



**The Alaska  
State Plan for  
Senior Services  
FY 2012 – FY 2015  
Abbreviated Version**



**State of Alaska  
Department of Health  
& Social Services  
Alaska Commission  
on Aging**

**State of Alaska  
Department of Health & Social Services**

**ALASKA COMMISSION ON AGING  
State Plan for Senior Services**

**FY 2012 – FY 2015  
(July 1, 2011 – June 30, 2015)**

**Sean Parnell, Governor  
State of Alaska**

**William J. Streur, Commissioner  
Alaska Department of Health & Social Services**



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*Special thanks to Barbara Lavalley for the use of her beautiful prints entitled “Senior Prom” and “Table Games”.*





JUL 28 2011

The Honorable Governor Sean Parnell  
State of Alaska  
550 West 7<sup>th</sup> Avenue, #1700  
Anchorage, AK 99501

Dear Governor Parnell:

It is my pleasure to inform you that the four-year Alaska State Plan on Aging under the Older Americans Act, beginning July 1, 2011 through June 30, 2015 is approved.

I am particularly pleased with the ongoing efforts in Alaska to coordinate across Title III and Title VI, including that 12 of your state grantees are also Title VI grantees. In addition I appreciate the progress being made on your Aging and Disability Resource Center initiative with four sites now open across the state. As a result of these and similar efforts, the State Plan reflects a sound strategy to deliver quality services to meet the needs of older persons and their caregivers across the state.

The Regional Office staff of the U.S. Administration on Aging in Seattle and I look forward to working with you in the implementation of the State Plan. If you have questions or concerns, please do not hesitate to contact us.

I appreciate your dedication and commitment toward improving the lives of older persons in Alaska.

Sincerely,

A handwritten signature in black ink, reading "Kathy Greenlee", is positioned below the word "Sincerely,".

Kathy Greenlee  
Assistant Secretary for Aging



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Governor Sean Parnell  
STATE OF ALASKA

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May 19, 2011

Mr. David Ishida  
Region X Administrator  
United States Administration on Aging  
90-Seventh Street, Suite 8 100  
San Francisco, CA 94103

Dear Mr. Ishida,

As Governor of the State of Alaska, I hereby designate the Alaska Department of Health and Social Services as the sole State agency on aging as required under Section 305 of the Older Americans Act.

If you have any questions regarding this designation, please contact Commissioner Streur directly at 907-269-5195 or [william.steur@alaska.gov](mailto:william.steur@alaska.gov).

Best regards,

A handwritten signature of Sean Parnell in black ink.

Sean Parnell  
Governor

cc: The Honorable William Streur, Commissioner, Alaska Department of Health and Social Services  
Duane Mayes, Director, Division of Senior and Disabilities Services, Alaska Department of Health and Social Services  
Sharon Howerton-Clark, Chair, Alaska Commission on Aging, Alaska Department of Health and Social Services  
Denise Daniello, Executive Director, Alaska Commission on Aging, Alaska Department of Health and Social Services

# STATE OF ALASKA

## DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

**SEAN PARNELL, GOVERNOR**

P.O. BOX 240249

ANCHORAGE, ALASKA 99524-0249

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### ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES STATE PLAN FOR SENIOR SERVICES APPROVAL

The Alaska Department of Health and Social Services (DHSS) hereby submits the Alaska State Plan for Senior Services for the period of July 1, 2011 through June 30, 2015 (State fiscal years 2012-2015). Governor Sean Parnell has designated the Department of Health and Social Services as Alaska's sole state agency on aging. The Alaska Commission on Aging within DHSS is authorized by Alaska Statute 457.45.240(a)(1) to develop the state plan for senior services in accordance with the provisions of the Older Americans Act and its amendments. The plan, as submitted, documents the needs of older Alaskans and establishes direction for the coordination of all State activities related to seniors, with an emphasis on those efforts related to the Older Americans Act, including the development of a comprehensive and coordinated system for the delivery of supportive services.

The Plan, as submitted, has been developed in accordance with all federal statutory and regulatory requirements.

The State Plan for Senior Services is hereby approved by the Commissioner of the Department of Health and Social Services, as the Governor's designee, and constitutes authorization to proceed with activities under the Plan upon approval by the Assistant Secretary for Aging.

I hereby approve this State Plan and am pleased to present it to Alaskans.

5/17/2011  
Date

  
William J. Streur, Commissioner  
Alaska Department of Health and Social Services

**ALASKA COMMISSION ON AGING  
STATE PLAN FOR SENIOR SERVICES  
APPROVAL**

*The Alaska State Plan for Senior Services, FY 2012-2015 is hereby approved by the Alaska Commission on Aging, as the agency authorized by the Commissioner of the Department of Health and Social Services and by Alaska Statute (AS 47.45.240(a)(1)) to develop the state plan on aging in accordance with the provisions of the Older Americans Act and its amendments.*

Sharon Howerton, Chair  
Paula Pawlowski, Vice Chair  
Banarsi Lal, Planning Committee Chair  
Barb McNeil, Planning Committee Vice Chair  
Patricia Branson  
Betty Keegan  
Duane Mayes, Designee, Department of Health and Social Services  
Iver Malutin  
Eleanor Dementi  
Marie Darlin  
Nita Madsen, Designee, Department of Commerce, Community and Economic Development

May 24, 2011  
Date

  
Sharon Howerton, Chair  
Alaska Commission on Aging



## **Executive Summary**

The Alaska State Plan for Senior Services, FY 2012 – FY 2015, is the product of an 18-month process that began with the Alaska Commission on Aging’s first elder/senior community forum in Kotzebue in August of 2009. Five other community forums followed, each presenting a series of topic questions for seniors, family members, and service providers to consider. At each step of the process, older Alaskans graced the Commission with their candid assessments of all that needs attention within the system of services for seniors – as well as their ideas for solutions, and even their praise for what’s working well. We thank them – without their openness, this process would have been less rigorous and far less engaging.

A state plan steering committee of agency partner representatives gathered for the first time in summer of 2010 to plot the development of the plan and continued to meet, first monthly and ultimately weekly, to resolve the many issues that helped to shape the plan into its final form.

With the help of the steering committee, the Commission developed a widely-distributed survey, to which 2,835 Alaskans age 60 and over responded. The elder/senior community forums, the senior survey, the provider survey, and the ongoing input from our agency partners were the building blocks from which the essence of this state plan (the goals, objectives, and strategies) was constructed.

The initial section of the plan comprises the core information required by the U.S. Administration on Aging, which provides funding for Older Americans Act (OAA) programs. (The State of Alaska adds general funds to boost the reach of the OAA senior services grant programs, and the Alaska Mental Health Trust Authority provides additional funding.) The core section of the plan focuses primarily on describing programs and issues covered by the Older Americans Act, including a set of goals, objectives, strategies, and performance measures designed to help Alaska move forward in its response to senior needs. We chose four overall goals, which are phrased in the form of our vision for older Alaskans:

- (1) Alaskan seniors are healthy, safe, financially secure, and make vital contributions to their communities.
- (2) Seniors have the choice to remain in their own homes and communities, living with high quality of life for as long as possible through the provision of home- and community-based services, including support for family caregivers.
- (3) Seniors have access to safe, affordable housing and supports appropriate to their needs.
- (4) Seniors are protected from abuse, neglect, self-neglect and exploitation.

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A description of the funding formula selected for this state plan is included in Appendix B. The formula is used for the distribution of State funding as well as federal Older Americans Act funds. It is designed to ensure that priority in funding is given to areas with the most economic and social need, as indicated by advanced age (80+), minority status, low income, and rural residency, with an additional factor for total senior (60+) population and a cost-of-living adjuster to compensate for the much higher cost of living (and doing business) in very remote areas of the state.

Also included in the state plan are a variety of appendices, including organizational charts (Appendix A), a description of the intrastate funding formula (Appendix B), a summary of the demographic make-up of Alaska seniors (Appendix C), a needs assessment based on the elder/senior forums, the senior survey, the provider survey, and the Commission's full-time advocacy work on behalf of older Alaskans – including for the first time a set of regional profiles highlighting the unique settings and challenges of Alaska's nine service regions (Appendix D), a description of the many programs provided for seniors by the State of Alaska (Appendix F), and a short summary of the Older Americans Act in Appendix E.

Assurances required under the Older Americans Act are contained in Appendix G, a sustainability plan for Alaska's ADRCs can be found in Appendix H, a visual representation of the continuum of care along with service definitions is in Appendix I, and a group of emergency preparedness checklists (useful for seniors as well as providers who are now required to work with local emergency planners to ensure the coverage of the needs of vulnerable seniors) is contained in Appendix J.

Finally, the reader can access a list of web links to agencies, reports, studies, and concepts referenced in the plan (Appendix K), a list of decoded acronyms (Appendix L), and the list of state plan steering committee partners and their agencies in Appendix M.

In addition to assisting with the development of the plan, our agency partners also participate in an annual state plan implementation assessment, in which they help the Commission to review the extent to which the plan strategies have been accomplished, and use updated performance measures to set a course for the upcoming year.

As Alaska's senior population continues to expand at the fastest rate in the U.S., the Alaska Commission on Aging looks forward to keeping pace with its needs through planning, advocacy, public awareness efforts, and collaboration with other organizations focused on the well-being of older Alaskans.

## Introduction

Alaska's State Plan for Senior Services describes the programs and services available to older Alaskans, both those paid for by Older Americans Act funding and those paid for through the State of Alaska. An analysis of the results generated from a senior survey, a provider survey, and six senior/elder community forums provided input to a multi-agency State Plan Steering Committee. From this data, the Committee developed goals, objectives, and strategies intended to give Alaska's senior agencies, advocates, and service providers a shared focus for the next four years.

The state of Alaska constitutes a single planning and service area under the terms of the Older Americans Act. The Alaska Department of Health & Social Services is the State Unit on Aging, with most senior services administered by the Division of Senior & Disabilities Services and with planning, advocacy, and public awareness functions performed by the Alaska Commission on Aging in collaboration with a number of other agency partners.

This core section of the plan describes Alaska's Older Americans Act programs and related efforts, as well as the plan's goals, objectives, strategies, and performance measures for the FY 2012-2015 period. Appendices address a range of supplementary topics.

## Our Vision

The Alaska State Plan for Senior Services FY 2012 – 2015 builds on strong partnerships to provide high-quality, respectful, culturally-sensitive support services for older Alaskans to live healthy, independent, and productive lives in the place and manner of their choosing.

## Guiding Principles

From a discussion of the key quality of life values of older Alaskans, the State Plan Steering Committee identified the following guiding principles for senior programs and services to be provided under the state plan:

1. ***Highlight Seniors' Community Contributions.*** Above all, programs and services seek to acknowledge and support the abundant vital contributions of older Alaskans to their families, communities, and the state of Alaska. Seniors are one of Alaska's greatest assets; serving them increases their capacity to contribute to the well-being of all Alaskans.
2. ***Keep Seniors Strong and Healthy.*** Seniors are given information, education, and resources to assist them in making healthy choices (including good nutrition, physical activity, community involvement, healthy relationships and peer support) that will



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### *Alaska Commission on Aging*

reduce their risk of chronic disease, mental illness, and substance abuse and increase their ability to lead healthy and productive lives.

3. **Promote Independence, Empowerment, and Choice.** Older Alaskans are recognized as a valuable resource as well as a powerful economic and political force affecting business and public policy direction. Wherever possible, we seek to strengthen the voice and participation of seniors on issues affecting them.
4. **Focus on Partnerships.** Services are provided in an efficient, economical, streamlined manner by emphasizing coordination with other appropriate agencies as well as communities, families, and individuals.
5. **Build Community-Centered Agencies.** Community-based services provided through senior centers and other agencies are safe, accessible, culturally relevant, and responsive to seniors' needs for life enrichment – including favorite foods and activities as well as volunteer, social, and educational opportunities. They reach out to all senior age groups and contingents, always with a vision of inclusion and community.
6. **Provide Home- and Community-Based Care.** Services aim to assist seniors to thrive in their own homes and communities for as long as possible through the provision of person-centered, coordinated care.
7. **Offer a Full Continuum of Care.** Services are provided in each community or region to supply what seniors need at each stage of the continuum of care, from independent living through supportive home- and community-based services, to assisted living and nursing facility care.
8. **Individualize the Response.** Services are flexible, integrated into each community, and designed to respect consumer choice and self-determination, including education for seniors and their families when appropriate.
9. **Include Younger Generations.** Wherever possible, services and programs are designed to provide inter-generational interaction, with an emphasis on the sharing of knowledge and appreciation between the generations.
10. **Target Services to the Most Vulnerable Seniors.** Service providers focus on outreach to frail elders, low-income seniors, minority seniors, non-English-speakers, and those living in rural areas, ensuring that they are aware of and able to access services.
11. **Support High-Quality Staff.** Services are provided by staff who are trained, understanding, respectful, and culturally aware, who listen carefully to seniors' concerns, and can communicate clearly as they offer person-centered services.

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12. **Respect Rights.** Services are provided in a manner that respects the legal and human rights of seniors and protects them from all forms of abuse, neglect, and exploitation.
13. **Aim for Excellence.** Services are performed to high quality standards, as shown by accessible data measuring performance and client satisfaction.
14. **Give Fair Reimbursement.** Services for seniors are reimbursed at a fair rate in consideration of increasing costs of services, rates paid to other types of providers, and impact on availability of services such as assisted living and other types of services often needed by seniors.

### **Older Americans Act Requirements:**

In Alaska, the State Unit on Aging is the Department of Health & Social Services (DHSS). Older Americans Act Title III and some Title VII services are provided to seniors through that department's Division of Senior & Disabilities Services, which offers Medicaid waiver services, personal care attendant (PCA) services, and senior grant services. The Alaska Commission on Aging, also an agency within DHSS, coordinates the planning function of the State Unit on Aging, in addition to advocating for senior needs to the state legislature and leading public awareness campaigns on civic health, behavioral health, and civic engagement issues.

Older Americans Act Title V services are provided through the MASST (Mature Alaskans Seeking Skills Training) Program within the Department of Labor & Workforce Development. The Office of the Long-Term Care Ombudsman (OLTCO), which carries out the Title VII long-term care ombudsman services, is located within the Department of Revenue.

For organizational charts of the State departments containing these programs, see Appendix A, Organizational Charts.

### **Older Americans Act Core Programs:**

#### **Division of Senior & Disabilities Services**

The Division of Senior & Disabilities Services (DSDS) is responsible for the administration of home- and community-based programs for seniors and individuals with developmental and physical disabilities for the State of Alaska. DSDS programs provide necessary services and supports along a continuum of care which allows for individuals to remain independent and in their communities for as long as possible. Programs administered by DSDS include Adult Protective Services, General Relief Program, Senior Community-Based Grant Programs, Community Developmental Disabilities Grant Program, Medicaid Waiver Programs, Medicaid Personal Care Assistant Program, Medicare Information Office and Senior Medicare Patrol, Aging and Disability Resource Center Program, and the Nursing Facility Transition Program.

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DSDS also administers the Older Americans Act programs, including grants for home- and community-based services to seniors as well as ADRC (Aging and Disability Resource Center) and RCSC (Real Choice Systems Change) grant funds. Home- and community-based grants provide services for seniors and individuals with developmental disabilities who do not qualify for the Medicaid Waiver. State of Alaska funds also contribute to these programs. The State of Alaska uses State funds for its Adult Protective Services and General Relief programs, which provide a safety net for Alaska's most vulnerable individuals age 18 and over.

Older Americans Act (OAA) services are available to all Americans age 60 and older, but service providers are required to outreach to the specific target populations highlighted in the OAA and to prioritize service to these groups of elders. They include all minority populations, the frail elderly, low-income individuals, residents of rural areas, and non-English-speaking seniors. These priorities are also reflected in the state plan's funding formula, which weights these factors (with the exception of non-English-speaking seniors), as well as total senior population and cost of doing business.

### **Senior Home- and Community-Based Grant Programs**

As an agency within the State Unit on Aging, the Division of Senior & Disabilities Services uses a combination of Title III and State general funds for the provision of home- and community-based services to meet the needs of individuals who are 60+ years old or have a disability, and may not qualify for Medicaid (or other) services. Home- and community-based services grant programs administered by the Division of Senior & Disabilities Services provide a safety net for individuals who need assistance in order to remain independent, but who do not qualify for other publicly funded programs. Services provided with grant funds mirror those provided through the Medicaid Waiver and PCA programs, and are intended to provide care for individuals who are at risk for institutionalization and wish to remain in their own homes.

Grant funds are awarded to provider agencies statewide through a competitive grant process that prioritizes target populations.

Individuals may access home- and community-based services through a number of grant programs administered by the State, as described below. For FY 2010, the Senior Community Grant Programs served an estimated 26,181 unduplicated individuals, including 10,801 who received registered services under the Older Americans Act. Registered services include those such as meals, assisted transportation, and homemaker services for which client data is maintained, as opposed to unregistered services such as information and referral or unassisted transportation, for which providers track only the number of clients they serve.

**Nutrition, Transportation, and Support Services (NTS) Grant Program.** The NTS grant program services comprise the largest proportion of services provided under the Older Americans Act Title III grants. (NTS is the Alaskan name for the largest senior grant program, providing funding for meals, rides, information and assistance, and several other OAA



## The Alaska State Plan for Senior Services, FY 2012 – FY 2015

### *Alaska Commission on Aging*

supports.) Title III-B, C1, C2, and D funding is combined with a State match to provide grants to organizations statewide for the provision of essential services to older Alaskans age 60 and over. The Division of Senior & Disabilities Services administers the NTS grants through a competitive grant process that provides funding to partner organizations throughout the state, including non-profits, tribal governments, school districts, and local governments. NTS grants are matched with local funds and provide essential base funding for senior services throughout the state. NTS programs utilize volunteers and Title V enrollees to meet the increasing demand of our growing senior population.

In accordance with the OAA, NTS services target seniors whose health and welfare is at highest risk, including older Alaskans with ADRD, those who have a physical disability, those who are age 80 and older, those with the greatest social or economic need, minority seniors, or those who reside in a rural area. Services provided by the NTS program include:

- Outreach to vulnerable seniors and their families about available services
- Information and assistance
- Congregate and home-delivered meals
- Assisted and unassisted transportation
- Homemaker services
- Nutrition counseling and nutrition education
- Health promotion and disease prevention activities
- Legal assistance
- Community services, including RSVP, Foster Grandparents, and Senior Companion, and
- Media services (The Senior Voice monthly statewide newspaper).

For details on NTS services, see Appendix F, Senior Programs in Alaska.

**Senior In-Home Services Grant Program.** An array of home- and community-based services are provided throughout the state with State of Alaska general funds. Grant funds are awarded to non-profit agencies to provide services to individuals who qualify under the requirements of the Older Americans Act or who are at risk for institutionalization and who do not qualify for services under the Medicaid Waiver program. Priority of service is given to individuals with ADRD, those who live alone, those with a physical disability, those with the greatest social or economic need, minority individuals, and those who reside in a rural area. Senior In-Home Services provides funding for the following services: Care Coordination, Chore, Respite, and Extended Respite.

**Adult Day Service.** Adult Day Service (ADS) is the provision of an organized program of services during the day in a center-based group setting. Grants for this program are also provided using State of Alaska general funds. In FY 2010, 12 provider agencies received grant funds for Adult Day programs.

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ADS provides supervision and a secure environment for individuals who experience Alzheimer's Disease and Related Disorders (ADRD), as well as those with physical, emotional, and/or cognitive impairments who are not safe staying alone while their caregivers are away. ADS supports an adult's personal independence and promotes social, physical, and emotional well-being. ADS provides a variety of program activities designed to meet the individual's needs and interests, including social, recreational, and therapeutic activities to assist in supporting optimal mental and physical functioning. Services and activities are planned incorporating person-centered planning approaches in response to an assessment of the participant's functional, health, and social needs. Services are flexible to meet the changing needs of the participant and provide continuity of support as defined in the plan of care. ADS is an integral part of the network of services to seniors in the state, providing the opportunity for clients to remain in their homes and communities, preventing or forestalling the need for institutionalization.

**National Family Caregiver Support Grant Program.** Caregivers often make it possible for disabled adults to remain in their home setting rather than moving into a long-term care facility. Although providing care to a family member can be a positive and rewarding experience, family caregiving can be stressful. Alaska has recognized the importance of family caregiving and has offered services to benefit caregivers for a number of years. Since the reauthorization of the Older Americans Act in 2000, Alaska has implemented the National Family Caregiver Support Program, whose purpose is to provide relief from the emotional, physical, and financial stress experienced by family caregivers.

Alaska's Family Caregiver programs are funded with a combination of Title III-E and State funds, and administered by the Division of Senior & Disabilities Services through a competitive grant process which allows local providers to develop programs that meet the specific needs of the caregivers in their communities. Ten percent of Family Caregiver funds are dedicated to supporting Grandparents Raising Grandchildren. Services are provided specifically to family caregivers and may include:

- Information about available resources
- Assistance in gaining access to support services
- Counseling, support groups, and training to assist caregivers in making decisions and solving problems related to their caregiving roles
- Respite care, and
- Supplemental services.

**ADRD Education and Support Grant Program.** The Alzheimer's Disease and Related Disorders (ADRD) Education and Support grant program provides funding to a statewide organization to provide information and education to providers, caregivers, and individuals about the early signs, symptoms, causes, diagnosis, and effects of ADRD on an individual and their family. Availability of information about ADRD is critical to family caregivers or anyone experiencing memory loss and can assist in developing strategies in dealing with the disease. The Alzheimer's Disease Resource Agency of Alaska provides information and education to organizations and individuals throughout the state.

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**Senior Residential Services Grant.** Through designated funding from the Alaska State Legislature, the Division of Senior & Disabilities Services oversees two grants to rural/remote providers in Kotzebue (Manilaq Association) and Tanana (Tanana Tribal Association) for supported residential living services to frail elders who do not have access to the Pioneer Homes or other long-term care facilities in their community or region. Senior Residential Services facilities supported by these funds served 96 individuals in FY 2010. Many of the residents are Alaska Native elders who have relocated from surrounding villages. The assisted living facilities provide meals and assistance with activities of daily living to enable the elders to remain in or near their community of choice. The Kotzebue facility is scheduled to close with the opening of a hospital nursing home wing in the near future.

### FY 2010 Statewide Senior Grant Statistics

Program	# Served	Units	# Units	% ADRD	# Providers
<b>Senior In-Home Services</b>					
Care Coordination	1,039	contacts	13,661	26%	15
Chore	383	hours	33,529	14%	10
Respite	231	hours	29,016	50%	8
Extended Respite	8	days	16	67%	1
Supplemental Services	36	occurrences	66	22%	4

Program	# Served	Units	# Units	% ADRD	# Providers
<b>Adult Day</b>	472	hours	220,662	56%	12

Program	# Served	Units	# Units	% ADRD	# Providers
<b>Family Caregiver</b>	1,242	various	19,085	34%	9

Program	# Served	Units	# Units	% ADRD	# Providers
<b>NTS</b>					
Assisted Transportation	1,573	one-way rides	84,736		18
Congregate Meals	8,166	meals	260,481		30
Health Education	158	contacts	3,856		6
Health Services to Individuals	1,193	contacts	4,108		2
Home Delivered Meals	3,278	meals	273,568		29
Homemaker	332	hours	7,703		7
Information and Assistance	n/a	contacts	99,148		22
Nutrition Education	groups	contacts	34,236		10
Outreach	n/a	contacts	31,059		21
Unassisted Transportation	1,936	one-way rides	121,223		21
Legal Assistance	n/a	hours	10,251		1
Media	17,500	newspapers	210,000		1

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*Alaska Commission on Aging*

Program	Program	Program	Program	Program	Program
<b>NTS (continued)</b>					
Senior Companion	91	hours	61,932		1
Foster Grandparent/Elder Mentor	172	hours	110,952		1
Retired Senior Volunteer Program	364	hours	127,135		2

Program	# Served	Units	# Units	% ADRD	# Providers
<b>ADRC – Total Served (Undup.)</b>	8,790				
<b>ADRC – Age 60+ (Undup.)</b>	3,217				
<b>ADRD Info and Assistance</b>					
Individuals/Families	202	consults	226	100%	1
Providers	187	consults	251	100%	1
Training/Educ. Activities		activities	120	100%	1
Support Groups		groups held	197	100%	1
Communities Served	79				

### Discretionary Grants

As of FY 2011, the State of Alaska has two AOA or CMS discretionary grants – one Aging & Disability Resource Centers (ADRCs) grant and one Real Choice Systems Change grant.

#### Aging & Disability Resource Centers (ADRCs)

The national vision of the ADRCs is the creation of a single, coordinated system of information and access for all persons seeking long-term care support services. Such centers are envisioned as highly visible and trusted places where people of all incomes, ages and disabilities can turn for information on the full range of long-term support options, public and private. The goal of these centers is to minimize confusion, enhance individual choice, support informed decision-making, and increase the cost-effectiveness of long-term support systems.

As a part of the New Freedom Initiative, AoA and the Centers for Medicare & Medicaid Services (CMS) view the ADRCs as a critical component of a long-term support system that supports and facilitates consumer choice. Access to service information across the public and private sectors, options counseling, and assistance in linking to services are key in the development of a consumer-driven system.

Alaska's Aging & Disability Resource Centers (ADRCs) are administered by the Division of Senior & Disabilities Services. There are currently four ADRCs in operation, serving four of the nine service areas established by the Alaska Department of Health & Social Services. The ADRCs in operation serve Southeast Alaska (region 9); Bristol Bay and Kodiak (region 7); Kenai Peninsula, Valdez, Cordova, and Mat-Su (region 5); and Anchorage (region 4). Each ADRC has 1.5 FTEs

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dedicated to the ADRC who provide options counseling directly to consumers. Each grantee provides information, referral and assistance, care transitions, and presentations to educate people about various aspects of long-term care.

Both the Mat-Su and the Anchorage areas will be evaluated to determine staffing needs to meet the increased demand in these rapidly growing population centers. A statewide marketing and outreach plan and quality assurance plan will be established. A statewide training plan will be drafted. SHIP (State Health Insurance Assistance Program) and ADRC functions will be coordinated to improve efficiency of both programs.

The ADRC Sustainability Plan is included in Appendix H.

### **Real Choice Systems Change Grant**

The Division of Senior & Disabilities Services was awarded a Real Choice Systems Change grant from CMS to implement person-centered planning in the hospital discharge plans for Medicaid-eligible patients with a chronic condition or long-term care need. The ADRCs are utilized to deliver the service in partnership with local hospitals.

The Care Transitions Intervention, an evidence-based practice, was selected to motivate patients to use health care system resources to meet their personal health goals. A patient receives one visit while in the hospital, one in their home, and is contacted two or three times by phone within four to six weeks of discharge. Topics discussed with patients include: what information they need prior to discharge, how to establish personal health goals, how to organize a personal health record, how to communicate effectively with health professionals, medication self-management, and how to make follow-up appointments. Goals of the project include increased patient activation in health care self-management, increased patient satisfaction, and reduced hospital readmission rates.

This is a demonstration grant with an expected end date of September, 2012.

### **Medicare Information Office (Including SHIP)**

As part of the Medicare Modernization Act (MMA) of 2003, the Medicare Information Office was established and housed in the Division of Senior & Disabilities Services. The office provides a toll-free number that anyone may call 24/7 for information on any aspect of Medicare, including enrollment in Medicare Parts A and B, Medi-gap insurance, Medicare Part D prescription drug plans, paying for Medicare programs – including Extra Help and the Medicare Savings Plan, coverage questions, training, finding local Medicare counselors, etc.

As one of the most visible programs offering a toll-free hotline, the office receives approximately 1,000 calls a month, triaging simple questions to local counselors and mentoring

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counselors while answering more complex calls and managing the complex calls to prioritize people who need their medications within a week and/or have other emergent health needs.

The Medicare Information Office houses the Alaska SMP (Senior Medicare Patrol), a program that emphasizes identification and prevention of Medicare fraud, waste, and abuse, and the Alaska State Health Insurance Program (SHIP), a national program that offers one-on-one counseling and assistance to people with Medicare and their families. All the programs in the Medicare Information Office are federally funded by the Centers for Medicare & Medicaid Services and the U.S. Administration on Aging, and have a special focus on reaching people with a limited income and people with mental health and other disabilities who are younger than 65 and on Medicare.

Consistent with the spirit of the SHIP and SMP programs, there is a cadre of trained volunteer counselors throughout the state of Alaska to assist the public with all aspects of Medicare and to refer as appropriate. Training occurs via phone mentoring, webinar, in person, and through regional training that the two full-time Medicare experts provide. Alaska's SHIP program is #10 in the nation as measured by the nine CMS performance measures, which include the number of beneficiaries reached to provide assistance, the degree to which partnering agencies assist, and the number of media and outreach events held. In addition to providing Medicare information to recipients in their communities, volunteers also are trained to spot and stop fraud, waste, and abuse in the Medicare program.

Partners providing counselors include many senior centers, all the sites that provide home-delivered or congregate meals, advocates that provide training on Consumer Protection such as the Office of Elder Fraud and Assistance, AARP, Access Alaska, the Salvation Army's Older Alaskans Program, the ADRCs, the Alzheimer's Disease Resource Agency of Alaska, and others.

Alaska's SHIP and SMP continue to develop effective ways to communicate authoritative and current information about Medicare such as websites, e-lists, webinars, and the recruitment of retired teachers and nurses. Grantees include OPAG (Older Persons Action Group), which has a bilingual Medicare counseling program featuring speakers of Spanish, Hmong, Tagalog/Ilocano, Mien, and Malaysian. Within the network of counselors affiliated with the Medicare Information Office there are speakers of many Alaska Native languages serving Medicare beneficiaries from Kotzebue to Ketchikan. Grantees also work closely with the ADRCs and other information and referral agencies to assist seniors and people with disabilities to access resources as efficiently as possible.

### **Legal Assistance Developer**

The Legal Assistance Developer is the individual in each state who is responsible for providing leadership in developing legal assistance programs for persons 60 years of age and older and plays a key role in assisting states in the development and the provision of a strong elder rights

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system. The Developer provides oversight of the Older Americans Act (OAA) Title III B legal assistance programs and assures that at-risk older people have access to the civil justice system. The activities of these legal programs and the legal services developer help in supporting those most vulnerable older adults enabling them to retain autonomy and remain in the community, and assist in the prevention of many kinds of abuses against older adults.

The Legal Assistance Developer for the State of Alaska is currently housed at the Division of Senior & Disabilities Services and provides oversight of the OAA Chapter 4 Section 731 legal assistance program through close collaboration with Alaska Legal Services and the Alaska Commission on Aging. The Legal Assistance Developer collaborates with AOA's "Model Approach to Statewide Legal Delivery Systems" grantee, Alaska Legal Services, in the development of recommendations to ensure the provision of a strong elder rights system.

Legal assistance for seniors is provided statewide by Alaska Legal Services and assures that seniors, especially those at greatest social and economic risk, have access to the civil justice system. Access to legal information, advice and assistance helps older Alaskans preserve financial and personal independence, maintain control of their financial and health care decisions, maintain appropriate family relationships, and protect personal assets, clan property, and well-being.

### **Consumer Choice: Personal Care Assistance**

Personal Care Assistance (PCA) services provide support related to Medicaid-eligible individuals who need help with activities of daily living (such as bathing, dressing, and eating) as well as instrumental activities of daily living (like shopping, laundry, and light housework). PCA services are provided in Alaska through private and non-profit agencies, with administration of the program by the PCA Unit of the Division of Senior & Disabilities Services.

Consumers in some communities may choose to receive services through an agency that oversees, manages, and supervises their care. ABPCA (Agency-Based Personal Care Assistance) has been operational for over ten years in Alaska. PCAs working in this program must successfully complete the approved PCA training program, have current CPR/First Aid certification, and pass a criminal history background check. RN supervision of the PCA service plan is provided by the ABPCA agency.

Alternatively, consumers may manage their own care by selecting, hiring, firing, scheduling, and supervising their own personal care assistant. The agency provides administrative support to both the consumer and the assistant. CDPCA (Consumer-Directed Personal Care Assistance) became operational on October 1, 2001. PCAs working in this program must pass a criminal history background check. The recipient may hire a family member (excluding a spouse or minor child) or friend to work as their PCA; the recipient also decides what training, if any, they will require for their PCA. There is no RN supervision provided by the CDPCA agency.

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Both types of PCA programs are covered by the Alaska Medicaid program. In Alaska, about 95% of PCA clients utilize the consumer-directed approach, with about five percent choosing the agency-based approach. From testimony of seniors at its quarterly meetings, the Alaska Commission on Aging understands that older Alaskans throughout the state wish to have a choice between the agency-based and the consumer-directed PCA programs. While consumer-directed services fit the needs of many seniors, others have told us they simply lack the energy or focus to manage their own PCA, and would prefer to have an agency to handle the details for them.

Together the ABPCA and CDPCA programs provide support for over 4,000 Alaskan seniors and individuals with disabilities.

### **Medicaid Waiver Program**

The Division of Senior & Disabilities Services provides Medicaid waiver programs, including an Older Alaskans Waiver, for Medicaid-eligible individuals who are age 65 or older and meet a nursing home level of care. In FY 2010, 1,710 older Alaskans received services under the Older Alaskans Waiver program. At an average annual cost per beneficiary of \$23,503, this program not only supports seniors in living in their own homes and communities (which is where they wish to be), but does so at a cost equal to about ten percent (10%) of the cost of a skilled nursing facility in Alaska.

On June 26, 2009, CMS (the Centers for Medicare & Medicaid Services) placed a temporary hold on new applications to the waiver programs and Personal Care Assistance services because of a backlog of annual needs re-evaluations and other concerns including staffing, provider training, and assessment accuracy. A corrective action plan was submitted by DSDS, and the moratorium on new applications was lifted in August, 2009.

A long-time concern related to the Medicaid waiver in Alaska is that an individual in the early or middle stages of AD/DR (Alzheimer's Disease and Related Disorders) may not be functionally eligible for the waiver if he or she needs primarily cueing or supervision, because they do not meet a nursing facility level of care. For an individual living alone, or even one with a caregiver who works during the day, this creates a great hardship as well as safety concerns. Many of these individuals can and do receive services through the Senior Grants programs, although the need for services exceeds their availability. The Alaska Commission on Aging and its advocacy partners continue to seek ways to meet the needs of persons with AD/DR for home- and community-based services.

### **Nursing Facility Transition Program**

Alaska offers a Nursing Facility Transition Program (within the Division of Senior & Disabilities Services) which helps families by offering care coordination to enable seniors and disabled



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citizens to return to independent or family living after a stay in a nursing facility. Originally piloted under a Real Choice System Change Grant, this program can provide funding for one-time expenses such as home or environmental modifications, travel, room and board to bring caregivers in from a rural community to receive training, security deposits, initial cleaning of a home, basic furnishings necessary to set up a livable home, transportation to the new home, and other needed items or services approved by program coordinators.

To be eligible for this program, a person must qualify both medically and financially for the Medicaid Home- and Community-Based Services (HCBS) Waiver program or the Medicaid-funded Personal Care Assistance Program. The grant is used only for one-time costs associated with the transition; after that, the Medicaid program pays for all services when the HCBS waiver or PCA services are approved. The nursing facility transition process may take from one to three months to complete.

In FY 2010, the program helped 42 people to transition from nursing facilities. The program's current goal is to transition 50 people per year out of nursing homes and back into the community. FY 2010 costs averaged \$1,286 per person, using State of Alaska general funds. (Note: The average cost of a private room in an Alaska nursing home is \$687 a day, three times the average cost for a day of nursing home care in the U.S. as a whole, according to the MetLife Mature Market Institute 2010 Market Survey of Long-Term Care Costs)

## **Health Promotion, Disease Prevention for Older Alaskans**

The Division of Senior & Disabilities Services (DSDS) supports health promotion and disease prevention services for older Alaskans through grants, partnerships, and the provision of technical assistance.

Title III-D provides limited funding for health promotion and disease prevention. These funds can be used for a range of services, including health screening and health risk assessments, health education, physical fitness, and other activities. Physical activity programs can also be provided by using Nutrition Education grant funds. Medication education is currently provided through a partnership with the University of Alaska. DSDS is working to expand coverage of this program so that additional older Alaskans may benefit.

DSDS is introducing evidence-based practices for specific health promotion aims, specifically "A Matter of Balance" for falls prevention, and Chronic Disease Self-Management, currently provided through the Division of Public Health (DPH) as "Better Choices, Better Health: Living Well Alaska." Future DSDS Title III-D grant funding will require that at least a portion of any grant be used for evidence-based programming.

DSDS is expanding older Alaskans' access to health promotion and disease prevention programming beyond what is possible through the grants by collaboration with other agency partners. Activities include work with DSDS' Quality Assurance Unit and other DSDS-funded programs, the Alaska Native Tribal Health Consortium, the Division of Public Health, the Alaska

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Pharmacists Association, senior centers and other providers of services for older adults, and other agency partners.

Facilitator training for both “Better Choices, Better Health” and “A Matter of Balance” can be provided by Alaska master trainers to assist agencies in meeting requirements. Health promotion information, tailored for the needs and interests of an older audience, is provided to service providers, including both grant recipients and non-recipients. Useful health-related materials in multiple languages are identified and shared with providers who serve immigrant populations.

**Healthy Body, Healthy Brain Campaign.** The Alaska Commission on Aging (ACoA) developed a public awareness campaign to publicize four lifestyle factors linked to lower risk of Alzheimer’s disease and related disorders (ADRD): healthy eating, physical activity, mental challenges, and social engagement. The Commission ran a series of print ads, movie theatre ads, and bus posters, and also produced bookmarks, handouts and other materials intended to stimulate Alaskans of all ages to think about how their habits today might translate into brain health (or loss of it) tomorrow. The project was funded by the Alaska Mental Health Trust Authority during FY 2007-2008, however, the ACoA continues to promote brain health at every opportunity.

**ADRD Mini-Grants.** The Alaska Mental Health Trust Authority (a State of Alaska agency) provides mini-grants to individuals who experience ADRD. These mini-grants for up to \$2,500 per individual can include, but are not limited to, therapeutic devices, access to medical, vision and dental, special health-care, and other supplies or services that might remove or reduce barriers to an individual’s ability to function in the community in the least restrictive environment possible. The Trust’s mini-grant program has \$260,300 in FY 2011. The program is administered by the Alzheimer’s Resource Agency, a statewide non-profit social service provider for individuals and families with a member who has Alzheimer’s disease or other related dementia conditions.

## **Senior Behavioral Health**

The Alaska Commission on Aging (ACoA) advocates for behavioral health programs and services targeted to older Alaskans as part of its role as a beneficiary board of the Alaska Mental Health Trust Authority, and also directly to the Alaska Legislature. During the period covered by the current state plan, ACoA helped to formulate and to obtain funding for the SOAR (Senior Outreach, Assessment, and Referral) program within the State’s Division of Behavioral Health (DBH). At its current funding level (\$300,000 per year), the program is concentrating on training “gatekeepers” in a limited number of communities to identify seniors who may be dealing with depression, other mental illness, or substance abuse issues and to refer them to professionals who can help assess and treat them. ACoA will seek additional funding to expand the program to include additional communities and services.

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Other projects for which ACoA advocated and which were begun during this period included two evidence-based systems designed to screen for depression and substance abuse in the primary care setting, where many seniors are comfortable and engaged with trusted care providers. Both IMPACT (Improving Mood, Promoting Access to Collaborative Treatment – for depression screening) and SBIRT (Screening, Brief Intervention, Referral, Treatment – for substance abuse screening) are undergoing limited-scale trials in Alaska, with plans to expand these programs into additional venues.

For more on Alaska’s assessment of senior behavioral health needs, see Appendix D, Needs Assessment.

### **Emergency Preparedness**

While the Department of Military & Veterans Affairs’ Division of Homeland Security & Emergency Management is the State of Alaska’s lead agency for emergency management, the Division of Public Health takes the lead within the Department of Health & Social Services. For the past three years, the Division of Public Health’s Section of Emergency Programs has been working with urban, rural, and tribal communities on emergency planning for vulnerable populations. These populations are defined as functional needs populations, the elderly, and anyone who needs more than basic medical care. (Functional needs populations are groups who may not be able to comfortably or safely access and use the standard resources offered in disaster preparedness, response, and recovery. This includes, but is not limited to those who are physically or mentally disabled, the non-English-speaking or those with limited English-speaking ability, the medically or chemically dependent, the geographically or culturally isolated, the frail elderly, and children. The experiences of Hurricane Katrina and other natural disasters highlighted the need to improve disaster response preparedness and planning for vulnerable populations during a disaster.)

To assist with this effort, the Section developed an emergency planning checklist. While the planning for these populations is ultimately a local responsibility, the Section utilized its community outreach workshops to work directly with local emergency planners on plans developed using the checklist. Planning for the elderly population of Alaska is also being managed by the regional emergency preparedness nurses from the Section of Public Health Nursing. They work with each of their Public Health Centers to make sure their plans include strategies for the vulnerable populations they serve.

The Section of Emergency Preparedness also works with the Alaska Pioneer Homes (six long-term care assisted living home facilities operated by the State of Alaska) to assist them in their emergency planning and Continuity of Operations Planning (COOP) for their residents and facilities.

The Division of Senior & Disabilities Services’ (DSDS) Senior Grants Program requires recipients of senior services grants to submit an emergency plan for their facility. Beginning with the next

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grant cycle, as a condition of their grant, they will also be asked to supply documentation that they are working with their local emergency preparedness planners to ensure consideration of the special needs of seniors. Support and technical assistance is available from DSDS.

A Health Program Manager within the Division of Senior & Disabilities Services (DSDS) serves as the Division's senior emergency preparedness coordinator, with the following duties:

- Ensure that senior services grantees (NTS, SIH, Adult Day, and Family Caregiver) are coordinating with their local emergency preparedness planners to provide for the safety of vulnerable seniors
- Identify a contact person in each grantee agency who will directly communicate information about the safety and needs of seniors to DSDS in the event of an emergency or natural disaster
- Communicate directly with the Administration on Aging regarding local emergency response as well as requests for emergency funding in the event of an emergency or natural disaster, and
- Coordinate with Public Health, the DMVA Division of Homeland Security & Emergency Management, and other State agencies in the development of a statewide emergency preparedness planning process to ensure the safety of vulnerable adults.

The individual currently holding this position holds master's degrees in nursing and public health, and has 20 years of background in health promotion and disease prevention.

## **Title VI Coordination**

The State of Alaska encourages providers of Title III services to collaborate with tribal governments which receive Title VI funds in order to make more services available for older Alaskans. (See Appendix E, Summary of the Older Americans Act, for details on what Title VI, Title III, and other OAA sections cover.) Title VI grantees (there are 46 of them in Alaska) are also encouraged to collaborate with Title III grantees to maximize services available for their elders. In twelve cases (see below), the same organization is the Title VI and the Title III grantee in an area. In a number of other communities, coordination, collaboration, and cooperation between the agencies responsible for these separately-funded services is occurring.

For example, Senior Citizens of Kodiak, Inc. (SCOK) and Kodiak Area Native Association (KANA) have been collaborating for more than a decade to assure that elders in Kodiak Island villages have meals and elder care while they continue to live in their communities. SCOK uses Title III funds and contracts with KANA to provide meals in all six villages on the island. These funds along with Title VI funds assure that at least three meals a week (congregate and home-delivered meals) are available in each village. Family Caregiver Support funds are also used to contract with KANA in providing Elder Caregiver Advocates in the villages as a point of contact and support for elders and their families. By combining Title VI and Title III funds, more consistent programs are being delivered to the six villages on Kodiak Island.

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In Southeast Alaska, Southeast Senior Services (SESS), a Title III grantee, approached the area's tribal organizations years ago to help protect the current level of services in various communities, in anticipation of a funding shift of Title III monies to other areas of the state. (Although all regions of the state have seen at least a 20% increase in the number of seniors between 2001 and 2009, funding under the last state plan shifted to the fastest-growing regions, to some degree.) SESS conducts a needs assessment for each tribe, assists with the Title VI grant application, provides the services, and handles the necessary reporting. As it does each tribe's needs assessment, SESS revisits with each tribe how it would like its Title VI Part A (nutrition and supportive services) and Part C (family caregiver support) monies used.

During the period of coverage of this state plan (FY 2012 through FY 2015), the State of Alaska agrees to continue to increase coordination, collaboration, cooperation, and partnerships between Title III and Title VI programs for older Alaskans. Title III grantees are to develop partnerships with Title VI grantees in their communities, and to submit a memorandum of agreement to ensure coordination of services to Native elders. Coordination of Title III and Title VI services is required in order to reduce duplication of services, develop services to address unmet needs, expand resources, and share information with Native elders about additional services, benefits, and resources available to them.

The State of Alaska facilitates planning and partnerships between Title III and Title VI grantees through the Rural Long Term Care Developer program. Regional needs assessments are required to examine all resources including Title VI and Title III, and to include recommendations for increased collaboration where needed. The State of Alaska acknowledges that coordination is also a requirement for Title VI grantees, and will initiate increased partnerships and collaboration between Title III and Title VI grantees.

Title VI participants within Alaska are shown in the table below. The last column indicates whether or not the tribal government is also a Title III grantee.

<b>Tribe Name</b>	<b>Part A/B</b>	<b>Part C</b>	<b>Title III Grantee?</b>
Aleutian/Pribilof Islands Association	\$ 46,720	\$ 13,410	
Association of Village Council Pres.	\$ 67,450		
Bristol Bay Native Association	\$ 67,450	\$ 23,470	<b>x</b>
Central Council, Tlingit and Haida Indian Tribes of Alaska	\$ 88,560	\$ 26,820	
Copper River Native Association	\$ 41,140	\$ 10,060	
Hoonah Indian Association	\$ 36,260	\$ 6,700	<b>x</b>
Kodiak Area Native Association (Northern Section)	\$ 36,260	\$ 6,700	
Kodiak Area Native Association (Southern Section)	\$ 36,260	\$ 6,700	
Metlakatla Indian Community	\$ 46,720	\$ 13,410	<b>x</b>
Native Village of Barrow	\$ 46,720	\$ 13,410	
Tanana Chiefs Conference for Kuskokwim subregion	\$ 36,260	\$ 6,700	
Tanana Chiefs Conference for Lower Yukon	\$ 36,260	\$ 6,700	

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Subregion			
Tanana Chiefs Conference for Yukon Flats Subregion	\$ 36,260	\$ 6,700	
Tanana Chiefs Conference for Yukon Koyukuk Subregion	\$ 41,140	\$ 10,060	
Tanana Chiefs Conference for Yukon Tanana Subregion	\$ 36,260	\$ 6,700	
Fairbanks Native Association, Inc.	\$ 67,450	\$ 23,470	
Maniilaq Association	\$ 67,450	\$ 23,470	x
Native Village of Unalakleet	\$ 36,260	\$ 6,700	
Chugachmiut	\$ 41,140	\$ 10,060	
Arctic Slope Native Association, Limited	\$ 36,260	\$ 6,700	
Denakkanaaga, Inc.	\$ 41,140	\$ 6,700	
Klawock Cooperative Association	\$ 36,260	\$ 6,700	x
Kootznoowoo Inc.	\$ 36,260	\$ 6,700	x
Gwichyaa Zhee Gwich'in Tribal Government	\$ 36,260	\$ 6,700	
Native Village of Point Hope	\$ 36,260	\$ 6,700	
Seldovia Village Tribe, IRA	\$ 36,260		
Sitka Tribes of Alaska	\$ 46,720	\$ 13,410	x
Yakutat Tlingit Tribe	\$ 74,650	\$ 14,360	x
Ketchikan Indian Community	\$ 67,450	\$ 23,470	x
Kuskokwim Native Association	\$ 41,140	\$ 10,060	
Southcentral Foundation	\$ 88,560	\$ 26,820	
Kenaitze Indian Tribe	\$ 58,230	\$ 20,120	
Wrangell Cooperative Association	\$ 36,260	\$ 6,700	x
Native Village of Savoonga	\$ 36,260	\$ 6,700	
Native Village of Gambell	\$ 36,260	\$ 6,700	
Native Village of Eyak	\$ 36,260	\$ 6,700	
Organized Village of Kake	\$ 36,260	\$ 6,700	x
Chickaloon Native Village	\$ 41,140		
Yakutat Tlingit Tribe & Craig Community Association	\$ 36,260	\$ 6,700	x
Galena Village (aka Loudon Village Council)	\$ 36,260	\$ 6,700	
Asa'carsarmiut Tribal Council	\$ 36,260		
Orutsararmuit Native Council	\$ 46,720		x
<b>Total</b>	<b>\$ 1,850,760</b>	<b>\$ 405,580</b>	

### Personal Safety and Long-Term Supports:

#### Long-Term Care Ombudsman's Office

The Office of the Long-Term Care Ombudsman (OLTCO) is authorized by federal and state law to investigate and resolve complaints made by, or on behalf of, older Alaskans in skilled nursing and assisted living facilities. Alaska Statute 47.62 also authorizes the Long-Term Care Ombudsman to provide assistance to seniors having difficulty with issues impacting their residential circumstances, such as unfair billing practices by utilities, unlawful evictions, neglectful guardians, or poor public housing management. Like other state LTCO programs, Alaska's also provides facility coverage statewide so that seniors have regular and timely access

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to ombudsman services. This latter role challenges the Alaska OLTCO, which is a small program serving more than 300 facilities scattered across the largest state in the nation.

The location of the OLTCO in the Department of Revenue is made necessary by the fact that the State of Alaska administers six Pioneer Homes, long-term care facilities that are based within DHSS; because the Pioneer Homes are within the jurisdiction of the OLTCO, the agency is located outside of DHSS.

The Office of the Long-Term Care Ombudsman (OLTCO) is administratively housed by the Alaska Mental Health Trust Authority, but is overseen and legally represented by the State Attorney General. Alaska has no local long-term care ombudsman programs, but only one State office located in Anchorage. The program does train and certify volunteer ombudsmen for service statewide, though as of March 2011, volunteers are only available for homes in Anchorage, Fairbanks, and Juneau.

Alaska is one of five states nationally that mandates the Office of the Long-Term Care Ombudsman to investigate reports of harm involving seniors in residential care; most states defer all such investigations to Adult Protective Services. Thus, Alaska's OLTCO works closely with the Alaska Department of Health & Social Services (DHSS) to coordinate investigations so that seniors are protected and State resources are used efficiently. In FY 2010, DHSS initiated an interagency workgroup that developed an investigative protocol to ensure that all State agencies understand and respect one another's roles and responsibilities.

Between 2006 and 2011, the Alaska OLTCO received a rapidly rising number of complaints, paralleling the rising number of complaints filed with Adult Protective Services for all vulnerable adults. In 2006, the OLTCO received 268 complaints; in FY 2010, the Office received 486 complaints. In the first seven months of FY 2011, the OLTCO had already received 465 complaints, almost as many as in the whole of FY 2010. In both FY 2010 and FY 2011, nearly 90 percent of complaints involved seniors residing in assisted living facilities. The most frequent types of complaints related to poor medication management, falls or improper handling of residents, shortage of staff, and neglectful care.

The Alaska Commission on Aging successfully advocated for legislative approval of a one-time increment for a new OLTCO investigator position in FY 2011, a position the Governor proposed for continued funding in FY 2012. The new position was sorely needed, given the increased number of complaints requiring investigation. As of March 2011, the Alaska OLTCO has 5 FTE staff who are responsible for:

- Investigation and complaint resolution
- Facility coverage
- Consultation with providers and members of the public
- Legislative advocacy
- Monitoring of laws, regulations, and government policies relating to vulnerable seniors
- Volunteer engagement
- Training for caregivers

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- Public awareness on issues relating to the safety of seniors

In FY 2011, the OLTCO's annual budget was \$642,800. State general funds accounted for approximately \$320,900. Thanks to the additional staff investigator position, the OLTCO was able to respond within one working day to 95% of complaints involving threat of imminent harm.

With the hiring of a new State Long-Term Care Ombudsman in August 2010, the Office charted a new direction, focusing on improving its performance in three key areas: facility coverage, volunteer management, and legislative advocacy. By March 2011, staff had accomplished the following:

- Facility Coverage – Between FY 2010 and FY 2011, LTCO staff increased the average number of monthly facility visits from 9 to 17.
- Volunteer Management – The LTCO and her Deputy rewrote the volunteer manual and training curriculum, reconfigured staff to provide more supervision to volunteers, and increased public recognition for the volunteers' work. Twelve volunteers were placed in 25 facilities.
- Legislative Advocacy – The State LTCO assisted the ACoA Executive Director in crafting a legislative resolution promoting the safety of vulnerable older Alaskans, sponsored by Representative Cathy Muñoz, which was passed by the 27<sup>th</sup> Alaska State Legislature. The LTCO also presented information about the OLTCO to the State House and Senate Health and Social Services Committees, and sent letters to legislators supporting bills that improved protection of vulnerable adults from financial exploitation.

The OLTCO also initiated a quality assurance program to improve the timeliness and accuracy of data submission to Ombudsmanager, the database that is used for annual reporting to the Administration on Aging.

The State Long-Term Care Ombudsman and the Senior Medicare Patrol manager have met and discussed ways to partner productively. Both attended an AoA teleconference that described the ways that other states' SLTCO and SMP programs work together. Additionally, the possibility of "sharing" volunteers was discussed. However, many of the SMP volunteers are actually conducting SMP case management as a part of their employment at senior centers. Thus, since many senior centers also manage long-term care programs, their staff would not be appropriate LTCO volunteers, because of a conflict of interest.

In the next four years, the OLTCO's goals will focus on expanding the volunteer ombudsman corps and improving facility coverage. These goals are intended to provide more frequent monitoring for assisted living homes and to result in a higher quality of life for the seniors who reside in them.



## **Adult Protective Services**

Within the Division of Senior & Disabilities Services, Adult Protective Services (APS) responds to reports of harm to vulnerable adults. Vulnerable adults are those age 18 or older with a physical or mental impairment or condition that prevents them from protecting themselves or seeking help from someone else. Allegations may involve abuse, neglect, self-neglect, or exploitation. Alaska law requires that protective services not interfere with elderly or disabled individuals who are capable of caring for themselves.

In FY 2010, APS received 3,119 intakes (contacts), and conducted 2,763 investigations. Self-neglect was the most frequently alleged type of harm (905 allegations in FY 2010), followed by financial exploitation (543 allegations in FY 2010). The average response time was 5 days. Caseworkers handled an average of 347 cases during the year. Currently they average 95 cases at any given time, roughly three times the recommended caseload of 35 cases per worker. Statewide, Adult Protective Services has 19 staff, including 10 investigators, two intake workers, three General Relief staff, three supervisors and one program manager.

During the past four years, APS has developed and distributed a mandated reporter CD that trains the community and providers about the different types of abuse, what to look for, and how to report.

APS has taken over the role of intake and screening for all Critical Incident Reports that come into Senior & Disabilities Services. Approximately 40% of the Critical Incident Reports received turn into actual APS reports of harm.

APS is developing a data base which, when complete, will provide the ability to track and trend incidents of abuse across the state.

APS has seen significant increases not only in the number of reports of harm that come in, but also in the complexity of the cases. APS resources are not keeping pace with these changes. As a result it is difficult to maintain adequate staffing levels and training. APS investigators in Alaska carry the highest caseloads in the country and have the most geographical challenges and area to cover. Involvement of the criminal justice system and other partners, in particular financial institutions, is not always adequate, impeding APS' ability to resolve cases.

Stronger efforts in coming years will focus on abuse prevention and public education. Public awareness can be part of an overall approach to preventing adult abuse and neglect.

The average age of elders who have been the subject of a substantiated APS report of harm for both FY 2009 and FY 2010 was 75 years old. There was a total of 701 reports of harm towards Alaskan elders in FY 2009. Of these, 308 were substantiated and the remaining 393 were determined to be unsubstantiated. In FY 2010 there were 813 total reports of harm for Alaskan elders. Of those, 343 were substantiated, and the remaining 470 were found unsubstantiated.

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Of the substantiated reports of harm against elders in FY 2009, 25.3 percent involved family members. In FY 2010, 26.2 percent of the substantiated reports involved family members. The most common types of substantiated reports of harm were self-neglect (48.6% in FY 2009 and 49.9% in FY 2010) and financial exploitation (21.4% in FY 2009 and 18.7% in FY 2010).

### **Community Service Employment for Older Americans:**

#### **Mature Alaskans Seeking Skills Training (MASST) Program**

The Alaska Department of Labor & Workforce Development (AK DOLWD), Employment Security Division (ESD), is the grantee of the Title V Senior Community Service Employment for Older Americans program. In Alaska, the Title V program is known as the Mature Alaskans Seeking Skills Training (MASST) program. The MASST program provides training and part-time paid work experience opportunities for low-income individuals 55 years of age and older who desire to enter or re-enter the workforce. The program's statutory goals are to foster individual economic self-sufficiency, to provide community service opportunities, and to increase participation in unsubsidized employment. The program provides an average of about \$155 per week to participants. In Alaska, the program is working extremely well getting older workers back to work.

MASST's vision includes a strong working relationship between other Older Americans Act programs and the Alaska One Stop Network. On the federal level, the Title V program will be transferring to Health & Human Services to foster better coordination between MASST and the many other senior-serving programs at the Administration on Aging, strengthening the focus on improving the comprehensive well-being of seniors, and achieving administrative efficiencies within both MASST and existing Administration on Aging programs. The reason for the transfer of this program is the coordination with other senior programs to better support not only employment, but also health, wellness, and independence for seniors. It is noted that the program works well with its OAA partner agencies in providing services to those most in need statewide.

As currently structured, the MASST program is cost-effective, returning approximately \$1.50 for every dollar invested by empowering individuals to become self-sufficient, productive, taxpaying members of their communities. About 80 cents of every dollar is expended on participant wages and fringe benefits; less than 15 cents of every dollar is expended on administration, one of the lowest rates among federal programs. The balance is expended on participant training, counseling, and related expenses.

During State fiscal year 2010, MASST served 271 older Alaskans who worked in service to the general community and 282 participants who worked in service to the elderly community. The program served an unduplicated 492 clients. Fifty-nine percent of participants were female, and

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forty-one percent were male. Eighty percent of clients were under age 65, and twenty percent were age 65 and older. Thirty-two percent of participants identified their race as American Indian, Alaska Native, Asian, Black, or Hawaiian/Pacific Islander. Five percent of participants had less education than a high school diploma or equivalent, while forty-five percent had a high school diploma or equivalent, and fifty percent had some post-secondary education, including 14% with a bachelor's degree or advanced college degree. Nine out of ten participants (91%) had a family income at or below the poverty level. Twenty percent were individuals with documented disabilities. Ninety-one percent were individuals with poor employment history or prospects. Twenty-five percent were homeless, six percent were displaced homemakers, and twenty-seven percent were veterans or spouses of veterans.

For State fiscal year 2010, the program exceeded its goal of twenty-three percent of participants placed into unsubsidized employment – in fact, a majority (53.2%) of program participants were able to achieve unsubsidized employment. Fully 81.7% of those placed into unsubsidized employment were still employed in those jobs one year later, topping the program goal of 69.8%. The average earnings were \$29,744 for those finding employment, a full nineteen percent higher than the national goal.

MASST's common measures goals for State fiscal year 2011 are:

Entered Employment:	At least 35% will enter employment (federal law states 24%)
Employment Retention:	At least 70% will stay in job for one year after MASST
Service Level:	50%, with at least 10% more than the minimum number of participants required receiving skill-specific on-the-job training
Service to Most in Need:	Program will serve those most in need as evidenced by average number of barriers (at least 1.5)
Average Earnings:	Increase average wages from zero to \$7,100 per quarter

### **Alaska Commission on Aging**

Since 1982, the Alaska Commission on Aging, an agency within the Department of Health & Social Services (which serves as Alaska's State Unit on Aging), has served to ensure the dignity and independence of all older Alaskans by addressing their needs through planning, advocacy, education, and interagency cooperation.

As part of its continuing commitment to the State Plan for Senior Services, FY 2007 – FY 2011, the Commission held annual implementation and planning meetings with its agency partners, to both identify their accomplishments related to the plan's goals and objectives and also to plan further activities for the coming year. In 2010, the Commission began coordinating planning activities with senior consumers and representatives from public and non-profit agencies serving older Alaskans to develop the Alaska State Plan for Senior Services, FY 2012-FY 2015. The plan fulfills a requirement of the Older Americans Act.

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As part of its efforts to develop the needs assessment for the state plan, the ACoA hosted six elder/senior community forums, in Kotzebue, Anchorage, Fairbanks, Juneau, and Bethel, and with the Alaska Native Tribal Health Consortium. The purpose of these forums was to gather first-hand public input concerning access to primary health care, long-term supports, senior housing, financial security, social well-being, and healthy lifestyles to identify “what is working” and “what is not working” in Alaska’s communities.

In addition, the ACoA distributed a senior survey and a senior provider survey to learn about the variety of issues related to aging in Alaska. More than 2,800 Alaskans age 60 and older completed the senior survey in paper and electronic formats, providing information about their demographic/socio-economic status, access to primary health care, financial security, housing, use and satisfaction with local home- and community-based services, family caregiving, and other data. The four-page senior survey was enclosed with the August 2010 issue of the *Senior Voice*, Alaska’s statewide senior newspaper. In addition to the 17,500 copies distributed with the paper, packets of surveys were mailed to senior centers and other senior services providers across the state.

The senior provider survey was distributed to community-based senior service provider agencies and community health centers. This survey, to which 50 responses were received, asked providers about the types and amount of services they provide for seniors, their projections of service needs over the next five years, their perceptions of senior concerns, their evaluations of unmet needs of seniors in their service areas, and other information pertinent to primary health care and home- and community-based services.

The ACoA provided an overview of the development of the State Plan to the Alaska State House and Senate Health and Social Service Committees highlighting findings from the elder-senior community forums, provider survey, and senior survey during the FY 2011 legislative session. ACoA’s presentations were part of discussions among policy makers regarding the needs of Alaskan seniors, long-term care, and elder protection.

## **Relationship between AOA Strategic Plan Goals and Alaska State Plan Goals**

The Alaska State Plan for Senior Services for FY 2012 through FY 2015 has four goals: a broad health promotion and disease prevention goal which also includes an array of health-promoting elements such as financial security, participation in civic and service efforts, emergency preparedness, engaging senior centers, and positive images of seniors in the media; a long-term care goal focused on supporting seniors to live in their own homes and communities for as long as possible; a housing goal emphasizing the need for many types of housing options for seniors, including a focus on senior-friendly design and accessibility; and an elder safety goal to increase both the public awareness of elder maltreatment and the legal, policy, and financial resources to ensure that older Alaskans are safe.

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Many of Alaska's goals, objectives, and strategies parallel the focal points of AOA's own strategic plan, as noted below.

<b>AOA Goal 1</b>	Alaska Goal 1, Objectives A, L; Goal 2, Objectives A, B
<b>AOA Goal 2</b>	Alaska Goal 2
<b>AOA Goal 3</b>	Alaska Goal 1, Objectives B, D, E, H, L
<b>AOA Goal 4</b>	Alaska Goal 4, Objectives A, B, C
<b>AOA Goal 5</b>	Alaska Goal 2, Objectives E, F, I

#### **AOA Goal 1:**

***Empower older people, their families, and other consumers to make informed decisions about, and be able to easily access, existing health and long-term care options.***

Information and assistance related to long-term care is a top concern for Alaskan seniors. Likewise, access to both health care (in urban areas where few doctors accept Medicare patients) and long-term care (especially in rural and remote areas) is frequently identified as a need.

Issues of access to health care are addressed under our **Goal 1: Alaska seniors are healthy, safe, financially secure, and make vital contributions to their communities, Objective A (Ensure access to primary care) and Objective L (Support the outreach and information services of the State of Alaska's Medicare Information Office)**. The top concern among older Alaskans at this time is the lack of access to primary care in parts of the state (including Anchorage) because of the scarcity of physicians willing to accept Medicare patients. Medicare's low reimbursement rates fail to compensate doctors for their costs of care. The Alaska Commission on Aging and its advocacy partners are seeking federal and state solutions to this crisis, which is causing many older Alaskans to contemplate leaving the state.

Access to information and assistance regarding long-term care options is addressed in our **Goal 2: Seniors remain in their own homes with high quality of life for as long as possible through the provision of home- and community-based services, including support for family caregivers, Objective A (Provide convenient access to information and assistance regarding long-term care options, benefits, and assistance)**. The strategies under this objective consider both senior centers and ADRCs as natural hubs to which seniors turn for information. The ADRCs are a national information, referral and assistance program supported by the AoA. ADRCs, senior service providers and disability service providers work together at a community and statewide level to ensure consumers have access to information, referral and assistance regarding long-term supports and services and benefits. The Alaska Commission on Aging's 2010 senior survey revealed that senior centers are currently the most-utilized information source for older Alaskans, with 45% turning to someone at their local senior center for the information they need about services and benefits. At this time, only five percent report seeking information from an ADRC. We believe this is because Alaska's ADRCs are currently limited in the areas of the state that they cover, have low levels of funding and staffing, and are not recognized by many seniors as a familiar resource.

Access to long-term care is also a crisis for Alaskan elders in remote parts of the state. Programs such as the Medicaid waiver are unavailable in some areas because of high costs, and not enough senior grant funding is available to cover the needs. Many areas lack assisted living facilities. Elders have told the Alaska Commission on Aging over and over that they do not want to leave their home communities just

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to be able to access services in a city such as Anchorage or Fairbanks. It's imperative that we find ways to offer them the care they need in their areas.

This effort is covered under our **Goal 2, Objective B (Increase access to flexible, high-quality home- and community-based services (HCBS))**, especially in rural and remote areas of the state). Strategies under this objective cover needs assessment in underserved areas, development of service infrastructure in remote areas, providing access to care for modest-income seniors and elders (who may have a small pension or Native dividend that puts them over the Medicaid Waiver income threshold but who, especially in remote areas, cannot afford the cost of services), and the need to expand available home- and community-based services statewide to meet the needs of Alaska's rapidly growing senior population.

#### **AOA Goal 2:**

***Enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home- and community-based services, including supports for family caregivers.***

Alaska's Goal 2 closely parallels AOA's Goal 2. Under this goal, we include objectives focused on information and assistance, increasing access to home- and community-based services (especially in remote areas), providing for the needs of family caregivers, participating in the development and implementation of a statewide long-term care plan, coordinating with Alaska's Title VI programs and with programs serving Alaskan veterans, identifying and meeting seniors' behavioral health needs, building a high-quality direct care senior services workforce, and working to remedy procedural concerns with the senior grants process.

#### **AOA Goal 3:**

***Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.***

AOA's Goal 3 is covered under our **Goal 1: Alaskan seniors are healthy, safe, financially secure, and make vital contributions to their communities**. Health promotion and disease prevention are the focus of our **Objective B, Provide health promotion and disease prevention programs and materials**.

**Objective D, Assist seniors in finding good-paying employment opportunities**, includes services provided under Title V of the Older Americans Act, which in Alaska are provided through the MASST (Mature Alaskans Seeking Skills Training) Program within the Alaska Department of Labor & Workforce Development. The objective goes beyond the services of this valuable program, though, to include the promotion of the value of older workers, working to eliminate age discrimination by Alaskan employers, and support for an increase in the minimum wage. Alaska has a higher rate of senior employment than the national average, perhaps because of the state's high cost of living. The Alaska Commission on Aging and its agency partners believe that good-paying employment opportunities are of vital importance to the many seniors who remain in the workforce.

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**Objective E, Expand community transportation options to enable seniors to travel to community events, volunteer work, services, shopping, and medical appointments**, highlights one of the most important Older Americans Act services, one which many seniors tell the Alaska Commission on Aging is of the utmost importance in their lives, making the difference in whether they are able to get to a doctor's appointment, grocery store, social event, or scheduled community service commitment.

Much research now shows the importance of civic and social engagement in preserving seniors' health and preventing disease. **Objective H, Encourage and facilitate the engagement of seniors in a wide variety of civic, educational, and service programs**, emphasizes a less direct but equally powerful form of prevention – ensuring that all seniors have the opportunity to live an engaged life of purpose and connection within their community.

**Objective L, Support the outreach and information services of the State of Alaska's Medicare Information Office**, ensures that Alaska will continue to provide support for this vital information resource which includes SHIP (the State Health Insurance Assistance Program), a program that provides one-on-one personalized counseling, education and outreach to Medicare beneficiaries and their families, allowing them to better understand and utilize their Medicare benefits, including Medicare Part D prescription drug benefits and the new prevention benefits.

#### **AOA Goal 4:**

***Ensure the rights of older people and prevent their abuse, neglect, and exploitation.***

AOA's Goal 4 closely matches the Alaska State Plan's **Goal 4: Seniors are protected from abuse, neglect, self-neglect, and exploitation**. Alaska's Goal 4 includes three objectives, **Objective A, Educate members of the public to recognize signs of elder maltreatment, report harm, and collaborate with authorities to protect vulnerable seniors**; **Objective B, Increase advocacy for statutes, regulations, policies, programs, and funding that protect the safety and rights of older Alaskans**; and **Objective C, Make legal assistance available to Alaska seniors with a priority placed on providing assistance to those in social and economic need**.

In Alaska, the Office of the Long-Term Care Ombudsman, the Adult Protective Services office, and the Office of Elder Fraud and Assistance reside in three different State departments – the Department of Revenue, the Department of Health & Social Services, and the Department of Administration, respectively. All three work closely together, however, to handle the rapidly increasing stream of complaints of abuse, neglect, self-neglect, and exploitation of older Alaskans. The Alaska Commission on Aging and its partners have advocated for budget and staffing increases for these agencies, as well as for clarification and expansion of their statutory jurisdictions, and will continue to do so. ACoA and its partners are also developing statewide educational campaigns to increase the public's ability to recognize the signs of abuse and report possible cases of abuse, as well as to de-stigmatize elderly victims and reporters of abuse.

**AOA Goal 5:**

***Maintain effective and responsive management.***

While many of Alaska's goals, objectives, and strategies imply movement toward more effective and responsive activity on behalf of seniors in various context, several strategies in Alaska's State Plan more directly address the management and policies of the State Unit on Aging, the Alaska Department of Health & Social Services.

**Goal 2, Objective E (Coordinate with Title VI programs to maximize resources and services available)** prioritizes cooperation between the Division of Senior & Disabilities Services, which administers the Title III grants, and the Title VI agencies, tribal entities providing parallel services within their jurisdictions. This coordination is already well-established, with many Title VI providers serving non-Natives in their area via Title III funds as well. During the period covered by this State Plan, DSDS staff will facilitate two teleconferences with Title VI grantees each year and will participate in national meetings held for Title VI and tribal long-term care programs.

Likewise, under **Goal 2, Objective F (Coordinate with programs serving veterans in order to best meet the needs of seniors and veterans with disabilities and chronic health conditions)**, DSDS staff are beginning to coordinate with the Veterans Administration regarding veterans' long-term care programs that help ensure that our veterans have maximum access to home- and community-based services.

The Alaska Commission on Aging, the planning, education, and advocacy arm of the State Unit on Aging, stays in close contact with the needs of older Alaskans. The Commission holds a public comment period at each of its quarterly meetings, held in various locations around Alaska. The Commission also holds extended senior/elder community forums and conducts senior surveys in connection with specific needs assessment directives for projects such as the State Plan for Senior Services (2006-2007 and 2010-2011) and the White House Conference on Aging (2005). In this way, the Commission stays in direct contact with the needs, observations, and suggested solutions of seniors and is able to use this grassroots information in its advocacy and planning work.



## **Goals, Objectives, Strategies & Performance Measures State Plan for Senior Services, FY2012-2015**

### **Alaska State Plan Goals**

**Goal 1:**

**Alaskan seniors are healthy, safe, financially secure, and make vital contributions to their communities.**

**Goal 2:**

**Seniors have the choice to remain in their own homes, living with high quality of life for as long as possible through the provision of home- and community-based services, including support for family caregivers.**

**Goal 3:**

**Seniors have access to a range of attractive, safe, affordable housing options.**

**Goal 4:**

**Seniors are protected from abuse, neglect, self-neglect, and exploitation.**

## Alaska State Plan Goals and Objectives

### Goal 1:

**Alaskan seniors are healthy, safe, financially secure, and make vital contributions to their communities.**

#### **Objectives:**

- A. Ensure access to **health care**.
- B. Build capacity to provide **health promotion, disease prevention, and health self-management** programs and materials for more older Alaskans throughout the state.
- C. Prioritize the needs of vulnerable populations, including seniors and people with disabilities, in statewide and community **emergency preparedness planning**.
- D. Assist seniors in finding good-paying **employment** opportunities.
- E. Expand **community transportation** options to enable seniors to travel to community events, volunteer work, services, shopping, and medical appointments.
- F. Work to **prevent senior falls**.
- G. Support communities in creating **senior-friendly environments**.
- H. Encourage and facilitate the **engagement** of seniors in a wide variety of **civic, educational, and service programs**.
- I. Promote the work of **senior centers** in offering social engagement, classes, health maintenance activities, information, and services.
- J. Engage in statewide **outreach** to make seniors aware of available financial **benefits** and health **support programs**.
- K. Ensure that seniors have access to information and **education** on **financial literacy, including estate planning, long-term care planning, investments**, and other means of building and sustaining their assets.
- L. Support the outreach and information services of the State of Alaska's **Medicare Information Office**.
- M. Promote **positive images of senior citizens** in the media, including State publications, portraying seniors as an integral part of our society and fully capable of valuable contributions to their family and community.
- N. Promote older Alaskans' access to dental care.

### Goal 2:

**Seniors have the choice to remain in their own homes, living with high quality of life for as long as possible through the provision of home- and community-based services, including support for family caregivers.**

#### **Objectives:**

- A. Provide convenient access to **information and assistance** regarding long-term care options, benefits, and assistance.

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- B. Increase **access to flexible, high-quality home- and community-based services (HCBS)**, especially in rural and **remote** areas of the state.
- C. Provide **family caregivers** with access to an array of information, education, and supports that allow them to continue to provide care to their loved ones for as long as possible.
- D. Participate in the development and implementation of a statewide **long-term care plan** to guide the orderly expansion of facilities, infrastructure, and services to meet the full spectrum of needs of Alaska's fast-growing senior population.
- E. Coordinate with **Title VI programs** to maximize resources and services available.
- F. Coordinate with **programs serving veterans** in order to best meet the needs of seniors and veterans with disabilities and chronic health conditions.
- G. Ensure that seniors with **behavioral health** needs are screened, identified, referred, and treated in a senior-friendly context.
- H. Work to increase, support, train, and retain a high-quality senior services **direct care workforce**.

### **Goal 3:**

**Seniors have access to a range of attractive, safe, affordable housing options.**

#### ***Objectives:***

- A. Increase Alaska's capacity to house seniors in **affordable, safe, and accessible housing** in their own communities.
- B. Increase State funding that will **reduce or prevent senior homelessness**.
- C. Advocate for the development of **accessible housing with supports** for seniors with physical, behavioral health and cognitive disabilities such as Alzheimer's Disease and Related Dementias.

### **Goal 4:**

**Seniors are protected from abuse, neglect, self-neglect, and exploitation.**

#### ***Objectives:***

- A. Educate members of the public to **recognize signs of elder maltreatment**, report harm, and collaborate with authorities to protect vulnerable seniors.
- B. Increase **advocacy for statutes, regulations, policies, programs, and funding** that protect the safety and rights of older Alaskans.
- C. Make **legal assistance** available to Alaska seniors with a priority placed on providing assistance to those in social and economic need.

## Alaska State Plan Goals, Objectives, and Strategies

### Goal 1:

**Alaskan seniors are healthy, safe, financially-secure, and make vital contributions to their communities.**

#### ***Objectives:***

- A. Ensure access to **health care**.
  - 1.A.1 Support legislation providing additional resources to health care providers to treat Medicare patients.
  - 1.A.2 Support legislation designed to offer loan forgiveness and other financial incentives to medical professionals who practice in Alaska.
  - 1.A.3 Identify impediments to health care access and work to reduce the barriers.
- B. Build capacity to provide **health promotion, disease prevention, and health self-management** programs and materials for more older Alaskans throughout the state.
  - 1.B.1 Work together with the Division of Public Health and other state and local agencies to build statewide and local support for provision of evidence-based health promotion, disease prevention, and health self-management programs.
  - 1.B.2 Offer educational presentations on health promotion and disease prevention topics at senior centers, community health centers, and other community locations.
  - 1.B.3 Work with State and local public health and community development agencies to identify and implement solutions to water and sewer problems in the many remote villages currently lacking basic sanitation infrastructure.
  - 1.B.4 Encourage the offering of medication management information via classes, talks, and consultation with volunteer pharmacists.
  - 1.B.5 Develop and offer presentations on identifying and coping with caregiver burnout.
  - 1.B.6 Advocate for funding to assist Alaska's aging network in providing Health Promotion, Disease Prevention (HPDP) opportunities for older Alaskans and train local providers on the implementation of HPDP activities.
  - 1.B.7 Create a HPDP network in which information about existing HPDP activities can be shared by partner organizations (such as, for example, the Division of Behavioral Health, Division of Public Health, Alaska Native

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- Tribal Health Consortium, and the Alaska Mental Health Trust Authority).
  - 1.B.8 Advocate for legislation and policies to support HPDP and initiatives.
  - 1.B.9 Promote awareness of the social determinants of health, particularly as they apply to senior health and well-being.
  - 1.B.10 Advocate for policy that encourages primary care providers to support screening seniors for physical and psychological trauma (past or present), and referring them to trauma-informed behavioral health care.
  - 1.B.11 Promote the use of assistive technology and adaptive techniques to help seniors with disabilities remain healthy and independent.
- C. Prioritize the needs of vulnerable populations, including seniors and people with disabilities, in statewide and community **emergency preparedness planning**.
  - 1.C.1 Engage with federal, state, and local organizations to create a culture of emergency preparedness that recognizes and incorporates the needs of vulnerable populations including seniors and persons with disabilities.
  - 1.C.2 Disseminate information and support local disaster response organizations and senior organizations in efforts to promote and assist in emergency preparedness activities with seniors and persons with disabilities.
- D. Assist seniors in finding good-paying **employment** opportunities.
  - 1.D.1 As funds are available to support the MASST program, increase collaboration with the MASST (Mature Alaskans Seeking Skills Training) program to place Alaskans age 55 and older in work experience opportunities designed to prepare them for successful employment.
  - 1.D.2 Promote the value of older workers by dispelling myths about them and highlighting their advantages.
  - 1.D.3 Support seniors in or re-entering the workforce by providing specialized case management, adaptive skill training and assistive technology for those with disabilities, job search assistance, appropriate job training, and placement. (MASST)
  - 1.D.4 Strengthen awareness of and opportunities for business sector partnerships which will benefit seniors. (ACOA and MASST)
  - 1.D.5 Encourage comprehensive, coordinated systems at the federal, state, and local levels for streamlining access to a wide ranges of program benefits for seniors seeking work. (MASST)
  - 1.D.6 Develop networking opportunities for older job seekers to locate employment openings, including maintaining the ALEXSYS (Alaska Labor Exchange System) website displaying statewide job openings for seniors.

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- 1.D.7 Annually highlight employers who recognize the contributions and value of older workers, and highlight the accomplishments of individual older workers. (ACOA and MASST)
  - 1.D.8 Coordinate services with the aging network, providing information for seniors on finding and keeping employment. (MASST)
  - 1.D.9 Support efforts to eliminate age discrimination practices by Alaskan employers. (ACOA and MASST)
  - 1.D.10 Support an increase in the minimum wage on the federal and/or state levels, sufficient to provide a living wage for all Alaskan workers, including seniors. (ACOA and MASST)
- E. Expand affordable **community transportation** options to increase seniors' access to community events, volunteer work, services, shopping, and medical appointments.
- 1.E.1 Examine the availability of existing transportation options for older Alaskans throughout the state.
  - 1.E.2 Collaborate with the Governor's Task Force on Coordinated Transportation and with the Alaska Mobility Coalition to help identify and implement long-term solutions to increase seniors' access to comprehensive, convenient transportation options.
  - 1.E.3 Promote the expansion of community transit services to include longer hours, greater geographical range, and more flexible scheduling options.
  - 1.E.4 Advocate for legislation and policies that support increased funding for affordable, appropriate transportation for older Alaskans.
- F. Work to **prevent senior falls**.
- 1.F.1 Continue and expand the Alaska Senior Fall Prevention Coalition.
  - 1.F.2 Work with communities statewide to raise awareness of the need for improved winter maintenance of sidewalks, parking lots, and other access points.
  - 1.F.3 Advocate for legislation and policies to support senior fall prevention and other senior safety initiatives.
  - 1.F.4 Raise awareness of the increased risk of falls due to vision loss or other disabilities and connect at-risk seniors to preventive services.
- G. Support communities in creating **senior-friendly environments**.
- 1.G.1 Partner with communities and senior advisory commissions to promote commitment to safe, ice-free, senior-friendly business and civic spaces.
  - 1.G.2 Work to increase statewide and community awareness of the economic Impact of the senior retirement "industry" as one of Alaska's most lucrative and well-balanced industries.

- H. Encourage and facilitate the **engagement** of seniors in a wide variety of **civic, educational, and service programs**.
  - 1.H.1 Provide information to older Alaskans on the opportunities and benefits of civic engagement and volunteerism.
  - 1.H.2 Work to ensure that seniors have access to transportation (or a travel stipend) to get them to their service sites.
  - 1.H.3 Honor the efforts of outstanding senior volunteers.
  - 1.H.4 Provide ample opportunities for volunteering in senior centers.
  - 1.H.5 Promote more opportunities for inter-generational contact to promote sharing of knowledge and mutual appreciation.
- I. Promote the work of **senior centers** in offering social engagement, classes, health maintenance activities, information, and services.
  - 1.I.1 Encourage senior centers to plan for the needs of seniors representing a range of ages, interests, and ability levels.
  - 1.I.2 Provide training and assistance to senior centers to utilize a logic model or other similar structured approach to strategic planning to evaluate and measure services, improve program quality, maximize program and funding efficiency, and expand access to services.
  - 1.I.3 Develop performance standards for service delivery at senior centers.
- J. Engage in statewide **outreach** to make seniors aware of available financial **benefits** and health **support programs**.
  - 1.J.1 Work with the Division of Public Assistance, Alaska Legal Services Corporation, and other agency partners with a rural presence to create outreach opportunities so that all older Alaskans are aware of the Senior Benefits program, Food Stamps, heating assistance, and other public assistance supports and can easily apply for them.
- K. Ensure that seniors have access to information and **education on financial literacy, including estate planning, long-term care planning, investments**, and other means of building and sustaining their assets.
  - 1.K.1 Identify at least three additional resources for providing education and guidance to seniors regarding how to preserve and protect their homes and financial assets.
  - 1.K.2 Coordinate with ALSC (Alaska Legal Services Corporation) to ensure that seniors receive basic information about the legal issues involved in long-term care planning.

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- L. Support the outreach and information services of the State of Alaska's **Medicare Information Office**.
  - 1.L.1 Promote and publicize the Medicare Information Office as a source of valuable information to older Alaskans as they join or continue as a Medicare beneficiary.
- M. Promote **positive images of senior citizens** in the media, including State publications, portraying seniors as an integral part of our society and fully capable of valuable contributions to their family and community.
- N. Promote older Alaskans' **access to dental care**.
  - 1.N.1 Coordinate with the Department's Oral Health Program in developing senior dental assessments and surveys to help identify needs related to access to dental care.
  - 1.N.2 Participate in planning, advocacy, and promotion efforts to increase the number of older Alaskans able to access a full range of dental services.



**Goal 2:**

**Seniors have the choice to remain in their own homes and communities, living with high quality of life for as long as possible through the provision of home- and community-based services, including support for family caregivers.**

***Objectives:***

- A. Provide convenient access to **information and assistance** regarding long-term care options, benefits, and assistance.
  - 2.A.1 Support the standardization of information, referral and assistance across the state to provide seniors with the highest quality information, referral and assistance services.
  - 2.A.2 Continue to build upon the Aging & Disability Resource Center (ADRC) network by strengthening partnerships across senior and disability services, enabling seniors to get all the help they need in the most convenient location.
  - 2.A.3 Support Alaska's Aging & Disability Resource Centers (ADRCs) to become fully functional in all core ADRC components: Information, Referral and Awareness, Options Counseling and Assistance, Person-Centered Transition Support, Streamlined Eligibility Determination for Public Programs, Consumer Populations, Partnerships and Stakeholder Involvement, and Quality Assurance and Continuous Improvement.
  - 2.A.4 Work with other agencies, including Alaska's ADRC networks, to conduct a public information campaign to make Alaskans aware of all senior services, benefits, and long-term care information and where to go for detailed information.
  - 2.A.5 Expand the availability of information and referral to seniors and caregivers through ADRCs and senior centers to include long-term care options counseling, benefits counseling, and streamlined access to public programs.
  - 2.A.6 Build upon existing partnerships between the ADRCs and Alaska 2-1-1 so that a coordinated statewide information data base of services and a centralized call center exists to be easily accessed by the public and service providers, both by phone and via the Internet.
  - 2.A.7 Coordinate with the Division of Public Assistance to develop a plan for the co-location of the ADRC, Medicare Information Office, and Public Assistance Eligibility office in Anchorage.

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- B. Increase **access to flexible, high-quality home- and community-based services (HCBS)**, especially in rural and **remote** areas of the state.
  - 2.B.1 Assess the need and capacity to develop HCBS in underserved areas of the state.
  - 2.B.2 Examine options for increasing Medicaid waiver, PCA, and senior grant programs in rural and remote communities.
  - 2.B.3 Present information and education to community groups regarding the hospital discharge grant program and the nursing home transition program.
  - 2.B.4 Increase outreach to older Alaskans and their families on the availability of HCBS in their communities, presenting the information in senior-friendly formats.
  - 2.B.5 Advocate for legislation, policies, and funding that support expansion of HCBS to meet needs of the rapidly increasing population of older Alaskans.
  - 2.B.6 Advocate for funding to develop service infrastructure in underserved areas of the state.
  - 2.B.7 Examine solutions that allow access to care for modest-income seniors and elders who may have a small pension or Native dividend that puts them over the Medicaid Waiver income threshold but who, especially in remote areas, cannot afford the cost of home- and community-based services.
  - 2.B.8 Advocate for the availability of hospice and end of life care in every community.
- C. Provide **family caregivers** with access to an array of information, education, and supports that allow them to continue to provide care to their loved ones for as long as possible.
  - 2.C.1 Present education and public awareness efforts to increase the public's knowledge of family caregiver support programs.
- D. Participate in the development and implementation of a statewide **long-term care plan** to guide the orderly expansion of facilities, infrastructure, and services to meet the full spectrum of needs of Alaska's fast-growing senior population.
- E. Coordinate with **Title VI programs** to maximize resources and services available.
  - 2.E.1 Conduct two teleconferences annually with Title VI grantees to provide an opportunity to discuss their programs, solicit peer support, understand and discuss coordination with Title III programs and grantees, discuss gaps in service in their service area and region, address questions

and discuss additional home-and community-based services and other issues. This will be a coordinated effort between the State of Alaska and the Alaska Native Elder Resource Center.

- 2.E.2 Participate in national meetings held specifically for Title VI and Tribal Long-Term Care programs annually, and use them as an opportunity for networking with Alaska tribes and strengthening the coordination process.

- F. Coordinate with **programs serving veterans** in order to best meet the needs of seniors and veterans with disabilities and chronic health conditions.

- 2.F.1 Partner with agencies serving Alaska veterans to ensure maximum access to home- and community-based services.

- G. Ensure that seniors with **behavioral health** needs are screened, identified, referred, and treated in a senior-friendly context.

- 2.G.1 Collaborate with the Division of Behavioral Health in order to ensure outreach and response to seniors with behavioral health needs.
- 2.G.2 Work to integrate behavioral health screening with primary care, including support for increased resources for IMPACT (Improving Mood, Promoting Access to Collaborative Treatment) and SBIRT (Screening, Brief Intervention, Referral to Treatment), screening programs to help identify depression and substance abuse among primary care clients, which have been demonstrated to be especially successful with seniors.
- 2.G.3 Work with senior centers, care coordinators, and other senior service providers to implement evidence-based home-based depression care management programs such as PEARLS and Healthy IDEAS.
- 2.G.4 Advocate for more financial resources for behavioral health services and treatment for seniors, including (but not limited to) those with severe disruptive behaviors who cannot be safely served in most assisted living, nursing, or Pioneer homes.
- 2.G.5 Prioritize the integration of seniors with behavioral health needs into their communities and living facilities wherever possible, by making appropriate treatment and staff training available and providing funding for increased staffing and behavioral health specialization.
- 2.G.6 Highlight Alaska's elevated senior suicide rates and advocate for funding for programs and research to determine and address the causes and contributing factors of this unnecessary loss of life.

- H. Work to increase, support, train, and retain a high-quality senior services **direct care workforce**.
  - 2.H.1 Collaborate and advocate with other agencies, and support the Alaska Health Workforce Development Plan, to ensure the recruitment, retention, and training of a skilled, stable workforce for senior and health care services.
  - 2.H.2 Advocate for greater funding for training for senior direct care workers.
  - 2.H.3 Advocate for initiatives, such as those described by the University of Alaska's Expanding Access to Health Programs project (see Appendix K), that focus on expanding access to education and training via technology for the health workforce that services Alaska seniors.
  - 2.H.4 Offer increased trainings for working with special populations such as those with Alzheimer's Disease and Related Disorders (ADRD) and the seriously mentally ill.
  - 2.H.5 Increase the safety of seniors by providing elder safety training to the caregiving workforce.
  - 2.H.6 Support and encourage implementation of the Alaskan Core Competencies in the design of training programs for assisted living staff, direct service providers, and peer support specialists.

**Goal 3:**

**Seniors have access to safe, affordable housing and supports appropriate to their needs.**

***Objectives:***

- A. Increase Alaska's capacity to house seniors in **affordable, safe, and accessible housing** in their own communities.
  - 3.A.1 Advocate for an increase in AHFC's Senior Citizen Housing Development Fund (SCHDF) and other public funding sources to reach an annual target of \$10 million for the development of senior housing to cover the decreased amount of federal funds, increased development costs, and continued growth of the senior population.
  - 3.A.2 Advocate for an increase in the amount of funding available for weatherization, energy upgrades and accessibility modifications that improve housing and accessibility for Alaska seniors.
  - 3.A.3 Advocate for the development of senior housing with supportive services.
  - 3.A.4 Promote the use of universal design in the construction of homes and apartments.
  - 3.A.5 Research affordable, accessible congregate-style senior housing designs appropriate to an arctic environment and educate developers and agencies with an interest in senior housing regarding these choices.
- B. Increase state funding that will **reduce or prevent senior homelessness**.
  - 3.B.1 Meet with municipal senior advisory commissions annually to discuss the results of AHFC's point-in-time enumeration for senior homeless populations and to develop advocacy strategies on their behalf.
  - 3.B.2 Work with municipal senior commissions statewide and with AHFC to develop a joint housing advocacy plan and position paper (with baseline data on senior homelessness and senior housing needs for Alaskans age 60 and over).
  - 3.B.3 Mobilize advocates to educate legislators about the housing needs of homeless seniors.
  - 3.B.4 Advocate to AHFC and the State of Alaska to create more rental subsidies for seniors who are low income with disabling conditions.

- C. Advocate for the development of **accessible housing with supports** for seniors with physical, behavioral health and cognitive disabilities such as Alzheimer's disease and related dementias.
  - 3.C.1 Collaborate and partner with AHFC, the Alaska Mental Health Trust (Trust), Senior & Disabilities Services (SDS), the State Independent Living Center (SILC) and other partners to identify an effective housing model for seniors with physical, behavioral health and cognitive disabilities.
  - 3.C.2 Collaborate and partner with AHFC, the Trust, SDS, the SILC and other Partners to target housing pre-development funds specifically for developing new senior housing with supports for seniors with physical, behavioral health, and cognitive disabilities.
  - 3.C.3 Partner with the Alaska Mental Health Trust and other agencies to provide technical assistance to non-profit housing developers who are willing to develop and manage senior housing with supports for seniors with physical, behavioral health, and cognitive disabilities statewide.
  - 3.C.4 Partner with the Trust to forge housing partnerships between housing managers, service providers, State and local agencies to ensure that senior housing with supportive services is funded and staffed at levels appropriate to the residents' needs.
  - 3.C.5 Reduce the number of seniors with ADRD and challenging behaviors inappropriately admitted to the Alaska Psychiatric Institute (API) by developing more appropriate assisted living options for this population.

**Goal 4:**

**Seniors are protected from abuse, neglect, self-neglect, and exploitation.**

***Objectives:***

- A. Educate members of the public to **recognize signs of elder maltreatment**, report harm, and collaborate with authorities to protect vulnerable seniors.
  - 4.A.1 Adult Protective Services (APS) provides mandated reporter training to professional groups and organizations as well as service providers statewide.
  - 4.A.2 APS and/or Office of Long-Term Care Ombudsman (OLTCO) provide information to Alaskan medical providers to screen routinely for elder maltreatment in emergency and urgent care facilities.
  - 4.A.3 ACoA works with Alaska Mental Health Trust Authority, OLTCO, AARP and Other partners on public awareness campaigns encouraging seniors, senior services providers, and members of the public to notice and address isolation of seniors as well as to recognize and report abuse and other rights violations.
  - 4.A.4 Office of Elder Fraud and Assistance (OEFA) works with Alaska Legal Services (ALS), AARP, ACoA and other entities to improve seniors' access to civil representation in cases of exploitation.
  - 4.A.5 APS and OEFA work with financial institutions to develop elder exploitation prevention training programs for staff.
  - 4.A.6 APS and OLTCO work with the Governor's Domestic Violence Data Workgroup to include tracking of elder abuse and exploitation measures for the Governor's "Alaska Dashboard on Domestic Violence."
  - 4.A.7 OEFA, APS, and OLTCO work with courts to develop a system to track exploitation in guardianship cases involving seniors.
- B. Increase **advocacy for statutes, regulations, policies, programs, and funding** that protect the safety and rights of older Alaskans.
  - 4.B.1. ACoA, OLTCO, APS, and OEFA prepare and distribute to legislators an information packet on elder maltreatment and exploitation in Alaska, including data about reports of harm, rates of substantiation, complaint resolution rates, and cases prosecuted.
  - 4.B.2. ACoA advocates for adequate funding for APS and OLTCO to ensure that the agencies have the staffing and resources to meet the increasing demand for their assistance.
  - 4.B.3. APS, Certification and Licensing, OLTCO, and Alaska Mental Health Trust Authority collaborate to revise and strengthen State licensing regulations for assisted living facilities.

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- 4.B.4. The Trust Training Cooperative, Alaska Mental Health Trust Authority, OLTCO, and Certification and Licensing advocate for training for caregivers in long term care facilities.
  - 4.B.5. ACoA, the Alaska Mental Health Trust Authority, OLTCO, APS and other stakeholders collaborate on a State long term care plan that includes strategies for protection and quality assurance in long term care facilities.
  - 4.B.6 The ACoA will advocate for additional funds to be budgeted to increase training and public awareness regarding elder abuse and exploitation as well as mandatory reporting requirements.
  - 4.B.7 Advocate for State funding for a full-time legal assistance developer position within the State Unit on Aging (at the Division of Senior and Disabilities Services).
  - 4.B.8 The OEFA will work with the Court System to develop a tracking procedure to extract information on abuse from cases, in a manner which would not compromise confidentiality.
  - 4.B.9 Advocate for laws, regulations, policies, and practices that promote the protection of seniors' rights in assisted living facilities.
  - 4.B.10 Support quality assurance programs and strategies to ensure that seniors receive the highest quality long-term care services.
- C. Make **legal assistance** available to Alaskan seniors with a priority placed on providing assistance to those in social and economic need.
- 4.C.1 Alaska Legal Services and other agency partners coordinate community outreach, trainings, and workshops, informing the public of free legal assistance available to Alaska seniors.



## Alaska State Plan Performance Measures

*Note: Those performance measures for which a current baseline was not available will be tracked using the first available year's data as the baseline.*

### Goal 1 Performance Measures:

1-PF-1 Increase to 5 the number of seniors evidence-based health promotion/disease prevention programs offered at sites throughout the state.

**FY 2011 Baseline:** Two (CDSMP; A Matter of Balance)

*Reference Strategy: 1.B.1*

1-PF-2 Double the number of seniors participating in evidence-based health promotion/disease prevention programs.

*Reference Strategy: 1.B.1*

1-PF-3 Increase by 5% the number of seniors participating in volunteer service programs such as RSVP and Foster Grandparents.

**Baseline FY 2010:** Senior Companion – 91; Foster Grandparents – 172; RSVP – 364

*Reference Objective: 1H*

1-PF-4 Require all senior grantees utilizing a logic model or similar system to help with defining desired program outcomes and the necessary steps for achieving those outcomes.

**Baseline FY 2010: 0**

*Reference Strategy: 1.I.2*

1-PF-5 Increase by 5% the number of seniors accessing assisted transportation.

**Baseline FY 2010:** 1,573 persons served

*Reference Strategy: 1.E.3*

*Reference Objective: 1E*

1-PF-6 Increase by 5% the number of seniors receiving Medicare counseling.

**Baseline FY 2010:** 7,612 persons counseled

*Reference Strategy: 1.L.1*

*Reference Objective: 1L*

1-PF-7 Increase by one percentage point the proportion of the senior population served by the Senior Benefits program.

**Baseline FY 2010:** 19.3% of seniors

*Reference Objective: 1J*

*Reference Strategy: 1.J.1*

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1-PF-8 Ensure that at least 35% of MASST program workers enter employment.

*Reference Objective: 1D*

1-PF-9 Ensure that at least 70% of MASST program workers stay in the job for one year after completing the program.

*Reference Objective: 1D*

1-PF-10 Provide skill-specific on-the-job training to at least 10% more than the minimum number of MASST program participants.

*Reference Objective: 1D*

1-PF-11 Maintain an average number of barriers of at least 1.5 for MASST program participants.

*Reference Objective: 1D*

1-PF-12 Increase average wages per quarter to \$7,100 for MASST program participants.

*Reference Objective: 1D*

1-PF-13 Increase the number of senior centers that offer at least one training or activity per year that increases awareness regarding emergency preparedness.

**Baseline FY 2010:** None

*Reference Objective: 1.C.2*

*Reference Strategy: 1C*

1-PF-14 Require all grantees to submit a copy of a collaborative agreement with their local emergency planning agency which adequately addresses the needs of vulnerable populations (including seniors and persons with disabilities) in emergency preparedness and response activities.

**Baseline FY 2011:** None

*Reference Strategy: 1.C.1*

1-PF-15 Decrease by two the number of villages lacking modern water and sewer facilities.

*Reference Strategy: 1.B.3*

**Goal 2 Performance Measures:**

2-PF-1 Increase by 2% the proportion of the senior population who receive registered services funding by senior grants.

**FY 2010 Baseline:** 10,809 served (12.7% of senior population)

*Reference Objective:* 2B

*Reference Strategy:* 2.B.4

2-PF-2 Increase by one percent the percentage of seniors indicating satisfaction with grant services received.

**FY 2011 Baseline:** ACOA 2010 Senior Survey shows –

77% satisfied with congregate meals

78% satisfied with home-delivered meals

78% satisfied with senior transportation

78% satisfied with information & referral

80% satisfied with care coordination

81% satisfied with chore

81% satisfied with respite

81% satisfied with PCA

80% satisfied with caregiver support

84% satisfied with adult day

*Reference Objectives:* 2B, 2C

2-PF-3 Establish a memorandum of agreement between DSDS and the VA to coordinate services for aging Alaskan veterans.

**Baseline FY 2011:** No MOA

*Reference Objective:* 2F

*Reference Strategy:* 2.F.1

2-PF-4 Increase by 5% per region the number of seniors receiving long-term care services in rural areas.

*Reference Objective:* 2B

2-PF-5 Increase by 5% the number of seniors receiving help for behavioral health issues, including those served through the SOAR (Senior Outreach, Assessment, and Referral) Project.

*Reference Objective:* 2G

*Reference Strategies:* 2.G.1, 2.G.3

2-PF-6 Adoption of a long-term care plan for the State of Alaska.

**FY 2011 Baseline:** DHSS team forming to produce plan within 12 months

*Reference Strategy:* 2.B.5

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2-PF-7 Hold two State/Title VI teleconferences per year and one face-to-face conference during the term of the plan to increase collaboration among Older Americans Act programs in Alaska.

**FY 2011 Baseline:** 0

*Reference Objective:* 2E

*Reference Strategy:* 2.E.1

2-PF-8 Increase to at least 120,000 the total number of Information & Referral contacts.

**FY 2010 Baseline:** 99,148 contacts

*Reference Objective:* 2A

2-PF-9 Increase to 50 the number of memoranda of agreement between the ADRCs and other long-term support service providers.

**FY 2011 Baseline:** 43 MOAs

*Reference Strategy:* 2.A.2

2-PF-10 Increase by 500 the number of caregiver contacts for information and referral.

**FY 2010 Baseline:** 19,085 contacts

*Reference Strategy:* 2.C.1

*Reference Objective:* 2C

2-PF-11 Increase by 5% the number of participants in the nursing home transition program. FY 2010 Baseline: 42 individuals

*Reference Strategy:* 2.B.3

2-PF-12 Increase by at least one facility per year the number of assisted living providers who provide care for seniors with Serious Mental Illness (SMI).

**FY 2011 Baseline:** 21 facilities serve seniors or persons with developmental disabilities with SMI

*Reference Objective:* 2G

2-PF-13 Increase by 10% the number of seniors screened for depression and/or substance abuse using IMPACT or SBIRT in a primary care setting.

*Reference Strategy:* 2.G.2

2-PF-14 Develop standards for all home- and community-based grant and waiver services. (DSDS)

**FY 2010 Baseline:** No standards

*Reference Objective:* 2B

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2-PF-15 Increase by at least 2% the OAA target populations served by senior grants.

**FY 2010 Baseline:** 36.53% Minority  
79.94% Rural  
39.23% Below Poverty  
13.09% Age 85+

*Reference Strategy: 2.B.2*

*Reference Objective: 2B*

2-PF-16 At least 80% of senior and long-term care direct service staff and their supervisors who participate in or complete Trust Training Cooperative trainings are satisfied or highly satisfied with the training the received.

**FY 2010 Baseline:**

Reference Strategy: 2.H.1, 2.H.4, 2.H.5, 2.H.6

Reference Objective: 2H

2-PF-17 At least 80% of senior and long-term care direct service staff and their supervisors who participate in or complete Trust Training Cooperative trainings increase their learning objective(s) knowledge level by 20% or more.

**FY 2010 Baseline:**

Reference Strategy: 2.H.1, 2.H.4, 2.H.5, 2.H.6

Reference Objective: 2H

2-PF-18 Increase the total number of people (including seniors) served through the ADRCs by 15%.

**FY 2010 Baseline:** 8,790 individuals (unduplicated)

Reference Strategy: 2.A.2, 2.A.3, 2.A.4

Reference Objective: 2A

**Goal 3 Performance Measures:**

- 3-PF-1 Increase the annual level of funding in AHFC's SCHDF budget by at least 100%.  
**FY 2012 Baseline:** \$4.5 million.  
*Reference Strategy: 3.A.1*
- 3-PF-2 Increase the number of senior housing units produced under the HUD Section 202 program by 10% annually, if these funds are available.  
*Reference Objective: 3A*
- 3-PF-3 Increase the number of senior housing units developed by regional housing authorities by 10% annually.  
*Reference Objective: 3A*
- 3-PF-4 Increase the number of senior housing units produced by private for-profit development entities by 10%.  
*Reference Objective: 3A*
- 3-PF-5 Reduce the percentage of homeless persons age 62 and over who are identified during the AHFC homeless point-in-time count by 5%.  
*Reference Objective: 3B*
- 3-PF-6 Increase the number of assisted living units for seniors by 15% annually.  
*Reference Objective: 3C*
- 3-PF-7 Increase the number of appropriate assisted living facilities licensed to care for seniors with AD/RD and challenging behaviors to reduce those admitted to the Alaska Psychiatric Institute (API) by at least 10%.  
*Reference Strategy: 3.C.5*

**Goal 4 Performance Measures:**

4-PF-1 Increase by 5% the number of reports of harm to seniors to APS and complaints to OLTCO.

**FY 2010 Baseline:** 459 OLTCO complaints; 2,433 allegations of harm to APS

*Reference Objective: 4A*

4-PF-2 Increase by 5% requests for assistance involving seniors to Alaska Legal Services and the Office of Elder Fraud & Assistance.

*Reference Strategy: 4.A.4*

4-PF-3 Reduce by 5% the number of serious rights violations (gross neglect, abuse, exploitation) in long-term care facilities.

**FY 2010 Baseline:** 47

*Reference Strategy: 4.A.2*

*Reference Objective: 4A*

4-PF-4 Increase funding by at least 5% for State staff providing investigation, protection, and complaint resolution in cases involving seniors (OLTCO, APS, OEFA).

**FY 2011 Baseline:** \$642,800 OLTCO budget

*Reference Strategy: 4.B.2*

4-PF-5 Increase by at least 5% the number of seniors utilizing ALSC (Alaska Legal Services Corporation) services.

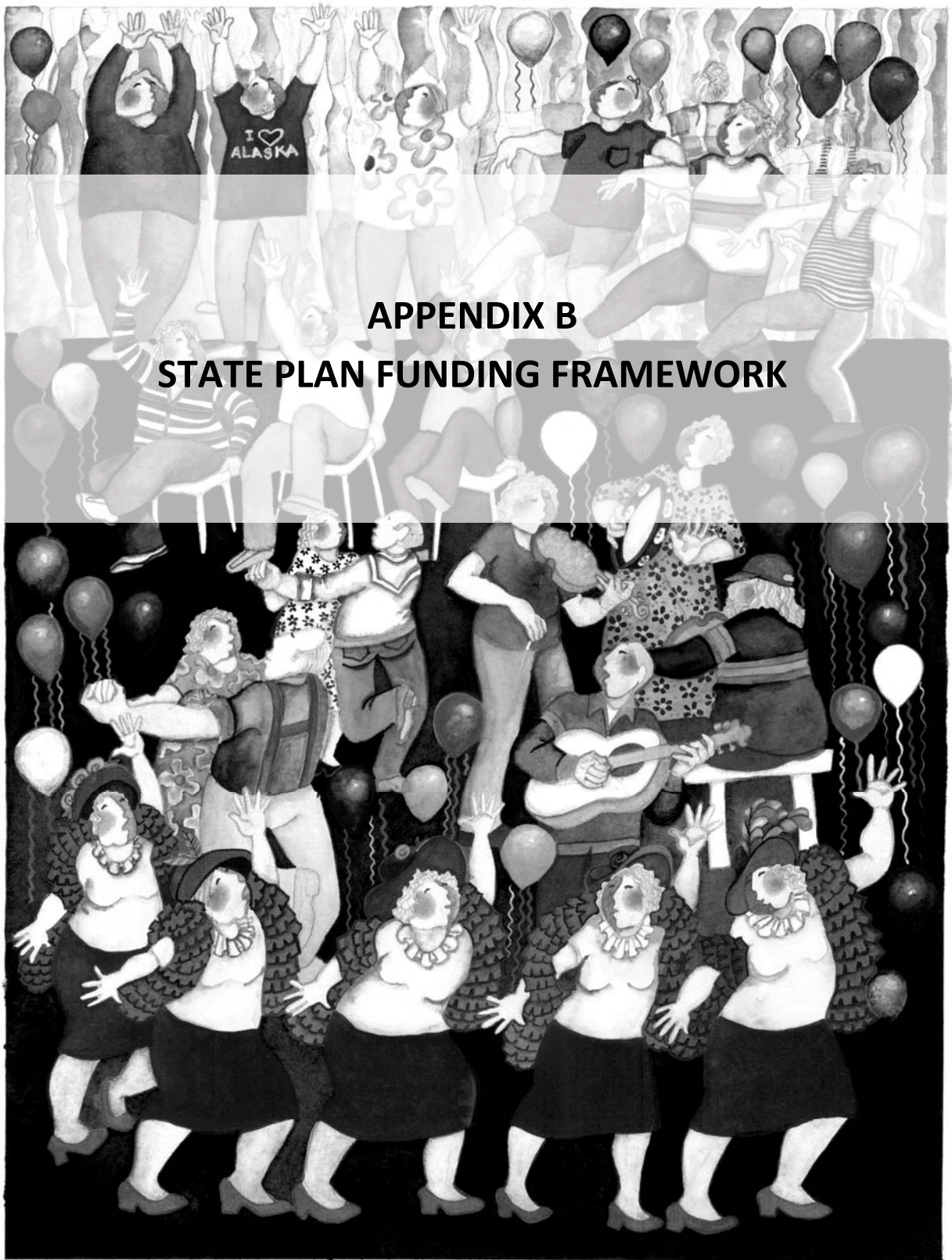
*Reference Objective: 4C*

*Reference Strategy: 4.C.1*

4-PF-6 Increase funding by at least 5% for the senior legal assistance program.

**FY 2012 Baseline:** \$145,375

*Reference Objective: 4C*



**APPENDIX B**  
**STATE PLAN FUNDING FRAMEWORK**



## APPENDIX B: State Plan Funding Framework

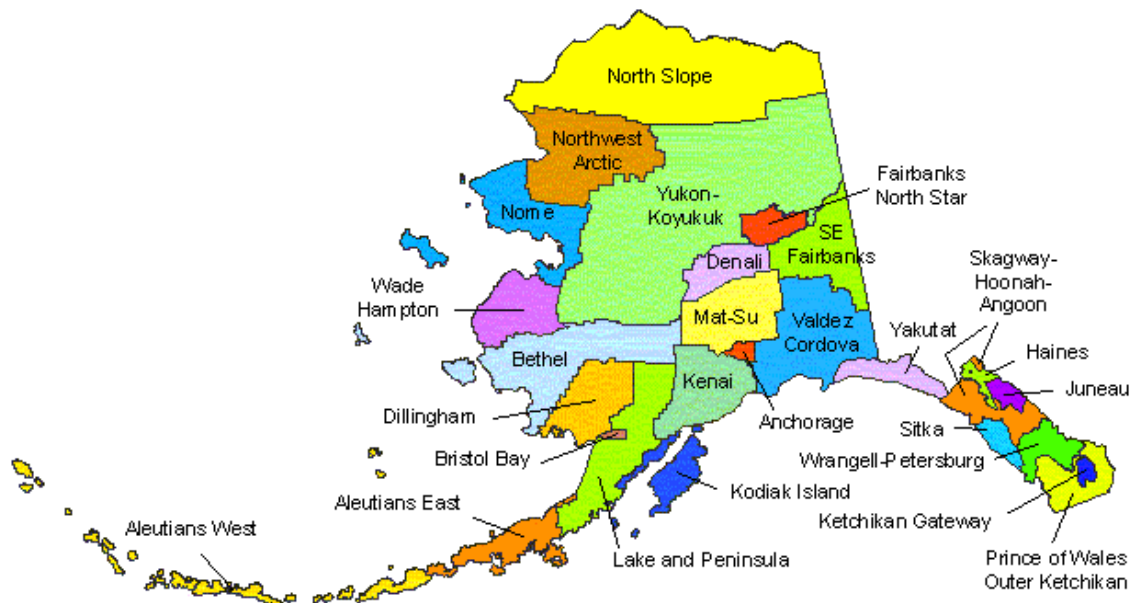
**Single Planning and Service Area.** The state of Alaska constitutes a single planning and service area under the Older Americans Act.

### Funding Framework

**Regions.** In past state plans, the State of Alaska has used a funding framework for allocating funds to regions that were formed by grouping together census areas that share common geographic and other conditions. Beginning in FY 2008 with the last state plan, region definitions shifted to the system adopted by the Alaska Department of Health & Social Services, in which the state's 27 census areas are apportioned among nine service regions. This same nine-region framework will be used to allocate funding during the term of this state plan, though the designations of Region VI and Region VIII are reversed from the previous state plan in order to match the official Department region map.

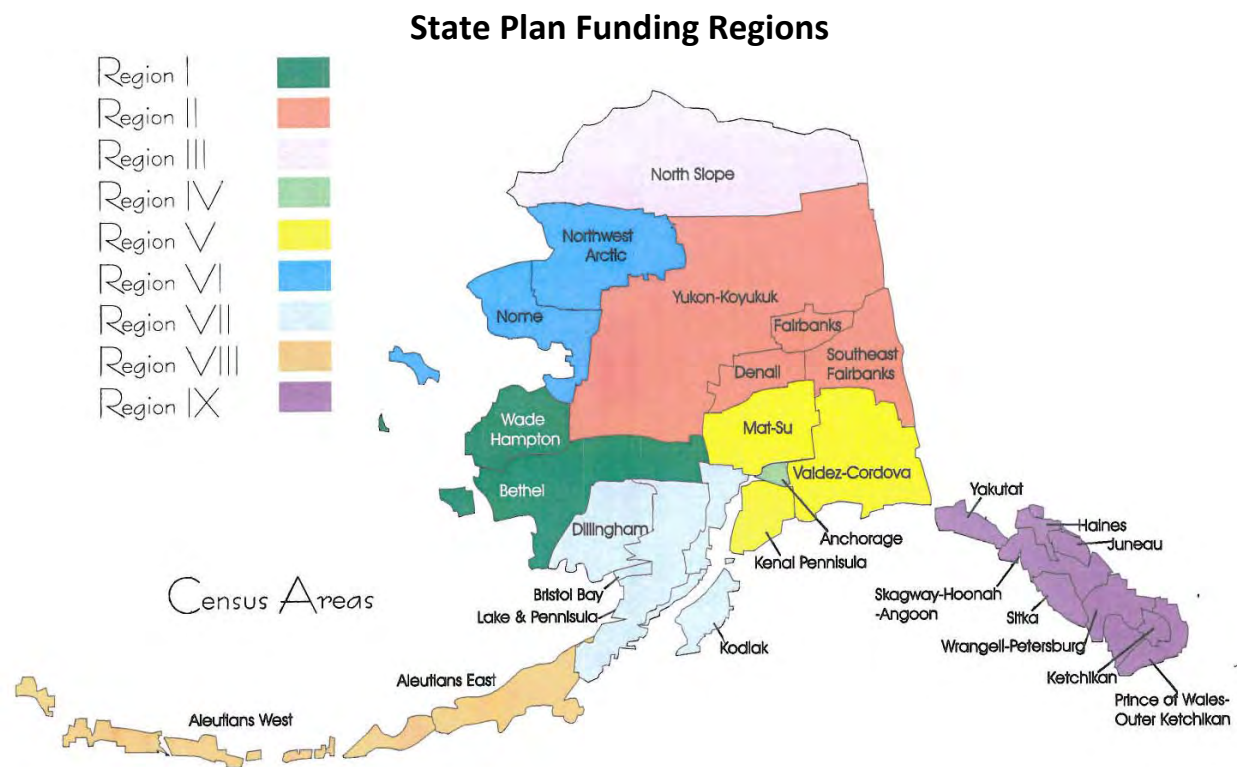
The illustrations below show how Alaska's census areas are grouped into the nine DHSS regions.

### Alaska's Census Areas



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**Application of Formula.** The state plan funding formula as described below will be applied to both federal and state funds received for the NTS (Nutrition, Transportation, and Support Services), Senior In-Home Services, and Family Caregiver Support grant programs for the FY 2012 – FY 2015 period. As in the FY 2011 actual expenditures, a total of 5.74% will be held out from total funding for statewide programs, including legal services and media services.

**Formula Factors.** The Older Americans Act mandates, in Section 305(a)(2)(C), that each state distribute funds in accordance with “(i) the geographical distribution of older individuals in the state; and (ii) the distribution among planning and service areas of older individuals with the greatest economic need and older individuals with the greatest social need, with particular attention to low-income minority individuals.”

In the past, the State of Alaska has used a funding formula based on the total number of seniors (age 60+) living in a region, the number of minority seniors, the number of seniors living in poverty, the number of seniors age 80+ (most likely to be frail and in need of services), and the number of rural seniors in the region to assign a funding allocation to each of the nine regions. This state plan’s funding formula uses similar factors, with changes to the definitions of “living in poverty” and “rural,” and also applies a cost-of-living factor based on a recent statewide study. Because Alaska’s communities range from small villages in extremely remote regions

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with severe climate challenges and no road access where all supplies must be transported by air or water, to a large metropolitan area with competition for goods and services and concentration of population producing economies of scale, the cost-of-living factor was added to reflect significant differences in costs of doing business among the state's nine regions. These costs were viewed as reflecting more than a simple urban-or-rural differential.

The Older Americans Act requires that state funding plans give preference to seniors in economic and social need. The Act defines this need as follows:

*Greatest economic need* – refers to need resulting from an income level at or below the poverty line.

*Greatest social need* – refers to need caused by the non-economic factors, which include physical and mental disabilities; language barriers; and cultural, social, or geographic isolation, including isolation caused by racial or ethnic status, that restricts an individual's ability to perform normal daily tasks or threatens his or her capacity to live independently.

The weighting factors used in the Alaska funding framework relate to both social and economic need.

**Frail Factor.** A frail older individual is defined under the Older Americans Act in Section 102(a)(22) as one who is functionally impaired because he or she is unable to perform two or more activities of daily living without substantial assistance or who, due to a cognitive or other mental impairment, requires substantial supervision in order to safeguard his or her health or safety or that of other individuals to whom he or she may pose a threat.

Alaska's state plan continues to quantify frail seniors as those people who are age 80 and older, because increased age can be correlated with a greater likelihood of need for assistance with activities of daily living, greater risk of a cognitive impairment such as AD/DRD, and greater risk of placement in an institutional setting if assistance is not available. We have increased the weight for this factor from 12.5% in the previous state plan to 16%, following the recommendation received from many of the service providers responding to our provider survey who requested that more weight be given to the oldest group of seniors.

**Minority Factor.** Minority is defined as those seniors who are not Caucasian. Beginning with the 2000 census, individuals were asked to report multiple racial and ethnic backgrounds, if applicable. We include all those who report ancestry which is wholly or partly minority, as minority seniors. We have applied a 21% weight to the minority factor, somewhat less than the 25% weight this factor received in the last state plan.

**Poverty Factor.** Using census data (or American Community Survey results), Alaska may appear to have lower poverty rates among seniors than many other areas of the country. Unfortunate-

## The Alaska State Plan for Senior Services, FY 2012 – FY 2015

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ly, the census makes no allowance for the variability in cost of living by location. In reality, the costs of commodities and services, including food, fuel, housing, health care, and many other necessities are substantially higher in Alaska. Because the 2010 census did not collect any information on income, and the American Community Survey poverty rates for Alaska seniors appear unusually low relative to participation in State programs serving low-income individuals, we have chosen to use participation in Alaska's Senior Benefits Program as our measure of poverty. The program (which provides a small monthly cash benefit) is available to any Alaskan age 65 and over with an income up to 175% of the Alaska poverty guidelines. We assign the poverty factor a weight of 23%, slightly less than the 25% weight given in the previous plan.

**Total Senior Population Factor.** The total number of seniors in each region is a major factor in the demand for services in that area. Since 2000, Alaska's senior population has grown rapidly, especially in the Railbelt area of the state, parts of which have become a retirement destination, and which also attract seniors from more remote parts of Alaska in search of greater access to services. While younger seniors, including the oldest of the baby boomer generation, are less likely to need services, their numbers alone mean that more individuals are in need of meals, rides, and other senior services. Every one of the state's nine regions has witnessed at least a 20% increase in its total senior population since 2001. We have increased the weight for this factor from 12.5% to 17%, on the recommendation of senior services providers, who see the demand for their services rising rapidly.

**Rural Factor.** After consideration, the Alaska Commission on Aging decided to apply the U.S. Census Bureau definitions of urban and rural, which is also used by the Division of Senior & Disabilities Services in reporting service data to the Administration on Aging. According to the Census Bureau's definition, urban areas include (1) an urbanized area (a central place and its adjacent densely settled territories with a combined minimum population of 50,000), and (2) an incorporated place or a census designated place with 20,000 or more inhabitants. Rural areas include any areas not defined as urban.

By this definition, the Municipality of Anchorage, the City and Borough of Juneau (served by one governmental entity), and the City of Fairbanks (though not the remainder of the Fairbanks North Star Borough, which includes a number of small cities) are counted as urban, with all other areas designated as rural. Anchorage has a 2010 population of 291,826; the City and Borough of Juneau has a 2010 population of 31,275; and the City of Fairbanks has a 2010 population of 31,535.

Both the Municipality of Anchorage and the City and Borough of Juneau were also considered urban in the previous state plan. The Fairbanks North Star Borough was apportioned into urban and rural areas in the previous plan, based on that plan's rural definition (which took into consideration a community's population, location on or off the road system, and distance from Anchorage or Fairbanks). The biggest change under the new definition of rural is that a number of smaller communities considered urban in the previous plan (including Palmer, Wasilla, Valdez, Kenai, Seward, and Homer) are now considered rural.

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The steering committee, in keeping with the intent of the Older Americans Act to encourage the directing of resources toward rural areas, believes that providing home- and community-based services in the rural and remote regions of the state to the greatest extent possible is the best way of helping Alaska seniors age in place and avoid forced moves to far-away cities where they may be isolated from not only family and friends but also from their culture, language, and traditional foods.

The weight for the rural factor has been changed to 23%, a slight change from its former 25%.

**Cost-of-Living (COL) Factor.** The essence of this factor was a combination of the degree to which a region has the infrastructure to provide services plus the cost of obtaining the necessary commodities and labor to provide those services. The steering committee felt that cost-of-living factors arrived at in a study recently funded by the State of Alaska provided the fairest assessment of a region's cost of providing services. A rural factor alone does not do justice to the difference between two rural areas, for example, a farm community in the Mat-Su Valley area, less than an hour by highway from Anchorage, and a small Alaska Native village in a remote area of the state with no roads, which receives all supplies by air or water but only when the weather is cooperative. Similar cost of living factors, based on the same study, are being used by the Department of Health & Social Services to arrive at Medicaid rates to be paid to providers in different areas of the state. This factor is not a stand-alone factor, but is applied to the subtotal of the other five factors for all nine regions.

**“Hold Harmless” Phased-In Approach.** Given the great increase in Alaska's senior population and the continuing migration of seniors to population centers, but also the fact that all regions are seeing double-digit percentage increases in their senior populations, the steering committee found it impossible to select a funding framework which would both “hold harmless” each region (guarantee no loss of funding) and also distribute funds on the basis of the shifting locations of frail, minority, low-income and rural seniors. Again, the committee's goal was, to the greatest extent possible, to have the funding formula accurately reflect the distribution of the target populations among the regions, but also to ensure that no region would be forced to absorb massive funding cuts which might cause the elimination of much-needed services.

As in the last state plan, in which the funding formula was phased in over the course of the plan's four-year period in order to minimize the effects of funding shifts among regions, this state plan also seeks to ensure that no region of the state will receive less funding because of the updated funding formula. This will be accomplished by keeping the current (FY 2011) allocation of funds in place for all regions, with only new funding (increments received for FY 2012 and beyond) distributed according to this state plan's funding formula, for the NTS Grant Program. For the Family Caregiver Grant Program and the Senior In-Home Grant Program, this funding formula will be used from the start of FY 2012. Every region received NTS funding in FY 2011, whereas some regions did not apply for and did not receive funding for Family Caregiver

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Support (FCS) or Senior In-Home Services (SIH) in FY 2011; it was felt that since a “hold harmless” provision for FCS and SIH would hold some regions at zero funding, it would be best to simply transition immediately to the new (FY 2012 – FY 2015) formula. The funding formula will not be used to fund Adult Day or Alzheimer’s Education programs. Title III (D) funds, for health promotion and disease prevention programs, also are not included in the “hold harmless” designation.

Beginning in FY 2012, all regions will receive at least the same amount of “actual” funding they received in FY 2011 for NTS grants (see Table 1). “Actual” funding for FY 2011 differed from the funding formula percentages shown in the last state plan, because of the receipt of legislative funding specifically for the purpose of eliminating any losses to regions slated to lose funds as the previous funding formula was phased in. Thus the regions which would have lost funding gained in their percentage of “actual funding,” while those regions not scheduled to lose money under the final formula ended up with a lower percentage (though they experienced no loss of funds).

Beginning in FY 2012, an amount equal to the NTS grant program funding for FY 2011 (a total of \$5,851,235) will be distributed as shown in Table 1 below. Additional funding beyond FY 2011 levels, however, will be distributed according to the percentages in the new FY 2012 – FY 2015 formula, shown in Table 2. ***When total program funding reaches the level where the use of Table 2 percentages no longer results in a funding loss to any region, all grant program funding, including NTS, will be distributed according to the percentages shown in Table 2.***

The funding formula is subject to continuation of funding at current levels or above. With a senior population growing at the rate of five to six percent per year, and as one of the few states with a current budget surplus, it is hoped that Alaska will continue to devote more resources to providing senior services. However, it is always possible that total funding may decrease at some point in the future. In that event, the funding formula would “retreat” in the reverse sequence to its implementation; in other words, if funding had reached the level where the new “Table 2” formula was in use for all grants, and then was decreased, Table 1 would go back into effect for NTS, so that no region would receive less than its FY 2011 allocation. Should total funding drop below the FY 2011 level, funding would be distributed at percentages used in earlier years, as needed.

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The FY 2011 “actual” NTS funding amounts (after allotment of 5.74% of total funding - \$356,313 - to statewide projects) equal the FY 2012 – 2015 “hold harmless” amounts, which are shown in Table I below:

**Table 1: FY 2011 Actual NTS Funding Amounts by Region**

<b>Region</b>	<b>NTS Actual \$\$</b>
Region I	\$293,733
Region II	\$829,120
Region III	\$116,434
Region IV	\$1,548,236
Region V	\$1,218,814
Region VI*	\$283,199
Region VII	\$493,848
Region VIII*	\$73,142
Region IX	\$994,709
<b>Total</b>	<b>\$5,851,235</b>

\*Using this state plan’s region numbers

In FY 2011, an additional \$395,965 was allocated to statewide programs.

The FY 2012 – FY 2015 funding percentages are as follows:

**Table 2: FY 2012 – FY 2015 Funding Shares Based on Funding Formula**

<b>Region</b>	<b>Actual %</b>
Region I	7.7732%
Region II	13.8593%
Region III	1.7152%
Region IV	27.0612%
Region V	24.4741%
Region VI*	4.9955%
Region VII	4.8546%
Region VIII*	1.8071%
Region IX	13.4597%
<b>Total</b>	<b>100.0000%</b>

\*Using this state plan’s region numbers

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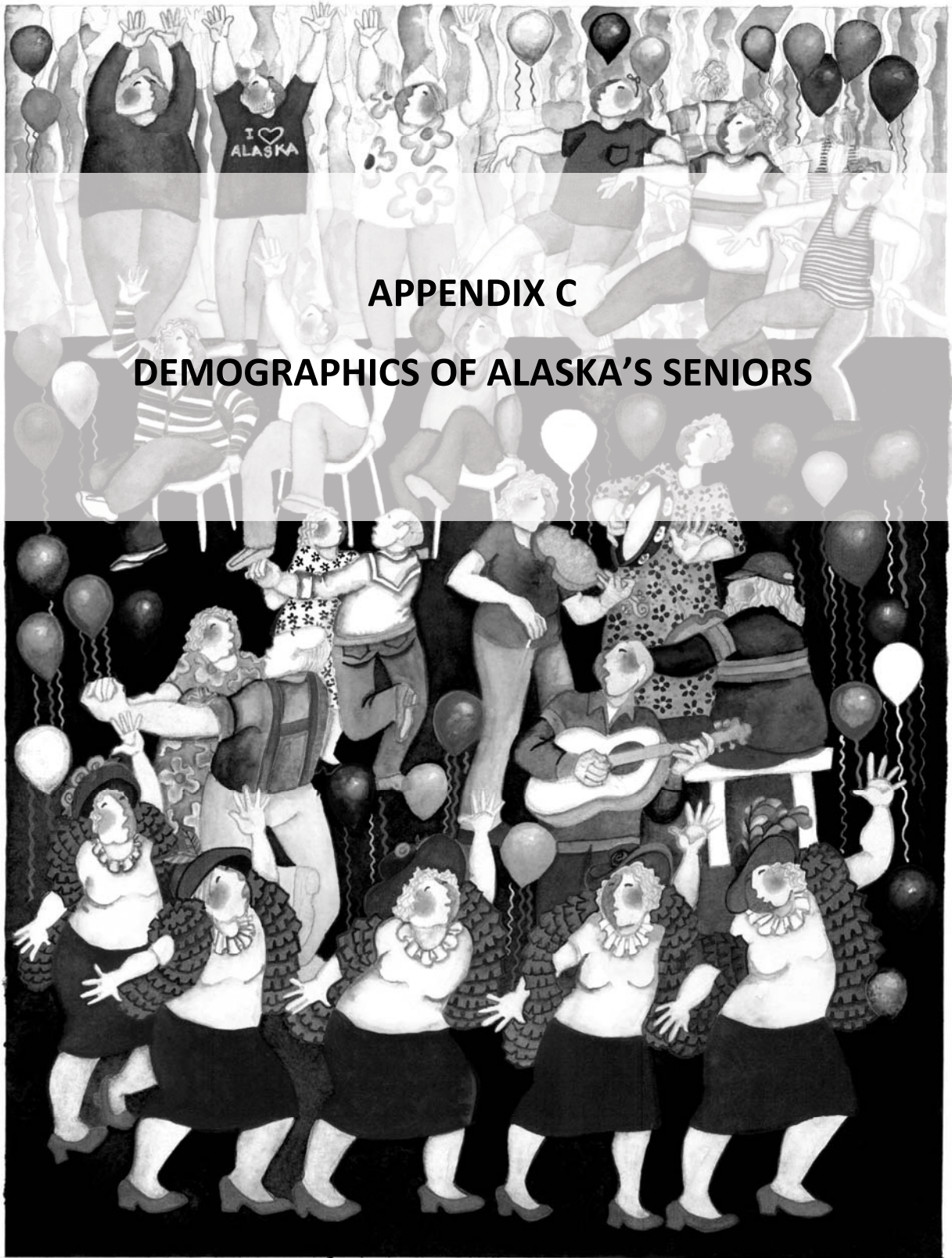
See Table 3 below for detailed data on the computation of Table 2 formula percentages.

**Table 3: FY 2012 – 2015 Funding Formula for Title III Programs**

– with NTS Regional funding to be “held harmless” at FY 2011 levels until total funding under the new formula results in no loss to any region; new funding for FY 2012 and beyond for NTS, and all Family Caregiver and Senior In-Home funding beginning in FY 2012, will use this formula. (Sample Funding of \$1,000,000; note: formula applies to remaining funds after 5.74% is held out for statewide programs)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	60+ Pop. 17% (2010)	80+ Pop. 16% (2010)	60+ Minority 21% (2010)	65+ 175% Pov. 23% (2010)	60+ Rural Pop. 23% (2010)	5-Factor Subtotal	Cost-of- Living (Applied to Subtotal)	Total Allocation (\$1 mil base)	% of Available Funds
<b>Region I</b>	<b>2,266</b>	<b>264</b>	<b>1,964</b>	<b>812</b>	<b>2,266</b>	\$56,883.83	<b>1.4</b>	\$77,731.95	<b>7.7732%</b>
Bethel Census Area	1,644	183	1,375	558	1,644				
Wade Hampton	622	81	589	254	622				
<b>Region II</b>	<b>13,179</b>	<b>1,461</b>	<b>2,374</b>	<b>1,214</b>	<b>9,647</b>	\$143,922.12	<b>1.05</b>	\$138,593.02	<b>13.8593%</b>
Denali Borough	255	8	33	13	255				
Fairbanks North Star Borough	10,950	1,240	1,572	756	7,418 (est.)				
Southeast Fairbanks	1,079	101	156	186	1,079				
Yukon-Koyukuk	895	112	613	259	895				
<b>Region III</b>	<b>856</b>	<b>68</b>	<b>512</b>	<b>38</b>	<b>856</b>	\$12,636.75	<b>1.48</b>	\$17,152.27	<b>1.7152%</b>
North Slope Borough	856	68	512	38	856				
<b>Region IV</b>	<b>35,079</b>	<b>4,348</b>	<b>8,293</b>	<b>3,642</b>	<b>0</b>	\$295,068.33	<b>1.00</b>	\$270,612.04	<b>27.0612%</b>
Anchorage	35,079	4,348	8,293	3,642	0				
<b>Region V</b>	<b>22,760</b>	<b>2,559</b>	<b>2,057</b>	<b>2,353</b>	<b>22,760</b>	\$264,217.55	<b>1.01</b>	\$244,741.46	<b>24.4741%</b>
Kenai Peninsula	9,986	1,172	827	932	9,986				
Matanuska-Susitna	11,353	1,256	948	1,249	11,353				
Valdez-Cordova	1,421	131	282	172	1,421				
<b>Region VI</b>	<b>1,681</b>	<b>206</b>	<b>1,359</b>	<b>401</b>	<b>1,681</b>	\$36,803.73	<b>1.50</b>	\$49,954.90	<b>4.9955%</b>
Nome Census Area	964	109	756	239	964				
Northwest Arctic	717	97	603	162	717				
<b>Region VII</b>	<b>2,444</b>	<b>247</b>	<b>1,330</b>	<b>421</b>	<b>2,444</b>	\$42,688.28	<b>1.24</b>	\$48,546.16	<b>4.8546%</b>
Bristol Bay Borough	139	10	67	7	139				
Dillingham	552	68	415	151	552				
Kodiak Island	1,555	148	702	224	1,555				
Lake and Peninsula	198	21	146	39	198				
<b>Region VIII</b>	<b>847</b>	<b>41</b>	<b>617</b>	<b>35</b>	<b>847</b>	\$13,136.32	<b>1.48</b>	\$18,071.30	<b>1.8071%</b>
Aleutian Islands East	326	22	259	20	326				
Aleutian Islands West	521	19	358	15	521				
<b>Region IX</b>	<b>11,764</b>	<b>1,502</b>	<b>2,862</b>	<b>1,188</b>	<b>7,269</b>	\$134,643.09	<b>1.09</b>	\$134,596.90	<b>13.4597%</b>
Haines Borough	587	62	74	83	587				
Juneau Borough	4,495	545	927	339	0				
Ketchikan Borough	2,192	329	518	251	2,192				
Prince of Wales – Outer Ketchikan	922	67	387	181	922				
Sitka Borough	1,520	267	397	97	1,520				
Skagway – Hoonah - Angoon	642	52	216	67	642				
Wrangell - Petersburg	1,296	168	277	155	1,296				
Yakutat Borough	110	12	66	15	110				
<b>TOTAL</b>	<b>90,876</b>	<b>10,696</b>	<b>21,368</b>	<b>10,104</b>	<b>47,770</b>	<b>\$1,000,000</b>		\$1,000,000	<b>100.00%</b>





**APPENDIX C**  
**DEMOGRAPHICS OF ALASKA'S SENIORS**

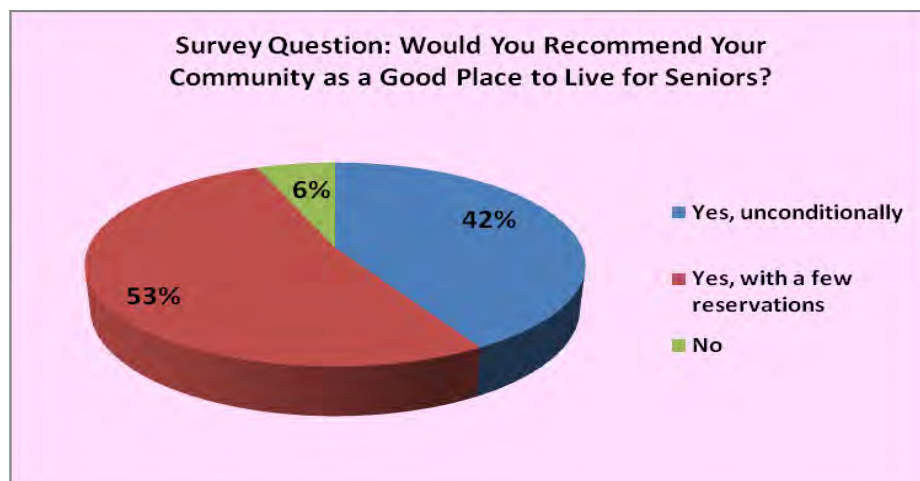
## **APPENDIX C:**

### **DEMOGRAPHICS OF ALASKA'S SENIORS**

Asked to identify the state with the fastest-growing senior population, most Americans would think of Florida, Nevada, or Arizona. Few would imagine that Alaska, land of frozen tundra and long winters where the sun is not seen for months in parts of the state, is that state. And yet according to the Administration on Aging's "A Profile of Older Americans: 2010," Alaska saw a 52.1% increase in its age 65 and older population in the decade from 1999 through 2009. This was the top growth rate in the U.S., more than 3-1/2 times the national growth rate of 14.6%.

The reason behind the rapid expansion of Alaska's senior population lies in the events of the 1970s – the construction of the Trans-Alaska Pipeline and the economic boom that oil development brought about, drawing thousands of young people to the state for newly-created jobs in every sector. Those young people established homes and families, and grew extremely fond of Alaska's lifestyle. Many of them stayed on for their entire working lives, and are now choosing to retire in the state as well (representing a shift in a long-term pattern where most seniors left the state upon retirement).

The Alaska Commission on Aging's 2010 senior survey provided a glimpse of just how much older Alaskans like living here. Asked whether they would recommend their community as a good place to live for seniors, a whopping 94% said that they would.

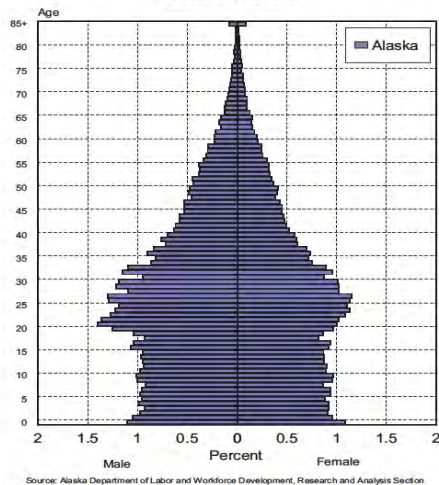


At the time of the 2000 Census, Alaska's population had the largest proportion of baby boomers (32%) of any state. At that time, the boomers (who were born between 1946 and 1964) were still middle-aged – ranging from 36 to 54 years old. By 2011, the older contingent of this population bulge was well into its senior years. The population distribution charts below, for 1977 (left) and 2009 (right), illustrate the aging of Alaska's baby boomer cohort over that 32-year period.

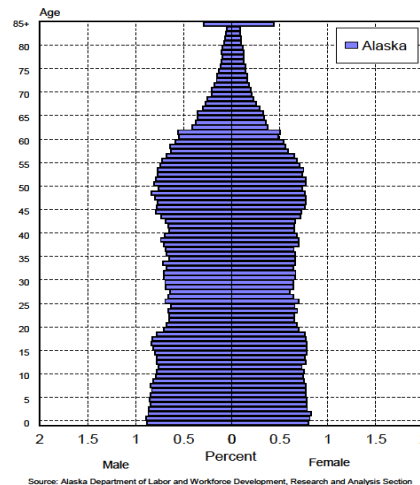
## The Alaska State Plan for Senior Services, FY 2012 – FY 2015

### *Alaska Commission on Aging*

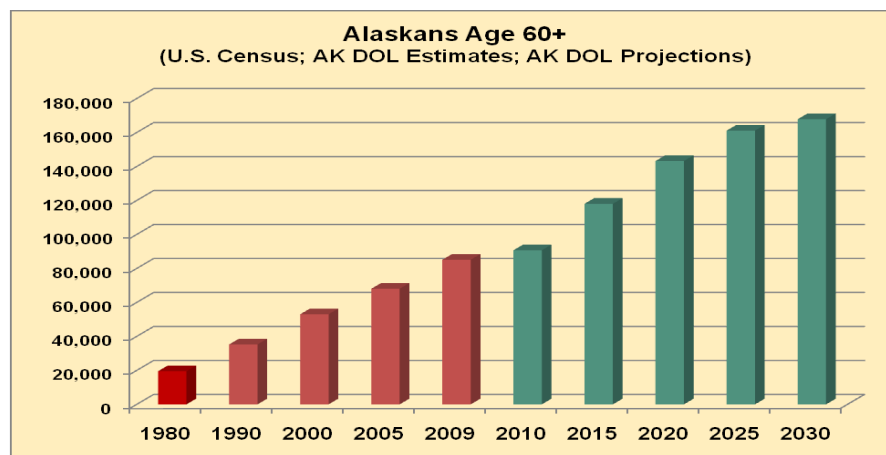
Alaska Population by Age and Sex, July 1, 1977  
Percent Distribution



Alaska Population by Age and Sex, July 1, 2009  
Percent Distribution



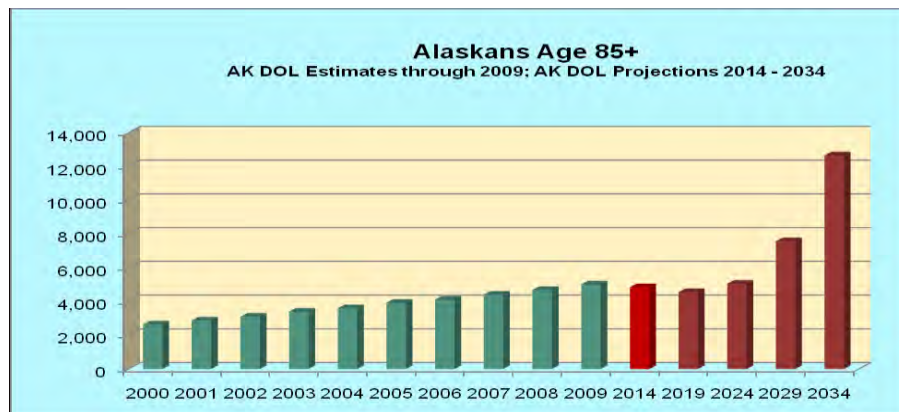
In 2009, there were 85,100 Alaskans age 60 and over, with 52,263 of them age 65 and over. This represents increases of 60.5% and 46.4% in the 60+ and 65+ populations respectively since 2000. In 2000 only 6.3% of Alaska's population consisted of those age 65 and over, the smallest proportion of any of the states; by 2009 that percentage had increased to 7.5%. The Alaska Department of Labor and Workforce Development projects that there will be 155,254 seniors by 2034, and those age 65 and over – an estimated 124,857 individuals - will make up 14.5% of the state's population at that time. (By 2030 the U.S. Census Bureau expects that 20% of the population of the United States will be 65+, with Florida still ranked number one at 27%.)



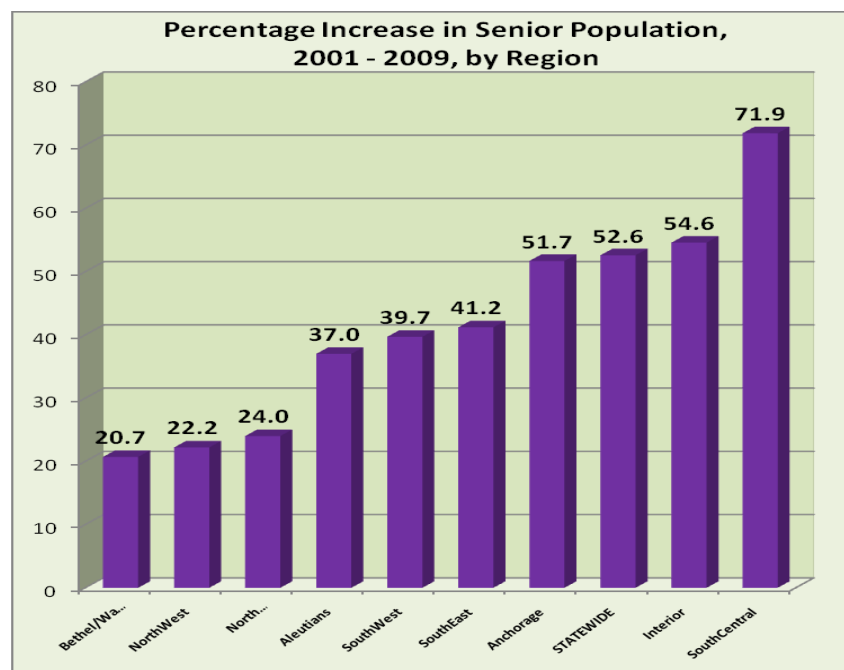
While Alaska's total senior population is expected to grow very rapidly in the next 20 years, the number of seniors age 85 and over will increase even more dramatically. Because this is the group most likely to need services, including home- and community-based services as well as long-term care, it is especially significant in terms of the need to plan for greater capacity and infrastructure.

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All of the Department of Health & Social Services' nine service regions have experienced at least a 20% increase in their senior populations from 2001 through 2009. While some regions saw far more population growth than others, there is no region of the state that is losing senior population.



Because of the size of the baby boomer population, as well as historical trends in migration and longevity, the growth of Alaska's senior population is predicted to be strong and continuous over the next 20 years. After 2030, the growth of this segment of the population will slow, but that is when the oldest boomers will begin to reach age 85, a time when their need for services is likely to become more intensive.

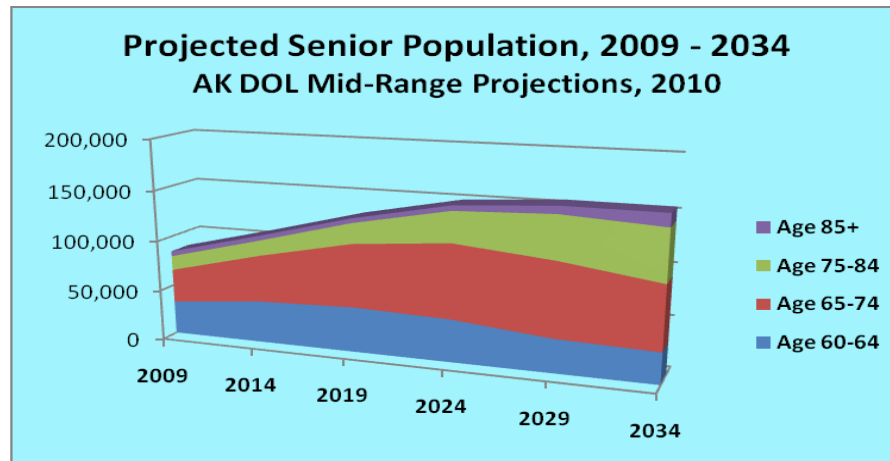
According to the Alaska Department of Labor & Workforce Development, "The population aged 65+ is largely composed of retirees. Very strong growth for this age group is expected throughout the projection period. Currently, Alaska's population aged 65+ is estimated to be 52,263 people. The most

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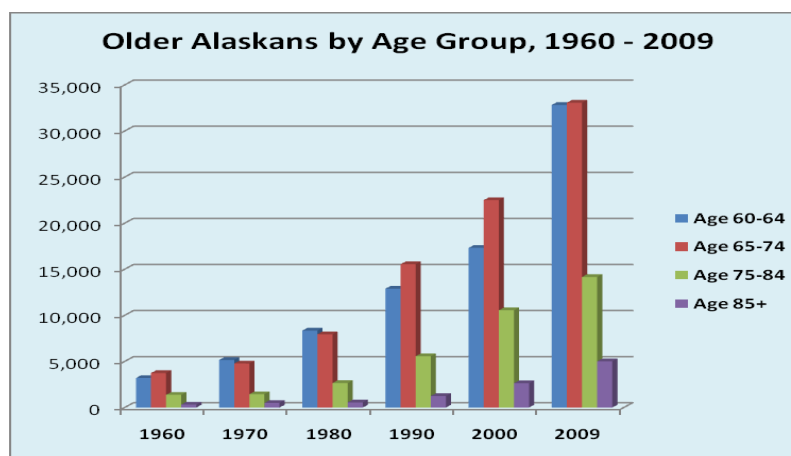
likely scenario for this group projects 124,857 people aged 65+ in 2034... This increase represents a more than doubling in size over the 25-year period. Growth in this age group is fully attributable to the large cohort of baby boomers.

The massive change in the size of the population age 65+ will play a major role in shaping Alaska's future. The growth of the senior population will surely present new challenges to find funding and build infrastructure in support of more retirees."



Over the next 25 years, the population age 60+ is projected to grow at an average annual rate of 3.3%. This is more than three times the expected rate of increase of the total population of Alaska over this time period. Already during the period from 2001 through 2009, the growth rate of Alaska's senior population has been 13 times that of the state's under-18 population (52% versus 4%).

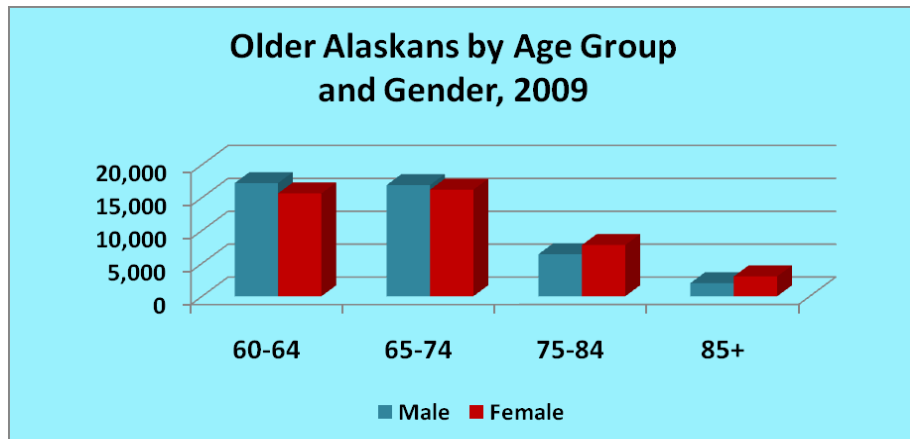
Because the characteristics of the senior population change with age, for purposes of discussion the population is sometimes divided into four groups – the near old (60 – 64), the young old (65 – 74), the old (75 – 84), and the old old (85+).



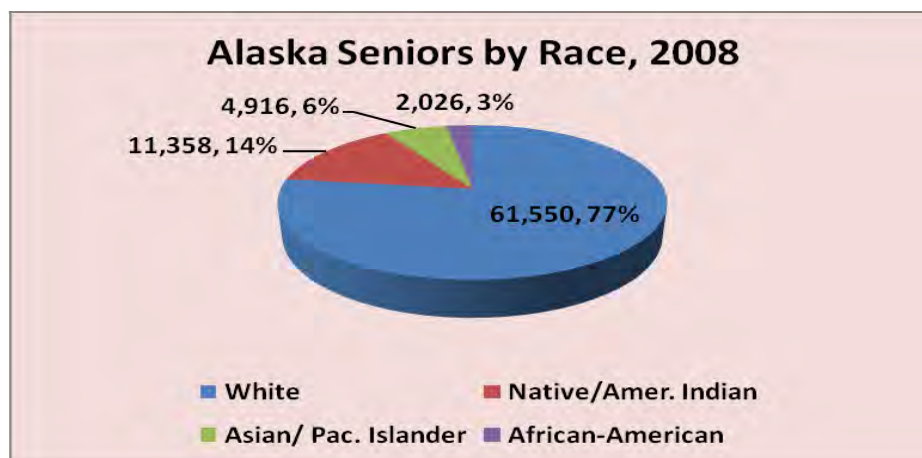


## Alaska Seniors' Population Characteristics

**Gender.** Alaska's 60+ population is evenly divided between men and women, although men predominate in the 60 – 64 and 65 – 74 age groups and women in the 75+ age groups.



**Race.** Whites and Asians are slightly over-represented among seniors, compared to the total population, while other races are slightly under-represented. For example, 76.5% of seniors 60+ are white, while only 70.4% of the total population is white; and 5.6% of seniors are Asian, compared with 4.2% of the total population. Meanwhile, only 14.9% of seniors are Alaska Native (alone or in combination with other races), although 18% of the state's total population is Alaska Native, according to estimates by the Alaska Department of Labor & Workforce Development (2009) .



African-Americans are also under-represented in the senior population. Some 2.7% of Alaska seniors are African-American while 5% of the state's total population is African-American.

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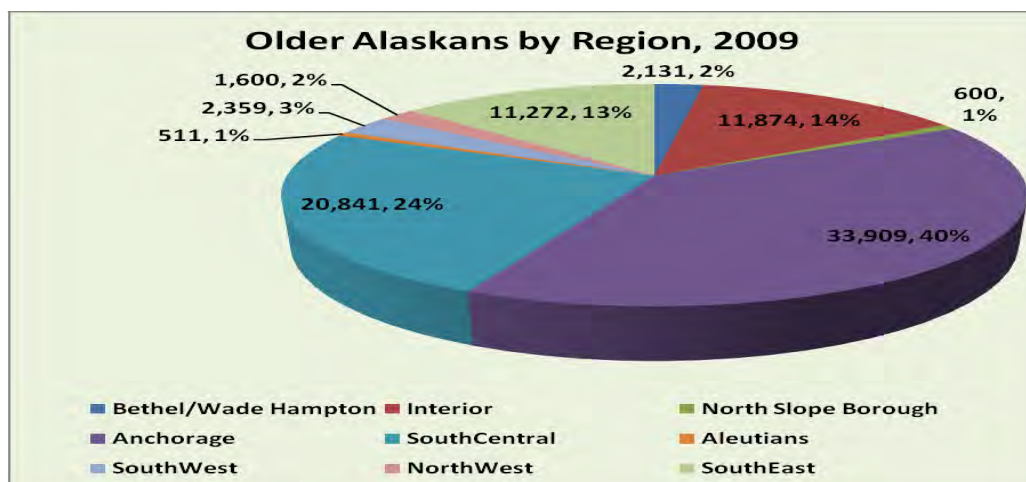
**Migration.** National demographic trends reflect changes in settlement patterns as the population ages. Seniors tend to be attracted to places with warm climates, low taxes, cultural opportunities, and other amenities. University towns as well as much of the West and South are hotspots for seniors.

The net migration rate for Alaska seniors has traditionally been negative, with many older individuals leaving the state soon after retirement. This pattern is changing as more and more older Alaskans choose to remain in the state as they age, in part because of improved systems of care and support.

**Regional Patterns.** The highest concentrations of seniors 65+ are in several of the communities in Southeast Alaska, an area of the state with generally milder temperatures. For example, in 2000, seniors aged 65+ comprised 20.5% of the population of Haines. The lowest concentration of seniors 65+ was found in the Aleutians.

The population growth rate of seniors also varies across the state. Anchorage (the state's largest city) had the largest numerical increase during the 2000s, but the fastest rate of increase was in the Matanuska-Susitna Borough, which experienced an increase of 72% from 2001 through 2009.

In general, senior population growth was more rapid in the Railbelt (Anchorage, Kenai, Mat-Su, Fairbanks, and Southeast Fairbanks census areas) as compared to the remainder of the state. Nonetheless there were at least 20% more seniors in every region of the state at the end of the decade compared to the start. There is no area of the state that is losing senior population.

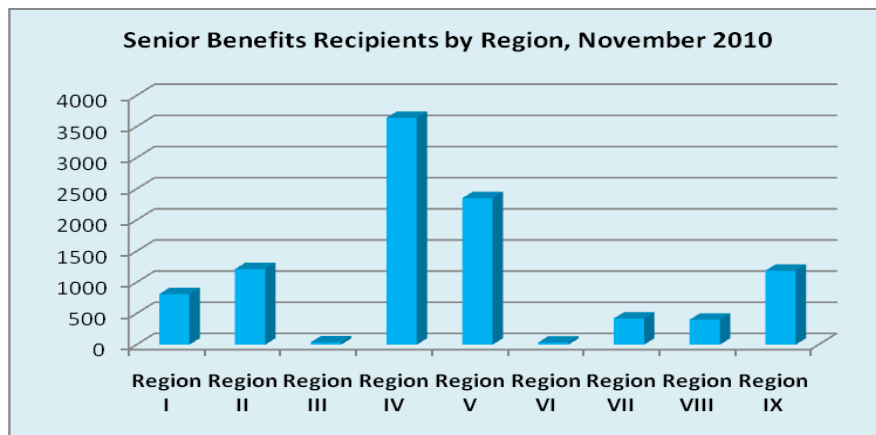


One of the factors contributing to the relatively rapid growth rate of the senior population in the Railbelt is the movement of seniors from rural to urban Alaska, a trend which is projected to continue well into the future.

**Income and Poverty.** Approximately one in five Alaskans age 65 and older receives a monthly cash benefit through Alaska's Senior Benefits Program, which assists those with incomes up to 175% of the Alaska poverty level.

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Region I = Bethel/Wade Hampton

Region II = Fairbanks/Interior

Region III = North Slope

Region IV = Anchorage

Region V = Southcentral

Region VI = Aleutians

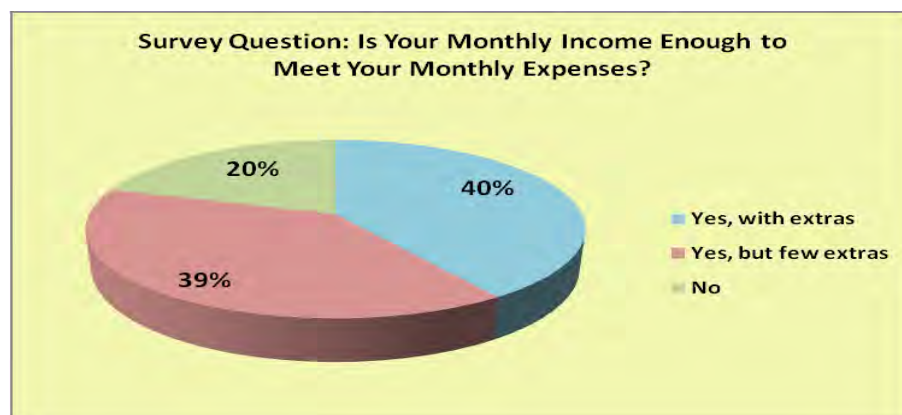
Region VII = Southwest

Region VIII = Northwest

Region IX = Southeast

**NOTE:** The Department of Health & Social Services issued a memo on June 10, 2011 clarifying that the Aleutian Region is now considered Region VIII and the Northwest Region is now considered Region VI.

Senior surveys conducted by the Alaska Commission on Aging in 2005 and 2010 also found that about one in five of those responding reported they did not have enough monthly income to pay for all the necessities. Another two in five said they were barely getting by. Changing economic trends, such as elimination of defined benefit pensions, lower retirement savings due to stagnant wages, possible diminishment of Social Security and Medicare benefits, and greater investment volatility, may portend more financial stress for future seniors during their retirement years.



Alaska seniors are more likely to be participants in the labor market (see Labor Force Participation section below). The main sources of income for seniors who are not working include Social Security, retirement pensions, and dividends/interest/rent. Social Security provides a higher proportion of retirement income for low-income seniors than for other groups, frequently helping to prevent a plunge into poverty.



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A new Census Bureau analysis which calculated poverty rates by including the costs of medical care and other common costs of living found a poverty rate of 16.1% among Americans age 65 and older. This rate is higher than the 14.3% poverty rate for the overall U.S. population. While Alaska seniors tend to have higher average incomes than U.S. seniors, the cost of living in Alaska (not considered in Census Bureau calculations) is also considerably higher.

**Alaska Natives.** Approximately 15 percent of Alaskan seniors are Alaska Natives. While many live in extremely remote communities, unconnected by road to the state's urban centers, there has been an increasing trend for Native elders to migrate to the Railbelt region, particularly Anchorage and Fairbanks, to be closer to more specialized health care, to obtain assisted living or nursing home care, and often to live near family members who have migrated to the city for greater opportunity. While many move by choice, others move to a hub community or urban area for care unavailable in their home villages, despite their desire to continue living in their home communities where they are immersed in familiar culture, language, foods, and social networks.

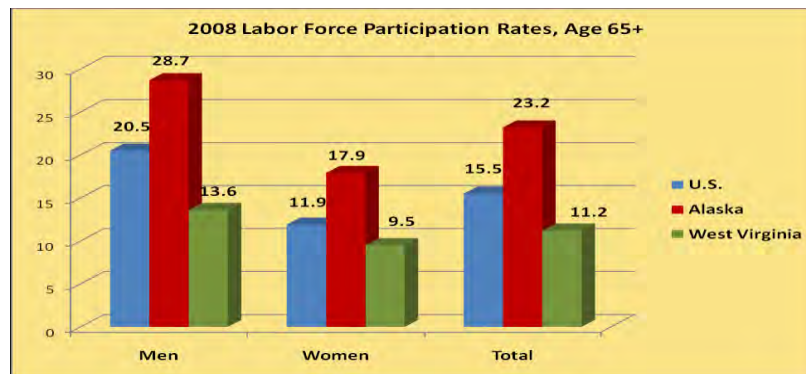
Urban health care and service providers may lack an understanding of Native culture. As members of a collective culture which assigns a deeply meaningful role to its elders, Alaska Natives do not “retire” or disengage from society; they retain an important role, acting as transmitters of valued cultural knowledge. Native elders can cease to feel a sense of connection and meaning when they are away from their families, communities, and tribes. Elders often speak indirectly in metaphors and stories, as English may not be their first language. Access to traditional Native foods is essential for elders' health and well-being. Finally, the long-term effects of mass trauma such as Native children's forced removal from their homes and communities to distant boarding schools; the destruction of Native languages, spiritual practices, and cultural traditions; the influence of western commercial culture; and the influenza and tuberculosis epidemics of the early 20<sup>th</sup> century are all traumas still impacting living Natives today.

In the past, Native elders were cared for at home by members of their extended families. Today, with longer life spans, smaller families, and more geographic dispersion of family members, many elders do not have a traditional support system which would help them to remain living in their villages. Supported senior housing and assisted living facilities are needed in the rural hub communities that serve a network of Native villages. For elders who remain at home, help with household chores and shopping is a priority.

**Labor Force Participation.** The labor force participation rate is the proportion of the population that is either working or looking for a job. A striking feature of the current recession has been the decline of labor force participation. However, the one age group in which labor force participation has been increasing rather than declining has been the age 65 and older group. In fact, senior labor force participation rates are now at their highest levels on record. It's likely that people close to or past retirement age feel the need to continue working (or to return to work) because their retirement savings have shrunk during the recent financial crisis. While older women have lower labor force participation rates, their rates are growing much faster than older men's.

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More Alaska seniors are in the labor market than are seniors nationally and these seniors are engaged in a wide variety of work. Alaskans age 65 and over have the highest labor force participation rate for that age group in the U.S.; West Virginia residents age 65+ have the lowest rates. Seniors work in all occupations and industries.

### Senior Economic Contributions

Seniors make an enormous contribution to Alaska's economy and to the well-being of its communities. While seniors require continuum of care services to be in place in their communities, policy-makers and the public must also recognize the irreplaceable role of older Alaskans in the economic life of those communities.

In 2010, it is estimated that retired Alaskans age 60 and older brought in at least \$1.7 billion to Alaska's economy, primarily from retirement income and health care spending. The cash seniors contribute to the economy can be viewed as a separate economic enterprise or industry, more lucrative than other important Alaskan industries such as tourism, mining, seafood, and international air cargo.

Seniors spend their retirement income on a broad range of goods and services in Alaska. This local spending has an economic multiplier effect resulting in the creation of Alaskan jobs and the generation of income that further expands the size of the economy. In comparison, for example, the harvest of the fishing industry has an annual value in excess of \$1 billion, with a wholesale value of over \$2 billion after processing. However, Alaska residents hold only 36 percent of the full-time jobs in the seafood industry. A lower share of the income generated by the fishing industry remains in Alaskan communities.

In spite of the amount of public funds spent on services for seniors, the "retirement industry" is a very healthy enterprise for Alaska's economy. Some of its many advantages relative to other industries are:

- **Local spending** – most of the incoming money is spent within Alaska's economy
- **Diverse job mix** – senior spending creates jobs in trades and services as well as high-paying jobs in health care
- **Year-round employment** – there is very little seasonality involved in senior spending
- **Stability** – the level of economic activity in the senior sector is stable from year to year, and does not depend on fluctuating world market conditions

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- **Environmentally benign** – senior spending does not create any significant adverse effects on the natural environment
- **Compatible with other industries** – senior spending does not compete with other industries for scarce resources
- **Non-enclave** – the economic impacts of senior spending occur throughout the state; they are not concentrated in remote rural areas
- **Stable potential tax base** – the incomes and seniors and of service providers, including the health care sector, create an important potential state and local tax base which remains stable from year to year and
- **Economies of scale** – senior spending fosters economies of scale in the provision of goods and services; especially in the health care industry, it allows fixed costs of operations to be spread over a larger customer base, thus reducing unit costs for all Alaskans.

In addition to their cash contributions to the economy, Alaskan seniors act in a wide range of volunteer capacities in service to their communities in addition to providing much unpaid caregiving to family members and friends. According to the University of Alaska's Institute for Social and Economic Research (ISER) the economic value of these contributions is estimated to be \$60 to \$100 million annually.

A 2010 study of all 50 states by the Corporation for National and Community Service (CNCS) found that Alaska had the fifth highest rate of volunteerism, with 37.3% of the population age 16 and older participating in volunteer efforts. The 2010 senior survey conducted by the Alaska Commission on Aging found that at least 50% of the Alaskan seniors responding volunteer their services to the community on a regular basis.

Many seniors fill the role of family caregiver. Among the ACoA survey respondents, 22% said they provided this type of care, with ten percent caring for a spouse or partner, four percent caring for a child or grandchild under age 18, three percent caring for a parent, three percent caring for a disabled family member under age 60, three percent caring for a friend age 60 or older, and three percent acting as a long-distance caregiver for an elder who lives elsewhere.

For all these reasons, in addition to the important role of seniors as keepers of the history and culture of their communities, older Alaskans are clearly an invaluable resource for the state, their families, and communities.

## **Health of Alaskan Seniors**

In spite of the fact that Americans pay far more for their health care than residents of any other country, our overall health is relatively poor compared with other developed nations and some developing countries. At least 49 countries have a longer life expectancy than the United States, including Bermuda, Jordan, Bosnia/Herzegovina, Puerto Rico and Portugal. There are a variety of reasons for the discrepancy between our high U.S. health care expenditures and our underperforming health outcomes, but two key factors include lack of prevention and health maintenance and the disparities in population groups seen in this country – not only disparities in access to health care but wide gaps in income and opportunity. Research shows that those states or countries with the widest income disparities tend to have poorer

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health as a whole, regardless of access to care. Living in a highly economically stratified society is hazardous to the health of the affluent and the poor alike.

According to population health specialist Dr. Stephen Bezruchka, senior lecturer with the University of Washington Department of Global Health, programs such as the Alaska Permanent Fund Dividend and Alaska's Senior Benefits Program operate as population-wide income equalizers, and in that sense can be expected to have a positive impact on the health of Alaskans overall.

Generally, seniors today do live longer and remain in better health than their predecessors. Better health and improved medical treatments translate into far fewer deaths from *acute* causes. Today the most common causes of death are heart disease, cancer, stroke, chronic respiratory disease, injury, and diabetes.

It is important to note that although people are generally living longer and remaining in better health, several studies have documented the persistent problem of shortened life expectancies for individuals with behavioral health disorders. Adults with serious mental disorders die an average of 25 years earlier than their counterparts (Colton, 2006). Studies have shown that Individuals with serious mental illness have more physical illness and receive worse medical care (Viron and Stern, 2010). Premature death contributes to lower prevalence of behavioral health disorders among the elderly. Though these disparities exists, efforts are underway that have already helped individuals with behavioral health disorders live longer than they have in the past. These two realities place unique challenges on our systems of care.

A longer life means that a large share of the senior population may experience dementia, disabilities, and/or periods of frailty in their later years. The cost of their care may place seniors in an economically stressful position. Most seniors can expect to be chronically ill for an extended period at the end of their lives. But the health care system traditionally is oriented toward acute care, and has been slow to adapt to the chronic illness and disability that elderly Americans are likely to face.

As improvements help individuals with disabilities live longer lives, our systems of care must be redesigned to provide better support as they age. Within families, seniors are increasingly called upon to take care of their adult children with physical, behavioral, and cognitive disabilities. Likewise, seniors are more often faced with the difficult decision of how best to provide for their adult children with disabilities after they, their child's primary care provider, are no longer able to take care of them. Residential care and other support options for adults with chronic severe disabilities in Alaska remain limited.

Initiatives to reform healthcare, whether transforming a system responsive to acute problems to a system better able to support chronic care management, focusing on preventative care, or integrating physical health care with other specialty care to address the whole health needs of the person, these improvements require additional resources.

In 2005, Alaskans had a life expectancy of 78.5 years, slightly higher than the national life expectancy of 78 years. Life expectancy at age 65 increased from 12 additional years in 1900 to 18.6 more years in 2007 (that is, an average 65-year-old in 1900 could expect to live another 12 years, till age 77; an average 65-year-old in 2007 could expect to live another 18.6 years, till he or she was over 83 years old).

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When comparing age-adjusted death rates for those ages 65 and over, the Alaska rate is 15.4 percent below the U.S. rate (for 2007). (The age-adjusted death rate shows how many people out of every 100,000 in a particular age group died during a given time period.) Male seniors in Alaska and the U.S. have higher age-adjusted death rates than females. The risk of death also differs by race in Alaska. Alaska Natives consistently have the highest age-adjusted death rates of any racial group in Alaska, while Asian/Pacific Islanders consistently have the lowest.

### Death Rates (per 100,000) for Age 55+ by Age Group and Race, Alaska and the U.S., 2009

Age Group	U.S. Total	Alaska Total	Alaska Asian	Alaska Black	Alaska Native	Alaska White
55 – 64	871.3	727.4	569.1	869.6	1,220.4	650.5
65 – 74	1,928.5	1,973.9	1,154.0	1,536.3	2,831.6	1,869.5
75 – 84	4,775.1	5,208.2	2,101.2	2,924.0	6,446.2	5,283.4
85+	13,021.1	11,988.8	7,329.8	6,278.0	15,804.6	12,015.1

### Death Rates (per 100,000) for Age 65+ by Cause of Death, Alaska and the U.S., 2007

Cause of Death	Alaska Age-Specific Rate	U.S. Age-Specific Rate
Heart Disease	862.8	1,310.1
Cancer	1,011.5	1,029.2
Stroke	286.9	306.2
Chronic Lower Respiratory Disease	291.1	289.3
Cause of Death	Alaska Age-Specific Rate	U.S. Age-Specific Rate
Alzheimer's Disease	136.0	194.9
Influenza and Pneumonia	74.4	121.3
Diabetes Mellitus	127.5	136.1
Nephritis, Nephrosis, Nephrotic Syndrome	63.8	101.6
Unintentional Injuries (Accidents)	102.0	101.1
Suicide	20.7 (2005 – 2009)	14.3 (2007)
Alcohol-Induced Death	38.8 (2005 – 2009)	11.9 (2007)
Drug-Induced Death	8.0 (2005 – 2009)	4.4 (2007)
All Causes	3,920.8	4,636.1

The above table illustrates Alaska seniors' overall lower age-specific death rate as well as lower disease-specific death rates for most of the major causes of death, with the exceptions of chronic lower

respiratory diseases, unintentional injuries, suicide, and alcohol- and drug-induced deaths. In other words, causes of death involving a behavioral factor (accidents, suicide, alcohol, drugs) are the areas where older Alaskans are at especially increased risk – and, perhaps where we can have the greatest impact in improving health and quality of life.

### **Health Risk Factors**

According to the Behavioral Risk Factor Surveillance System (BRFSS), an ongoing national telephone survey of adults conducted by states in conjunction with the Centers for Disease Control and Prevention, Alaskan Seniors (age 65+) are less likely than seniors nationally to have been diagnosed with diabetes or high blood pressure, less likely to describe themselves as being in fair or poor health, and more likely to engage in at least one moderate physical activity.

On the other hand, Alaska seniors are more likely to say they do not have health care coverage, are more likely to smoke, drink heavily or binge drink, more likely to be obese, and more likely to report having a disability that prevents them from engaging in certain activities.

According to the BRFSS, 38.3% of Alaskan seniors age 65+ say that they are limited in their activities because of a physical, emotional or mental disability. This is 25% higher than the 30.6% rate of U.S. seniors age 65+ who report being disabled. In the Alaska Commission on Aging's 2010 senior survey, 59 percent of seniors indicated that they had an illness or disability that limits the range of activities they can enjoy. This included 35% with a physical disability, 22% with a chronic disease, 20% with other physical health problems, five percent with a mental or emotional problem, and one percent with Alzheimer's disease or other type of dementia (responders could indicate more than one type of disability).

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### 2009 Behavioral Risk Factor Surveillance Data

Risk Factor	AK 65+	U.S. 65+	AK All Ages	U.S. All Ages
Current Smoker	8.6%	8.2%	20.6%	17.9%
Current Drinker	39.9%	41.0%	55.2%	54.4%
Heavy Drinker *	4.1%	3.1%	6.2%	5.1%
Binge Drinker **	5.1%	3.5%	17.9%	15.8%
Obese	30.7%	24.1%	25.4%	26.9%
Diabetes	18.3%	19.0%	5.8%	8.3%
High Blood Pressure	57.5%	59.1%	26.4%	28.7%
Exercise#	67.9%	67.0%	77.6%	76.2%
Fruits & Vegetables##	24.7%	27.6%	23.4%	23.4%
Fair or Poor Health	19.1%	24.7%	11.3%	14.2%
Physical Activity###	48.4%	40.3%	60.7%	51.0%
Health Care Coverage	97.2%	98.2%	82.3%	85.6%
High Cholesterol	55.1%	53.3%	35.0%	37.5%
Disability	38.3%	30.6%	21.4%	18.9%

\*Heavy drinkers: adult men who have more than two drinks per day, or adult women who have more than one drink per day

\*\*Binge drinkers: having more than five drinks on one occasion

\*\*\*Disability: limited in activities because of physical, mental, or emotional problems

#Exercise: participated in physical activity during past month

##Fruits and vegetables: eat five or more fruits and vegetables daily

###Physical activity: moderate exercise for 30 minutes or more at least five times a week, or vigorous exercise for 20 minutes or more at least three times a week

Source: Behavioral risk Factor Surveillance System (BRFSS)

As the table below shows, the National Survey on Drug Use and Health (NSDUH) corroborates the local findings above from our in-state Behavioral Risk Factor Surveillance System.

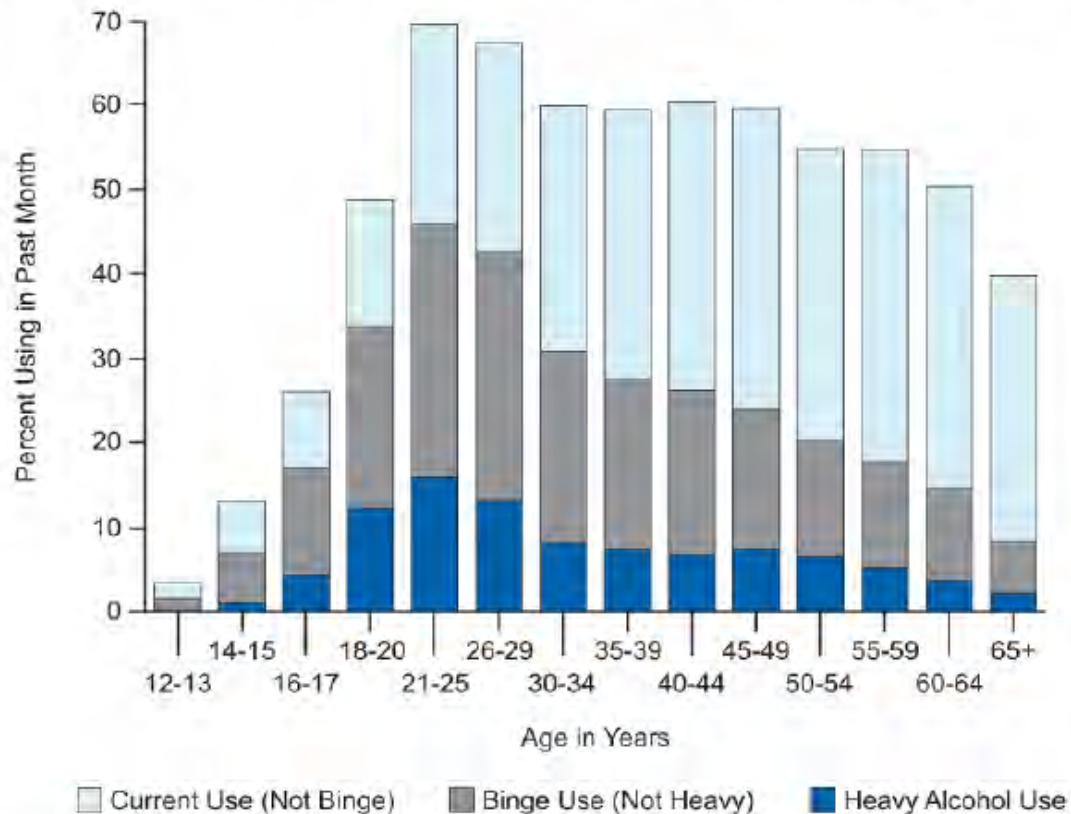
When surveyed, 39.7% persons aged 65 or older used alcohol in the past month, of these 6.1% are classified as binge drinkers and 2.2% are classified as heavy drinkers.

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### *Prevalence Estimates from the National Survey on Drug Use and Health*

#### Current, Binge, and Heavy Alcohol Use among Persons Aged 12 or Older, by Age: 2008



Source: Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD.

Available online at: <http://www.oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.htm#Fig3-1>

The State's Epidemiological Profile on Substance Use, Abuse, and Dependency found a strong association between substance abuse here in Alaska and the state's leading causes of premature death (including chronic liver disease, cirrhosis, homicide, suicide, and unintentional injuries). Their study links the behaviors reported in BRFSS and NSDUH (included above) with the consequences we see affecting the longevity and quality of life here in Alaska. An excerpt of the report focusing on senior health follows. The complete report is available online and from the Division of Behavioral Health.

Alaska strives to meet the behavioral health needs of its senior population, though struggles with effective strategies for outreach, early identification, treatment, and recovery supports for this age group.

Indicators of problems with alcohol, drugs, and/or mental illness typically present themselves in school, the workplace, and other public settings. Seniors living with these problems can isolate themselves from



their community, making it difficult to identify seniors with behavioral health needs and support them toward wellness.

Additionally, two prominent forms of stigma work against recovery for seniors with behavioral health disorders. The first is the stigma against mental illness and substance use disorders. Concerns over how friends, family, and the community at large will treat a person following a disclosure of a mental illness and/or substance abuse problem inhibit people from asking for the help they need. This form of stigma is so pervasive that we believe seniors may be under-reporting problems on self-reported surveys (such as those used with BRFSS and NSDUH, and even the senior needs survey used for this State Senior Plan for Services). While the first form of stigma is centered on attitudes surrounding behavioral health, the second is an aspect of the larger disparate treatment of seniors rooted in ageism. Dismissing depression and other mental illness as merely the inevitable result of aging, or passively allowing seniors to isolate from their community as they struggle with alcoholism and addictions by rationalizing it as their right, prevents people from getting the help they need.

### **Prevalence of Mental Illness, Substance Use Disorders, and Alzheimer's Disease and Related Disorders**

The State of Alaska contracted with the Western Interstate Commission for Higher Education (WICHE) to help determine the prevalence of serious behavioral health disorders in Alaska, including serious mental illness (SMI), substance use disorders (SUD), co-occurring disorders (CoD), and serious emotional disturbances (SED).

An excerpt of the report follows. The complete report is available online and from the Division of Behavioral Health.

Prevalence estimates are the basis for estimating need for services. Estimates of the need for services may be combined with counts of individuals served to provide indicators in two areas:

- 1) Indicators of the equitability of services (penetration rates).
- 2) Indicators of unmet need.

Indicators of the equitability of services may be assessed by comparing penetration rates for demographic and geographic areas. Penetration rates are calculated by dividing the number served by the number in need. A large discrepancy in the penetration rates for males versus females for instance would lead to discussion among stakeholders and possible analysis of other indicators to validate the discrepancy. This could then potentially lead to some changes to the service system.

Such prevalence rates would be difficult to interpret without having a good understanding of the amount of services provided to clients in addition to the number served. A region might conduct a large number of evaluations but provide very limited services and have a high prevalence rate.

Without assessing the amount of services an inaccurate opinion could be formed. The preferred approach is to add to prevalence estimates either an estimate of the amount of services needed in various groups or a minimum amount that might be considered adequate on average for the group.

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Then the next phase looking at the number of clients served would also include the amount of services received. Comparing the data on estimated amount of services needed with the amount received then would provide more valid indicators of disparities in care.

Indicators of unmet need would be calculated by subtracting the number served from the number in need. These indicators would also be calculated for various demographic and geographic groups. Large discrepancies would lead to actions similar to discrepancies in penetration rates. These indicators would be greatly improved by the addition of the amount of services similar to the value for penetration rates.

The prevalence estimates in this report are just the first step in the project. The next phase will add information developing the two indicators identified. Two noteworthy additions being Prevalence Report considered include an assessment of the demand for services and the addition of estimates of the amount of services needed.

A word of caution is in order prior to any consideration of making changes to the service system. Indicators are only what the word says; they ‘indicate’ what is going on in the service system. A set of indicators from one source may be supplemented with indicators from other sources and they should always be reviewed and discussed by a knowledgeable group of stakeholders prior to deciding on any action steps. The ultimate goal is to have quantifiable data to build indicators of unmet need and disparities in care for the various target groups across demographic groups in all areas of the State. The final indicators generated in this project may be used for:

- Planning to help target needed services for individuals in geographic areas and for demographic sub-populations (age, sex, race/ethnicity)
- Advocacy for individuals with serious behavioral health disorders who are not served
- Policy discussion

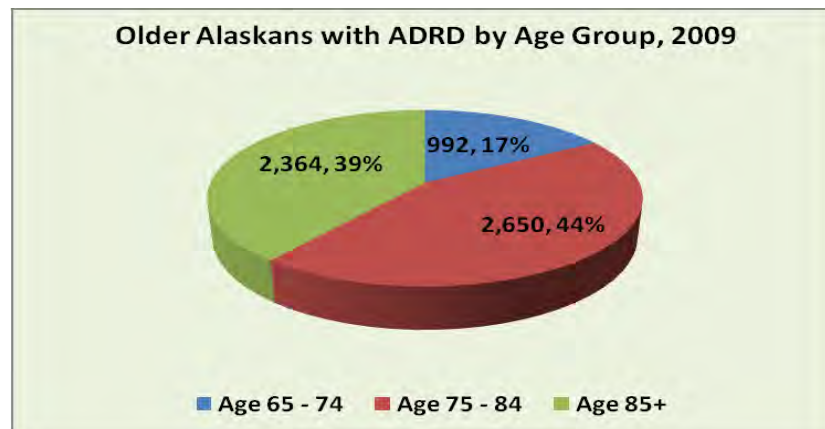
Findings should be integrated with other data and knowledge from stakeholders to inform decision-making. Limitations of findings should be recognized.

### **Alzheimer’s Disease and Related Disorders.**

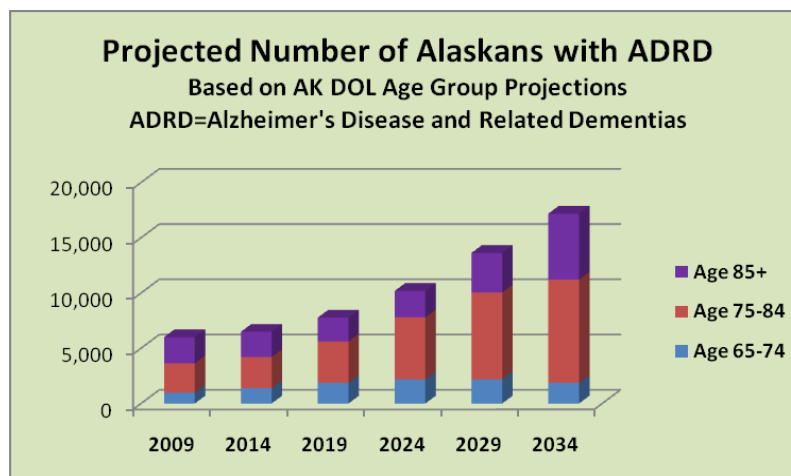
Over five million Americans currently have Alzheimer’s disease. There has been no prevalence study done in Alaska, but Alaska Commission on Aging estimates based on national prevalence rates suggest that there are approximately 6,000 Alaskans age 65 and older with this disease (applying estimated prevalence rates of 3% in the population age 65 – 74, 18.7% in those age 75 – 84, and 47.2% of those age 85 and older, to Alaska’s estimated 2009 population in those age groups). In total, 11.5 percent of Alaskans age 65 and older may have Alzheimer’s disease or a related disorder (ADRD).

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The number and percentage of the population with ADRD is expected to increase along with the growing proportion of older individuals in the population, attributable to greater longevity and the aging of the baby boomers. The rate of increase of Alzheimer's disease in Alaska is expected to be one of the highest, as Alaska has the fastest-growing population of seniors in the U.S. By 2034, some 17,186 Alaskans age 65 and older may have Alzheimer's, based on application of national prevalence rates to age group projections by the Alaska Department of Labor & Workforce Development. This represents a near-tripling of the number of individuals with ADRD in the state today.



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**Injuries.** Injuries are a major cause of pain, distress and costly medical care for Alaskans of all ages, and almost all of them are preventable.

### Five Leading Causes of Fatal Injuries in Older Alaskans by Age Group, 2005 - 2009

Rank	Ages 55 – 64	Ages 65 – 74	Ages 75 - 84	Age 85+
1	Suicide	Suicide	Falls	Falls
2	MV Traffic	MV Traffic	Suicide	Suicide
3	Poisoning	Falls	Suffocation	Suffocation
4	Drowning	Poisoning	MV Traffic	
5	Assault	Fire	Hypothermia / Frostbite	

Suicide among Alaska seniors is 45% more common than for seniors nationwide. This parallels the higher risk of suicide among younger Alaskans. While reasons for the higher rates of suicide among Alaskan seniors are not completely known, there is some evidence that colder, darker northern climates are more conducive to depression and it may be difficult for seniors to access behavioral health care, such as treatment for depression, in many Alaskan communities (data on utilization by seniors of behavioral services contracted through the Alaska Division of Behavioral Health is included in Appendix F, State of Alaska Programs and Services for Older Alaskans).

### Ten Leading Causes of Non-Fatal Hospitalized Injuries in Older Alaskans by Age Group, 2005 – 2009

Rank	Ages 55 – 64	Ages 65 – 74	Ages 75 – 84	Ages 85+
1	Falls (1,253)	Falls (998)	Falls (1,156)	Falls (796)
2	MV Traffic	MV Traffic	MV Traffic	MV Traffic
3	Suicide	Acc. Struck	Acc. Struck	Acc. Struck
4	Assault	Suicide	ATV	Hypothermia / Frostbite
5	Acc. Struck	Cut	Suicide	
6	Machinery	Hypothermia / Frostbite	Hypothermia / Frostbite	
7	Cut	(Tie) ATV, Fire/Flame	Assault	
8	(Tie) ATV, Bicycle	Snow Machine	(Tie) Fire, Pedestrian, Sports	
9	(Tie) Hypothermia / Frostbite, Pedestrian	Pedestrian		
10	Strain	Sports		

Falls in Alaska are the number one source of non-fatal hospitalized injuries in every age group but two (the 15 – 24 and the 25 – 34 age groups), making falls a serious public health problem. Between 2005

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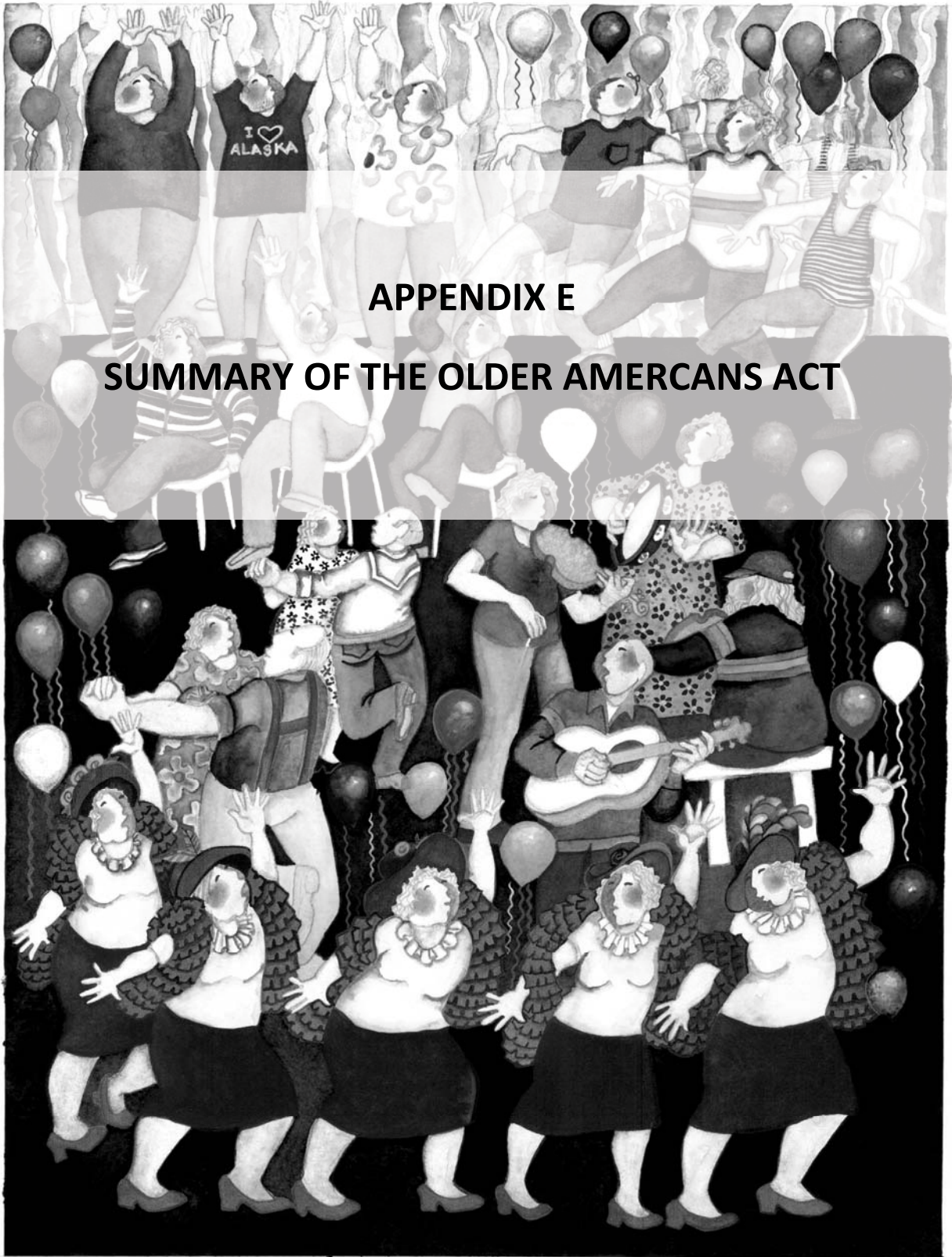
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and 2009, hospitals reported treating 4,203 non-fatal falls in Alaskans age 55 and older. During that period, there were 72 fatal falls in those age 55 and older.

Contributing risk factors to elder falls included pre-existing medical conditions, residing in nursing homes or assisted living facilities, and suspected alcohol use. Research indicates that use of narcotic pain-killers, anti-convulsants, or anti-depressants is a significant independent predictor of sustaining a serious fall. According to the Centers for Disease Control and Prevention, taking four or more medications of any kind, or any psychoactive medication(s), is a modifiable fall risk factor and seniors should ask their doctor or pharmacist to review all medications (prescription and over-the-counter) to reduce side effects and drug interactions.

Many seniors fear falling and restrict their activities in order to avoid possible risks. In FY 2011, the Division of Senior & Disabilities Services is introducing “A Matter of Balance,” an evidence-based eight-session class to help senior participants view falls and fear of falling as controllable; set realistic goals to increase activity; change their environment to reduce fall risk factors; and exercise to increase strength and balance. Senior centers will be encouraged to offer the program with the assistance of trained facilitators.

The Alaska Commission on Aging is a founding member of the Alaska Senior Fall Prevention Coalition, and will continue its efforts to publicize fall prevention information.



## APPENDIX E

### SUMMARY OF THE OLDER AMERICANS ACT

## APPENDIX E

### SUMMARY OF THE OLDER AMERICANS ACT

#### Older Americans Act (OAA) Programs in a Nutshell

**Title I:** Declaration of Objectives and Definitions

**Title II:** Administration on Aging

**Title III:** Grants for State and Community Programs\*\*

Part A: General Provisions

Part B: Supportive Services and Senior Centers\*\*

Part C: Congregate and Home-Delivered Meals\*\*

Part D: Disease Prevention and Health Promotion\*\*

Part E: National Family Caregiver Support Program\*\*

**Title IV:** Training, Research, and Discretionary Projects & Programs

**Title V:** Community Service Employment for Older Americans\*\*

**Title VI:** Grants for Native Americans\*\*

**Title VII:** Allotments for Vulnerable Elder Rights Protection Activities\*\*

\*\* indicates programs for which Alaska receives OAA funding

#### The Older Americans Act

The Older Americans Act was signed into law by President Lyndon Johnson in 1965. It was considered a direct outgrowth of the 1961 White House Conference on Aging. Created during a time of rising societal concern for the poor and

disadvantaged, the OAA set forth a broad set of objectives that continue to be relevant today. Objectives of the OAA include ensuring that the elderly have an adequate retirement income, the best possible physical and mental health, suitable housing at an affordable cost, a comprehensive array of community-based long-term care services (including family support), employment opportunities, efficient community services with emphasis on choice and continuity of care, benefits from research knowledge, participation in meaningful activities, and protection against abuse and neglect. Nearly half a century later, the OAA's vision of Americans aging with honor, dignity, freedom, and independence still inspires nearly universal allegiance by the public; the Act has been reauthorized numerous times since its inception.

The Older Americans Act continues to provide the framework for a partnership among the different levels of government and the public and private sectors with a common objective – to improve the quality of life for all older Americans by helping them to remain independent and productive. The activities which are mandated and funded under the OAA carry no income eligibility requirements, unlike numerous other federal assistance programs. All seniors (age 60 and over) are eligible. Service providers must follow priorities set by the Area Agency on Aging (or sole state agency on aging, in the case of single planning and service area states such as Alaska) for serving older persons with the greatest economic or social need, with particular attention to low-income minority older persons and older individuals residing in rural areas, individuals with disabilities, those whose primary language is not English, and Native Americans. Each client is provided the opportunity to contribute to the cost of the service; however, denial of service for non-contribution is prohibited.

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The Older Americans Act established the federal Administration on Aging (AOA), now within the Department of Health and Human Services. Since 1993 the AOA has been headed by an Assistant Secretary on Aging, appointed by the president with the advice and consent of the Senate. Kathy Greenlee is the current Assistant Secretary on Aging. The AOA is charged with acting as an effective and visible advocate for older individuals, collecting and disseminating information related to problems of aging, administering grants, evaluating programs, providing technical assistance and consultation to states, and stimulating more effective use of existing resources.

The overall purpose of the Older Americans Act was to establish an aging network, provide for the funding of local service programs, establish training and research projects, and stimulate the development of innovative and/or improved services for the elderly. Congress has continued to appropriate funds and update the law with periodic amendments under this Act for research and demonstration projects and for the operation of the Administration on Aging.

Amendments in 1969 emphasized planning and resource mobilization. A set of amendments in 1973 required states to set up planning and service areas, and authorized grants for model projects, multipurpose gerontology centers, senior centers, and the new Nutrition Program for the Elderly. The Comprehensive Older Americans Act Amendments of 1978 reorganized the Act, authorized separate funding for specific services, including a strong advocacy responsibility, and provided for more focused work on long-term care for older Americans. In the 1978 amendments Congress recognized the special sovereign status of Tribal governments and created Title VI, Grants for Indian Tribal Organizations. The purpose of Title VI was to promote the delivery of supportive and nutrition services to American Indians and Alaska Natives that are comparable to services offered to other older persons under the Title III program. The Older Americans Act Amendments of 2000 established an important new program, the National Family Caregiver Support Program (NFCSP), after listening to the needs expressed by family caregivers in discussions held across the country. Increases in funding accompanied many of the amendments and reauthorizations of the OAA. The Older Americans Act was again reauthorized in 2006, with added emphasis on disease prevention and health promotion, senior behavioral health services, and emergency preparedness, among other changes.

In 2011 Congress will again consider reauthorization and amendment of the Older Americans Act. A number of potential changes are under consideration, including a focus on creating livable communities for all ages, an expanded role in affordable housing with supportive services, enhanced coordination between Title V (Community Service Employment for Older Americans) and the Workforce Investment Act, greater authority to protect older adults' legal rights, transfer of SHIP (the State Health Insurance Assistance Program) to the Administration on Aging from CMS (Centers for Medicare and Medicaid Services), capacity-building for Title VI programs, and increased coordination with emergency management agencies to better serve the needs of older adults during disasters. Typically the OAA receives broad bi-partisan support. The AOA distributes funds to states under a formula based largely on the number of people aged 60+ in each state. In order for a state to receive these funds, its governor must designate



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an agency as the state unit on aging and the state must develop a multi-year plan for services. In Alaska, the Department of Health and Social Services is that agency, with state plan development delegated to the Alaska Commission on Aging. Like its federal counterpart, the state agency serves as an advocate for the elderly. While all seniors are eligible for services, preference must be given to providing services to older individuals with the greatest economic and social need, with particular attention to low-income, minority individuals, those in frail health, and older people residing in rural areas. While most states are divided into a number of “planning and service areas,” each served by an “Area Agency on Aging” (AAA), in Alaska the entire state is considered a single planning and service area, with the state unit on aging responsible for assessing the needs of all older persons within the state. The AAA (or sole state agency on aging) must have an advisory council of older persons. In Alaska the Alaska Commission on Aging (ACoA) is an eleven-member commission appointed by the governor, with four staff to carry out the Commission’s directives on planning, education and public awareness, and advocacy. The current state plan for services is available for review on the ACoA’s website at [www.AlaskaAging.org](http://www.AlaskaAging.org).

For more than 30 years, Area Agencies on Aging (AAAs) and Title VI Native American aging programs, which serve as the local component of the Aging Network, have leveraged federal dollars with other federal, state, local and private funds to meet the needs and provide a better quality of life for millions of older adults.

Statewide programs and services for Alaskan seniors have existed since the advent of the Older Americans Act in the mid-1960s. The Alaska Commission on Aging works closely with the Division of Senior and Disabilities Services within the Department of Health and Social Services to develop a service plan and innovative projects through the Division’s Senior Grant Programs. Services are funded by the U.S. Administration on Aging, State general funds, the Alaska Mental Health Trust Authority, local government, community fundraising, and individual contributions.

**Title III** of the Older Americans Act outlines the types of supportive services funded by the Act, services which have remained fairly constant for nearly a decade. Title III services, provided through the Senior Community Based Grants program administered by the Division of Senior and Disabilities Services, are organized as follows:

- Part A provides guidelines and funding for State and Area Agencies on Aging.
- Part B provides for supportive services to seniors and for the operation of senior centers
- Part C provides for congregate and home delivered nutrition services
- Part D provides disease prevention and health promotion services
- Part E funds the National Caregiver Support Program

Senior transportation services (funded under Title III, Part B) allow older Alaskans to access medical appointments, senior center or adult day care participation, shopping, errands and other engagements through a door-to-door service equipped to handle special needs. Nutrition programs (funded under Title III, Part C) offer meals both in congregate settings and for

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homebound individuals. The nutrition program is more than a meal. It provides nutrition education, counseling, and screening, and is often the gateway to many other services. The Older Americans Act Nutrition Program (OAANP) is the largest single component of the OAA. In Alaska funds for senior transportation, meals, and other Title III support services are provided under the Nutrition, Transportation, and Support Service Program, widely known as “NTS.”

Each state’s unit on aging provides disease prevention and health promotion services (funded under Title III, Part D) and information and referral services at senior centers, meal sites, and other appropriate locations. Health promotion is the process of enabling people to increase control over and to improve their health. Disease prevention covers measures not only to prevent the occurrence of disease, but also to arrest its progress and reduce its consequences once established. States give priority to areas which are medically underserved and in which there are a large number of older individuals who have the greatest economic need for such services.

The National Family Caregiver Support Program (NFCSP), established by the OAA amendments of 2000 (Title III, Part E), was modeled after several successful state long-term care programs. States provide five basic services for family caregivers: information about available services; assistance in gaining access to supportive services; individual counseling, help in organizing support groups, and caregiver training to assist in making decisions and solving problems related to their caregiving roles; respite care; and supplemental services, on a limited basis, to complement the care provided by caregivers. Funds for this program are distributed to the states using a congressionally mandated formula that is based on a proportionate share of the age 70+ population. Priority consideration is to be given to those in greatest social and economic need, and older individuals providing care and support to persons with mental retardation and developmental disabilities.

**Title V** of the Older Americans Act provides for programs that foster and promote useful part-time work opportunities in community service activities and offer skills training for unemployed low-income persons who are fifty-five years old or older and who have poor employment prospects. In Alaska, Title V funds the MASST (Mature Alaskans Seeking Skills Training) program is administered by the Alaska Department of Labor and Workforce Development.

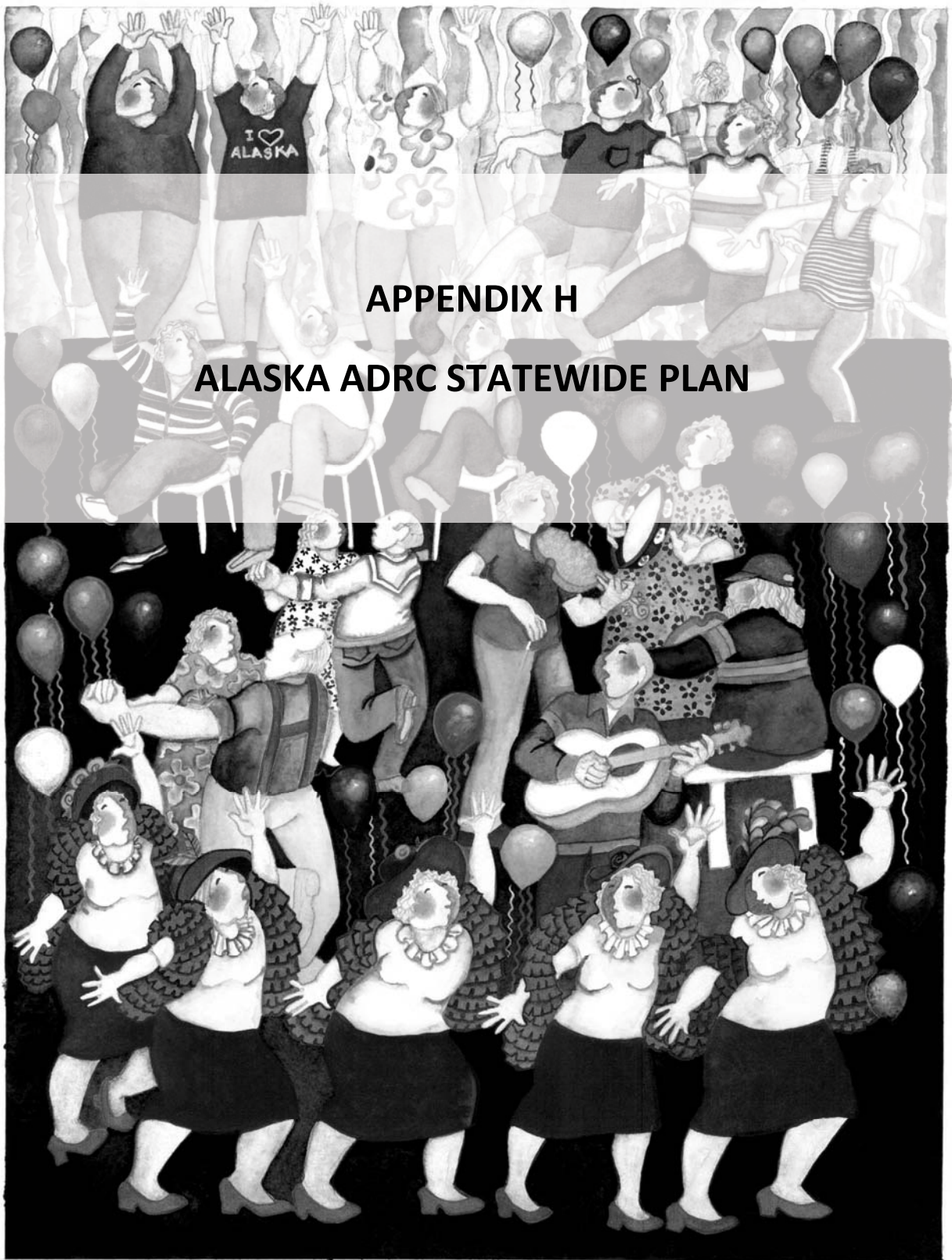
**Title VI** of the Older Americans Act provides grants directly through tribal organizations in Alaska for services to Native Americans. These grants provide supportive and nutrition services comparable to the services provided elsewhere within the statewide planning and service area through the state unit on aging under Title III of the OAA.

**Title VII** of the OAA was created by Congress in the 1992 Amendments to the OAA to protect and enhance the basic rights and benefits of vulnerable older people. Individuals may need advocacy on their behalf because their physical or mental disabilities, social isolation, limited educational attainment or limited financial resources prevent them from being able to protect or advocate for themselves. Title VII brings together and strengthens three advocacy programs

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– the Long-Term Care Ombudsman program, programs for the prevention of abuse and exploitation, and state legal assistance development programs in each state. It also calls on the state units on aging to take a holistic approach to elder rights advocacy. Alaska provides a Long-Term Care Ombudsman in the Department of Revenue (within the Alaska Mental Health Trust Authority) and Adult Protective Services in the Department of Health and Social Services' Division of Senior and Disabilities Services (DSDS). DSDS also administers the legal assistance development program.



## APPENDIX H

### ALASKA ADRC STATEWIDE PLAN

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### Alaska ADRC Statewide Plan SFY 2012-2015

#### Contact Information

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#### Participants in ADRC Statewide Plan Development\*

<b>Name &amp; Title</b>	<b>Organization</b>
Kimberli Poppe-Smart, Deputy Commissioner	DHSS, State Medicaid Agency (required)
Duane Mayes, Director**	SDS, State Unit on Aging (required)
Duane Mayes, Director**	SDS, State Disability Agency (required)
Millie Ryan, Executive Director**	Governor's Council on Disabilities and Special Education, GCDSE
Denise Daniello, Executive Director**	Alaska Commission on Aging, ACOA
Kate Burkhart, Executive Director**	Advisory Board on Alcoholism and Drug Abuse, ABADA and Alaska Mental Health Board, AMHB
Andi Nations, Executive Director**	Centers for Independent Living, SILC
Judith Bendersky, Program Manager**	SHIP/Medicare Information Office
Karen Bitzer, Director**	Alaska 211

**\* The above participants have indicated that they have actively participated with the planning of the ADRC Statewide Plan and agree with its content. Letters of support are also acceptable for documenting active participation and support.**

**\*\*Indicates ADRC Advisory Council participation by agency. Designee appointed as determined applicable by organization's director.**



### **Section I: Vision and Goals**

#### ***National Vision***

The national vision of ADRCs is the creation of a single, coordinated system of information and access for all persons seeking long term support services. Such centers will be highly visible and trusted places where people of all incomes, ages and disabilities can turn for information on the full range of long term support options, public and private. The goal of these centers is to minimize confusion, enhance individual choice, support informed decision-making and increase the cost effectiveness of long term support systems. As a part of the New Freedom Initiative, AoA and CMS see the ADRCs as a critical component of a long term support system that supports and facilitates consumer choice. Access to service information across the public and private sectors, options counseling and assistance in linking to services underpin a consumer driven system.

#### ***Need for Systems Change:***

From a system standpoint, AoA and CMS recognize the future need for long term supports as the population continues to age, waiting lists for home and community-base services for persons with disabilities continue to grow, and long term care costs mushroom.

Additionally, federal and state agencies are concerned about the ability of the federal government (as the primary payer for long term care) to meet this growing challenge. It becomes more critical that consumers become wise users of the long term supports, knowing what is available and using them in a cost efficient manner. However, persons in need of long term support services and their families are faced with disconnected services, redundant and confusing application forms and a lack of consolidated easy-to-understand information on available options. Faced with such daunting barriers, people spend too much time and money on the wrong services or course of action, or find themselves in a care setting they do not prefer. ADRCs, through options counseling and integration of information about private as well as public resources, are a powerful tool for empowering consumers. Alaska plans to follow the national vision adding a commitment to provide unbiased information to consumers. The structure of service delivery for both senior and disability services in Alaska is primarily through private service providers. It is necessary to avoid conflict of interest to maintain this standard.

#### ***State Administration:***

The Alaska Aging and Disability Resource Centers (ADRCs) are administered by the Division of Senior and Disabilities Services. Senior and Disabilities Services is both the state agency on aging and state disability agency. There are currently four ADRCs in operation, serving four of the nine service areas established by the Alaska Department of Health and Social Services. Please refer to Goal #2 for more information about the individual sites and service areas. A draft of this plan was reviewed and adjusted by the ADRC Advisory Council and





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sent out for public comment as a part of the Alaska statewide plan for senior services. The ADRCs have an Advisory Council meets quarterly, with additional email updates or discussion as needed. Any referenced Fiscal Years (FY) are by state fiscal year which runs from July 1<sup>st</sup> through June 30<sup>th</sup>.

#### **State ADRC Vision Statement:**

Alaska ADRCs are an unbiased coordinated system of information and access for all persons statewide seeking long term support services, public and private. ADRCs will improve the long term support service system by minimizing confusion, enhancing individual choice, supporting informed decision-making and increasing the cost effectiveness of long term support systems.

#### **State ADRC Goal #1:**

Alaska ADRCs will be fully functional providing all core program components: 1. Information, Referral and Awareness, 2. Options Counseling and Assistance, 3. Streamlined Eligibility Determination for Public Programs, 4. Person-Centered Transition Support, 5. Partnerships and Stakeholder Involvement and 6. Quality Assurance and Continuous Improvement.

### **Description of Approach**

The ADRCs in operation serve Southeast Alaska, Bristol Bay and Kodiak, Kenai Peninsula, Valdez, Cordova, MatSu and Anchorage (service regions 9, 7, 5 and 4). An interactive map is located at: <http://hss.state.ak.us/dsds/grantservices/adrcmap/default.htm> Each ADRC has 1.5 FTEs or more dedicated to the ADRC work. Two agencies are Centers for Independent Living, one is a Municipality and one an Alaska Native Association.

Each site provides Information, Referral and Awareness through face-to-face meetings, phone calls and presentations to the public. The Alaska ADRCs have contracted Alaska 211 to provide and manage the resource database for the state. This database meets AIRS standards. This partnership has led to cooperative training events, cooperative outreach trips and a refined referral protocol to serve the public more efficiently. A statewide outreach and marketing plan is in development with a product expected by the end of 2011.

Each site has hired an ADRC Specialist who provides options counseling directly to consumers. Each agency has staff able to respond to inquiries and complete enrollment for Medicaid, Medicare and other public benefit programs. Staff describe the long term support services available regionally and objectively provide referrals that are based on individuals needs and preferences. Each agency is prepared to triage crisis calls and



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situations as they arise. There are occasional requests for futures planning, but this service is not well developed. The work to be done in this area focuses on establishing statewide standards and protocols for options counseling and ensuring follow up is conducted for every consumer on a regular basis. Futures planning would be the next service to define and standardize in this service array once options counseling is formalized.

A single entry point ADRC could do the following: every person needing long term care or with long term support needs would be referred to an ADRC and would be the only place people could receive a screening for public long term care waiver services. This would improve the accuracy of people being referred to public programs. Because each individual's situation is considered person by person with an emphasis on independence and personal responsibility, that person will be able to make an informed choice about what the best services will be to meet their needs out of all of their options and know the impact of each choice. People who request to apply for public services would not be denied the option to do so, but would be informed of the likelihood of being accepted and if that person does not qualify they will still be assisted in finding other ways to meet their needs. People who are likely to qualify or are in crisis will benefit from a streamlined eligibility process through which financial and programmatic determination can be obtained quickly through the ADRCs in a manner that appears seamless to the consumer. This can be done by co-locating staff from various agencies or delineating the responsibility for these functions to the ADRC offices and staff. The Advisory Council has approved of the ADRCs doing this work.

The State of Alaska is currently exploring how the ADRCs can be used for streamlining eligibility determination for public programs. ADRCs are capable in assisting consumers with benefits applications and guidance through the many benefit enrollment processes. A pilot project has been proposed for the ADRCs to complete the intake and screening for the Medicaid waiver programs and to connect people with co-occurring disorders of substance abuse and any other disability to services via the ADRC. The success of this submission will be known in the fall of 2011. The ADRCs have received permission from the Division of Public Assistance (DPA) to utilize their database to check and track application status for public assistance programs. In Anchorage, plans are moving forward for the co-location of DPA, the Medicare Information Office and Anchorage ADRC by the end of 2011. It is expected that the already strong partnership between these agencies will continue to grow.

The three established ADRC sites for Anchorage, Southeast and Kenai Peninsula have staff trained as transition coaches for the Coleman Model. Partnerships with hospitals and health organizations have been established, standards and protocols have been developed and a small number of transitions have been made to date. Each area has established





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criteria for patient selection and is working within the constraints of Medicaid Eligible as designated by a demonstration grant received from CMS. This grant will end in FFY 2012. However it is expected this work will continue as the foundation has been established for continued partnership between the hospitals and ADRCs. All of the ADRCs are designated as the Local Contact Agencies for Section Q in reference to nursing home transition. Once these transition processes are strong components of the ADRC service array, additional opportunities for transition support will be sought out such as collaborating on a hospital discharge project to support Medicare patients or other groups identified as needing this service.

Partnerships are discussed in a later section. Please refer to the information listed in Section II: Partner Involvement.

A quality assurance plan will be established to provide standardization and guidance to each site. A statewide training plan will also be drafted. These tools are expected to be developed in the next fiscal year; completion estimated around 7/12. The ADRCs have extensive reporting requirements however the effectiveness of this information is limited due to the disconnected databases utilized across systems and programs. The ADRC Program Manager will continue to advocate for the state to purchase a database that has consumer tracking and reporting ability across waiver and grant services that can incorporate the ADRC functions as well. This will allow for easier coordination of services for consumers and provide more meaningful data on the impact of services.

#### **How will you measure progress toward your goal?**

Through FY12 the University of Alaska, Anchorage, Center for Human Development has been contracted to evaluate the expansion work of the ADRCs. To date this grant has had quarterly formative progress reports. A customer feedback survey and provider feedback survey is in development and a summative report will be produced by October 2012. It is desirable to continue a contract with an outside evaluator to objectively track progress. If this is not possible, the Division of Senior and Disabilities Services will collect quarterly quantitative and qualitative data and report through the federal SART reporting system to track implementation progress toward stated goals. The Division of Senior and Disabilities Services will collaborate with the Lewin group and other partners to develop a quality assurance plan and tools in FY12. The plan will be adjusted as needed based on this information. Reports on statewide implementation progress for the State plan period will be completed by 8/30/13 and 8/30/15 at a minimum.



### **What are your anticipated barriers? How will you address these challenges?**

Streamlined access to benefits is an area where the ADRCs would like to serve the public. Some provider agencies do not support this work as they are currently paid to conduct the screenings for the Medicaid waiver programs. The existing system has problems with conflict of interest with this process in place as the providers completing the screenings would also be the providers administering the long term care coordination service. Currently the screenings are yielding only a 50% acceptance rate based on functional assessment with anecdotal reports of clients not being fully informed of the assessment process or services requested. This identifies both a potential cost savings and improvement in customer service to eliminate this conflict of interest. The State of Alaska would need to determine whether or not the ADRCs would be participating in this initial benefits screening work and CMS would need to approve this change in process for the waiver programs. The Personal Care Assistant Program is another program where the ADRCs could serve as the screening agency to improve acceptance rates and better match people with needed services.

The State of Alaska does not currently have electronic benefit applications and requires an original signature for applications (though faxes are now accepted). This can cause delays in service if a person must be mailed an application or directed to one or more locations to complete necessary applications. Due to complex eligibility requirements, most programs require lengthy forms and multi-step processes that can be difficult to navigate. The Division of Senior and Disabilities Services and the Division of Public Assistance will continue to identify where systems change can benefit consumers through streamlined eligibility processes. Monthly meetings have been established to further this work.

There also exists opportunities to work with the Division of Behavioral Health, Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse as the Alaska ADRCs broadly define disability. The potential of these relationships has only initially been explored. This type of systems change is key to improving service delivery yet is expected to be the most difficult endeavor due to the complexity of the work that requires the involvement of multiple Divisions within the Department of Health and Social Services. It is likely this area of work will be explored with implementation of integrated service occurring beyond the time period specified in this state plan.

Presently, our State has multiple opportunities to make system changes that yield not only a better served public, but reduce the initial costs of care. This shows a need for a change in practice. No one program or intervention will fix all areas in need of improvement, however the ADRCs can significantly improve how Alaskans obtain and consider their available choices for long term supports.

**What is your overall timeline and key dates?**

Please refer to the attached work plan.

**State ADRC Goal #2:**

Alaska ADRCs will provide statewide coverage in the most effective and efficient manner possible.

**Description of Approach**

The ADRCs in operation serve Southeast Alaska, Bristol Bay and Kodiak, Kenai Peninsula, Valdez, Cordova, MatSu and Anchorage (service regions 9, 7, 5 and 4). These service areas include 75% of the population of Alaska. An interactive map is located at: <http://hss.state.ak.us/dsds/grantservices/adrcmap/default.htm> Each ADRC has at least 1.5 FTEs dedicated to the ADRC work. Each agency has varying ADRC experience, expertise and challenges in their service region. Initial attempts to expand statewide were not successful due to a lack of community readiness and budget issues at the division level. Presently the Alaska ADRCs have work to be done both in expanding statewide to cover areas with no ADRC and ensuring adequate service provision to the populations where ADRCs are established.

The Municipality of Anchorage serves a small area in geography but serves roughly half of the state's population in Alaska's most metropolitan area. The Anchorage ADRC has been in operation since 2009 with only base funding available. The Anchorage ADRC has developed excellent marketing tools and has developed and administered a consumer satisfaction survey for the past two years. This ADRC has worked closely with homeless initiatives, emergency preparedness, assisted living homes and other housing issues. It is recognized that the Anchorage area population is underserved due to staffing limitations. Anchorage is also the medical service hub for the state and the primary location for the business office of many statewide services. The Anchorage area has many services available and the coordination and networking of the services is challenging.

The Kenai Peninsula Independent Living Center serves the Kenai Peninsula, Valdez and Cordova and MatSu census areas for their service region. This ADRC was established in 2004 and has considerable expertise in delivering the service components. The Peninsula ADRC has been active in integrating community services and local networking. Valdez and Cordova are served by phone and on an outreach basis due to geographic separation and travel costs however depending on frequency, that structure may meet local needs based

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on the small population of the area. This ADRC is trying out the use of webcams to deliver services “face-to-face” without incurring the cost of travel each time an individual need arises. Though the population of the MatSu census area is quite large, it has been served primarily by phone and outreach trips. It has been recognized that the area has been underserved with only base funding available. The MatSu area has been underserved and may not be a good fit in this region due to geographical separation and rapid population growth in the last decade. The MatSu community has conducted a local assessment identifying an ADRC as a solution to improve coordination of services in the area and is interested in having more ADRC services available locally. SDS, KPILC and MatSu community providers and other organizations will be meeting over the course of FY12 to determine how to best serve this area.

The Southeast Alaska Independent Living Center serves Southeast Alaska. This ADRC was established in 2004 and also has considerable experience in delivering the service components. This ADRC initiated the first care transitions for the State in 2010 and has a close partnership with Bartlett Regional Hospital. The Southeast ADRC is networked throughout the community and conducts regular outreach trips to the areas of Southeast where they do not have a physical office. Southeast Alaska is a grouping of islands and peninsulas that are not connected by road so travel must be done by boat or plane.

The Bristol Bay and Kodiak ADRC services the Bristol Bay area and Kodiak Island. This ADRC was established in 2010 and is in the process of building its infrastructure and delivering a basic ADRC service array. Kodiak is underserved and may not be a good fit for the service area. The Bristol Bay area has a very small population with a central hub community and many small villages. These communities are not connected by road and travel by small plane is necessary to reach them. The frequency of travel to the villages in order to provide needed ADRC services has not yet been determined due to the newness of this ADRC site.

All of the ADRC sites are committed to working toward full ADRC functionality in their communities and to work with the state and other organizations to assess the needs of each service area to serve the population as effectively as possible.

### **How will you measure progress toward your goal?**

Through FY12 the University of Alaska, Anchorage, Center for Human Development has been contracted to evaluate the expansion work of the ADRCs. To date this grant has had quarterly formative progress reports. A customer feedback survey and provider feedback survey is in development and a summative report will be produced by October 2012. It is



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desirable to continue a contract with an outside evaluator to objectively track progress. If this is not possible, the Division of Senior and Disabilities Services will collect quarterly quantitative and qualitative data through the federal SART reporting system to track implementation progress toward stated goals. The Division of Senior and Disabilities Services will collaborate with the Lewin group and other partners to develop a quality assurance plan and tools in FY12. The plan will be adjusted as needed based on this information. Reports on statewide implementation progress for the State plan period will be completed by 8/30/13 and 8/30/15 at a minimum.

#### **What are your anticipated barriers? How will you address these challenges?**

Serving the population of Alaska statewide is a challenge due to limited staff and high transportation costs in rural areas. The ADRCs currently have approximately 1.5 FTEs dedicated to four of nine service areas in the state. This leaves vast areas underserved even within areas that presently have an ADRC. Travel costs are high with remote locations requiring travel by plane or boat to reach. The population, especially the aging population, has increased significantly over the past ten years. Areas with high growth rates feel the strain of regionally funded services the most.

An analysis of how to deliver ADRC services effectively to balance consumer focus and cost will need to be completed. What services must be in person, what can be conducted over the phone or video service, how can standardization and local customization be balanced to ensure a person-centered approach, how can partnerships be leveraged to benefit consumers and provide better service and how can the ADRC services show cost neutrality and savings in a statewide system are just some of the questions that need to be part of the service delivery discussion. Additional resources will be needed to conduct these analyses beyond what the ADRC program manager has readily available. All expansion activities are dependent on future funding.

These challenges are not unique to the ADRCs. The Statewide Independent Living Council has contracted consultants to analyze the challenges of providing statewide services and make recommendations as how to best identify service areas and fund services in regions that have vastly different populations and costs of living and travel. It is anticipated that this study will be issued the final quarter of 2011 and will provide valuable information to both the CILs and the ADRCs about how to better deliver statewide services. The MatSu area released its plan for senior services in May of 2011. Other communities are expected to complete like needs assessments and analyses. More detailed census data is being released which will greatly assist with planning as well. The ADRC program will incorporate applicable information in statewide planning as it becomes available.



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ADRC programs are granted out to local agencies that meet request for proposal requirements for the service area. It is necessary that the local agency not be a paid provider of Home and Community Based Services through the Medicaid Waiver or Personal Care Assistance programs in order to provide unbiased information, referral and assistance and options counseling services. Locating an ADRC in an agency that provides care coordination, case management or personal care assistant services would give that agency a competitive business advantage and has great potential to influence the referrals given or not given to consumers. An agency must present a plan that eliminates conflict of interest in the situation where a large organization that runs multiple programs wishes to apply. Specifics will be outlined in a request for proposal as they have in past requests. In order to maximize the choice and independence of consumers, unbiased referrals must be available to them. This can be a challenge in smaller communities since the State of Alaska grants out most of its waiver and HCBS services. Some communities have not been able to locate an appropriate unbiased agency that is ready to be an ADRC and the 2010 request for proposal did not receive many responses. A regional development or community hub approach may be a better mechanism for the ADRC grant than a traditional competitive bid due to the complexity of the work to be done. The ADRC Program Manager will work with grants and contracts through DHSS to explore alternative equitable processes.

#### **What is your overall timeline and key dates?**

Please refer to the attached work plan.

### **Section II: Partner Involvement**

#### **Who are the key players and responsible parties?**

The ADRC program for the state of Alaska is fortunate to have excellent partners. Existing partnerships with Alaska 211 and the Medicare Information Office have helped ensure that consumers receive accurate and timely information and assistance while working together to ensure a reduction in the duplication of service. Current grantees include two Independent Living Centers, an Alaska Native Association and a Municipality. State agency partners include: the Division of Senior and Disability Services including the Medicare Information Office, the STAR program for people with developmental disabilities and Adult Protective Services, the Division of Health Care Services, the Division of Behavioral Health, the Division of Public Assistance, the Alaska Commission on Aging, the Governor's Council on Disabilities and Special Education and the Advisory Board on Alcoholism and Drug Abuse and Alaska Mental Health Board. Additional statewide partners include the Alaska Mental





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Health Trust Authority, Statewide Independent Living Council, Alaska Native Tribal Health Consortium, AGENET, Mountain-Pacific Health QIO, the United Way of Alaska via Alaska 211 and The University of Alaska Anchorage Center for Human Development. The ADRC grantees are comprised of two centers for independent living, a municipality and an Alaska Native association. There are also dozens of partners that collaborate with the ARDCs at a local and regional level including senior centers, skilled nursing facilities and many other organizations that serve people with disabilities, seniors or provide a broader array of community based services or crisis intervention.

Coordination with key partners will take place all four years. The ADRC Program Manager will provide recommendations for a coordinated data system that would improve service coordination and data tracking system wide. In coordination with this effort the ADRCs will continue to advocate for and assist with developing a screening tool that will streamline access to appropriate services and decrease unnecessary assessments and denials for ineligible individuals. This work will be done with the Division of Senior and Disabilities Services and the Division of Public Assistance so that both financial and functional eligibility can be coordinated more efficiently for the consumer. There is a large unmet need of behavioral health services specific to seniors and people with disabilities. The ADRCs will increase involvement and coordination with the Division of Behavioral Health to improve systems efficiencies for mental health screenings. Collaboration with the Veteran's Administration is expected to increase toward the end of this planning period with 2014 being the target year for implementing veteran directed HCBS federal program. Within the Division of Senior and Disabilities Services, the consolidation of Information and Assistance efforts will be examined with an end goal of standardization of entry into the Long Term Care system across services for all beneficiaries throughout the continuum of care. Senior management will be meeting at a Department level in July 2011 and at a Division level in August 2011 to identify these priorities.

### **Section III: Financial Plan – Resources to Sustain Efforts**

#### **What existing funds/programs are currently being used to carry out ADRC activities?**

Funding that is currently in place:

Administration on Aging ADRC Expansion Grant (Award No. 90DR0035); Centers for Medicare and Medicaid Services Real Choice Systems Change (Award No. 1LOCMS030305) to implement care transitions; Alaska Mental Health Trust Authority grant; and State of Alaska general funds. Local agency grantees also provide matching funds as a grant requirement.



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### What additional programs and service offerings are necessary to operate fully functional ADRCs across the state?

The Alaska ADRCs are ready to begin the work of streamlined eligibility into public long term care services, but do not yet have the approval from the state to do so. Barriers specific to functionality and statewide coverage are addressed earlier in the goals section.

### What is your estimated cost to expand statewide (e.g., new MIS purchase)?

Establishing a new ADRC for a service region with one dedicated specialist is estimated at a cost of \$110,000 per year with an additional match requirement expected. This cost is estimated to be the same for a statewide ADRC Specialist position covering sparsely populated areas including a small travel budget. This is based on the initial ADRC site establishment through SDS into an established organization and provides a basic level of ADRC services including I&R, options counseling and benefits counseling.

The 2011 Mat-Su Regional Plan for Service Delivery used the Wisconsin ADRC Cost Model Budgeting Tool to determine a total program cost to operate an ADRC. This has some application to Alaska, but does not include transition services, public presentations or account for travel costs. A halftime director may not be needed depending on the existing agency structure. This plan does have a good consideration of the population served, estimating an average utilization rate of 1.55% in 2012 and details staff costs per service of the ADRCs. If the Mat-Su plan rates are used based on population the regional cost estimates would be as follows.

<b><i>Service Area – Based on DHSS Regions</i></b>	<b>Population Est. 18+**</b>	<b>Total salary \$ ***</b>	<b>Total non-salary</b>	<b>Total (90%)*****</b>
1. Wade Hampton, Bethel	15,153	\$35,761	\$75,070	\$99,748
2. YK, Denali, Fairbanks and SE Fairbanks	83,211	\$196,378	\$75,070	\$244,303
3. North Slope	7,179	\$16,942	\$75,070	\$82,811
4. Anchorage	216,040	\$509,854	\$75,070	\$526,432
5. Kenai Peninsula, Valdez and Cordova (w/o MatSu)	49,577	\$117,002	\$75,070	\$172,865
6. NW Arctic and Nome	11,101	\$26,198	\$75,070	\$91,141
7. Bristol Bay, Dillingham,	14,861	\$35,072	\$75,070	\$99,128





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Kodiak and Lake and Peninsula				
8. Aleutians East and West	7,516	\$17,738	\$75,070	\$83,527
9. Southeast Alaska	54,939	\$129,656	\$75,070	\$184,253
MatSu Borough *	63,276	\$149,344	\$75,070	\$201,973
Total				\$1,786,180

\*Source: McDowell Group, Inc./HDG, Mat-Su Regional Plan for Senior Service Delivery, pgS.75-79. 2012 calculations used for population. 2013 non-salary costs used as it is expected for an ADRC to be placed in an established organization.

\*\* Though ADRCs serve people with disabilities of all ages, few children and youth are served so the utilization rates are based on the adult population.

\*\*\*Other estimates are based on this funding formula in proportion to MatSu costs, approximation of ADRC services by population only as compared to MatSu. Limits of this approach are that it is based on Wisconsin service model and does not directly reflect all services provided and non-salary costs do not reflect different staff sizes or travel costs. This assumes that an ADRC would be present in each DHSS region and that Mat-Su would have its own physical ADRC site.

\*\*\*\*Currently a 10% match is required from the grantee.

Additional evaluation to take place in FY 2012 may show that these amounts are not an accurate reflection of necessary funding. In the next fiscal year, service areas will be scrutinized as to the best fit for service delivery. The estimated costs could also change based on how the service regions are broken out. More analysis is needed in identifying how to implement quality service in areas that have small populations and determining a true service cost across varied areas considered urban, rural and remote both on and off of the road system.

**How will you access the resources and create the revenue opportunities necessary for sustainable ADRC implementation on a statewide basis?**

Continued funding will be requested as opportunities arise from various sources. The program manager will continue to seek out new grant funding opportunities as they match ADRC mission and readiness and gain approval from the Office of the Governor. Some of these potential grants include Money Follows the Person, care transitions, Benefit Enrollment Center and other like opportunities. The process for obtaining Medicaid Administrative funding for the ADRCs will be reviewed.



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SDS is considering combining grant programs with similar functions for the developmentally disabled with the ADRC, especially in rural and remote areas. Existing AoA grants that provide I&A through Title III-E, SHIP and SMP funds will be explored. An increased match requirement is also being considered. These discussions will occur over FY12 as the next RFP cycle for the grants begins in FY13.

SDS has received a capital grant to upgrade its management information system to combine the separate databases in the division. One of the upgrades will be incorporating the ADRC consumer tracking and reporting needs into this system. This will be an incredible resource for the ADRCs. The upgrades are expected to be completed within 3 to 5 years.

#### **What are the estimated projected cost savings/offsets of having fully functional ADRCs statewide?**

Every choice has a monetary and opportunity cost. Public programs are appealing because there is usually no direct cost to the consumer when receiving them. Qualifying for public programs can greatly impact a person's life from everything from where they live, how much money they can make to who can assist them. Often only the benefits of obtaining a public program are discussed without taking into account what a person is giving up in order to receive the benefit.

Alaska's public long term care system has evolved to placing the responsibility of helping people decide what services are needed with the service providers themselves or with eligibility specialists and coordinators who are trained to assess a person primarily for public programs. Reports from Senior and Disability Services show that as high as 50% of all Older Alaskans and Adults with Physical Disabilities waiver requests are denied due to not meeting financial or level of care eligibility. The cost of these bad referrals goes beyond the screening fee when you factor in all of the State of Alaska staff necessary to support the application and review process. The reduction of inappropriate referrals would be a cost savings to the State even when taking into consideration the increase needed in ADRC staff.

The community and State of Alaska would benefit from having a routine referral process and agency to refer non-eligible consumers to so that they can be served outside the state system. Many workers are not aware of services outside what their agency provides and do not have the time allocated or mission to serve community members who are not eligible for services. Centralizing long term care service denial referrals to the ADRCs would ensure a minimum level of support to serve those not eligible for public programs and have the ability to track service demand trends as well as areas of need for particular communities.



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The ADRCs would then communicate these needs both to the State and local partners to address filling the gaps of service.

A fully functioning ADRC will also inform the public at large of the long term care system and service options. A long term goal of the centers is to perform more public education and individual futures planning so that people can best prepare for long term service needs before a crisis occurs. Emphasizing health and wellness in all areas of life to best prepare for aging is a key component of futures planning. It is far cheaper to serve a planned need than a crisis need and much more likely for a person to receive the type of services desired and be satisfied if planning can occur. Understanding the breadth of long term services and supports is invaluable to caregivers and family members so they can receive the support they need to assist with caring for their family member or friend even if that work has not yet begun.

The public is generally unaware of long term care supports and services and many people falsely believe that assisted living or nursing home care is an inevitable part of aging. The average payment for assisted living care is \$5,000 a month and nursing home care is \$12,000 a month. Should a family choose home and community based services and/or caregiver support services instead there is typically a cost savings of thousands of dollars each month that a person is able to remain in their home. For a person with Medicaid insurance, switching from or avoiding nursing home care (with an average annual cost of \$109,476 to OA or APD waiver services with an average annual cost of \$24,495) the annual savings would be \$77,389. The State of Alaska would see an annual savings of \$38,695 per person per year based on a 50% match rate. If the ADRCs assist 26 people to remain in their own home there would be a cost savings to the state of over 1 million dollars. This is considering only two of the existing waiver programs. This does not include additional savings for improving system efficiencies. There certainly are times where assisted living home or nursing home care is the best option for a person, however most people prefer to remain in their own homes in their home communities as they age with or without a disability.

The knowledge, experiences and contributions that people share with their family, friends and community when they remain integrated within their communities are invaluable benefits that are critical to consider. Our elders, persons with disabilities and caregivers – our friends, family and community members – deserve the respect of a person centered service system that is efficient and informative, supporting people to live healthy productive lives and giving each person the freedom and responsibility of choice.

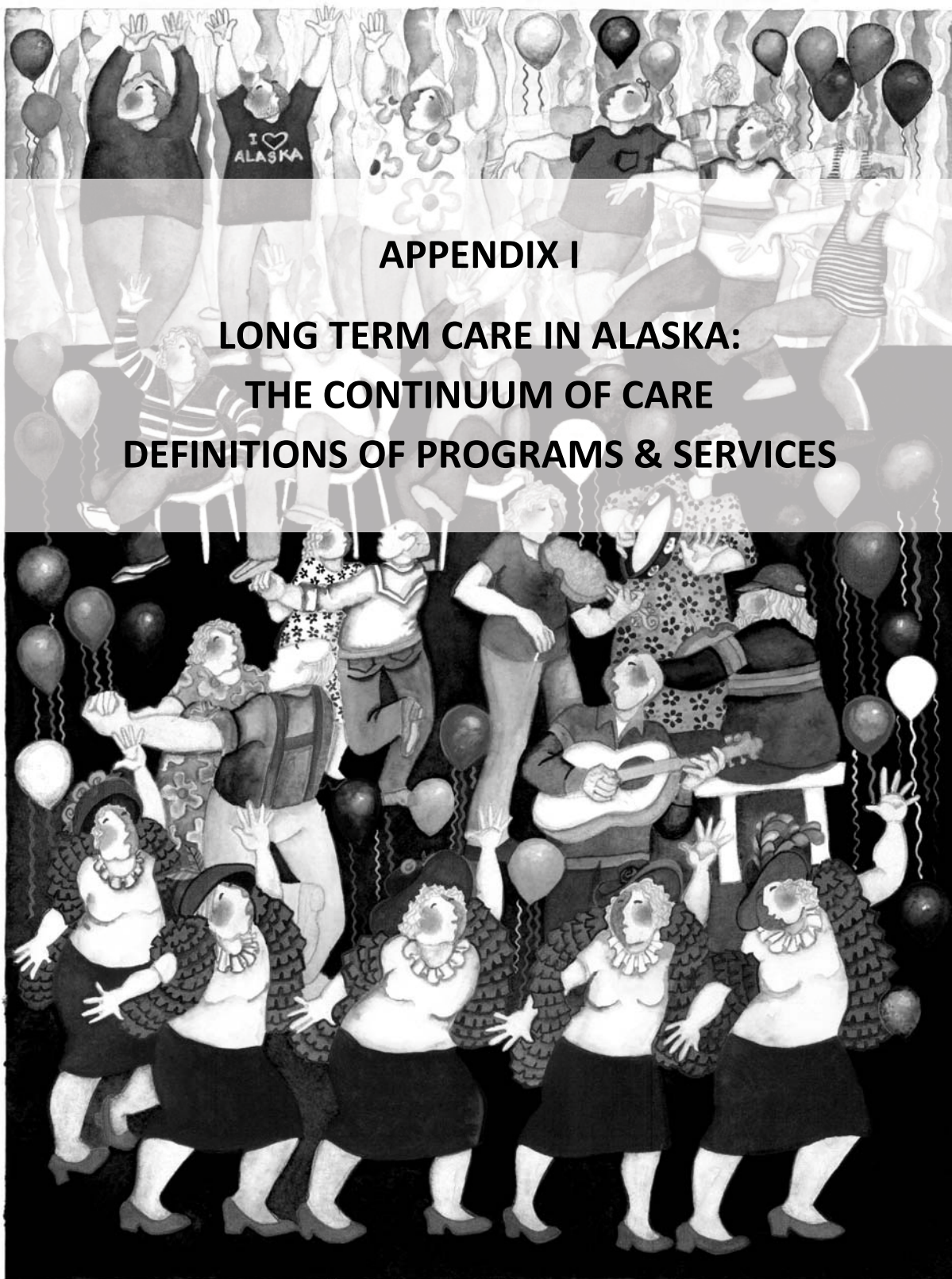


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Project Checklist	Yes	No
Are these goals reflected in the State Plan on Aging?	x	
Do these goals require changes that must be proposed through the current budget cycle?	x	
Does implementing these goals require regulatory, legislative, or statutory changes?	x	
Does your plan seek private funding to augment public resources to support sustainability?		x
Have the necessary stakeholders been identified and contacted?	x	x
Are your data systems prepared to track progress towards these goals?		x





## **APPENDIX I**

### **LONG TERM CARE IN ALASKA: THE CONTINUUM OF CARE DEFINITIONS OF PROGRAMS & SERVICES**



## Long Term Care in Alaska The Continuum of Care

Community-Based Services	Home-Based Services	Intensive Home & Community-Based	Services in a Residential Care Setting	Most Intensive Institutional Services
*Congregate Meals *Transportation *Information/Referral *Physical Fitness *Health Promotion/ Disease Prevention Classes & Activities *Senior Employment Services *Independent Living *Senior Centers *Senior Volunteer Programs *Legal Services *Health Screening *Social, Recreational & Educational Activities	*Home Delivered Meals *Assisted Transportation *Shopping Assistance *Congregate Housing *Supported Housing *Home Repair & Renovation *Senior Companion Volunteers *Homemaker/Chore Service *Companion Programs *Tele-health	*Adult Day Services *In-Home Respite Care *Home Health Care *Personal Care *Palliative & Hospice Care *Family Caregiver Support *Outpatient Care *Rehabilitation *Counseling	*Assisted Living *Facility Respite Care *Pioneer's Home *Adult Foster Care *CCRC: Continuing Care Retirement Community	*Acute Care *Nursing Home Care *Residential Hospice Care *Psychiatric Hospital
<b>Office of Elder Fraud &amp; Assistance</b>				
<b>Adult Protective Services: Investigations and Services to Abuse/ Neglect Victims</b>				
<b>Care Coordination (Targeted Case Management), Assessment/Plan of Care/Follow-up</b>				
<b>Long Term Care Ombudsman: Advocacy for Residents of Long Term Care Facilities</b>				

**Long-Term Care in Alaska  
The Continuum of Care  
Definitions of Programs & Services**

**Community-Based Services**

**Congregate Meals.** Congregate meal programs provide at least one hot or other appropriate meal per day to qualified individuals in a group setting. Congregate nutrition programs may also provide nutrition education and, based on a Nutrition Risk Assessment, referral to a dietitian for counseling (if available).

**Transportation.** Transportation includes assisted and unassisted rides provided by bus, van, taxi, boat or any other vehicle for a maximum of five days a week. All vehicles must comply with Department of Transportation vehicle safety standards. Rides are scheduled according to the following priorities: 1) Medical services, 2) Congregate meal site, 3) Adult Day Care, 4) Employer/Volunteer site, and 5) Other.

**Information and Referral.** Information, assistance, and referral services provide information about services available to seniors (health care, social, legal, financial, counseling, and other home- and community-based services) for continued independent living or for locating appropriate long-term care, and include follow-up to the maximum extent possible.

**Physical Fitness.** Programs include a wide range of senior-appropriate exercises to promote cardio-vascular health, strength, balance, flexibility, endurance, and overall physical well-being.

**Health Promotion/Disease Prevention Classes & Activities.** Activities include routine health screening, nutritional counseling and education services, health promotion programs, physical fitness, group exercise, music, art, and dance-therapy programs, home injury control services, fall prevention awareness and balance training, mental health screenings, preventive health services, medication management screening and education, diagnosis, prevention, treatment and rehabilitation information.

**Senior Employment Services.** Mature Alaskans Seeking Skills Training (MASST), a program under Alaska's Department of Labor, is the grantee of the Community Service Employment for Older Americans (OAA Title V) program. The MASST Program provides training and part-time paid work experience opportunities for low-income individuals 55 years of age and older who desire to enter or re-enter the mainstream workforce. The intent of this program is to place older individuals in community service positions and provide job training to help them become self-sufficient, provide much needed support to organizations that benefit from increased civic engagement, and strengthens the communities that are served by such organizations. The program, which is temporary in nature, helps Alaska retain the valuable resources of older workers while enabling them to maintain an independent lifestyle and make meaningful contributions to their communities.

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**Independent Living.** Independent senior housing offers apartments for seniors and adults with disabilities. Facilities may have common space for group activities, but usually other services are not provided. For more information please see the Alaska Housing Finance Corporation website at: [http://www.ahfc.us/home/senior\\_guide.cfm](http://www.ahfc.us/home/senior_guide.cfm)

**Senior Centers.** Senior Centers are social institutions that address the needs of older individuals, their families, and their caregivers as a vital and inclusive part of the community. They provide a variety of services including nutrition, recreation, social and educational services, and comprehensive information and referral to help seniors help themselves through assistance in finding appropriate services and care.

**Senior Volunteer Programs.** Volunteer opportunities benefit seniors by keeping them active and involved, and adding to seniors' self-esteem and social value as well as providing benefits to the communities they serve. Examples of volunteer programs include Retired Senior Volunteers (RSVP), Senior Companions (SCP), Foster Grandparent/Elder Mentor Program (FG/EM), and other local volunteer opportunities.

**Legal Services.** The legal services program for seniors provides legal advice, counseling and representation by an attorney or other person acting under the supervision of an attorney. Activities include legal advice, representation, and investigation related to resolution of civil legal matters and protection of civil rights; assistance with administrative hearings and small claims court preparation; and community legal education presentations. For further information please see Alaska Law Help at <http://www.alaskalawhelp.org/AK/index.cfm> or Alaska Legal Services at: <http://www.alsc-law.org/>

**Health Screening.** Activities include routine, non-invasive screening for conditions such as hypertension, high cholesterol, diabetes, iron deficiency, under- or overweight, and other common medical or physical conditions, generally performed by a nurse or other health care professional or paraprofessional.

**Social, Recreational & Educational Activities.** Activities, often provided through senior centers, range widely to include classes, games, arts and crafts, dances, study groups, exercise programs, travel opportunities, and many other one-time or ongoing gatherings which encourage social interaction, exchange of ideas, and/or physical activity.



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#### **Home-Based Services**

**Home Delivered Meals.** Home-delivered meals are an in-home nutrition service that provides for at least one hot, cold, frozen, dried, canned, or supplemental-food meal with the number of meals per week determined by local service providers in their grant proposals. Recipients of home delivered meals must have documented need for the service based on eligibility criteria (inability to perform ADLs and IADLs). Provider agencies “target” those with the greatest need. Home delivery includes social contact and informal checks on the senior’s well-being.

**Assisted Transportation.** This service provides help with vehicular transportation, through an escort, to a senior with physical or cognitive difficulty.

**Shopping Assistance.** Volunteers provide shopping assistance to homebound senior citizens. Shopping assistants have a flexible schedule coordinated directly between volunteer and senior. Some of the seniors are able to shop for themselves; however, they may need assistance with transportation to the store and/or assistance carrying packages into their home. Other seniors are not able to shop due to physical limitations. In this case, the senior would prepare a shopping list for the assistant.

**Congregate Housing.** Congregate Housing is similar to independent living except that it may provide some supportive services like information and referral, meals, housekeeping, and transportation in addition to rental housing.

**Supported Housing.** Supported housing is available to individuals who, for health, safety, or other reasons, choose not to remain in their own homes. In the past, leaving one’s home for these reasons usually meant living with a relative or going into a nursing home. Today, people have a variety of other arrangements to choose from, including this option, in which a range of supportive services targeted to the individual’s need are provided on-site in a congregate housing living arrangement.

**Home Repair & Renovation.** Provides adaptation and/or renovation to the living environment intended to increase ease of use, safety, security, and independence. Modifications that would make a home more accessible include widening doorways, adding wheelchair ramps, and adding hand rails in bathrooms. For more information please see the Alaska Housing Finance Corporation website at:

[http://new.ahfc.state.ak.us/Grants/accessibility\\_modification.cfm](http://new.ahfc.state.ak.us/Grants/accessibility_modification.cfm)

**Senior Companion Volunteers.** Senior volunteers are matched with frail seniors who need assistance with everyday tasks such as shopping, reading mail, and running errands, or perhaps just someone to talk to or to keep them company on a regular basis. The social contact as well as the assistance with needed household tasks helps the individual maintain the ability to live on his or her own.

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**Homemaker/Chore Service.** Homemaker service can include meal preparation, shopping, light housekeeping, assisting with paperwork for financial, health care, insurance or other issues, making telephone calls on the senior's behalf, or assisting with using the telephone, escorting and assisting the senior to medical appointments, shopping, and other errands (does not include general transportation). Chore services assist the client in keeping a safe and clean environment to enable them to live independently in their own home. Chore helps individuals who are unable to perform one or more instrumental activities of daily living (IADLs): meal preparation, shopping, managing money, housework, yard work, or sidewalk maintenance.

**Companion Services.** Include cueing and support to individuals with mild to moderate dementia living at home. Such services include assistance with activities of daily living including meal preparation, dressing, grooming, and other daily tasks.

**Tele-health.** Tele-health is the delivery of health-related services and information via telecommunications technologies. Tele-health is an expansion of telemedicine, but unlike telemedicine (which more narrowly focuses on the curative aspect) it encompasses preventive, promotive *and* curative aspects. Tele-health stresses a myriad of technology solutions, from physicians using email to communicate with patients to remote monitoring of a patient's health status to a teleconference session with a behavioral health professional located 500 miles away.

### **Intensive Home & Community-Based**

**Adult Day Services.** Adult day services provide supervised care in an organized program of services during the day in a community group setting for the purpose of supporting an adult's personal independence and promoting social, physical and emotional well-being. A variety of program activities is offered, designed to meet individual needs and interests. These services help seniors remain in their communities and offer respite for family caregivers on a planned or scheduled basis.

**In-Home Respite Care.** Respite care service provides temporary relief to non-paid caregivers and family members who are caring for seniors. Services are provided in the client's home.

**Home Health Care.** Skilled health-related services are provided by a nurse or certified nursing assistant on an intermittent or short-term basis at home under the home health program. Individuals must be determined "home-bound" to qualify for home health services.

**Personal Care.** A personal care assistant (also known as a PCA) performs tasks of a non-technical medical nature which help individuals remain safely at home. Personal care includes assistance with personal hygiene, going to the bathroom, incontinence care, medication reminders, taking vital signs, and care of bed-bound and chair-bound clients (skin care, turning, positioning). To qualify for PCA services, individuals must require extensive assistance with two

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or more ADLs (activities of daily living). For Further information please see the State of Alaska Division of Senior and Disabilities Services at:

<http://www.hss.state.ak.us/dsds/pca/default.htm>

**Palliative & Hospice Care.** Hospice care is a coordinated program of palliative care for individuals with a terminal illness. There is focus on symptom management rather than recovery. Programs include nursing care and support, pain management, and training for family and friends. More information is available at the following national website:

<http://www.hospicenet.org/>

**Family Caregiver Support.** The National Family Caregiver Support Program offers support services to non-paid family caregivers of older adults (age 60 years and older) and grandparents and relative caregivers, 55 years and older, of children not more than 18 years of age (including grandparents who are sole caregivers of children and those individuals who are affected by mental retardation or who have developmental disabilities). Services include information, assistance, caregiver counseling, caregiver support groups, caregiver training, respite care, and supplemental services. A family caregiver is defined as an adult family member, or another individual, who is an informal provider of in-home and community care to an older individual.

**Outpatient Care.** Patient follow-up care is delivered to a senior outside of a medical facility, generally in a doctor's or other medical provider's office.

**Rehabilitation.** Services (such as physical therapy, occupational therapy, and other approaches) designed to promote recovery from an injury, surgery, other physical trauma, or addiction and a return to normal functioning are provided, usually at a rehabilitation facility.

**Counseling.** Provides appropriate behavioral health intervention to older adults who experience depression, anxiety, substance abuse and other behavioral conditions in senior-friendly settings.

### **Services in a Residential Care Setting**

**Assisted Living.** Assisted living homes provide 24-hour care for individuals who are not able to live in their own homes. This service provides assistance with activities of daily living and supervision of individuals who require it. Often transportation to outside activities is included by the home. Pioneers' Homes are a unique type of assisted living home which specializes in caring for individuals who experience dementia. A list of licensed assisted living homes is available at the State of Alaska Division of Public Health website at:

<http://www.hss.state.ak.us/dph/CL/default.htm>

**Facility Respite Care.** Respite care service provides temporary relief to non-paid caregivers and family members who are caring for seniors. Facility respite services can be provided in an adult day center or a licensed assisted living facility.

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**Pioneer's Home.** Assisted living homes administered by the State of Alaska which provide 24-hour care for individuals who are not able to live in their own homes. This service provides assistance with activities of daily living and supervision of individuals who require it. Pioneer's Homes are a unique type of assisted living home which specializes in caring for individuals who experience dementia. A list of licensed assisted living homes is available at the State of Alaska Division of Public Health website at:

<http://www.hss.state.ak.us/dph/CL/default.htm>

The Pioneer's Home information including waitlist registry information is available at:

<http://www.hss.state.ak.us/dalp/>

**Adult Foster Care.** This service provides care in a safe home setting for vulnerable adults who may have experienced abuse, neglect, self-neglect or exploitation.

**CCRC (Continuing Care Retirement Community).** A type of living arrangement in which a senior may smoothly transition from independent living to supported living to assisted living and skilled nursing care within the same home or complex as his or her needs change. CCRCs provide a model for the way many seniors would like to age – with an assurance that they will be able to stay in their homes and obtain the services they need, rather than facing the disruption of a physical move at a time when their health may be declining.

### **Most Intensive Institutional Services**

**Acute Care.** Generally provided in a hospital or other skilled nursing facility, acute care provides needed medical support for an individual suffering from a life-threatening health crisis.

**Nursing Home Care.** Nursing homes provide a cost-effective way to enable patients with injuries, chronic diseases, some acute illnesses or postoperative care needs to recover or remain medically stable in an environment outside a hospital. They are staffed by medical professionals on a 24-hour basis and offer rehabilitative services as well as social and recreational opportunities for long-term residents.

**Residential Hospice Care.** Hospice care is a coordinated program of palliative care for individuals with a terminal illness. There is focus on symptom management rather than recovery. Programs include nursing care and support, pain management, and training for family and friends. Rather than a home-based hospice program, residential hospice provides a facility in which palliative care takes place.

**Psychiatric Hospital.** Alaska Psychiatric Institute, Alaska's only psychiatric hospital, provides assessment, diagnostic, and therapeutic services to support individuals whose ability to function is severely limited by mental health problems.

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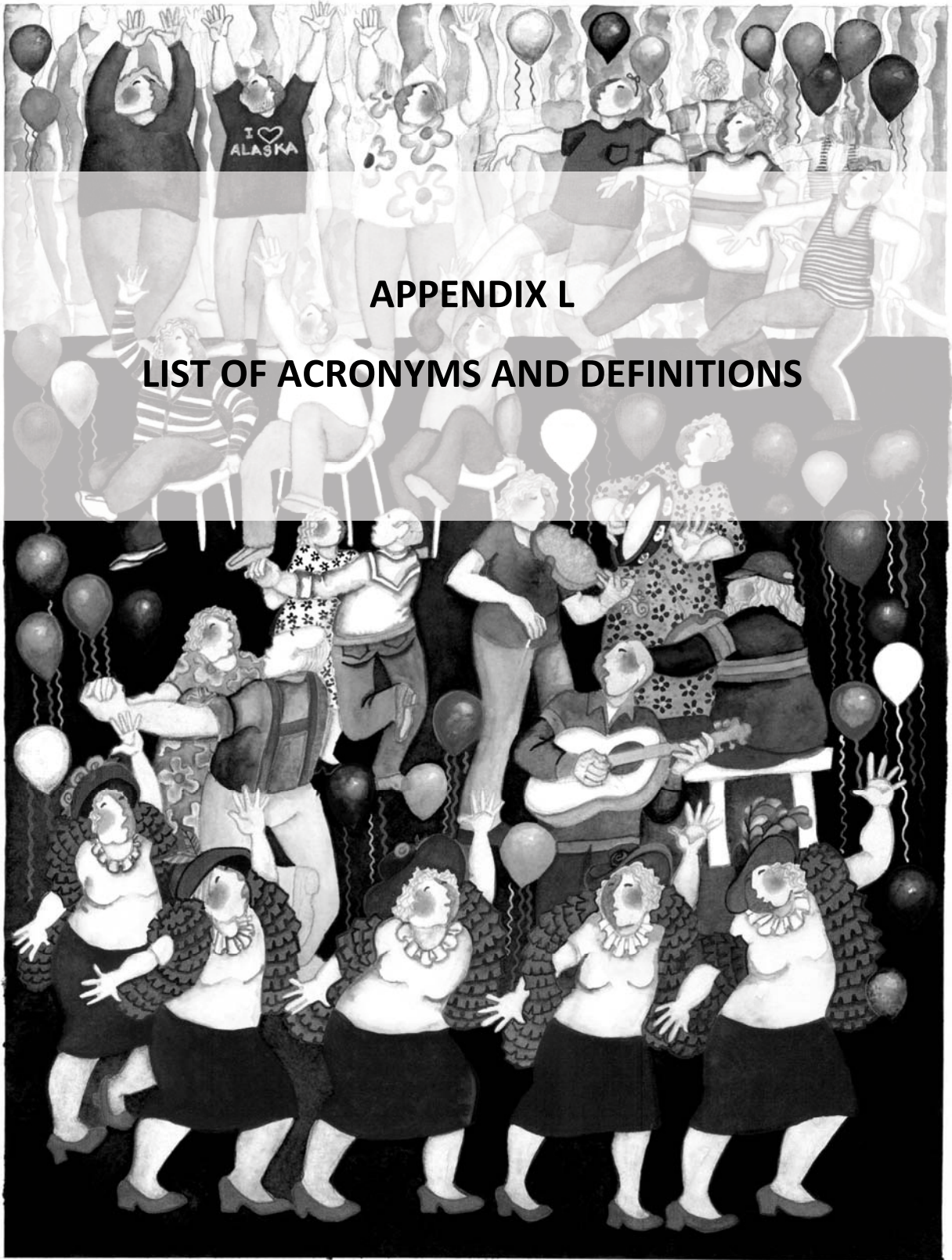
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**NOTE: Medicaid Waivers** are a type of payment arrangement rather than a specific service. Waiver programs allow people who would otherwise need an institutional level of care to live in their home or community and receive the array of services they need. These "waivers" are approved by the federal government and allow Alaska Medicaid to provide expanded services to people who meet the eligibility criteria for the specific waiver (as well as Medicaid income guidelines). For further information please see the State of Alaska Division of Senior and Disabilities Services at:

<http://www.hss.state.ak.us/dsds/hcbcwaivers.htm>

**Guardianship.** Guardianship is a legal arrangement where a person or institution is appointed as a guardian to make decisions for an incapacitated person - decisions about housing, medical care, legal issues, and services. For more information please see the Alaska Court System Family Law Self-Help Center at:

<http://www.state.ak.us/courts/guardianship.htm>



## APPENDIX L

### LIST OF ACRONYMS AND DEFINITIONS

## APPENDIX L:

### LIST OF ACRONYMS and DEFINITIONS

#### Alaska State Plan for Senior Services, FY 2012-2015 List of Acronyms and Definitions

**ABPCA** – Agency-Based Personal Care Assistance

**ACoA** – Alaska Commission on Aging

**ADRC's** – Aging & Disability Resource Centers

**ADRD** – Alzheimer's Disease and Related Disorders

**AK DOLWD** – Alaska Department of Labor & Workforce Development

**ALEXSYS** – Alaska Labor Exchange System

**AMHTA** – Alaska Mental Health Trust Authority

**ANTHC** – Alaska Native Tribal Health Consortium

**AOA** – Administration on Aging

**APS** – Adult Protective Services

**BRFSS** – Behavioral Risk Factor Surveillance System

**CDPCA** – Consumer-Directed Personal Care Assistance

**CMS** – Centers for Medicare & Medicaid Services

**COL** – Cost of living

**COOP** – Continuity of Operations Planning

**DBH** – Division of Behavioral Health



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**DHSS** - Department of Health & Social Services

**DPH** – Division of Public Health

**DSDS** – Division of Senior & Disabilities Services

**ESD** – Employment Security Division

**HCBS** – Home and Community Based Services

**HPDP** – Health Promotion, Disease Prevention

**IMPACT** – Improving Mood, Promoting Access to Collaborative Treatment

**KANA** – Kodiak Area Native Association

**LTCO** – Long-Term Care Ombudsman

**MASST** - Mature Alaskans Seeking Skills Training

**MIPPA** – Medicare Improvements for Patients and Providers Act

**MMA** – Medicare Modernization Act

**NTS** – Nutrition, Transportation, and Support

**OAA** – Older Americans Act

**OLTCO** – Office of the Long-Term Care Ombudsman

**OPAG** – Older Persons Action Group

**PCA** – Personal care attendant

**RCSC** – Real Choice Systems Change

**RSVP** – Retired & Senior Volunteer Program

**SBIRT** – Screening, Brief Intervention, Referral, Treatment

**SCOK** – Senior Citizens of Kodiak, Inc.

**SCSEP** – Senior Community Service Employment Program



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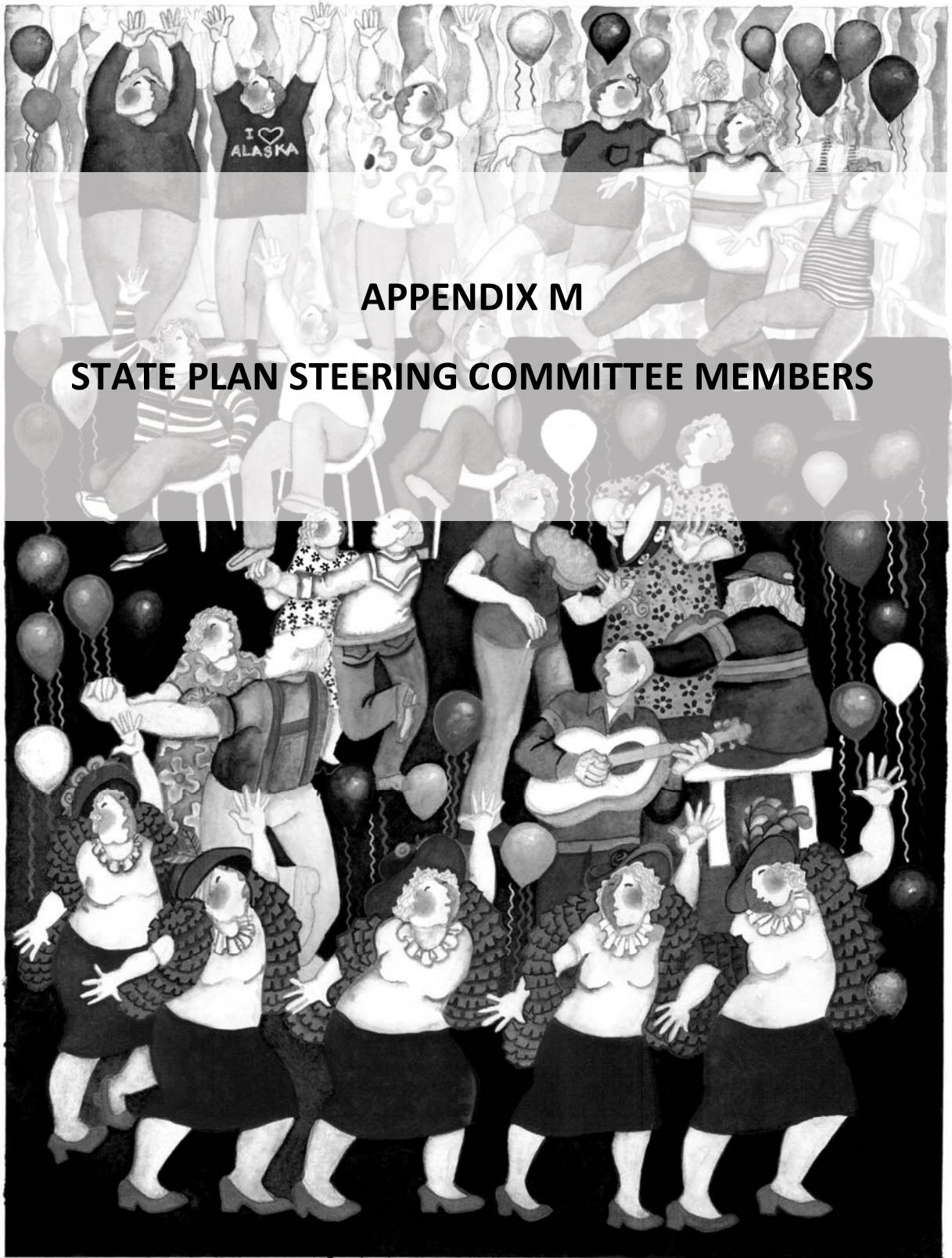
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**SESS** – Southeast Senior Services

**SHIP** – State Health Insurance Assistance Program

**SMP** – Senior Medicare Project

**SOAR** – Senior Outreach, Assessment, and Referral



## APPENDIX M

### STATE PLAN STEERING COMMITTEE MEMBERS

## APPENDIX M:

### STATE PLAN STEERING COMMITTEE MEMBERS

#### Alaska State Plan for Senior Services Steering Committee Members

Name	Affiliation	Role
Pete Andrew	Bristol Bay Native Association	Elderly Services Program Manager
Bill Black	Citizen	Consumer
Rita Bowen	Mature Alaskans Seeking Skills Training Program	Program Coordinator
Kay Branch	Alaska Native Tribal Health Consortium	Elder Care Program Coordinator
Pat Branson	Alaska Commission on Aging	Commissioner
Nancy Burke	Alaska Mental Health Trust Authority	Program Officer
Ruth Butts	Citizen	Consumer
Tom Chard	Alaska Mental Health Board & Advisory Board on Alcoholism & Drug Abuse	Planner
Dave Cote	Division of Alaska Pioneer Homes	Director
Denise Daniello	Alaska Commission on Aging	Executive Director
Marie Darlin	Alaska Commission on Aging	Commissioner
Joanne Gibbens	Division of Senior and Disabilities Services	Chief of Operations
Karen Godnick	Alaska Legal Services	Attorney, Senior Outreach Program
Rachel Greenberg	Palmer Senior Center	Deputy Director
Sharon Howerton-Clark	Alaska Commission on Aging	Chair
Betty Keegan	Alaska Commission on Aging	Commissioner
Banarsi Lal	Alaska Commission on Aging	Chair, Steering Committee
Amanda Lofgren	Division of Senior and Disabilities Services	Rural Long-Term Care Coordinator
Pat Luby	AARP	Advocacy Director
Jim McCall	Alaska Housing Finance Corporation	Senior Housing Program Officer
Barbara McNeil	Alaska Commission on Aging	Vice Chair, Steering Committee
Lynda Meyer	Municipality of Anchorage	Senior Services Coordinator
Marianne Mills	AgeNet	Member
Lisa Morley	Division of Senior and Disabilities Services	Senior Grants Manager
Dulce Nobre	Alzheimer's Disease Resource Agency of Alaska	Executive Director
Carrie Predeger	Governor's Council on Disabilities & Special Education	Planner
Barbara Stillwater	Division of Public Health	Nurse Consultant II
Lesley Thompson	Alaska Commission on Aging	Planner
MaryAnn VandeCastle	Alaska Commission on Aging	Senior Planner
Diana Weber	Office of the Long-Term Care Ombudsman	Long-Term Care Ombudsman



