PIEDMONT TRIAD
AREA AGENCY ON AGING

Four-Year Area Plan on Aging Update

2021-2024

Piedmont Triad Regional Council Area Agency on Aging 2021-2024 Area Plan Goals/Updates: SFY 2021

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 finance 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.

Update/Status
Elder Abuse Training for RACA Members is planned for June 2021. The title of the presentation was, “Elder Abuse: Our Elders Deserve Better.”

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.

Update/Status

Due to the COVID-19 Pandemic, we are unable to hold the Elder Abuse Awareness Walk in 2020. In lieu of a Walk, we held a virtual educational event in June 2021 in partnership with AARP-NC. The event, titled: *Elder Abuse in the Time of COVID-19: Where Are We Now?* Featured a Keynote presentation by nationally-recognized expert in Elder Abuse and former Deputy District Attorney in San Diego County, CA, Paul Greenwood. Following the keynote presentation, a panel of representatives from local agencies including the Guilford County Family Justice Center, Forsyth County Family Justice Center and the Corporation of Guardianship shared information about local efforts to combat elder abuse during COVID.

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.

Update/Status
December 2020 virtual presentation to the Greensboro Chapter-Society of Financial Professionals.

Strategy 4: Utilize PTRC's Facebook page and website to provide information on scams targeting older adults. Measure:

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.

Update/Status
At least two sessions will be held each year for financial institutions with informational materials distributed at each session. We have had 8 Facebook posts related to scams. Each post reaches between 33-50 individuals. We do not currently have an Elder Abuse quiz on the website, but plan to have it in place in the next few months.

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.

Update/Status
Ombudsman attends NC Consumer fraud taskforce meetings quarterly. Ombudsman participates in the SAFE in LTC Task Force. Guilford County Elder Justice Committee- committee has continued to meet virtually from March 2020-present. The Elder Abuse Task Force in Forsyth County meets monthly and has continued to do so in the past year virtually due to COVID. The meetings have been virtually through teams. The Task Force consists of Forsyth County Law Enforcement, Adult Protective Services and a representative from the Ombudsman program. The Task Force focuses on abuse such as exploitation, mental health concerns, long term care complaints, etc. The Ombudsman Program regularly attends and participates in the SALT (Seniors and Law Enforcement Together) Committee in Randolph County, however, committee meetings have been on hold since March 2021. We look forward to resuming meetings when they are held again.

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.

Update/Status
The Ombudsman Program partnered with the Guilford County Family Justice Center to host Vital Signs: Ending Sexual Abuse in Nursing Homes in November 2020. In December 2020, the Ombudsman Program partnered with the Guilford County Family Justice Center to provide a presentation about Elder Financial Abuse to the Greensboro Society of Financial Professionals. The Ombudsman Program also partnered with the Guilford County Family Justice Center to provide training about elder abuse initiatives during the NC School of Government Elder Justice "Office Hours" in August 2021.

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.

Update/Status
Outreach has been limited due to COVID-19 pandemic. We look forward to additional opportunities in the coming year.

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.

Update/Status
Since January 2020, Ombudsmen have provided 23 In-Service trainings to LTC facility staff related to Residents' Rights and Elder Abuse. Note that training opportunities have been limited due to the COVID-19 pandemic.

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.

Update/Status
Ombudsman assisted in presenting Vital Signs: Preventing Sexual Abuse in LTC Facilities in November 2020.

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 an LTC facility.

Update/Status
This initiative has been put on hold due to the COVID-19 pandemic. At this time, LTC facilities are overwhelmed with testing and maintaining staffing. We will revisit this strategy once the pandemic has subsided.

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.

Update/Status
As part of Disaster Preparedness, designated staff stays updated on the Opioid informational articles published by SAMHSA Example: https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001

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.

Update/Status
PTRC/AAA partnered with Disability Rights of NC to plan COVID 19 vaccination outreach in Stokes County. Vaccination rates are low and this team approach plans to raise awareness and help citizens make informed decisions. Events are planned for September 2021. The Ombudsman Program has created trainings (Elder Sexual Abuse in LTC) as well as information about Frauds and Scams in partnership with the Guilford County Family Justice Center. The Ombudsman Program also partners with local EMS representatives and the Mental Health Association to provide "Working with Older and Disabled Adults" training during Crisis Intervention Training for First Responders. Regional partners have been trained on the new statewide Caregiver Online Learning platform called Trualta, offered by NC DAAS. Through this platform caregivers can have access to the online training modules to learn how to provide care and to focus on their own health. Stakeholders can request more information on particular topics, and these will be added to the sessions list available.

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.

Update/Status

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 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.

Update/Status
SFY 21 Update Prior to the Pandemic, PTRC AAA conducted three meetings with providers of HCCBG IHA services to introduce them to HCI. There was mixed interest in starting this service in their county. Then the pandemic struck and the topic was put on the shelf as HCCBG providers took on the challenges of providing services during the pandemic. As of this writing, we will bring up the HCI program again this Fall as we experienced several providers not spending all their IHA SFY 21 funding because they could not find In-home aides.

Two virtual meetings are scheduled in September 2021, to provide the region's In-home Aide providers with an overview of the Home Care Independence service. The aim is to have a number of the region's In-home Aide providers offer the Home Care Independence service using ARPA funding.

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.

Update/Status
All twelve counties in the region have respite services available. Due to COVID one provider had a small amount of respite funds unspent, but they were used by another county. Other respite funds were spent. Survey data for decreased burden and stress measurements are not yet available for the entire region. Ensure that by 2021 Respite services for family caregivers will be available in all counties in our region.

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.

Update/Status
The Ombudsman Program provides information and consultation to LTC Facilities regarding community-based services and the Money Follows the Person program. Specific outreach to LTC Facilities has been put on hold due to the COVID-19 pandemic. At this time, LTC facilities

are overwhelmed with testing and maintaining staffing. We will revisit this strategy once the pandemic has subsided.

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.

Update/Status
Since January 2020, Ombudsmen have assisted with 122 complaints related to Admission, Transfer, Discharge, and Eviction.

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.

Update/Status
43 people have successfully completed PTRC AAA classes in telephone, in-person and online delivery formats. Class completers report reduced fatigue, increased activity level and greater self-efficacy for managing their conditions. 12 workshops have been offered. Classes delivered include Diabetes Self-Management, Living Healthy with Diabetes and Living Healthy with Chronic Conditions and a Matter of Balance. PTRC AAA has trained 7 people to become A Matter of Balance coaches. PTRC AAA currently has A Matter of Balance and Living Healthy with Diabetes classes scheduled at senior centers and recreation centers across 4 counties and more will be scheduled. Presentations have been made at churches to develop awareness and recruit participants We will also offer training for Living Healthy with Chronic Conditions facilitators this fall.

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.

Update/Status
The Piedmont Area Falls Prevention Coalition (PAFPC) has consistently held quarterly meetings. During this year the PAFPC met on May 26 and Aug. 25. The next meeting is scheduled for November. We have also scheduled our 2nd annual Falls Prevent Awareness Week events with a robust schedule of activities and presentations for community engagement and falls prevention awareness. In this endeavor we have partnered with other community organizations. Meeting attendance has steadily increased from 10-12 participants to 38 at our most recent meeting. The listserv for the PAFPC is now at 51 members. Partners on the listserv include healthcare entities, educational institutions, parks and recreation, senior centers, AARP, adult day centers, home health agencies, advocates, and service providers. PAFPC is utilizing the NC Healthy Aging site to post classes for increased referrals and to partner with other organizations for class facilitation and training. The PAFPC participates with the NC Falls Prevention coalition and is engaged with the state coalitions strategic action plan. PAFPC reports data to the NC Coalition and participates in the NC Coalition's meetings. The AAA has promoted falls awareness and education on its websites, Facebook page, through community presentations (4 this year with more scheduled) and information sharing with listservs.

Strategy 3: Expand Diabetes Age Well Services beyond our current capacity by contracting with Medicare Advantage (MA) Plans and Accountable Care Organizations (ACO's) 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.

Update/Status
This initiative is in the strategy and planning phase. PTRC AAA is working with a consultant to develop this approach. PTRC AAA is looking at ways to increase capacity to serve in order to be attractive to Medicare Advantage Plans and meet their standards for timeliness and accessibility of services. Our Diabetes program was recently reaccredited by ADCES and this will help us as we seek contracts.

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.

Update/Status
Due to COVID in-person PTRC classes were postponed, but two counties conducted virtual classes. Powerful Tools classes are not yet available in all counties. The leader training cancelled and a virtual training was not scheduled in the region. This goal is continued for SFY2022.

Objective 2.3: Older Adults and Caregivers will have access to evidence-based health promotion (EBHP), wellness, and disease prevention programs

Strategy 5: Evidence-based classes will be advertised to 60+ population.

Measure(s): The number of advertisements and size of population reached.

Outcomes: More referrals to the regional evidence-based at home programing.

Update/Status
Two advertisement campaigns via ads on Harris Teeter Pharmacy prescription bag in April of 2021, with a total estimated population reached of 48,000. PTRC AAA has participated in 3 health fairs and made 4 individual presentations and 3 group Zoom presentations. Sites included schools, churches, recreation centers, senior centers, adult day centers and at community provider meetings.

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.

Update/Status
County Aging PCs and CACs receive information at meetings regarding Medicare, Evidence-Based classes; and tips and skills for healthy aging, and members are encouraged to carry the information back to their communities, churches and agencies. All twelve counties participated and continue to participate in this endeavor.

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.

Update/Status
The AAA Regional Advisory assisted with the development of the Area Plan by participating in round table discussions about needs in the region. September 9, 2021 Regional Advisory members will receive an update by AAA staff on progress.

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.

Update/Status

Advocacy continues to be a prime directive to ensure the needs and issues of older adults are heard. In SFY21, PTRC issued 8 Advocacy Alerts, encouraging aging service providers and hundreds of others on our email distribution lists to contact their legislators regarding issues of importance to older adults. These Advocacy Alerts are on the agenda of most every planning committee meeting (six to ten times/year in each county). PTRC staff reaches out to federal and state officials to discuss older adults and caregivers that need support, services and legislation that protects them. Due to the pandemic, annual in person visits to legislators in Washington DC and Raleigh were cancelled. PTRC staff are familiar with local elected officials such as county commissioners who attend planning committee meetings, strategic planning sessions and other events where PTRC staff take time to bring up issues facing 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.

Update/Status
Over the past year, PTRC has been in monthly meetings with Wake Forest Baptist Health System and CHESS (an Accountable Care Organization [ACO]) about a pilot project that would use PTRC's Community Health Workers to help discharged patients achieve better health outcomes through having their social determinants of health needs met. In SFY21 PTRC partnered with UNC Asheville's NC Center for Health and Wellness on a three-year ACL Nutrition Innovation grant to combine diabetic friendly meals and Evidence-Based diabetes programs for Congregate and Home Delivered Meal clients in Rockingham County, which has a high incidence of diabetes. We partnered with the meal provider, ADTS, but also with non-traditional partners, including: the Rockingham County Health Dept, The Rockingham County Diabetes Coalition, Cone Health System, Triad Health Network (an ACO), and a Federally Qualified Health Center.

Strategy 5: PTRC/AAA will continue to serve as a host location for college interns interested in the field of aging.

Measure(s): College interns will be better educated about actual issues affecting older adults through the ground up experience provided.

Outcomes: College interns will be better informed as to their preference in working in the field of aging.

Update/Status
PTRC AAA has utilized 4 interns thus far this year. The interns have been given meaningful assignments that allow them to directly engage with older adults, service providers and community agencies. The interns have participated in research, providing technology assistance to class participants, contributing input to initiatives, developing technology instructions for older adults, and other relevant work that informs them about issues affecting older adults. Interns are also exposed to the various job roles within the organization in order to get a sense of their preferred area of career focus.

Well Informed Communities

Goal 3: Support and encourage older adults of all backgrounds and their support systems to access information that helps them make informed choices about support 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 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.

Progress/Update
The PTRC AAA Service Provider Directory was updated and uploaded to the PTRC website at https://www.ptrc.org/home/showpublisheddocument?id=1434. The document updated on the following dates: June 6, 2020; December 15, 2020 and March 1, 2020. Staff provided assistance with education and promotion of HCCBG programs in Rockingham and Alamance County. The AAA will continue to work with Planning Committees through the Aging Plan implementation to address consistent and reliable program information in their county.

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.

Progress/Update
Plans are in the works for SFY 22.

Strategy 3: Maintain an updated directory of available HCCBG and FCSP services and provider contact information.

Measure: 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.

Progress/Update
The list of FCSP services and provider information is updated at least annually, with changes usually made as needed. Public callers are made aware of types of services available, and are also directed to their local service provider as well as the AAA Directory. Participation with virtual meetings has allowed information sharing of services with other agencies, such as the Veterans Administration, Adult Children of Aging Parents, Hospice organizations, and others to provide up-to-date information. NC DAAS list of FCSP providers and contacts was provided in August 2021 to be shared with all AAAs. Printed copies of this Directory are provided when individuals representing businesses, universities, students or interns, etc. come to the PTRC office for information.

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.

Progress/Update
PTRC AAA is participating on the committee for Equity and Inclusion in Evidence Based Programs and also the Healthy Equity Task Force. Engagement in these initiatives has helped us to more specifically identify underserved and underrepresented populations and develop additional strategies to reach them. PTRC AAA has increased diversity representation in photos its evidence-based program marketing materials. Specific marketing has been done at sites that serve minority populations including a recreation center and 2 churches. PTRC has trained its first Spanish speaking facilitator in the A Matter of Balance program and is actively recruiting persons from underserved and underrepresented communities to become trained as facilitators for evidence-based classes.

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.

Progress/Update
PTRC AAA has mapped out low-income housing communities in our region and will be making direct appeals to those sites for delivery of evidence-based classes. In person and phone outreach will take place in September-November 2021.

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.

Progress/Update

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.

Progress/Update
SFY 21: The PTRC AAA is part of an IT Workgroup that is working to develop software that will track and show outcomes of clients/participants. This software will hopefully have the ability to pinpoint by zip code areas of disparities in services; as well as track the increase of client demographics and ADLS and IADLS over time. PTRC AAA participates with Age Friendly Forsyth, an initiative that collects data on the needs of older adults and advocates for their access to information and resources. PTRC AAA has reviewed the data collected and identified target

areas. PTRC AAA has also delivered information at a family health fair in Guilford County that serves underserved populations. A second community health fair event in an underrepresented community is scheduled for September. PTRC delivered a presentation and class demonstration at a recreation center that serves a primarily minority population.

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 Fiends trainings per year to form diverse champions.

Outcomes: Champions across the region will raise awareness of Dementia and support families in the community.

Progress/Update
Two Dementia Friends training sessions were conducted in the region among diverse populations in community settings. This strategy will be continued for FY2022 with attempts to conduct 3 per year. COVID prevented adequate sessions from being conducted.

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.

Progress/Update
There has been advertising in three pharmacies located within the underrepresented population areas with MIPPA funding, in order to spread awareness about the Medicare prescription Drug Low-Income Subsidy program and Living Healthy at Home Classes.

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.

Progress/Update
PTRC AAA staff continues to be a part of and attend the Triad Healthcare Preparedness Coalition. PTRC AAA has participated in the Triad Healthcare Preparedness Coalition. Previous to the COVID-19 pandemic, meetings were bi-monthly, however, due to the pandemic meetings were moved to quarterly. In addition to the Triad Preparedness Coalition, Ombudsman have joined the Duke Healthcare Preparedness Coalition and the MidCarolina's coalition. PTRC AAA will be prepared to respond to emergencies that impact the safety and well-being of older adults.

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.

Progress/Update
PTRC AAA has a Disaster Plan that is updated annually. Staff are trained annually as well as new staff receiving specific disaster plan training during the on-boarding orientation. Employees are given a copy of the PTRC AAA Disaster plan so that all employees are aware of their role in the event of an emergency.

Part of the PTRC AAA disaster preparedness plan is to alert staff when adverse weather conditions face the region. In FY 20 and FY 21 PTRC AAA's region experienced several adverse weather situations. The PTRC AAA completed Disaster/Weather Incident reports and those reports were submitted to the NC Dept. of Aging and Adult Services.

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.

Progress/Update
Across the region Family Caregiver Service Coordinators have conducted virtual events to inform the public and caregivers of available services - Caregiver Resource Fairs, Community Forum, Radio and podcast events have been conducted, and information shared via social media platforms and organizational websites. Families and caregivers have been engaged in person-centered choices for assistance. Survey outcome data has not yet been tabulated. The number of contacts is entered monthly into the ARMS system, and phone logs are maintained at the local level, with information noting the services selected.

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

Progress/Update
Outreach done to county senior centers. Due to COVID many of the centers are still not open to full capacity so virtual information sessions have been scheduled. The Kernersville Senior Center and the Forsyth County Shepherd Center-Coalition of Ministries for Older Adults will work with PTRC AAA to get valuable information out regarding advocacy for loved ones in long term care facilities, as well as family caregiver support programs. Forsyth Senior Services will highlight the advocacy efforts in their Winston Salem Journal column "Age Wise".

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 addition and access to information on additional resources.

Progress/Update

At this time no information about opioid addiction has been posted, but we will be posting this information soon.

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.

Progress/Update
PTRC AAA is planning to train new Living Healthy with Chronic Pain facilitators and update current facilitators who were unable to update their training during the pandemic. Once these facilitators are trained we will offer the Living Healthy with Chronic Pain in early 2022. There is information in the curriculum that talks about opioid and medication management.

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

Progress/Update
Information with Virtual webinar opportunities addressing Opioid Awareness have been shared and made available with FCSP partners in the region. Due to the pandemic this strategy will continue into SFY2022, with documentation of attendance and evaluations administered as possible.

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 attention 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.

Update/Status
Funded partner meeting was held February 8, 2021. The next is scheduled for October 7, 2021. Meetings discuss opportunities to perform more efficient and plan for expanded service delivery. As a network we are moving toward health care contracting. Funded partners have to get to a position to deliver services on demand. Due to the pandemic, no training on capacity building topics was offered this year. The plan is to address capacity building topics in SFY 2022 with our region's funded partners.

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.

Update/Status

On-going conversations with Wake Forsyth Baptist Health and Chess the ACO partnership. In February 2021, the AAA instituted a community health worker program. Three community health workers are on board to service referrals from the health system targeted geographic area. Conversations are happening to build a strong working relationship.

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.

Update/Status
Due to the pandemic this was delayed for the regional senior centers.

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 report satisfaction with AAA assistance.

Progress/Update
PTRC AAA in coordination with State DAAS office and Centralina provided training on ARMS. This training took place on November 20, 2020, with 48 PTRC AAA service providers participating. Provider Trainings were held virtually when FCSP and CARES grants were made available, with program requirements and standards presented and posted on the AAA website. The FCSP CARES information meeting was held 8-10-20. Commonly occurring questions were posted. The Family Caregiver Program provides at least quarterly meetings to discuss best practices, programmatic updates and to answer common questions and share TA topics and responses. FCSP meetings were held 8-7-20, 11-19-20, 1-8-21, 2-12-21, and 4-9-21.

Funded partner meeting was held February 8, 2021. The next is scheduled for October 7, 2021. Meetings discuss opportunities to perform more efficient and plan for expanded service delivery. As a network we are moving toward health care contracting. Funded partners have to get to a position to deliver services on demand.
A Provider Training was held for Supplemental Nutrition Funding (HDC5) on August 16, 2021.

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.

Progress/Update
Over the course of the fiscal year, approximately 600 technical assistant requests regarding ARMS and/or budget preparation/revision were fulfilled by PTRC AAA staff.

The PTRC AAA receives an average of 22 ARMS technical assistance calls per month. The technical assistance includes, but is not limited to:

- Adding Clients to ARMS
- Adding assessments to Clients in ARMS
- FCSP client recipient errors in ARMS
- Functional Status errors in ARMS
- Adding units to ARMS
- HCCBG and FCSP budget revision assistance
- CARES funding assistance in ARMS
- Families First funding assistance in ARMS
- Waitlist 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.

Progress/Update This strategy has been delayed due to the impact of the COVID-19 pandemic.

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.

Progress/Update Planning Committees have a number of organizations or service providers attend meetings. This includes staff from Health Departments involving PC members in their community health surveys; Sheriff's officers; Parks n rec; County commissioners; Wake Forest Baptist Health System; local pastors: library staff; AARP representatives and others. AARP has held meetings with Planning Committee members in a few counties to discuss and collaborate on Livable Age Friendly Communities.

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.

Progress/Update PTRC held one virtual training via for new and existing planning committee members (who needed a refresher). Registration was required so that training materials could be sent to their home to have available during the training. Most every county had at least one representative at the training. Attendees reported they appreciated the training and that it better prepared them to serve as a member of their planning committee.

Objective 4.4: Diversity 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.

Progress/Update
Due to the pandemic holding in person classes were delayed. This also delayed the ability to bill Medicare. The AAA is exploring virtual options.

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.

Progress/Update
PTRC began the work to develop a Community Health Worker (CHW) program through many meetings with consultants who guided the process to start a program from ground zero. In the Spring of 2021, PTRC hired 3 CHWs. These three were oriented to PTRC policies and procedures and then signed up to attend NC's CHW Certification program. We are currently working on a pilot project with Wake Forest Baptist Health and CHESS (an ACO) to use our CHWs to improve the health and well-being of their discharged patients. The goal is to produce positive outcomes and positive Return on Investment (ROI) that we can then take to insurance companies or local Health Systems to demonstrate our value. The ultimate goal is to obtain contracts with healthcare payors.

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.

Progress/Update
Over the past year, PTRC AAA has been working with consultants Ted Rooney and Tim Gallagher on the development of a business plan for the AAA. We have been meeting weekly about the AAA's desires to connect with healthcare and insurance payors and are making progress on development of a business plan. Sylvia Coleman is also part of the consultant team that is working to build our Community Health Worker model that is part of the business plan.

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, and DHHS' Internal Auditor and other state agencies. The lead monitor acts as "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 NORS. 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 lead 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 revenue which can be reinvested to reach more people.