

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

133 A



FROM: Office on Aging

SUBMITTAL DATE:
April 13, 2015

SUBJECT: Approval of the Office on Aging's 2015–2016 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 2015–2016 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," approved the first update on

(Continued on Page 2)

Michele Haddock
Director

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:	POLICY/CONSENT (per Exec. Office)
COST	\$ 0	\$ 0	\$ 0	\$ 0	Consent <input checked="" type="checkbox"/> Policy <input type="checkbox"/>
NET COUNTY COST	\$ 0	\$ 0	\$ 0	\$ 0	

SOURCE OF FUNDS: N/A

Budget Adjustment: N/A
For Fiscal Year: 2015/2016

C.E.O. RECOMMENDATION:

APPROVE

BY:
Lari Sibson

County Executive Office Signature

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Jeffries, seconded by Supervisor Benoit and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes: Jeffries, Tavaglione, Washington, Benoit and Ashley
Nays: None
Absent: None
Date: April 28, 2015
xc: Office on Aging

Kecia Harper-Ihem
Clerk of the Board
By:
Deputy

2-10

Prev. Agn. Ref.: 05/20/2014 (#2-6) | District: ALL | Agenda Number:

Departmental Concurrence

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

SUBMITTAL TO THE BOARD OF SUPERVISORS, COUNTY OF RIVERSIDE, STATE OF CALIFORNIA
FORM 11: Approval of the Office on Aging's 2015–2016 Update of the 2012–2016 Strategic Plan; "Focusing on a Healthy Tomorrow". [Districts – All] [Total Cost: \$0]

DATE: April 13, 2015

PAGE: Page 2 of 2

BACKGROUND:

Summary (continued)

April 30, 2013 (Agenda #2.6), and the second update on May 20, 2014 (Agenda #2-6). This is the third and final 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 February 11, 2015, a Public Hearing was held and changes to the Strategic Plan were discussed and approved by the Riverside County Advisory Council on Aging on March 11, 2015. Primary changes include slight modifications to the goal statements and timelines.

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 as set forth by the Area Plan.

ATTACHMENTS:

- A. 2012–2016 STRATEGIC PLAN ON AGING: *Focusing on a Healthy Tomorrow*
2015–2016 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) Jeff Stone Marion Ashley

Marion Ashley
Signature: Governing Board Chair¹

4/29/15
Date

2. (Type Name) Gloria Sanchez Gary Kelley

Gary Kelley
Signature: Advisory Council Chair

4-10-15
Date

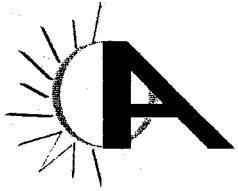
3. (Type Name) Michele Haddock

Michele Haddock
Signature: Area Agency Director

4/10/2015
Date

ATTEST:
KECIA HARPER-IHEM, Clerk
[Signature]
DEPUTY

¹ Original signatures or official signature stamps are required.



RIVERSIDE COUNTY
OFFICE ON AGING



Riverside County Office on Aging Aging and Disability Resource Connection

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

Focusing on a Healthy Tomorrow

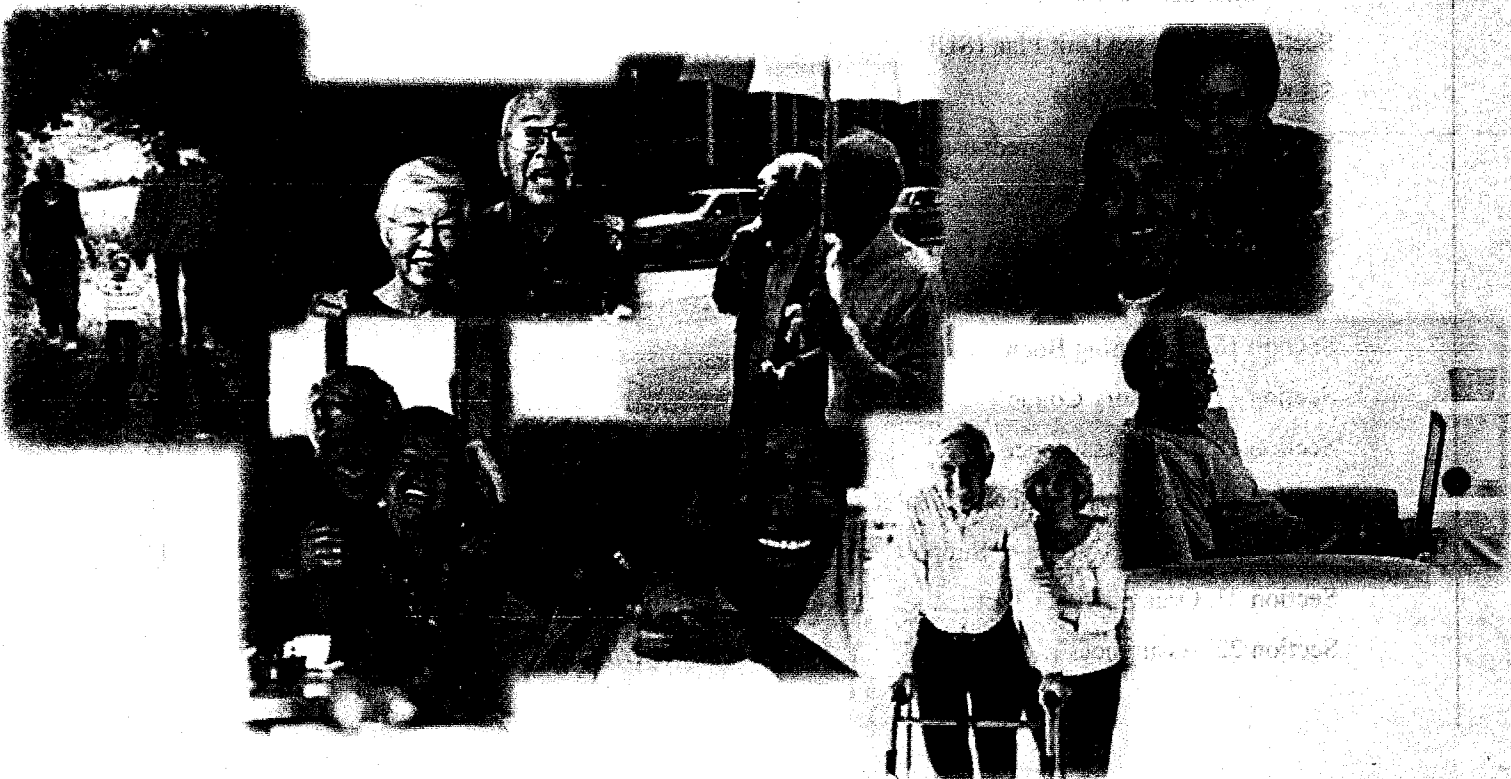


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Overview

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.
-

FY 2015-2016 AREA PLAN UPDATE (APU) CHECKLIST
 (Revised February 2015) Submit a copy with your APU due 5/1/15

AP Guidance Section	APU Components (To be attached to the APU)	Checklist Included
	<i>I.> Update/Submit A) through F) ANNUALLY:</i>	
n/a	•A) Transmittal Letter--(requires <i>hard copy</i> with original ink signatures or official signature stamp- no photocopies)	<input type="checkbox"/>
n/a	•B) APU-(submit entire APU electronically only)	<input checked="" type="checkbox"/>
2, 3, or 4	•C) Estimate-of the number of lower income minority older individuals in the PSA for the coming year	<input checked="" type="checkbox"/>
7	•D) Public Hearings-that will be conducted	<input checked="" type="checkbox"/>
n/a	•E) Annual Budget	<input type="checkbox"/>
10	•F) Service Unit Plan (SUP) Objectives and Long Term Care Ombudsman Program Measures and Targets	<input checked="" type="checkbox"/>
	<i>II.> Update/Submit the following only if there has been a CHANGE or the section was not included in the 2012/16 Area Plan:</i>	Mark Changed/Not Changed (C or N/C)
		C N/C
5	Minimum Percentage/Adequate Proportion	<input type="checkbox"/> X
5	Needs Assessment ¹	<input type="checkbox"/> X
9	AP Narrative Objectives:	
9	• System-Building and Administration	<input type="checkbox"/> X
9	• Title III B-Funded Programs	<input type="checkbox"/> X
9	• Title III B-Transportation	<input type="checkbox"/> X
9	• Title III B-Funded Program Development/Coordination (PD or C)	<input type="checkbox"/> X
9	• Title III B/VIA-Long-Term Care Ombudsman/Elder Abuse Prevention Program	<input type="checkbox"/> X
9	• Title III C-1	<input type="checkbox"/> X
9	• Title III C-2	<input type="checkbox"/> X
9	• Title III D	X <input type="checkbox"/>
20	• Title III E-Family Caregiver Support Program	<input type="checkbox"/> X
9	• Title V-SCSEP Program	<input type="checkbox"/> X
9	• HICAP Program	X <input type="checkbox"/>
14	Notice of Intent-to Provide Direct Services	<input type="checkbox"/> X
15	Request for Approval-to Provide Direct Services	<input type="checkbox"/> X
16	Governing Board	X <input type="checkbox"/>
17	Advisory Council	X <input type="checkbox"/>
18	Legal Assistance	<input type="checkbox"/> X
21	Organizational Chart(s)	X <input type="checkbox"/>

¹ Prior to the development of the 2016/2020 Area Plan, at least one Needs Assessment must be conducted.

TRANSMITTAL LETTER
Four-Year Area Plan
2012-2016

AAA Name: Riverside County Office on Aging

PSA 21

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1. (Type Name) Jeff Stone Marion Ashley

Signature: Governing Board Chair¹

Date

2. (Type Name) Gloria Sanchez Gary Kelley

Signature: Advisory Council Chair

Date

3. (Type Name) Michele 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

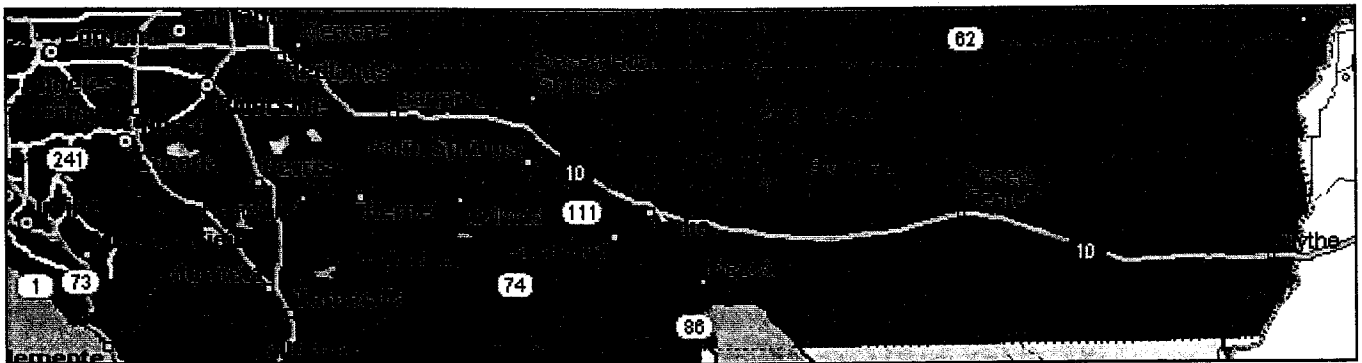
Riverside County, one of 58 counties in the state of California, covers 7,296 square miles in the southern part of the state stretching from Orange County to the Colorado River, which forms the state border with Arizona. Riverside County lies inland of Los Angeles County and is bordered by Orange County 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 26 incorporated cities, unincorporated communities and neighborhoods, and 12 federally recognized Indian reservations. Over 87% of the county is unincorporated land.



Retrieved from: 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 represented 5.88% of the total population of California at that time. As of January, 2013², the total Riverside County population was 2,292,507^{68,783}~~2~~ with approximately 23% of the county's residents living in unincorporated areas. In 2015, Riverside County's population is projected to reach 2,323,527, which represents a 1% increase in just 2 years.³ Of the 58 counties within the State of California, Riverside County is still 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.⁴ 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 demonstrates provides the total population by incorporated cities and census designated places (CDP) as of April, 2010 and 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

² Riverside County QuickFacts from the US Census. Retrieved from: <http://quickfacts.census.gov/qfd/states/06/06065.html>
~~Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2012; 2012 Population Estimates~~

³ Total Population Projections for California and Counties: July 1, 2015 to 2060 in 5 Year Increments, Demographic Research Unit, California Department of Finance (December 2014).

⁴ U.S. Census Bureau, Preliminary Annual Estimates of the Resident Population for Counties: April 1, 2000 to July 1, 2010, CO-PEST2010-TOTALS

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
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

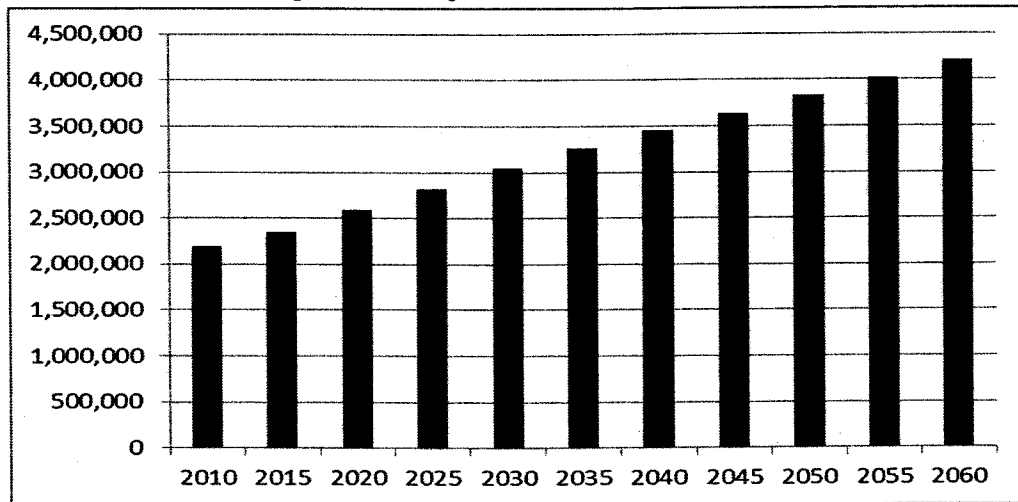
Source: Center for Demographic Research, Department of Finance, April, 2010

California's population is projected to increase by ~~grew by 4%~~0.7% between July 1, 2010 and 2015 July 1, 2011 to total more than 38.8 ~~7.5~~ million persons, according to the official population estimates released by the Department of Finance.⁵ Between the years 2000 to 2010, Riverside County grew 41.7%. New studies show that Riverside County's population will continue to grow, reaching approximately 4.2 million by 2060.⁶ This growth will make Riverside County the second largest county in California, surpassed only by Los Angeles County.³

⁵ Total Population Projections for California and Counties: July 1, 2015 to 2060 in 5 Year Increments, Demographic Research Unit, California Department of Finance (December 2014). *State of California, Department of Finance, California County Population Estimates and Components of Change by Year, July 1, 2010-2011. Sacramento, California, December 2011.*

⁶ State of California, Department of Finance, *New Population Projections: California to Surpass 50 Million in 2049*

TABLE 2: Total Population Projections for Riverside County (2015-2060)



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, December 2014 January 2013

ELDER POPULATION

The aging of the Boomer generation (those born between 1946 and 1964) means that the oldest of the Boomers began turning 60 in 2006. The advance of this generation into older adulthood equates to ~~which equates to~~ 330 people turning 60 every hour until December 31, 2024. Beyond 2024, Riverside can anticipate the advance of Generation X, who begin to turn 60 in 2026, and then the Generation Y/Millennials, who start turning 60 in 2037⁷. 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 below⁸.

TABLE 32. 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

⁷ P-1 (Age): State and County Population Projections by Major Age Group: 2010-2060. California Department of Finance, Demographic research Unit (December 2014)

⁸ U.S. Census Bureau, 2010 Census Demographic Profile Summary File. Table prepared by Demographic Research Unit, California Department of Finance.

Total 60 years and over

6,078,711

357,560

For Riverside County, the population projections and percentage increase according to the Department of Finance 20142007 demographic information for the years 201000-20650 for older adults are shown in Table 43.⁹

TABLE 43. Riverside County Population Projections 201000-20650

Age Group	2000	2010	2060	% of Increase
ALL Age Group (Total Population)	2,194,933	3,678,439	68%	
	4,559,039	2,239,053	2,904,848	
60-69 Working Age (25-64 years)	1,085,492	1,750,307	61%	
	406,508	451,469	250,274	
70-79 Young Retirees (65-74 years)	141,479	388,792	194%	
	95,456	96,608	133,969	
80+ Mature Retirees (75-84 years)	86,228	293,310	240%	
	49,463	69,734	80,483	
ALL 60+ Seniors (85+)	32,776	178,133	443%	
	251,127	317,811	464,726	

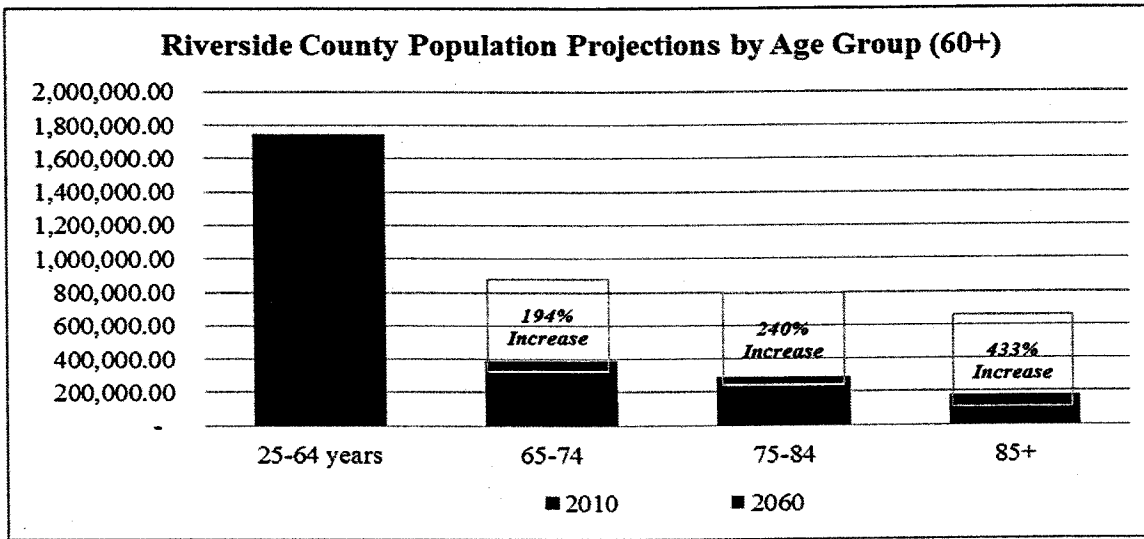
Clearly the projections in the above table (Table 3) underestimated the impact of the boomers in the 2007 Department of Finance projections as compared to the actual 2010 census figures. The 60+ age group was projected to be 317,811 in 2010 from the 2007 data. However, the actual 2010 population was 357,560! Excluding the subset of those 55-64 contained within the "Working Age" category, the data shows that by the year 20640, the age 65+ group will exceed half a million in Riverside County, and will be approaching 1 million (or approximately ¼ of the total projected population in Riverside County by 2060! The fastest growing cohort proportionately is the age 80+, which is projected to grow between 24055% (75-84 years of age) and 443531% (85+) by 2060.¹⁰ ——— The unprecedented growth in the older adult population will mean a demographic change that will necessitate infrastructure changes to meet the needs of this e-growing population. The Bboomers will are expected to be the longest lived generation in history. Of the 78 million Boomers in the nation, more than 58% are expected to live into their ninties. are living longer but not necessarily healthier. In addition, California boasts the highest number of Centurians, persons aged 100 or older, than any other 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 overall population of the state increases.¹¹

⁹ P-1 (Age): State and County Population Projections by Major Age Group: 2010-2060. Year 2010. California Department of Finance, Demographic Research Unit (December 2014)
State of California, Department of Finance, Population Projections for California and Its Counties 2000-2050, Sacramento, California, July 2007.

¹⁰ P-1 (Age) State and County Population Projects by Major Age Group (Numeric and Percent Change 2010 to 2060 By Age Group) California Department of Finance, Demographic Research Unit (December 2014)
State of California, Department of Finance, New Population Projections: California to Surpass 50 Million in 2049, Sacramento, California, January 2013.

¹¹ 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 Group (60+)



Source: P-1 (Age) State and County Population Projections by Major Age Group (Numeric and Percent Change 2010 to 2060 By Age Group) California Department of Finance, Demographic Research Unit (December 2014)

DISABLED POPULATION

In The 2013 the 10 U.S. Census estimated that the total civilian, non-institutionalized population within Riverside County living with a disability was is 246,387 20,121 persons, which represents about 10.1% of the total population; which is slightly higher than the over all percentage for the State of California (10.3%) (10%).¹² 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%. Table 4 is a brief summary of disability statistics by age grouping as well as by type of disability.

¹² U.S. Census Bureau, 2010 American Community Survey 2011-2013 3-Year American Community Survey

TABLE 4: DISABILITY CHARACTERISTICS FOR RIVERSIDE COUNTY⁴³
2011 to 2013 3 Year 10 American Community Survey

Subject	Riverside County, California		
	Total	With a disability	Percent with a disability
	Estimate	Estimate	Estimate
Total civilian noninstitutionalized population	2,240,719	246,387	11%
Population under 5 years	160,314	1,211	0.8%
With a hearing difficulty		952	0.6%
With a vision difficulty		804	0.5%
Population 5 to 17 years	456,127	19,909	4.4%
With a hearing difficulty		2,974	0.7%
With a vision difficulty		4,293	0.9%
With a cognitive difficulty		13,183	2.9%
With an ambulatory difficulty		3,280	0.7%
With a self-care difficulty		4,657	1.0%
Population 18 to 64 years	1,346,280	125,537	9.3%
With a hearing difficulty		25,019	1.9%
With a vision difficulty		22,733	1.7%
With a cognitive difficulty		51,762	3.8%
With an ambulatory difficulty		62,954	4.7%
With a self-care difficulty		25,749	1.9%
With an independent living difficulty		48,156	3.6%
Population 65 years and over	277,998	99,730	35.9%
With a hearing difficulty		42,348	15.2%
With a vision difficulty		19,570	7.0%
With a cognitive difficulty		24,285	8.7%
With an ambulatory difficulty		64,494	23.2%
With a self-care difficulty		25,137	9.0%
With an independent living difficulty		43,750	15.7%
Overall Percentage Imputed			
Disability status	6.4%		
Hearing difficulty	4.8%		
Vision difficulty	5.0%		
Cognitive difficulty	5.3%		
Ambulatory difficulty	5.3%		
Self-care difficulty	5.4%		

⁴³ Ibid.

Independent living difficulty	5.2%		
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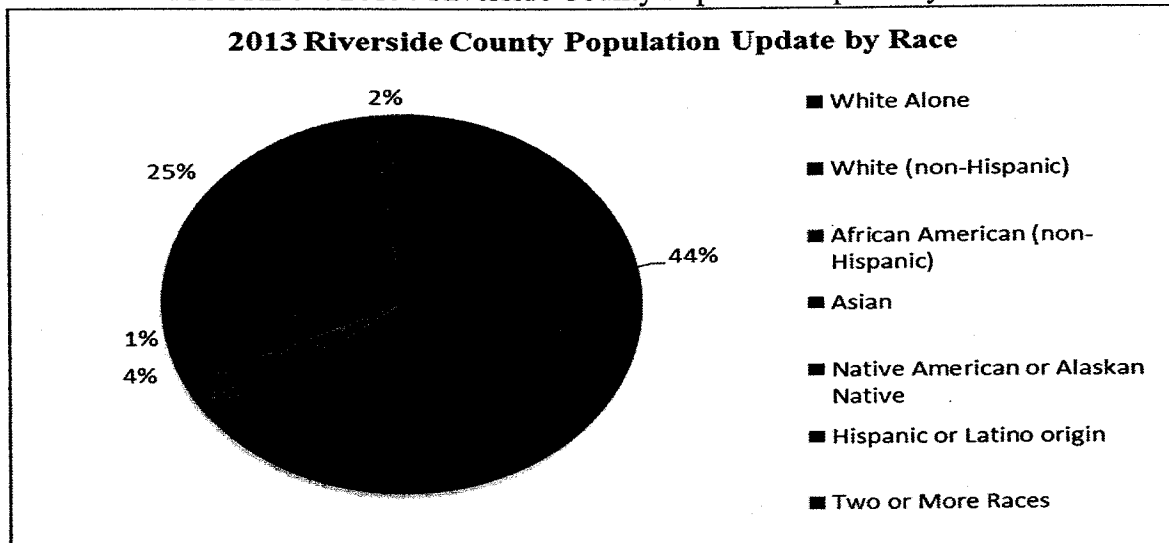
Source: U.S. Census Bureau, 2011-2013 3-Year American Community Survey

As expected, the older adults category has have a significantly higher percentage of persons living with disabilities (35.9%) ~~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.¹⁴ Thus, the ~~60 and older population has more than 3 times the disability rates than their younger cohorts in the County~~. With ~~Greater~~ longevity coupled with greater rates of disabilities, the cost of and need for adequate health care and community based services and ~~need of healthcare~~ must be ~~should be~~ anticipated.

RACE AND ETHNICITY

A 2013 update of the ~~The 2010 United States Census~~ reported that Riverside County had a population of 2,292,507. ~~189,641~~. The racial makeup of Riverside County in 2013 was 39.781% White alone non-Hispanic; 38% White (non-Hispanic or Latino); ~~4745.5%~~ persons of Hispanic or Latino origin; ~~76.4%~~ African American (non-Hispanic), ~~76.0%~~ Asian alones; ~~1.11.9%~~ Native American and Alaska Native; and 0.4% Hawaiian Native or other Pacific Islander alone ~~Alaska Native persons~~, 0.3% Native Hawaiian and Other Pacific Islander, and 3.34.8% persons reporting two or more races.¹⁵ The racial and ethnic population of the County is shown on Figure 32.

FIGURE 32. 2013 Riverside County Population Update by Race



Source: Riverside County QuickFacts from the US Census. Retrieved from: <http://quickfacts.census.gov/qfd/states/06/06065.html>

¹⁴ ~~2010 American Community Survey 1-Year Estimates Population 60+ in U.S.~~

¹⁵ ~~U.S. Census Bureau, 2010 Decennial Census~~ Riverside County QuickFacts from the US Census. Retrieved from: <http://quickfacts.census.gov/qfd/states/06/06065.html>

As shown above, the Riverside County population is becoming more -racially and ethnically diverse, which will have an impact on the delivery of social services, mental health services, and health care. Diverse 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, Non-Hispanic Whites are no longer the “majority” group.

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 Finance¹⁶:

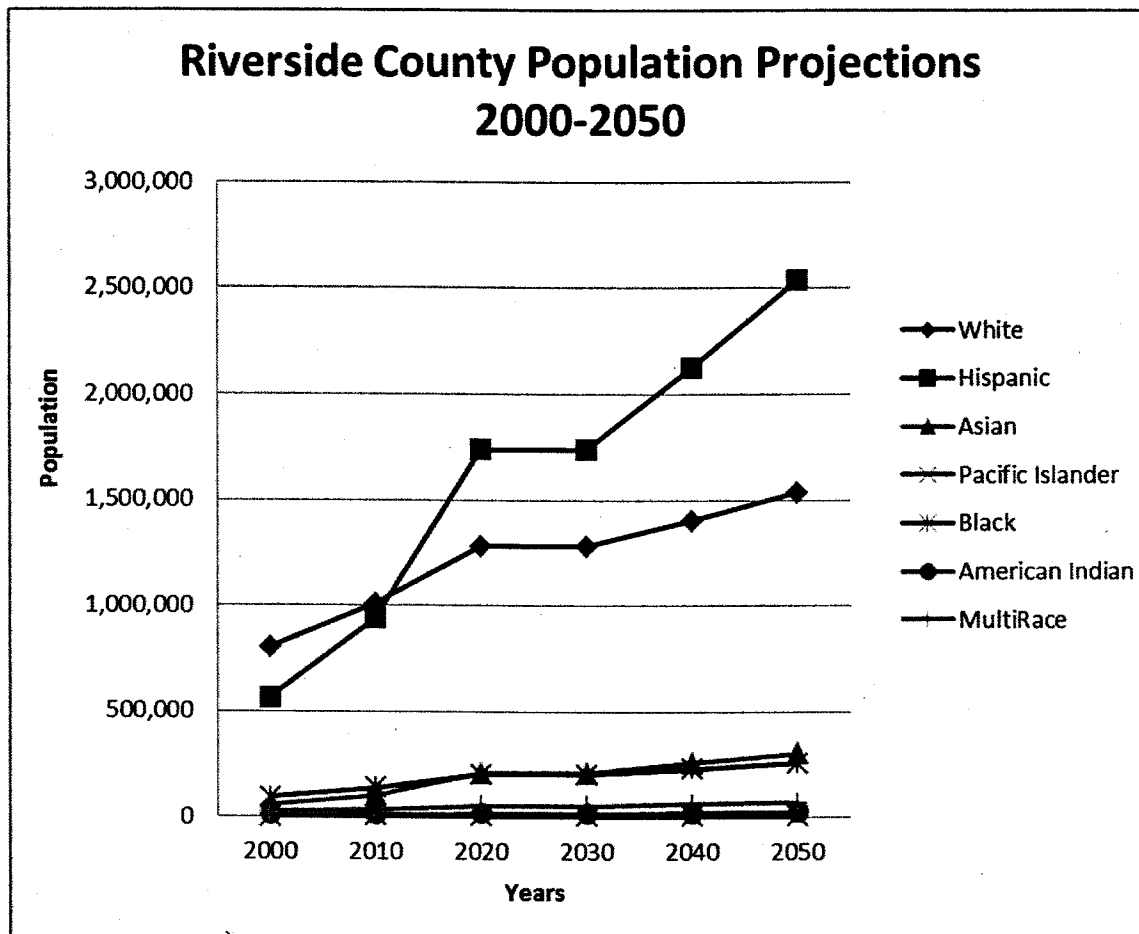


FIGURE 4: Riverside County Population Projections by Race for 2000-2050

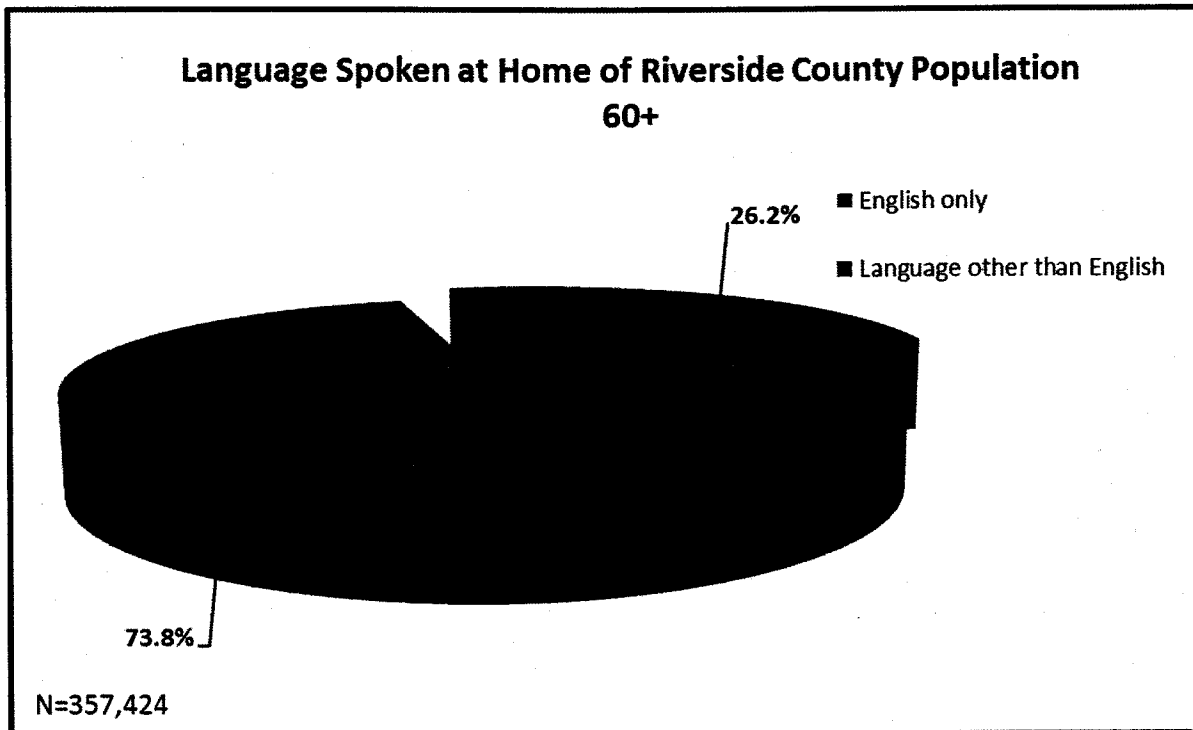
¹⁶ State of California, Department of Finance, Population Projections for California and Its Counties 2000-2050, by Age, Gender and Race/Ethnicity, Sacramento, California, July 2007

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

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 AAAs.

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).¹⁷

Rural Population

Despite high population growth during the last decade, the overall population density remains low, estimated at 303±.68 persons per square mile.¹⁸ 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.¹⁹

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 2010.²⁰ In December 2014, the California Department of Labor reported that the unemployment rate in Riverside County is now approximately 7.4%.²¹ ~~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 employed and 3.5% are unemployed. Riverside County adults 60+ comprise 13.8% of the civilian labor force.²²

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

¹⁷ Riverside County Transportation and Land Management Agency

¹⁸ Riverside County QuickFacts from the US Census. Retrieved from: <http://quickfacts.census.gov/qfd/states/06/06065.html>
California Department of Finance 2010 Census Data and Riverside County Transportation and Land Management Agency GIS

¹⁹ Riverside County Transportation and Land Management Agency, August 2011

²⁰ California Employment Development Department Historical Annual Average Labor Force for the United States

²¹ State of California Employment Development Department, Riverside County Profile (December 2014), Retrieved from:

<http://www.labormarketinfo.edd.ca.gov/cgi/databrowsing/localAreaProfileQSRResults.asp?menuChoice=localAreaPro&state=true&geogArea=0604000065&selectedArea=Riverside%20County>

²² 2010 American Community Survey 1-Year Estimates Population 60+ in U.S.

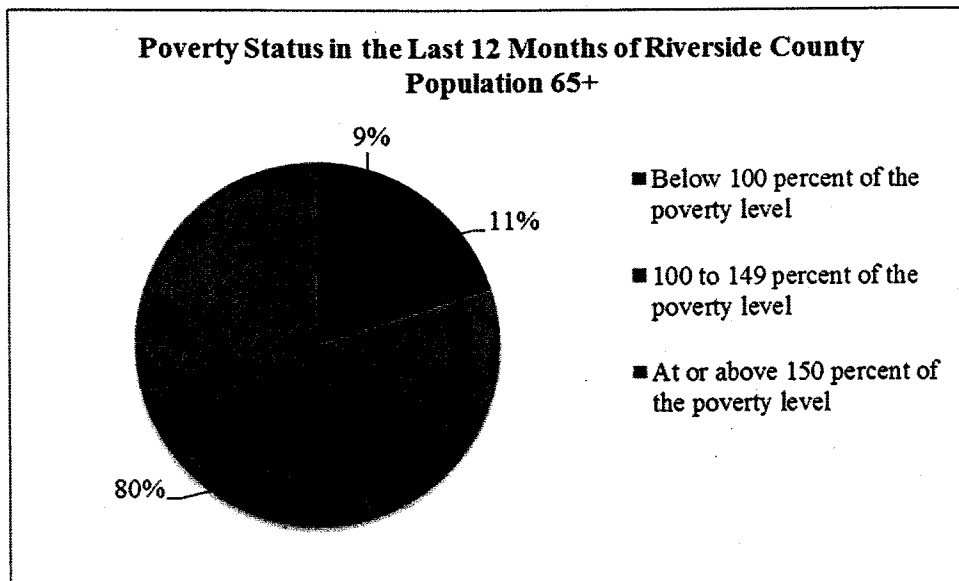
employment increased 17% in the same time period. ²³ In December 2013, the unemployment rate in Riverside County was down to 9%. ²⁴

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 (80%) of residents 65+ for whom poverty status could be determined have incomes at or above 150% of poverty. The remaining residents (18%) are either between 100-149% of poverty (11%) or below 100% of the federal poverty level (9%). These increases represent a 1% increase in poverty levels since 2010. ²⁵ These data are shown in figure below:

Figure 6. Poverty Level of Population 65+



Source: Population 65 Years and Over in th United States (Riverside County, California) 2009-2015 American Community Survey 5 Year Estimates United States Census Bureau 2010 American Community Survey 1 Year Estimates Population 60+ in U.S.

²³ California Employment Development Department, Employment by Industry Data for Riverside County.

²⁴ 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

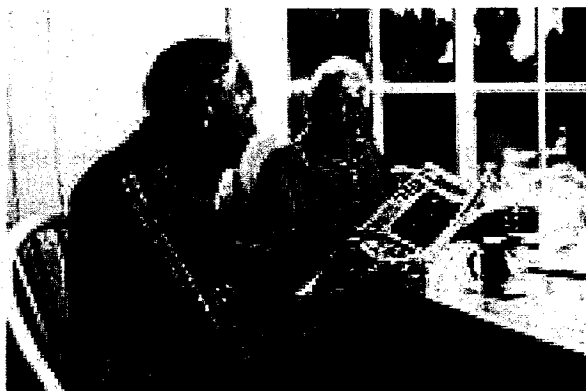
²⁵ Population 65 Years and Over in th United States (Riverside County, California) 2009-2015 American Community Survey 5 Year Estimates, United States Census Bureau

Housing/Household

Most homes in Riverside County are single-family, detached homes. A majority of the housing units are owner occupied (678%) compared to renter occupied (321%).²⁶ 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.²⁷

For the population 650 years of age or older, there are 155,881 203,777 occupied housing units in Riverside County. Of these, 804.4% are owner-occupied (average household size is 2.0514) and 2018.6% are renter-occupied (average household size is 1.7894).²⁸

In addition to the larger household size, Riverside County remains high on national lists for foreclosure rates. In December 2014, October of 2011, 1 in 276 457 housing units es 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.~~



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

²⁶ Riverside County QuickFacts from the US Census. Retrieved from:

<http://quickfacts.census.gov/qfd/states/06/06065.html> U.S. Census Bureau, 2009 American Community Survey

²⁷ 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.

²⁸ Population 65 Years and Over in th United States (Riverside County, California) 2009-2015 American Community Survey 5 Year Estimates, United States Census Bureau

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.²⁹

New research from the Alzheimer’s Association of America³⁰ 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.³¹

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.³²

Receipt of Income and Benefits

As shown in the Table 5 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.

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

²⁹ National Council on Aging, *Healthy Aging Fact Sheet*, October 2012

³⁰ Alzheimer’s Association, *2014 Alzheimer’s Disease Facts and Figures*, *Alzheimer’s & Dementia*, Volume 10, Issue 2.

³¹ Falconi, April and Dow, William H. “Will Boomers Bust the Budget?” *University of California, Berkley’s Division of Health and Policy Management*, November 2013.

³² *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

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.³³ 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).

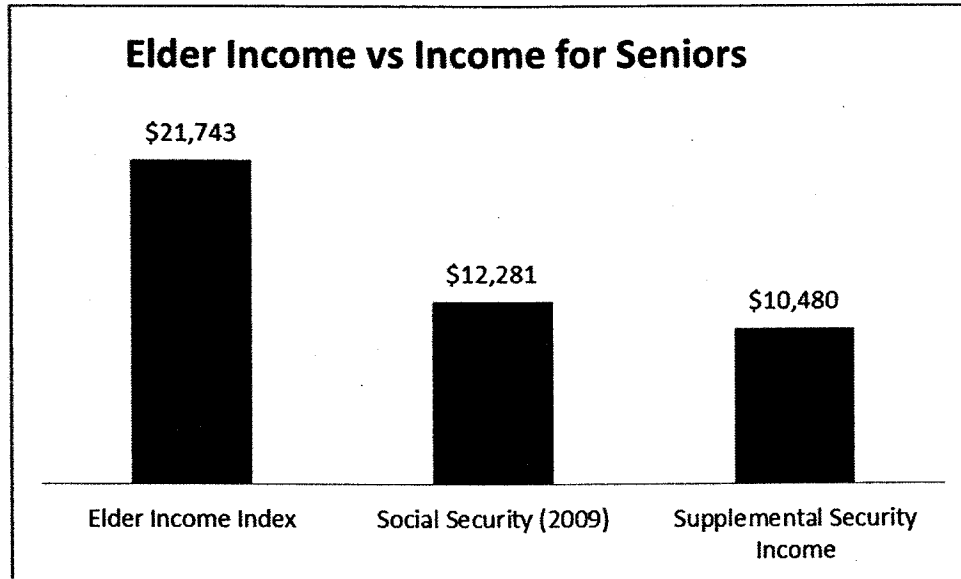
TABLE 6. Elder Income Index Comparison to FPL (Per Person) 2010

	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).

³³ 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

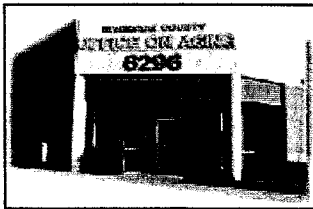
SECTION 3. DESCRIPTION OF THE AREA AGENCY ON AGING (AAA)

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 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 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? ³⁴ Yes or No	Was hearing held at a Long-Term Care Facility? ³⁵ 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	2/11/2015	Riverside CA	18	No	No

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, 2012, two (2) external and internal focus groups were conducted in 2012, during the development of the Plan 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 February 11 ~~March 12~~, 2015, 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 two ~~three~~ regional newspapers and members of the public were allowed to submit written comment (via email, fax or correspondence) until 5:30 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: With reference to TABLE 4. Riverside County Population Projections 2010-2060, will the increase in the older adult population change the level of services?

Answer: No, it does not affect services at this time. The importance of these data is that they begin to reframe the conversation about older adults, which is brand new. Now, the older adult category is broken down into stages of older adulthood, with "seniors" being labeled as those individuals over 85 years old.

Comment: The number of people over the age of 85 implies that people might be living past the age of 85.

Response: Interestingly, there is a report that came out from the Government Accountability Office, that highlighted the population that we serve. More and more, across programs and across the nation, AAAs are serving older adults with low incomes. The report found that only about 9% of 18,000,000 low income seniors are being served in terms of meals, an estimated 19% of low income older adults are food insecure and 90% of older adults do not receive any meal services at all. At this time, most AAAs are reliant on federal funding (Older American Act). Because of this, the important role that our Council will be playing in advocacy and coordination will be critical.

Question: Can you copy the new population slide onto an 8 1/2 by 11 sheet? .

Answer: Absolutely.

Comment: In your demographic analysis, there is a large population subset missing, those under 25 years old.

Response: That is correct. That population subset was not included in the demographic analysis because it does not pertain to our work. That population is expected to have the highest overall population growth, but will not proportionally increase as much as the aging population subsets are expected to increase.

Comment: I think we are going to have a crisis in care giving because as people live longer there could possibly be three generations both providing and needing caregiving services and long term care is going

to occur in the home, rather than in more expensive institutions. Most of these caregivers will also still be working.

Response: Yes, the Boomers are going to be the first ever "sandwich generation". This generation will find themselves caring for both their aging parents and their children at the same time.

Question: Did you look at the poverty levels of each of the aging subgroups?

Answer: We did not, but we certainly can.

Additional Comment: The Advisory Council's Community Connections committee community assessment survey goal for the new plan development is set at 250, and all of the agency programs are collecting the assessments, in order to get a better understanding of what the community needs so that we can be responsive in our services.

Question: Have you delineated the types of services or is it just an open question?

Answer: There are choices.

Question: So there are choices?

Answer: There is a whole Comment section. You can write in anything additional, but the core services are categorized.

Question: Is the Advisory Council doing its part by going out to Senior Centers and working with the Info Van to assist with outreach and assessment?

Answer: Yes we are. Is there more we can do? Absolutely! That is one of the things we are going to talk about in Community Connection Committee in the next few months. We will be looking at the assessments we have collected so far to see which areas we have covered and which areas we still need to get assessments from. All of the information we get from the assessments will become part of the next four year plan.

Comment: Is there a way to get income information of our county at the city level?

Answer: Yes, it is possible. In the Census, Community Profiles can provide detailed data down to a minute level, which can be mapped.

~~**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 IIB and Title IIE were impacted with sequester and have lowered those levels of service.

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.

7. Note any changes to the Area Plan which were a result of input by attendees.

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 submitted a written statement after the public hearing. The comment indicated that older adults need access to transportation, food and medications. reiterating the points made at the Hearing, which has been summarized above.

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 to prioritize the needs. The areas that were identified as a need include 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 likely 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:	Projected Start and End Dates	Title III B Funded PD or C ³⁶	Update Status ³⁷
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.	See Action Steps Below	See Action Steps Below	
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 – 6/30/2016		Continued 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

³⁶ 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.

³⁷ 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
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Goal I, Objective B:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
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.	See Action Steps Below	See Action Steps Below	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 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 (such as Network of Care) that allows consumers to review program guidelines, check eligibility and prepare applications for public benefit programs, such as Cal Fresh, in an efficient person centered focus.	7/1/2012 – 6/30/2016		Continued Revised
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:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
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.	See Action Steps Below	See Action Steps Below	
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:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
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.	See Action Steps Below	See Action Steps Below	
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.	7/1/2012 – 6/30/2016 ⁵	PD	Continued 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 a healthy lifestyle, 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 likely 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:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
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.	See Action Steps Below	See Action Steps Below	
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 – 6/30/2016	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:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
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.	See Action Steps Below	See Action Steps Below	
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 and via the SNAP-Ed program. -	7/1/2012 – 6/30/2016		Continued Revised

<p>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; Info Van outreach, Care Coordination programs-, the Clinton Foundation Health Matters Initiative and the Desert AIDS “Get Tested Coachella Valley” Project.</p>	<p>7/1/2012 – 6/30/2016</p>	<p>C</p>	<p>Revised Continued</p>
<p>4. Expand and explore additional evidence based fitness programs promoting physical activity to meet the needs of targeted populations such as Boomers and the Limited English Speaking consumer with emphasis on behavior activation, and-disease prevention and increased physical activity. -</p>	<p>7/1/2012 – 6/30/2016</p>	<p>PD</p>	<p>Revised</p>
<p>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.</p>	<p>7/1/2012 – 6/30/2016</p>		<p>Continued</p>
<p>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.</p>	<p>7/1/2012 – 6/30/2016</p>		<p>Continued</p>
<p>7. Advocate for intergenerational learning programs and interaction in the community to combat ageism and mentor community residents.</p>	<p>7/1/2012 – 6/30/2016</p>		<p>Continued</p>
<p>8. Explore programs that encourage “brain fitness” exercises and education with emphasis on online learning and other new alternatives for social activation.</p>	<p>7/1/2012 – 6/30/2016</p>		<p>Continued</p>
<p>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.</p>	<p>7/1/2012 – 6/30/2016</p>		<p>Revised Continued</p>

<p>10. Explore and develop key partnerships to increase access to public services or performance outcomes for older adults and persons with chronic illnesses, such as Cal Fresh in conjunction with other public, non-profit and private agencies and regional partners that serve the older adult population.</p>	<p>7/1/2012 – 6/30/2016</p>	<p>C</p>	<p>Revised</p>
<p>11. Provide evidence based falls prevention, chronic disease management using credentialed practitioners to provide health and wellness interventions such as Fit After 50 and the Healthy Options Program (HOP).</p>	<p>7/1/2012 – 6/30/2016</p>		<p>Continued</p>

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:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
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.	See Action Steps Below	See Action Steps Below	
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	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:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
Advocate through legislative and collaborative networks for restored service levels and adequate funding and pursue on an ongoing basis other opportunities for service funding.	See Action Steps Below	See Action Steps Below	
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:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
Promote an aging friendly environment responsive to the needs of diverse, cultural, social, and economic elder, disabled, and caregiver populations.	See Action Steps Below	See Action Steps Below	
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, 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 trends related to existing and emerging health care crisis including, but not limited to, 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 Continued
6. Advocate for an elder's right to positive and healthy aging.	7/1/2012 – 6/30/2016		Continued

Goal III, Objective D:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
Act in accordance with local, state, and federal statutes and regulations.	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:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
Maximize operational efficiencies through enhanced quality improvement initiatives and maintain an effective and responsive leadership team.	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:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
Support employee professional development and succession planning.	See Action Steps Below	See Action Steps Below	
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

<p>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.</p>	<p>7/1/2012 – 6/30/2016</p>		<p>Continued</p>
<p>3. Provide opportunities for employee participation on Motivation and Morale (M&M) Team to enhance employee leadership and effectiveness in the organization.</p>	<p>7/1/2012 – 6/30/2016</p>		<p>Continued</p>

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:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
Provide leadership for the development of a streamline system to provide consumers, caregivers, and providers with information, assistance, and support.	See Action Steps Below	See Action Steps Below	
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		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	Continued

<p>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.</p>	<p>7/1/2012 – 6/30/2016</p>	<p>C</p>	<p>Revised Continued</p>
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<p>Goal IV, Objective B:</p>	<p>Projected Start and End Dates</p>	<p>Title III B Funded PD or C</p>	<p>Update Status</p>
<p>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.</p>	<p>See Action Steps Below</p>	<p>See Action Steps Below</p>	
<p>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.</p>	<p>7/1/2012 – 6/30/2016</p>		<p>Continued</p>
<p>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.</p>	<p>7/1/2012 – 6/30/2016</p>		<p>Continued</p>
<p>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</p>	<p>7/1/2012 – 6/30/2016</p>		<p>Continued</p>

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/lrc/i51-caregiving.pdf](http://assets.aarp.org/rgcenter/ppi/lrc/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:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
Collaborate with local stakeholders and provide leadership to improve coordination of services and provide a more seamless system of access for caregivers.	See Action Steps Below	See Action Steps Below	
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 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 to better assist grandparent relative caregivers with preparing their grandchildren for independence and success.	7/1/2012 – 6/30/2016		Revised Continued

Goal V, Objective B:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
Collaborate with local stakeholders to provide leadership in the development of education, outreach, and resources for family caregivers and Grandparents Raising Grandchildren (GRG).	See Action Steps Below	See Action Steps Below	
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	Revised Continued
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 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		Revised Continued
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:	Projected Start and End Dates	Title III B Funded PD or C	Update Status
Sustain/improve support systems for caregivers and grandparents raising grandchildren to enhance family stability.	See Action Steps Below	See Action Steps Below	
1. In coordination with local officials, County departments, Grandparents Raising Grandchildren Task Force (GRGTF), the Riverside County Youth Advisory Council (YAC) 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		Revised Continued

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 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 Continued
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		Revised Continued
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 – 6/30/2016		Revised Continued
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 and the Volunteer Connection programs in Coachella Valley in partnership with the Office on Aging to bring volunteers into classrooms, 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		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	II	
2015-2016	5191	II	

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	3839	II	

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	N/A		

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	320,000	II	
2015-2016	320,000	II	

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	10,154	II, IV	

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	1871	II	

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	13,321	I, II	

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	190,739	II	

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	N/A		

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	N/A		

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	2,255	IV	

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	11,004	II	

*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	32, 560	III, IV	

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	13,250	I,II, IV	

*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 ³⁸

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	1,550	II, IV, V	II.D.7 IV.B.1

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	

³⁸ Other Supportive Services: Visiting (In-Home) now includes telephoning (See Area Plan budget).

2015-2016	N/A	II	
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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	1357	II, IV	

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	10,990*	II	

*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	16	II	

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	30	I, II, IV	

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: Physical Fitness (Evidence Based)

- **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. 11
2013-2014	18,113	II	II.D. 11
2014-2015	19,924	II	II.D. 11
2015-2016	19,924	II	II.D. 11

Title III D Evidence Based Health Promotion ³⁹

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.11
2013-2014	800	II	D.11
2014-2015	800	II	D.11
2015-2016	800	II	D.11

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

Title III D Evidence Based Health Promotion ⁴⁰

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	1200	II	D.10

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 2010-2011 National 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: <u>77%</u> Number of complaints resolved <u>388</u> + Number of partially resolved complaints <u>335</u> divided by the Total Number of Complaints Received <u>936</u> = Baseline Resolution Rate <u>77%</u>

2. FY 2012-2013 Target: Resolution Rate <u>80%</u>
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3. FY 2011-2012 AoA Resolution Rate <u>72%</u> FY 2013-2014 Target: Resolution Rate <u>82%</u>
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4. FY 2012-2013 AoA Resolution Rate <u>74%</u> FY 2014-2015 Target: Resolution Rate <u>85%</u>
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5. FY 2013-2014 AoA Resolution Rate <u>80%</u> FY 2015-2016 Target: Resolution Rate <u>86%</u>
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Program Goals and Objective Numbers: Goal II, Objective D.5.
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B. Work with Resident Councils (AoA Report, Part III-D, #8)

FY 2010-2011 Baseline: number of meetings attended <u>92</u>
2. FY 2012-2013 Target: <u>86</u>
3. FY 2011-2012 AoA Data: <u>129</u> FY 2013-2014 Target: <u>90</u>
4. FY 2012-2013 AoA Data: <u>62</u> FY 2014-2015 Target: <u>95</u>
5. FY 2013-2014 AoA Data: 65 FY 2015-2016 Target: <u>98</u>
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 <u>3</u>
2. FY 2012-2013 Target: number <u>5</u>
3. FY 2011-2012 AoA Data: <u>9</u> FY 2013-2014 Target: <u>7</u>
4. FY 2012-2013 AoA Data: <u>8</u> FY 2014-2015 Target: <u>9</u>
5. FY 2013-2014 AoA Data: <u>9</u> FY 2015-2016 Target: <u>11</u>
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 <u>95</u>
2. FY 2012-2013 Target: <u>500*</u>
3. FY 2011-2012 AoA Data: <u>279</u> FY 2013-2014 Target: <u>280*</u>
4. FY 2012-2013 AoA Data: <u>372</u> FY 2014-2015 Target: <u>530*</u>
5. FY 2013-2014 AoA Data: 530 FY 2015-2016 Target: <u>535*</u>
Program Goals and Objective Numbers: Goal II, Objective D.5.

* These target numbers 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 <u>278</u>
2. FY 2012-2013 Target: <u>500*</u>
3. FY 2011-2012 AoA Data: <u>642</u> FY 2013-2014 Target: <u>645*</u>
4. FY 2012-2013 AoA Data: <u>993</u> FY 2014-2015 Target: <u>530*</u>
5. FY 2013-2014 AoA Data: <u>995</u> FY 2015-2016 Target: <u>535*</u>
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 <u>4</u>
2. FY 2012-2013 Target: <u>10</u>
3. FY 2011-2012 AoA Data: <u>0</u> FY 2013-2014 Target: <u>6</u>
4. FY 2012-2013 AoA Data: <u>14</u> FY 2014-2015 Target: <u>16</u>
5. FY 2013-2014 AoA Data: <u>16</u> FY 2015-2016 Target: <u>18</u>
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)

- III.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.
- IV.II. The Ombudsman Program will meet regularly with Operational Area Planning Committee and Voluntary Organization Active in Disaster (VOAD) in preparation for a disaster.
- V.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 16 certified volunteers

FY 2014-2015 Projected Number of certified LTC Ombudsman volunteers
as of June 30, 2015 25

5. FY 2013-2014 AoA Data: 25 certified volunteers

FY 2015-2016 Projected Number of certified LTC Ombudsman volunteers
as of June 30, 2016 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	25*

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

*Transitioning work from current community partner to new community partner for the 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	2

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

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	1200	Fraud Prevention and Protection

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

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 1, 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: 55 Total est. audience for above: 90,437		
Access Assistance	Total contacts		
2012-2013	1,105	V	
2013-2014	4,420*	V	
2014-2015	4,420	V	
2015-2016	4,420	V	
Support Services	Total hours		
2012-2013	3,615	V	
2013-2014	3,732	V	
2014-2015	3,732	V	
2015-2016	3,732	V	

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

*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: 16 Total est. audience for above: 6,000	V	
Access Assistance	Total contacts		
2012-2013	366	V	
2013-2014	360	V	
2014-2015	600**	V	
2015-2016	600**	V	
Support Services	Total hours		
2012-2013	111	V	
2013-2014	105	V	
2014-2015	111	V	
2015-2016	111	V	
Respite Care	Total hours		
2012-2013	N/A		
2013-2014	N/A		
2014-2015	N/A		
2015-2016	N/A		
Supplemental Services	Total occurrences		
2012-2013	N/A		
2013-2014	N/A		
2014-2015	N/A		
2015-2016	N/A		

*More accurate projections based on inclusion of additional activities

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

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):
Number of paid staff <u> 0 </u> Number of participant staff <u> 2 </u>
How many participants are served at this site? 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):
Number of paid staff <u> 0 </u> Number of participant staff <u> 3 </u>
How many participants are served at this site? 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): Lynette Worrell – Program Manager
Number of paid staff <u> 1 </u> Number of participant staff <u> 9 </u>
How many participants are served at this site? 35

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

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

**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	2565	II, IV
2015-2016	2646 2727	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	182	II, IV
2015-2016	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	17,838	II, IV
2015-2016	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	41,774	II, IV
2015-2016	42,609 22,000	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	2,400	II, IV
2015-2016	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	10,203	II, IV
2015-2016	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	12,708	II, IV
2015-2016	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 all 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	10,334	II, IV
2015-2016	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	4,982*	II, IV
2015-2016	5,081* 6787	II, IV

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

Section 3: HICAP Legal Services Units of Service (if applicable) ⁴²

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	

⁴² 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 Geronio 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

Designated Community Focal Point	Address
Jerry Rummonds Senior Center	87-225 Church Street PO Box 701 Thermal, CA 92274
Joslyn Senior Center	73-750 Catalina Way Palm Desert, CA 92260
Kay Cenicerros Senior Center	29995 Evans Road Sun City, CA 92586
La Quinta Senior Center	78-450 Avenida La Fonda La Quinta, CA 92247
La Sierra Senior Center	5215 La Sierra Riverside, CA 92505
Lake Elsinore Activity Center	420 East Lakeshore Drive Lake Elsinore, CA 92530
Marion Ashley Community Center	25625 Briggs Road Menifee, CA 92585
Mary Phillips Senior Center	41845 Sixth Street Temecula, CA 92590
Mead Valley Community Center	21091 Rider Street Perris, CA 92570
Mizell Senior Center	480 South Sunrise Way Palm Springs, CA 92262
Moreno Valley Senior Center	25075 Fir Avenue Moreno Valley, CA 92553
Moses Schaffer Community Center	21565 Steele Peak Drive Perris, CA 92570-8296
Murrieta Senior Center	41717 Juniper Street Murrieta, CA 92562
Norco Senior Center	2690 Clark Avenue PO Box 428 Norco, CA 92860
Norton Younglove Community Center	459 West Center Street Riverside, CA 92507
Norton Younglove Community Center	908 Park Street PO Box 1190 Calimesa, CA 92320
Perris Senior Center	100 North "D" Street Perris, CA 92570
Riverside-San Bernardino County Indian Health	11555 ½ Potrero Road Banning, CA 92220
Ruth H. Lewis Community Center at Reid Park	701 North Orange Street Riverside, CA 92501
San Jacinto Community Center	625 South Pico Avenue San Jacinto, CA 92583
Stratton Community Center at Bordwell Park	2008 Martin Luther King Boulevard Riverside, CA 92507
The Center	611 S. Palm Canyon Drive, Suite 201 Palm Springs, CA 92262
Ysamel Villegas Community Center	3091 Esperanza Street Riverside, CA 92503

SECTION 12 - DISASTER PREPAREDNESS

PSA 21

Disaster Preparation Planning Conducted for the 2012-2016 Planning Cycle OAA Title III, Sec. 306(a)(17); 310, CCR Title 22, Sections 7529 (a)(4) and 7547, W&I Code Division 8.5, Sections 9625 and 9716, CDA Standard Agreement, Exhibit E, Article 1, 22-25, Program Memo 10-29(P)

1. Describe how the AAA coordinates its disaster preparedness plans and activities with local emergency response agencies, relief organizations, state and local governments, and other organizations responsible for emergency preparedness and response as required in OAA, Title III, Section 310:

Riverside County Office on Aging (OoA) in its role as area agency on aging is responsible for creating a disaster plan that will ensure the provision of critical services that will meet the emergency needs of its consumers in the event of a natural disaster, such as an earthquake, fire or flood.

Office on Aging's Disaster Plan has been developed to coordinate with the County of Riverside's disaster plan, which includes five Standardized Emergency Management System (SEMS) functional units which may be activated at any time following an official activation by the Emergency Operations Center in a major disaster. The five SEMS are as follows:

- Care and Shelter Operations
- Resources and Support Operations
- Mental Health Operations
- Disaster Assistance Centers
- Radiological Protection

OoA is represented under the Care and Shelter Operations unit, which provides basic human needs and relocation of those in need, along with specific services targeted to the elderly and individuals with disabilities.

OoA's Disaster Response Coordinator is responsible to execute activation of OoA's Disaster Plan's policies and procedures, following an agency emergency/disaster and/or an official activation by the Emergency Operations Center. In the absence of the Disaster Response Coordinator, the designated alternate or the Director shall execute activation. In the absence of all three persons, the highest level supervisor available is authorized to execute activation of these policies and procedures.

In the event the emergency/disaster occurs during non-working hours, staff must report to the nearest operating OoA site and assume normal operating duties unless designated or assigned otherwise.

Information and Assistance staff has been provided written emergency procedures on how to provide services during and after a disaster. Earthquake and fire evacuation procedures occur twice a year as required by Riverside County Safety. In addition, the Disaster Response Coordinator participates in the Riverside County Operations Committee meetings and trains quarterly with Riverside County Public Health, Bioterrorism Branch, Riverside County Environmental Health, Riverside County Office of Emergency Services, and Riverside County Fire.