NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Aging and
Adult Services

Piedmont Triad Regional Council Area Agency on Aging

Four-Year Area Plan on Aging

July 1, 2020 to June 30, 2024

Piedmont Triad Regional Council Area Agency on Aging

AREA PLAN ON AGING

July 1, 2020 - June 30, 2024

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I. NARRATIVE

Executive Summary

Piedmont Triad Regional Council (PTRC) is a voluntary association of local governments - urban and rural - authorized by state law to:

- Develop and implement joint regional decisions
- Provide management, planning and technical services to local governments
- Identify and solve short and long-term problems best addressed at the regional level
- Bring together local elected officials on a regular basis, giving them an opportunity to form working relationships
- Promote regional issues and cooperation among members

PTRC is one of the largest regional councils in NC, serving 73 members in and around the Greensboro / Winston-Salem / High Point metro area, including the following twelve-county area:

Alamance | Caswell | Davidson | Davie | Forsyth | Guilford |
Montgomery | Randolph | Rockingham | Stokes |Surry | Yadkin

PTRC's governing body is its Board of Delegates, comprised of locally elected and appointed officials designated to represent member governments. Among PTRC's many responsibilities is housing the designated Area Agency on Aging (AAA) for the twelve-county region. As an Area Agency on Aging, we provide services in the following areas:

- Management and Staffing
- Planning
- Funds Administration and Quality Assurance
- Information Brokerage
- Program, Resource and Systems Development
- Advocacy

The PTRC AAA provides services for older adults, adults with disabilities and caregivers in our region with an annual budget of approximately $1.8 million and 16 full and part-time staff. The PTRC AAA administers approximately $11 million to support community-based care services, advocates for older adults and adults with disabilities, develops community-based long-term care services and seeks funds from various sources through business strategies to implement services that are not grant supported. During the COVID-19 national pandemic, the PTRC AAA is also charged with administering nearly $8.8 million dollars in additional support to older adults, adults with disabilities and caregivers to provide services to support the unique needs that have arisen during this crisis.

As the population of older adults steadily rises, we need to seek opportunities to diversify funding outside of traditional funding streams. Across the aging network, aging service providers and Area Agencies on Aging are adopting business practices to increase opportunities for funding from other

payors, such as healthcare, Medicare Advantage Plans, private business, etc. This thinking is supported on the federal level, by Kathy Greenlee, former Assistant Secretary for Aging at the U.S. Department of Health and Human Services and Administrator of the Administration for Community Living and by Sandy Markwood, CEO for the National Association of Area Agencies on Aging. We continue to follow their guidance and seek opportunities to create partnerships to better meet the needs of aging and older adults in our region, which is our primary purpose.

Seniors, caregivers, and individuals with disabilities must remain at the center of everything we do and why we do it. As we develop our capacity and that of our funded partners, we intend to enhance and improve service delivery and program development. We remain committed to serving as many people as possible and promoting independence and service options for older adults in our region.

This 2020-2024 Area Aging Plan highlights our efforts to provide services and programming for older adults, adults with disabilities and caregivers, while ensuring we address the unique needs of:

- Older and disabled adults limited income
- Older and disabled adults who are socially isolated, and those that live alone
- Older adults with limited English proficiency
- Older and disabled adults who reside in rural areas
- Minority elders

We aspire to implement a variety of strategies to enhance the quality of life for those we serve, coordinate a comprehensive plan of programs and services across the region, develop new partnerships and grow and expand our existing networks, while continuing to make the PTRC AAA a great place to work.

2. Goals and Objectives, Strategies and Outcomes

Safety and Protection

Goal 1: Older North Carolinians will be safe from abuse, neglect and exploitation, and have their rights protected.

The impacts of elder abuse are felt not only by the elders themselves, but also by their families and caregivers. Research shows that approximately 10 percent of adults age 60 and older have experienced physical abuse, psychological or verbal abuse, sexual abuse, neglect, or financial exploitation. Older Americans lose an estimated $2.9 billion a year as a result of financial exploitation. Furthermore, survivors of elder abuse report higher rates of depression and have higher rates of hospitalization and institutionalization, and are three times more likely to die prematurely. Increased awareness of preventing, detecting and reporting elder abuse will help older adults remain protected from abusers looking to take advantage. Abuse of older adults due to opioid addiction has risen significantly in recent years. The conditions that prescription opioids treat are more prevalent in older adults, making their medicine cabinets a target for theft by addicted family members or others. Addiction can drive abusers to target the finances of vulnerable elders.

Objective 1.1:	**Training and outreach regarding the protection of vulnerable older adults will be provided to community stakeholders**
Strategy 1	Hold annual training for Regional Advisory Council on Aging (RACA) members.
Measure(s)	At least one training session will be held for the RACA members per year.
Outcomes	RACA members will report increased knowledge on protecting older adults in their communities, which will better inform their function as an advisory council to the Area Agency on Aging.
Strategy 2	Hold an Elder Abuse Awareness Walk each year.
Measure(s)	Number of participants, vendors and sponsors will be documented.
Outcomes	Participants will report increased awareness and knowledge of: elder abuse signs, how to report and available resources.
Strategy 3	Provide information on elder abuse topics to banks, credit unions and other financial institutions at least twice per year to help them recognize and thwart potential exploitation.
Measure(s)	At least two sessions will be held each year for financial institutions with informational materials distributed at each session.
Outcomes	Participant feedback will indicate increased knowledge and awareness of signs of abuse and available resources.
Strategy 4	Utilize PTRC's Facebook page and website to provide information on scams targeting older adults.

Measure(s)	Engagement on social media posts and number of hits on the PTRC website.
Outcomes	The majority of participants completing the Elder Abuse quiz on the website will demonstrate 80% knowledge proficiency.

Objective 1.2:	**Partner with organizations in local counties to address elder abuse through multidisciplinary committees.**
Strategy 1	Meet regularly with multidisciplinary committees in counties where these groups exist.
Measure(s)	The number of multidisciplinary meetings held.
Outcomes	Multidisciplinary committees in counties will have increased knowledge of elder abuse resources as reported in their surveys.
Strategy 2	Partner with local multidisciplinary committees to provide training on elder abuse.
Measure(s)	The number of training sessions held.
Outcomes	Training participants will have increased knowledge on elder abuse.
Strategy 3	Ombudsmen will reach out to stakeholders in counties where no multidisciplinary committees exist.
Measure(s)	The number of established relationships with stakeholders in counties where no committees exist.
Outcomes	The establishment of new multidisciplinary committees.

Objective 1.3:	**Long-term care residents and adults under guardianship, and those who care for and support residents will understand and be better-equipped to assist and empower their rights through training and outreach.**
Strategy 1	Long-Term Care (LTC) Ombudsmen will provide training to LTC facility staff regarding residents' rights and elder abuse.
Measure(s)	Number of LTC facilities and staff receiving training.
Outcomes	Staff will demonstrate increased knowledge of residents' rights and elder abuse topics.
Strategy 2	In partnership with Guilford County Family Justice Center, the Ombudsman program will offer Vital Signs: Preventing Sexual Abuse in LTC facilities.
Measure(s)	The program will be offered at least once a year for any LTC facility to be held at the Family Justice Center in Guilford County.
Outcomes	Participants will increase knowledge and understanding of sexual abuse prevention.

Strategy 3	Emphasize the inclusion of the Resident's Bill of Rights in LTC facility admission documents.
Measure(s)	LTC facilities report that Resident's Bill of Rights is included in each resident's admission packet.
Outcomes	Incoming residents and/or legal representatives will be aware of their rights and who their local LTC Ombudsman is upon admission into a LTC facility.

Objective 1.4:	**The aging network, including AAA's and other organizations assisting seniors, will be better-informed regarding exploitation, opioids, and the connection between them through training and outreach.**
Strategy 1	Designated staff will participate in DHHS' annual conference focused on opioid use, misuse, and the exploitation of older adults and people with disabilities by caretakers and others.
Measure(s)	Yearly attendance by a representative of PTRC AAA.
Outcomes	Staff will have increased knowledge and awareness of exploitation and opioid use/misuse.
Strategy 2	Partner with stakeholders providing services to older adults, people with disabilities and their caregivers, to develop information and training resources.
Measure(s)	The number of interactions (meetings, email, phone calls) with community stakeholders.
Outcomes	Developed training materials created in partnership with stakeholders.
Strategy 3	Provide information regarding the connection between exploitation and opioids to aging network service providers and the community through meetings and communication.
Measure(s)	At least one documented information session will be held yearly.
Outcomes	Service providers and older adults in the community will have an increased awareness of the signs, preventions and treatment of exploitation and opioid abuse.

Quality of Life

Goal 2: Create opportunities for older adults and their families to lead active and healthy lives.

Approximately two thirds of older Americans are estimated to have two or more chronic physical or behavioral health problems. For many decades, the healthcare industry has attempted to treat or manage these conditions through medical interventions. Only in recent years has attention been given to the impact that non-medical factors have on our health. In fact, research shows that 80% of our health is determined by social factors rather than costly medical interventions. Dr. Mandy Cohen, Secretary for the North Carolina Department of Health and Human Services, is reshaping North Carolina's approach to healthcare, with the understanding that the provision of social determinants of health (SDOH) leads to improved health outcomes and improved quality of life. Under Dr. Cohen's direction, NC Medicaid is undergoing transformation from fee for service to Managed Care. As part of this transformation, Medicaid has proposed three pilots that will provide food, housing services, transportation and abuse prevention services in addition to medical care to eligible Medicaid recipients. PTRC applied in February 2020 to become one of three Lead Pilot Entities that will form a connection between Managed Care plans and Human Service Organizations (HSOs) to coordinate the delivery of non-medical services and supports. For the past two years, PTRC AAA has been heavily involved in leading our region's collaborative efforts to bring one of these pilots to the Piedmont Triad region with the hope that it will revolutionize healthcare as we know it and bring more attention to the aging network as a valued provider of SDOH supports.

Healthy behaviors discovered and practiced in evidence-based health promotion and disease prevention classes have proven benefits for older adults. These classes help participants learn how to set goals and use a tool box of resources to help remain healthy, live independently, incur fewer health-related costs, and continue to engage with family and friends.

Quality of life is important for all, regardless of whether one lives at home or resides in a congregate living setting. Through our Long-Term Care Ombudsmen, we will ensure older adults residing in skilled nursing facilities, adult care homes and family care homes have their rights protected. Beyond having their basic rights protected, LTC residents experience greater quality of life when their preferences are factored in to the provision of their care.

Objective 2.1:	**Promote expansion of home and community-based services to support older adults aging in the least-restrictive setting.**
Strategy 1	PTRC AAA will provide training and technical assistance to In-Home Aide (IHA) providers exploring the HCCBG program, Home Care Independence (HCI).
Measure(s)	The number of providers in our region that implement Home Care Independence. The number of clients who receive these services.
Outcomes	Program participants will complete surveys indication 90% or greater satisfaction. IHA providers that implement the HCI will successfully operate the program according to DAAS program standards.
Strategy 2	Ensure that by 2024 Respite services for family caregivers will be available in all counties in our region.

Measure(s)	The number of counties in which FCSP respite services are available. Respite funds will be fully utilized in each county by year end. The number of participating caregivers will be tracked annually.
Outcomes	95% of caregivers using respite services will report decreased caregiver burden and reduced stress after receiving respite care.

Objective 2.2:	**Long-Term Care (LTC) settings will allow residents to live in minimally restrictive environments while protecting their rights.**
Strategy 1	Share information with LTC facilities about programs and resources to assist residents in returning to independent living options in the community.
Measure(s)	The number of LTC facilities that discharge residents back to the community
Outcomes	LTC facilities will be more knowledgeable about independent living options and programs available to residents. More residents will have the opportunity to live in the setting of their choosing.
Strategy 2	Advocate on behalf of residents when they feel their rights to return to the community have been violated.
Measure(s)	The number of LTC Ombudsman cases addressing this issue.
Outcomes	Residents will have rights to return to the community upheld.

Objective 2.3:	**Older Adults and Caregivers will have access to evidence-based health promotion (EBHP), wellness, and disease prevention programs.**
Strategy 1	Senior centers, churches and/or libraries in each of our counties will offer evidence-based classes on a regular basis.
Measure(s)	The number of scheduled evidence-based classes in each county.
Outcomes	Participants will experience reduced fatigue, increased activity level and greater self-efficacy upon successful completion of EBHP classes .
Strategy 2	Reestablish the Piedmont Area Falls Prevention coalition; hold quarterly PAFP meetings; and align with the NC state coalition's strategic action plan.
Measure(s)	The number of scheduled meetings of the Piedmont Area Falls Prevention coalition. An established listserv and roster of active participants.
Outcomes	More referrals to regional evidence-based falls prevention programs. Increased awareness of fall risk factors and interventions among coalition members. Increased partnerships among non-traditional partners.

Strategy 3	Expand Diabetes Age Well Services beyond our current capacity by contracting with Medicare Advantage (MA) Plans and Accountable Care Organizations (ACOs) to offer this program to their members.
Measure(s)	The number of contracts with MA plans and ACOs for Diabetes Age Well classes.
Outcomes	Increased utilization of DSMT/MNT benefits for older adults with Type 2 diabetes.
Strategy 4	Powerful Tools for Caregivers classes will be available in each county of the region.
Measure(s)	Leaders will be trained. The number of classes and participants will be tracked.
Outcomes	Caregivers enrolled in the classes will complete evaluations with 90% or more indicating they have increased their knowledge about the importance of monitoring their health and the methods to promote healthy practices for mind, body and spirit.

Objective 2.4:	**Promote the dignity, independence and quality of life of older persons through advocacy, information, programs and services.**
Strategy 1	Provide information about the needs and preferences of older adults to members of the AAA's Regional Advisory Council on Aging (RACA), County Aging Planning Committees (PCs), Community Advisory Committees (CACs) and the general public.
Measure(s)	Information will be distributed to members of RACA, County Aging PCs, and CACs via regularly scheduled meetings. The general public will receive information via social media and website articles, radio and TV spots, newspaper articles and health/informational fairs.
Outcomes	Members of RACA, County Aging PCs and CACs and the general public will report a better knowledge of the needs and preferences of older adults.
Strategy 2	Advise on the development of the Area Plan and its subsequent updates.
Measure(s)	Track the progress and implementation of the development of the Area Plan and its subsequent updates.
Outcomes	An Area Plan will be created and implemented that promotes the dignity, independence and quality of life of older persons and their caregivers throughout the 12-county region.
Strategy 3	Advocate for the issues that matter to older adults.
Measure(s)	The number of Advocacy Alerts sent. The number of contacts with federal, state and local elected officials. The number of LTC ombudsman contacts with residents and staff of residential living facilities.

Outcomes	The public, legislative bodies, and residential facility staff will be more informed as to the needs and preferences of older adults.
Strategy 4	Develop connections and collaborations with non-traditional partners that serve older adults.
Measure(s)	Interactions (meetings, email and phone calls) with non-traditional partners.
Outcomes	New initiatives and partnerships that benefit older adults
Strategy 5	PTRC/AAA will continue to serve as a host location for college interns interested in the field of aging
Measures(s)	College interns will be better educated about actual issues affecting older adults trough the ground up experience provided
Outcomes	College interns will be better informed as to their preference in working in the field of aging.

Well Informed Communities

Goal 3: Support older adults and their caregivers by providing information that helps them make informed choices about supportive services at home or in the community.

Information leads to knowledge and knowledge leads to wisdom. We will ensure older adults and their caregivers have accurate information that leads them to make wise decisions regarding their care needs and planning for the future. Frequently, we in the aging network hear people say they were unaware of aging programs and services until they had need of them or that they had to call 4, 5 or 6 times to various agencies trying to find answers to their questions. Information and Options Counseling providers as well as Senior Centers should be promoted in their counties as the primary organizations for older adults or caregivers to contact when seeking resources. In addition to these aging service providers, the internet and social media are often used by those searching for information. Incorporating use of the internet and social media allows PTRC AAA and our service providers to more frequently update information regarding new resources, services, and activities.

Objective 3.1:	**Ensure older adults and the agencies who serve them are educated on the availability of services that foster independence, self-sufficiency, and enhanced planning for long-term needs.**
Strategy 1	Partner with regional organizations (i.e service providers, health care entities) to host and/or sponsor educational events in the Piedmont Triad region.
Measure(s)	The number of events (health fairs, seminars, webinars, etc.) across the region will be reported and tracked each year, as will the number of community partners participating, and number of attendees at events.

Outcomes	The community is more informed about long-term planning and options available to them.
Strategy 2	PTRC AAA will conduct trainings for professional partners and the public about community-based services available, as well as workshops to plan ahead as care needs change.
Measure(s)	Number of workshops held each year will be documented, along with attendance.
Outcomes	Evaluations at trainings will document an increased knowledge of community assistance and resources available to aid independence, as well as what to consider as needs change through the aging process.
Strategy 3	Maintain an updated directory of available HCCBG and FCSP services and provider contact information.
Measure(s)	Update Service Provider Directory when changes occur. Upload Service Provider Directory to PTRC website. Provide a hard copy of the Service Provider Directory upon request.
Outcomes	Older adults and caregivers will be more informed about available services and the agencies they should contact for assistance

Objective 3.2:	**Foster equity and inclusion of underserved and underrepresented populations through education.**
Strategy 1	Hold “Pride in Care NC” trainings for skilled nursing facility (SNF) staff, resident/family councils and CAC members over the next three years.
Measure(s)	The number of SNF’s, SNF staff, resident/family council members and CAC members that participate in trainings. The number of meetings/trainings incorporating “Pride in Care NC” training topics.
Outcomes	SNF staff, resident/family council members and CAC members will have increased knowledge and sensitivity in working with LGBTQ residents.
Strategy 2	Partner with low-income housing and other senior housing to offer more evidence-based workshops.
Measure(s)	Number of workshops in low-income or senior housing.
Outcomes	Older adults in public housing will have access to evidence-based programs.
Strategy 3	Educate HCCBG and FCSP service providers on equity and inclusion barriers and strategies for increasing equity and inclusion.
Measure(s)	The number of equity and inclusion training/listening sessions held. Outreach to underserved and underrepresented populations in our region for input and feedback and empowerment strategies. Provision of technical assistance (TA) to strengthen HCCBG providers’ County Funding Plan Service Methodologies.

Outcomes	Provide opportunities for equity and inclusion education in the community and across network. Community participation in development of equity and inclusion strategies.
Strategy 4	Develop a list of underserved and underrepresented older adult populations in our region and reach out to them to obtain input and feedback to inform our equity and inclusion training and programmatic planning.
Measure(s)	Number of outreach sessions/contacts conducted and diverse populations reached.
Outcomes	AAA will be more informed about the needs and perspectives of underserved and underrepresented older adults. The perspectives of underserved and underrepresented older adults will be represented in equity and inclusion training and programmatic planning.
Strategy 5	Train Dementia Friends Champions across the region to provide training that changes the way people think, act, and talk about dementia.
Measure(s)	Hold at least 3 Dementia Friends trainings per year to form diverse champions
Outcomes	Champions across the region will raise awareness of Dementia and support families in the community
Strategy 6	PTRC AAA will continue to promote MIPPA outreach to underserve populations across the region in creative ways.
Measure(s)	Each year see a substantial number of individuals reach through outreach
Outcomes	The region will see increased numbers of beneficiaries served through wellness and also receiving benefits.
Objective 3.3:	**PTRC AAA will be prepared to respond to emergencies that impact the safety and well-being of older adults.**
Strategy 1	PTRC AAA will continue to be a part of the Triad Healthcare Preparedness Coalition.
Measure(s)	Attendance at bi-monthly meetings of the Triad Healthcare Preparedness Coalition.
Outcomes	PTRC AAA will be more prepared to respond to emergencies should they arise
Strategy 2	Annually conduct training of PTRC AAA staff on the AAA emergency response plan to ensure that staff are knowledgeable of their roles and how to implement the plan.
Measure(s)	Annual training is conducted for staff.
Outcomes	Staff are aware of their roles and prepared to implement the plan if necessary.

Objective 3.4:	Caregivers will be aware of available resources to assist them in their caregiving roles.
Strategy 1	Caregiver Service Coordinators, housed in local county service provider agencies, will participate in public awareness events and host community groups to educate caregivers about available services and supports.
Measure(s)	The number of caregivers making inquiries, needing assistance and participating in informational and educational events will be documented each month, with follow-up provided as needed.
Outcomes	85% of caregivers attending community events and programs will report a better understanding of services available to family caregivers.
Strategy 2	Caregiver Service Coordinators will engage with caregivers, older adults and their family members to offer person-centered choices for assistance.
Measure(s)	The number of family caregiver contacts completed. Contacts with older adults, family members and caregivers will be documented, noting the selection of services that meet their needs.
Outcomes	Caregivers will experience: • decreased caregiver stress • Increased confidence in their caregiving role • Increased quality of life • Improved self care

Objective 3.5:	Educate older adults and caregivers about the dangers of opioid addiction.
Strategy 1	Post information about opioid addiction on our website and Facebook page including information on where to get help.
Measure(s)	Information is posted on our website and Facebook page.
Outcomes	Older adults and caregivers will have increased knowledge of opioid addiction and access to information on additional resources.
Strategy 2	PTRC AAA will offer the evidence-based workshop, Living Healthy with Chronic Pain, which includes discussion of opioids and alternative treatments and tools to manage chronic pain. PTRC will work with pharmacists and physician offices to market these workshops.
Measure(s)	The number of Living Healthy with Chronic Pain classes held. The number of pharmacists and physicians' offices contacted.
Outcomes	Participants completing the Living Healthy with Chronic Pain class will have better understanding of how to manage pain with or without opioids. Increased awareness in the community about the workshop.

Strategy 3	FCSP providers will receive annual training to ensure Caregiver Support Groups include an Opioid Awareness discussion at least once each year.
Measure(s)	Opioid Education sessions will be documented at each provider location, and will be reported to AAA at the end of each fiscal year. Number of people attending the education sessions will be documented and reported as well.
Outcomes	Evaluations of attendees will indicate 90% or more are able to list at least one action each can take to prevent opioid addiction and awareness.

Strong and Seamless Continuum of Services

Goal 4: AAA will lead efforts to diversify our funding streams and strengthen community partners' service delivery and capacity.

The federal Older Americans Act charges AAA's to provide a comprehensive service delivery system to meet the needs of older adults. PTRC AAA is committed to ensuring older adults and their caregivers in the Piedmont Region have options in their communities to live independently, with dignity and a sense of well-being. Through training and technical assistance, PTRC AAA will help funded service providers' capacity to serve more older adults and reduce waiting lists. With more attention focused on the connection between the provision of services that improve health while driving down medical costs, we seek to help aging network providers develop their understanding of business practices that will increase capacity. In addition, PTRC AAA will foster connections between the aging network and healthcare systems to provide a more comprehensive approach to a more coordinated system of care.

Objective 4.1:	**Train network providers on capacity-building topics and opportunities.**
Strategy 1	Hold two meetings with funded partners annually at which education on capacity-building topics will be introduced.
Measure(s)	Agendas will indicate capacity-building topics addressed.
Outcomes	40% of funded partners will explore and/or initiate new capacity-building activities in their programs, as reported annually.
Strategy 2	Facilitate panel discussion between healthcare payors and funded partners to showcase best practices for cost saving measures and healthier outcomes.
Measure(s)	Facilitate at least one such discussion with one major health system each year.
Outcomes	Documented efforts of funded partners in connecting with health systems to expand their capacity to provide more services to older adults and caregivers.

Strategy 3	Fostering partnerships for potential contracting with payors for senior center services.
Measure(s)	The number of contract discussions/negotiations held.
Outcomes	Contracts developed between senior centers and payors.
Objective 4.2:	**Building competency in HCCBG and FCSP service providers**
Strategy 1	Hold trainings for service provider staff to increase knowledge of program standards and operations
Measure(s)	Annual training on HCCBG budget preparation, ARMS usage Two annual funded partner meetings to provide updates, best practices, etc. Create e-learning for commonly requested TA topics
Outcomes	Service providers will exhibit increased knowledge in fulfilling operational requirements
Strategy 2	Provide TA to funded partners on program specific challenges
Measure(s)	Number of TA contacts answered
Outcomes	Service providers will report satisfaction with AAA assistance

Objective 4.3:	**Strengthen planning committees**
Strategy 1	Form Task Groups within the planning committee to focus on identified County Aging Issues.
Measure(s)	Task group members routinely report the number of community presentations or contacts made on the assigned issue.
Outcomes	Post-presentation or communication surveys will document an increased awareness of the issue, as well as identifying one thing or one step the community can do.
Strategy 2	Identify potential community partners (non-funded agencies) to invite to join the Planning Committee.
Measure(s)	Document other sectors represented and identify roles.
Outcomes	Increased awareness of county's Aging Services, increased representation of the PC at other county and community organizations' meetings. In four years, at least two new partnerships should be developed to propose joint sponsorships of services or events to serve the older population.
Strategy 3	Hold orientation training for newly appointed PC members
Measure(s)	Two trainings per year will be offered. Development of a PC Orientation virtual training
Outcomes	Newly appointed PC members will report an increased understanding of the Aging Network, HCCBG and FCSP programs and funding, and advocacy.

Objective 4.3:	Diversify funding streams.
Strategy 1	Expand our offerings of Diabetes Self Management Training (DSMT) and Medical Nutritional Therapy (MNT) Medicare reimbursable services
Measure(s)	The number of billings for DSMT and MNT services.
Outcomes	Increased unrestricted revenue from Medicare, Medicaid and Medicare Advantage Plans to meet unique needs in communities.
Strategy 2	Develop a Community Health Worker program
Measure(s)	The number of contracts for Community Health Worker services
Outcomes	Increased wellness and reduced medical costs for persons discharged from hospitals
Strategy 3	Write a business plan for the AAA to develop and expand revenue generating services to contract with nontraditional payors
Measure(s)	A written business plan
Outcomes	A document that informs our work to expand revenue generating services

3. Quality Management

The Division of Aging and Adult Services uses the "DHHS DAAS Plan for Monitoring Subrecipients" as a guide to manage quality of service programs for subrecipients. The plan provides the basis for programmatic and fiscal compliance monitoring in response to state and federal requirements. DAAS monitors HCCBG and non-HCCBG-based services, social services block grant eligibility, services and contracts funded by SSBG funds, the Special Assistance Program, Medicaid Administrative Claiming, the State Adult Day Care Fund – Social Services Block Grant, Alzheimer's disease grants, and cash assistance.

The DAAS's lead monitor will continue coordinating all monitoring activities for the agency. This position is responsible for ensuring the division's monitoring plan is maintained and implemented. The lead monitor is responsible for subrecipient audit reviews and audit-finding resolutions, financial management monitoring, compliance audit supplement development, and provides training, technical assistance, and consultation to division staff, the 16 Area Agencies on Aging (AAA's) and their subrecipients. The lead monitor is also the liaison between the division, and DHHS' Internal Auditor and other state agencies. The lead monitor acts as a "clearinghouse" for monitoring reports and corrective actions.

Each program is proactive in developing monitoring tools and data specific to their program areas. Federal and state guidelines are used as a standard for monitoring these program areas. These program tools are very effective and used on a consistent basis. Data collection is used via federal and state systems for several program areas. For example, our Senior Community Service

Employment Program (SCSEP) uses a system called SPARQ (SCEP Performance and Results QPR system). This system is used to manage data collection reports and monitoring. Staff can use this system in addition to their monitoring tools to assess ongoing implementation and remediation of problem areas. Our Ombudsman program uses a similar system called ODIS. This system also manages data collection reports and monitoring.

During the next four years, DAAS will continue to strive for excellence in quality management. The new DAAS Monitoring Plan FY19 is currently being drafted and will include updates for this fiscal year. Each program will continue to improve monitoring tools as needed based on feedback from subrecipients and staff, as well as recommendations from the lad monitor and DAAS management. Also, an annual risk assessment meeting will be conducted every January to evaluate the level of risk for HCCBG and Non-HCCBG programs in all 16 regions.

The DAAS risk assessment team includes Ombudsman, SCSEP, service operations, and fiscal staff. The team considers the information in AAA self-assessment tools (submitted annually by the AAAs in December), along with other factors such as staff turnover, compliance history, and the amount of time since the last site visit.

Based on the level of risk, appropriate staff is assigned to conduct on-site monitoring visits. Regardless of the level of risk, however, each AAA is visited by at least one DAAS staff member annually.

4. Conclusion

PTRC AAA remains committed to meeting the needs of the Piedmont Triad region's rapidly growing population of older adults and their caregivers through traditional as well as innovative programming. We are proud to work in conjunction with the Division of Aging and Adult Services and a large network of funded partners to provide quality services to these populations. In the next four years of this plan, PTRC AAA looks to expand our network by partnering and contracting with non-traditional partners, such as Medicare Advantage plans, Accountable Care Organizations, insurance plans, healthcare systems and other payors that will provide dividends in terms of both better health outcomes and increased revenue which can be reinvested to reach more people.