AREA PLAN ON AGING FOR THE
SOUTH CENTRAL CONNECTICUT PLANNING AND SERVICE AREA
As defined in response to requirements under
THE OLDER AMERICANS ACT OF 1965, as amended

For the four-year period of October 1, 2013 to September 30, 2017

AREA PLAN DETAIL
STATEMENT OF GOALS, OBJECTIVES AND STRATEGIES

Priority Area 1: Physical and Mental Health

Broad Background:

"For most older adults, good health ensures independence, security, and productivity as they age." (2012, NCOA) A United Nations Population Fund study states that older adults must have access to age-friendly and affordable preventive, curative and long-term care. "Ensuring that people, while living longer lives, live healthier lives will result in greater opportunities and lower costs to older persons, their families and society." (2012, United Nations Population Fund and HelpAge International) A survey of AARP members found the three most important topics of interest, across all racial and ethnic groups, to be: staying mentally sharp, staying physically fit, and maintaining a healthy diet.

Older Americans use more health care per capita than any other age group and average costs increase substantially with age. Per capita health care spending in Connecticut is the third highest in the country. (Connecticut Association for Healthcare at Home) Medicare covers a little over one-half of the total health care costs of Medicare enrollees. Other sources of payment for health care vary by income but people in the poor/near poor income category spend a higher percentage of their household income on health care services. (Older Americans 2012 *Key Indicators of Well-Being*) Additionally, racial/ethnic minority groups suffer from many conditions at disproportionately higher rates (2013, CT DPH) leading to increased health care costs.

According to NCOA, approximately 92% of older adults have at least one **chronic disease**. Chronic health conditions negatively affect quality of life, contributing to declines in functioning and the inability to remain in the community. (*Key Indicators)* Chronic diseases and injuries are leading causes of premature death and morbidity. (2013, CT DPH) Many chronic conditions can be prevented or modified with behavioral interventions. Chronic diseases account for 75% of the money our nation spends on health care, yet only 1% of health dollars are spent on public efforts to improve overall health. (NCOA)

"**Behavioral health** problems—such as depression, anxiety, and medication and alcohol misuse—are associated with higher health care use; lower quality of life; and increased complexity of illnesses, disability and impairment, caregiver stress, mortality,

and risk of suicide." (2012 AoA/SAMHSA) One in four older adults experiences some mental disorder such as depression, anxiety disorders, and dementia. Two-thirds of older adults with mental health problems do not receive the treatment they need. People aged 85+ have the highest suicide rate of any age group. (NCOA) One in three seniors dies with Alzheimer's or another **dementia** and the number of Connecticut seniors with the disease is expected to rise by nearly 9% in the next 12 years. (2013, Alzheimer's Association)

One-third of Americans aged 65 and older **falls** each year resulting in deaths, serious injuries, and billions of dollars in health care costs. In addition, fear of falls leads to self-limiting activities resulting in further physical decline, depression, social isolation, and feelings of helplessness. (2012, NCOA)

Approximately 14.8% of older adults were **food insecure** in 2010 including 10.6% of Connecticut's seniors. From 2001 to 2010, the number of seniors experiencing the threat of hunger increased by 78%. (National Foundation to End Senior Hunger) Yet only one-third of eligible older adults are enrolled in the Supplemental Nutrition Assistance Program. (NCOA) Food insecurity is associated with a host of poor health outcomes for seniors. This implies that the recent increase in senior hunger will likely lead to additional nutritional and health challenges for our nation. Lack of physical activity and poor nutrition are among the modifiable risk factors for the most common chronic diseases. (2013, CT DPH)

Physical activity is beneficial for the health of people of all ages, including the age 60 and over population. It can reduce the risk of certain chronic diseases, may relieve symptoms of depression, helps to maintain independent living, and enhances overall quality of life. Yet only about 11% of people age 65 and over report participating in aerobic and muscle-strengthening activities. (*Key Indicators)*

As people age, functioning may be diminished if illness, chronic disease, or injury limits physical and or mental abilities. (*Key Indicators)* The Scan Foundation estimates that 70% of those reaching age 65 will eventually need some form of **long-term services and supports** for an average of 3.5 years. The DSS Strategic Rebalancing Plan identifies lack of sufficient services and lack of a sufficient workforce as barriers to providing these needed services in the community. Estimates are that at least 75% of these services will be provided by family, friends, and other non-professional **caregivers**, many of whom will be seniors themselves. Experts suggest that by 2020 the U.S. will need more caregivers than teachers. (Weinberg Foundation)

Disability and need for assistance increases with age. A US Census report published in 2012 gave the following statistics. Twelve percent of individuals 65 and older are restricted in at least one **Activity of Daily Living** (ADL) and 3.6 percent of individuals age 65 and over need assistance with three or more ADL's. "Disability was 1-in-20 for people aged 15 to 24, while 1-in-4 for those aged 65 to 69. Among the oldest group, more than half (55.8 percent) had a severe disability. Of individuals 55 to 64 years old and nearing retirement, about

6.0 percent needed assistance with one or more ADLs or IADLs. The percentage needing assistance for those aged 80 and older was about 5 times as large (30.2 percent)."

Early detection and treatment for **vision** limitations, **hearing** limitations, and **oral health** problems can prevent, or at least postpone, some of the debilitating physical, social, and emotional effects these impairments can have on the lives of older people. Glasses, hearing aids, and regular dental care are not covered services under Medicare. (*Key Indicators)*

Connecticut and Region-Specific Background:
According to the AARP Public Policy Institute's *Connecticut Quick Health Facts 2012* (data is from 2010), which focuses on adults age 50 and older, 16.2% of this population were in in poor or fair general health in 2010, 45% had high blood pressure, 64.1% were overweight or obese, 12.6% had diabetes, 9.9% smoked cigarettes, and 9.9% reported their mental health was not good for more than one week in a month.

Various indicators of the health status of respondents to the Connecticut Long-Term Care Needs Assessment illustrate important areas of concern. These include incidence of disability, prevalence of use of preventative health screenings, falls, unintended loss or gain of weight, hospitalizations, and report of depression.

Although 78% of all respondents described their health as good or excellent, 22% reported fair or poor. Of particular note is that health status varies across ethnicity and income.

Among respondents, 45% of Latinos and 32% of Blacks rated their health as fair or poor, almost twice the rate at which Whites did so. Generally, Black and Latino respondents had fewer wellness checks than Whites, with 54% of Blacks and 47% of Latinos reporting that they had not received one in the past two years as compared to only 38% of Whites.

While 86% of those in top three income categories rated their health as excellent or good, 45% of low-income group rate health as fair or poor. Low-income respondents were also less likely to have received preventative health screenings. Across age tiers, those age 61-74 reported either the highest or one of the highest rates of screenings in all areas, with the exception of wellness exams. Of note is that only about 1/3 of those 61-84 have had bone density or sigmoid/colonoscopy in the past two years. Further, while 75% of respondents age 75+ had received flu vaccine, the pneumonia vaccine had been much less utilized by any age group.

Further, 28% of respondents reported that they had gained or lost at least 10 lbs. without trying in the year prior to completing the survey. The low-income group was twice as likely to have gained or lost weight without trying as compared to individuals in the top three income categories. Among respondents, those age 85 and older reported the largest percentage of unintended weight loss (22%).

A regional breakdown of this study reported that New Haven area respondents had a higher than average report of fair or poor health status as compared to those in other regions. Further, respondents were less likely, along with their peers in the Willimantic area, than those in any other region to have received a wellness check within the past two years.

Approximately 14.8% of older adults were food insecure in 2010 including 10.6% of Connecticut's seniors. A 2012 University of Connecticut study that reviewed food insecurity in Connecticut ranked New Haven as having the second highest at-risk population for food insecurity. Further, a 2012 study published by Feeding America identified New Haven County as having the highest food insecurity rate in Connecticut (14%) and 61% of the food insecure population in Connecticut does not qualify for food stamps or other federal benefits.

Generally, there was a high report of mental health needs among respondents to the Connecticut Long-Term Care Needs Assessment, with almost one-third, or 27%, reporting that they often felt down, depressed or hopeless and 23% reporting little interest or pleasure in doing things. Almost half (48%) of the low-income group reported that they had experienced feelings of depression or hopelessness over the month prior to completing the survey. This compared to 17% of those in top three income categories. This key indicator of mental health status ranged across ethnicity, with 43% of Latinos reporting feeling down, depressed or hopeless in last month as compared with 33% of Blacks and 25% of Whites.

Although these statistics compellingly illustrate the incidence of mental health needs, they are somewhat mitigated by the fact that 87% of respondents reported that they can count on someone to provide emotional support for problems or difficult decisions. Further, 31% of respondents used some kind of mental or behavioral health service three or more times in past year and 21% used those services six or more times in that period.

Of concern, however, is that the regional breakdown showed that New Haven area residents, along with those in Willimantic and New Britain, reported the highest rate of depression (29%). Further, New Haven area respondents reported having mental illness at twice the average rate reported for regions in Connecticut.

According to 2010 census data, in Connecticut, 6% of adults over 60 had Alzheimer's disease or a related disorder according to the census data, and the same rate, or 8,834 in the south central region (NASUAD-Muskie Connecticut Demographic Profile). The Alzheimer's Association estimates that the percentage of those with dementia in Connecticut will increase from 3 percent in 2010 to 12 percent in 2015. Alzheimer's is the sixth leading cause of death in the United States And the fifth-leading cause of death for individuals age 65 and older.

Almost one fourth, or 23%, of respondents experienced a fall within the twelve months preceding the Connecticut Long-Term survey. Among all respondents, the low-income group was twice as likely to have fallen as compared to individuals in the top three income categories. Compellingly, 40% of respondents age 85 and older reported falling

in last year. Falls are caused by a multiplicity of factors, including environmental risks, poly-pharmacy, health conditions and others. In unpacking the high incidence of falls, it may be instructive to note that 33% of respondents reported that their homes are only "somewhat accessible", and that 8% described their homes as "not at all accessible". Further, while 54% of respondents leave home for some reason every day, 8% leave only one day per week or only for medical appointments and 28% of those 85+ are effectively homebound.

Among other indicators, the survey asked respondents to indicate how often they had been hospitalized, if at all, in the year prior to completing the survey. Generally, 37% of respondents had been admitted to and stayed overnight in the hospital in that time period, and 11% reported three or more admissions to the hospital. Also important to note is that 49% had at least one emergency room visit in last year, and that 15% used ER services 3 or more times in that period.

Of Connecticut residents aged 65 and over, one-third have a disability (2013, CT DPH). Consistent with this statistic, the Connecticut Long-Term Survey reported that 30% of older adult in the New Haven area reported at least one disability. Low-income individuals were much more likely to report disability than those in the top three income tiers, including physical (55%), intellectual (31%), and psychiatric (29%) disabilities. Incidence of disability ranges across ethnicity. Latino respondents reported the highest incidence of intellectual disability (20% of respondents), mental illness (22% of respondents), deafness (10% of respondents) and blindness (9% of respondents) and the second highest incidence of physical disability (40% of respondents). Black respondents reported the highest incidence of physical disability (42% of respondents), and the second highest incidence of intellectual disability (15% of respondents) and mental illness (16% of respondents). Black and Latino respondents were almost twice as likely to require at least some help with ADL's and to need assistive devices as were White individuals.

In regards to assistance with daily living activities, almost one-third, 28%, of New Haven area respondents indicated need for help with at least one IADL, and reported the highest rate of need among the Connecticut regions for help with doing routine chores and managing money, and the second highest rate of need among the Connecticut regions for help with getting to places outside walking distance, shopping for groceries, preparing meals, and doing laundry.

Further, 12% of New Haven area respondents reported need for assistance with ADL's, the highest rate of need among Connecticut regions. Consistent with this indicator, respondents from New Haven area showed the highest rates of use of home health aide, homemaker, visiting nurse, friendly visitor and care management services among the regions. Notwithstanding, respondents indicated the second highest rate of unmet need for community-based services (15%) of the Connecticut regions. Specifically, there was high unmet need for home health aide and homemaker services, despite the fact that there are multiple providers of such services in the area.

In south central Connecticut 2% of adults over 60 had severe disabilities, as defined by needing assistance with three or more Activities of Daily Living, consistent with the overall percentage in the state. (NASUAD-Muskie Connecticut Demographic Profile).

When coupled with having a severe disability, factors that increase the risk for institutionalization are living in at or below 100% of the Federal Poverty Rate, living alone and an age of 80 years or more. According to the 2010 census, in Connecticut:

- 6% of individuals 60 years of age or older area at or below the Federal Poverty Level
- 162,363 individuals are age 80 or over (4.6% of the population)
- 2.9 of men age 65 and over live alone and 7.6 of women.

The census data for south central Connecticut identifies 1.3% of this region's older adult population at risk of institutionalization, 1,793 individuals (NASUAD-Muskie Connecticut Demographic Profile).

Regional Focus Group Results:

Areas of need identified during the focus groups in regards to Physical and Mental Health included:

- Transportation
- Assistance with homemaking (light housekeeping) and chores (heavy cleaning and outside work)
- Assistance with personal care
- Information and referral on services and benefits
- Companion Services
- Meals (home delivered and assistance with food preparation)
- Cultural/Recreation Opportunities
- Home modification (ramps etc.)
- Family/Caregiver education and support
- Support older adults with disabled children
- Support for older adults raising grandchildren
- Affordable personal emergency response system
- Education and assistance with scams and financial abuse
- Language interpreters
- Assistance completing benefit paperwork
- Assistance with bill paying
- Financial assistance (cited need for affordable housing, decrease in government programs, high health care costs)

Goal 1: Health
To advocate for and promote improvements of the physical and mental health and well-being of older adults.

Objective 1:

To enhance use of preventative health services (e.g. screening, prescription drugs, nutrition counseling, social work services).

Strategy 1:
Provide CDSMP workshops for consumers. Two trainings per year conducted in English throughout twenty town region. New leader trainings to expand pool of providers of CDSMP; two trainings per year throughout region. [ADRC]

Strategy 2:
Provide Moviemiento program (Diabetes and heart prevention). Two courses in years 1 and 2, and then evaluate for possible expansion. [ADRC]

Strategy 3:
Make four CHOICES presentations at area senior centers in English and Spanish on Medicare preventative benefits using Medicare Bingo. [ADRC: by September 30, 2014]

Strategy 4:
Annually to issue e-mail & snail mail alerts to caregivers seeking their assistance in getting care recipients vaccinated; alerts to include information on Medicare coverage, a basic overview of the benefits of the vaccine, and locations at which vaccines are being administered. [ADRC, by November 30th each year]

Strategy 5:
Create and provide staff support to a regional flu shot hotline. [ADRC: by November 30, 2014]

Strategy 6:
Contingent on available funding, continue to grant Title III funds to a Dental Clinic in support of promotion of oral health, screenings and direct dental services. [Grants: annually]

Strategy 7:
Develop and deliver one mental health in-service per year to care management staff to assist care managers in working with clients with long-term mental illness. [Care Management: annually]

Strategy 8:
Develop media opportunities to promote the positive effect volunteerism may have on the mental health and longevity of older adults. [VAT ongoing]

Objective 2:

To increase consumer and provider awareness and understanding of health conditions that affect disproportionately people of color.

Strategy 1:
Conduct Tomando training; one per year in different area each year (New Haven, Wallingford, Valley, Hamden, East Shore) [ADRC: annually]

Strategy 2:
Provide Mouth cancer awareness program targeted toward African-Americans. Program at Dixwell Senior Center; partner with Cancercare [ADRC, May 30, 2015]

Strategy 3:
Conduct diabetes education series targeted toward Hispanic older adults using the Moviemiento curriculum at senior housing sites. [ADRC Center: by July 30, 2015]

Strategy 4:
Expand the array of cancer awareness materials in the Aging and Disability Resource Center library that are targeted to people of color. [ADRC: by September 30, 2014]

Strategy 5:
Deliver a seminar for the care management staff on physical aspects of aging with emphasis on how race can impact health. [Care Management: by July 31, 2014]

Objective 3:

To increase awareness of the risks associated with falls, increase participation in fall prevention programs for and reduce incidence of falls among older adults. [Care Management: July, 2014]

Strategy 1:
Conduct Tai Chi at additional housing locations annually if Title III funding continues [ADRC: 2014, 2015]

Strategy 2:
Incorporate education regarding fall prevention techniques at regularly scheduled face-to-face visits with CHCP clients and their families/caregivers [ADRC rolling, beginning July, 2014]

Strategy 3:
Through care management, identify older adults with risk for falls and as appropriate refer for intervention. [Care Management: October, 2014]

Strategy 4:
Provide Moving for Better Balance program throughout the south central region to decrease risk of institutionalization due to falls.
[ADRC: by June 30, 2015]

Objective 4:
To improve outlook and capabilities of family caregivers.

Strategy 1:
Continue to provide seven caregiver trainings annually to Valley caregivers through Valley Senior Services Council [ADRC: by November 30, 2014 and 2015]

Strategy 2:
Hold Fearless Caregiver Conference [ADRC: annually]

Strategy 3:
Promote development of four community caregiver support groups through training, technical assistance and resource material support. [ADRC: annually by May 30th]

Strategy 4:
Contingent upon available funding, provide respite services to at least 200 families utilizing both traditional respite models as well as the Cash and Counseling option [ADRC: annually]

Objective 5:
To achieve improved coordination and partnership between the elderly services network and mental health services.

Strategy 1:
Provide information on a monthly basis and in-person training four times per year to aging network partners about Medicare D, Title XIX, Medicare Savings Program, and Medicare/Medicaid fraud. [ADRC: Information, annually and in-person training four times per year, 2014, 2016 and 2017]

Strategy 2:
Meet quarterly with the CoSTARR advisory group and continue to work with the mental health providers to enhance community knowledge about mental health resources. [Care Management: ongoing]

Objective 6:
To reduce risk factors associated with undernourishment.

Strategy 1:
Provide nourishment education jointly with nutrition assessment for home-delivered meals participants [ADRC: ongoing]

Strategy 2:
Ensure that all clients who are being re-assessed for home-delivered meals also receive a nutrition education session from the AASCC Nutrition Assessor or another qualified individual. [Grants: ongoing]

Strategy 3:
Provide assessment of nutritional status, nutrition education and home delivered meals to home bound elders to increase and maintain their ability to continue living in the community. [ADRC: Annually by June 30, 2015, 2016, 2017]

Goal 2: To promote programs which improve the quality of life of older adults with severe disabilities.

Objective 1:
To increase awareness of benefit programs for older adults with disabilities by employing a no wrong door model.

Strategy 1:
Provide assessments and options counseling to older adults with severe disabilities through Community Choices program in the co-located space at the Center for Disability Rights, 3 times per week. Completion date 2/28/15. [ADRC]

Strategy 2:
Renew Memorandum of Agreement with Center for Disability Rights (CDR) to continue Community Choices as a co-located partnership between AASCC and CDR.
[ADRC: by December 30, 2015]

Objective 2:
To promote the safety of older adults with severe disabilities through information and assistance in the area of emergency preparedness.

Strategy 1
Create slide show training about emergency preparedness for people with severe disabilities to be available through AASCC website. [ADRC: by March 2015]

Strategy 2
Provide training on emergency preparedness for persons with severe disabilities in partnership with the Greater Valley Council on Health and Human Services. [ADRC: by Oct. 2015]

Goal 3:
To advocate for programs that reduce the risk of institutionalization.

Objective 1:
To provide access to services that assist older adults at-risk for institutionalization to remain safely in their homes. [ongoing]

Strategy 1
All callers to ADRC who have the following risk factors for institutionalization: live alone, are 80+ years and report needing assistance with 1 or more IADLs, will be referred to the CT Home Care Program. [ADRC, annually by September 30, 2015,2016 and 2017]

Strategy 2
Provide in-home services to clients at risk of institutionalization, identified using the Katz Scale, during waiting period for enrollment in CT Home Care Program to enable them to remain at home while completing CHCP application process. [ADRC: by September 30, 2015]

Strategy 3
Provide companion services to consumers recently discharged from Yale Medical Center to increase socialization and monitoring and reduce risks for re-hospitalization. [VAT: by December 30, 2015]

Strategy 4
Provide in-home companion services to older clients who are at-risk of being prematurely institutionalized. [VAT, ongoing]

Strategy 5
Provide in-home services and adult daycare to consumers with Alzheimer's disease to maximize time they can remain living in the community with family support. [Grants/Care Management, Annually by June 30, 2015, 2016 and 2017]

Goal 4:
To advocate and support elder rights and abuse prevention.

Objective 1:
To increase awareness of risk factors and indicators of elder abuse, neglect and exploitation.

Strategy 1:
Host an Elder Abuse Conference in New Haven. [ADRC/Grants: Annually October]

Strategy 2:
Assign agency staff to participate in the Meriden Elderly Task Force and Lower Naugatuck Valley Elder Response Team. [Grants: annually]

Strategy 3:
Through the MTEAM, continue to sponsor presentations addressing elder abuse and neglect five times per year. [Care Management: annually September through June]

Strategy 4:
Continue to provide community education about financial abuse of elderly through the Senior Medicare Patrol [ADRC: ongoing]

Strategy 5:
Provide training to police officers who attend the New Haven Police Academy. Training includes how to recognize the signs and symptoms of elder abuse & neglect in the areas of physical, emotional and financial abuse and how to report to Protective Services. [ADRC, annually July]

Priority Area 2: Access to Services with Reduced Barriers

Broad Background:

Agencies on Aging have an obligation to promote older adults' awareness and effective use of services throughout the continuum. This obligation arises out of the Older Americans Act mandate that AAAs fulfill planning, coordinative and advocacy functions. The AoA Strategic Action Plan emphasizes these obligations by including in its priorities, empowering and enabling seniors and their families:

- To make informed decisions about health and long-term care options;
- To remain in their own homes;
- To stay active and healthy; and
- Ensuring the rights of older people and the prevention of elder abuse, neglect and exploitation.

A 2013 MetLife Mature Market Institute study lists the following livable community characteristics to enable aging in place:

- Offers a variety of accessible, affordable, and visitable housing options so that older adults have a place to live.
- Has features that promote access to the community, including safe and walkable neighborhoods, transportation and safe driving options, and emergency preparedness.
- Provides a wide range of supports and services, including health care, supportive services, general retail, healthy food, and opportunities to participate in community life.

The 2013 report of the Connecticut Long-Term Care Planning Committee includes the following recommendations which address "providing real choices and options for older adults and individuals with disabilities":

- Provide true individual choice and self-direction to all users of long-term services and supports.
- Ensure the availability of a wide array of support services for those living in the community, including meals and adult day care.
- Address the long-term services and supports (LTSS) education and information needs of the Connecticut public, including specialized educational efforts to specific groups, such as baby boomers and employers.
- Address the anticipated long-term services and supports workforce shortage.
- Preserve and expand affordable and accessible housing for older adults and individuals with disabilities
- Increase availability of readily accessible, affordable, and inclusive transportation that accommodates the need for family and direct care worker companions.
- Provide timely eligibility decisions regarding eligibility in all government sponsored long-term services and supports programs.

Ensuring access to needed home and community based services, then, requires three elements: an adequate supply of services, knowledge about available services, and the ability to access needed services.

Adequate supply of services

- As mentioned by all of the above sources, the provision of home and community based services (HCBS) is dependent on seniors being able to maintain affordable, safe, and accessible housing. The 2013 CT Department of Social Services' Strategic Rebalancing Plan states that "Finding adequate housing can be more challenging than developing the array of services needed to assist consumers to remain in or return to the community."
- The Scan Foundation estimates that 70% of those reaching age 65 will need some form of long-term services and supports for an average of 3.5 years. The DSS Strategic Rebalancing Plan identifies lack of sufficient services and lack of a sufficient workforce as barriers to providing these needed services in the community.
- While various options exist for financing these services, Medicaid is the largest payer, covering 42% of the costs of long-term services and supports in Connecticut. Adequate and sustainable provider reimbursement levels are necessary to ensure capacity to meet current and future needs. Home health providers have not received a rate increase since July 1, 2005. Three VNAs closed their doors in 2012 and other agencies are being forced to reduce their exposure to Medicaid. (CT Association for Home Care & Hospice)
- Transportation is an essential support that allows older adults to remain independent and provides them with access to services. Yet, the DSS Strategic Rebalancing Plan finds that transportation is "Frequently acknowledged as one of the greater unmet needs in communities." AARP anticipates that the number of older non-drivers will increase by about 15% by 2025. An AARP report on The Impact of Baby Boomers on U.S. Travel finds that "One type of travel that has seen astonishing growth and can be expected to continue growing is travel to access medical services. While the distance traveled for the average trip to access medical services has remained about the same for the past three decades, the number of medical trips has skyrocketed."

Knowledge about available services

- In order to provide individual choice and self-direction to all users of long-term services and supports, seniors and their family members need to be able to obtain accurate and useful information about available services.
- According to the National Council on Aging, "In theory, financial services are available to seniors with economic needs. In reality, it's often difficult for disadvantaged seniors to take advantage of those services." They have to find out about and get access to many different offices, and complete multiple application forms for support services that are dwindling. In addition, in Connecticut significant delays in processing applications add to the expenses and lack of support that clients experience.
- The Recommendations section of the Long-Term Care Planning Committee Report endorses creation of a consumer friendly statewide No Wrong Door system, a conflict free case management, and a uniform assessment tool that

would serve individuals across all ages and disabilities. The Community Choices (ADRC) is a "no wrong door" model to provide information and access services to older adults and people with disabilities. Community Choices is a statewide model. AASCC operates the first such program opened in CT in 2008. Community Choices provides I&A, assessments, advocacy, counseling and short term case management.

- Serving an important information & referral and counseling function in Connecticut is the CHOICES program. Connecticut's Health Insurance Assistance, Outreach, Information and Referral, Counseling and Eligibility Screening Program (CHOICES) is a collaborative effort among the Connecticut Area Agencies on Aging, the State Unit on Aging, the Center for Medicare Advocacy, and numerous community partners, including senior centers.
- One thing learned from NCOA's Economic Security Initiative project is that "Seniors and caregivers need help navigating the maze of resources available in their communities."

Ability to access needed services

- Not only do consumers and caregivers need information, but they need streamlined means of accessing supports. The DSS Strategic Rebalancing Plan identifies the "lengthy process for accessing Medicaid" as a barrier to obtaining services.
- Average processing time for home care Medicaid eligibility increased 65% from 102 days in 2009 to 169 days in 2011.
- A recommendation from the Connecticut Long-Term Care Planning Committee is to "Provide timely eligibility decisions regarding eligibility in all government sponsored long-term services and supports programs."
- The National Senior Citizens Law Center states that "a Medicaid recipient with LTSS needs has guaranteed access to institutional care, but often cannot get similar, potentially more cost-effective, services at home and in the community."

Connecticut and Region-Specific Background:

Connecticut-specific: Data from the Connecticut Long-Term Care Needs Assessment help to substantiate the nature and incidence of barriers to accessing and receiving information, services and supports. Details follow on barriers relating to identifying and connecting with appropriate services, availability of services, linguistic/communications barriers and lack of suitable, affordable, and accessible transportation and housing.

Respondents to the Connecticut Long-Term Care Needs Assessment typically sought information from the following sources:

Social workers/care managers	42%
Health providers	30%
State agencies	27%
Relatives/friends	21%

In general, 62% of respondents to the Connecticut Long-Term Care Needs Assessment reported that can obtain any of the services that they require. Among those who need services, however, 38% reported that they are unable to get all the services that they need because of various factors. These include:

high cost of services	53%
lack of knowledge of available services	42%
inability to find someone to hire	22%
unreliable or poor care	17%
unavailability of service in area	5%

Further, 7% of individuals age 61-74, 14% of individuals age 75-84, and 27% of individuals age 85 and older report unmet need for service. Even where people are receiving services, it is important to note that 23% of respondents reported that they have had communication problems with providers of service. These include language barriers and cultural differences. Further, while 57% report that services meet their needs very well, 6% report that services do not meet their needs well at all.

Related, Connecticut's long-term care system does not offer sufficient self-directed care options to accommodate consumer preference. In general, a majority, 60%, of respondents stated that they would prefer to work jointly with agency to find, schedule and coordinate services, with the agency handling financial paperwork. Across age tiers, however, a surprising 29% would prefer to manage their own care independent of an agency, including financial paperwork. This is especially true for the three older adult tiers, with 32% percent of individuals age 61-74, 44% of individuals 75-84, and 37% of those 85 and older expressing a preference for this option.

Reflecting the results of national surveys, almost 80% of Connecticut respondents indicated that they would prefer to remain at home as they age, with or without home modifications. Assisted living and continuing care retirement communities were the next most preferred response, but a high proportion of respondents reported that they would be unable to afford these options. Unsurprisingly, the least preferred setting in which to receive long-term care is a nursing home, and respondents' second least preferred option was to live with adult children.

Somewhat surprisingly, 77% of all respondents indicated that they did not have any problems with transportation. For those who did report transportation difficulties, however, the main presenting problems were:

- for 47%, lack of a car and/or inability to drive themselves
- for 47%, lack of a person to assist or drive
- for 36%, unavailability/unreliability of public buses
- for 28%, fixed route does not take them where they wish to go

- for 27%, dial-a-ride service is unavailable or unreliable
- for 24%, cost of rides

Reflecting the impact of having difficulty with transportation, 40% of respondents indicated that transportation makes it challenging to socialize, to get to medical appointments and to complete errands. This also affected respondents' socialization, with 33% reporting that transportation difficulties made it hard to participate in community activities. Among the older adult age tiers of respondents, transportation (availability, reliability, cost and impact on participation in activities) was most difficult for individuals age 85 and older, with almost twice as many of this oldest group having difficulty as compared with the other two age tiers.

Finally, when asked open-ended questions about what services should be provided by the state of Connecticut, respondents indicated the following themes, in order of priority:

- transportation (20% indicated that this is an extremely important issue):
    - expanded schedule including weekends
    - town-to-town service
    - options in rural/suburban areas
    - transportation options for reasons (work, social engagements, shopping, religious services) other than medical transportation
    - more accessible, affordable and reliable service
    - discounts or free service

- healthcare (17% indicated that this is an extremely important issue)
    - affordable, comprehensive coverage (universal)
    - more affordable and accessible (e.g. with respect to health underwriting) long-term care insurance options
    - less cost-sharing for prescription drugs
    - dental insurance options
    - vision and audiology care
    - behavioral health (counseling, group therapy, detoxification programs)
    - wider range of services: geriatric assessment, health education, rehabilitation services
    - better quality nursing home care (staff ratios, more pleasant environment)

- home and community-based services (13% indicated that this is a significant need)
    - subsidy for adult day providers, with an emphasis on small centers
    - more personal care assistant options

- better pay for workers
- more residential group homes to prevent unnecessary institutionalization
- liberalization of the Acquired Brain Injury waiver for people who don't meet the functional requirements for eligibility
- more information & referral to identify available services

- financial assistance (13% indicated that this is a need)

  - tax breaks
  - tax incentives
  - assistance with utility costs and purchase of food, medication, dentures, hearing aids, home care, transportation, and home modifications
  - financial/money management services

- expanded array of programs and services (13% indicated that this is a need)

  - more services
  - more social workers and care managers to help consumers navigate the system
  - central information hub
  - better quality home-delivered meals
  - respite services for caregivers
  - improved reliability and continuity of services

- affordable housing options (9% indicated that this is a need)

  - more affordable assisted living options
  - enhanced controls on rent increases
  - rent subsidies
  - inventory of trustworthy handyman services

- recreational/social activities (7% indicated that this is a need)

  - exercise groups
  - outside activities (day trips)
  - entertainment
  - companions/friendly visiting

<u>Region-specific:</u> Of interest and concern with respect to serving New Haven is that:

> *Core urban areas, in Connecticut, distinguished by their low income level, high poverty rate and very high population density [Center for Population Research, 2004] can present challenges such as affordability, provider*

availability, and increased demands on availability of services and supports [National Center for Health Status, 2007].

There was a high report (4.8%) from New Haven area respondents of unmet need for home health care and visiting nurse services, and a very high report (7.1%) of unmet need for homemaker services.

New Haven area also has the highest incidence of all of the regions of report of difficulty with transportation to medical appointments, shopping and socializing.

Regional Focus Group Results:

Areas of need identified during the focus groups in regards to Access to Services with Reduced Barriers included:

- Transportation
- Assistance with homemaking (light housekeeping) and chores (heavy cleaning and outside work)
- Assistance with personal care
- Information and referral on services and benefits
- Companion Services
- Home modification (ramps etc.)

Goal 1: To promote timely and relevant connections to the services network.

Objective 1:

To streamline consumers access to information and referral by employing a single point of entry (no wrong door) model.

Strategy 1:
Continue operation of Community Choices, AASCC's ADRC pilot project. [ADRC: ongoing]

Strategy 2:
Educate critical pathways about Community Choices through eight presentations and four mailings. [ADRC: by June 30, 2015]

Strategy 3:
Through various media, disseminate information about Community Choices to consumers [ADRC: by December 30, 2015]

Strategy 4:
Through the quarterly CoSTARR advisory group meetings, continue to identify and address gaps in the care transition system. [Care Management: ongoing]

Objective 2:

To improve cultural competency in service provision.

Strategy 1:
Host HOPE meetings quarterly. [ADRC]

Strategy 2:
Conduct Brown Bag reviews for Hispanic consumers [ADRC:2014, 2015]

Strategy 3:
Develop and deliver a cultural awareness program for the care management staff. [Care Management: by June 2016]

Objective 3:

Expand awareness of existing transportation services.

Strategy 1:
Distribute transportation flyer to critical pathways [ADRC: by September 30, 2015]

Strategy 2:
Feature transportation information on website [ADRC: ongoing]

Strategy 3:
Working with DSS/ACU to track issues with medical transportation with the goal of improving the system. [Care Management: ongoing]

Priority Area 3: Income Security

Broad Background:

According to a report by the United Nations Population Fund, "Among the most urgent concerns of older persons worldwide is income security." (2012, United Nations Population Fund and HelpAge International.) The National Council on Aging reports that over 23 million Americans aged 60+ are economically insecure. The AGing Integrated Database reports that 6.46% of all Connecticut residents age 60 and over live at 100% of poverty level or below but 16.04% of minority seniors are at or below 100% of poverty level. To meet basic needs in Connecticut, a single older adult renter needs to earn at least twice the poverty level. (Elder Economic Security Index, 2009)

The recession hit low-income seniors hard. An August 2012 Reuters article reports that "The decline of pensions, the erosion of Social Security and the housing crash all are pointing toward a new crisis of poverty among lower- and middle-class seniors in the years ahead." (2012, Miller, *Why You May Retire in Poverty*, Reuters.)

- The National Institute on Retirement Security reports that the percentage of Americans over age 60 who received income from a defined benefit pension dropped from 52% in 1998 to 43% in 2010. In 2010, poverty rates were nine times greater in households without defined benefit pension income.
- Social Security provides at least 90% of income to more than one-third of America's seniors (2012, National Council on Aging.)and keeps 35% of Connecticut residents over 65 above the poverty level. One in four older Connecticut residents relies on Social Security as their only source of income. (2012, AARP) The Social Security Cost of Living Adjustment (COLA) has averaged about 2 percent annually over the last 10 years but costs for food and medical care have gone up much more. Proposals currently being considered that would lower the COLA would exacerbate financial hardships for Social Security recipients with each passing year. (AARP)
- Home values have dropped due to the housing crash, often providing additional stress or financial drain instead of providing a fall-back asset or source of reirement income.

Additional factors contributing to income insecurity among older Americans include:

- Americans are living longer, creating a need for retirement income to stretch over more years;
- Those nearing retirement who lost jobs during the recession have used up savings, and possibly limited the amount of retirement benefits they are eligible to receive;
- Older women have a higher poverty rate (10.7%) than older men (6.7%). (A Profile of Older Americans: 2011) According to Wider Opportunities for Women, 60% of older women are unable to cover their basic, daily expenses compared to 41% of older men. Older women often lose a significant portion of their retirement income with the loss of a spouse;
- Older persons living alone are much more likely to be poor (16%) than are older persons living with families (5.3%). The highest poverty rates are experienced

among Hispanic women (40.8%) who live alone and also by older Black women (30.7%) who live alone. (A Profile of Older Americans: 2011)

- Being slightly above the poverty level makes seniors ineligible for certain programs, but does not provide economic self-sufficiency in our high-cost state. (CT Commission on Aging Fact Sheet)
- Seniors are carrying more debt into retirement. 14% of adults aged 65+ face retirement with negative net worth (Aging and Bankruptcy, U.S.Courts);
- Seniors' expenses are increasing, especially medical expenses, utility bills, food, housing, and transportation, including increasingly expensive gasoline.
- "Seniors are not getting benefits for which they are eligible. Reasons include pride, lack of awareness, and trouble negotiating complicated service systems. The average low-income senior is leaving an estimated $7,000 in eligible benefits on the table each year." (2013, Senior Friendship Centers, Senior Economic Security Symposium)

According to the National Council on Aging, "In theory, financial services are available to seniors with economic needs. In reality, it's often difficult for disadvantaged seniors to take advantage of those services." They have to find out about and get access to many different offices, and complete multiple application forms for support services that are dwindling. In addition, in Connecticut significant delays in processing applications add to the expenses and lack of support that clients experience.

Region-Specific Background:

Statistics provided to the Connecticut Area Agencies on Aging by the National Association of States United for Aging and Disabilities in conjunction with the Cutler Institute for Health and Social Policy, Muskie School of Public Service, University of Southern Maine, indicate that 136,641 individuals age 60 and older reside in AASCC's service area. Of the 44,102 individuals served by Title III programs funded by AASCC, 7,880 (almost 18%) were living below 100% of the Federal Poverty Level (FPL), which was $11,170 per year for an individual in 2012 and $15,130 for a couple. Consumers who fell between 100% and 149% of the FPL comprised almost 22% (i.e., 9,544) of those served by AASCC. Low-income minority consumers (i.e., less than 100% of the FPL) comprised almost 13% (2,540) of the 19,595 minority consumers served. In the south central region, 2010 Census figures show that there is a total population of 136,641 individuals age 60 and older. Of note is that 6.0% of this population, 7,880 individuals, report incomes at or below 100% of the Federal Poverty Level (FPL).). In 2013, the FPL for an individual is $11,496 per year, and for a couple is $15,516 per year.

According to the University of Connecticut State Data Center analysis of "The Five Connecticuts", the south central region is comprised of eight suburban towns (Guilford, Madison, North Branford, North Haven, Orange, Oxford, Shelton, Wallingford and Woodbridge), eight urban periphery towns (Ansonia, Branford, Derby, East Haven, Hamden, Meriden, Milford, and Seymour), and two urban core towns (New Haven and West Haven). For purposes of this analysis, the south central region does not include any wealthy or rural towns.

The Elder Economic Security Standard Index for Connecticut (2009, UMass Gerontology Institute, Wider Opportunities for Women, the Atlantic Philanthropies), older adult residents of **suburban** Connecticut towns:

- require the following annual income to meet basic living expenses:
  - for an individual who owns his or her home free and clear: $23,460
  - for an individual who rents an apartment: $25,092
  - for a couple who owns their home free and clear: $34,024
  - for a couple who rents an apartment: $35,656
- can cover only 56-60% of an individual's basic living expenses with the average Social Security benefit ($13,972 for New Haven County in 2008)
- can cover only 41-44% of an individual's basic living expenses on an income equal to 100% of the FPL
- will likely lose a significant amount of income upon the death of a spouse, but see living expenses reduced by only 30%

Older adult residents of **urban periphery** Connecticut towns:

- require the following annual income to meet basic living expenses:
  - for an individual who owns his or her home free and clear: $21,314
  - for an individual who rents an apartment: $23,646
  - for a couple who owns their home free and clear: $32,463
  - for a couple who rents an apartment: $34,795
- can cover only 59-65% of an individual's basic living expenses with the average Social Security benefit
- can cover only 44-49% of an individual's basic living expenses on an income equal to 100% of the FPL
- will likely lose a significant amount of income upon the death of a spouse, but see living expenses reduced by only 32%

Older adult residents of **urban core** Connecticut towns:

- require the following annual income to meet basic living expenses:
  - for an individual who owns his or her home free and clear: $22,904
  - for an individual who rents an apartment: $25,645
  - for a couple who owns their home free and clear: $34,117
  - for a couple who rents an apartment: $36,858
- can cover only 54-61% of an individual's basic living expenses with the average Social Security benefit
- can cover only 41-45% of an individual's basic living expenses on an income equal to 100% of the FPL

- will likely lose a significant amount of income upon the death of a spouse, but see living expenses reduced by only 30%

Among respondents to the Connecticut Long-Term Care Needs Assessment, nearly 50% reported that they have money left over at the end of the month after paying all of their expenses. Compellingly, however, one-third of respondents can just cover their expenses, and, reflective of the above data, 16% do not have enough income to cover their expenses.

Among those respondents who cannot cover their expenses:

- 8% have difficulty paying rent, mortgage or real estate taxes
- 12% have difficulty paying utilities
- 11% have difficulty maintaining a car
- 9% have difficulty paying for prescription drugs
- 6% have difficulty paying for other medical care

Meeting monthly housing costs was twice as difficult for the baby boomer group of respondents as it was for the other older adult age tiers. Further, Black and Hispanic individuals reported difficulty in meeting housing and food expenses at much higher rates than did Whites.

Some respondents indicated that they have other options for financial support, with 42% reporting that they can count on someone to help them pay bills, housing costs, medical costs or food/clothing. When this is broken out across age tiers, 45% of individuals age 75-84 and 52% of those age 85 and older can do so, but only 40% of individuals age 61-74 report having this option.

An issue that presents serious financial implications is that both respondents who are current beneficiaries and those who are prospective enrollees have an unfounded reliance on Medicare as a source of funding for long-term care, and have not saved adequately to self-fund their long-term care needs. When respondents were asked how they plan to pay for their own long-term care, the top three responses were:

- Medicare (38%)
- savings or investments (33%)
- “don’t know” or have no plans (32%)

What is problematic is that despite their avowed reliance on savings, respondents do not have sufficient resources to pay the costs of long-term care out of pocket:

- 23% can pay nothing
- 32% could pay less than $10,000 per year
- 23% could pay between $10,000 and $25,000 per year
- 22% could pay over $25,000 per year

Further, because of high cost and stringent health underwriting standards, few have self-insured, with only 18% of respondents indicating that they have long-term care insurance.

While all ethnic groups have the same misconceptions about the extent to which Medicare will cover the costs of long-term care, this issue is of particular concern for people of color in that nearly 75% of Black, Latino and other race groups indicate could not afford to pay anything for long-term care. Further, those groups reported much more frequently than White individuals that they expected to rely on Medicaid than on savings/investments or selling a home to pay for needed services.

Contrary to public perception, Medicare pays for long-term care services to a very limited extent, subject to durational limits and cost sharing for coverage of nursing home care, and weekly caps on the number of hours of home health care for which an individual can qualify. While a very significant percentage of Medicare beneficiaries have Medigap coverage, most such plans do not cover long-term care expenses. Further, the cost of Medigap plans in Connecticut in has increased significantly in recent years. In 2013, plans range in cost from $122.00 to $496.00 per month, an untenable expense for many who are on fixed incomes.

According to an article published by Weiss Ratings on October 24, 2011, *Connecticut Seniors Pay Highest Premiums for Medigap Plans, "*Seniors living in Connecticut pay more for Medicare supplement insurance (Medigap) than those in any other state, according to a study by Weiss Ratings, an independent rating agency of U.S. financial institutions. For seven of the 10 standard Medigap plans, the average annual premium among all insurers in Connecticut is the highest in the U.S. — on average more than double the premiums charged in the least expensive states." The article goes on to state that average annual premium for the two most popular Medigap plans, Plan C and Plan F, are $3,768 and $3,068, respectively. The average annual preminium for Plan C in Connecticut is ranked first in regard to most expensive in the U.S.; Plan F is ranked second.

New Haven respondents reported the highest percentage (16%) of any region of individuals with income of less than $12,000 per year. An additional 25% of respondents have income of less than $24,000. Only 52% of respondents have funds left over at the end of the month.

Regional Focus Group Results:

Areas of need identified during the focus groups in regards to Income Security included:

- Affordable personal emergency response system
- Education and assistance with scams and financial abuse
- Assistance completing benefit paperwork
- Financial assistance (cited need for affordable housing, decrease in government programs, high health care costs)

Goal 1: To enhance real and perceptual income security of older adults.

Objective 1:

To increase participation of eligible individuals in entitlement programs that provides financial support.

Strategy 1:
Continue to assist consumers with access of benefits. [ADRC: ongoing]

Strategy 2:
Explore feasibility of providing appeals assistance to consumers who receive SSA rejections. [ADRC: ongoing]

Strategy 3:
To recruit and train 15 RSVP volunteers to conduct regular scheduled Benefits Quick Link screenings at locations within the RSVP service area and to place CHOICES-trained RSVP volunteers at these locations to provide CHOICES counseling, as needed. [VAT: ongoing]

Strategy 4:
To ensure that individuals who are screened through Benefits Quick Link are connected to benefits by providing telephone and mail follow-up and in-person assistance in completing applications. [VAT: ongoing]

Strategy 5:
In collaboration with the ADRC, to ensure that all newly referred CHCP clients have knowledge of how to access the CHOICES Program, with particular emphasis on the Benefits Check-Up function [Care Management: ongoing beginning October 1, 2013]

Objective 2:
Improve awareness of financial exploitation.

Strategy 1:
Administer SMP Program through recruitment, coordination and placement of volunteers in key community locations. [ADRC: ongoing]

Strategy 2:
Administer CT Money School (dependent on continuation of DSS funding). Work with CAHS to provide education to MFP clients (2014-2016); provide six education classes in community annually. (by June 30, 2013 and June 30, 2015) [ADRC]

Strategy 3:
Present an educational session about scams and fraud in medical billing. [ADRC: by December 30, 2015]

Strategy 4:
Provide an in-service program for care management staff on POA and conservatorship. [Care Management: June, 2014]

Objective 3:

Improve understanding of insurance coverage.

Strategy 1:
Administer CHOICES program, recruit new volunteers annually, host new counselor training. [ADRC: ongoing]

Strategy 2:
Provide update training for volunteers three times per year (annually). [ADRC}

Strategy 3:
Provide telephone assistance to consumers. [ADRC: on-going]

Strategy 4:
Provide six regional Medicare Part D forums (one in each sub-region of south central CT) for consumers prior to open enrollment. [ADRC: September and October, annually 2014, 2015]

Strategy 5:
Host a Long-Term Care Insurance Forum annually. [ADRC]

Objective 4:

To enhance income of older adults through volunteer stipends and work opportunities.

Strategy 1:
To provide opportunities for 150 low-income seniors to serve as stipended volunteers in the Foster Grandparent and Senior Companion Programs. [VAT: September 30, 2017)

Strategy 2:
To provide older adults with financial incentives to enable their participation in Experience Corps as stipended AmeriCorps members. [VAT: ongoing]

Strategy 3:
To provide, through the Senior Community Service Employment Program, 30 workers age 55 and older with stipends and job training opportunities. [VAT: annually]

Strategy 4:
To expand Senior Companion T-3B funded services to the CoSTARR program. [VAT; 2014 contingent on funding]

Strategy 5:
To develop a connection with NCOA's new web portal "Job Source" to enhance job training skills for older workers. [VAT: 2014]

Priority Area 4: Public Image of Older Adults

Broad Background:

Each day over 10,000 members of Baby Boom cohort turns age 65 and this rate will continue for another 17 years. As the 65+ population has increased to approximately 35 million based on the 2010 census , traditional conceptions of aging will be challenged as outmoded and overly homogenous. No longer will it be adequate to frame individuals in this age range as economically secure retirees as they have not adequately saved for their retirement years. Nor will it be acceptable to presume that aging necessarily implicates dependence and reliance on institutional care supports. As overall health indicators for those age 60 and older have begun to improve, it is necessary to frame a public image that is elastic to a new conception of aging that resists presumptions of dependency and social isolation. In doing so, however, it is also necessary to make renewed commitment to those who do require assistance and supports, with special emphasis on minority groups and others that have historically been under-served by the social services network.

Properly, public policy debate has focused on unmet needs of older adults who are dependent on assistance. At a time when domestic social services funding is increasingly scarce, this is a necessity. Of benefit in the overall analysis of use of public resources, however, would be a more complete profile that included the substantial societal contributions of older adults through work and volunteerism. Examples of this include:

- A Gallup poll estimated that 80% of retirees expect to keep working
- 45% will seek volunteer opportunities and provide service through major volunteer programs such as the Senior Service Corps (Senior Companion, Foster Grandparents, Retired and Senior Volunteer programs), Senior Corps of Retired Executives (SCORE), CHOICES, Experience Corps and civic groups.

- The vast amount of unreported and uncompensated caregiver support provided by older adults (notably, women) to their spouses, siblings and adult children with disabilities.

Absent such contributions, our economy would lose the benefit of seasoned, mature and work-ready employees, and place our social services network at substantial deficit of resources to serve older adults and their families.

A more complete profile would also encompass the increasing incidence of the “oldest-old”, those in the 85+ age range which includes approximately 10.8 million Americans. The 2010 Census showed a national total of over 53,000 centenarians, approximately 900 of whom live in Connecticut. It is important that the public and policy makers understand the unique attributes of this population,

who are likely to have avoided major acute health conditions such as cardiac disease and cancer, but still need targeted intervention to remain as independent as possible. It is also vital that society recognize that the “oldest-old”, notably centenarians, represent living social histories.

Goal 1: To promote a public image of aging that encompasses the full range of abilities and contributions represented by that population.

Objective 1:

To promote and publicize the work and volunteer activities of older adults.

Strategy 1:

Feature CHOICES volunteers on website. [ADRC: 2015]

Strategy 2:

Hold an annual recognition event for participants in the Senior Companion Programs. [VAT: annually]

Strategy 3:

Publicize the accomplishments of older volunteers serving in our Senior Corps, AmeriCorps and VISTA program on AASCC website and other social media. [VAT: ongoing]

Strategy 4:

Feature older workers served by the T-5 Senior Employment Program who successfully complete training programs or found employment on the AASCC website and other social media. [VAT: ongoing]

Objective 2:

To celebrate successful aging

Strategy 1:

Host annual centenarian celebration event. [Board]]