Metropolitan Area Agency on Aging, Inc.

Proposed 2011 Area Plan on Aging Outcomes

Program Development & Coordination and Access Services
September 2010

Program Development & Coordination

Risk Management for High Risk Individuals

1. **Live Well at Home:** Facilitate training and technical assistance to metro Community Living Program grant partners incorporating the Risk Management Screen and support services into their usual case management practice. Work with additional partners, including Title III providers to integrate risk management approaches with other client assessment and care management practices.

Evidence-Based Health Promotion/Disease Prevention Programs (EBHP)

1. **Matter of Balance:** Develop 12 additional host sites with coach training and follow-up support, technical assistance to host sites, and promotion of program to potential participant referral sources. Continue developing for MAAA's long-term dissemination and support role.

2. **Chronic Disease Self-Management Program:** Develop new host sites with community partners in the west metro and Dakota and Washington counties. Implement technical assistance processes and tools to support leaders and host sites; coordinate activities with Metro CDSMP Consortium; develop plan for MAAA's long-term dissemination and support role.

3. **EnhanceFitness™:** Work with existing programs to sustain availability.

4. **Provider Outreach**: Develop and implement outreach plan to prepare community organizations to adopt and offer evidence-based health promotion programs; provide tailored technical assistance to organizations adopting specific EBHP programs focused on healthy eating, depression, chronic disease management, and falls prevention.

Dementia Care Best Practices

1. **Metro Alzheimer's Innovations Project:** Assist Payne Phalen Living at Home project to complete this demonstration that promotes early identification of persons with dementia and provides culturally acceptable support services to Latino elders and their caregivers.

2. **Family Memory Care Project Expansion:** Support partner organizations through consultation and coordination to implement the Family Dementia Care Intervention with African-American and Latino spousal caregivers of persons with dementia.

3. **Dementia Care Best Practices Exchanges:** Convene quarterly meetings for health system and community based providers engaged in dementia care system changes to exchange best practice information and to foster continued innovations and system development.

4. **Health Care Homes**: Convene a workgroup to explore opportunities for community based aging and health care provider partnerships under health care home initiatives resulting from health care reform policies.

Expand and Strengthen Home and Community Based Services Capacity

1. **Collaborative System Development for Caregiver Support**: Co-convene and facilitate bi- monthly membership and workgroup meetings focused on developing the effectiveness and reach of the collaborative - priorities include: outreach to build referrals from counties, health plans and home care organizations and best practice education for network members; coordinate and facilitate expansion of Powerful Tools for Caregiver program offerings in the metro area.

2. **Working Caregiver Project**: Offer monthly working caregiver policy and program news summary to employers promoting work place policy options with employers to support family caregivers.

3. Work with Southeast Metro SAIL/EDP to **promote on-line sustainability training curriculum to quasi-formal aging network service providers** to increase use of best practices that increase revenue and community support. Coordinate provision of technical assistance to applicants for CS/SD funds.

4. **Conduct introductory aging system "101" training sessions** for minority service agencies/individuals wishing to serve elders and/or develop public-pay reimbursement services.

5. **NAPIS Program Data Technical Assistance**: Provide implementation technical assistance on new NAPIS program data collection software system; provide data analysis training to increase capacity to reach target populations with Title III Services

6. **Self-Directed Supports Options development**: Re-design Self Directed Support models for nutrition and respite services to improve options for high risk individuals.

Communities for a Lifetime – Preparing for an Aging Population

1. **Communities for a Lifetime:** Complete planning project and submit proposal to the Corporation for Community and National Service to recruit, train and deploy older adult

AmeriCorps Members as civic leaders in 4-6 metro communities. Members will engage community partners in projects that meet physical, social, service or civic infrastructure needs for people of all ages. Partner with the Vital Aging Network.

2. **Develop 3-5 presentations, scripts and supporting materials** on concepts of Communities for a Lifetime for use with citizen groups, organizations, planners and elected officials. Presentations can be used by staff, volunteers, interns and others.

Access

1. **Coordinate an integrated information and assistance service system** for the Metropolitan Region designed to assist consumers with system navigation and service connections while meeting rigorous state performance standards. System components include the Senior LinkAge Line®, SHIP (health insurance counseling), and RxConnect™ (prescription access for Minnesotans of all ages). Measure service quality via consumer satisfaction survey and maintain high level of customer satisfaction.

2. **Expand outreach efforts** focused on reaching underserved and low-income populations as follows: prescription drug expense assistance serving people of all ages (increase numbers served by 3%); system navigation assistance for Medicare beneficiaries with mental illness (designate a minimum of 5% of SHIP funding to serve this population); access assistance for beneficiaries eligible for the Low Income Subsidy for Part D plan coverage; and system navigation within diverse communities with limited English proficiency (increase numbers served by 5%).

3. **Maintain and expand MinnesotaHelp Network™ sites** designed to improve access to long-term care services and promote planning ahead to prepare for aging and retirement needs. Partner with provider organizations to offer model at 3 new community sites.

4. **Provide consumer and provider education** to increase knowledge of resources with a focus on abuse, aging, caregiving, community resource finding, computer education and on-line resources for long-term care options counseling. Coordinate 500 community presentations, targeting 75% of events to underserved individuals, including minority and low-income populations.

5. Partner with the Minnesota Board on Aging and others to **refine the elements and scope of Long-term Care Options Counseling, the Return to Community initiative, the Veterans Administration's Consumer Directed Care program, and the Live Well at Home initiative**. Develop staff expertise to meet the requirements of the service and assist individuals to successfully and safely remain or return to the community.

6. Serve as the **access point for Transitional Consultation services** designed to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings and to delay spend-down to eligibility for publicly funded programs.