Index Per Year	$15,811	$30,914	$21,743
Federal Poverty Level	$10,830	$10,830	$10,830

Utilizing the above table, the 100% FPL would increase to 146% for owner without a mortgage, 285% for owner with a mortgage, and 201% for a renter with 1 bedroom if the Elder Index were utilized. These higher income eligibility levels would take into account the higher cost of living in Riverside County and also account for those who are "house rich" but have less than adequate income. Not just older adults who are "poor" (those at 100% of FPL) are struggling in Riverside County. Forty-two percent (42%) of all adults age 65+ do not have enough income to meet their most basis needs. Thirty-four percent (34%) of adults age 65+ fall into the eligibility gap with incomes above the FPL but below the Elder Index. These individuals don't have enough money to cover their most basis needs, but have too much to qualify for many public programs. (See Figure 7 below).

[28] Wallace SP, Padilla-Frausto DI, Smith SE. *Older Adults Need Twice the Federal Poverty Level to Makes Ends Meet in California.* Los Angeles, CA: UCLA Center for Health Policy Research, 2010.

Figure 7: Elder Income vs. Benefit Income for Riverside County, 2010



UCLA Center for Health Policy Research (http://www.healthpolicy.ucla.edu/elder index12jan.aspx)

"You are never too old to set another goal or to dream a new dream."
~C.S. Lewis

SECTION 3. DESCRIPTION OF THE AREA AGENCY ON AGING (AAA)

On June 18, 1974, the Board of Supervisors designated the Riverside County Office on Aging as a County Department on Aging for the Planning and Service Area (PSA) 21. It serves as the Area Agency on Aging (AAA) for all of Riverside County and is one of 33 AAA's within the State of California.

The Office on Aging is one of fifty-five departments within the County of Riverside and is located within the city boundaries of Riverside (for its West County office), with satellite offices in La Quinta and in Hemet. Although there are three (3) community based offices, all offices can be contacted by calling one telephone number to handle all inquiries and needs:

1-800-510-2020

The specific addresses for the three locations are:

West County Office:
6296 River Crest Drive, Suite K
Riverside, CA 92507
(951) 867-3800

La Quinta Office:
78-900 Avenue 47, Suite 200
La Quinta, CA 92253
(760) 771-0501

Hemet Office:
749 North State St.
Hemet, CA 92543
(951) 791-3565

The Riverside County Office on Aging, under the federal Older Americans Act and the Older Californian Act, is charged with the role of leadership relative to all aging issues on behalf of all older persons in the County. Under the leadership and direction of the California Department on Aging, the Office on Aging will proactively carry out a wide range of functions related to advocacy, planning, coordination, interagency linkages, information sharing, brokering, monitoring and evaluation, designed to lead to the development or enhancement of comprehensive and coordinated community based systems in, or serving, each community within the County. These systems shall be designed to assist older persons, adults with disabilities, and their caregivers in leading independent, meaningful and dignified lives in their own homes and communities as long as possible.

Under the governance of the Riverside County Board of Supervisors and a seventeen-member citizen advisory council called the ~~,~~the Advisory Council on Aging, the Office on Aging provides customer-centered services based on the vision, purpose, core value, and promise statement defined in our 2012-2016 Strategic Plan. System delivery goals are defined as a result of the following Plan activities:

1. Four Year Strategic Plan – presents future vision and opportunities; identifies key trends and gaps in services; measures progress toward outcomes; and recommends policy, service and funding priorities.
2. Community Assessment – measures assets and local needs of the communities, families, seniors, caregivers, and adults with disabilities in Riverside County.
3. Advocacy – raises visibility of emerging issues and recommends changes in local, state, and national public policy or regulations.
4. Education – sponsors events that address emerging issues and brings key stakeholders together to consider system changes.
5. Systems Coordination – promotes redesign of services to improve customer access and satisfaction.
6. Program Development – creates and pilots new program initiatives to address changing and emerging needs.

Riverside County Office on Aging administers more than ~~over a~~ ten million dollars through an annual budget comprised of public and private funds from Federal, State, County and local sources, including direct, voluntary contributions from older adults who ~~elder individuals who~~ receive services. Funds are used to provide home and community-based services detailed in the Strategic Plan. All decisions are guided by this Plan that analyzes demographic data, evaluates needs and resources, identifies those in greatest need, and sets policy direction and priorities in areas of advocacy, program development, coordination, outreach/education, funding and planning.

SECTION 4. PLANNING PROCESS / ESTABLISHING PRIORITIES

All Area Agencies on Aging (AAA) are charged with addressing challenges and planning activities that reflect the needs, barriers, and gaps in services in the Planning and Service Areas (PSA) that they serve. The planning process and subsequent development of the Strategic Plan provide the format and structure to identify and document needs and address concerns in a manner consistent with the Older American's Act (OAA) and the Older Californians Act (OCA), which enable the communities and AAAs to plan for the future.

The planning process for the development of the Riverside County Office on Aging's (OoA) 2012-2016 Strategic Plan "Focusing on a Healthy Tomorrow" began in 2010, in order to involve as many older adults, caregivers, other consumers, key stakeholders, advisory council members, providers, and the general public in the process so that their concerns and comments could be heard. The first step of the planning process was to share information with the Advisory Council on Aging related to particular mandated components of the Plan. This occurred during Advisory Council on Aging meetings and Leadership Roundtables in various presentation formats and included opportunities for discussion and comments. Topics presented included, but were not limited to, the planning process, issues of LGBT elders, cultural diversity, boomers, and caregivers, including grandparents raising grandchildren, the coordinated care initiative and the dual MediCal/Medicare eligible population. These processes provide the Advisory Council with a baseline of information and ongoing feedback related to the mandated components and better prepares them for understanding and contributing to the Plan development.

A critical step in the planning process was to first identify and understand the targeted population, their needs, existing and potential barriers and gaps in the AAA's ability to meet those needs, and what actions can be taken to meet those needs. The initial assessment of the community needs was done through a variety of methods including, but not limited to, an in-depth analysis of census and other related demographic data sources; researching existing surveys and reports; developing, implementing, and providing analysis of new surveys; gathering input from the community and key stakeholders via focus groups or public hearings; analyzing data obtained from existing programs; determining availability of services; and considering future trends. Ongoing annual assessments serve the same purpose as the initial assessment process.

Focusing on a Healthy Tomorrow

Assessment activities are intended to help eliminate fragmentation of service systems, improve service delivery, and ensure that maximum benefits are obtained through efficient delivery of services to those most in need. Additionally, a critical component of the Plan development process is to take into consideration available funding, regulatory guidelines, partnerships, and pending and existing legislation. The OoA's 2012-2016 Strategic Plan, "Focusing on a Healthy Tomorrow", is a living document that can be viewed as an educational and marketing tool for seniors, families, caregivers, adults with disabilities, and the public at large, as well as an internal roadmap and management tool.

"No one can avoid aging, but aging productively is something else"

~Katharine Graham

SECTION 5 - NEEDS ASSESSMENT

The Older Americans Act and the Older Californians Act mandate that each Area Agency on Aging (AAA) develop an Area Plan every four years, with updates each year under the guidance of the California Department of Aging. In order to develop the four-year plan, the Office on Aging must assess the needs of the community. This process can include, but is not limited to: an in-depth analysis of U.S. Census data and other data sources related to population projections, focus groups with key stakeholders, surveys (in person, via phone, and/or by mail) developed in partnership with other agencies or by the Office on Aging alone, public hearings, and thorough review of existing current reports and assessments from external sources within the County. Once all of the information is compiled and analyzed then the Agency can identify existing and emerging issues.

Needs assessment is a formal process that determines the gaps between current outputs or outcomes and the required or desired outputs or outcomes, orders these gaps by priority, and selects the most important gap or gaps to be addressed. The needs assessment consists of four main tasks:

1. Demographic Data – secondary data obtained from the U.S. 2010 Census, the recent American Community Surveys, Department of Finance, Riverside County Transportation and Land Management's Center for Demographic Research, Riverside County Department of Public Health, and the California Department of Aging.

2. Review of Existing Data – The Riverside County Office on Aging (OoA) determined that it is very helpful, efficient, and cost effective to first research what data is currently available within the county, state, and national networks and communities related to aging. The existing data is then reviewed and analyzed to determine its relevance and incorporation into the development of the Plan.

3. Focus Groups – consists of data from Riverside County residents and providers collected through Plan developed surveys and focus groups conducted by OoA throughout Riverside County. The surveys were done in person or through the web site. Further information regarding the focus groups is described below.

4. Secondary Data Analysis – contracted through Health Assessment Resource Center (HARC) for HARC specific data for the Coachella Valley as well as for California Health Interview Survey (CHIS) for the entire County. Both HARC and CHIS data provides objective, timely, and comprehensive health needs data for the County.

To enhance the demographic data currently available through various sources as well as existing data and to get community involvement and active solicitation of community needs, OoA conducted 19 focus groups, both internal and external, throughout Riverside County, utilizing a survey instrument developed in conjunction with HARC. These focus groups were done either in a group setting or on a one-to-one basis, ranging in size from less than 20 to over 100. The survey information allowed for collection of specific demographic information as well as open ended questions to gather more detailed information of needs. The focus groups were scheduled and conducted at sites that included target population groups: LGBT, institutionalized, limited English, rural, and family caregivers. As well as hard copy survey instruments, electronic voting cards were utilized whenever possible so that the survey participants were able to obtain instant results. The total number of respondents is 1074.

The summary of the focus groups are as follows:

1. Residency of participants:
    - 65% lived in west Riverside County, including the cities/unincorporated areas of Riverside, Moreno Valley, Mira Loma, Murrieta, Menifee, Perris, Sun City, Corona, and the March Air Reserve Base.
    - 8% lived in mid county, including Hemet, Banning, San Jacinto and Beaumont.
    - 27% lived in east County, including Blythe, Palm Springs, Cathedral City, Palm Desert, Desert Hot Springs, Rancho Mirage, Thermal, La Quinta, Coachella, and Indio.

2. Age of participants:
    - The average age is 67.3, with responses ranging from 21 to 99 years of age.
    - The largest proportion of respondents is in the age group 61-70.
    - The second largest proportion of respondents is in the age group 71-80.

3. Sexual Orientation:
    - 81% self-identified as heterosexual or straight.
    - 17% self-identified as gay or lesbian.

4. Race/Ethnicity:
    - Almost two-thirds (62%) self-identified as White.
    - 17% Black or African American
    - 13% Hispanic/Latino

5. Primary Language Spoken at Home:
    - 95% primarily speak English at home
    - 5% speak Spanish

6. Household Income:
    - 36% had household incomes of less than $25,000
    - 27% had incomes of $25,000 to $49,999

7. Need for services were ranked in the following order (most needed to least needed):

- Services for Older Adults and Caregivers, such as transportation, help with homemaker services, personal care, respite care, adult day care, and other services to help individuals remain independent.
- Information, Education and Referrals, including information about health insurance, legal assistance, advocacy for nursing home residents, care coordination, and elder abuse.
- Nutrition, Disease and/or Medical Management, including health promotion and exercise.
- Employment and Volunteer Services, focused on keeping older adults engaged with their community.
- Meal Services, either on-site or home-delivered, ranked the lowest.

8. Gaps or Barrier to Service for **all respondents**: (ranked from Large Barrier to Not at all a Barrier)
    - Chronic medical condition
    - Not having anyone to help
    - Not knowing where to go for help
    - Lack of transportation
    - Disability
    - Isolation
    - Stressed or overwhelmed family caregiver
    - Persistent sadness or sense of hopelessness
    - Limited income

9. Gaps or Barrier to Service for **Respondents 60+ only**: (ranked from Large Barrier to Not at all a Barrier)
    - Limited income
    - Chronic medical condition
    - Not knowing where to go for help
    - Disability
    - Not having anyone to help
    - Lack of transportation
    - Persistent sadness or sense of hopelessness
    - Stressed or overwhelmed family caregiver
    - Isolation

SECTION 6. TARGETING

The Older Americans Act defines a number of "target populations" that have to be taken into consideration by the Area Agency on Aging in their efforts of planning, advocacy, coordination, services, and systems development. Riverside County Office on Aging (OoA) has made concerted efforts to include these target populations in the planning and delivery of community-based services. These target populations include older individuals who are in the social and economic need, with special emphasis on those who are frail, isolated, neglected, and/or exploited, low-income minorities, limited English speaking, those residing in rural areas and Lesbian, Gay, Bisexual, Transgender (LGBT) Elders. Examples of efforts to meet the needs of targeted populations include the following:

- Including language in all contracts requiring a service provider to serve minorities in the same proportion that they represent in Riverside County's older population;
- Ongoing mandatory cultural & diversity training for all staff of the OoA;
- Outreach, educational events, support groups and focus groups sponsored for Limited English speaking older individuals;
- Presence in specific LGBT events, such as the Palm Springs Pride events annually, for distribution of information regarding services available through OoA;
- Working in collaboration with the Department of Mental Health and other county stakeholders on the LGBT task force to help develop policies or advocate for LGBT elders;
- Direct Service delivery systems development in rural areas, such as Blythe, where contracted providers are not available;
- Ongoing educational events that respond to emerging issues in the elderly community, such as the CarFit older driver safety program;
- As an Aging and Disability Resource Center, providing a one-stop resource for information and assistance and referrals throughout Riverside County;
- Conducting on-going Fit After 50 classes, a free fitness programs for seniors aimed at fall prevention and prolonging healthy independence through strength, balance & flexibility training;
- Organizing a local Caregiver Coalition (Inland Counties Caregiver Coalition) with various stakeholder agencies to ensure that caregiver's concerns are effectively recognized through advocacy, education, and empowerment. Through this coalition, efforts include sponsoring and collaborating to host key educational events throughout the County;
- Conducting on-going efforts around disaster preparedness, including partnering with other stakeholders to conduct trainings and to provide starter disaster kits to low income seniors and to their caregivers.

To address the need for "target populations", the California Department of Aging (CDA) has developed a cumulative formula, the Intrastate Funding Formula (IFF), to distribute funding to Area Agencies on Aging. The IFF is as follows:

1 point for each non-minority older adult (60 years and older)
2 points for each ethnic minority older adult
2 points for each low-income older adult

1.5 points for each older adult residing in a rural area

Although not included in the IFF, the OoA also considers the unique needs of caregivers, grandparents raising grandchildren, LGBT individuals, individuals with disabilities, and baby boomers in the planning and delivery of community based services.

"Our lives begin to end the day we become silent about things that matter."

Dr. Martin Luther King

SECTION 7. PUBLIC HEARINGS

PSA 21

At least one public hearing must be held each year of the four-year planning cycle.
CCR Title 22, Article 3, Section 7302(a)(10) and Section 7308, OAA 2006 306(a)

Fiscal Year	Date	Location	Number of Attendees	Presented in languages other than English? [29] Yes or No	Was hearing held at a Long-Term Care Facility? [30] Yes or No
2012-13	2/08/2012	Riverside, CA	24	No	No
2013-14	3/13/2013	Riverside, CA	27	No	No
2014-15	3/12/2014	Riverside, CA	24	No	No
2015-16					

The following must be discussed at each Public Hearing conducted during the planning cycle:

1. Summarize the outreach efforts used in seeking input into the Area Plan from institutionalized, homebound, and/or disabled older individuals.

   In addition to the initial Public Hearing on March 13, 20123, two (2) external and internal focus groups were conducted in 2012, during the development of the Plan ~~during the plan development~~ to seek input from the community. As part of the strategic plan development, specific target populations were identified and focus groups were conducted with members of these identified populations. These target groups included individuals from rural areas, those with limited English speaking ability (translators were provided), Lesbian, Gay, Bisexual, and Transgendered (LGBT), long term care facility residents, elders, caregivers, individuals with disabilities, grandparents raising grandchildren, and service providers. Although a Public Hearing was not held at a Long-Term Care Facility, a focus group was held at a Long-Term Care Facility.

   For the March 123, 20143, Public Hearing, notice of the meeting was posted at the Office on Aging and the Riverside County Administrative Building. In addition, notices were posted in three regional newspapers and members of the public were allowed to submit written comment (via email, fax or correspondence) until 5:306~~:00~~ PM on the day of the Hearing.

2. Were proposed expenditures for Program Development (PD) and Coordination (C) discussed?

   ☒ Yes. Go to question #3

   ☐ Not applicable, PD and C funds are not used. Go to question #4

2 A translator is not required unless the AAA determines a significant number of attendees require translation services.
3 AAAs are encouraged to include individuals in LTC facilities in the planning process, but hearings are not required to be held in LTC facilities.

3. Summarize the comments received concerning proposed expenditures for PD and C. No comments were received concerning proposed expenditures for PD and C.

4. Attendees were provided the opportunity to testify regarding setting of minimum percentages of Title III B program funds to meet the adequate proportion funding for Priority Services

   ☒Yes. Go to question #5

   ☐No, Explain:

5. Summarize the comments received concerning minimum percentages of Title III B funds to meet the adequate proportion funding for priority services.

   Question *(related to Adequate Proportion allocations)*: Where is the rest of the money? That is only 35% or 40%?

   Staff Response: The agency is required to identify these allocations, but you are right, there are other items but these are a minimum requirement. The full plan will show exactly where those dollars are. So I would say that for example, the minimum allocation for the In Home Supports Service category where we have personal care, homemaker, chore, social day care, is 6%. However, 11% as actually allocated due to one-time only money. These are those thresholds that must be identified in the public planning process.

   Question: So then those minimums are then reported back to the federal government? And you have to meet those?

   Staff Response: Yes. We have to meet those.

   Question: They are somewhat discretionary to meet the plan?

   Staff Response: Right, we have some flexibility in those other categories and that is based on even what today's discussion will tell us. Also at some level, there has been other impact to that bigger supportive network if you will. The other concern around these adequate proportions is that title IIIB and Title IIIE were impacted with sequester and have lowered those levels of service.

   ~~No comments received concerning minimum percentages of Title IIIB funds.~~

6. List any other issues discussed or raised at the public hearing.
   One participant expressed concern about the level of service that seniors in her area had been receiving over the past two years. She requested that her senior center be added to the list of Focal Points and advocated for the restoration of congregate meals at the site. No other major issues were discussed or raised. Additional comments were related to sequester cuts and their effect on services and some areas related to health outcomes. A summary of the comments/questions from the Public Hearing and those submitted in writing are listed below.

   ~~No major issues were discussed or raised. Comments/questions that were raised were mainly clarification of particular areas related to health outcomes. All the comments/questions are listed below.~~

7. Note any changes to the Area Plan which were a result of input by attendees.
   ~~Goal II, Objective D. 3 Reference to "emotional wellbeing" has been added to this objective~~

Goal V, Objective D. 2 – Reference to "public and private" after school programs has been added to this objective.

Comments/Questions and Responses:

Public Comment *(on Goal V Objectives related to assistance with grandparents caring for children)*: I don't know if this is the place, but I worked in the Catholic school system, and that is not included, and we have grandparents there too and parents, and the new charter system isn't included. Now maybe that might come up under district as a partnership too if you want to expand that. Another thing is for after school, we increased, in the Catholic School, the time for PE and art education. That gave the teachers time off and they could keep clubs after school. They would have time off to do work or whatever they wanted to do. They would have an extra PE course, and they would have a certain day of the week. Now not all kids wanted to come after school to the clubs, but it really helped the kids and helped the parents in babysitting which they appreciated and also it gave a motivation for kids to come to school. Another thing in Catholic school is that we paid the parents, most if it was grandparents coming in to the schools, we paid for their lunch and we paid for their bus tickets. And I don't know that could not be done in the public school and we didn't have very many volunteers. I taught 21 years in the Catholic school and that will give you an idea in those areas.

Staff Response: So if I understand you correctly on that one you are referring to Goal V, Objective D. 2 and asking us to make sure that we are inconclusive of private and public schools and other forms of school programming?

Public Comment: After school programming, that's correct. We had clubs. I don't know how you want to word it.

Staff Response: It's a form of coordination that is intergenerational. Our RSVP program that is in Coachella Valley utilizes volunteers to assist with mentoring our future leaders. That is a piece of the Clinton health Matters Initiative, which we are a part of and a function of the RSVP program, which we operate in Eastern part of the county.

Public Comment: I live in Good Hope. One of the reasons why I am here today is because our seniors have asked me to be here since I am that MAC (Municipal Action Committee). The other thing that is in your paperwork when I read the plan, it still has us listed as Good Hope and Meadowbrook. Meadowbrook is also part of our MAC in that area, listed under another supervisor.

Staff Response: That district changed.

Public Comment: The other thing I wanted to ask about is in-house or homemaker or chore services and how seniors can be apprised of that service, what information I can take back to our MAC meeting, to let them know how to get those kinds of services. Also, we are also not listed as one of the community focal points in the plan as the Moses-Schaffer Center, which used to be the Good Meadow Center located in Good Hope area of the unincorporated county.

Response: *(from the audience)* Someone from this group could go out and we can talk to the seniors there and if it has to be in Spanish that's OK too. Because we have people that speak the language so we can go out and talk about what the Office on Aging does and what we have to offer them. We don't want your seniors to think that we forgot about them.

Public Comment: Well they do [feel forgotten].

Response: *(from the audience)* That is what we don't want.

Public Comment: It has been almost 2 years and our lunches have stopped. There are no lunches at our center at all. There is nothing happening at our center at all anymore. I am a senior also. And I used to eat the lunches there. My husband is a disabled Vietnam Vet and we are, and I am also a Veteran, from the Marine Corps. We have paid taxes, we are paying taxes. We know that the Office on Aging is getting money and we want to know how come we're not getting the services that we are supposed to get.

Staff Response: We will certainly look into the congregate site and we will certainly work with our council and program staff and certainly the Supervisor's office about your concern. The number for seniors to access all kinds of services is 1-800-510-2020. This might make the right time to maybe introduce a comment about these are federal dollars. Any time we are talking about the Older American Act we are talking about federal dollars. Now the other side of the coin though is that of all the nutrition, and all of the Older American Act cuts, congregate nutrition was cut by last year due to sequester by 8%. It was cut more than any of those Titles you saw on the screen there.

Public Comment: We understand that. Since Good Hope and Mead Valley are two of the poorest places in this county, we should be a little bit higher up on your priority list.

Staff Response: Would you mind sending us an email and our Planner can give you a business card, and you can talk about the focal point and we certainly want to make that correction.

Public Comment: I was going to do that this afternoon so that it will be written. Because normally I turn in paperwork to have my comments become a part of the official minutes of the meeting. I know how it works. I have been doing this for 40 years.

Staff Response: It will help us. We will certainly want to make sure the focal points are very important throughout any community and they really are the local gateway to services for seniors and the Older American Act recognizes that so we want to make sure that we address that.

Public Comment: I appreciate that.

Question: I was just wanted to make something straight from what I have heard in other sources. I don't know about 10%, but I heard that 3 years ago we had 10%, a year again we had 10%, and I think we also had three years of 10 %. This last year, the organization in general and then there was approximately a negotiation down to 5%. Now is this true, do you happen to know if this is true or not from what I heard? Or isn't true? Do you know? Have they had three years of cuts from sequester? Down to 5%? Or is it just 2?

Staff Response: Riverside County lost 9.6 % of the federal baseline funding under the Older Americans Act, which translates into approximately $700,000. My understanding is that the Budget Control Act, which is what triggered sequester, is not going to happen this year, but it can potentially happen in the future if Congress sees that those spending limits must be met.

Public Comment: I would like to have considered when you talk about health initiatives and you have Fit After 50 and I see that you have added a few others. I think one of the other health initiatives, I am not sure of where it would fit, is has to do with Alzheimer's. Depression is under diagnosed and it is a

very costly problem in regard to cost of service and there are very good programs that are very effective in treating depression for older adults and have been adjusted for their particular needs and what they would like to see in programs and I didn't see that reflected in the plan and I think that would be something that would really add some both in the Alzheimer's and also in just the health initiatives.

Staff Response: I do believe we have depression and we have it in there listed as emotional health. Office on Aging is in a partnership with the Department of Mental Health and I think we have been doing a minimum of 1200 screenings per year, specifically for depression for older adults. We have also implemented a Healthy Ideas program, which is an evidence based program specifically to address depression.

Public Comment: You know the other thing that could be added is there is a National Depression Screening Day and it would seem like that would be a very good avenue in which the Office on Aging could partner because they do that yearly. You could just do it at locations where seniors frequent like senior centers or congregate meals and they do that once a year and that seems like a nice partnership that would not cost a lot of resources and you could just get and make submit your application, you could just actually just do screenings.

Staff Response: That is a very good suggestion.

Written Comment Submitted: One of the persons present at the Public Hearing summited a written statement reiterating the points made at the Hearing, which has been summarized above.

Question: Why are people 50 and older getting HIV, do you know how or why or what is going on?

Answer: (From other participant) HIV was not a major concern for those of us over 55 when we were younger. Our major concern was birth control. As our cohort ages and feels less inhibited about sex, our lack of information about this area has left many of us vulnerable. Written information needs to be available and disseminated.

Question: Coachella Valley is largely Hispanic and their first language is Spanish and there is so much negativity regarding HIV, would it be wise to recruit female volunteers fluent in that language.

Answer: This is something we should look at, not only for HIV, but for all our programs.

Question: Is it much more prevalent in one particular group? Hispanics, Whites, Blacks?

Answer: It's more prevalent in the LGBT community and Whites in the Coachella Valley.

Comment: (From a participant) It's because the Coachella Valley is heavily gay and elderly and the numbers will go up. Also in the east valley it is a predominantly Hispanic population and they do not want to talk about HIV or sex. It is a problem, it's going to be a generation or two before there is change.

Response: According to the study outside of the Coachella Valley in Western Riverside County, the prevalence of HIV and AIDS is highest amongst African Americans.

Comment: (From a participant) It's important to remember even though it is uncomfortable to talk about HIV, it's important to the 45 and 65 year old woman to hear this information; this is the group, those who are now widowed, that is re-establishing their lives and having fun.

Response: The need to educate and bring this out (HIV) is important.

Comment: (From a participant) It's interesting the discussion about centenarians and the Blue Zone publication… There are a number of Blue Zones throughout the world and California happens to have one of them. Our Blue Zone is in Loma Linda. It has the highest percentage of people over a hundred. Besides diet, the meshing of the community keeps people involved to give them purpose through being a part of the greater whole.

Questions: What about their minds, are they alert?

Answer: (From a participant) The key is interaction in the community, research shows they are engaged and keep involved in their community. Diet and exercise is a key component.

Comment: The study can be accessed on the internet.

Comment: Page 40 number 3.[Goal II, Objective D. 3] speaks about being fit but states nothing about emotional well-being, and it does not mention mental health, we need to reflect this, it needs to be included as part of the plan. Financial stress takes a toll on emotional, mental health.

Answer: Yes, emotional well-being will be added and clarified.

Comment: With the proposed changes, is everyone in agreement? You will want to take this back to your agencies to review, comments can be submitted until 6PM today if you have any proposed changes.

Question: The full Plan is 118 pages, are these just the changes?

Answer: Yes, these are just the changes.

Question: Where and what is the Older Americans Act mentioned in the hand out?

Answer: The Older Americans Act is federal legislation and outlines this work and how it is funded. An explanation of the Act was in the first few slides of the planning presentation, prior to the Public Hearing. More information can be provided by contacting Jamiko Bell, OoA Planner, and her contact information is in the handout.

Comment: Please explain page 53 number 5. [Goal V, Objective C. 5.]

Response: Webcast for caregivers are being developed, but more time is needed to develop them, hence the extension of the timeline. Caregivers are a growing population and this constituency needs more resources to assist them.

SECTION 8 - IDENTIFICATION OF PRIORITIES

The Riverside County Office on Aging (OoA) planning process includes a needs assessment focusing on older adult residents, as well as organizations and agencies that provide services to older adult. As discussed in Section 5, the needs assessment is a formal process that determines the gaps between current outputs or outcomes and the required or desired outputs or outcomes, orders these gaps by priority, and selects the most important gap or gaps to be addressed. The needs assessment consisted of results from secondary data analysis from existing sources (such as U.S. Census Bureau, American Community Surveys, Health Assessment Resource Center, and California Health Interview Survey) and other county departments (such as Transportation Land Management and Department of Public Health), data from Riverside County residents collected through surveys and focus groups, and data collected from service providers through on line surveys and focus groups. Once all the information was analyzed, the needs identified were quantified in order prioritize the needs. The areas that were identified as a need includes the following:

- Services for Older Adults and Caregivers (such as transportations, personal care, respite care, adult day care, and other services to help individuals remain independent.
- Information, education, and referrals (including information about health insurance, legal assistance, and advocacy for nursing home residents, care coordination, and elder abuse).
- Nutrition Education, Disease and/or Medical Management (including health promotion and exercise).
- Employment and Volunteer Services (focus on keeping older adults engaged with their community).
- Meals Services (either home delivered or on-site).

While the needs for services are many, the resources available in today's economy are limited and, unfortunately, all needs cannot be met under such resource constraints. Revenue insufficiencies with growing program needs, funding silos, fragmented systems, competing priorities, and restrictive eligibility criteria have a major impact on service delivery. As such, setting priorities is essential in the development of the Area Plan. Additionally, there is a time constraint as all priorities established must be accomplished in the four years of the plan cycle.

After a thorough review of the identified top needs and challenges from the needs assessment process described above, as well as Older Californian and Older American Act mandates and guidelines, the Advisory Council on Aging members, Executive Team, Management Leadership Team members, the registered dietitian, and planning staff developed the following five priority goals and associated goal statements:

GOAL I: COMMUNITY FOR ALL AGES

To promote aging friendly communities by engaging new partners and strengthening existing alliances, increasing awareness, providing information and assistance, and streamlining access to service through collaborative and community based program integration. To invest in person centered, community planning efforts to encourage aging within the community through program development and coordination, including transportation, access to needed services, and the continuum of care, affordable housing, and other community based organizations' support.

GOAL II: VITAL AGING

To promote and empower constituents to improve their health and quality of life cycle by providing choices in settings that promote community integration, encourage preventive health and wellness, social activation, and life-long learning. To promote and develop programs and behavior change for managing chronic medical conditions and adopting healthier lifestyles.

GOAL III: AGING FORWARD

To provide responsive service delivery system and strengthen infrastructure through legislative, administrative, and advocacy actions, including promoting programs that results in increased numbers of geriatric competent professionals and paraprofessionals in Riverside County. To advocate and participate in the aging infrastructure, which is the backbone of the home and community based programs.

GOAL IV: AGING WITH INDEPENDENCE

To assist older adults, individuals with disabilities, family caregivers, and community partners to better understand and plan for aging in place for short and long term care needs, including financial sustainability, planning for aging in place, community based supports and services, and end of life issues. To promote a person centered, informed choice options for independence.

GOAL V: CARING FOR ONE ANOTHER

To provide essential support services, such as information and referral assistance, counseling and training, and respite care to people who serve as the primary caregiver for an aging relative or friend. To recognize, advocate, and educate family caregivers, including grandparents raising grandchildren, as a vital resource for long term care and enhanced family stability.

After the completion of the needs assessment, the prioritization of needs, and the development of the five priority goals, the next step in the planning process included the development of broad narrative objectives reflecting issues identified, emerging issues, or mandated requirements. Actions steps, or intended outcomes for each of the objectives were then developed. Consideration was taken in terms of limited funding and resources, targeted populations, and mandated changes. The goals and their objectives and action steps can be found in Section 9 – Area Plan Narrative Goals and Objectives. Finally, service unit plan (SUP) objectives (those for which we must report units of service as required by guidelines related to Older Americans Act revenue) were projected. These objectives are in addition to the above mentioned objectives and actions steps. The SUP objectives are found in Section 10 of this Area Plan.

As presented, the Area Plan goals continue to be in alignment with the mandates of the Older Americans Act and the California Code of Regulations, which require that AAAs allocate Title IIIB federal funds to provide services to older adults in our community under the following priority service categories:

- **Access:** includes transportation, assisted transportation, case management, information and assistance, outreach, comprehensive assessment, health, mental health, and public information.

- **In-Home Services:** includes personal care, homemaker, chore, adult day/health care, Alzheimer's, Residential Repairs/Modifications, Respite Care, Telephone Reassurances, and Visiting.

- **Legal Assistance:** includes legal advice, representation, assistance to the Ombudsman Program and involvement in the private bar.

In the remaining three years, the OoA will provide a breakdown of adequate proportion of funding for access, in-home services, and legal assistance consistent with previously established allocations that have proven to be successful in addressing the need of our community. The minimum proportions of IIIB funding allocated to each of these services are as follows: 25.9% for access, 6% for in-home services, and 3.5% for legal assistance.

SECTION 9 - AREA PLAN NARRATIVE GOALS AND OBJECTIVES

Goal # 1: COMMUNITY FOR ALL AGES

Goal: To promote aging friendly communities by engaging new partners and strengthening existing alliances, increasing awareness, providing information and assistance, and streamlining access to service through collaborative and community based program integration. To invest in person-centered community planning efforts to encourage aging within the community through program development and coordination, including transportation, access to needed services, and the continuum of care, affordable housing, and other community based organizations' support.

Rationale:

- Analysis of Focus Groups results ranked the need for services for older adults and caregivers as a top priority to help individuals remain independent in their community.
- An awareness of reduced capacity of resources and dissemination of the remaining available services and how to access the services continues to be a challenge.
- Increased collaboration and community integration to allow improved access to services is an identified objective that needs to be addressed
- Services are fragmented, duplicative, and program eligibility requirements may be confusing and have become too restrictive.
- Competing priorities exist between public and private sectors and cities and counties due to silos, limited funding, and lack of strategic collaboration.
- The average annual cost of owning an automobile and driving 10,000 to 15,000 miles a year ranges $7,600 to $8,700, which is 78% of an individual's income for those living at Federal Poverty Level. (Source: AAA, "Your Driving Costs 2011"). Thus, for income limited older adults, transportation options are a necessity to remaining in their community.
- Older Californian's are increasingly experiencing income-insecurity. Community service agencies struggle with meeting increased service demands.
- In the Coachella Valley of Riverside County, 5% of older adults (age 55+) report cutting the size or skipping meals because there was not enough money for food. Hispanics were twice as lively to skip meals due to cost. (*HARC Eastern Riverside County Health Monitor Executive Report, 2010*).
- In Eastern Riverside, older adults (55+) were having difficulties finding service or assistance in the areas of financial (58.0%), rental (36.1%), housing (36.3%), utility (18.8%), transportation (11.4%), food (11.4%), and home health care assistance (7.0%). (*HARC Eastern Riverside County Health Monitor Executive Report, 2010*).

Goal I, Objective A: Collaborate with local stakeholders and provide leadership to improve coordination of services and improve access for vulnerable populations, especially via key providers and health care organizations.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** [31] See Action Steps Below	**Update Status** [32]
1. Promote increased coordination of Riverside County Office on Aging's contracted service providers and provide technical assistance as necessary.	7/1/2012 – 6/30/2016		Continued
2. Coordinate with local, public and statewide associations, coalitions, workgroups, and committees such as Riverside County Department of Mental Health's Older Adult System of Care Committee and the California Mental Health Directors Association Older Adult System of Care Committee to promote system improvement and advocacy for increased access to and effectiveness of service delivery related to the unique mental health issues and needs of older adults and individuals with disabilities.	7/1/2012 – 6/30/2016	C	Continued
3. In identified communities, explore alternative options for aging services, education, outreach, resources and referrals by working with local managed care providers involved in the successful Community-Based Adult Services (CBAS) transition and integration managed LTSS and community care.	7/1/2012 – 6/30/20164		Revised
4. Strengthen partnerships and collaborative efforts with senior centers by establishing visits and improved communication in the role of ambassadors to Office on Aging and the community.	7/1/2012 – 6/30/2016		Continued
5. Convene Leadership Roundtable Sessions to educate community partners about aging issues, new program opportunities and trends.	7/1/2012 – 6/30/2016		Continued
6. Actively participate in committees/organizations that serve older adults, persons with disability, and/or caregiver issues.	7/1/2012 – 6/30/2016		Continued

[31] Indicate if Program Development (PD) **or** Coordination (C) – **cannot be both.** If a PD objective is not completed and is continued the following year, the objective must be revised and restated with the remaining or additional tasks.

[32] Use for Area Plan Updates only: Indicate if objective is **New, Continued, Revised, Completed**, or **Deleted.**

7. Coordinate with transportation providers and community partners to promote improved transportation options for elders and disabled.	7/1/2012 – 6/30/2016	C	Continued

Goal I, Objective B: Build on an existing web-based information system to provide a comprehensive, easy-to-use website which will give older adults, caregivers, and adults with disabilities an opportunity to direct their own services.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status** New
1. Coordinate with public, private and nonprofit community agencies, health care providers and businesses to promote the use of Network of Care (NOC) and CalCare Net with an emphasis on reaching those who are culturally diverse, at-risk due to socio-economics ~~diverse cultural, socio-economically at risk~~ and the isolated population.	7/1/2012 – 6/30/2016	C	~~Continued~~ Revised
2. Collaborate in the exploration and future potential for implementation of a Countywide, internet-based consolidated application system that allows consumers to review program guidelines, check eligibility and prepare applications for public benefit programs, such as Cal Fresh, -in efficient person centered focus.	7/1/2012 – 6/30/2016		Continued
3. Collaborate with key stakeholders on the development and implementation on a formal feedback mechanism between providers for mutual consumers, increasing access and satisfaction to Health Care Reform Act.	7/1/2012 – 6/30/2016		Continued
4. Increase database and other resources to provide sources for financial planning and asset management for those consumers with income above poverty levels also referred to as private pay consumers for enhanced life care planning including advanced directives.	7/1/2012 – 6/30/2016		Continued

Goal I, Objective C: Encourage individuals to be active participants in the development of their communities to enable them to age within their communities as long as possible, including being self-prepared in the event of emergency/disaster.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status**
1. Coordinate with county departments, local municipal leadership, contract agencies, social service, and faith based organizations to develop an innovative, coordinated public/private disaster response system to effectively leverage financial, volunteer, and service resources across agencies and geographic areas in the event of a disaster.	7/1/2012 – 6/30/2016	C	Continued Revised
2. Empower individuals in the community about the importance of being self-prepared for an emergency or a disaster through the use of the Info Vans, volunteers, and other outreach and education methods.	7/1/2012 – 6/30/2016		Continued
3. Provide information to individuals about resources available within their communities, such as transportation and housing, to promote independence and choices for aging at home.	7/1/2012 – 6/30/2016		Continued

Goal I, Objective D: Enable older adults and individuals with disabilities 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 and support.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status**
1. Collaborate with acute care and long term care facilities to build a strong care management interface with community based care with the location of a liaison from community based care management systems in targeted facilities.	7/1/2012 – 6/30/2016		Continued
2. Advocate for affordable/accessible housing for elders and individuals with disabilities.	7/1/2012 – 6/30/2016		Continued

3. Advocate for sustained funding for existing rideshare and escort transportation programs, such as the Transportation Reimbursement and Information Project (TRIP).	7/1/2012 – 6/30/2016		Continued
4. Expand the Eric Coleman Care Transitions Intervention Model to include pilot projects with Desert Regional Medical Center, Eisenhower Medical Center, and John F. Kennedy Memorial Hospital as well as to explore other avenues to expand service delivery. ~~addition of a new partnership with managed care organizations or other types of health care organizations and implementation into other care delivery service sites.~~	7/1/2012 – 6/30/20145	PD	~~Revised~~ Revised
5. Through program development of mobility management programs (and the training of community members), educate and increase awareness of and mobility options (such as Car Fit) for older adults, caregivers and adults with disability.	7/1/2012 – 6/30/2016	PD	~~Revised~~ Continued
6. Develop education components and provide information to older adults and adults with disabilities in various formats (including webinars) on topics of healthy behaviors such as managing chronic disease, good nutrition, managing stress, social engagement and at risk behaviors such as gambling, alcohol and substance abuse.	7/1/2012 – 6/30/2016		Continued

GOAL II. VITAL AGING

To promote and empower consumers to improve their health and quality of life cycle by providing choices in settings that promote community integration, encourage preventive health and wellness, social activation, and life-long learning. To promote and develop programs and behavior change for managing chronic medical conditions and adopting healthier lifestyles.

Rationale:

- Analysis of Focus Groups results ranked the need for services for older adults and caregivers as a top priority to help individuals remain independent in their community.
- Collaboration and community integration to promote better self-management of chronic diseases. Studies have found between 40 to 50 percent of costly hospital readmissions are linked to social problems and lack of community resources. (Proctor et al. (2000). *Adequacy of Home Care and Hospital Readmission for Elderly Congestive Heart Failure Patients.* Health and Social Work: 25(2): 87-96 (10)).
- Services are fragmented, duplicative, and program eligibility requirements may be confusing and/or too restrictive.
- Competing priorities exist between public and private sectors and cities and counties due to silos, limited funding, and lack of collaboration and, at the same time, while the fastest growing population is the 85+ age group.
- The average annual cost of owning an automobile and driving 10,000 to 15,000 miles a year ranges $7,600 to $8,700, which is 78% of an individual's income for those living at Federal Poverty Level. (Source: AAA, "Your Driving Costs 2011"). Thus, for income limited older adults, transportation options are a necessity to remaining in their community.
- Older Californian's are increasingly experiencing income-insecurity. Community service agencies struggle with meeting increased service demands.
- In the Coachella Valley of Riverside County, 5% of older adults (age 55+) report cutting the size or skipping meals because there was not enough money for food. Hispanics were twice as lively to skip meals due to cost. (*HARC Eastern Riverside County Health Monitor Executive Report, 2010*).
- In Eastern Riverside, older adults (55+) were having difficulties finding service or assistance in the areas of financial (58.0%), rental (36.1%), housing (36.3%), utility (18.8%), transportation (11.4%), food (11.4%), and home health care assistance (7.0%). (*HARC Eastern Riverside County Health Monitor Executive Report, 2010*).
- Researchers at Brigham Young University in Utah found that people who have good social relationships are half less likely to die early than more isolated people. Lack of social relationships was equivalent to smoking up to 15 cigarettes a day, equivalent to being an alcoholic, was more harmful than not exercising and twice as harmful as obesity.
- In the 85+ population, 1 out of 2 is diagnosed with Alzheimer's disease.
- Every year, one in three Americans age 65+ fall, leading to injury, loss of independence, and even death (NCOA),
- One in 5 older adults struggle with mental health issues, including depression, anxiety, and suicide (NCOA).

Goal II, Objective A: Empower elders, individuals with disabilities, and family caregivers to make informed decisions about, and to be able to easily access existing health and long-term care options.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status**
1. Expand Preventative and Early Intervention (PEI) service programs into Western Riverside County, which will include identifying caregivers, older adults, and individuals with disabilities and those who speak limited English who are at risk of mental health issues such as grief, end of life and clinical depression. These PEI Mental Health services will provides support, counseling, education for the identified clients.	7/1/2012 – 6/30/2014	PD	Revised
2. Inform and empower individuals and caregivers to be self-advocates for emotional/health management long term care including palliative care and end of life care planning and decision making.	7/1/2012 – 6/30/2016		Continued

Goal II, Objective B: Provide opportunities for Office on Aging staff to cross train with local independent living center staff in order to increase OoA's knowledge about individuals with disabilities, long term care, and deinstitutionalization.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status**
1. Coordinate with Community Access Center, the Inland Empire Disability Collaborative, and other organizations to arrange for opportunities for cross training of Information and Assistance Specialists and sharing of resources for persons with disabilities so that OoA can provide enhanced and responsive service to this population.	7/1/2012 – 6/30/2016	C	Continued

Goal II, Objective C: Coordinate with County Human Resources Department and community partners to expand/enhance mature worker employment opportunities.	**Projected Start and End Dates**	**Title III B Funded PD or C**	**Update Status**
	See Action Steps Below	See Action Steps Below	
1. Advocate for mature worker programs in County Strategic or General Plans through the Workforce Investment Board and other local networks.	7/1/2012 – 6/30/2016		Continued
2. Coordinate and collaborate with private and public businesses/agencies to promote employment opportunities that promote and sustain the value and contribution of mature workers/volunteers and improve recruitment and retention policies and initiatives, through pilot programs such as Enhanced Network of Community Opportunities and Resources for Employment (ENCORE) program.	7/1/2012 – 6/30/2016	C	~~Continued~~ Revised

Goal II, Objective D: Encourage healthy aging through the promotion of proper nutrition, disease prevention, medication management, fall prevention, and importance of socialization and prevention of isolation.	**Projected Start and End Dates**	**Title III B Funded PD or C**	**Update Status**
	See Action Steps Below	See Action Steps Below	
1. Provide information to elders, disabled, and family caregivers via the OoA Info Van Program, through community presentations, with the focus on the proper use and importance of management tools, such as a personal health guide to record medications/health information and/or assistive devices available, self-management of chronic conditions, and fitness of the brain and body.	7/1/2012 – 6/30/2016		Continued
2. Provide nutrition education to congregate and home delivered meal participants and the community in general via the Nutrition Info Van.	7/1/2012 – 6/30/2016		Continued

3. Inform and coach consumers on ways to prevent falls, manage chronic disease, increase awareness and safe practices for sexually active older adults and provide opportunities to improve overall health, wellness, and mental wellbeing; for example, through coordination with key partners such as through the Fit-After-50 Program and other evidence based programs, ~~(which is a strength, flexibility and balance exercise program),~~ Info Van outreach, Care Coordination programs~~.~~, the Clinton Foundation Health Matters Initiative and the Desert AIDS "Get Tested Coachella Valley" Project.	7/1/2012 – 6/30/2016	C	Revised
4. Expand evidence based fitness~~/exercise programs~~ promoting physical activity to meet the needs of targeted populations such as ~~the~~ B~~b~~oomers and the Limited English Speaking consumer with emphasis on behavior activation and disease prevention.	7/1/2012 – 6/30/2014	PD	Revised
5. Participate in community collaborations that address elder abuse prevention, issues of elder abuse and neglect, and provide community outreach/education, such as, the CARE Team, Clinical MDT, Elder Death Review Committee, Ombudsman Program, etc.	7/1/2012 – 6/30/2016		Continued
6. Encourage elders, individuals with disabilities, and caregivers to educate themselves about ways to keep safe and healthy in relation to elder abuse, falls, home safety, and healthy behaviors/wellness activities.	7/1/2012 – 6/30/2016		Continued
7. Advocate for intergenerational learning programs and interaction in the community to combat ageism and mentor community residents.	7/1/2012 – 6/30/2016		Continued
8. Explore programs that encourage "brain fitness" exercises and education with emphasis on online learning and other new alternatives for social activation.	7/1/2012 – 6/30/2016		Continued
9. Enhance 911 Senior Emergency Cellular Phone Program that provides elders and persons with disabilities immediate access to 911 for emergencies. Program Development will include the marketing, collections, programming, and distribution of donated cell phones through the advocacy efforts of the Riverside County Advisory Council on Aging.	7/1/2012 – 6/30/2016		~~Revised~~ Continued

10. Explore and develop key partnerships to increase ~~additional~~ evidence based programs for improved emotional assessment management, access to public services or performance outcomes for older adults and persons with chronic illnesses, such as the Healthy Options Program (HOP) and Cal Fresh in conjunction with other public, non-profit and private agencies and regional partners that serve the older adult population.	7/1/2012 – 6/30/2016	C	Revised

GOAL III. AGING FORWARD

To provide responsive service delivery system and strengthen infrastructure through legislative, administrative, and advocacy actions, including promoting programs that results in increased numbers of geriatric competent professionals and paraprofessionals in Riverside County. To advocate and participate in the aging infrastructure, which is the backbone of the home and community based programs.

Rationale:

- Riverside County's aging population continues to grow at a rate that outpaces that of the average rate of California, with the 2010 U.S. Census showing 357,560 adults age 60+ and the 85+ cohort growing at the fastest proportional rate (75% growth rate as compared to 69% for the 60+ age group).
- Riverside County is becoming more ethnically diverse which necessitates infrastructural changes to meet the demands of the diversity. In 2010, 39.69% of the county's population self-identified as White while 45.45% was Hispanic.
- Implementation of state and federal regulations at the local level may result in administrative policies which inhibit movement toward integration/coordination.
- Revenue insufficiencies have implications on the infrastructure and its related service delivery system.
- Increased populations in older adults will result in an even greater shortage of geriatric professionals and paraprofessionals, particularly in a county as large as Riverside County. It is predicted that 3000 physicians will be needed by 2020 in the county (Press Enterprise, "*Inland: 3000 Doctors Already Needed*", Lora Hines). According to the California Healthcare Foundation 2009 report, nationally, there are 220 physicians/100,000 residents, California has 170 doctors/100,000 residents, and Riverside County has only 100 physicians/100,000 residents.
- A lack of knowledge of and sensitivity to the aging process and unique needs of diverse cultural populations, including Lesbian, Gay, Bisexual, and Transgendered (LGBT), impacts service delivery and progress toward an aging and culturally friendly community.
- In 2010, the population of Riverside County reached 2,189,641. More than half of the total population are people of color and from 65,689 to 218,964 residents are LGBT.

Goal III, Objective A: Active participation in local, state, and national policy organizations, committees, and networks to ensure that any trends and regulations are incorporated into the Office on Aging's operational structure.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status**
1. Attend and/or participate in local, state, and national conferences, summits, committees and networks in order to be kept current on aging, disabled, and caregiver related programs/policies, and advocate for change as necessary.	7/1/2012 – 6/30/2016		Continued
2. Coordinate with public and nonprofit agencies, and cities within Riverside County to address issues related to older adults, persons with disability and family caregivers and provide input on stable and safe communities, chronic disease self-management, preventative medical and mental health screenings, proper nutrition, exercise, maintaining social connections and caregiving as appropriate to civic and county leaders for local planning initiatives and community needs.	7/1/2012 – 6/30/2016	C	~~Revised~~ Continued
3. Network with Board of Supervisor appointed Veterans Advisory Committee members and other county service organizations to advocate for the needs of Veterans.	7/1/2012 – 6/30/2016		Continued
4. Explore other funding opportunities centered on community-based initiatives in order to leverage existing and potential future services.	7/1/2012 – 6/30/2016		Continued

Goal III, Objective B: Advocate through legislative and collaborative networks for restored service levels and adequate funding and pursue on an ongoing basis other opportunities for service funding.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status**

1. Collaborate with associations, such as the California Association of Area Agencies on Aging (C4A), National Association of Area Agencies on Aging (N4A), Triple-A Council of California (TACC), and others, to develop an advocacy plan for restored service levels and adequate service funding as necessary.	7/1/2012 – 6/30/2016		Continued
2. Coordinate with other County departments and key stakeholders to develop an advocacy strategy to advocate with federal and state officials for equitable distribution of funds and local flexibility of the Older Americans Act funding to best leverage service needs.	7/1/2012 – 6/30/2016	C	Continued
3. Review and appropriately respond as possible to reductions in service levels for at-risk populations.	7/1/2012 – 6/30/2016		Continued

Goal III, Objective C: Promote an aging friendly environment responsive to the needs of diverse, cultural, social, and economic elder, disabled, and caregiver populations.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status**
1. Review and modify as necessary methods of reaching targeted populations, such as low income elders, LGBT, limited English speaking, those residing in rural areas, family caregivers, individuals with disabilities, and others who are underserved or have unmet needs.	7/1/2012 – 6/30/2016		Continued
2. Promote an aging and culturally friendly work environment, addressing issue in the workplace that may arise, and provide a leadership model for our partners.	7/1/2012 – 6/30/2016		Continued
3. Provide ongoing sensitivity training to staff on the unique needs of multi-faceted, diverse populations such as limited English speakers~~ing~~, Boomers and LGBT individuals with an emphasis on improving any cultural constraints.	7/1/2012 – 6/30/2016		~~Continued~~ Revised
4. Outreach to other County agencies and key community partners to share LGBT and culturally sensitivity training materials for consumers.	7/1/2012 – 6/30/2016		Continued

5. Coordinate with managed care organizations, universities, and health care coalitions and networks to address ~~issues~~ trends related to existing and emerging health care crisis including, but not limited to ~~Alzheimer's~~, Alzheimer's disease, and the significant lack of geriatric competent health care professions, and promote opportunities and pathways for such professions, including providing work placements to reduce ageism through work experience.	7/1/2012 – 6/30/2016	C	Revised
6. Advocate for an elder's right to positive and healthy aging.	7/1/2012 – 6/30/2016		Continued

Goal III, Objective D: Act in accordance with local, state, and federal statutes and regulations.	**Projected Start and End Dates**	**Title III B Funded PD or C**	**Update Status**
	See Action Steps Below	See Action Steps Below	
1. Keep abreast of local, state, and federal statutes and regulations and comply with reporting requirements/mandates, including but not limited to, strategic plan updates, financial reporting, etc.	7/1/2012 – 6/30/2016		Continued
2. Explore grant opportunities and other creative funding avenues to assist in the leveraging of programs and services consistent with future outcome trends.	7/1/2012 – 6/30/2016		Continued

Goal III, Objective E: Maximize operational efficiencies through enhanced quality improvement initiatives and maintain an effective and responsive leadership team.	**Projected Start and End Dates**	**Title III B Funded PD or C**	**Update Status**
	See Action Steps Below	See Action Steps Below	
1. Leadership Team will meet minimally on a monthly basis to review agency operations and programs, make decisions as necessary to be responsive to occurring priority needs, and ensure the most efficient delivery of services, especially related to high priority needs.	7/1/2012 – 6/30/2016		Continued

2. Apply techniques and outcome measures routed in the continuous quality improvement (CQI) paradigm to enhance CQI initiatives.	7/1/2012 – 6/30/2016		Continued
3. Provide opportunities for consumers to give feedback on program operations and customer service, and make appropriate improvements as necessary.	7/1/2012 – 6/30/2016		Continued
4. Provide an opportunity for staff to evaluate their roles/satisfaction with the agency on an annual basis and make improvements as necessary.	7/1/2012 – 6/30/2016		Continued
5. Provide growth and enrichment opportunities for Leadership Team members via bi-annual professional seminars, in-service, etc.	7/1/2012 – 6/30/2016		Continued

Goal III, Objective F: Support employee professional development and succession planning.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status**
1. Support employee professional development by encouraging continued education at schools of higher learning, attendance at in-service trainings, and participation in conferences, etc. when funding permits.	7/1/2012 – 6/30/2016		Continued
2. Provide opportunities for certification and/or recertification of HELPLINK and Info Van employees through the California Association of Information and Referral Systems (CAIRS) program and allow for additional training as a means of enhancing staff's knowledge and capacity for engaging consumers with services and support. This includes certification of all new I&A staff, enhanced skill training, options counseling basics, and Care Transitions Intervention (CTI) information.	7/1/2012 – 6/30/2016		Continued
3. Provide opportunities for employee participation on Motivation and Morale (M&M) Team to enhance employee leadership and effectiveness in the organization.	7/1/2012 – 6/30/2016		Continued

GOAL IV. AGING WITH INDEPENDENCE

To assist older adults, individuals with disabilities, family caregivers, and community partners to better understand and plan for aging in place for short and long term care needs, including financial sustainability, planning for aging in place, community based supports and services, and end of life issues. To promote a person centered, informed choice options for independence.

Rationale:

- There is a misconception by a large majority of the American public that the government will provide long term care when needed. In fact, MediCare, with very minimal exceptions, does not cover long term care.
- Consumer confusion and difficulty in accessing needed service results in over-utilization of unnecessary and costly care, such as emergency room visits or longer-than-required nursing home stays.
- The state administrative structure for long term services and support (LTSS) is fragmented, siloed, and expensive ($7 billion of state funding in fiscal year 2005-2006). (Little Hoover Commission, April 2011).
- In Office on Aging Focus Group surveys, Chronic Medical Conditions (47%), disability (42%), and Limited Income (58%) continues to be "Somewhat of a Barrier" or a "Large Barrier".
- Studies have found between 40 to 50 percent of costly hospital readmissions are linked to social problems and lack of community resources (Proctor et al. (2000). *Adequacy of Home Care and Hospital Readmission for Elderly Congestive Heart Failure Patients.* Health and Social Work: 25(2): 87-96(10)).
- Many seniors (25.2%) nearing retirement have found themselves looking for employment in Riverside County, where the unemployment rate was 14.7% in 2010 (California Employment Development Department, 2010). In fact, in some cities like Perris in Riverside County, 1 in 5 workers of all ages are without a job.
- 70% of older adults (65+) will need 3 years of Long Term Care. 66% could not afford LTC for more than 3 months.
- According to the UCLA Center for Health Policy Research, older adults need twice the Federal Poverty Level to make ends meet due to housing and health care cost. The Long Term Care costs per month in Riverside County for 6, 16, and 36 hours per week is $6,786, $18,403, and $33,076 in 2007. The Elder Income Index for the same time period is $20,703. (http://www.healthpolicy.ucla.edu/elder_index08feb.html.)
- California is ranked in the bottom quartile for Quality of Life and Quality of Care: Dimension and Indicator Ranking in the state scorecard ranking of long-term services and support (Source: Reinhard, Susan et. al, *Raising Expectations – A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*. September, 2011).

Goal IV, Objective A: Provide leadership for the development of a streamline system to provide consumers, caregivers, and providers with information, assistance, and support.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status**
1. Convene meetings of public benefits programs to determine efficacy of streamlining local processes for eligibility to Long Term Care (LTC) programs. Continue evaluation of LTC counseling standards as an ADRC.	7/1/2012 – 6/30/2016		Continued
2. Build upon existing framework of broad service network by providing older adults, adults with disabilities, caregivers and their families with enhanced access to enrollment assistance and referral to appropriate resources/programs through a comprehensive intake, options counseling, decision support and follow up.	7/1/2012 – 6/30/2016		Continued
3. Expand information and assistance services to include Option Counseling, an interactive decision-support and counseling process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate long-term care choices in the context of consumer's needs, preferences, values and individual circumstances.	7/1/2012 – 6/30/2016		~~Revised~~ Continued
4. Collaborate with critical partners and stakeholders for improved coordination of LTSS for better access of public benefits and community based services through promotion of an integrated seamless service delivery system, increasing access and support for at-risk populations. This includes, but is not limited to, working with local managed care providers on the Dual Eligible Demonstration Project and health insurance expansion through the Affordable Care Act.	7/1/2012 - 6/30/2016	C	~~Revised~~ Continued

5. Coordinate with managed care organizations, LTSS stakeholders, community based organizations, and others to advocate for LTSS needs of older adults and adults with disabilities, especially with the Health Care Reform Act implementation by participating in advocacy efforts to improve the quality of life for older adults, insuring consumer rights practices and supporting community based options.	7/1/2012 – 6/30/2016	C	Revised

Goal IV, Objective B: Educate older adults, caregivers, and the community, including identified target populations, such as limited English speaking, Lesbian, Gay, Bisexual, Transgendered (LGBT) and Boomers about the Office on Aging and its Aging and Disability Resource Connection (ADRC) program and long-term services and supports.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status**
1. Enhance current Office on Aging services with the development of new program components and partnerships that will expand awareness of healthy aging from birth through the lifespan and provide information resources to assist individuals, families, and communities to plan for aging, manage chronic disease and plan for future treatment and care options with an emphasis on independence and choice.	7/1/2012 – 6/30/2016		Continued
2. Outreach to caregivers, train and provide community education on the benefits of adult day care (when appropriate and available) and respite through other community-based supportive services as appropriate and available.	7/1/2012 – 6/30/2016		Continued
3. Increase awareness to community based options and benefits and provide education of OoA programs and services to promote long term care options and increase informal social support within the local community	7/1/2012 – 6/30/2016		Continued

GOAL V. CARING FOR ONE ANOTHER

To provide essential support services, such as information and referral assistance, counseling and training, and respite care to people who serve as the primary caregiver for an aging relative or friend. To recognize, advocate, and educate family caregivers, including grandparents raising grandchildren, as a vital resource for long term care and enhanced family stability.

Rationale:

- Although informal caregivers (those adults who provide care to a family member or friend coping with an illness or disability) appear to be as healthy as non-caregivers of the same age, they report higher levels of psychological distress and engagement in poor health related behaviors, such as smoking and binge drinking (Source: Hoffman GJ and Mendez-Luck CA. *Stressed and Strapped: Caregivers in California*. Los Angeles, CA: UCLA Center for Health Policy Research, 2011).
- In 2009, California caregivers provided an estimated 3.9 billion hours of care at an estimated value of $47 billion (AARP Public Policy Institute 2011). (Website: Http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf)
- Of the almost 6.28 million caregivers in California, 11.4% (706,000) are age 65+. (2009 California Health Interview Survey). 51.6% of caregivers are working full time and 11.2% work part time.
- In 2009, California's informal caregivers may have experienced financial pressures as 15% were at 100% Federal Poverty Level (which is $10,830 for an individual) and nearly 20% of caregivers spent more than $250 of their own money caregiving. If the actual cost of living was applied through the Elder Income Index, a single older adult renting would need $21,763 per year to make ends meet, which is over 200% of FPL.
- Although the strains of caregiving may be alleviated by respite services, only 13.5 % of caregivers report ever utilizing respite care (2009 California Health Interview Survey).
- Older caregivers are more likely to be caring for a spouse or partner (29.8%), living with the person they are caring for (45.2%), and caregiving for a longer period of time (61.8 months). All of these result in greater need for support services, respite services, and psychosocial education and support groups.
- California is home to approximately 10% of people with Alzheimer's disease in the U.S. By 2030, the number in California will double to over 1.1 million. At least 25% of California's caregivers have been providing care for 6 years or more and there are approximately 1.1 million Californians who provide unpaid care for a person with AD or dementia.
- The total monetary cost of providing care people with dementia is $159-$215 billion. It is the most costly disease in America at this time; more than heart disease and cancer.
- The number of Grandparents Raising Grandchildren (GRG) continues to increase, as shown by the following GRG demographic statistics:
  - According to the 2010 Census, there are nearly 60,000 households in Riverside County where grandchildren are living with a grandparent.

Goal V, Objective A: Collaborate with local stakeholders and provide leadership to improve coordination of services and provide a more seamless system of access for caregivers.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status**
1. Develop and distribute GRG newsletters to inform grandparents about health and wellness resources, legal system links, financial resources as well as upcoming training and workshops.	7/1/2012 – 6/30/2016		Continued
2. Expand existing resource framework to be inclusive of ~~children~~ persons with disabilities in conjunction with our community partners of Community Access Center, the Multi-Disciplinary Team (MDT), and OoA GRG program and promote improved financial literacy.	7/1/2012 – 6/30/2016		~~Continued~~ Revised
3. The GRG Program and the Public Relations Committee will partner key stakeholders including the Department of Public Social Services to collaborate ~~for youth outside of the foster care system~~ to better assist grandparent relative caregivers with preparing their grandchildren for independence and success.	7/1/2012 – 6/30/2016		~~Continued~~ Revised

Goal V, Objective B: Collaborate with local stakeholders to provide leadership in the development of education, outreach, and resources for family caregivers and Grandparents Raising Grandchildren (GRG).	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status**
1. Through the local caregiver coalition, Inland Counties Caregiver Coalition (ICCC), comprised of AAA staff, local agencies, non-OoA funded agencies, community based organizations, and faith based organizations, coordinate activities that will include education, outreach, and addressing the service needs of the caregivers by leveraging resources and reducing duplication and fragmentation of service delivery.	7/1/2012 – 6/30/2016	C	~~Continued~~ Revised

2. Collaborate with health care, managed care and other community based organizations to provide education and resources for caregiving community.	7/1/2012 – 6/30/2016		Continued
3. Collaborate with existing Adult Day Care (ADC) and other organizations to leverage existing partnerships in order to explore alternative options that may be available to meet the needs of caregivers and care recipients.	7/1/2012 – 6/30/2016		Continued
4. Provide support to leaders/facilitators (volunteers and professionals) of local caregiver and GRG support groups	7/1/2012 – 6/30/2016		Continued
5. Expand existing resource framework ~~to be inclusive of children with disabilities~~ in conjunction with our community partners of Community Access Center, the MDT, and OoA GRG program and promote improved financial literacy.	7/1/2012 – 6/30/2016		~~Continued~~ Revised
6. Develop caregiver education components and provide information in various formats (including webinars) on topics of healthy behaviors such as managing chronic disease, good nutrition, managing stress, social engagement and at risk behaviors such as gambling, alcohol and substance abuse.	7/1/2012 – 6/30/2016		Continued

Goal V, Objective C: Sustain/improve support systems for caregivers and grandparents raising grandchildren to enhance family stability.	**Projected Start and End Dates** See Action Steps Below	**Title III B Funded PD or C** See Action Steps Below	**Update Status**
1. In coordination with local officials, County departments, Grandparents Raising Grandchildren Task Force (GRGTF), the Riverside County Youth Advisory Council (YAC) ~~Commission,~~ Child Protective Services, and community networks to address changing/emerging needs and make appropriate influences on the service delivery system, including educating public social workers and mental health workers about the unique issues, barriers and challenges facing grandparents raising grandchildren.	7/1/2012 – 6/30/2016		~~Continued~~ Revised

2. Provide care management and supportive services to assess needs of grandparents and link them to necessary resources and support systems; convening Multi-Disciplinary Team (MDT) meetings as needed to assist grandparents with more complex situations that require outside intervention from other county departments and community agencies.	7/1/2012 – 6/30/2016		Continued
3. GRG Program and the GRGTF Public Relations Committee will be a leaders in the development and coordination and coordination of countywide regionalized training seminars and/or collaborative resource fairs related to the unique needs of grandparents raising grandchildren.	7/1/2012 – 6/30/2016		Revised
4. GRG Legislative Committee will partner with the Riverside County Office on Education (RCOE) and local school districts to better assist grandparents with school issues continue advocacy efforts with state and county representatives on legal, housing and financial issues to improve family stability.	7/1/2012 – 6/30/2016		~~Continued~~ Revised
5. Offer Webcasts and/or webinars of specialists in fields pertinent to caregivers and older adults targeting hard to serve populations such as working caregivers and rural caregivers.	7/1/2012 – 6/30/20146		Revised
6. Increase accessibility to and promote use of caregiver library web site and technology whenever possible.	7/1/2012 – 6/30/2016		Continued

Goal V, Objective D:	**Projected Start and End Dates**	**Title III B Funded PD or C**	**Update Status**
Promote civic engagement in Riverside County communities through coordination with community partners to provide information about the health and wellness benefits regarding social engagement and social connections.	See Action Steps Below	See Action Steps Below	

1. Promote volunteer opportunities and explore new volunteer opportunities to reduce risk of social isolation and/or depression for caregivers, older adults and adults with disabilities.	7/1/2012 – 6/30/2016		Continued
2. Promote cross generational programs and reduce ageism through utilization of volunteers (Boomers and older adults) through the RSVP program in partnership with the Office on Aging to bring volunteers into classrooms, ~~or~~ public and private after school or youth programs to tutor/mentor school aged children and provide rewarding opportunities for volunteers.	7/1/2012 – 6/30/2016		~~Continued~~ Revised

Instructions for Title III D /Health Promotion and Medication Management written Objectives:
Health Promotion and Medication Management activities require written objectives for all services provided with Title III D funds. The objective should clearly describe the **Service Activity** being performed to fulfill the service unit requirement.

- **Service Activity:** List all the specific allowable service activities provided in the definition of Title III D/Health Promotion in the CDA Service Categories and Data Dictionary, i.e., health risk assessments; routine health screening; nutrition counseling/education services; evidence-based health promotion; physical fitness, group exercise, music, art therapy, dance movement and programs for multigenerational participation; home injury control services; screening for the prevention of depression and coordination of other mental health services; gerontological and social service counseling; and education on preventive health services. Primary activities are normally on a one-to-one basis; if done as a group activity, each participant shall be counted as one contact unit.

If Title III D Health Promotion funds are designated to support Title III C Nutrition Education and/or Nutrition Counseling services, report the service units under Title III C NAPIS 9. Nutrition Counseling and/or NAPIS 12 Nutrition Education.

Instructions for Title III B/VII A Long-Term Care (LTC) Ombudsman written Objectives:
In addition to the data required for the LTC Ombudsman Outcome Measures, AAAs are required to provide one or more written LTC Ombudsman-specific objectives for services provided with Title III B and Title VII A funds.

Objectives related to the LTC Ombudsman Program should clearly explain activities that can include, but are not limited to, the following examples:

1. Targeted community outreach to explain the mission of the LTC Ombudsman Program and the role of ombudsman representatives to advocate for the rights of LTC residents.

2. Coordination efforts of the AAA to assist the LTC Ombudsman Program in achieving objectives, including the provision of technical assistance to Program staff.
3. Activities related to recruitment and retention of volunteer LTC Ombudsman representatives.

Instructions for Title VII B Elder Abuse Prevention written Objectives:
Title VII B Elder Abuse Prevention: AAAs must provide at least one written objective for services provided with Title VIIB Elder Abuse Prevention funds.

Objectives related to Title VII B Elder Abuse Prevention may include:

1. Recommendations/suggestions for developing/enhancing programs for the prevention and treatment of elder abuse, neglect, and exploitation.
2. Providing for public education and outreach to identify and prevent elder abuse, neglect, and exploitation.
3. Ensuring the coordination of services provided by AAAs with services provided by Adult Protective Services, local law enforcement agencies, legal services providers, and other agencies involved in the protection of elder and dependent adults from abuse, neglect, and exploitation.
4. Conducting training for individuals, professionals, and paraprofessionals in relevant fields on the identification, prevention, and treatment of elder abuse, neglect, and exploitation, with particular focus on prevention and enhancement of self-determination and autonomy.
5. Providing technical assistance to programs that provide or have the potential to provide services to victims of elder abuse, neglect, and exploitation and for family members of the victims.

SECTION 10 - SERVICE UNIT PLAN (SUP) OBJECTIVES

PSA 21

TITLE III/VII SERVICE UNIT PLAN OBJECTIVES
CCR Article 3, Section 7300(d)

The Service Unit Plan (SUP) uses the National Aging Program Information System (NAPIS) Categories and units of service. They are defined in the NAPIS State Program Report.

For services not defined in NAPIS, refer to the Service Categories and Data Dictionary.

Report the units of service to be provided with **ALL funding sources**. Related funding is reported in the annual Area Plan Budget (CDA 122) for Titles III B, III C-1, III C-2, III D, VII (a) and VII (b).

1. Personal Care (In-Home) **Unit of Service = 1 hour**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	5185	II	
2013-2014	5191	II	
2014-2015	5191		
2015-2016			

2. Homemaker **Unit of Service = 1 hour**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers(if applicable)
2012-2013	3952	II	
2013-2014	3839	II	
2014-2015	3839	II	
2015-2016			

3. Chore **Unit of Service = 1 hour**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	N/A		
2013-2014	N/A		
2014-2015	N/A		
2015-2016			

4. Home-Delivered Meal **Unit of Service = 1 meal**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	290,610	II	
2013-2014	276,080	II	
2014-2015	290,610	II	
2015-2016			

5. Adult Day Care/Adult Day Health **Unit of Service = 1 hour**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	10,154	II, IV	
2013-2014	10,154	II, IV	
2014-2015	10,154	II, IV	
2015-2016			

6. Case Management **Unit of Service = 1 hour**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	1970	II	
2013-2014	1871	II	
2014-2015	1871	II	
2015-2016			

7. Assisted Transportation **Unit of Service = 1 one-way trip**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers(if applicable)
2012-2013	12,250	I, II	
2013-2014	13,321	I, II	
2014-2015	13,321	I, II	
2015-2016			

8. Congregate Meals **Unit of Service = 1 meal**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	190,739	II	
2013-2014	181,190	II	
2014-2015	190,739	II	
2015-2016			

9. Nutrition Counseling **Unit of Service = 1 session per participant**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	N/A		
2013-2014	N/A		
2014-2015	N/A		
2015-2016			

10. Transportation **Unit of Service = 1 one-way trip**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	N/A		
2013-2014	N/A		
2014-2015	N/A		
2015-2016			

11. Legal Assistance **Unit of Service = 1 hour**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	2,255	IV	
2013-2014	2,255	IV	
2014-2015	2,255	IV	
2015-2016			

12. Nutrition Education **Unit of Service = 1 session per participant**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	7,331	II	
2013-2014	11,004*	II	
2014-2015	11,004	II	
2015-2016			

*More accurate projection based on the combination of quarterly Info Van nutrition education for home-delivered meal clients and quarterly nutrition education conducted at congregate nutrition sites.

13. Information and Assistance **Unit of Service = 1 contact**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers(if applicable)
2012-2013	38,240	III, IV	
2013-2014	34,512	III, IV	
2014-2015	32, 560	III, IV	
2015-2016			

14. Outreach **Unit of Service = 1 contact**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers(if applicable)
2012-2013	5050	I, II, IV	
2013-2014	13,250*	I, II, IV	
2014-2015	13,250	I,II, IV	
2015-2016			

*More accurate projection based on the combination of IIIB Outreach conducted by the East and West Info Vans and program specific IIIB Outreach.

15. NAPIS Service Category – "Other" Title III Services

- Each **Title III B** "Other" service must be an approved NAPIS Program 15 service listed on the "Schedule of Supportive Services (III B)" page of the Area Plan Budget (CDA 122) and the CDA Service Categories and Data Dictionary.

- Identify **Title III D**/Medication Management services (required) and all **Title III B** services to be funded that were not reported in NAPIS categories 1–14 and 16. (Identify the specific activity under the Service Category on the "Units of Service" line when applicable.)

- **Title III D/Health Promotion and Medication Management requires a narrative goal and objective.** The objective should clearly explain the service activity being provided to fulfill the service unit requirement.

Title III B, Other Supportive Services [33]

For all Title IIIB "Other" Supportive Services, use the appropriate Service Category name and Unit of Service (Unit Measure) listed in the CDA Service Categories and Data Dictionary. All "Other" services must be listed separately. Duplicate the table below as needed.

Service Category Senior Center Activities **Unit of Service I Hr**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	1,550	II, IV, V	II.D.7 IV.B.1
2013-2014	1,550	II, IV, V	II.D.7 IV.B.1
2014-2015	1,550	II, IV, V	II.D.7 IV.B.1
2015-2016			

Service Category Senior Center Staffing **Unit of Service I Hr**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	N/A	II	
2013-2014	N/A	II	
2014-2015	N/A	II	
2015-2016			

6 Other Supportive Services: Visiting (In-Home) now includes telephoning (See Area Plan budget).

Service Category Comprehensive Assessment **Unit of Service** I Hr

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	1,175	II, IV	
2013-2014	1234	II, IV	
2014-2015	1357	II, IV	
2015-2016			

Service Category Cash/Material Aid **Unit of Service** I Assistance

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	15,020	II	
2013-2014	15,000	II	
2014-2015	10,990*	II	
2015-2016			

***More accurate estimate based on 2012-2013 and 2013-2014 performance data.**

Service Category Community Education **Unit of Service** I Activity

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	16	II	
2013-2014	16	II	
2014-2015	16	II	
2015-2016			

Service Category Public Information **Unit of Service I Activity**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	30	I, II, IV	
2013-2014	30	I, II, IV	
2014-2015	30	I, II, IV	
2015-2016			

Instructions for Title III D /Health Promotion and Medication Management: List number of contacts for unit of service being performed to fulfill the service unit requirement. If Title III D Health Promotion funds are designated to support Title III C Nutrition Education and/or Nutrition Counseling services, report the service units under Title III C NAPIS 9. Nutrition Counseling and/or NAPIS 12. Nutrition Education. Add an objective under Title III D Nutrition Education to identify if Title III D funds are used to pay for Title III C Nutrition Education service units.

- **Service Activity:** List all the specific allowable service activities provided in the definition of Title III D/Health Promotion in the CDA Service Categories and Data Dictionary, i.e., health risk assessments; routine health screening; nutrition counseling/education services; evidence-based health promotion; physical fitness, group exercise, music, art therapy, dance movement and programs for multigenerational participation; home injury control services; screening for the prevention of depression and coordination of other mental health services; gerontological and social service counseling; and education on preventive health services. Primary activities are normally on a one-to-one basis; if done as a group activity, each participant shall be counted as one contact unit.

16. Title III D Health Promotion **Unit of Service = 1 contact**

Service Activities: <u>Physical Fitness (Evidence Based)</u>

- **Title III D/Health Promotion:** Enter program goal and objective numbers in the Title III D Service Plan Objective Table below.

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers(if applicable)
2012-2013	17,250*	II	II.D.3
2013-2014	18,113	II	II.D.3
2014-2015	19,924	II	II.D.3
2015-2016			

* ~~2012-2013 goal reduced due to sequestration.~~

Title III D Evidence Based Health Promotion [34] **Units of Service = 1 Contact**

Service Activities: Chronic Disease Self-Management

- **Title III D/Medication Management:** Enter program goal and objective numbers in the Title III D Service Plan Objective Table below.

Fiscal Year	**Proposed** Units of Service	Program Goal Number	Objective Numbers (required)
2012-2013	800*	II	D.10
2013-2014	800	II	D.10
2014-2015	800	II	D.10
2015-2016			

*More accurate projection based on mid-January 2013 actual start of the program and contact count.

Title III D Evidence Based Health Promotion [35] **Units of Service = 1 Contact**

Service Activities: Pre-Depression Screening

- **Title III D/Medication Management:** Enter program goal and objective numbers in the Title III D Service Plan Objective Table below.

Fiscal Year	**Proposed** Units of Service	Program Goal Number	Objective Numbers (required)
2012-2013	1200	II	D.10
2013-2014	1200	II	D.10
2014-2015	1200	II	D.10
2015-2016			

7 Refer to Program Memo 01-03
7 Refer to Program Memo 01-03

TITLE III B and Title VII A:
LONG-TERM CARE (LTC) OMBUDSMAN PROGRAM OUTCOMES

2012–2016 Four-Year Planning Cycle

As mandated by the Older Americans Act, the mission of the LTC Ombudsman Program is to seek resolution of problems and advocate for the rights of residents of LTC facilities with the goal of enhancing the quality of life and care of residents.

Baseline numbers are obtained from the local LTC Ombudsman Program's FY 2010-2011National Ombudsman Reporting System (NORS) data as reported in the State Annual Report to the Administration on Aging (AoA).

Targets are to be established jointly by the AAA and the local LTC Ombudsman Program Coordinator. Use the baseline year data as the benchmark for determining FY 2012-2013 targets. For each subsequent FY target, use the most recent FY AoA data as the benchmark to determine realistic targets. Refer to your local LTC Ombudsman Program's last three years of AoA data for historical trends. Targets should be reasonable and attainable based on current program resources.

Complete all Measures and Targets for Outcomes 1-3.

Outcome 1. The problems and concerns of long-term care residents are solved through complaint resolution and other services of the Ombudsman Program. [OAA Section 712(a)(3),(5)]

Measures and Targets:

A. Complaint Resolution Rate (AoA Report, Part I-E, Actions on Complaints)
The average California complaint resolution rate for FY 2009-2010 was 73%.

1. FY 2010-2011 Baseline Resolution Rate: 77% Number of complaints resolved 388 + Number of partially resolved complaints 335 divided by the Total Number of Complaints Received 936 = Baseline Resolution Rate 77%
2. FY 2012-2013 Target: Resolution Rate 80 %
3. FY 2011-2012 AoA Resolution Rate 72% FY 2013-2014 Target: Resolution Rate 82%
4. FY 2012-2013 AoA Resolution Rate 74 % FY 2014-2015 Target: Resolution Rate 85%
5. FY 2013-2014 AoA Resolution Rate 80 % FY 2015-2016 Target: Resolution Rate 86%
Program Goals and Objective Numbers: Goal II, Objective D.5.

B. Work with Resident Councils (AoA Report, Part III-D, #8)

FY 2010-2011 Baseline: number of meetings attended 92
2. FY 2012-2013 Target: 86
3. FY 2011-2012 AoA Data: 129 FY 2013-2014 Target: 90
4. FY 2012-2013 AoA Data: 62 FY 2014-2015 Target: 95
5. FY 2013-2014 AoA Data: 65 FY 2015-2016 Target: 98
Program Goals and Objective Numbers: Goal II, Objective D.5.

C. Work with Family Councils (AoA Report, Part III-D, #9)

1. FY 2010-2011 Baseline: number of meetings attended 3
2. FY 2012-2013 Target: number 5
3. FY 2011-2012 AoA Data: 9 FY 2013-2014 Target: 7
4. FY 2012-2013 AoA Data: 8 FY 2014-2015 Target: 9
5. FY 2013-2014 AoA Data: 9 FY 2015-2016 Target: 11
Program Goals and Objective Numbers: Goal II, Objective D.5.

D. Consultation to Facilities (AoA Report, Part III-D, #4) Count of instances of ombudsman representatives' interactions with facility staff for the purpose of providing general information and assistance unrelated to a complaint. Consultation may be accomplished by telephone, letter, email, fax, or in person.

1. FY 2010-2011 Baseline: number of consultations 95
2. FY 2012-2013 Target: 500*
3. FY 2011-2012 AoA Data: 279 FY 2013-2014 Target: 280*
4. FY 2012-2013 AoA Data: 372 FY 2014-2015 Target: 530*
5. FY 2013-2014 AoA Data: 530 FY 2015-2016 Target: 535*
Program Goals and Objective Numbers: Goal II, Objective D.5.

* These target t number have been reduced due to a reduction in phone based assistance and an increase in face-to-face contact

E. Information and Consultation to Individuals (AoA Report, Part III-D, #5) Count of instances of ombudsman representatives' interactions with residents, family members, friends, and others in the community for the purpose of providing general information and assistance unrelated to a complaint. Consultation may be accomplished by telephone, letter, email, fax, or in person.

1. FY 2010-2011 Baseline: number of consultations 278
2. FY 2012-2013 Target: 500*
3. FY 2011-2012 AoA Data: 642 FY 2013-2014 Target: 645*
4. FY 2012-2013 AoA Data: 933 FY 2014-2015 Target: 530*
5. FY 2013-2014 AoA Data: 995 FY 2015-2016 Target: 535*
Program Goals and Objective Numbers: Goal II, Objective D.5.

* These target t number have been reduced due to a reduction in phone based assistance and an increase in face-to-face contact

F. Community Education (AoA Report, Part III-D, #10) LTC Ombudsman Program participation in public events planned to provide information or instruction to community members about the LTC Ombudsman Program or LTC issues. The number of sessions refers to the number of events, not the number of participants.

1. FY 2010-2011 Baseline: number of sessions 4
2. FY 2012-2013 Target: 10
3. FY 2011-2012 AoA Data: 0 FY 2013-2014 Target: 6
4. FY 2012-2013 AoA Data: 14 FY 2014-2015 Target: 16
5. FY 2013-2014 AoA Data: 16 FY 2015-2016 Target: 18
Program Goals and Objective Numbers: Goal II, Objective D.5.

G. Systems Advocacy

- FY 2012-2013 Activity: In the box below, in narrative format, please provide at least one new priority systemic advocacy effort the local LTC Ombudsman Program will engage in during the fiscal year.

Systems Advocacy can include efforts to improve conditions in one LTC facility or can be county-wide, State-wide, or even national in scope. (Examples: Work with LTC facilities to improve pain relief or increase access to oral health care, work with law enforcement entities to improve response and investigation of abuse complaints, collaboration with other agencies to improve LTC residents' quality of care and quality of life, participation in disaster preparedness planning, participation in legislative advocacy efforts related to LTC issues, etc.)

Enter information in the box below.

Systemic Advocacy Effort(s)

I. The Ombudsman program will collaborate with the Curtailing Abuse Related to the Elderly (CARE) Team in order to improve the quality of life and to expedite investigations of abuse in the County.

II. The Ombudsman Program will meet regularly with Operational Area Planning Committee and Voluntary Organization Active in Disaster (VOAD) in preparation for a disaster.

III. The Ombudsman Program will work with the local Skilled Nursing and Assisted Living facilities with a focus on the changes within the law based on AB-40.

Outcome 2. Residents have regular access to an Ombudsman. [(OAA Section 712(a)(3)(D), (5)(B)(ii)]

Measures and Targets:

A. Facility Coverage (other than in response to a complaint), (AoA Report, Part III-D, #6)
Percentage of nursing facilities within the PSA that were visited by an ombudsman representative at least once each quarter **not** in response to a complaint. The percentage is determined by dividing the number of nursing facilities in the PSA that were visited at least once each quarter not in response to a complaint by the total number of nursing facilities in the PSA. NOTE: This is not the total number of visits per year. In determining the number of facilities visited for this measure, no nursing facility can be counted more than once.

1. FY 2010-2011 Baseline: 83% Number of Nursing Facilities visited at least once a quarter not in response to a complaint 45 divided by the number of Nursing Facilities 45.
2. FY 2012-2013 Target: 90%
3. FY 2011-2012 AoA Data: 83% FY 2013-2014 Target: 100 %
4. FY 2012-2013 AoA Data: 67 % FY 2014-2015 Target: 100 %
5. FY 2013-2014 AoA Data: 90 % FY 2015-2016 Target: 100 %
Program Goals and Objective Numbers: Goal II, Objective D.5.

B. Facility Coverage (other than in response to a complaint) (AoA Report, Part III-D, #6)
Percentage of RCFEs within the PSA that were visited by an ombudsman representative at least once each quarter during the fiscal year **not** in response to a complaint. The percentage is determined by dividing the number of RCFEs in the PSA that were visited at least once each quarter not in response to a complaint by the total number of RCFEs in the PSA. NOTE: This is not the total number of visits per year. In determining the number of facilities visited for this measure, no RCFE can be counted more than once.

1. FY 2010-2011 Baseline: 25% Number of RCFEs visited at least once a quarter not in response to a complaint 365 divided by the number of RCFEs 365
2. FY 2012-2013 Target: 83 %
3. FY 2011-2012 AoA Data: 15% FY 2013-2014 Target: 85 %
4. FY 2012-2013 AoA Data: 23 % FY 2014-2015 Target: 100 %

5. FY 2013-2014 AoA Data: 85 % FY 2015-2016 Target: 100 %
Program Goals and Objective Numbers: Goal II, Objective D.5.

C. Number of Full-Time Equivalent (FTE) Staff (AoA Report Part III. B.2. - Staff and Volunteers) (One FTE generally equates to 40 hours per week or 1,760 hours per year) This number may only include staff time legitimately charged to the LTC Ombudsman Program. For example, the FTE for a staff member who works in the Ombudsman Program 20 hours a week should be 0.5. Time spent working for or in other programs may not be included in this number.
Verify number of staff FTEs with Ombudsman Program Coordinator.

1. FY 2010-2011 Baseline: FTEs 6.0
2. FY 2012-2013 Target: 8.0 FTEs
3. FY 2011-2012 AoA Data: 6.15 FTEs FY 2013-2014 Target: 6.15 FTEs
4. FY 2012-2013 AoA Data: 6.15 FTEs FY 2014-2015 Target: 6.15 FTEs
5. FY 2013-2014 AoA Data: 6.15 FTEs FY 2015-2016 Target: 8.0 FTEs
Program Goals and Objective Numbers: Goal II, Objective D.5.

D. Number of Certified LTC Ombudsman Volunteers (AoA Report Part III. B.2. – Staff and Volunteers)
Verify numbers of volunteers with Ombudsman Program Coordinator.

1. FY 2010-2011 Baseline: Number of certified LTC Ombudsman volunteers as of June 30, 2010 26
2. FY 2012-2013 Projected Number of certified LTC Ombudsman volunteers as of June 30, 2013 27
3, FY 2011-2012 AoA Data: 27 certified volunteers FY 2013-2014 Projected Number of certified LTC Ombudsman volunteers as of June 30, 2014 30

4.	FY 2012-2013 AoA Data: ~~30~~ 16 certified volunteers FY 2014-2015 Projected Number of certified LTC Ombudsman volunteers as of June 30, 2015 ~~34~~ 25
5.	FY 2013-2014 AoA Data: ~~34~~ 25 certified volunteers FY 2015-2016 Projected Number of certified LTC Ombudsman volunteers as of June 30, 2016 ~~36~~ 30
Program Goals and Objective Numbers: Goal II, Objective D.5.	

Outcome 3. Ombudsman representatives accurately and consistently report data about their complaints and other program activities in a timely manner. [OAA Section 712(c)]

Measures and Targets:

A. At least once each fiscal year, the Office of the State Long-Term Care Ombudsman sponsors free training on each of four modules covering the reporting process for the National Ombudsman Reporting System (NORS). These trainings are provided by telephone conference and are available to all certified staff and volunteers. Local LTC Ombudsman Programs retain documentation of attendance in order to meet annual training requirements.

1. FY 2010-2011 Baseline number of Ombudsman Program staff and volunteers who attended NORS Training Parts I, II, III and IV 31 **Please obtain this information from the local LTC Ombudsman Program Coordinator.**
2. FY 2012-2013 Target: number of Ombudsman Program staff and volunteers attending NORS Training Parts I, II, III and IV 31
3. FY 2011-2012 number of Ombudsman Program staff and volunteers who attended NORS Training Parts I, II, III, and IV 34 FY 2013-2014 Target 38
4. FY 2012-2013 number of Ombudsman Program staff and volunteers who attended NORS Training Parts I, II, III, and IV 38 FY 2014-2015 Target 43
5. FY 2013-2014 number of Ombudsman Program staff and volunteers who attended NORS Training Parts I, II, III, and IV 38 FY 2015-2016 Target: 49
Program Goals and Objective Numbers: Goal II, Objective D.5.

TITLE VII B ELDER ABUSE PREVENTION SERVICE UNIT PLAN OBJECTIVES

Units of Service: AAA must complete at least one category from the Units of Service below.
Units of Service categories include public education sessions, training sessions for professionals, training sessions for caregivers served by a Title III E Family Caregiver Support Program, educational materials distributed, and hours of activity spent developing a coordinated system which addresses elder abuse prevention, investigation, and prosecution.

When developing targets for each fiscal year, refer to data reported on the Elder Abuse Prevention Quarterly Activity Reports. Set realistic goals based upon the prior year's numbers and the resources available.

AAAs must provide one or more of the service categories below. NOTE: The number of sessions refers to the number of presentations and not the number of attendees

- **Public Education Sessions** – Please indicate the total number of projected education sessions for the general public on the identification, prevention, and treatment of elder abuse, neglect, and exploitation.

- **Training Sessions for Professionals** – Please indicate the total number of projected training sessions for professionals (service providers, nurses, social workers) on the identification, prevention, and treatment of elder abuse, neglect, and exploitation.

- **Training Sessions for Caregivers Served by Title III E** – Please indicate the total number of projected training sessions for unpaid family caregivers who are receiving services under Title III E of the Older Americans Act (OAA) on the identification, prevention, and treatment of elder abuse, neglect, and exploitation. OAA 302(3) 'Family caregiver' means an adult family member, or another individual, who is an informal provider of in-home and community care to an older individual or to an individual with Alzheimer's disease or a related disorder with neurological and organic brain dysfunction.

- **Hours Spent Developing a Coordinated System to Respond to Elder Abuse** – Please indicate the number of hours to be spent developing a coordinated system to respond to elder abuse. This category includes time spent coordinating services provided by the AAA or its contracted service provider with services provided by Adult Protective Services, local law enforcement agencies, legal services providers, and other agencies involved in the protection of elder and dependent adults from abuse, neglect, and exploitation.

- **Educational Materials Distributed** – Please indicate the type and number of educational materials to be distributed to the general public, professionals, and caregivers (this may include materials that have been developed by others) to help in the identification, prevention, and treatment of elder abuse, neglect, and exploitation.

- **Number of Individuals Served** – Please indicate the total number of individuals expected to be reached by any of the above activities of this program.

TITLE VIIB ELDER ABUSE PREVENTION SERVICE UNIT PLAN OBJECTIVES

Fiscal Year	Total # of Public Education Sessions
2012-13	40
2013-14	40
2014-15	25*
2015-16	

Fiscal Year	Total # of Training Sessions for Professionals
2012-13	N/A
2013-14	N/A
2014-15	N/A
2015-16	

*Transitioning work from current provider to new provider for same service

Fiscal Year	Total # of Training Sessions for Caregivers served by Title III E
2012-13	N/A
2013-14	N/A
2014-15	2
2015-16	

Fiscal Year	Total # of Hours Spent Developing a Coordinated System
2012-13	N/A
2013-14	N/A
2014-15	N/A
2015-16	

Fiscal Year	Total # of Copies of Educational Materials to be Distributed	Description of Educational Materials
2012-2013	1200	Fraud Prevention and Protection
2013-2014	1200	Fraud Prevention and Protection
2014-2015	1200	Fraud Prevention and Protection
2015-2016		

Fiscal Year	Total Number of Individuals Served
2012-2013	1200
2013-2014	1200
2014-2015	1200
2015-2016	

TITLE III E SERVICE UNIT PLAN OBJECTIVES
CCR Article 3, Section 7300(d)

2012–2016 Four-Year Planning Period

This Service Unit Plan (SUP) utilizes the five broad federally-mandated service categories defined in PM 11-11. Refer to the CDA Service Categories and Data Dictionary Revisions Effective July I, 2011 for eligible activities and service unit measures. Specify proposed audience size or units of service for ALL budgeted funds.

Direct and/or Contracted III EServices

CATEGORIES	1	2	3
Family Caregiver Services Caring for Elderly	***Proposed*** **Units of Service**	***Required*** **Goal #(s)**	***Optional*** **Objective #(s)**
Information Services	**# of activities and Total est. audience for above**		
2012-2013	# of activities: 70 Total est. audience for above: 101,500	V	
2013-2014	# of activities: 61 Total est. audience for above: 100,485	V	
2014-2015	# of activities: 55 Total est. audience for above: 90,437	V	
2015-2016	# of activities: Total est. audience for above:		
Access Assistance	**Total contacts**		
2012-2013	1,105	V	
2013-2014	4,420*	V	
2014-2015	4,420		
2015-2016			
Support Services	**Total hours**		
2012-2013	3,615	V	
2013-2014	3,732	V	
2014-2015	3,732		
2015-2016			

Respite Care	Total hours		
2012-2013	7,618	V	
2013-2014	7,350	V	
2014-2015	7,350		
2015-2016			
Supplemental Services	**Total occurrences**		
2012-2013	15	V	
2013-2014	10	V	
2014-2015	10		
2015-2016			

*More accurate projection based on program specific III E Access Assistance services.

Direct and/or Contracted III E Services

Grandparent Services Caring for Children	*Proposed* Units of Service	*Required* Goal #(s)	*Optional* Objective #(s)
Information Services	**# of activities and Total est. audience for above**		
2012-2013	# of activities: 16 Total est. audience for above: 6240	V	
2013-2014	# of activities: 16 Total est. audience for above: 6240	V	
2014-2015	# of activities: 16 Total est. audience for above: 6,000*	V	
2015-2016	# of activities: Total est. audience for above:		
Access Assistance	**Total contacts**		
2012-2013	366	V	
2013-2014	360	V	
2014-2015	600**	V	
2015-2016			
Support Services	**Total hours**		
2012-2013	111	V	
2013-2014	105	V	
2014-2015	111	V	
2015-2016			
Respite Care	**Total hours**		
2012-2013	N/A		
2013-2014	N/A		
2014-2015	N/A		
2015-2016			
Supplemental Services	**Total occurrences**		
2012-2013	N/A		
2013-2014	N/A		
2014-2015	N/A		
2015-2016			

*More accurate projections based on inclusion of additional activities

** More accurate based upon IIIE and IIIB I&A numbers combined.

PSA #21 [36]

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM (SCSEP)

List all SCSEP monitor sites (contract or direct) where the AAA provides services within the PSA (Please add boxes as needed)

Location/Name (AAA office, One Stop, Agency, etc): Hemet Service Center
Street Address: 749 North State Street, Hemet, CA 92543
Name and title of all SCSEP staff members (paid and participant): Art Howard, Program Assistant; Karen Stewart, Service Aid ~~Ronald Holt Service Aide 1, Virginia Mastrogiacomo Service Aide 1, Irma Blackmon – Program Assistant~~
Number of paid staff ___0___ Number of participant staff ___2 ~~4~~___
How many participants are served at this site? ~~20~~ 16

Location/Name (AAA office, One Stop, Agency, etc): Riverside County Office on Aging
Street Address: 78-900 Ave 47, Suite 200, La Quinta, CA 92253
Name and title of all SCSEP staff members (paid and participant): Michael Cohen Program Assistant, Rosemary Aguirre Service Aid, Margaret Little Service Aid ~~Teddy Bryant – Program Assistant, Linda Madison– Program Assistant~~
Number of paid staff __0___ Number of participant staff ___~~2~~ 3___
How many participants are served at this site? ~~12~~ 16

Location/Name (AAA office, One Stop, Agency, etc): Riverside County Office on Aging
Street Address: 6296 River Crest Drive, Suite K, Riverside, CA 92507
Name and title of all SCSEP staff members (paid and participant): Deborah Allen service Aide 1; Alfred LeCesne – Supervising Program Assistant; Bernice Gains – Service Aid; Susan Peters Supervising Program Assistant, Lillian Chapman Service Aid, Sandra Washington Service Aid, Laura Jackson Service Aid, Karen Walls Program Assistant, Karen Gibson Program Assistant and Lynette Worrell – Program Manager ~~Jo Ellen Williams – Service Aide 1; Deborah Allen – Service Aide 1; Alfred LeCesne – Senior Program Assistant; Bernice Gains – Program Assistant; Georgia Lloyd – Senior Program Assistant; Earsy Dickson, Irene Xanders (Program Asst); Susan Peters Participants and Lynette Worrell – Program Manager~~
Number of paid staff ___1___ Number of participant staff ___9 ~~11~~___
How many participants are served at this site? ~~40~~ 35

8 If not providing Title V, enter PSA number followed by "Not providing".

More accurate projection based on Federal vs. California minimum wage differential, and 5% sequester cuts.

HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM (HICAP)
SERVICE UNIT PLAN
CCR Article 3, Section 7300(d)

MULTIPLE PSA HICAPs: If you are a part of a multiple PSA HICAP where two or more AAAs enter into agreement with one "Managing AAA," then each AAA must enter State and federal performance target numbers in each AAA's respective SUP. Please do this in cooperation with the Managing AAA. The Managing AAA is responsible for providing HICAP services in the covered PSAs in a way that is agreed upon and equitable among the participating parties.

HICAP PAID LEGAL SERVICES: Complete Section 3 if your Master Contract contains a provision for using HICAP funds to provide HICAP Legal Services.

STATE & FEDERAL PERFORMANCE TARGETS: The Centers for Medicare and Medicaid Services (CMS) requires all State Health Insurance Assistance Programs (SHIP) to meet certain targeted performance measures. To help AAAs complete the Service Unit Plan, CDA will annually provide AAAs with individual PSA state and federal performance measure targets.

Section 1. Primary HICAP Units of Service

Fiscal Year (FY)	1.1 Estimated Number of Unduplicated Clients Counseled	Goal Numbers
2012-2013	1,690	II, IV
2013-2014	2,000	II, IV
2014-2015	~~2,020~~ 2565	II, IV
2015-2016	~~2,100~~ 2616	II, IV

Note: Clients Counseled equals the number of Intakes closed and finalized by the Program Manager.

Fiscal Year (FY)	1.2 Estimated Number of Public and Media Events	Goal Numbers
2012-2013	137	II, IV
2013-2014	138	II, IV
2014-2015	~~140~~ 182	II, IV
2015-2016	~~144~~ 185	II, IV

Note: Public and Media events include education/outreach presentations, booths/exhibits at health/senior fairs, and enrollment events, excluding public service announcements and printed outreach.

Section 2: Federal Performance Benchmark Measures

Fiscal Year (FY)	2.1 Estimated Number of Contacts for all Clients Counseled	Goal Numbers
2012-2013	8,039	II, IV
2013-2014	8,712	II, IV
2014-2015	~~9,175~~ 17,838	II, IV
2015-2016	~~9,605~~ 18,195	II, IV

Note: This includes all counseling contacts via telephone, in-person at home, in-person at site, and electronic contacts (e-mail, fax, etc.) for duplicated client counts.

Fiscal Year (FY)	2.2 Estimated Number of Persons Reached at Public and Media Events	Goal Numbers
2012-2013	15,203	II, IV
2013-2014	20,000	II, IV
2014-2015	~~21,000~~ 41,774	II, IV
2015-2016	~~22,050~~ 42,609	II, IV

Note: This includes the estimated number of attendees (e.g., people actually attending the event, not just receiving a flyer) reached through presentations either in person or via webinars, TV shows or radio shows, and those reached through booths/exhibits at health/senior fairs, and those enrolled at enrollment events, excluding public service announcements (PSAs) and printed outreach materials.

Fiscal Year (FY)	2.3 Estimated Number of contacts with Medicare Status Due to a Disability Contacts	Goal Numbers
2012-2013	1,183	II, IV
2013-2014	1,302	II, IV
2014-2015	~~1,370~~ 2,400	II, IV
2015-2016	~~1,439~~ 2,448	II, IV

Note: This includes all counseling contacts via telephone, in-person at home, in-person at site, and electronic contacts (e-mail, fax, etc.), duplicated client counts with Medicare beneficiaries due to disability, and not yet age 65.

Fiscal Year (FY)	2.4 Estimated Number of contacts with Low Income Beneficiaries	Goal Numbers
2012-2013	3,077	II, IV
2013-2014	3,869	II, IV
2014-2015	~~4,062~~ 10,203	II, IV
2015-2016	~~4,266~~ 10,407	II, IV

Note: This is the number of unduplicated low-income Medicare beneficiary contacts and/or contacts that discussed low-income subsidy (LIS). Low income means 150 percent of the Federal Poverty Level (FPL).

Fiscal Year (FY)	2.5 Estimated Number of Enrollment Assistance Contacts	Goal Numbers
2012-2013	5,988	II, IV
2013-2014	6,489	II, IV
2014-2015	~~6,813~~ 12,708	II, IV
2015-2016	~~7,154~~ 12,962	II, IV

Note: This is the number of unduplicated enrollment contacts during which one or more qualifying enrollment topics were discussed. This includes <u>all</u> enrollment assistance, not just Part D.

Fiscal Year (FY)	2.6 Estimated Part D and Enrollment Assistance Contacts	Goal Numbers
2012-2013	2,816	II, IV
2013-2014	3,052	II, IV
2014-2015	~~3,205~~ 10,334	II, IV
2015-2016	~~3,365~~ 10,540	II, IV

Note: This is a subset of all enrollment assistance in 2.5. It includes the number of Part D enrollment contacts during which one or more qualifying Part D enrollment topics were discussed.

Fiscal Year (FY)	2.7 Estimated Number of Counselor FTEs in PSA	Goal Numbers
2012-2013	29.4	II, IV
2013-2014	29.4	II, IV
2014-2015	~~30.87~~ 4,982*	II, IV
2015-2016	~~32.41~~ 5,081*	II, IV

~~Note: This is the total number of counseling hours divided by 2000 (considered annual fulltime hours), then multiplied by the total number of Medicare beneficiaries per 10K in PSA.~~

*This number reflects the total number of counseling hours, rather than FTEs.

Section 3: HICAP Legal Services Units of Service (if applicable) [37]

State Fiscal Year (SFY)	3.1 Estimated Number of Clients Represented Per SFY (Unit of Service)	Goal Numbers
2012-2013	N/A	
2013-2014	N/A	
2014-2015	N/A	
2015-2016	N/A	
State Fiscal Year (SFY)	**3.2 Estimated Number of Legal Representation Hours Per SFY (Unit of Service)**	**Goal Numbers**
2012-2013	N/A	
2013-2014	N/A	
2014-2015	N/A	
2015-2016	N/A	
State Fiscal Year (SFY)	**3.3 Estimated Number of Program Consultation Hours per SFY (Unit of Service)**	**Goal Numbers**
2012-2013	N/A	
2013-2014	N/A	
2014-2015	N/A	
2015-2016	N/A	

37 Requires a contract for using HICAP funds to pay for HICAP Legal Services.

SECTION 11 - FOCAL POINTS **PSA 21**

COMMUNITY FOCAL POINTS LIST

CCR Title 22, Article 3, Section 7302(a)(14), 45 CFR Section 1321.53(c), OAA 2006 306(a)

In the form below, provide the current list of designated community focal points and their addresses. This information must match the total number of focal points reported in the National Aging Program Information System (NAPIS) State Program Report (SPR), i.e., California Aging Reporting System, NAPISCare, Section III.D.

Designated Community Focal Point	Address
Ageless Reflections – Blythe Community Center	445 North Broadway Blythe, CA 92225
Albert A. Chatigny Senior Community Recreation Center	1310 Oak Valley Parkway Beaumont, CA 92223
Arlanza Community Center – Bryant Park	7950 Philbin Avenue Riverside, CA 92503
Banning Senior Center	769 North San Gorgonio Avenue PO Box 998, Banning, CA 92220
Cathedral Center	37-171 West Buddy Rogers Avenue Cathedral City, CA 92234
Coachella Senior Center	1540 Seventh Street Coachella, CA 92236
Colorado River Senior Community Center	HCR 20, Box 3408 – Rio Loco Blythe, CA 92225
Corona Senior Center	921 South Belle Street Corona, CA 92882
Dales Senior Center	3936 Chestnut Street Riverside, CA 92501
Desert Hot Springs Senior Center	11-777 West Drive Desert Hot Springs, CA 92240
Eddie Dee Smith Senior Center	5888 Mission Boulevard Rubidoux, CA 92509
Idyllwild Town Hall	25925 Cedar Street Idyllwild, CA 92549
Indio Senior Center	45-700 Aladdin Street Indio, CA 92201
James A. Venable Community Center	50-390 Carmen Avenue Cabazon, CA 92230
James Simpson Memorial Center	305 East Devonshire Avenue Hemet, CA 92543
Janet Goeske Center	5257 Sierra Street Riverside, CA 92504