

Virginia's

State Plan for Aging Services

October 1, 2015 – September 30, 2019

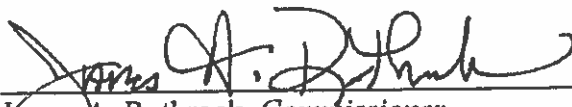


**VIRGINIA DEPARTMENT FOR AGING
AND REHABILITATIVE SERVICES**

VERIFICATION OF INTENT

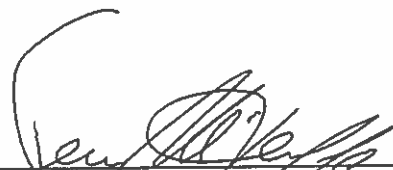
The Virginia State Plan for Aging Services, funded under Title III and Title VII of the federal Older Americans Act of 1965, as amended, (Act) covers the period from October 1, 2015, to September 30, 2019. The Virginia Department for Aging and Rehabilitative Services has been given the authority to administer the Title III and Title VII programs in accordance with all requirements of the Act, and is primarily responsible for the coordination of all state activities related to the purposes of the Act including the development of comprehensive and coordinated systems for the delivery of supportive services and nutrition services, and to serve as an effective and visible advocate for the older citizens of the Commonwealth.

The Virginia Department for Aging and Rehabilitative Services will conduct the activities outlined in this Plan in accordance with the Older Americans Act, as amended, and with the regulations, policies, and procedures established by the Assistant Secretary for Aging of the United States Administration for Community Living.


James A. Rothrock, Commissioner
Virginia Department for Aging and Rehabilitative
Services

Date May 25, 2015

I hereby approve this State Plan for Aging Services funded under the federal Older Americans Act of 1965, as amended, and authorize its submission to the United States Administration for Community Living:


The Honorable Terence R. McAuliffe, Governor
The Commonwealth of Virginia

Date 6/2/15

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EXECUTIVE SUMMARY

MISSION:

The Virginia Department for Aging and Rehabilitative Services, in collaboration with community partners, provides and advocates for resources and services to improve the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families.

A restructuring of Virginia state government in 2012 created the Department for Aging and Rehabilitative Services (DARS), now responsible for planning and oversight of aging, employment, rehabilitative, and adult services and adult protective services. The new agency brought together the former Department of Rehabilitative Services, the Virginia Department for the Aging, Virginia's Long-Term Care Ombudsman Program, and the Adult Protective Services Division formerly housed within the Department of Social Services (DSS). Although these agencies and their local counterparts had a long history of collaboration, combining staff and systems has enhanced communication, streamlined access, and increased opportunities to coordinate home and community-based supports (HCBSs) for older adults and adults with disabilities.

In accordance with the Older Americans Act of 1965(OAA), as amended, and pursuant to Virginia Code § 51.5-136, DARS, as the designated state unit on aging, is mandated to submit a state plan on aging services (State Plan) to the U.S. Administration on Community Living (ACL), the Governor and the General Assembly. DARS developed the State Plan in collaboration with the state's aging network, including the Commonwealth Council on Aging, the Area Agencies on Aging (AAAs), the Virginia Long-Term Care Ombudsman, and other state agencies, stakeholder organizations, and the older adults DARS serves. Virginia Code § 51.5-136 also requires that all state agencies submit reports on the impact of aging on their services, including unmet needs, and this was accomplished as part of this planning process. Further, state agencies designated staff in these reports who review agency policies and programs and identify opportunities to make those policies and programs more accommodating to older adults and persons with disabilities as required by Virginia Code § 2.2-604.1. The reports and agency staff can be found at: <http://www.vda.virginia.gov/2015AgencyReports.asp>. The State Plan reflects feedback from a public listening session held in Fishersville on February 13, 2015 before members of the Commonwealth Council on Aging with statewide input from videoconference sites in Roanoke, Abingdon, Fairfax, and Norfolk. DARS staff also worked with the Commonwealth Four-Year Plan Work Group (*See Appendix G*) to establish the State Plan goals and vision on March 6, 2015. The Work Group provided comment on a previously distributed exposure draft of the State Plan at its final meeting on April 17, 2015. The final draft State Plan was sent out to all members of three DARS advisory boards and interested parties and posted on the agency website for a public comment period. The State Plan describes the agency's goals and strategies to achieve its mission, emphasizing the common themes that will enhance the lives of older Virginians moving forward.

STATE PLAN VISION FOR VIRGINIA:

Age-friendly livable communities that foster independence for all Virginians.

The 2010 census confirmed, nationally and statewide, the predicted yet unprecedented growth of the older population—1,419,306 Virginians over the age of 60, with the over 85 age group being the fastest growing segment of the population. Virginia's population, like that of the

nation, is becoming older and more racially and ethnically diverse and with a growing number of individuals with limited English proficiency. Today, there are an estimated 1,484,173 adults in the Commonwealth who are over 60 years old, and this population will expand to more than 2 million by 2030 (U.S. Census, 2013 American Community Survey Estimate). By 2030, the entire baby boom generation will be between 66 and 84 years old. Just as older adults show big variations in their skills and abilities—one 80-year old might play tennis, while another might live in a nursing home—the internal process of aging differs in all of us. But it is a fact that the aging population will live longer due to advances in technology and medicine, and those older Virginians with chronic conditions may need more assistance for longer periods of time.

The critical need to provide supports to more older adults while resources are limited has reinforced a growing trend that emphasizes strategies to integrate long-term services and supports (LTSSs) into the community. HCBSs help older adults accomplish everyday tasks such as bathing, dressing, preparing a meal, or balancing a checkbook. Assistance with just a few of these tasks help frail elderly adults remain in their own homes independently. Therefore, these strategies not only reflect the cost-efficiency of HCBSs, but also reflect the predominant preference of older adults to age in place in their homes and communities. Research also supports this approach, documenting that supporting individuals at home can lead to better health outcomes. Agencies at the federal, state, and local levels should be identifying and addressing the need for the appropriate types and amounts of long-term care, emphasizing HCBSs.

Livable communities bring together enhanced partnerships to provide aging services, housing, health care services, and transportation. All services have a significant educational component to ensure person-centered planning. The following are just a few exciting advancements toward livable communities that promote optimal aging and improve the lives of older Virginians.

- Eight Virginia communities have adopted age readiness plans, and the Greater Richmond Region was named the 2015 Metlife Foundation/Generations United Best Intergenerational Community.
- In December 2014, Virginia received a \$2.6 million one-year grant from the Centers for Medicaid & Medicare Services (CMS) that includes funding for the Eastern Virginia Care Transitions Partnership to develop a plan to expand Care Transitions statewide through the AAA network with program enhancements including medication adherence, behavioral health screening, and advanced care planning.
- Under a one-year planning grant from the ACL, CMS, and the Veterans Health Administration, Virginia is developing a three-year plan to expand Virginia's Aging and Disability Resource Connection (ADRC) called No Wrong Door (NWD) to all populations and payers. The plan will focus on assessment of the current NWD system, common language, education and awareness, person-centered tools for assessments, quality, and sustainability.
- There are 14 Programs of All Inclusive Care for the Elderly (PACE) that help individuals who are 55 years of age or older remain in the community and address their health and social needs.
- In 2014, Virginia received an Alzheimer's Disease and Supportive Services Program (ADSSP) three-year grant to provide caregivers of persons with dementia counseling services and supports and referrals to community resources in the greater Charlottesville

and Williamsburg areas.

- The 2015 Virginia Governor's Housing Conference will hold a competition to design a safe, affordable, energy-efficient home that allows for people to "age in place" in Virginia.
- DARS has partnered with the Virginia Department of Health to accept the 2015 President's Challenge on Healthy Aging by taking the Healthy Aging Pledge. This challenge aims to galvanize state and local health officials and the aging network to implement evidence-based strategies for increasing the number of older adults who are living well in the community.

Virginia not only recognizes the growing demand on services and supports that this aging demographic shift will produce, but also the increasing intellectual capital, time, and expertise that it will provide, generating unprecedented and as yet untapped levels of available skills, abilities, and diverse human resources. For example, the State Plan for Volunteerism and Services includes a goal to increase service opportunities for adults age 55 or older, including how to utilize their skills and experience to address community needs. DSS will collaborate with DARS, the Department of Labor and Industry, Virginia Employment Commission, AARP, local AAAs, local volunteer centers, institutions of higher education, the faith community, and other business and community organizations to increase service opportunities for older Virginians.

The mission of DARS has evolved to promote security and independence while providing the right care that empowers older adults and persons with disabilities to have and make choices about their lives. Moreover, older adult LTSSs that are rooted in the principles of the Culture Change or person-centered care movements have increasingly enhanced choice, dignity, respect, self-determination, and purposeful living. Utilizing demographic and service data, state agency reports on the impact of the aging population, and input from older adults and caregivers during listening sessions held by the Commonwealth Council on Aging and from aging network stakeholder meetings, DARS adopted the following service goals:

1. Assess and facilitate statewide community readiness for an aging population, recognizing both the untapped resources and the unmet needs of this population;
2. Empower older adults and their families to make person-centered and informed decisions about personal health and well-being, long-term services and supports, and end-of-life care options;
3. Enable people to live in the community as appropriate through the availability of formal and informal high-quality LTSSs, including supports for families and caregivers;
4. Strengthen statewide systems that protect the rights and prevent the abuse, neglect, or exploitation of older adults; and
5. Enhance effective and responsive management of programs serving older adults to ensure the fiscal and programmatic accountability of those programs.

These service goals support the overarching State Plan vision of creating livable communities that are age-friendly and foster independence, and they form the framework for the State Plan's strategic goals for 2015-2019.

2015 Virginia State Profile

Population by Age ¹		
All ages	8,100,653	100.0%
Total 60+	1,484,173	18.3%
60 - 64	460,887	5.7%
65 - 74	586,264	7.2%
75 - 84	311,054	3.8%
85+	125,968	1.6%

Population by Race (60+) ¹		
White	1,172,497	79.0%
Black or African American	230,047	15.5%
American Indian & Alaskan Native	2,968	0.2%
Asian	56,399	3.8%
Other	22,262	1.5%

Population by Ethnicity (60+) ¹		
Hispanic or Latino origin (any race)	35,620	2.4%
Not Hispanic or Latino	1,448,553	97.6%

Population by Geographic Area (60+)		
Living in Rural Area*	364,209	24.5%

Population by Gender (60+) ¹		
Male	666,394	44.9%
Female	817,779	55.1%

Financial Status (60+) ¹		
Pop for whom poverty status is determined	1,454,518	100.0%
Below 100% of FPL**	110,543	7.6%
100 – 149% of FPL	122,180	8.4%
Above 150% of FPL	1,221,795	84.0%

Living Situation (60+) ¹		
Households	901,971	100%
Living Alone	348,161	38.6%

Grandparents (60+) ¹		
Living with grandchild(ren)	84,598	5.7%
Responsible for grandchild(ren)	25,231	1.7%

Medically Underserved (60+) ²	
Total Medically Underserved	875,681

Number of Licensed Long-Term Care Beds	
Total Beds	67,927
Nursing Facility Beds ³	35,242
Assisted Living Facility Beds ⁴	32,370
Mental Health Geriatric Beds ⁵	315

Adult Foster Care ⁶	
Providers	58
Number of Residents in Program	74

Adult Day Care ⁷	
Facilities	73
Capacity	3,860

Home Care Services ⁸	
Certified Home Health Agencies	234
Home Care Organizations	611

Homemaker & Companion Service Companies ⁹	
Companies (Self-reported)	513

Employment Status		
In Labor Force	454,157	30.6%
Employed	434,863	29.3%
Unemployed	19,294	1.3%
Not in Labor Force	1,030,016	69.4%

*A rural county is one in which the county's population density is less than 500 people/square mile, and 90 percent of the county population is in a rural area or the county has no urban area with population of 10,000 or more.

**FPL = Federal Poverty Level

Data Sources:

1: U.S. Census, 2009 -2013 American Community Survey 5-Year Estimates; 2: VDH, The Office of Minority Health and Health Equity, email transmission from Adrienne McFadden dated 4/5/15 (adrienne.mcfadden@vdh.virginia.gov) ; 3: VDH, Office of Licensure and Certification "Directory of Long Term Care Services", updated July, 2013 - www.vdh.virginia.gov/OLC/Facilities; 4: Va. Dept of Social Services, Licensing Division, "Electronic List of Licensed Assisted Living and Adult Day Care Facilities", as of 4/30/14 ; 5: E-mail transmission from Linda Grasewicz dated 5/01/14, (linda.grasewicz@dbhds.virginia.gov); 6: DARS, Adult Protective Services 7: Virginia Dept. of Social Services, <http://www.dss.virginia.gov/facility/search/adc.cq>; 8: VDH, Office of Licensure and Certification "Directory of Home Care Providers in Virginia", updated Nov. 2013 - www.vdh.virginia.gov/OLC/Facilities; 9: Senior Navigator, email transmission from Katie Benghauser dated 4/2/15 (katie@seniornavigator.org)

CONTEXT

Virginia's Changing Aging Services Network

DARS, in collaboration with community partners, advances its mission to provide and advocate for resources and services to improve the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families. Established by the Virginia General Assembly in 2012, DARS brought together the former Department of Rehabilitative Services, the Virginia Department for the Aging, Virginia's Long-Term Care Ombudsman Program, and the Adult Protective Services Division formerly housed within DSS. DARS as the designated State Unit on Aging includes the Virginia Division for the Aging (VDA) whose role is to plan, coordinate, fund, and evaluate programs for older Virginians made possible through funding from the OAA, discretionary grants, and state general funds appropriated by the General Assembly. VDA oversees fiscal management of, serves in an advisory capacity to, and monitors implementation of quality standards for a full range of nutrition, transportation, health promotion, in-home supports, education, socialization and recreation services, and family caregiver services provided by Virginia's 25 AAAs. VDA serves as the coordinator for Virginia's ADRC, known as No Wrong Door (NWD). VDA also provides staff support for three advisory boards whose members are appointed by the Governor and General Assembly:

- the Commonwealth Council on Aging that held State Plan listening sessions;
- the Alzheimer's Disease and Related Disorders Commission (Alzheimer's Commission) that is responsible for the Dementia State Plan; and
- the Public Guardianship and Conservator Advisory Board that oversees the Public Guardian Program.

Virginia's network of 25 local AAAs, established under the OAA, are designated by DARS and local governments to plan, coordinate, and administer services to older adults at the community level. Most AAAs are private non-profits agencies, others are a part of local government, and still others are jointly sponsored by counties and cities within their planning districts. AAAs serve specific geographic areas that generally correspond with the boundaries of Virginia's Planning Districts. (*See Appendix D*).

Hundreds of thousands of the Commonwealth's older residents have benefited from services provided by the AAAs. Funded through federal, state, and local government allocations, private grants, fees, and contributions, AAAs provide HCBSs designed to assist older adults with the basic activities of daily living that enable them to age in place. Other AAA services promote healthy lifestyles, prevent chronic diseases, and strive to improve the quality of life for older adults and their families. Most of the services funded through the OAA are targeted to adults 60 years old and older in greatest social and economic need with particular attention to low income individuals, minority individuals, those in rural communities, those with limited English proficiency, and those at risk of institutional care. Although these federally-funded programs are available at no cost for those who qualify, AAAs offer services as legally permitted on a sliding-fee scale to those who can afford to pay for all or a portion of the cost.

AAAs offer directly or through contracts a common set of core OAA programs including: home-delivered meals and meals at congregate sites, transportation, legal assistance, elder abuse prevention, in-home and family caregiver support services, and information and referral to community resources. Each AAA has considerable flexibility to develop and provide additional

services, often reflecting local needs. The OAA, the Governor, the Virginia General Assembly, and DARS encourage AAAs to work with their localities to create a range of programs that are responsive to the unique needs of their older residents – programs like care coordination and care transitions, employment assistance, older adult volunteer programs, tax counseling, and support for grandparents raising grandchildren. Some AAAs manage senior centers, provide opportunities for recreation, education, and socialization, or operate adult day care centers with daily supervision and activities for older adults who can no longer safely remain alone at home. Others have developed comprehensive transportation systems to include vans, buses, and trolleys, filling a void for older adults and other populations, especially in rural Virginia. A few AAAs also own and manage housing for older adults and assisted living facilities, administer senior housing programs, operate or partner with PACE centers, offer home modification, serve as local weatherization programs, manage the local community action agency, and offer other valuable programs to local older adults and their families.

The OAA and other federal programs bring \$35.9 million in federal dollars to Virginia and the state provides an additional \$17.6 million (*See Appendix E*). Most of these funds are administered and distributed by DARS using a formula developed in cooperation with the AAAs with input from stakeholders. Considering the rapid increase in the aging population and the cuts required due to the 2008 recession and more recent sequestration,¹ the gap in services continues to grow and could have significant negative impacts if the aging network does not receive additional funding. AAAs have responded by developing creative funding development strategies and entrepreneurial initiatives. Relying on philanthropic dollars can be an uncertain path, but some AAAs have experienced early success thanks to training and innovative approaches. Fundraising alone will not fill the gap created by the combination of budget cuts and increased demand on services, however. Maintaining effective and responsive management practices support Virginia's **goal to ensure the fiscal and programmatic accountability of programs serving older adults**.

Achieving a person-centered, statewide comprehensive and coordinated system of programs and services for all, regardless of age or disability, has required DARS and the AAAs to partner with public and private organizations, including various state agencies and educational institutions, to advocate for and develop the necessary LTSSs, in addition to finding ways to address the critical issues of housing and transportation. While Virginia has made great strides in aligning service delivery to older adults and adults with disabilities beginning with the creation of DARS in 2012, this State Plan is primarily focused on aging services and supports.² Virginia believes livable communities have the ability to bring together enhanced partnerships among providers of aging services, housing, health care services, and transportation so that all Virginians can age successfully. The following is an overview of Virginia's progress in each of these areas that demonstrates how Virginia is supporting livable communities and the

¹ The DARS-VDA programs continue to be affected by sequestration. Many OAA programs continue to be negatively impacted. Since 2012, the year prior to sequestration, federal funding has decreased \$1,115,000. Although federal funding for the congregate (group) and home delivered meals funding have been restored, the following programs have been negatively impacted: Title III-B In-Home and Community Support Services reduced 8.5% or \$716,000; Title III-D Disease Prevention reduced 6.2% or \$30,000; Title III-E Family Caregiver Program reduced 3.5% or \$121,000; Title VII Ombudsman reduced 5.3% or \$21,000; Title VII Elder Abuse reduced 12.6% or \$15,000; and Nutrition Supplement reduced 9.3% or \$212,000. Fortunately, the 2014 Virginia General Assembly increased nutrition funding by \$1.2 million to improve nutrition counseling, the quality of the meals, and mitigate some of these other reductions.

² The growing aging population will include people with lifelong disabilities and people aging into disability. For more information on aging with disability see <http://www.giaging.org/issues/disability>.

improvements that have already begun to foster independence for all Virginians to meet Virginia's goal to enable people to live in the community as appropriate through the availability of formal and informal high-quality LTSSs, including supports for families and caregivers.

Creating Livable Communities

While many state and local, public and private organizations offer programs and services for older adults, the AAAs, with the guidance of VDA, serve as the focal points for information and referral for many of the HCBSSs utilized by older Virginians (See Appendix F). The vision of the State Plan is to effect systems change for HCBSSs within Virginia by fostering "age-friendly" livable communities.

Mandated by the Governor and the Virginia General Assembly in 2010 pursuant to Virginia Code § 2.2-213.4, Virginia's Department of Rehabilitative Services (prior to becoming DARS) convened an 18-member Citizen Advisory Group comprised of individuals and state agency representatives with expertise and background experiences in critical fields involved in livable communities planning to develop a Blueprint for Livable Communities (Blueprint) and LTSSs for older Virginians and people with disabilities. The Blueprint is found at www.vadars.org/vblc. With localities as diverse as Abingdon and Arlington, the Blueprint is not a "one-size-fits-all" document, but a compilation of planning resources, policy information, and research that is universally adaptable to any size or type of community. This document is the first step in a long-range state effort to support the changes urgently needed to provide all Virginians with the opportunity to live and age optimally in their communities. The online Blueprint launched in July 2011 and the Citizen

<i>Virginia Communities with Age Readiness Plans</i>
Alexandria - The City of Alexandria developed a four-year Strategic Plan on Aging (2013-2017) entitled, <i>The Alexandria of Our Future, A Livable Community for All Ages</i> . This plan was a collaborative effort among the Alexandria Division of Aging and Adult Services, the Alexandria Commission on Aging, city officials, and community members. Key features of the plan include a description of livable communities and the need for planning and goals for communications and outreach, housing, transportation, community services, economic and workforce development, quality of life, and health, wellness, and safety.
Arlington - The Arlington County Elder Readiness Plan was developed by the Arlington County Board of Supervisors Elder Readiness Task Force that encompasses a number of community partners including the Arlington Agency on Aging. The goals and objectives of the plan include communication and increased volunteerism, housing, transportation, supportive services and health care, community involvement, civic engagement, and legislative proposals.
Chesapeake - The "55 and Better Comprehensive Plan" was developed with the active participation of many community stakeholders. This Plan aligns the city's priorities for older adults across not only all city departments but also the community, including many organizations that help older adults in Chesapeake. The Plan is an agenda for action and an advocacy tool, and it creates a focus on the most important issues for the older adult population.
Greater Charlottesville Area - The 2020 Plan: Aging in Community represents an effort by the Jefferson Area Board for Aging and many partners within the Jefferson Area Planning District to create a comprehensive, integrated approach to age wave readiness. The goals and objectives focus on a framework of promoting coordinated and accessible healthcare, supporting maximum independence and lifelong health, offering choices, designing communities to enhance quality of life, fostering vibrant engagement, strengthening active citizenship, and strengthening intergenerational connections.
Greater Richmond Area - The Greater Richmond Regional Plan for Age Wave Readiness was developed by a large coalition of stakeholders including Senior Connections, the Capital Area Agency on Aging, United Way of Greater Richmond & Petersburg, Genworth Financial, Memorial Health Foundation, Richmond Regional Planning District Commission, VCU Department of Gerontology and School of Social Work, and many more individual and community partners. The goals and objectives focus on a framework of age wave ready, engaged, livable, well, and stable communities. The plan utilizes demographic maps and regional charts and graphs to track indicators.
Greater Williamsburg Area - The Community Action Plan on Aging (CAPOA) was created by the Senior Services Coalition of Greater Williamsburg (SSC). SSC is a membership organization of health care providers, government entities, local businesses, academics, and community members working collaboratively to promote a healthier and more livable community for older adults in the Greater Williamsburg Area and is a program of the Peninsula Agency on Aging. The goals and objectives of the plan include improving the skills of family caregivers, the Age Friendly Community Indicators Project, helping seniors age in place, healthy aging, workforce development, and job training.
Fairfax - The Fairfax County Board of Supervisors adopted the <i>The Fairfax County 50+ Community Action Plan</i> on September 23, 2014. This plan was a collaborative effort among the Board of Supervisors, Fairfax Area Agency on Aging, Fairfax Area Commission on Aging, county officials, and community members. Key features of the plan include initiatives regarding housing, transportation, community engagement, services, safety and health, and long-range planning.
Rappahannock-Rapidan - The Aging Together 2013-2015 Plan - Aging Together has been active for more than a decade and enjoys strong community partnerships. The goals and objectives include: 1) identifying gaps in services, transportation, accessible and affordable housing, long-term care workforce, access to needed information, resources and supports; 2) increasing older adults' knowledge of healthy living; 3) decreasing elder abuse and neglect; and 4) supporting "Aging in Place" and the "Livable Community" concept.

Advisory Group continues its work with agency representatives to remove barriers and expand opportunities that support Virginia's communities in this evolutionary process toward "livability." To date, eight Virginia communities have adopted age readiness plans that endorse the State Plan vision of "age-friendly" livable communities and Virginia has set as a **goal to assess and facilitate statewide community readiness for an aging population, recognizing both the untapped resources and the unmet needs of this population.** The eight active age readiness plans are found at <http://www.vadars.org/vblc/awp.htm>. Community living supports and models that are emerging in the Commonwealth are the Village Concept, Co-Housing, Mixed Generation, and Easy Living Homes (see chart).

In 2014, DARS partnered with the United Way of Greater Richmond & Petersburg to sponsor an Age Wave Leadership Forum for communities throughout Virginia that have been active in age readiness planning. Participants represented diverse geographic areas such as Roanoke, Fauquier, Culpeper, Greater Williamsburg, Fredericksburg, Greater Richmond, the Peninsula, Charlottesville, and Northern Virginia. The purposes of the meeting were to learn from existing age readiness planning initiatives, align efforts, and disseminate best practices statewide. Other active age readiness planning coalitions have formed or are forming in the Southeastern, Southwest, Roanoke, New River Valley, Southern, Eastern Shore, and the Hampton Roads regions. Each group has its own unique composition and focus based upon local needs and community desires.

To assist residents and leaders in their communities with getting involved in livable communities planning, multiple planning toolkits and other resources have been developed to offer detailed suggestions and even step-by-step guides to the basic planning process. One example, the Transportation and Housing Alliance (THA) Toolkit, offers assistance with the comprehensive planning process; and because comprehensive plans must address the welfare of people with disabilities and older adults, the process provides an important opportunity for parties to become involved and bring livable communities planning into focus. Recognizing this opportunity, advocates from the disability community have utilized funding from Title VII of the

<i>Community Living Supports and Models that are Emerging in the Commonwealth</i>
The Village Concept - The village model evolved out of a concept developed in the Beacon Hill neighborhood of Boston in which older adults living in the area can pay a membership fee to receive an array of services through a concierge-style system. Villages using this model as inspiration have developed in communities through local grassroots efforts nationwide, and as a result each village operates uniquely. Services frequently offered through villages include grocery delivery, information and referral, social activities, home maintenance and repair, and other supports that enable adults to continue to live healthy lives independently in their own homes. Typically members of villages are older adults who pay a membership fee; and many models include options for residents to volunteer their in-kind services to other members within the program. According to the national Village to Village Network, Virginia currently has nine villages in operation and six in development. For more information, visit: http://vtvnetwork.org/
Co-Housing -The ElderSpirit Community at Trailview in Abingdon is the first mixed-income, mixed ownership Elder Co-Housing Community in the United States. This model was developed by members of the ElderSpirit Community organization, a participatory membership organization for older adults that provides opportunities for growth through later life spiritual programs and through the formation of communities and residential centers. Residents live in the community voluntarily as part of their membership in the ElderSpirit organization, supporting one another's day-to-day needs through volunteerism, service, and fellowship.
Mixed Generation - Timberlake Place is the site of a development in Charlottesville designed specifically for senior-friendly housing, at least 80 percent of which is targeted for low to moderate income seniors. Approximately 20% of the units are mixed-generation workforce housing that, to the extent permitted by funding sources, is designated for persons such as caregivers and law enforcement. All but two of the units are constructed with Universal Design features and the entire project is designed to meet EarthCraft Multi-Family standards. Also in Charlottesville, the Jefferson Area Board for Aging provides nursing services at a local public housing community that is home to older adults and adults with disabilities. Nurses provide monitoring of chronic health conditions, medication management, first aid, and collaboration with primary care physicians. These services help reduce emergency room visits and hospitalizations and allow aging in the community.
Easy Living Homes - Easy Living Homes feature a zero step entrance, ample room for maneuvering, and a master bedroom and bath on the main floor. These features enable individuals to age in place, remaining mobile within the main floor of their homes even as they encounter new and different needs over the course of their lifetimes. In addition, an EasyLiving Home is a "visitable" home, meaning that visitors of any age or ability can easily navigate the home's main floor and have access to the necessary amenities. The EasyLiving Homes certification process guarantees that a home has been built to exacting specifications and meets the necessary criteria to qualify the home as EasyLiving. Virginia Accessible Housing Solutions, Inc. (VAHS) is a non-profit corporation licensed to certify Easy Living Homes in Virginia.

federal Rehabilitation Act to advocate for the use of the THA Toolkit and the inclusion of disability issues in comprehensive plans in localities throughout the Commonwealth. DARS distributes over \$475,000 to Virginia's 16 Centers for Independent Living for systems change activities that focus particularly on the areas of transportation, housing, and personal assistance services.

Best Practice Awards

The Best Practice Awards, developed and sponsored by the Commonwealth Council on Aging, provide state-wide recognition of successful, unique, local or regional programs that serve older Virginians and their families. With a special focus on aging in place, the awards are designed to recognize creativity and effectiveness in services that foster Livable Communities and provide HCBSs. From transportation to housing and caregiver support to multi-generational programming, the awards acknowledge and promote best practices, raise awareness about the value of HCBSs, and encourage replication of stellar programs across the state. For more details on the awards, see <http://www.vda.virginia.gov/ccoa-bpa.asp>.

In 2015, Senior Connections, The Capital Area Agency on Aging, won the top 2015 Best Practices Award for its advance care planning initiative in the Richmond region. Senior Connection's Faith to Fate Advance Care Planning Initiative works with area African-American congregations to encourage awareness about the need for advance care planning and offers information for individuals to make end-of-life decisions and legal documents to help relatives and others know what type of medical care is wanted. The second place award recognizes the Central Senior Center, in Centreville, for its meal and home care programs that help thousands of older residents. The center opened in 1994 to serve Koreans, Fairfax County's third largest immigrant community, and its programs help older Korean-Americans age in place and maintain their independence. The third place award was given this year to the Volunteer Solutions program of the Fairfax Area Agency on Aging. The program, which has expanded to other organizations, connects volunteers to older adults and adults with disabilities in the community, and recruits volunteers for senior centers in Fairfax County.

Honorable mention went to Successfully Aging at Home in the New River Valley – a Grassroots, Community-Based Initiative guided by the New River Valley Aging in Place Leadership Team (Team) made up of eight community organizations. Initiative activities utilize the strengths of team members to bring together a wide range of sectors in the community to develop viable options to address two co-occurring needs that challenge older adults to remain in their homes and communities: home accessibility and supportive services. The Team has sponsored innovative community projects and programs promoting aging in place including a Home Modifications Program partnership with Habitat for Humanity, development of a time bank program, and establishing a regional Aging-in-Place Action Plan.

Livable Communities Connecting through No Wrong Door

Virginia has created its ADRC, called No Wrong Door (NWD) to streamline access to publicly and privately-funded supports. NWD promotes local coordination and planning through community advisory councils, uses technology to increase the efficiency of providers and stretch resources, empowers consumers with information and options, and supports individuals in self-advocacy, self-direction, and choice.

Virginia's NWD serves older adults and adults with disabilities by addressing individual long-term support preferences and needs and providing a vehicle for coordinating and integrating multiple state-administered and private pay programs. DARS serves as the statewide public lead working hand-in-hand with VirginiaNavigator as the statewide private-sector lead. The Code of Virginia designates the AAAs as the local lead agencies for implementing NWD in their respective communities. NWD is also driving AAAs to broaden their service delivery to include adults under the age of 60 with disabilities and is underscoring the importance of strengthening interagency and cross-organizational coordination across populations.

NWD provides the technology and protocols for public and private providers to access and share client information with consent and within a protected environment. NWD strengthens coordination of services, streamlines eligibility determination for public programs, enables electronic referrals between agencies, and improves tracking of services. The goal is for all public and private HCBS providers to be connected through the NWD system, using a module called CRIA (Communication, Referral, Information and Assistance). Currently, 62 providers utilize CRIA, which interfaces with a referral provider database of over 26,300 LTSSs to directly serve over 41,500 unique individuals across Virginia last year.

Beyond CRIA, Virginia's NWD is used for Options Counseling, Care Transitions, Section Q support,³ and streamlined eligibility for certain publicly paid supports. All these programs are also integrated into the NWD system to enable client data on 160,281 unique individuals in the system, to be securely shared, and to track movement and progress across programs. Virginia is well on its way to its **goal to empower adults and their families to make person-centered and informed decisions about personal health and well-being and LTSSs.**

Under a one-year planning grant from the ACL, CMS, and the Veterans Health Administration, Virginia is developing a three-year plan to expand the NWD system to all populations and payers. The effort is being co-led by the Virginia Office of the Secretary of Health and Human Resources and DARS, the Department of Medical Assistance Services (DMAS), and the Department of Behavioral Health and Developmental Services (DBHDS). A state-level NWD Resource Advisory Council was convened in December 2014 and is meeting monthly through September 2015 to develop the three-year plan. The plan will focus on assessment of the current NWD system, common language, education and awareness, person-centered tools for assessments, quality, and sustainability.

Options Counseling

Virginia has developed statewide standards for Options Counseling (OC) using person-centered practices that closely align with the OC federal standards. Additionally, DARS and the Partnership for People with Disabilities created an accessible online training certification program to encourage LTSS providers to become OC certified and offer person-centered OC to older adults and individuals with disabilities. An online refresher module is updated annually and serves as the training for options counselors to fulfill their annual recertification requirement. To date, 12 AAAs and 6 CILs have been certified and currently provide OC under a state reimbursement model. Over the past year, 893 unique individuals have received person-centered decision-support through this program.

³ Virginia's AAA network serves as the Local Contact Agency (LCA) for MDS 3.0 Section Q, guided by a statewide protocol for decision support and referrals to Money Follows the Person and HCBS programs. The Section Q process is tracked in the NWD System and quarterly reports are fed to DMAS for inclusion in a data report to CMS.

Aging Services

State Health Insurance Program (SHIP): Virginia Insurance Counseling and Assistance Program (VICAP)

VICAP counselors provide personalized decision support and assistance including accurate, understandable, and objective information on a wide range of health insurance issues such as Medicare, Medicaid, long term supports, and prescription drugs. Available to the nearly 1.328 million Medicare beneficiaries, VICAP counselors track approximately 80,000 contacts annually, helping beneficiaries understand and compare benefits, apply for low-income subsidies (LIS), resolve problems, file appeals, explore options, and become better informed about their rights as patients. With Medicare Improvements for Patients and Providers Act (MIPPA) grant funding, VICAP is able to target low income beneficiaries, especially in rural areas, for enrollment in the LIS, as well as provide statewide outreach and education on Medicare's health and wellness benefits. With Virginia's VICAP offices physically located in AAAs, cross referrals between the ADRC/NWD network and VICAP are standard practice. VICAP also provides community presentations and awareness on Medicare and insurance-related issues. In partnership with the DMAS, VICAP provides education to Medicare and Medicaid eligible individuals enrolled in the Commonwealth Coordinated Care Program. VICAP works closely with the Virginia Bureau of Insurance and Senior Medicare Patrol (SMP) to ensure Medicare beneficiaries are protected from fraud or misleading information that could result in enrollment in a plan that is not best for the beneficiary.

Care Transitions

The Community-based Care Transitions Program (CCTP) was initiated by the CMS in April 2011 with the goal of improving transitions of Medicare beneficiaries from inpatient hospitals to home or other care settings. Care transition services are designed to improve quality of care, reduce readmissions to hospitals by high-risk beneficiaries, and achieve cost savings for the Medicare program. Under the Affordable Care Act, hospitals may be subject to penalties for patients who are readmitted within a 30-day period post discharge and CCTP is being used to reduce readmissions. Over the past three years, eight separate Care Transitions programs have developed across Virginia. Two were established with CMS CCTP awards to utilize the Coleman Care Transitions Intervention (CTI) Model for successful transitions from the hospital to home. One program is lead by the Appalachian Agency for Senior Citizens in collaboration with four community hospitals. The second program, the Eastern Virginia Care Transitions Partnership, is a formal coalition of five major health systems, 11 hospitals, five AAAs led by Bay Aging, independent physician's groups, and other public and private health and human services providers. Both programs provide a collaborative approach to reducing 30-day readmissions. Six other programs utilize variations of CTI, some in combination with other evidence-based practices.

The Virginia Partnership for Care Transitions is a state level coalition of the Virginia Hospital and Healthcare Association, Virginia Health Quality Center (VHQC), and DARS to promote the model statewide. In December 2014, Virginia received a \$2.6 million one-year grant from CMS to develop a state health innovation plan for delivering health care that includes the Eastern Virginia Care Transitions Partnership with program enhancements that include medication adherence, behavioral health, and advanced care planning. The Virginia Health Innovation plan will create accountable care communities in five regions of the state to develop

ways to improve health care delivery and outcomes in their areas. The plan will be developed by the Virginia Center for Health Innovation, which is collaborating with public and private health partners. Virginia plans to seek a federal waiver under the Medicaid program that would allow Virginia to make incentive payments to hospitals and health systems for innovations in delivering health services and significant improvements in the quality of care.⁴

Alzheimer's Disease and Related Dementias

In Virginia, an estimated 130,000 adults aged 65 and older are affected by Alzheimer's disease with an expected increase to 190,000 by 2025.⁵ In December 2011, the Virginia Alzheimer's Commission adopted a Dementia State Plan (DSP) for Virginia to improve the quality of life for individuals with dementia and their caregivers. Virginia hired its first Dementia Services Coordinator in 2013 to oversee dementia-focused efforts among state agencies and organizations to improve service delivery, identify gaps and duplication, administer grants, and recommend policy. The Virginia Alzheimer's Commission and the Dementia Services Coordinator are in the process of updating the DSP.

Currently, the Virginia Respite Care Initiative Program, administered by several AAAs and private contractors, offers a small support for caregivers of older Virginians, especially those suffering from Alzheimer's disease. Caregivers for persons with dementia in Virginia, estimated to be around 447,000 individuals in 2013, provided 509 million hours of unpaid care valued at \$6.3 billion.⁶ While many caregivers, especially older spouses, are key to individuals staying at home, they often face health problems of their own, which also places the care recipient at risk. An important factor in reducing caregiver stress is figuring out how to interact with the person with Alzheimer's disease, day after day. With an Alzheimer's Disease and Supportive Services Program (ADSSP) Grant in 2010 from ACL, Virginians caring for an individual with Alzheimer's disease received help with strategies to interact positively, help the individual maintain cognitive functioning, and reduce behavioral symptoms through an evidence-informed intervention known as *Connections* that was tested by the Alzheimer's Association Central and Western Virginia Chapter and the University of Virginia.

In September 2014, DARS received a three-year \$441,000 ADSSP Grant cooperative agreement from ACL. The grant goals are to:

- Increase knowledge and awareness of and resources for treating dementia in Virginia's NWD system and Virginia's AAAs, and
- Help family and informal caregivers feel more confident in their role, feel more satisfied with the social and emotional support networks they have, reduce the depression that can hit caregivers, and help caregivers assess and feel comfortable responding to the behavior that can sometimes affect people with dementia.

The New York University Caregiver Intervention, a best practice in dementia care, is being implemented in Virginia as F.A.M.I.L.I.E.S.- Family Access to Memory Impairment and Loss Information, Engagement and Supports. FAMILIES will provide caregivers of persons with dementia with counseling services and supports and referrals to community resources. The three-year grant partners with organizations in the greater Charlottesville and Williamsburg areas including:

⁴ http://www.richmond.com/news/state-regional/virginia-receives-first-federal-grant-for-health-care-innovation/article_c5ad09cb-1f2a-51ea-8f14-f6a672320431.html

⁵ Alzheimer's Association Facts and Figures, 2014.

⁶ *Ibid.*

- University of Virginia Memory and Aging Care Clinic,
- Jefferson Area Board for Aging,
- Riverside Center for Excellence in Aging and Lifelong Health,
- Peninsula Agency on Aging,
- and the Alzheimer's Association Central and Western Virginia Chapter and Southeastern Virginia Chapter.

This grant represents a significant opportunity for Virginia to expand services for people with dementia and their families. It will do much to reinforce social support networks and to offer crucial assistance to the thousands of family caregivers providing unpaid care for individuals with Alzheimer's and other dementias in Virginia.

Adult Protective Services Division

HCBSs (See Appendix F) are also offered to eligible adults of any age (including older adults) through local departments of social services (LDSS) working with the new Adult Protective Services (APS) Division within DARS. Although funding is very limited, financial assistance is available to support companion care, adult day services, chore, and homemaker services for low income adults with a disability. The APS Division administers other programs, adult protective services and the auxiliary grant program for assisted living and adult foster care. In FY 2014, shared state and local government support for these services was \$9,513,546 with an additional \$22,130,602 million in state funding alone for the auxiliary grant program, for a combined total of \$31,644,148 million.

Virginia APS has seen nearly a 39 percent increase in APS reports and a 13 percent increase in substantiated reports since 2009. There was less than a nine percent increase in expenditures during the same period. In 8,000-9,000 of these reports, the adult is determined to need protective services. Approximately 4,000-4,500 adults in need of protective services accept some or all of the services offered by APS workers.

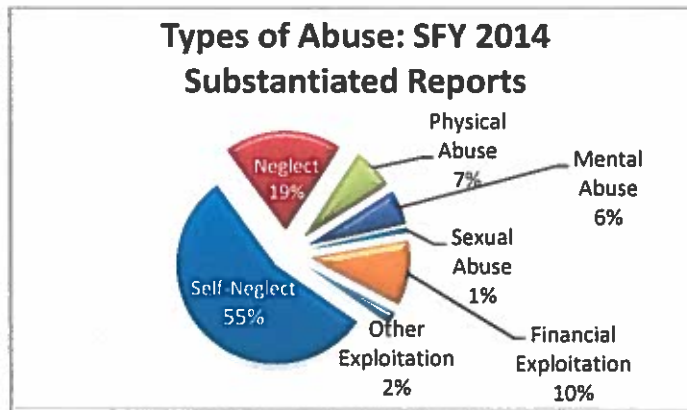
Six Year Comparison of APS Reports

Year	Total Reports	Substantiated Reports
2009	15,625	8,076
2010	17,141	8,752
2011	17,936	8,941
2012	19,990	9,610
2013	20,704	9,075
2014	21,650	9,140

Six Year Comparison of APS Expenditures

Year	APS Expenditures
2009	\$810,916
2010	\$804,628
2011	\$840,284
2012	\$896,396
2013	\$913,291
2014	\$882,104

The majority of substantiated reports involve self neglect as noted in the pie chart below, yet 10 percent of abuse cases involved financial exploitation in SFY 2014. In a 2012 article published in the American Society on Aging's journal, *Generations*, direct costs associated with financial exploitation of older adults were estimated to be nearly \$3 billion in 2011, a 12 percent increase from 2008. This is money that can and should be returned to the victims of such exploitation through APS intervention in collaboration with law enforcement and court processes, yet few cases are ever actually prosecuted.



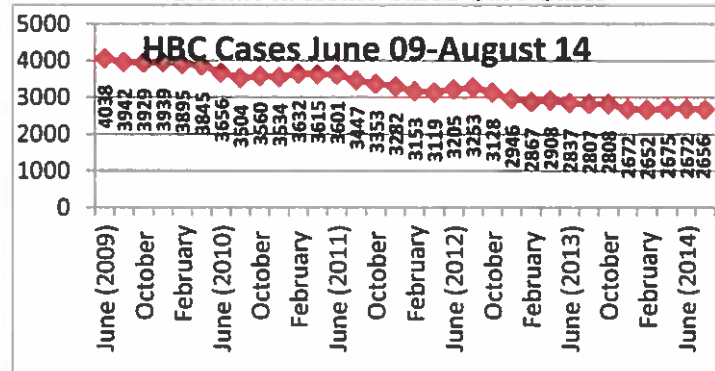
According to the 2015 White House Conference on Aging Elder Justice Policy Brief, “Financial exploitation of older adults can cause large economic losses for older adults, families, and society. In addition, abuse increases the reliance on federal health care programs such as Medicaid and Medicare. Research suggests that the victims of elder abuse may be four times more likely to be admitted to a nursing home, and three times more likely to be admitted to a hospital.” However, it is difficult for APS workers to provide protective services to adults who are abused, neglected, or exploited, when there is inadequate funding available for these services. Forty-six percent of 78 LDSS that participated in a 2014 adult abuse survey identified increasing APS funding as a top priority. Despite rising APS reports and the multiple service needs of many victims, state funding for APS has remained almost flat for the past five years.

Moreover, funding for supportive home-based care (HBC), such as LDSS homemaker, chore or companion services, has declined almost 32 percent from SFY 2009 to SFY 2014. Funds are used to pay providers hired by the LDSS or from home care agencies to help clients with activities of daily living such as bathing and dressing, instrumental activities of daily living such as housekeeping and meal preparation, or minor house repairs with the goal of keeping older adults and individuals with disabilities in their homes. Many older adults indicate that they wish to remain in their home for as long as possible.⁷ However, as funding has decreased, LDSS have been forced to reduce HBC clients’ hours, close less critical cases, and add clients to the waiting lists for services. The graph below highlights the 34 percent decline in caseloads that has mirrored the funding reductions.

Home-based Services Cases 2009-2014

Year	HBC Allocations
2009	\$8,087,504
2010	\$7,379,840
2011	\$6,051,469
2012	\$6,054,107
2013	\$6,054,107
2014	\$5,536,481

Decline in Home-based Care Cases



⁷ AARP (2011). *Aging in place: a state survey of livability policies and practices*. Retrieved from <http://assets.aarp.org/rgcenter/ppi/liv-com/aging-in-place-2011-full.pdf>

When home-based services funding is not available, adults who still need assistance turn to more costly interventions, including assisted living or nursing facility care. A 2011 analysis by the DSS Office of Research & Planning determined that eliminating the home-based services programs (which are funded via the Social Services Block Grant) would increase state general fund costs by an estimated \$6.6 million as adults sought more costly supports.⁸ It is also important to note that home-based services often prevent vulnerable adults from descending into self-neglecting situations by helping these adults meet basic needs such as cooking meals, bathing, or minor house repairs. Restoring approximately \$3 million in funding would return funding for HBC to SFY 2009 levels.

Public Guardian and Conservator Program

The Public Guardian and Conservator Program (PGP) administered by VDA currently serves 606 individuals 18 years and older who are legally incapacitated, indigent, and have no one else willing or able to serve as their guardian. The PGP does not provide direct services to individuals but contracts guardianship services through 14 providers that cover 85 percent of the state. Four AAAs have public guardian programs, Mountain Empire Older Citizens, Inc. (MEOC), Appalachian Agency for Senior Citizens, District Three Senior Services, and Senior Connections, the Capital Area Agency on Aging (Senior Connections). The cost of the petitioning process and a lack of suitable persons available to serve as guardians have emerged as chronic issues contributing to the unmet need for more guardianship services to vulnerable adults. With an increase in the older adult population and as a result of individuals with intellectual disabilities transitioning to the community from state training centers under a Department of Justice settlement agreement with the Commonwealth of Virginia, the unmet need continues to grow with a documented waiting list of almost 1,000 individuals. Recognizing the need, the 2015 General Assembly provided \$500,000 to fund an additional 100 PGP slots. Without additional funding, it will be impossible to increase the capacity of the PGP to meet more of the identified unmet need.

Legal Services Development

For older adults with social and economic needs, the OAA is a major funding source for senior legal assistance, which is necessary to protect the rights and financial security of older persons. Legal services also help address threats to independence, such as the loss of one's home to predatory lending practices and consumer scams, and protect and enhance public assistance benefits. In 2012, DARS established a legal services developer (LSD) position to improve the quality and quantity of legal services for older adults. Coordination of the LSD with guardianship, the APS Division and the Office of the State Long-Term Care Ombudsman (State Ombudsman Program) provides a valuable collaborative approach to strengthen the efforts to reduce abuse and financial exploitation. Virginia therefore supports a **goal to strengthen its statewide systems that protect the rights and prevent the abuse or exploitation of older adults.**

⁸ Results of analysis provided by DSS Office of Research & Planning via email to DSS Adult Protective Services staff, October 17, 2011.

Office of the State Long-Term Care Ombudsman

The State Ombudsman Program with its network of designated representatives located in AAAs throughout the state investigates and works to resolve complaints made by or on behalf of long-term care recipients, including residents of nursing homes and assisted living facilities and those receiving long-term care in the community. The State Ombudsman Program works with the APS Division, regulatory entities, legal services, community advocates, policy makers, legislators, and others, but performs a unique role driven by the interests and wishes of long-term care recipients. The program is a part of the family of Title VII (OAA) services that help protect the interests of the most vulnerable individuals who often are reluctant to raise concerns without an advocate's support for fear of a retaliatory response from the caregivers upon whom they depend. The State Ombudsman Program assists long-term care recipients to understand and exercise their rights and protect their health, safety, and welfare. The person-centered, solution-oriented, and confidential approach of the program provides a unique and critical safety net for older and disabled persons while actively working to prevent abuse and neglect and promote quality care.

The program includes not only individual advocacy but also systems advocacy – all of which focus on improving quality of care and quality of life through principles of individualized care, personal choice, and dignity. In addition to investigating and resolving complaints, ombudsmen help mediate conflicts between residents or families and facilities and provide consultations to help caregivers improve quality of life for long-term care recipients. The program regularly provides information about public benefits and long-term care options and resources and monitors and addresses regulations and policies affecting long-term care recipients and services.

With the growth of the aging population and the shift toward community-based care, the State Ombudsman Program plays an increasing role beyond the walls of long-term care facilities to include complaint resolution for persons receiving community-based long-term care. As a result, the program is uniquely positioned to address the critical growing need for advocates to follow and support individuals across multiple care venues. Unfortunately, the expansion of the program's responsibilities to cover home and community-based long-term care recipients has never been accompanied by additional federal or state funding sufficient to support these expanded efforts. There is a clear need for additional resources to address the strain this unfunded mandate places on the program and to ensure access to this critical protection by the older or disabled adults who need it.

Division of Rehabilitative Services: Senior Community Service Employment Program (SCSEP)

SCSEP is a community service and work-based job training program for older Americans. Authorized by the OAA, this program provides training for low-income persons age 55 and older who have low employment prospects. Participants also have access to employment assistance through American Job Centers. The program fosters economic self-sufficiency by providing opportunities for older adults to develop marketable skill sets and supporting individuals with job search and retention training. At the same time, it builds capacity for community nonprofits, enhances community engagement, and underscores the value of sustaining older adults in the workplace. In light of the economic downturn in recent years, this program has been particularly valuable in assisting older adults to secure and retain employment.

Housing

The Virginia Department of Housing and Community Development (DHCD), the Virginia Housing Development Authority (VHDA), and the 44 public housing agencies comprise a major component of the state's housing infrastructure through which housing services and supports are provided for older adults and Virginians with disabilities, often in partnership with state and local offices of Virginia's health and human resources and housing agencies.

VHDA works with lenders, developers, state agencies, local governments, and community service organizations. It does not receive any state funds, but instead issues bonds and uses the proceeds to fund mortgages primarily to first-time homebuyers and developers of quality rental housing. VHDA also administers the federal low-income housing tax credit (LIHTC) that is available to support the development and preservation of affordable rental housing. VHDA provides incentives for units designed to meet the needs of an aging population, especially those with very low incomes. Significant scoring points are awarded to developments incorporating universal design principles. In 2010-2014, VHDA allocated \$13,768,801 in LIHTCs to 47 senior housing developments containing 2,212 affordable rental units. In addition, in Virginia communities where no directly-paid Housing Choice Voucher (HCV) program administrators exist, VHDA receives HCV program funds from HUD and subcontracts with locally-selected administrative agents or agencies that run the day-to-day operations under VHDA's direction. At the end of FY 2014, 1,987 (23 percent) of VHDA's HCV recipients were older adults.

Creating livable, sustainable communities continues as a focus of DHCD. DHCD works with local partners throughout the Commonwealth responsible for implementing the following federal and state housing rehabilitation and development programs, many of which allow for the prioritization of or service provision to the elderly: Community Development Block Grant (CDBG), Indoor Plumbing Rehabilitation (IPR), the Weatherization Assistance Program (WAP), the Emergency Home and Accessibility Repair Program (EHRP), Housing Trust Fund (HTF), and the Home Investment Partnerships Program (HOME). The Virginia Livable Home Tax Credit (LHTC) Program is designed to improve accessibility and universal visitability in residential units by providing state tax credits for the purchase of new units or the retrofitting of existing units that further allows older Virginians to age in place.

In 2014, Governor McAuliffe signed Executive Order 32, advancing Virginia's Housing Policy and furthering the work of the Housing Policy Advisory Council which originated in 2010. Appropriate housing options for an aging demographic is one of several policy issues emphasized in addition to the following: urban and rural revitalization issues including adaptive reuse, affordable housing, the housing needs of seniors and people with disabilities, and homelessness, particularly veteran homelessness, and an emphasis on the best practice of rapid re-housing. The 2015 Virginia Governor's Housing Conference will highlight the award of a project representing the design of a safe, affordable, energy efficient home that allows for persons to "age in place."

Building on efforts that began in 2008, representatives from key state agencies including DARS, DMAS, DBHDS, and DHCD as well as VHDA targeted efforts as an interagency group in 2014 to enhance the development of community-based services and to provide integrated community-based housing options through the implementation of the following goals:

- expansion of the inventory of affordable and accessible rental units;

- increasing access to rental subsidies;
- building an understanding and awareness of informed choices;
- reviewing potential federal and state policy changes that affect housing options; and
- advancing coordination of actions and resources.

According to the Virginia Department of Corrections (DOC), Virginia houses an increasing number of inmates with medical conditions or mental disabilities. Virginia's mandatory minimum sentencing, longer sentences, and tighter parole policies, produced a seven-fold increase in elderly inmates, those aged 50 or older as defined by the National Institute of Corrections, from 822 in 1990 to 6,709 in 2013.⁹ Similarly, older offenders have been an increasing percentage of new court commitments, growing from 2.8 percent in FY1990 to 11.4 percent in FY2011.¹⁰ These older inmates tend to have multiple health issues. At the time of release or discharge of ex-offenders with medical conditions or mental disabilities, challenges can arise. Families are often unavailable or unwilling to accept released or discharged individuals back into the community and long-term care facilities are unwilling to take ex-offenders. In addition, public programs and funding for housing are not available because of their offender status, leaving this group of ex-offenders without options for one of life's most basic needs. The lack of options for housing leads some of these ex-offenders to seek services through LDSS, often on an emergency basis, that has proven costly to Virginia communities. In 2012, representatives of Virginia's human services and public safety agencies at the state and community levels convened a task force to address reentry planning for the release of inmates with medical conditions or mental disabilities who have no home plan.

The DOC Reentry Planning Policy provides guidance to staff on reentry planning for these problematic cases, including the pre-release benefits application process and planning for mental health and medical needs. Similarly, the Governor's Coordinating Council on Homelessness which originated in 2010 is working towards the implementation of five key strategies to prevent and reduce homelessness including statewide pre-discharge policy development for institutions such as correctional facilities. However, housing for this aging population remains a critical need.

Health Care Services

While optimal aging is partially influenced by the ability to maintain good health, there are outside factors such as rural access, cultural competency, health literacy, and communication barriers that can undermine individual efforts. Developing a professional and direct service workforce trained in aging issues, promoting prevention, utilizing innovative service delivery practices and non-traditional partnerships, supporting family caregivers, and addressing challenges specific to individuals with dementia and behavioral health issues are paramount in helping us all to age optimally regardless of physical, cognitive, financial, educational, or geographic limitations. Maintaining optimal physical and cognitive health is partially driven by individual choice, partially by genetics, and partially by decisions made on statewide and community levels to ensure access to information and services that promote healthy aging.

⁹ Department of Corrections report "Geriatric Offenders within the State Responsible Population" July 2014.

¹⁰ Ibid.

Department of Social Services Medicaid Eligibility and Nutrition

Public assistance programs administered by DSS are utilized by older Virginians and will be impacted by the aging population. These programs include Medicaid eligibility and the Supplemental Nutrition Assistance Program (SNAP). In SFY 2014, a total of 140,196 older Virginians were enrolled in Medicaid, including 439 being treated at state and local mental health hospitals. This total represents 12 percent of the 1.2 million people who were enrolled in Medicaid in 2014. Between SFY 2010 and 2014, the number of older Medicaid recipients increased 11 percent, from 126,361 to 140,196. A similar percentage increase was seen in the total number of all Medicaid recipients during the same timespan.

The majority of older Medicaid recipients belong to one of three case types –Aged, Blind and Disabled (ABD), Long Term Care (LTC), and Supplemental Security Income (SSI). Certain Medicaid programs are meant to primarily serve older adults and individuals with disabilities. In SFY 2014, 71 percent of LTC recipients and 57 percent of ABD recipients were 60 years and older. In SFY 2014, 60,578 older Medicaid recipients were ABD, 28,857 were LTC, and 44,872 were SSI. A combined total of 134,407 (96%) older adults were in one of these three programs. Between SFY 2010 and 2014, the number of older ABD recipients steadily increased each year. The numbers of LTC and SSI recipients have either increased by a small percentage or decreased.

Number of Older Medicaid ABD, LTC, and SSI Recipients, SFY 2010 – 2014

Medicaid Case Type	State Fiscal Year					% Diff.: 2010 - 2014
	2010	2011	2012	2013	2014	
ABD	49,860	53,370	56,022	59,036	60,578	21%
LTC	29,011	30,163	31,029	31,042	28,857	-1%
SSI	43,907	44,501	44,756	45,095	44,872	2%

Source: ADAPT. Unduplicated counts obtained from the DSS Data Warehouse Client Cross-Program Statewide Yearly Analysis report.

In SFY 2014, 96,609 older Virginians received SNAP, representing eight percent of all (1.27 million) recipients enrolled during the year. While the total number of SNAP recipients regardless of age increased 19 percent between SFY 2010 and 2014, the increase was much greater – 30 percent – among recipients 60 years and older.

In March 2012, DSS launched CommonHelp, an online, self-service customer portal through which individuals can apply for benefits and child care assistance. Between July 1, 2014 and September 30, 2014, a total of 59,941 households made an application, change, or renewal transaction through CommonHelp. Nearly six percent (5.6%), or 3,394 applications were made by an individual 60 years or older.

Over the next ten years, Virginia DSS anticipates being impacted by the aging population in multiple ways. Because Virginia shares the cost of the Medicaid program with the federal government, a significant influx of state general funds will be needed to address the increased demand. Further, the increase in the number of individuals needing Medicaid will increase workload demands at LDSS that determine eligibility. Also, it is presumed that as the population ages, there will be an increase in the number of people who are eligible for SNAP. Individuals in low-wage jobs who may not have qualified for SNAP while employed will most likely qualify based on their lower retirement income.

Medicaid Long-Term Care

Virginia's Medicaid program is very large and complex and has many different components and activities. Several factors affecting Virginia's Medicaid program are: (i) an aging population, especially those age 65 and older; (ii) an increase in the number of persons with disabilities seeking services; (iii) health care reform and funding, (iv) new technology requirements such as electronic prescriptions and electronic health records, and (v) continued growth in overall program enrollees and costs. DMAS is looking for innovative ways to ensure adequate provider network access and strategies to bolster its own administrative capacity to handle a growing and changing recipient base.

An increased focus has been underway over the last several years to improve community options and integrate systems of care for individuals in order for them to remain in their communities, and afford them more person-centered options that enable them to have more control over their health care needs. To strengthen this focus, a Deputy Director of Complex Care and Services was established in 2013 to oversee long-term care and behavioral health services and ensure these issues remain a priority within DMAS. The increased focus has resulted in the following initiatives.

Commonwealth Coordinated Care Program

In May 2013, CMS and Virginia entered a Memorandum of Understanding Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees. This new program to provide integrated care, the Commonwealth Coordinated Care (CCC) Program, blends Medicare and Medicaid services and financing to provide high-quality, person-centered care to Virginians who are dually eligible for Medicare and Medicaid. Under the CCC Program the Medicare/Medicaid Plans or MMPs receive a blended capitated rate to provide and coordinate the full continuum of benefits currently provided under Medicare and Medicaid programs. This includes primary care, acute care, behavioral health services, nursing facility care, long-term support services through the Elderly or Disabled with Consumer Direction (EDCD) Waiver, and the added benefit of care coordination services for all eligible beneficiaries. MMPs also have additional benefits that older adults would not previously have access to, such as dental, vision, and podiatry services.

The program gives individuals and their families the peace of mind to know they have one card and one number to call to help them with navigating through both programs. The CCC Program is designed as an "opt out" model and as of March 2015 it served approximately 27,775 dually eligible individuals who receive community and nursing home level services. To learn more about the CCC Program please visit the following website:

http://www.dmas.virginia.gov/Content_pgs/alte-enrl.aspx. The State Ombudsman Program plays an advocacy role with the CCC Program. With the aid of a grant from CMS designed to support ombudsman demonstration initiatives related to states' financial alignment programs, the State Ombudsman Program built upon its existing strengths, adding additional training and staff to advocate on behalf of CCC enrollees. Even as the CCC Program offers great potential for improving and better coordinating care and services for some older adults, policy makers, beneficiaries, and their advocates acknowledge the critical need for beneficiary protections as the program weathers the inevitable tensions in balancing quality goals with benchmarks for efficiency and cost containment. Consistent with the core mission and mandate of the State

Ombudsman Program, ombudsman roles under the CCC Program include both assistance to individuals encountering obstacles or problems with care and services and working with DMAS, MMPs, and other stakeholders to address systemic issues.

Programs of All Inclusive Care for the Elderly (PACE) and other Medicaid Waiver Programs

Additionally, DMAS supports 14 Programs of All Inclusive Care for the Elderly (PACE), which provide another option for a coordinated, capitated, case management system in the Commonwealth for those 55 years of age and older designed to help individuals remain in the community and address their health and social needs. As of April 1, 2015, Virginia has eight PACE providers. MEOC, the Central Appalachia AAA in far southwest Virginia, which serves the City of Norton and Counties of Lee, Scott and Wise, implemented one of the nation's first rural PACE Programs. There are 12 formal PACE sites with two alternate care sites. There are two additional alternate care sites under development in Northern Virginia and two new PACE programs under development in the Gretna, Martinsville, and Danville area and the Halifax to Portsmouth area. Over 2,580 individuals have been served since the program's inception in 2007.

The provision of long-term services and supports in DMAS shifted in FY 2012 to over 50 percent of all Medicaid expenditures being provided in the home and community. DMAS is committed to ensuring individuals are served in the most integrated setting of their choice, which is evidenced by the shift from institutional care to a more community-based care approach. This is a tremendous accomplishment, and DMAS is continuing to work with its community and state partners to continue in this rebalancing effort. The number of people served in PACE and waiver programs, along with the costs of serving them can be found in fact sheets at http://www.dmas.virginia.gov/Content_pgs/ltc-home.aspx. The chart below shows how many people are being served in home and community-based settings, by waiver, as of October 2014:

Enrollment/Wait List Summary	EDCD*	ID**	DD+	TECH***	DAY SUPPORT**	ALZ*
Current Enrollment	29,607	9,984	951	300	276	54
Current Wait List	N/A	7597	1634	N/A	N/A	N/A

** Sources: Elderly and Disabled with Consumer Direction and Alzheimer waivers DMAS Alpha listing; ** Intellectual Disability waiver DBHDS; *** DMAS Tech Waiver database; + DMAS DD Waiver database. Total enrollment and wait lists are point in time counts and subject to frequent changes. MFP Slots are not included.*

Money Follows the Person

In 2008, Virginia launched Money Follows the Person (MFP) to provide extra supports to Virginians who choose to transition from long-term institutions to the community. Promoting choice and flexibility, MFP is a collaborative initiative among DMAS, DARS, and numerous other state agencies and local stakeholders where funds follow the person from the facility to the community, covering extra supports during the transition process. Individuals must qualify for, and enroll in upon discharge from a facility, a PACE or one of the following waiver programs with services provided in a qualified residence:

- Elderly or Disabled with Consumer-Direction Waiver (EDCD)
- Individual and Family Developmental Disabilities Support Waiver (DD)
- Intellectual Disabilities Waiver (ID)

- Technology Assisted Waiver (TECH)

Participants receive \$5,000 in one time assistance for transition services. DMAS conducts quality of life surveys at the one-and two-year marks post transition. This survey establishes the individual's satisfaction with community living and confirms the individual's needs are met and necessary services are being received.

Consumer-Directed Waiver Services

Consumer-directed (CD) is a service delivery model of care. In select waivers, three services are available through the CD model or the agency-directed (AD) model. These services are: personal care, respite care, and companion care. Enrolled individuals with a demonstrated need for these services may elect to receive them through either the CD model, the agency-directed (AD) model of service delivery, or a combination of both models. The CD model differs from the AD model by allowing the individual to assume the responsibility for directly hiring, training, scheduling, and firing staff and monitoring the provision of services provided. AD services are provided by a Medicaid enrolled provider agency. To receive CD services, the individual or a designated individual must act as the employer of record (EOR). The EOR hires, trains, and supervises the attendant(s). An individual may be found to be not eligible for CD services if:

- It is determined that he or she cannot be the employer, and no one else is able to assume this role.
- The individual wants CD services, but his or her health and safety cannot be assured.
- The individual has medication or skilled nursing needs or medical or behavioral conditions that cannot be met through CD services.

To facilitate the process of CD services, a fiscal and employer agent, Public Partnerships, LLC (PPL), is the state's contractor responsible for all fiscal agent services. In the largest waiver, the EDCD, there are 13,204 people over age 65 and of these, 3,610 people are self-directing their services. DMAS conducts quality management reviews of the services provided and interviews individuals for all service providers in this waiver to ensure the health and safety of all individuals.

Managed Care Organizations

In other DMAS programs, the over 60 population is served through managed care organizations (MCOs). Elderly individuals who are eligible for and enrolled in managed care will receive access to preventive and wellness services not available to adults enrolled in fee-for-service (FFS) medical care. Additionally, elderly members in MCOs have access to disease and case management services if their medical conditions warrant that additional, more intensive care management. Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care opportunities are significant.

MCOs provide health education services for its new and continuing members. MCOs also provide nonemergency transportation services to medical appointments to members. Additional information may be found about MCOs at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

Health and Acute Care Project (HAP)

Individuals with complex and acute care healthcare needs will be served under a new waiver as part of a joint project between the Divisions of Health Care Services and Long-Term Care Services in DMAS. The Health and Acute Care Project or HAP will enroll a projected 2,756 individuals in managed care who are currently receiving primary FFS medical care through the EDCD waiver into managed care starting December 2014. There are already 4,680 HCBS waiver individuals enrolled in managed care, which includes the EDCD, ID, DD, Day Support, and Alzheimer's waivers. These members get their acute and primary medical care services through the MCO and their waiver services are carved out and paid for through FFS. This program provides chronic care management and care coordination, where there is a patchwork of services now. The total number of individuals in HAP will be 7,436.

A Healthy Virginia

DMAS is embarking on a multi-pronged effort to provide health care to uninsured individuals, improve access to health care, and pursue innovative solutions for all Virginians. The following initiatives will be of particular benefit to those 60 years old and over by:

1. Providing medical and behavioral health services for insured people who have a serious mental illness (the Governor's Access Program);
2. Increasing enrollment in the Federal Marketplace through an extensive educational campaign and active assistance;
3. Becoming a partner with the Veterans Administration to make sure veterans receive quality care in a timely manner; and
4. Pursuing health homes for individuals with mental illness through a collaborative system of primary, acute, behavioral and long-term services.

A full copy of the report can be found at <https://governor.virginia.gov/media/3096/a-healthy-virginia-report-final.pdf>. A new waiver was created to address the needs of persons with serious mental illness needing acute care services.

Health and Human Resources (HHR) Emergency Preparedness and Response Workgroup

Virginia's geographic diversity means that it may experience a variety of natural disasters, ranging from winter storms to forest fires and from hurricanes to geologic hazards such as landslides and earthquakes. The entire state is subject to seasonal life threatening storm activity, with loss of electrical power and significant travel hazards. In addition, the Virginia Department of Emergency Management (VDEM) warns that localities must prepare for manmade threats as well, such as radiological and hazmat accidents and terrorist incidents.

The Emergency Preparedness and Response (EPR) Workgroup serves in an advisory capacity within the HHR secretariat to coordinate interagency emergency planning and response activities and address cross-agency and cross-secretariat issues. The ultimate goal is to promote community resiliency so that an "all needs, all hazards" approach to planning and response becomes the standard within the secretariat. Working in collaboration with VDEM, the EPR Workgroup creates an annual work plan, represents HHR in relevant statewide and regional exercises, inventories EPR resources, and coordinates response activities and communication

among agencies. DARS will be serving on a new Access and Functional Needs Advisory Committee being convened by VDEM.

Although AAAs are not involved as first responders in the event of a natural, chemical, biological, or other disasters, they often provide secondary assistance to older adults who may be affected by such events. Assistance may include providing information and referrals to appropriate agencies, food and water for homebound individuals, and assisting emergency agencies with transportation and sheltering.

In 2012, rural southern Virginia Beach's Senior Resource Center's Emergency Preparedness Plan won the first-place Best Practices Award from the Commonwealth Council on Aging. The center is a joint effort among area residents, religious organizations, civic groups, and the City of Virginia Beach. Its Emergency Preparedness Plan identifies older residents in the community who will need special assistance or contact during an emergency situation and builds relationships with them so they will accept assistance from emergency responders if needed. The senior center's volunteers identify those residents who might need certain supplies or may lack transportation or family support. They pair those residents with other older adults who help deliver supplies or just check to make sure they are safe during a storm.

Healthy Aging Pledge

DARS has partnered with the Virginia Department of Health (VDH) to accept the 2015 President's Challenge on Healthy Aging. This challenge aims to galvanize state health officials and the aging network to implement evidence-based strategies for increasing the number of older adults who are living well in the community. The State Health Commissioner and DARS Commissioner have developed a Virginia pledge to adopt Healthy Aging Strategies that are part of our State Plan objectives and performance measures.

The pledge promotes advance care planning to care partners, families, and individuals. Already, a number of AAAs are administering advance care planning. For example, the Advance Care Planning Coalition of Eastern Virginia, As You Wish, has a goal to increase the number of patients admitted to acute care with completed advance directives and promotes advance care planning through targeted education and public communication. The 2015 Commonwealth Council on Aging Best Practices First Place Award went to the Faith to Fate Advance Care Planning Initiative, an ongoing partnership between Senior Connections and five area churches that serve African American congregations and communities within the Greater Richmond and Tri-Cities regions. Ultimately enrolling 12 churches, its purpose is to deploy practical solutions to counter the alarming and widespread dearth of awareness and information about, access to, and assistance with end-of-life medical and property asset legal discussions, including planning and free legal documents execution. Consistently, national research has documented that this vital life-planning activity is done the very least among African Americans, as compared with every other group. Research also shows that this problem is expanding rapidly and imposing ever more avoidable suffering and wasteful medical costs upon all Americans, as new state laws, technologies, and treatment options and procedures have drastically altered the end-of-life medical landscape for everyone. Using the new professional advance care planning (ACP) program—Honoring Choices Virginia—as the best-practice “alternative to guardianship” for family members suddenly facing the incapacity of a family member, this is the first and only

effort nationwide to leverage local African American churches as permanent ACP resource centers.

Managing Chronic Disease

If older Virginians are to retain their autonomy and remain in their homes for as long as possible, they must be able to prevent or manage the chronic diseases which typically increase with age. Research shows that participants of chronic disease self-management programs handle symptoms better and communicate more easily with their physicians, family members, and caretakers. Participants feel better, are less limited by illness, and may spend less time at doctor appointments or in the hospital.

DARS received two ACL Chronic Disease Self-Management Education (CDSME) grants. One grant has enabled 14 AAAs to implement the program at the local level with oversight and coordination from VDA and VDH. Previously, CDSMP or DSMP workshops were offered in limited areas through VDH but there was no statewide effort to bring these programs to older Virginians. Through these grants to VDA for the period April 1, 2010 through March 18, 2015, a total of 626 workshops have been provided to 8,117 people with 6,231 individuals completing (attending at least four of the six sessions) the training. VHQC in partnership with DARS will allow AAAs to sustain their local CDSME programs beyond the grant period, which ends in August 2015, using VHQC's license for the next four years.

CDSME has been done in Virginia's prisons through a partnership with DOC. To date, 21 workshops have been held in state correctional facilities since November 2012, with 283 attending and 222 completing (attending at least 4 of the 6 sessions) the training. The program has been well received by offenders, prison staff, and state officials as it helps participants manage their conditions more effectively, increases their confidence and personal accountability, and can reduce health care costs to DOC and the communities to which the offenders return.

Further, the Regional CARE Coalition coordinates and implements the Stanford University evidence-based CDSME in Gloucester, Hampton, Newport News, Yorktown, Poquoson, and the Greater Williamsburg area. CARE serves 400,000 individuals in Hampton Roads: 24 percent of these adults have arthritis, 10 percent diabetes, and 36 percent high cholesterol (Virginia Atlas of Community Health, 2012). CARE has completed 16 workshops in 12 months, affecting 214 patients. The National Council on Aging (NCOA) estimates \$750 per person cost savings in emergency room and hospitalization costs (www.NCOA.org 2013). Thus, in the past year, CARE has produced an estimated \$160,500 in cost savings.

Mental Health or Substance Use Disorders

By 2030, there will be as many as 14 million older adults in America with mental health or substance use disorders, up from 5-8 million today according to the Institute of Medicine.¹¹ Virginia's publicly funded behavioral health services system under the leadership of DBHDS includes nine state hospitals, four training centers, a sexually violent predator program, 39 Community Services Boards (CSBs) and one behavioral health authority. At the request of the Alzheimer's Commission last year, DBHDS analyzed service delivery to persons with dementia by age group.

¹¹ A 'silver tsunami' of depression. Suzanne Allard Levingston. Richmond-Times Dispatch, March 2, 2015.

Individuals With Alzheimer's Disease or Related Dementias Who Received Services From CSB/BHAs and State Hospitals in FY 2014			
Diagnosis	CSB/BHA Mental Health Services	Total Unduplicated CSB/BHA Individuals	State Hospitals
Individuals 18 - 64	76,221	153,003	3,851
Other Dementias	32	50	11
Alzheimer's	155	247	25
Dementia	149	249	17
Unduplicated Total	322	519	53
Percent of 18 - 64	0.42%	0.34%	1.38%
Individuals 65+	4,825	9,540	529
Other Dementias	78	166	80
Alzheimer's	163	540	106
Dementia	228	826	24
Unduplicated Total	450	1,469	187
Percent of 65+	9.33%	15.40%	35.35%

Virginia will be tracking this data over time in order to better understand what proportion of the population being served through the publicly funded behavioral health services system has dementia.

Virginia's Suicide Prevention Across the Lifespan Plan indicates that older adults are a high risk population for suicide, necessitating targeted intervention planning. A component of the program has been gatekeeper training delivered to community members of organizations that serve older adults, including hospitals, churches, and CSBs. DBHDS works with other state agencies and a variety of suicide prevention stakeholders to support and coordinate suicide prevention efforts.

Virginia Department of Alcohol Beverage Control formed a coalition, the Alcohol and Aging Awareness Group (AAAG), to respond to the current and future impact of the aging population. Since 2007, AAAG initiatives have included substance abuse training, publications, conferences, exhibits, presentations, and public service announcements.

Professional and Direct Service Workforce

Although the experiences of individuals and communities vary, at the population level, evidence suggests that healthcare utilization increases with age. Success in supporting a growing older adult population requires a workforce: a) of sufficient size and productivity, b) that is accessible in the areas where older adults live, and c) trained to meet the needs of the older adult community, including medical needs and supporting services that improve quality of life and continuity of care, such as aging in place and community-based care.

As the population is aging so is the healthcare workforce, particularly among the most highly trained professionals. For instance, the latest estimates from the Virginia Healthcare Workforce Data Center suggest that 26 percent of Virginia's physicians, 29 percent of dentists, 30 percent of pharmacists, and 34 percent of clinical psychologists are age 60 or over. Although many of these professionals will continue working for some time, many others will choose to reduce their work hours or retire. The Association of American Medical Colleges (AAMC) is well on its way to achieving its goal of increasing the number of medical school graduates to 30

percent above 2002 levels by 2017. However, the number of residency slots has grown more slowly. The AAMC reports that in 2014 several hundred US medical students did not match to a first-year training program.¹²

Due in part to lower expenses and shorter timelines for training, many mid-level and allied health providers have increased in numbers rapidly. Half of Virginia's nurse practitioners, for instance, entered the profession after 2000, while 58 percent of physician assistants, 46 percent of physical therapists, and 41 percent of dental hygienists are under age 40.

Short-term projections from HRSA's National Center for Health Workforce Analysis (see chart) suggest that these workers will continue to make up a more prominent share of the health workforce in the future. Only one percent or fewer of Virginia's physicians, physician assistants, pharmacists, and physical therapists are certified in geriatrics. Only three percent of Virginia's registered nurses claim a self-designated specialty in geriatrics, including only two percent of nurse practitioners. As recently as 2008, only three percent of medical students chose to take geriatrics courses¹³, and in 2005 only one-third of baccalaureate nursing programs required a course in geriatrics.¹⁴

A strong primary care workforce is needed to provide care management for older adults, particularly those with chronic conditions. A recent AAMC study estimates that the US will experience a shortage of 12,500-31,100 primary care physicians by 2025.¹⁵ More primary care-associated residencies, along with efforts to make primary care a more desirable career choice among young physicians, are needed to fill this gap. Regulatory models and models of team-based care that allow mid-level and allied health providers to better support physicians by working safely up to their level of education and training, particularly in community and home-base settings, may also increase access.

Projections from the National Center for Health Workforce Analysis http://bhpr.hrsa.gov/healthworkforce/				
	National	% of Workforce	Virginia	% of Workforce
Primary Care (2020)				
Primary Care Physicians	-20,400	-9%	NA	NA
Primary Care Physician Assistants	+11,200	+25%	NA	NA
Primary Care Nurse Practitioners	+7,400	+10%	NA	NA
Oral Health (2025)				
Dentists	-15,600	-8%	-230	-4%
Dental Hygienists	+28,100	+14%	+642	+13%
Other Health Practitioners (2025)				
Registered Nurses	+340,000	+9%	+19,400	+18%
Licensed Practical Nurses	+59,000	+6%	+4,480	+13%
Occupational Therapists	+22,300	+18%	NA	NA
Physical Therapists	+19,100	+8%	NA	NA
Optometrists	+2,200	+5%	NA	NA
Pharmacists	+48,900	+14%	NA	NA

For older adults, more so than any other age group, continuity of care is vital. Long-term relationships with a primary care provider and support personnel increase the likelihood that

¹² AAMC Reporter "Despite Successful Match Day, Concern Remains over GME Slots".

<https://www.aamc.org/newsroom/reporter/april2014/378168/match-day.html>

¹³ IOM report *Retooling for an Aging America: Building the Health Care Workforce*, page 133.

¹⁴ Robert Wood Johnson Foundation. "United States in Search of Nurses with Geriatrics Training".

<http://www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2012/02/united-states-in-search-of-nurses-with-geriatrics-training.html>

¹⁵ AAMC/IHS *The Complexities of Physician Supply & Demand: Projections from 2013 to 2025*. March 2015

individuals will take their medications as directed and keep their medical appointments. Yet turnover rates among direct care personnel remain high. Only 45 percent of certified nurse aides (CNA) and 58 percent of licensed practical nurses have worked at their primary location for more than two years. Pay among Virginia's certified nurse aides is low. Typical wages are \$11-\$12 per hour, and 25 percent earn less than \$10 per hour. Fewer than a third have a retirement plan. Finally, 21 percent of CNAs worked part-time only, while an additional 18 percent worked two or more positions concurrently.

Informal Network of Unpaid Caregivers

Without a doubt, the single most valuable support to the health and well-being of Virginia's older adults is the network of informal care provided by family and friends. As the numbers of professional healthcare workers decrease relative to the numbers of older adults needing their services, the burden of care will likely increase for informal caregivers. Unfortunately, the trend of shrinking family size suggests that the availability of family caregivers will also decrease, placing an even greater burden on the informal care network. If Virginia is to manage the growing needs of its aging population, its success will depend on providing better support to the unpaid but critical network of informal caregivers.

Insufficient funding, an incomplete inventory of services and related financial assistance resources, and restrictive eligibility requirements coupled with a lack of affordable and accessible respite care programs have created barriers to successfully supporting the 1.7 million caregivers in Virginia.¹⁶ Virginia addressed the need for respite care by forming the Virginia Caregiver Coalition (VCC) in 2004. Although the accomplishments of the past 10 years are many with little funding, there remains much to be done to adequately support the informal network of care in Virginia. DARS secured valuable grant funding to develop a Lifespan Respite Voucher Program and, in 2013, provided brief respite to 516 families across Virginia, many of whom had not had a break from care giving responsibilities in years. VCC, in partnership with DARS, has established an online Virginia Family Caregiver Solutions Center devoted to providing respite resources for caregivers. See <http://www.virginiannavigator.org/vf/> for more information. The Lindsay Institute for Innovations in Caregiving is another initiative of VirginiaNavigator, a statewide public/private partnership non-profit that helps Virginia's seniors, caregivers, and families find vital information and community programs so they can live with independence, dignity, and hope. The goal of the Lindsay Institute is to improve the health of caregivers. See CaregivingInnovations.org for more information.

Transportation

The majority of the state's transportation services and supports for individuals with mobility limitations are provided in connection with the Department of Rail and Public Transportation (DRPT) and are delivered at the state and local level through a number of health and human resources agencies. DRPT's projection of future demand for transportation by older adults shows that by 2035, at a minimum, transportation for older adults will require over 14 million trips annually, approximately 25 percent of expected need for all Virginians. For a number of years, Virginia has emphasized development of coordinated human service

¹⁶ Lynn Feinberg, Susan C. Reinhard, Ari Houser, and Rita Choula - AARP Public Policy Institute *Valuing the Invaluable: 2011 Update* <http://assets.aarp.org/rgcenter/ppi/lrc/i51-caregiving.pdf>

transportation models that include a broad range of services designed to meet the needs of populations who need transportation options beyond a personal automobile, particularly older adults, people with disabilities, and people with lower incomes. Depending on their abilities, their environment, and the transportation services available in their communities, these individuals may require a variety of mobility options. Examples include transportation services provided by human service agencies for people participating in their programs, dial-a-ride paratransit services, taxi voucher programs, and transportation services provided through volunteer drivers.

MAP-21, the Moving Ahead for Progress in the 21st Century Act (P.L. 112-141), was signed into law by President Obama on July 6, 2012. Funding surface transportation programs at over \$105 billion for fiscal years 2013 and 2014, MAP-21 is the first long-term highway authorization enacted since 2005. By transforming the policy and programmatic framework for investments to guide the system's growth and development, MAP-21 creates a streamlined and performance-based surface transportation program and builds on many of the highway, transit, bike, and pedestrian programs and policies established in 1991. For more information, visit: <http://www.dot.gov/map21>. MAP-21 combines Section 5310 Capital (capital funding for transportation services for elderly persons and person with disabilities) and New Freedom grant programs and limits allocations.

For example, the New Freedom Mobility Management Program is a transportation service designed to improve transit opportunities for people with disabilities and those over 60 years of age. The project currently serves 12 counties throughout the Northern Neck and Middle Peninsula in addition to New Kent and Charles City Counties. It allows people to become more actively engaged in social and recreational events, retail shopping, access to jobs, and vocational training programs in addition to transportation for non-emergency medical appointments. New Freedom also offers expanded transit services outside of the public transportation service area and hours. Bay Transit, a division of Bay Aging, is the only public transportation provider to the 10 counties of the Northern Neck and Middle Peninsula and the counties of New Kent and Charles City. Data from the 2014 Bay Transit Survey showed that public transportation continues to be a critical need in this largely rural region. Bay Transit also provides a travel training service for Seniors called "Seniors on the Go." The program is designed to educate seniors about transportation services, and alleviate any fears they may have with hands-on experience to learn how public transportation works. The Prince William AAA partnered with the Potomac-Rappahannock Transportation Commission to do "On the Go" training for both older adults and persons with disabilities. Its Commission on Aging is updating the 2010 Prince William Area Mobility Management Plan developed under a federally-funded grant from the Metropolitan Washington Council of Governments. The Rappahanock AAA's Mobility Options Program schedules and provides trips for seniors and people with disabilities in Caroline, King George, Spotsylvania and Stafford counties and the City of Fredericksburg. In addition to being a clearinghouse of transportation resources for this region, Rappahanock AAA uses Senior Transportation funds to support a collaborative effort to provide travel training as well. District Three Senior Services has a 27-year partnership to provide local public transit services, including regular routes from residential and rural areas to commercial centers; specialized health-care transportation services; and route service to regional medical centers outside the service area. MEOC is the public transportation provider for Lee, Wise, and Scott Counties and Norton City. In far southwest Virginia, MEOC Transit provides mobility management services, passenger attendants on routes, gas vouchers and specialized transportation. Loudoun Volunteer

Caregivers Assisted Transportation Program and Bedford Ride are two Commonwealth Council on Aging Best Practices awardees for their volunteer transportation initiatives for low income older adults and adults with disabilities.

Virginia's Office of Intermodal Planning and Investment (OIPI) will lead the development of the Commonwealth's long-range multimodal transportation plan – VTrans2040. The plan will be developed in two phases and will result in the production of two companion documents: the VTrans2040 Vision and the VTrans2040 Multimodal Transportation Plan. VTrans2040 will identify multimodal needs across the Commonwealth. Moving forward, only projects that help address a need identified in VTrans2040 will be considered for funding under the statewide prioritization process. The plan will focus on the needs of the Commonwealth's statewide network of Corridors of Statewide Significance, the multimodal regional networks that support travel within metropolitan regions, and improvements to promote locally designated Urban Development Areas (UDAs). For more information, visit <http://vtrans.org/vtrans2040.asp>.

For older adults who are still driving, VDA and the Virginia Department of Motor Vehicles (DMV) Highway Safety Office are working together to address the disproportionate fatality rate for older adults. Funded by the National Highway Traffic Safety Administration (NHTSA), the Virginia GrandDriver Program is providing web-based resources that help older drivers compensate for age-related changes and promoting CarFit, a 12-point checklist that helps older adults to properly fit in their vehicles to avoid serious injuries. Additionally, the program provides a grant for certified comprehensive driver assessments for older adults who cannot afford them and gives options for alternative forms of transportation to help older Virginians maintain their mobility and independence. Still, older driver issues are currently not included in the list of NHTSA priorities and as a result, funding has decreased dramatically each year. A mature driver study conducted by the DMV has acknowledged Virginia GrandDriver as the primary resource in the Commonwealth for older drivers and their caregivers. Consequently, funding has increased slightly over the past two years. With an average of an additional 43,000 older drivers on the road each year, programs like GrandDriver are essential.

DMAS is responsible for administering Virginia Medicaid's fee for service (FFS) emergency ambulance and nonemergency Medicaid transportation (NEMT) services. DMAS FFS transportation services include emergency air, emergency ground, and NEMT services. The NEMT is managed and operated by the statewide contracted transportation broker, LogistiCare. LogistiCare takes transportation eligible member's reservations, assigns trips to providers, and pays providers for all nonemergency transportation services. NEMT services include ambulatory, wheel chair, stretcher van, and nonemergency ambulance. NEMT also includes alternative means of transportation that include volunteer drivers, gas reimbursement, and bus tickets. More information can be found at http://www.dmas.virginia.gov/Content_pgs/trn-home.aspx.

VIRGINIA'S STRATEGIC GOALS: 2015-2019

Virginia's five goals are designed to address the challenges and maximize the opportunities presented by the growing number of aging adults and adults with disabilities and the increasing need for formal (professional) and informal (unpaid) supports.

Goal 1: Assess and facilitate statewide community readiness for an aging population, recognizing both the untapped resources and the unmet needs of this population.

Objective 1.1. Promote holistic wellness, i.e., social connectivity, physical well-being, lifelong learning, community service, and employment, as the key to healthy aging and active community engagement.	
Strategies:	Promote social and emotional wellness by providing opportunities for social engagement including multi-generational engagement to reduce social isolation.
	Encourage intellectual endeavors for enrichment, physical activity, and specific educational programs targeted to older adults through senior centers, community colleges, colleges and universities, parks and recreation, and other organizations.
	Identify issues important to older adults and ensure representation of those issues in state and local decision-making agencies and groups.
	Promote and encourage lifelong learning, volunteerism, and other pursuits that help older adults to be engaged in their communities.
	Create a module within the NWD system for AAAs and NWD partners to report volunteer engagement and partner with DSS to track volunteer programs for older Virginians under the State Plan for Volunteerism and Services.
	Seek collaborative opportunities with community and faith-based organizations to enhance the resources and services of the aging network.
	Promote volunteer services by and for older adults, including the use of multi-generational activities.
	Encourage expansion of and develop a clearinghouse of best practices for coordinated multi-generational activities.
	Continue coordination of the SCSEP program to hire low-income older adults.
	Help older adults stay employed or acquire or refresh employment skills as necessary.
	Hold recognition events that promote the contributions of older adults to increase community awareness of those contributions.
Measures:	
• Replication of best practices volunteer programs that enhance local services and support the goals of the State Plan for Volunteerism and Services to fully engage older adults in volunteerism and other best practices that draw upon the knowledge and skills of older Virginians by 2017. • Clearinghouse of best practices on coordinated multigenerational activities on DARS website by 2018. • Older Virginians Month (May) Governor's Proclamations and events at AAAs recognizing contributions of older adults annually.	
Objective 1.2. Promote safe, affordable, and accessible communities for older adults that also will benefit people of all ages through age readiness planning.	
Strategies:	Promote aging in place, universal design, and livable communities for individuals to consider as they age.
	Encourage state and community programs that build societal support for physical activity by improving access to places where people can be active.

	Promote the development of affordable, accessible housing with access to long-term care facilities and LTSSs in urban and rural areas.
	Collaborate with academic research institutions to promote livable communities.
	Enhance housing options by increasing education and marketing strategies to promote development of alternatives such as Naturally Occurring Retirement Communities (NORCs), Villages, Co-Housing, and Easy Living Homes (visitability).
	Develop options to make transportation more easily accessible and responsive to the needs of older adults.
	Maximize the use of all NWD/ADRC resources such as Virginia Easy Access and VirginiaNavigator to raise awareness and educate and empower Virginians with information to age in place.
	Provide communities the data, tools, and assistance necessary to develop and implement comprehensive local or regional plans to address the array of demands and opportunities presented by the aging of Virginia's population at the Governor's Conference on Aging in the Spring of 2016.
	Increase access for older adults to assistive technology and new technology offerings.
	Promote the Virginia's Blueprint for Livable Communities website to share resources among constituents and promote awareness and understanding of the necessity of planning for livable communities.
	Plan for needs and abilities specific to special populations (persons with disabilities, victims of abuse, veterans, people who are homeless or isolated, and persons with linguistic or cultural barriers) when developing programs and services that support older adults aging in place and in outreach efforts to educate them about available supports.
	Promote the goals of the Governor's Advisory Council on Housing, emphasizing senior affordable housing, resident service coordination, and increased rental subsidies specifically for older adults.
Measures: • Governor's Conference on Aging in the Spring of 2016 to support Livable Communities initiatives. • Social media campaign regarding livable communities throughout the Commonwealth in 2016-2017 tied to Governor's Conference on Aging and thereafter as needed. • Annual meetings of Livable Communities Citizen Advisory Group. • Existing Age Readiness Plans annual update to Livable Communities Citizen Advisory Group. • Minimum of 4 new Virginia Communities with Age Readiness Plans by 2019. • Number of AAAs with Mobility Management Plans.	

Goal 2: Empower older adults and their families to make person-centered and informed decisions about personal health and well-being, long-term services and supports, and end-of-life care options.

Objective 2.1. Provide streamlined access to and person-centered decision support for long-term services and supports.	
Strategies:	Expand the NWD/ADRC system to include all populations and payers.
	Develop a marketing plan for NWD and provide innovative ways to get information on access to services to older adults.
	Provide access to information about health and long-term services and support options through CRIA (Communication, Referral, Information and Assistance) and Options Counseling.

	Develop common language for electronic universal care planning (eLTSS) across NWD providers.
	Share information between NWD System and Virginia's Health Information Exchange (HIE).
	Assist individuals with care transitions between different settings and types of care.
	Provide on-going education about long-term care supports and services with emphasis on person-centered education to older adults and providers.
Measures:	
• Implementation of NWD/ADRC Advisory Council 3-year plan to include all populations and payers in NWD by 2019. • 5 percent annual increase in number of unique individuals served by CRIA. • 10 percent increase in number of NWD partners using CRIA to make automated referrals and securely share client information. • 10 percent annual increase in number of referrals made through CRIA. • 5 percent increase in the number of LTSSs included in the NWD provider database by 2018. • Number of re-admissions to hospitals within 30 days through Community-based Care Transitions Programs. • Number of individuals enrolled in quality HCBSs to include adult day care, chore, companion care, homemaker, money management, and personal care.	
Objective 2.2. Empower adults to make informed decisions about personal health.	
Strategies:	Increase awareness in the medical community of the aging network's ability to provide: • Care transitions, • Patient education about disease prevention and management (e.g., CDSME), • Patient advocacy, and • Caregiver support.
	Increase the use of evidence-based health and wellness programs (e.g., CDSME) at the community level and promote nutrition and physical activity to maintain healthy lifestyles.
	Improve the effectiveness of HCBSs for older adults and people with disabilities.
	Increase the number and support the sustainability of Program for All Inclusive Care for the Elderly (PACE) sites.
Measures:	
• Minimum of 4 new PACE program sites in Commonwealth by 2019. • 20 percent increase in the number of AAAs and DOC prison sites implementing CDSME. • Number of persons completing CDSME.	
Objective 2.3. Provide comprehensive health insurance counseling through VICAP.	
Strategies:	Identify Virginia's diverse populations such as non-English speaking and low income older adults and work with DMAS, DSS, and NWD/ADRC local partners to develop and implement outreach strategies for health insurance counseling.
	Participate in education and outreach activities regarding the Medicare Annual Election Period (AEP) and fraud awareness initiatives, targeting beneficiaries potentially eligible for low-income subsidies and wellness and prevention services.
	Develop and implement outreach strategies for VICAP through partnerships, e.g., VirginiaNavigator centers, faith-based communities, schools, and culture-based community centers.
	Collaborate with all systems change outreach efforts to promote Medicare wellness and preventive benefits to potential beneficiaries.

Measures:

- 15 percent increase in the number of one-on-one contacts with beneficiaries through VICAP by 2018.
- 10 percent increase in the number of contacts through VICAP with individuals whose incomes are less than 150 percent of federal poverty level by 2018.
- 5 percent increase in the number of contacts through VICAP by individuals with disabilities.

Objective 2.4. Improve nutritional health, alleviate hunger, and prevent malnutrition.**Strategies:**

Provide nutritionally adequate and sensorily appealing meals to older adults in senior nutrition programs throughout Virginia.

Encourage and promote individual oral hygiene practices and affordable dental care.

Partner with state and local organizations to increase physical fitness and nutrition education opportunities that include nutritional counseling for older adults.

Assist AAAs with operation of senior nutrition programs through training, technical assistance, and monitoring of financial and program operations to maximize available resources.

Advocate for increased funding for home-delivered meals.

Provide education and technical assistance to farmers about the Senior Farmers' Market Nutrition Program.

Measures:

- 10 percent increase in the number of unduplicated persons served in senior nutrition programs by 2018.
- 10 percent increase in the number of eligible meals provided to home-bound individuals in senior nutrition programs by 2018.
- Number of individuals at high nutritional risk.
- 20 percent increase in the number of AAAs that provide nutritional counseling.
- Number of farmers registered or certified to participate in the Senior Farmers' Market Program.

Objective 2.5. Encourage individuals, including people under 60, to plan for future long-term care needs, incapacity, and end-of-life options.**Strategies:**

Promote information available on EasyAccess and VirginiaNavigator to health professionals who help older adults with estate, health, and long-term care planning.

Increase education and public awareness about long-term care options.

Promote advance legal planning for incapacity through durable powers of attorney and advance directives.

Educate individuals who identify with the LGBT community and their providers and the broader community about planning for long-term care needs.

Encourage incorporating planning for transportation needs as part of individual retirement needs for when one is no longer able to drive.

Provide education and awareness aimed at health care providers about being able to honor patients' end-of-life wishes.

Educate older adults, caregivers, and providers on end-of-life planning for guardianship and alternatives to guardianship, including advance directives, medical powers of attorney, and pre-planning for incapacity.

Measures:

- Advance directive initiatives added to all Community-based Care Transitions Programs by 2017.
- Governor's Conference on Aging in the Spring of 2016 to encourage long-term care planning for older adults and caregivers.
- 20 percent increase in the number of AAAs providing advance directive assistance by 2018.

Objective 2.6. Increase public awareness of existing resources for behavioral and physical health and long-term care.	
Strategies:	Promote awareness of behavioral and physical health and substance use disorders needs, services, and resources, especially public benefits for which older adults qualify.
	Support services that provide mental health and substance use disorders screening and counseling for older adults through the Geriatric Mental Health Partnership.
	Develop education sessions for AAA staff to increase understanding of older adults who are at risk for mental health or substance use disorders and suicide.
Measures: - Update in partnership with VDH and DBHDS the <i>Suicide Prevention Across The Lifespan Plan for the Commonwealth of Virginia</i> to include a comprehensive suicide prevention plan for older adults addressing public awareness, prevention education, early identification, intervention, and treatment and support for survivors by 2018. - Number of Geriatric Mental Health Partnership meetings. - Completion of education sessions for all AAA staff to elevate awareness of older adults who are at risk for mental health or substance use disorders issues and suicide by 2019.	
Objective 2.7. Build the workforce of direct support and health care professionals and make professional training programs available to all providers.	
Strategies:	Increase state fund appropriations for the Geriatric Training and Education Initiative, Virginia's only state-funded program to develop skills and build capacities of the gerontological/geriatric work force across disciplines from pre-professional to professional.
	Develop a comprehensive strategy to raise awareness about the positive aspects of careers related to eldercare and recruit direct care workers such as paid caregivers, CNAs, and personal and home health aides.
	Evaluate the feasibility of scholarships for students entering the medical professions who will concentrate on care for older adults and train the primary care workforce to improve coordination of care and communication with elderly patients.
	Reduce overuse of prescription drugs, including the inappropriate use of antipsychotic medications, in LTC facilities through enhanced training for health professionals.
	Ensure appropriate pain management through enhanced training for health professionals.
	Increase training for HCBS providers and LTC facilities about care issues for older adults.
Measures: - VDA advisory board(s) recommend to Governor and Virginia General Assembly to fund and train direct support and health care workforce for the aging population. - Train health professionals about care issues for older adults in partnership with the Department of Health Professions at 20 percent of the LTC facilities by 2018.	

Goal 3: Enable people to live in the community as appropriate through the availability of formal and informal high-quality LTSSs, including supports for families and caregivers.

Objective 3.1. Identify and serve target populations in need of HCBSs.	
Strategies:	Identify target populations, including older racial and ethnic minorities, through outreach to underserved communities and the areas served by the Commonwealth Coordinated Care Program.

	Increase access to and provide specialized behavioral health services for older adults, including dementia services.
Measures: • Number of HCBSs provided through AAAs. • 15 percent increase in the number of persons served in the Commonwealth Coordinated Care Program by 2017. • Number of individuals supported through Section Q, MDS 3.0.	
Objective 3.2. Ensure that efforts are in place to address unmet needs for LTSSs while serving as many older adults as possible using all available resources.	
Strategies:	Continue to pursue creative partnerships with universities and local entities to expand resources.
	Develop resources to address mental health or substance use disorder referrals.
Measures: • VDA advisory board(s) recommend to Governor and Virginia General Assembly to fund unmet needs for LTSSs. • 20 percent increase in the number of AAAs collaborating with CSBs to secure referrals for mental health or substance use disorder by 2018.	
Objective 3.3. Increase coordination of services to reduce fragmented care	
Strategies:	Facilitate improved coordination between health disciplines and care settings to facilitate care transitions.
	Educate families about what to expect during care and their role in care integration.
Measure: • 20 percent increase in the number of Community-based Care Transitions Programs.	
Objective 3.4. Increase awareness of services already available to support caregivers and expand caregiver supports.	
Strategies:	Identify funding for a caregiver public awareness campaign.
	Promote and seek additional funding for the Lifespan Respite Voucher program.
	Increase membership of the Virginia Caregiver Coalition to include all ages and disabilities.
	Advertise the Virginia Family Caregiver Solution Center and Lindsay Institute.
	Continue to explore ways to expand caregiver respite services.
	Increase caregiver education and public education of caregiver needs through NWD, Virginia Caregiver Coalition activities, and the ADSSP grant-funded activities.
	Connect grandparents to social resources through collaboration with state agency partners.
Measures: • 15 percent increase in the number of annual Virginia Caregivers' Month events by 2018. • Numbers of hits to the Virginia Family Caregiver Solution Center. • VDA advisory board(s) recommend to Governor and Virginia General Assembly to fund caregiver respite services.	
Objective 3.5. Provide services, education, and referrals to meet specific needs of individuals with Alzheimer's disease and related dementias.	
Strategies:	Promote the Virginia Dementia State Plan goals:
	• Coordinate quality dementia services in the Commonwealth, • Use dementia-related data to improve public health outcomes, • Increase awareness and create dementia-specific training,

	• Provide access to quality care for individuals with dementia in the most integrated setting, and • Expand resources for dementia-specific translational research and evidence-based practices.
	Continue to identify potential funding sources for serving persons with Alzheimer's disease and related dementias.
	Promote caregiver training that maximizes the abilities of caregivers to care for persons with dementia (e.g., FAMILIES).
Measures: • 2015 Dementia State Plan implementation by 2019. • Statistically significant improvements in caregiver depression and burden through ADSSP FAMILIES grant.	

Goal 4: Strengthen statewide systems that protect the rights and prevent the abuse, neglect, or exploitation of older adults.

Objective 4.1. Strengthen adult protection and abuse, neglect, or exploitation prevention through outreach, education, and advocacy.

Strategies:	Seek additional federal and state funding for APS training and services.
	Strengthen APS through interagency coordination and communication.
	Increase criminal investigations and prosecutions of APS cases substantiated for physical or sexual abuse or financial exploitation.
	Seek funding to expand the Ombudsman Program to fulfill its mandated responsibility to address concerns of older adults and their families regarding the quality of home and community-based long-term care.
	Partner with the judiciary to develop a uniform procedure for guardianship monitoring and complaints for guardianships outside the Public Guardian Program.
	Standardize and incorporate a curriculum into basic academy and in-service training for first responders and state and local law enforcement to assist them in recognizing, investigating, and addressing instances of elder abuse, neglect, and exploitation.
	Offer training programs to assist prosecutors in recognizing, addressing, investigating, and prosecuting instances of elder abuse, neglect, and exploitation.
	Offer educational programs for lawyers and judges on enhancing their skills and ability to adjudicate cases involving elder abuse, neglect and exploitation.
	Expand TRIAD partnerships and other community coalitions among public agencies and private-sector organizations to broaden training and education about older adult safety, crime and fraud prevention, and domestic violence.
	Continue funding through the Department of Criminal Justice Services to provide Alzheimer's-related training to first responders including law enforcement officers, emergency medical services, and fire services.

Measures: • Specific appropriation of state funds for APS and HBC by 2018. • 20 percent increase in the number of individuals served through the APS and Ombudsman Programs by 2019. • 15 percent increase in the number of first responders and state and local law enforcement trained about elder abuse curriculum by 2018. • 15 percent increase in the number of prosecutors and judicial officers trained about elder abuse, neglect, and exploitation. • Number and percent of criminal investigations and prosecutions resulting from APS referrals.	
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Objective 4.2. Increase the capacity and improve the quality of the Public Guardian Program (PGP) , and expand the PGP geographically to achieve statewide coverage in order to better serve individuals who need its services.

Strategies:	Seek funding through the state and other grant sources for additional slots and to contract for PGP services in underserved areas of the state.
	Collaborate with DBHDS to identify individuals with intellectual disability who will need public guardian services upon transition from Virginia’s training centers.
	Create mechanisms in jurisdictions so that court costs for indigent clients can be waived or substantially reduced.
	Identify ways to cover the cost of the petitioning process for family members who are willing and are appropriate to assume guardianship of indigent family members.
	Enhance provider training and implement training for judicial, medical, and related fields to strengthen identification of and understand options related to PGP cases involving elder abuse, neglect, or exploitation.
	Raise awareness and provide resources to individuals in the PGP and their service providers regarding elder abuse, neglect, or exploitation.
	Continue to use person-centered practices in annual provider training and program procedures.

Measures:

- 15 percent decrease in the number of individuals on waiting lists for services from the Public Guardian Program by 2018.
- Amount of additional funding for incapacitated persons who are eligible for the Public Guardian Program.
- Number of individuals served by the Public Guardian Program.
- Statewide coverage of the Public Guardian Program.

Objective 4.3. Continue statewide leadership and coordination of available legal resources for older adults by building upon and supporting the recommendations of the Project 2025 Legal Assistance initiative that began in 2006 as an AoA Model Approaches to Statewide Legal Assistance Systems grant funded project.

Strategies:	Continue to fund a full-time position for Virginia’s Legal Services Developer (LSD).
	Continue to convene Project 2025 Stakeholder meetings and implement the following recommendations: • develop suggested voluntary uniform model contracts to assist AAAs in contracting with legal assistance service providers in Virginia; and • develop uniform statewide legal assistance unit standards beyond the minimum federal standards currently in use in order to better define and measure the quality of legal assistance provided to individuals aged 60 and older.
	Increase the number of pro bono attorneys and the number of pro bono hours provided by those attorneys to serve older Virginians through: • development and presentation of free Continuing Legal Education (CLE) sessions, independently and in conjunction with other CLE providers, in exchange for a pro bono commitment from attorney-attendees, and • educational efforts to the private, corporate, and government bar about the unmet legal needs of Virginia’s growing older adult population and available pro bono opportunities to help meet those needs.

	Continue to refine and improve legal assistance systems to better reach specific target populations such as those in the greatest economic or social need as defined under federal standards, including low-income, rural, and non-English speaking individuals and those in long-term care facilities.
	Facilitate opportunities among government, public, and private entities to better work together to enhance the legal assistance system for Virginia's senior population.
Measures: - Continued funding for the Legal Services Developer. - Legal resources for older adults: - Number of model contracts with legal assistance providers. - Adoption of uniform legal assistance unit standards. 15 percent increase in number of pro bono attorneys. - Number of individuals 60 and over served by pro bono attorneys. - Type and amount of legal assistance received.	

Goal 5: Enhance effective and responsive management of programs serving older adults to ensure the fiscal responsibility and programmatic accountability of these programs.

Objective 5.1. Promote and incorporate management practices that encourage effectiveness and entrepreneurship.	
Strategies:	Develop and implement performance-based standards and outcomes for monitoring and oversight functions.
	Identify and implement data-driven measures to demonstrate program effectiveness and efficiencies
	Develop an infrastructure for collaborative research through coordination with aging-related experts at universities.
	Improve coordination of service delivery through regional collaborations.
	Develop a marketing strategy to encourage AAA to partner with the private sector.
	Advocate for and work toward increasing the quality of care through better care transitions.
	Coordinate medical and long-term care and improve effectiveness through development and implementation of measurable outcomes.
	Incorporate performance-based outcomes in AAA contracts.
	Encourage statewide implementation of Commonwealth Council on Aging Best Practices.
Measures: - Develop performance-based outcomes with AAAs by 2017. - Implement performance-based outcomes for AAAs by 2018. - Incorporate outcomes in performance-based Area Plan contracts with AAAs by 2019. - Implementation of a least one Commonwealth Council on Aging Best Practice at each AAA by 2018.	
Objective 5.2. Ensure that federal and state funds are used to effectively and efficiently meet the needs of older adults.	
Strategies:	Pursue alternative resource development to improve provision of services to older adults.
	Strengthen oversight of expenditures and ensure good stewardship.

Measures: • Number of AAA governing board trainings on board governance. • Number of Governance-Financial & Program Compliance Reviews completed.	
Objective 5.3. Ensure that state agencies, AAAs, and home and community-based service providers continue to strengthen their disaster preparedness plans to address the specific needs of older adults and adults with disabilities.	
Strategies:	Work with VDEM to review and analyze statewide disaster preparedness plans.
	Develop and implement flexible and responsive procedures for the continuity of operations in the event of a significant disaster.
	Ensure that older adults and adults with disabilities are adequately represented in statewide and community-level disaster preparedness planning and testing, especially related to accessibility of shelters and transportation.
	The agency's designated Emergency Coordination Officer shall stay in regular communication with the Office of Commonwealth Preparedness, the Virginia Department of Emergency Management, and other Commonwealth Preparedness Working Group agencies.
	Conduct the Agency Preparedness Assessment, an all-hazards assessment tool that measures agencies' compliance with requirements and best practices. The assessment has components including Physical Security, Continuity of Operations, Information Security, Vital Records, Fire Safety, Human Resources, Risk Management, and Internal Controls.
	Participate on VDEM's Access and Functional Needs Advisory Committee.
Measures: • Number of VDEM's Access and Functional Needs Advisory Committee meetings. • Agency Preparedness Assessment conducted annually.	
Objective 5.4. Enhance the development and implementation of quality measures.	
Strategies:	Develop a data warehouse for aging services.
	Continue to work with universities to conduct studies utilizing Virginia's warehouse for aging services.
	Work with ACL, other federal agencies, and other state units on aging to establish quality measures.
Measures: • Develop and implement a data warehouse for aging services by 2017. • Number of studies conducted by university partners utilizing aging's data warehouse. • Develop and implement quality measures by 2019.	
Objective 5.5. Ensure that data in the NWD system is accurately maintained.	
Strategies:	Review data in CRIA for quality assurance as part of the AAA program monitoring.
	Provide technical assistance to AAAs to ensure data errors are corrected.
	Encourage provider review processes to ensure data integrity and accuracy.
Measures: • Data quality standards developed by 2017. • Data quality standards implemented by 2018. • Data quality standards incorporated in performance-based contracting by 2019.	

APPENDIX A: INTRASTATE FUNDING FORMULA

Background

The Older Americans Act of 1965, as amended, Section 305(a)(2)(C) requires the state agency to:

In consultation with area agencies, in accordance with guidelines issued by the Assistant Secretary, and using the best available data, develop and publish for review and comment a formula for distribution within the State of funds received under this title that takes into account –

- (i) The geographical distribution of older individuals in the State; and
- (ii) The distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.

In October 2011, the Virginia Department for the Aging convened a Funding Formula Task Force (Task Force). The Task Force was similar to the previous Task Forces required by the Virginia General Assembly in the 2005 Virginia Appropriations Act.

After thoughtful discussion and careful consideration, the Task Force decided to avoid the drastic impact that application of the new census data would have on the distribution of funds without an adjustment. The decision was made not to change the formula factors. Instead, the group recommended that fifty percent of the Federal Fiscal Year's 2012 allocation would be the base. The other fifty percent would be distributed using the most recent 60 plus ACS compilation produced by the US Bureau of Census for AoA. The Task Force further decided that no agency would receive less funding than they received in Federal Fiscal Year 2006. The Task Force presented its recommendation to the Commissioner of the Department for the Aging. The recommendation was accepted as offered.

Title III and VII

[For Subtitles III-B, Supportive Services; III-C, Nutrition; III-D, Disease Prevention and Health Promotion; III-E, National Family Caregiver Support; and VII-Chapter 3, Prevention of Elder Abuse, Neglect, and Exploitation]

VDA, in consultation with Virginia's AAAs, developed an intrastate funding formula for Older Americans Act funds. The Commonwealth's Title III and VII-Chapter 3 funding factors and their weights are as follows:

Population 60+	30%
Population 60+ in Rural Jurisdictions	10%
Population 60+ in Poverty	50%
Population 60+ Minority in Poverty	10%

Note: Title III-D, Preventive Health, is further adjusted for medically underserved areas.

Description of Formula Factors

Population 60+: This factor is the basis for the distribution of funds by jurisdiction (county and city) of older Virginians. It reflects the proportion of persons age 60 and older throughout the Commonwealth by jurisdiction.

Population 60+ in Rural Jurisdictions: This factor addresses the geographical isolation faced by older Virginians who live in the rural areas. VDA defines "rural" as any jurisdiction (city or county) which is not within a Metropolitan Statistical Area (MSA) or any jurisdiction which is within an MSA but which has a population density of 50 persons or less per square mile. An MSA is calculated by the U.S. Bureau of the Census and is updated in the formula when the census population data is updated. Square mileage by jurisdiction is obtained from the US Bureau of Census and is updated in the formula when the decennial census population data is updated. The determination of rural or urban is reassessed when the population numbers are updated or when the US Bureau of Census updates land area.

Population 60+ in Poverty: This factor is an application of the definition of greatest economic need as required by the Older Americans Act. The financial condition of the older person is a major determinant of his or her ability to meet basic life needs such as food, shelter, mobility, and healthcare.

Population 60+ Minority in Poverty: This factor addresses the special needs of older racial and ethnic minorities in Virginia as well as the economic needs of this group.

Medically Underserved Area: Section 362 of the Older Americans Act of 1965, as amended, requires states to give priority to areas that are medically underserved. VDA applies a medically underserved factor to Title III-D, Disease Prevention and Health Promotion Services.

The U.S. Department of Health and Human Services, Health Resource and Services Administration (HRSA), maintains the Medically Underserved Areas/Populations. These areas or populations designated by HRSA have too few primary care providers, high infant mortality, high poverty or a high elderly population.

A base of \$2,000 per AAA has been established whether or not any portion of the area agency is medically underserved. Next, medically underserved is determined for each jurisdiction. VDA updates this factor when the population data is updated. If any portion in whole or part is medically underserved, the entire jurisdiction is included in the funding allocation.

Population Factors

All population factors for the state plan beginning with federal fiscal year 2013 uses the five year American Community Survey (ACS) special tabulation prepared for the Administration for Community Living (ACL) under contract by the U.S. Bureau of the Census. The population factors are updated with the most recent ACS tabulation available when the new area plan year's proposed funding allocations are prepared.

Funding Levels

Virginia, working with the Area Agencies on Aging, modified its intrastate funding formula beginning with Federal Fiscal Year's 2013 distribution. The funding formula includes a base of fifty percent of the Federal Fiscal Year's 2012 allocation for each Area Agency on Aging. All funds awarded above the base will be distributed using the formula with data from the most recent 60 plus ACS special compilation produced by the US Bureau of Census for ACL. In no case will an Area Agency on Aging receive less than it did in Federal Fiscal Year 2006.

Spending for Priority Services

Section 306(a)(2) of the Older Americans Act of 1965, as amended, requires the state to provide assurances that an adequate portion of the amount of Title III-B funding will be expended for the delivery of services associated with access, in-home, and legal assistance.

VDA's regulations, found in Section 22VAC5-20-100 (Priority Services), require AAAs to expend the following amounts:

- At least 15% of its Title III-B allotment for services associated with access to other services, such as care coordination, information and assistance, and transportation services.
- At least 5% of its Title III-B allotment for in-home services, such as (i) homemaker/personal care services, (ii) chore services, (iii) home health services, (iv) checking services, (v) residential repair and renovation services, and (vi) in-home respite care for families and adult day care as a respite service for families.
- At least 1% of its Title III-B allotment for legal assistance for older adults.

VDA may waive this requirement for any category of services described if the AAA demonstrates to VDA that services being provided in the area are sufficient to meet the need. Before a waiver is requested, the AAA must conduct a public hearing:

- The AAA shall notify all interested persons of the public hearing;
- The AAA shall provide interested persons with an opportunity to be heard;
- The AAA shall receive, for a period of 30 days, any written comments submitted by interested persons; and
- The AAA shall furnish a complete record of the public comments with the request for the waiver to VDA.

Cost Sharing/Fee for Service

Section 315(a) of the Older Americans Act of 1965, as amended, permits cost sharing/fee for service. Virginia has implemented cost sharing/fee for all service permitted to cost share or charge fees under the OAA.

AAAs use the most current Federal Poverty/VDA Sliding Fee Scale to determine client fees for all services except: Older Americans Act Care Coordination, Information and Assistance, Congregate and Home Delivered Meals, Public Information and Education, Legal Assistance, Elder Abuse, and Ombudsman. The Federal Poverty/VDA Sliding Fee Scale is based on the Virginia Board of Health's "Regulations Governing Eligibility Standards and Charges for Health Care Services to Individuals" found in 12VAC5-200.

AAAs may request a waiver to not implement cost sharing/fee for Older Americans Act services if it can adequately demonstrate:

- (A) That a significant proportion of persons receiving services subject to cost sharing in the planning and service area have incomes below the threshold established in state policy; or
- (B) That cost sharing would be an unreasonable administrative or financial burden upon the AAA.

Long-Term Care Ombudsman Program

Virginia's AAAs operate local Ombudsman programs. Two or more AAAs may operate a joint program provided the AAAs are adjacent to each other.

A base of \$15,000 has been established when an AAA operates a single Ombudsman program. A base of \$25,000 has been established when two or more AAAs operate a joint program.

The remainder of Title VII-Chapter 2 Ombudsman funds along with the state funds are distributed in proportion to the number of licensed nursing facility beds, licensed assisted living facility beds, and licensed geriatric mental health beds located in each PSA.

The Virginia Department of Health maintains the number of nursing facility beds, the Virginia Department of Social Services maintains the number of assisted living facility beds, and the Department of Behavioral Health and Developmental Services maintains the number of state mental health facility beds. The number of beds in each PSA is updated annually for the next fiscal year based on the most recent available data when the new area plan year's proposed funding allocations are prepared.

Virginia's Population by Funding Formula Factors For Federal Fiscal Year 2016 Based on U.S. Census 2008 -2012 American Community Survey (ACS) Estimates

The table below presents the population used in the funding formula factors for each Area Agency on Aging.

		2008 - 2012 ACS			
		<i>Pop 60+</i>	<i>Poverty 60+</i>	<i>Pov & Minority</i>	<i>Rural</i>
<i>Virginia</i>	<i>Totals</i>	1,437,675	108,036	40,531	310,830
<i>PSA 1</i>	Mountain Empire Older Citizens	21,440	3,123	63	21,440
<i>PSA 2</i>	Appalachian Agency for Senior Citizens	27,445	3,432	22	27,445
<i>PSA 3</i>	District Three Senior Services	50,485	5,772	172	31,860
<i>PSA 4</i>	New River Valley Agency on Aging	32,650	2,800	180	8,550
<i>PSA 5</i>	LOA Area Agency on Aging	63,590	4,797	1,152	7,165
<i>PSA 6</i>	Valley Program for Aging Services	61,160	5,194	324	38,955
<i>PSA 7</i>	Shenandoah AAA	46,550	3,298	273	16,500
<i>PSA 8A</i>	Alexandria Division of Aging and Adult Services	20,215	1,215	760	-
<i>PSA 8B</i>	Arlington Agency on Aging	27,610	1,765	955	-
<i>PSA 8C</i>	Fairfax AAA	175,900	6,929	3,824	-
<i>PSA 8D</i>	Loudoun County AAA	32,580	1,170	525	-
<i>PSA 8E</i>	Prince William AAA	51,495	1,889	1,024	-
<i>PSA 9</i>	Rappahannock-Rapidan CSB and AAA	34,885	1,939	759	22,345
<i>PSA 10</i>	Jefferson Area Board for Aging	46,960	3,083	938	4,470
<i>PSA 11</i>	Central Virginia AAA	55,905	4,959	1,564	3,745
<i>PSA 12</i>	Southern AAA	64,620	6,797	2,177	23,325
<i>PSA 13</i>	Lake Country AAA	22,860	3,394	1,794	22,860
<i>PSA 14</i>	Piedmont Senior Resources AAA	23,845	2,872	1,657	23,845
<i>PSA 15</i>	Senior Connections, The Capital AAA	174,210	12,077	5,937	1,960

<i>PSA 16</i>	Rappahannock AAA	46,550	3,060	1,170	3,865
<i>PSA 17</i>	Bay Aging	39,775	3,241	1,301	25,625
<i>PSA 19</i>	Crater District AAA	34,935	3,823	2,423	8,010
<i>PSA 20</i>	Senior Services of Southeastern Virginia	182,545	13,953	7,788	6,415
<i>PSA 21</i>	Peninsula Agency on Aging	87,015	5,390	2,715	-
<i>PSA 22</i>	Eastern Shore AAA - Community Action Agency	12,450	2,064	1,034	12,450

APPENDIX B: INFORMATION REQUIREMENTS

States must provide all applicable information following each OAA citation listed below. The completed attachment must be included with your State Plan submission.

Section 305(a)(2)(E)

Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

VDA requires all Area Agencies on Aging to contractually comply with the “Assurances – Local Plan for Aging Services.” The assurances require AAAs to comply with the assurances and/or provisions provided in Sections 306 and 307 of the OAA.

In Virginia the OAA programs are an important safety net program. Through the area plan process AAAs target services to older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority individuals, older individuals residing in rural areas, low-income individuals, and frail individuals (including individuals with any physical or mental functional impairment).

Section 306(a)(17)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

In Virginia state government, the Virginia Department of Emergency Management (VDEM) is responsible for working with local government, state, federal agencies and voluntary organizations to provide resources and expertise through the phases of emergency management. VDEM, in cooperation with the Virginia Department of Health, has established a workgroup to help older Virginians to plan and recover from a disaster. DARS has two representatives that serve on a HHR workgroup to provide overall disaster assistance. One DARS representative oversees the agency’s disaster preparedness plan with VDEM, while the VDA representative provides technical expertise to the workgroup to ensure state emergency efforts meet the needs of older Virginians.

VDEM has dedicated a portion of their website to inform, educate and help older citizens plan and recover from a disaster. The link is:
<http://www.vaemergency.gov/readyvirginia/makeaplan#older>. It provides useful information on taking control before a disaster strikes, preparing an emergency supply kit, making a plan (including contact information and insurance needs), planning for pets, and staying informed.

The local AAAs work with their clients to prepare for a disaster. Many AAAs have provided their clients that receive congregate and home delivered meals with a limited supply of shelf stable meals to be used in the event of a disaster.

The Area Plan Contract for Aging services requires the AAAs to develop a Continuity of Operations Plan (COOP) detailing how the agency plans to maintain its operations during an emergency or other situation that would disrupt normal operations. This plan must be approved by the agency's governing board or governing body.

In 2012, the Commonwealth Council on Aging recognized the Senior Resource Center's Emergency Preparedness Plan for the rural area of southern Virginia Beach as a Best Practices Awards recipient. The Senior Resource Center, at 912 Princess Anne Road in Creeds, is primarily run by volunteers with assistance from the city's Department of Human Services. It provides residents living in southern Virginia Beach with educational seminars, physical activity and social interaction needed to live their lives to the fullest. The award honored the center's Emergency Preparedness Plan for the rural area of southern Virginia Beach, which identifies older residents in the community who will need special assistance or contact during an emergency situation and builds relationships with them so they will accept assistance when needed.

Section 307(a)(2)

The plan shall provide that the State agency will:

(C) Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) (Note: those categories are access, in-home, and legal assistance). Provide specific minimum proportion determined for each category of service.

VDA has established through the Virginia Administrative Code (state agency regulations) the minimal amount of funding that can be spent on priority services such as access, in-home, and legal assistance. The regulations specify that at least 15% of an AAA's Title III-B allotment for services shall be spent on access to other services: care coordination, communication, information, assistance and referral, transportation.

At least 5% of the AAA's Title III-B allotment shall be spent on in-home services: adult day care, checking, chore, homemaker, personal care, residential repair and renovation.

At least 1% of the AAA's Title III-B allotment shall be spent on legal assistance.

Each AAA may apply for a waiver if it can demonstrate to VDA that services being provided in such category in the area are sufficient to meet the need for such services in such area. The request for waiver is submitted to VDA after a public comment period and reviewed by agency staff prior to approval.

Section 307(a)(3)

The plan shall:

(B) with respect to services for older individuals residing in rural areas:
(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

- (ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).
- (iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

In fiscal year 2000, VDA awarded rural jurisdictions of Virginia \$12,577,037. By fiscal year 2015, the amount of funding had increased to at least \$13.5 million. The increase occurred through additional federal funds that have been awarded and state funds that have been appropriated by the General Assembly and the Governor.

In 2010, the Virginia funding formula was modified so that no agency would receive less funding than they received in Federal Fiscal Year 2006. As a result future funding to rural areas is assured.

Section 307(a)(10)

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

Since the 1980's, Virginia's intrastate funding formula has had rural factor as one of its four components. The percent of funds allocated to rural regions has held steady at 10%. In 2000 68 of the approximately 134 jurisdictions were classified as rural. As of the 2014 funding allocations, 64 jurisdictions were classified as rural. As Virginia's population continues to grow, fewer jurisdictions benefit from the 10% allocation resulting in a smaller pool of jurisdictions benefiting from the 10% allocation pool of funds.

Section 307(a)(14) (14)

The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

- (A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and
- (B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

The intrastate funding formula allocates 10% of the funds to individuals age 60 and older that are in poverty and minority. For FFY 2014, Virginia used the five year compilation of the American Community Survey. The 2012 ACS indicates there are 40,531 individuals in poverty and minority.

To help address low-income minority older individuals with limited English proficiency, one of Virginia's intrastate funding formula factors is poverty. This factor alone, is used to allocate fifty percent of the funds. In a comparison with other state intrastate funding formulas, Virginia ranks very high in its allocation of funds based a poverty factor. Virginia has an additional factor to address minority in poverty and allocates ten percent based on this factor.

Section 307(a)(21)

The plan shall:

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title (title III), if applicable, and specify the ways in which the State agency intends to implement the activities.

Virginia does not have any federally recognized Native American tribes, although efforts are currently underway. Six Virginia tribes are attempting to gain federal recognition. The six tribes, which are recognized by the Commonwealth of Virginia are the Chickahominy, the Eastern Chickahominy, the Upper Mattaponi, the Rappahannock, the Monacan and the Nansemond. When federal recognition occurs, the newly recognized nations will receive direct funding from ACL for the OAA.

The 2012 American Community Survey indicates there are approximately 3,025 Native Americans in Virginia age 60 and older. Of these, only 400 were identified with income in the past 12 months below poverty.

The Commonwealth's 2014 National Aging Program Information System – State Program Report (NAPIS-SPR) indicated 44 Native Americans were receiving OAA Services provided by Virginia's AAA network. Of these individuals served more than half reported income below poverty.

Section 307(a)(29)

The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

In addition to the information reported in Section 306(a)(17) above, VDA has developed an "Area Agency on Aging and Guardian Program Disaster Status Report". This report is a checklist to quickly identify the agency's main offices and service sites impacted by a disaster. It also identifies factors causing any disruptions in services. The report focuses on the number and clients impacted and how the agency and the state if necessary can appropriately target a response.

If needed, in the event of a serious disaster, VDA has coordinated with Federal Emergency Management Agency (FEMA), the Virginia National Guard, and VDEM for the distribution of food.

Section 307(a)(30)

The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

The Commissioner of DARS has appointed two individuals to serve on the VDEM Access and Functional Needs Advisory Committee. This standing committee has been established to advise the State Coordinator (VDEM director) and the Virginia Emergency Response Team on how to meet the needs of individuals with access and functional needs during a disaster.

Section 705(a)(7)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6).

(Note: Paragraphs (1) of through (6) of this section are listed below)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their

households; and (C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

- (i) if all parties to such complaint consent in writing to the release of such information;
- (ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
- (iii) upon court order

All assurances within the this information requirement are met under federal and state regulations of the Older Americans Act through the State Unit on Aging, Virginia Department for Aging and Rehabilitative Services.



James A. Rothrock, *Commissioner*
Virginia Department for Aging and Rehabilitative
Services

June 1, 2015

Date

APPENDIX C: ASSURANCES

STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2006.

Sec. 305(a) - (c), ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--

(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--

- (I) older individuals residing in rural areas;
- (II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (IV) older individuals with severe disabilities;
- (V) older individuals with limited English proficiency;
- (VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
- (VII) older individuals at risk for institutional placement; and

(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:

in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--

- (i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
- (ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(17) Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--

- (i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
- (ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
- (iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--

- (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
- (ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
- (iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after

assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for-

- (A) public education to identify and prevent abuse of older individuals;
- (B) receipt of reports of abuse of older individuals;
- (C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
- (D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

- (A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and
- (B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

- (A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and
- (B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--
 - (i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order

- to assist such older individuals in participating in programs and receiving assistance under this Act; and
 - (ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.
- (16) The plan shall provide assurances that the State agency will require outreach efforts that will—
- (A) identify individuals eligible for assistance under this Act, with special emphasis on—
 - (i) older individuals residing in rural areas;
 - (ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
 - (iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
 - (iv) older individuals with severe disabilities;
 - (v) older individuals with limited English-speaking ability; and
 - (vi) older individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
 - (B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.
- (17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.
- (18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community based, long-term care services, pursuant to section 306(a)(7), for older individuals who--
- (A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
 - (B) are patients in hospitals and are at risk of prolonged institutionalization; or
 - (C) are patients in long-term care facilities, but who can return to their homes if community based services are provided to them.
- (19) The plan shall include the assurances and description required by section 705(a).
- (20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.
- (21) The plan shall-
- (A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made-

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

- (1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.
- (2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.
- (3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.
- (4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.
- (5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).
- (6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—
 - (A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--
 - (i) public education to identify and prevent elder abuse;
 - (ii) receipt of reports of elder abuse;
 - (iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
 - (iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
 - (B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
 - (C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--
 - (i) if all parties to such complaint consent in writing to the release of such information;
 - (ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
 - (iii) upon court order.

REQUIRED ACTIVITIES

Sec. 307(a) STATE PLANS

- (1)(A) The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and
- (B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

- (2) The State agency:
- (A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;
- (B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, volunteers and programs and services of voluntary organizations) have the capacity and actually meet such need;
- (4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*
- (5) The State agency:
- (A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
- (B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
- (C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.
- (6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--

- (i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
- (ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or
- (iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.



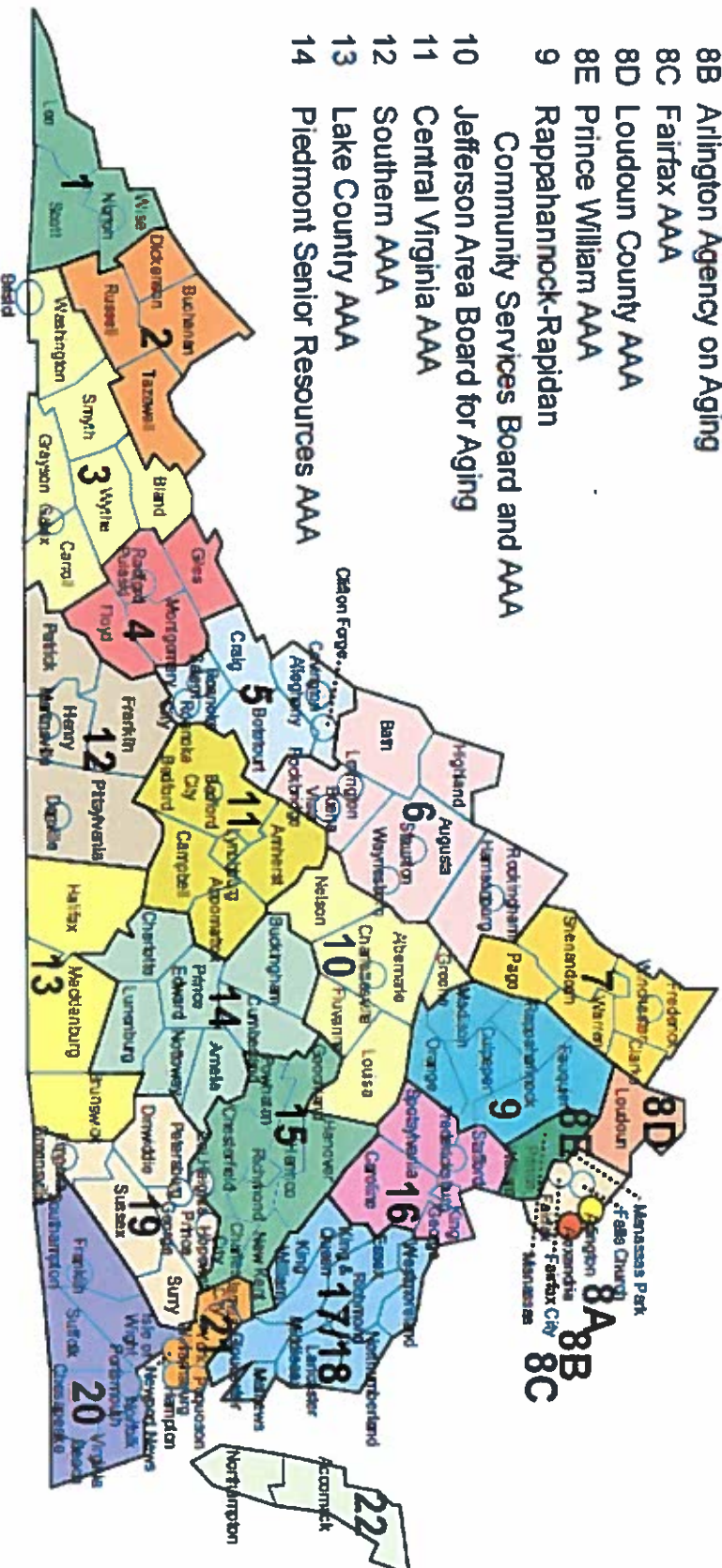
James A. Rothrock, *Commissioner*
Virginia Department for Aging and Rehabilitative
Services

June 1, 2015

Date

Virginia's 25 Area Agencies on Aging

- | | | | |
|----|--|-------|---|
| 1 | Mountain Empire Older Citizens | 15 | Senior Connections, The Capital AAA |
| 2 | Appalachian Agency for Senior Citizens | 16 | Rappahannock AAA |
| 3 | District Three Senior Services | 17/18 | Bay Aging |
| 4 | New River Valley Agency on Aging | 19 | Crater District AAA |
| 5 | LOA Area Agency on Aging | 20 | Senior Services of Southeastern Virginia |
| 6 | Valley Program for Aging Services | 21 | Peninsula Agency on Aging |
| 7 | Shenandoah AAA | 22 | Eastern Shore AAA - Community Action Agency |
| 8A | Alexandria Division of Aging and Adult Services | | |
| 8B | Arlington Agency on Aging | | |
| 8C | Fairfax AAA | | |
| 8D | Loudoun County AAA | | |
| 8E | Prince William AAA | | |
| 9 | Rappahannock-Rapidan
Community Services Board and AAA | | |
| 10 | Jefferson Area Board for Aging | | |
| 11 | Central Virginia AAA | | |
| 12 | Southern AAA | | |
| 13 | Lake Country AAA | | |
| 14 | Piedmont Senior Resources AAA | | |
-



Fiscal Year 2014 Funds



\$29.4 Million

+



\$2.0 Million

+

Competitive Federal Grants

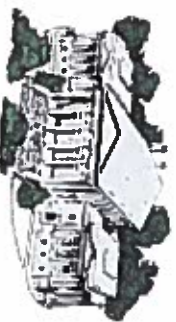
\$3.0 Million

+



\$1.5 Million

+



State Funds:

\$17.6 Million

=

Total Funds:

\$53.5 Million



DARS
VIRGINIA DEPARTMENT FOR AGING
AND REHABILITATIVE SERVICES

Fiscal Year 2014 State Funds

Community Based Services	\$6,226,000
Transportation	1,431,604
Home Delivered Meals	5,047,500
Care Coordination for Elderly Virginians	1,517,624
Respite Care Initiative	456,209
Long-Term Care Ombudsman	374,447
Guardianship Services	2,092,350
SeniorNavigator	201,875
<u>Directed Appropriations</u>	<u>215,500</u>
Total State Funds	\$17,563,109

Does not include VDA Admin General Funds Dollars

Supporting Virginians' efforts to secure independence and employment

Overview of the Delivery of State-Funded Community-based Services and Supports

Local or Regional Agency Type	Types of Services and Supports Offered	
25 Area Agencies on Aging (AAAs) • 5 Local Government • 5 Joint Exercise of Powers • 14 Private, Nonprofit • 1 Community Services Board Primary consumer: Older adults and their families and caregivers	• Adult Day Care • Care Coordination • Chiropractic (Reassurance) • Chiropractic • Congregate (Group) Nutrition • Disease Prevention • Elder Abuse Prevention • Emergency • Employment • Health Education & Screening • Home Delivered Nutrition • Homebased Communication, Referral and Information & Assistance • Information • Legal Assistance • Long-Term Care Ombudsman • Medication Management • Money Management	• Personal Care • Public Information / Education • Residential Repair & Renovation • Respite • Socialization & Recreation • Transportation (sub to curb) • Assisted Transportation (thru door) • Virginia Insurance Counseling & Assistance Program (VICAP) • Volunteer
16 Centers for Independent Living (CILs) • 16 Nonprofit • 4 Satellite Offices Primary Consumer: People over age 16 with significant disabilities and their families and caregivers	4 Core Services: (1) Information & Referral Services (2) Peer Counseling Services (3) Individual Advocacy (4) Independent Living Skills Training	• Preventive Services • Prosthetics • Children's Services • Communication • Counseling and Referral • Family Services • Mental Rehabilitation • Mobility Training • Orthotics and Other Appliances • Rehabilitation Technology • Therapeutic Treatment • Counseling • Teaching • Information sharing • Personal care assistance • Personal care instruction • Group Instruction • Financial Management training • Social skills training • Household management instruction
120 Local Department of Social Services (LDSS)-Adult Services and Adult Protective Services Primary Consumer: Any person 60 years of age or older or any person 18 years of age or older who is incapacitated and who resides in the Commonwealth	Provision of services to stop and prevent adult abuse, neglect, and exploitation including	• Auxiliary Grant Payment • Emergency Assistance • Emergency Shelter • Food Assistance • Home Repairs • Legal Services • Homemaker, Chaper, and Companion Services
Lead State Agency: Department for Aging and Rehabilitative Services		

Overview of the Delivery of State-Funded Community-based Services and Supports

Local or Regional Agency Type	Types of Services and Supports Offered
40 Community Services Boards (CSBs)¹⁰ • 27 Operating CSBs • 10 Administrative Policy CSBs • 2 Policy-Advisory CSBs with local government departments • 1 Behavioral Health Authority¹¹ Primary Consumer: People of all ages with mental health or substance use disorders, intellectual disability, or co-occurring disorders and their families Lead State Agency: Department of Behavioral Health and Developmental Services	10 Core Services with 22 Core Service Subcategories:¹² 1. Emergency Services 2. Archiving Services 3. Multisystem Treatment Services 4. Consumer Monitoring Services 5. Assessment & Evaluation Services 6. Early Intervention Services 7. Family Support Services 8. Consumer Risk Services 9. Local Inpatient Services 10. Acute Psychiatric or Substance Abuse Inpatient Services 11. Community Based Substance Abuse Medical Detoxification Inpatient Services 12. Outpatient Services 13. Outpatient Services 14. Intensive Outpatient Services 15. Medication Assisted Treatment 16. Assertive Community Treatment 17. Case Management Services 18. Day Support Services 19. Day Treatment or Partial Hospitalization 20. Ambulatory Crisis Stabilization Services 21. Rehabilitation or Habilitation 22. Employment Services 23. Sheltered Employment 24. Group Supported Employment 25. Individual Supported Employment 26. Residential Services 27. Highly Intensive Residential Services (All Residential Treatment Centers, Community ICH/HD, S.A. Medically Managed Withdrawal Services) 28. Residential Crisis Stabilization Services 29. Intensive Residential Services 30. Supervised Residential Services 31. Supervised Residential Services 32. Supportive Residential Services 33. Prevention Services
119 Local Health Departments Primary Consumer: Various Lead State Agency: Virginia Department of Health	41 Service Areas in the following general categories:¹³ • Communicable disease prevention and control • Environmental health hazards protection • Health assessment, promotion, and education • Health planning, quality oversight, and access to care • Drinking water protection • Vital records and health statistics • Medical examiner and anatomical services • Administrative and support services • Financial assistance to improve access to health care and emergency medical services

¹⁰ Source: Virginia Centers for Independent Living (VACIL) Annual Report (October 1, 2015 - September 30, 2016), p. 6 <http://www.vacil.org/VACIL%2005-06%20Final.pdf>

¹¹ Source: DBHIDS 2015 Overview of Community Services in Virginia: <http://www.dhhs.virginia.gov/library/documents/library/cocslb-overview.pdf>

¹² Source: Virginia Performance VDI Strategic Plan, Products and Services <http://vperforms.virginia.gov/agencylevel/analytchub/sofReport.cfm?AgencyCode=601>

¹³ Source: DBHIDS Core Services Taxonomy 7.3 <http://www.dhhs.virginia.gov/library/documents/library/coc2010-core-services-taxonomy7-2v2.pdf>



VIRGINIA DEPARTMENT FOR AGING
AND REHABILITATIVE SERVICES

Commonwealth Four-Year Plan Work Group

AARP—Peter Goldin	Virginia Department of Corrections—Scott Richeson
Alzheimer's Association—Carter Harrison	Virginia Department of Health—Brooke Rossheim, M.D., M.P.H.
Alzheimer's Disease and Related Disorders Commission—Lynne Seward	Virginia Department of Health Professions—Justin Crow, MPA
Commonwealth Council on Aging—Beth Barber and Richard Lindsay, M.D.	Virginia Department of Housing and Community Development—Monica Spradlin
Council on Virginia's Future—Jane Kuziak	Virginia Department of Medical Assistance Services—Terry Smith
Family and Children's Trust Fund—Hayley Mathews	Virginia Department of Planning & Budget—Kenny McCabe
League of Social Services Executives—Catherine Pemberton	Virginia Department of Rail and Public Transportation--John Mahoney
Office of the Attorney General—Mary Vail Ware	Virginia Department of Social Services—Paul McWhinney
Office of the Secretary of Health & Human Resources—Jennifer Lee, M.D.	Virginia Department of Veterans Services—Sandra Ranicki, BSN, LNHA
Virginia Adult Day Health Services Association—Michael DiGeronimo	Virginia Health Care Association—Mary Lynne Bailey, JD
Virginia Assisted Living Association--Judy Hackler	Virginia Hospital & Healthcare Association—Sara Hendon Heisler, JD, MHA
Virginia Association of Area Agencies on Aging—Cathy Galvin	Virginia Housing Development Authority—Bruce DeSimone
Virginia Association of Centers for Independent Living—Maureen Hollowell	Virginia Municipal League—Janet Areson
Virginia Association of Community Services Boards—Jennifer Faison	Virginia Parole Board-- Emily T. Sattie
Virginia Association of Counties—Dean Lynch	Virginia Poverty Law Center—Kathy Pryor, JD
Virginia Association for Home Care and Hospice—Marcie Tetterton, MSG, CAE	Virginia Public Guardian and Conservator Board—Lisa Moore
Virginia Association of Hospice and Palliative Care—Tina Williams	Virginia Senior Center Association—Peter Thompson
Virginia Association of Nonprofit Homes for the Aging—Bob Gerndt	Virginia Tech Center for Gerontology—Pam Teaster
Virginia Board for People with Disabilities—Linda Redmond	Virginia Department for Aging and Rehabilitative Services
Virginia Center on Aging—Ed Ansello	James Rothrock
Virginia Commonwealth University Department of Gerontology—Ayn Welleford	Katie Roeper
Virginia Department of Behavioral Health and Developmental Services—Beverly Morgan, MSG	Amy Marschean, JD
	Paige McCleary, MSW
	Marcia DuBois
	Ali Faruk
	Robert Brink
	Joanie Latimer
	Kathy Miller
	Tim Catherman
	Charlotte Arbogast

ACRONYMS

AAA	Area Agency on Aging	HAP	Health and Acute Care Project
AAAG	Alcohol and Aging Awareness Group	HBC	Home-Based Care
AAMC	Association of American Medical Colleges	HCBS	Home and Community-Based Services
ABD	Aged, Blind and Disabled	HHR	Health and Human Resources
ACL	Administration on Community Living	HRSA	Health Resource and Services Administration
AD	Agency-Directed	ID	Intellectual Disability
ADRC	Aging and Disability Resource Connection	LDSS	Local Department of Social Services
ADSSP	Alzheimer's Disease and Supportive Services Program	LTC	Long Term Care
APS	Adult Protective Services	LTSS	Long-Term Services and Supports
CCC	Commonwealth Coordinated Care	MCO	Managed Care Organization
CCTP	Community-based Care Transitions Program	MFP	Money Follows the Person
CD	Consumer-Directed	MMP	Medicare/Medicaid Plans
CDSME	Chronic Disease Self-Management Education	NWD	No Wrong Door
CIL	Center for Independent Living	OAA	Older Americans Act
CMS	Centers for Medicaid & Medicare Services	OC	Options Counseling
CRIA	Communication, Referral, Information and Assistance	PACE	Program for All-Inclusive Care for the Elderly
CNA	Certified Nurse Aide	PAS	Personal Assistance Services
CSB	Community Services Board	PGP	Virginia Public Guardian and Conservator Program
CTI	Coleman Care Transitions Intervention	SCSEP	Senior Community Service Employment Program
DARS	Department for Aging and Rehabilitative Services	SHIP	State Health Insurance Program
DBHDS	Department of Behavioral Health and Developmental Services	SMP	Senior Medicare Patrol
DD	Developmental Disability	SNAP	Supplemental Nutrition Assistance Program
DHCD	Department for Housing and Community Development	SSI	Supplemental Security Income
DMAS	Department of Medical Assistance Services	VDEM	Virginia Department of Emergency Management
DOC	Department of Corrections	VCC	Virginia Caregiver Coalition
DSS	Department of Social Services	VDA	Virginia Division for the Aging
DSP	Dementia State Plan	VDH	Virginia Department of Health
EDCD	Elderly or Disabled with Consumer Direction	VHQC	Virginia Health Quality Center
EPR	Emergency Preparedness and Response	VHDA	Virginia Housing Development Authority
EOR	Employer of Record	VICAP	Virginia Insurance Counseling and Assistance Program
FFS	Fee-For-Service		

Web-based Resources

EasyAccess.Virginia.gov

Virginia Easy Access is a web portal developed for older adults, adults with disabilities, their caregivers, and the providers that support them. As part of No Wrong Door (NWD), *Virginia Easy Access* is the gateway to VirginiaNavigator, Virginia's NWD/ADRC network provider database, designed to help individuals and providers identify and access local services and supports. In order to streamline access, *Virginia Easy Access* also links to CommonHelp, that state's portal, where the electronic Medicaid application can be completed on-line and submitted directly to the appropriate local social services department for processing. *Virginia Easy Access* is also supported by 2-1-1 Virginia, enabling individuals to ask online questions and receive a response from the 2-1-1 call center.

VirginiaNavigator.org

VirginiaNavigator is both a non-profit organization and the name of the website that serves as the NWD/ADRC database. Beyond serving as a universal site for NWD/ADRC, it also manages two subsidiaries, *SeniorNavigator* and *disAbilityNavigator*, through which specialized information and education about health, wellness, and lifestyle considerations is available for older adults and people with disabilities. The database of public and private supports is continually updated to ensure the most comprehensive list of providers is available.

VirginiaHousingSearch.com

VirginiaHousingSearch.com, sponsored by the Virginia Housing Development Authority, enables prospective tenants to conduct free searches for:

- Housing with accessibility features
- Affordable rental housing
- Age-restricted rental housing
- Market-rate rental housing
- Housing located on public transportation routes

AlzPossible.com

AlzPossible is an initiative of the Virginia Alzheimer's Disease and Related Disorders Commission designed to provide a cost-effective framework for coordinating educational, research, and technological resources and services throughout Virginia. Originally funded through ADSSP it has been sustained through an ongoing partnership with Virginia Commonwealth University's Department of Gerontology and partial funding from the Virginia Center on Aging's Geriatric Training and Education Initiative. As a virtual Alzheimer's Disease Center without walls, *AlzPossible* is a valuable vehicle through which many of the Commission activities are delivered, such as the *AlzPossible* website and the provision of state-wide continuing education webinars for professionals who support caregivers and persons with dementia.

dss.virginia.gov

dss.virginia.gov, the Department of Social Services public website, features several web pages on the topics of adult abuse, neglect, and exploitation and mandated reporting. Each May, in honor of Adult Abuse Prevention Month, several educational materials are made available on a dedicated web page that raises awareness of adult abuse, neglect, and exploitation. A free, online mandated reporter training is also accessible via the website.