

Idaho Area Agency on Aging V

Planning and Service Area V

Area Plan

Area Plan Dates	In Alignment with Current ICOA State Plan	Informing the Next ICOA Planning Date
October 1, 2022-September 30,2026	October 1, 2020-September 30, 2024	October 1, 2024-September 30, 2028



**Idaho Area Agency on Aging V (AAA V) at
Southeast Idaho Council of Governments (SICOG)**

AAA V at SICOG

214 E. Center

Pocatello, ID 83201

(208) 233-4032 or (800) 526-8129

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Attachment A: Idaho Area V Agency on Aging Needs Assessment

Attachment B: Idaho Area V Agency on Aging Program Reports

Executive Summary

Every four years, with annual updates thereafter, the Area Agency on Aging V (AAA) submits an Area Plan to the Idaho Commission on Aging (ICOA) for approval. An approved Area Plan is required to receive federal and state funding allocations through ICOA. The Area Plan establishes a “Single Access Point” for all eligible consumers to receive aging and disability resources and services. Eligible populations include Idahoans over the age of 60, their families, and vulnerable adults aged 18 and older living in the seven counties of the Planning and Service Area (PSA) V: Bannock, Bear Lake, Bingham, Caribou, Franklin, Power, and Oneida counties. Additionally, the Area Plan provides opportunities for individuals to choose between private and public pay, long-term care services and other resources vital for healthy aging.

AREA PLANS. (Idaho Administrative Procedures Act-IDAPA 15.01.20.052) Each AAA shall submit a four (4) year area plan to the ICOA by close of business June 15, 2022, and by October 15 every four (4) years thereafter. Annual updates shall be submitted by October 15 of each year. The area plan and annual updates shall be submitted in a uniform format prescribed by the ICOA to meet the requirements of the OAA and all pertinent federal regulations.

In developing the Area Plan, the AAA utilized ICOA’s statewide goals and objectives approved by the Administration for Community Living (ACL). The Area V Plan serves as a road map for the AAA in its Planning and Service Area (PSA) and allows the AAA to remain mission driven and accordant with ICOA. Area plans must include measurable objectives that address all the components of the strategic plan. In developing the strategies, consideration of the role these areas serve in optimizing the state’s long-term services and supports system (LTSS) for older adults and their caregivers was key.

To ensure that OAA and SSA services are delivered efficiently and effectively, the Area Plan establishes performance data, baselines, and benchmarks to measure ongoing progress. The Area Plan also identifies community partners who through coordination and collaboration will help the AAA reach targeted objectives, recognize opportunities for improvement and take actions that will mitigate service barriers.

AAA – Planning and Service Area V

Geographic Information: The region in PSA V covers 9,491 square miles in seven counties: Bannock, Bear Lake, Bingham, Caribou, Franklin, Oneida, and Power. The Southeast Idaho Council of Governments hosts the AAA for this region out of its offices in the city of Pocatello. Beyond Pocatello, most of the PSA is rural. Southeast Idaho is home to the Potato Expo, the National Oregon/California Trail Center, Bear Lake National Wildlife Refuge, Minnetonka Cave, Lava Hot Springs and Massacre Rocks State Park. The Shoshone-Bannock Tribes are located on the Fort Hall Reservation in Southeastern Idaho, between the cities of Pocatello, American Falls, and Blackfoot. The Reservation is divided into five districts: Fort Hall, Lincoln Creek, Ross Fork, Gibson, and Bannock Creek. It comprises 814.874 sq mi (2,110.51 km²) of land area in four counties: Bingham, Power, Bannock, and Caribou.

The seven counties of Southeast Idaho are comprised of diverse landscapes of mountain ranges, foothills, lava fields, ranches, irrigated farms, and small cities. The region is part of two major watersheds. The southern portion in Bear Lake, Franklin, Oneida, and Caribou counties is drained by the Bear River which enters Idaho heading north, but loops around the Bear River Range and leaves the state flowing south toward the Great Salt Lake. The Malad River which drains much of Oneida County is a tributary of the Bear River. The northern part of the region which includes Bannock, Bingham, Power, and part of Caribou counties, is in the Snake River watershed. The Snake flows west into the Columbia River and the Pacific Ocean.

The landscape of the Bear River watershed is composed of alternating, northwest southeast trending mountains and valleys. Most of its mountainous grazing lands are in the Caribou National Forest. Foothill areas are used for grazing and dry land grain farming. The valley floors are irrigated where water is available. The Snake River watershed has a more varied landscape. The Portneuf and Blackfoot Rivers and smaller tributaries flow north and west toward the Snake River from mountainous divides with the Bear River watershed. The landscapes drained by these tributaries are like those on the south side of the divide, but the northwestern part of the region, in Bannock, Bingham, and Power counties, is on the relatively level Snake River Plain, where extensive irrigated croplands are interspersed with lava fields, and the horizon is punctuated by occasional volcanic buttes.

The economy of southeast Idaho reflects its landscape. The counties in the Bear River watershed, Bear Lake, Franklin, and Oneida, are predominantly agricultural. None has less than 25 percent of its total employment in agriculture and all have strong trade ties with Northern Utah. Caribou County, which is divided between the watersheds, also occupies an intermediate position in the regional economy. It has significant agricultural employment and an industrial base in phosphate mining and processing. The northwestern counties of Area V ~ Bannock, Bingham, and Power, have more cropland and food processing area used than the area used by the major industrial employers. The Chubbuck-Pocatello urban area is the trade center of Bannock, Caribou, and Power counties and much of Bingham County. The northern parts of Bingham County area are included in the Idaho Falls trade area.

Public ownership of land is predominant in the area with approximately 37 percent of the land administered by the Federal government. Agencies involved include the Bureau of Land Management (BLM), U.S. Forest Service, the Bureau of Reclamation, and the Department of Energy (DOE/Idaho National Engineering and Environmental laboratory). The State of Idaho owns roughly 6.5 percent of the area's land. Another portion of land is held in trust for the Shoshone-Bannock Tribes and the Fort Hall Reservation.

Demographic Information: Based on the 2020 American Community Survey Estimates, the total population in PSA V was 175,045, of which 36,641 (20.9%) individuals were over the age of 60. The at risk populations which factors in Idahoans of 65 + living in poverty, Idahoans of 65+ living alone, Idahoans living in a rural county, racial minorities, Persons 60 + and Hispanic, Idahoans aged 75 and older & also 85 and older is 41,404.

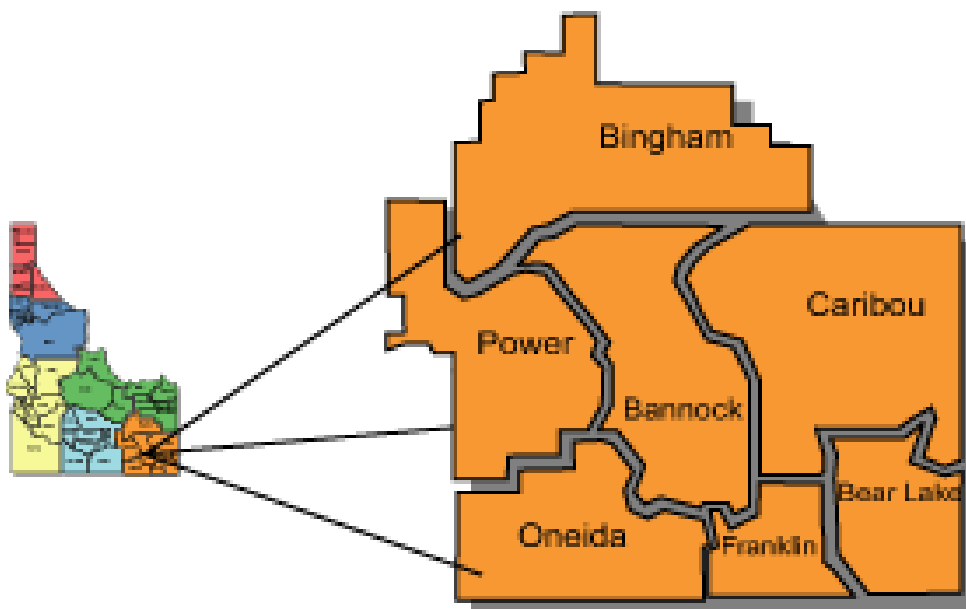
According to the 2020 US Census, the total senior population over the age of 60 in the PSA is 36,641.

The county breakdown for overall population and persons 60 and older is:

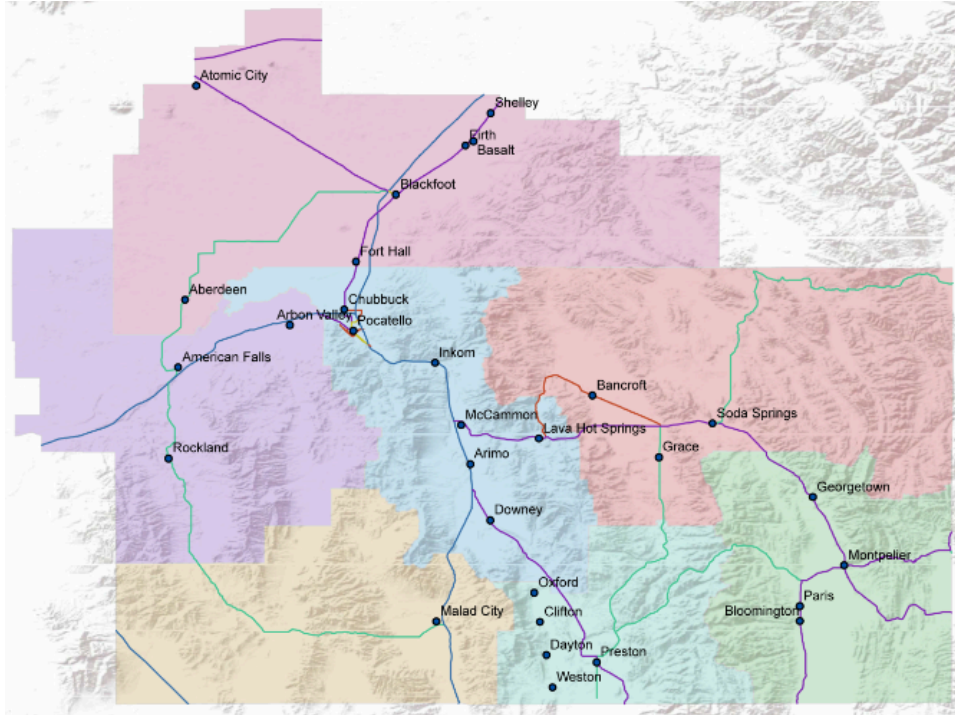
County	Population	Persons 60+
Bannock County	87,018	17,969
Bear Lake County	6,372	1,711
Bingham County	47,992	9,538
Caribou County	7,027	1,703
Franklin County	14,194	2,784
Oneida County	4,564	1,259
Power County	7,878	1,677
Area V	175,045	36,641

SERVICE AREA MAPS

The service area map below is intended to identify the seven-county planning and service area (PSA) of AAA V in Idaho.



The service area map below is intended to display the cities and transportation arteries within the boundaries of PSA V.



P.O Box 6079 · Pocatello, ID 83205-6079

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Attestation of Compliance with OAA and Area Plan Assurances

Bannock County

Arimo
Chubbuck
Downey
Inkom
Lava Hot Springs
McCannion
Pocatello

The Area Plan on Aging is hereby submitted for Planning and Service Area V for the period FY 2022 through FY 2026. We acknowledge and assume full authority to develop and administer the Area Plan in accordance with Older Americans Act, as amended during the period identified, and related State rules and regulations. In accepting this authority, We assume major responsibility to develop and administer the Area Plan for a comprehensive and coordinated system of services and to serve as the advocate and focal point for older people in our planning and service area.

Beaumont County

Bloomington
Georgetown
Montpelier
Paris
St. Charles

By our signatures we further attest:

We have read and understand the AAA obligations and responsibilities required to meet the Sec. 306 of the OAA.

Bingham County

Aberdeen
Atomic City
Basalt
Blackfoot
Firth
Shelley

We have developed a plan to serve older individuals who have greatest economic need, individuals who have greatest social need, individuals at risk for institutional placement and respond to the requirements of Sec. 306 of the OAA.

Caribou County

Barrcroft
Grace
Soda Springs

The AAA will comply with OAA rules and regulations through:

- AAA submission and ICOA approval of this plan and all attachments.
- AAA submission and ICOA approved budget.
- AAA submission of records required to verify compliance including contracts, forms, and other documents as requested by ICOA.
- Fidelity to ICOA published manuals, policies, official guidance and education.

Franklin County

Clifton
Dayton
Franklin
Oxford
Preston
Weston

The AAA has systems and processes in place to ensure ongoing compliance throughout the plan timeframe. The AAA will commit to data integrity and quality to ensure OAA service delivery is accurately tracked and monitored in fulfillment of this plan.

Oncida County

Malad

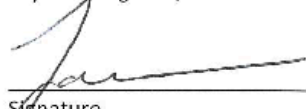
Power County

American Falls
Rockland

Representative from Parent Organization:
Layne Bourgeois, SICOG Executive Director

Representative from the Area Agency on Aging
Michael Hirschi, AAA V Director

Japanese American Citizens League


Signature Date 10-13-22


Signature Date 10/13/2022

National Association for the Advancement of Colored People

Pocatello Central Labor Council

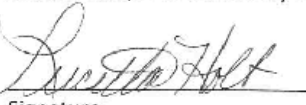
The Shoshone Bannock Tribes

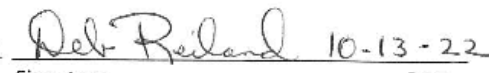
Representative from the Advisory Council
Lucetta Holt, AAA V Advisory Council

Appointed Commissioner
Deb Reiland, ICOA Commissioner Area V

Economic & Community Development Division

Area Agency on Aging


Signature Date 10/13/2022


Signature Date 10-13-22

Equal Opportunity Employer - TDD/TTY Through Idaho Relay Service 1-800-337-3529

Section 1 Planning and Organization

Area Plan Submission Timeline of Dates and Activities

Stakeholders	Meeting Date	Purpose
AAA Advisory Council	10/8/2020	Area Plan requirements and timeline
Needs Assessment Survey	December 2020-February 2021	Needs assessment survey
Power County Senior Center	12/21/2020	Group Meeting/SWOT
Blackfoot Senior Center	12/21/2020	Group Meeting/SWOT
Curlew Valley Senior Center	12/22/2020	Group Meeting/SWOT
Oneida County Senior Center	12/23/2020	Group Meeting/SWOT
AAA Advisory Council	2/9/2021	Executive Summary
Pocatello Senior Activity Center	2/12/2021	Group Meeting/SWOT
Contracted Providers	2/16/2021	Focal Points
AAA Advisory Council	5/6/2021	Needs assessment review
Contracted Providers	5/18/2021	Needs assessment review
AAA Advisory Council	6/17/2021	SWOT/Targeted, Universal and Crisis Programs/Services Meeting
AAA staff	7/9/2021	SWOT
AAA staff	7/23/2021	Mission, values, and vision statements
Contracted Providers	11/16/2021	Area plan strategy discussion
AAA Advisory Council	12/9/2021	Area plan strategy discussion
Contracted Providers	2/15/2022	Area Plan Submission and discussion of focal points
AAA Staff	2/22/2022	Area Plan submission and deliverables identified
AAA Advisory Council	3/10/2022	Area Plan submission
AAA Staff	5/31/2022	Area Plan review before submission
Area Plan Public comment	6/1/2022-6/14/2022	Area Plan Public Comment
AAA Advisory Council	6/9/2022	Area Plan review before submission
AAA Area Plan Submission	6/15/2022	Area Plan submission to ICOA

**AAA V Area Plan Steering Committees:
Universal Programs**

Program	Name	Organization
Information and Assistance Services	Laurie Keyes	AAA V
Congregate Meals	All Senior Center Directors	All AAA V Senior Centers
Health Promotion	Pam Wake	Candlewood Family Counseling
MIPPA/SMP	Angelyn Norgaard	AAA V
Loneliness Reduction	Gina Hubbard	AAA V
Loneliness Reduction	Amy Shelton	Justserve.org
Congregate Meals	Lucetta Holt	AAA Advisory Council
Multiple	Jessica Lewis	AAA Advisory Council
Multiple	BJ Stensland	Aid for Friends

Targeted Service Group

Program	Name	Organization
Family Caregivers	Gina Hubbard	AAA V
Transportation	Skyler Beebe	PRT
Home Delivered Meals/NSIP	All Senior Center Directors	All AAA V Senior Centers
Homemaker	Layne Bourgeois	AAA V
Dementia Capability	Ann Harrild	AAA Advisory Council/PTC class leader
Family Caregivers	Cara Fitzgerald	Comfort Home Care
Family Caregivers	Lisa Tornabene	AAA Advisory Council
Home Delivered Meals/NSIP	Lucetta Holt	AAA Advisory Council
Transportation	Cyril Westwood	AAA Advisory Council
Homemaker/Respite	Amber Davis	AAA Advisory Council and Care Connection of Idaho
Family Caregiver (Veteran)	Lynda Pfaff	Veteran Directed Care

Crisis Programs

Program	Name	Organization
Elder Rights	Susan Cronquist	AAA V
Ombudsman	Liz Delaney	AAA V
Legal Assistance	Karl Lewies	Idaho Legal Aid
Elder Rights	Layne Bourgeois	AAA V
Elder Rights	Therese Combs	AAA V
Advocacy and Rights	Rachelle Lish	Life, Inc.
Ombudsman	Bonnie Hamilton	AAA V Ombudsman SCSEP

AAA V strived to ensure that our efforts are focused on serving those individuals residing in rural areas, low-income, minorities, people with severe disabilities, limited English proficiency and people living with dementia. Representatives of each of these groups, including consumers receiving services from AAA V, were involved in our needs assessment, group meetings at local senior centers and the stakeholder meetings to ensure each at risk population was represented throughout the planning process.

Community Focal Points (45 CFR 1321.53(c)):

OLDER AMERICANS ACT OF 1965 [Public Law 89–73] [As Amended Through P.L. 116–131, Enacted March 25, 2020]

Sec 306: Area Plans

(3)(A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and (B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

The following are the community focal points that are designated:

Senior Activity Center-Pocatello	Bannock County
Lava Hot Springs Senior Center	Bannock County
Bingham County Senior Center	Bingham County
Bear Lake Senior Center	Bear Lake County
Aberdeen Senior Center	Bingham County
Shelley Senior Center-The Elite Retreat	Bingham County
Caribou County Senior Center	Caribou County
Franklin County Senior Center	Franklin County
Curlew Valley Senior Center	Oneida County
Oneida County Senior Center	Oneida County
Power County Senior Center	Power County

Expectations of community focal points in AAV

- Provide Area V Agency on Aging information at congregate meal sites
---Display brochures, fliers, business cards of AAA staff etc...
- Participate in program sign up day
---AAA staff will be at your center talking about services that the AAA offers
---AAA staff could assist with congregate re-registrations
---AAA staff would conduct assessments with consumers to see if they qualify for any other program the AAA offers (only if consumers are interested)
- Host a Chronic Disease Self-Management Program workshop (1 during the 2022-2026 4 Year Area Plan year)
---Chronic Disease Self-Management workshops consist of 2 ½ hour classes held weekly for 6 weeks
- Host a Powerful Tools for Caregivers workshop (2 during the 2022-2026 4 Year Area Plan year)
---Powerful Tools for Caregivers workshops consist of 1 ½ hour classes held weekly for 6 weeks

- Promote campaigns (i.e., Senior Nutrition Month in March, Older Americans Month in May and/or National Family Caregiver Month in November). Activities might include:
 - Putting out a press release
 - Proclamation by mayor or county commissioners
 - Letters to the editor
 - Classes and demonstrations
 - Social Media posts throughout the month

- Provide at minimum two social activity or health promotion related events monthly. Examples include:
 - Fit and Fall classes
 - Special parties
 - Monthly birthday party celebrations
 - Bingo
 - Cards

- Coordinate an Intergenerational activity (4 activities during the 2022-2026 4 Year Area Plan Cycle). Activities might include:
 - Cooking class
 - Gardening
 - Volunteer together to clean up a park
 - Reading and mentoring
 - Music classes or performance
 - Arts and crafts

Section 2 Environmental Analysis

Analysis of Existing and Anticipated Trends

Process of research and analysis

The AAA V area plan was developed in part by utilizing several tools to analyze existing and anticipated trends. It is important to note that the COVID 19 pandemic altered life when it hit our region in March 2020 and the degree of impact this may have had with the data being used in this analysis is unknown. Challenges/ weaknesses uncovered during this planning process have been addressed in the AAA V strategic plan (Page 40) to help mitigate the effects they would have in implementing the strategies to meet our goals.

The following tools were used:

1. **System of Record Reports (GetCare)**
2. **Census Data and Projections**
3. **ICOA Needs Assessment Survey (2020)**
4. **AAA V Needs Assessment Survey (2021)**
5. **SWOT Analysis**

1. **System of Record Reports (GetCare):** A review of the system of record reports (GetCare) was conducted to analyze service utilization and patterns to identify gaps in service delivery.
 - **Congregate Meals:** Congregate meal service utilization increased 32% from SFY 20 to SFY 21. We attribute a majority of this increase to the ability that consumers could pick up a congregated meal at a 'grab and go' setting instead of eating with other community members at their local senior centers.
 - **Respite:** AAVV seen a 55% increase of Respite care utilization from SFY 19 to SFY 21.
 - **Home Delivered Meals:** Home Delivered Meal utilization has increased steadily over the last several of years. We have had an increase of 51% of home delivered meals in our region in the last 5 years. In SFY 17, AAVV supported 62,679 home delivered meals to qualified consumers and this number jumped up to 94,578 in SFY 21.
 - **Homemaker:** AAVV has seen an increase in 6% of homemaker service utilization over the last couple of years. In SFY 19, 7072 were recorded compared to 7509.75 units of homemaker recorded in SFY 21.
 - **Transportation:** Ridership utilizing the AAVV provider of transportation seen a significant decrease over the last couple of years due to COVID-19. Transportation boardings from SFY 19 to SFY 21 decreased 32%. AAVV anticipates these numbers to rise as people's lives re-adapt to a new normal after the pandemic.
 - **Chore:** AAVV has not recorded any service units for chore in the last 5 years.
 - **Case Management:** AAVV has not recorded any case management units in the last several years. AAVV staff and some of our partners have discussed a growing need for service coordination among older adults in our area.
 - **Information and Assistance:** 3% decrease in calls were noted from SFY 19 to SFY 21

- **Adult Protective Services:** In SFY21, AAV Adult Protective Service staff investigated 283 allegations of abuse, neglect, exploitation, or self-neglect in our region out of 405 reports made.

2. Census Data and Projections: AAV evaluated census data to determine growing population trends/projections in our region. The following is a summary of these trends/projections:

- The overall population in our region from SFY 17 to SFY 22 increased 4% from 166,586 to 173,987.
- SFY 17 to SFY 22 saw an increase of 23% of the total persons in our region 60 and older from 29,842 to 36,64.
- Those 65 and older that are in poverty increased from 1,416 to 2,102 which is an increase of 48%.
- From SFY 17 to SFY 22 the number of adults 65 and older that live alone increased from 5,432 to 6,234 which is an increase of 15%.
- SFY 17 to SFY 22 persons 60 and older that live in a rural county increased 26% from 15,748 to 19,819.
- According to the Idaho Department of Labor's state forecast, the number of older adults in our planning and service area age 65 and older will grow 25% in the next 7 years.

3. ICOA Needs Assessment Survey (2020): AAV utilized the 2020 needs assessment conducted for ICOA by Institute of Rural Health at Idaho State University as part of our environmental scan. 24% of survey respondents were noted to be from the boundaries with the AAV planning and service area. Key highlights from this survey are as follows:

- 52% of respondents reported a major or minor problem with home maintenance over the previous 12 months.
- 45% of respondents reported a major or minor problem with housework over the previous 12 months.
- 38% of respondents reported having a major or minor problem with feeling sad, lonely or isolated over the previous 12 months.
- 25% of respondents reported having a major or minor problem with accessing nutritious meals.

- 4. AAA V Needs Assessment Survey (2021):** AAVV conducted our own needs assessment survey in late 2020 and early 2021 in preparation for the next Area Agency on Aging 4-Year Area Plan. There were 496 respondents to this survey. Key highlights from the survey are as follows:
- 51% of respondents were from rural areas.
 - 52% of respondents reported they live alone
 - 60% of respondents report having a computer at home and 63% reported they send and receive emails.
 - The top 5 activities that respondents reporting needing assistance with were housekeeping (32%), transportation (24%), shopping (21%), chore/yard care (20%) and dental/vision/hearing problems (19%).
 - The number one response of respondents of the survey reported they find out about community activities, events, and resources from family/friends/neighbors/church members. (65%)
- 5. SWOT Analysis:** A SWOT analysis was conducted by AAVV to help identify our strengths, weaknesses, opportunities, and threats to strategically plan for the future. This analysis will help us maximize our strengths and reverse potential weaknesses that we have. It is a source of information and a guide for our strategic planning as we look at opportunities to grow and serve our communities better. (See page 16 for results.)

SWOT (Strengths, Weaknesses, Opportunities, and Threats) Analysis

Internal and external partners and stakeholders had an opportunity to participate in the AAA V SWOT analysis. With 21 respondents, the strengths, weaknesses, opportunities, and threats listed below had 5 or more participants indicate they should be identified under the respective column they are located. The SWOT analysis should support the Area Agency on Aging of information, provide insight into barriers that may be present while engaging in social change processes, and identify strengths available that can be activated to counteract these barriers. Identification of SWOTs is important because they can inform the planning steps necessary to achieve goals and objectives. The responses to this SWOT Analysis have been reasonably and carefully built into our (3) year Goals and Objectives as well as other applicable sections of our final Area Plan.

In addition, this analysis can be used to do the following:

- Explore new solutions to problems,
- Identify barriers that will limit the ability to achieve goals/objectives,
- Decide on the direction that will be most effective,
- Reveal possibilities and limitations for change, and
- Revise plans to best navigate systems, communities, and organizations.

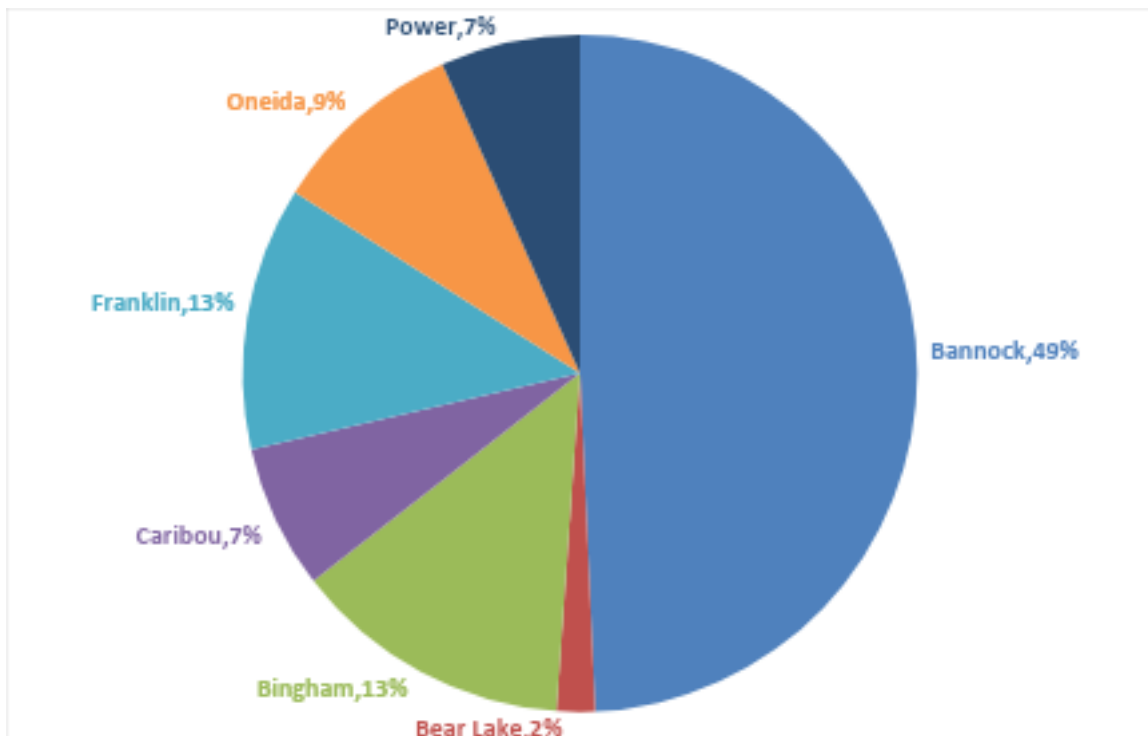
SWOT	Helpful to achieving the objective	Harmful to achieving the objective
<p>Internal Origin (Attributes of the Organization)</p>	<p>Strength: characteristics of the organization that give it an advantage over others</p> <ol style="list-style-type: none"> 1. Dedicated and passionate staff 2. Partners and Collaborations 3. AAA staff are subject matter experts in the programs they serve 4. Willingness of volunteers to help us serve the community 5. Programs and services we provide 6. Longevity of some of the AAA staff 	<p>Weakness: characteristics that place the organization at a disadvantage relative to others</p> <ol style="list-style-type: none"> 1. Lack of awareness and understanding of who we are and of the services and programs we offer 2. Funding stagnant and often does not cover expense of providing service 3. Inability to meet the need for services as population grows and funding isn't diversified 4. Compassion Fatigue/Burnout 5. Lack of succession plan for a couple of the AAA managers
<p>External Origin (Attributes of the Environment)</p>	<p>Opportunities: elements that the organization could exploit to its advantage</p> <ol style="list-style-type: none"> 1. If funding available for home repair and maintenance add to the programs and services the AAA offers 2. Opportunities to diversify funding sources 3. Using technology and social media for outreach 4. Opportunities to partner with other agencies, businesses, government, to enhance the services we provide and to better coordinate services for the consumers we serve 	<p>Threat: elements in the environment that present a challenge for the organization</p> <ol style="list-style-type: none"> 1. Funding limitations and overall lack of diversification of funding sources 2. Lack of awareness and understanding of who we are and of the services and programs we offer 3. Increased population growth and trying to meet the needs of an ever-growing segment of the population in our PSA 4. Workforce shortage issues with some of the AAA providers being able to meet the needs of the consumers that have a specific need

Section 3 Identified Opportunities

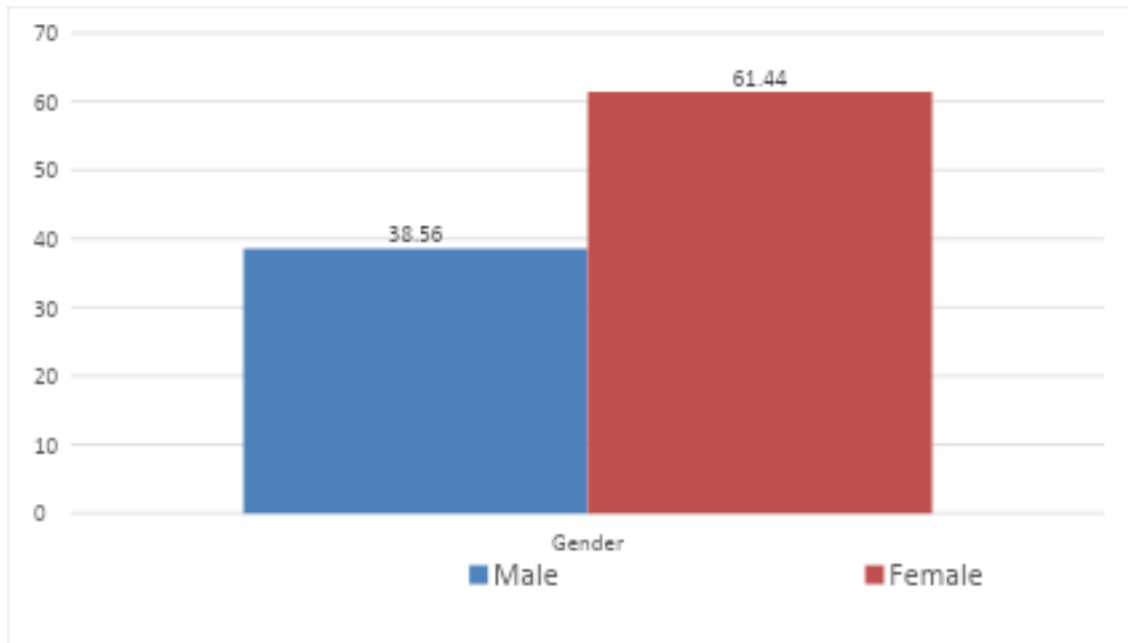
AAAV released our Needs Assessment survey in December 2020 to February 2021. The survey was disseminated out by email to our contracted home care providers, transportation provider, our nutrition providers, and other key partners in our region. AAAV also put ads in each of the newspapers in our planning and service area announcing the release of the survey. The emails included a link to encourage them to have their consumers fill out the survey on-line. Additionally, AAAV staff visited every senior center in the region between December 2020 January 2021 to hand deliver copies of the needs assessments to consumers at the centers. Hand copies of the survey were also distributed to the contracted home care providers to share with their consumers. AAAV also had postcards available at each location that paper copies of the survey were delivered. These postcards encouraged older adults to fill out the needs assessment survey on-line with a QR code. During the visits to the senior centers, AAAV staff talked to staff and consumers at each site about strengths and weaknesses of the aging network in general and particularly to them. These discussions helped facilitate the number of survey responses we received.

A total of 496 surveys were completed and analyzed to help guide the preparation of this 4-year area plan. Some of the demographic information of those that completed the needs assessment is as follows in the next 3 graphs:

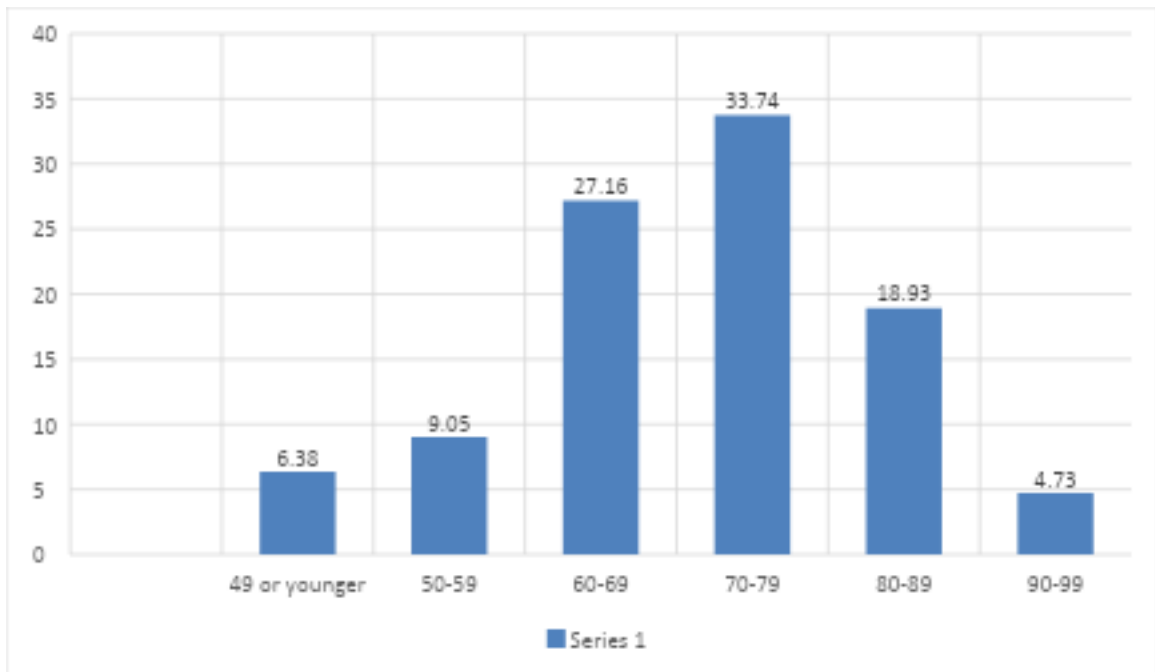
AAAV Needs Assessment snapshot of response rate by county



AAAV Needs Assessment snapshot of responses by Gender



AAAV Needs Assessment snapshot of age range of respondents



A complete compilation of the 496 survey results are identified below. Data and information from these survey's helped form the AAA V Strategic Plan

AAA V Needs Assessment Complete Results

Idaho Area V Agency on Aging Needs Assessment 2020-2021

1. What County do you live in?

Answer Choices	Responses	
Bannock	49.29%	243
Bear Lake	1.83%	9
Bingham	13.39%	66
Caribou	6.9%	34
Franklin	12.58%	62
Oneida	9.33%	46
Power	6.69%	33
	Answered	493
	Skipped	3

2. What city do you live in?

Answer Choices	Responses	
Aberdeen	0.41%	2
American Falls	5.70%	28
Blackfoot	7.94%	39
Chubbuck	1.02%	5
Downey	0.00%	0
Lava Hot Springs	1.02%	5
Malad	6.52%	32
Montpelier	1.43%	7
Pocatello	45.62%	224
Preston	8.55%	42
Shelley	2.65%	13
Soda Springs	4.89%	24
Stone	1.63%	8
Other (please specify)	12.63%	62
	Answered	491
	Skipped	5

3. What is your gender?

Answer Choices	Responses	
Male	38.56%	187
Female	61.44%	298

Answered	485
Skipped	11

4. What is your age?

Answer Choices	Responses	
49 or younger	6.38%	31
50-59	9.05%	44
60-69	27.16%	132
70-79	33.74%	164
80-89	18.93%	92
90-99	4.73%	23
100+	0.00%	0
	Answered	486
	Skipped	10

5. Are you a veteran?

Answer Choices	Responses	
Yes	16.70%	82
No	83.30%	409
	Answered	491
	Skipped	5

6. Are you the spouse of a Veteran?

Answer Choices	Responses	
Yes	17.31%	85
No	82.69%	406
	Answered	491
	Skipped	5

7. Which of the following best describes you?

Answer Choices	Responses	
Asian or Pacific Islander	0.61%	3
Black or African American	0.20%	1
Hispanic or Latino	1.83%	9

Native Indian or Alaska Native	3.87%	19
White or Caucasian	93.28%	458
Multiracial or Biracial	0.61%	3
A race/ethnicity not listed here	1.02%	5
Answered		491
Skipped		5

8. Are you: Please select one.

Answer Choices	Responses	
Widowed	28.31%	139
Divorced	20.77%	102
Single	13.85%	68
Married	37.07%	182
Answered		491
Skipped		5

9. Is your monthly income: Please select one.

Answer Choices	Responses	
Below \$1,063 per month	27.95%	128
Between \$1,064 and \$1,276	12.23%	56
Between \$1,277 and \$1,488	10.92%	50
Between \$1,489 and \$1,700	8.30%	38
Between \$1,701 and \$1,913	6.33%	29
Above \$1,914	34.28%	157
Answered		458
Skipped		38

10. How many people, including yourself, live in your household

Answer Choices	Responses	
1	52.13%	257
2	33.47%	165

3	8.32%	41
4	2.23%	11
5+	3.85%	19
Answered		458
Skipped		38

11. Who lives with you? Check all that apply

Answer Choices	Responses	
Spouse	35.37%	174
Significant Other/Partner	1.63%	8
At least one child	8.13%	40
Child(ren) and his/her/their family	4.47%	22
Other relative(s)	2.85%	14
Unrelated adults/friends	1.42%	7
Grandchildren/Great-Grandchildren	4.47%	22
Father	1.02%	5
Mother	2.24%	11
Live by myself	51.22%	252
Other (please specify)	1.02%	5
Answered		492
Skipped		4

12. What is your employment status

Answer Choices	Responses	
Working full-time	8.26%	40
Working part-time (semi-retired)	7.64%	37
Retired	70.04%	339
Not employed at this time	14.05%	68
Answered		484
Skipped		12

13. Do you have any family, friends or neighbors that contact you at least twice a week?

Answer Choices	Responses	
Yes	89.12%	426
No	10.88%	52
Answered		478
Skipped		18

14. Covid-19 has affected each of our lives differently. Over the last year- we have learned about the individual and collective impact of social isolation and loneliness. Social isolation is commonly described as based on objective indicators, such as a lack of relationships or infrequent social contact while loneliness is defined as the subjective perception of being alone. Research suggests that remaining socially engaged improves the quality of life for older adults and is associated with

better health. What are some of the ways that you remain socially engaged or active in the community you live? (Check all that apply)

Answer Choices	Responses	
Belong to a book club	2.34%	10
Participate in New Knowledge Adventures (NKA) - (Life-Long Learning)	2.10%	9
Attend a local senior center/community center	30.84%	132
Attend religious activities	33.64%	144
Play sports	2.34%	10
Play a musical Instrument	5.84%	25
Travel	3.74%	16
Volunteer	18.22%	78
Gardening	20.09%	86
Going to the library	10.51%	45
Member of a professional organization or club	8.64%	37
Go to the theater, symphony, or concerts	6.31%	27
Social Media group/On-Line group/message board	19.39%	83
I have a hobby (hobbies) I engage in	49.30%	211
Intergenerational activity	7.71%	33
Visits and contact with family	69.86%	299
Practice and prepare for the Southeast Idaho Senior Games	0.93%	4
Other (please specify)		63
	Answered	428
	Skipped	68

15. According to the Dietary Guidelines for Americans, a nutritious meal incorporates a variety of colorful vegetables and fruit, whole grains, fat-free or low-fat dairy, and lean protein options, and limits processed oils, fats, and sugar. Would you say that you have ongoing, adequate access to nutritious food?

Answer Choices	Responses	
Yes	93.00%	452
No	7.00%	34
	Answered	486
	Skipped	10

16. Is there anything keeping you from eating nutritious meals? (Check all that apply)

Answer Choices	Responses	
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No, I eat nutritious meals	72.92%	34
I live alone and don't feel like preparing meals	16.84%	2
I physically cannot cook or prepare meals	8.53%	79
I don't have enough money to buy nutritious foods	6.61%	40
I am physically unable to shop for or carry groceries	7.89%	31
Other (please specify)	5.12%	37
		24
		46
Answered		9
Skipped		27

17. On a typical day, what do you do for lunch?

Answer Choices	Responses	
I prepare my own lunch	33.19%	158
I eat lunch that is served by a senior center or Home Delivered Meal provider (home delivered meal, congregate meal, or curbside meal)	49.58%	236
Someone else prepares lunch for me in my own home	6.09%	29
I do not eat lunch	6.93%	33
I eat lunch at a restaurant	1.68%	8
Other (please specify)	2.52%	12
Answered		476
Skipped		20

18. Do you need help with any of the following activities?

Answer Choices	Responses	
Personal care such as bathing, dressing toileting	12.98%	54
Transportation	24.04%	100
Housekeeping	32.21%	134
Meal Preparation	14.66%	61
Shopping	21.15%	88
Emotional Support	14.66%	61
Financial Assistance (do not have enough money to pay for necessities)	6.01%	25
Money Management (unable to decide what to pay or need help writing checks)	3.85%	16
Companionship	11.78%	49
Chore or yard care	19.95%	83
Medicare, Medicaid, or other insurance issues	6.97%	29
Assistance with medications	8.65%	36
Legal Assistance	6.25%	26
Dental, Vision, or Hearing	19.47%	81
Housing	6.01%	25
Caregiving	8.89%	37
Access to mental health services	4.09%	17
Access to medical health care	6.25%	26
I do not need assistance, go to question 21	45.67%	190
Other (please specify)	2.16%	9
	Answered	416
	Skipped	80

19. Are you currently receiving the assistance to meet your needs?

Answer Choices	Responses	
Yes, Go to question 21	71.28%	211
No, Go to question 20	28.72%	85
	Answered	296
	Skipped	200

20. If you need help with any of the above activities and currently DO NOT receive that help, is it because: (Mark all that apply)

Answer Choices	Responses	
I do not know what is available in our community	46.67%	42
I do not have family, friends, neighbors, or church support available	13.33%	12
I do not want to ask for help	42.22%	38
I am afraid to ask for help because someone may say I need to be in a facility	10.00%	9
I do not have enough money to pay for help	36.67%	33
I do not want to pay for help	8.89%	8
The help I need is not available in our area	16.67%	15
Other (please specify)		11
	Answered	90
	Skipped	6

21. If you ever needed assistance or if you needed more assistance, is there someone you know that you could call to get the assistance you need? (Check all that apply)

Answer Choices	Responses	
Yes, a family member	62.44%	281
Yes, a friend or neighbor	11.11%	50
Yes, other	4.00%	18
Yes, medical provider	4.00%	18
Yes, Area Agency on Aging	4.44%	20
Yes, Clergy or church member	8.22%	37
No	5.78%	26
	Answered	450
	Skipped	46

22. Does someone you know (neighbor, friend, or family member) need help with any of the following activities or services? (Check all that apply)

Answer Choices		Responses	
Personal care such as bathing, dressing, toileting		24.06%	32
Transportation		36.09%	48
Housekeeping		46.62%	62
Meal Preparation		33.08%	44
Shopping		40.60%	54
Emotional Support		31.58%	42
Financial Assistance (do not have enough money to pay for necessities)		15.04%	20
Money Management (unable to decide what to pay or need help writing checks)		12.78%	17
Companionship		27.82%	37
Chore or yard care		36.84%	49
Medicare, Medicaid, or other insurance issues		15.79%	21
Assistance with medications		18.05%	24
Legal Assistance		6.77%	9
Dental, Vision, or Hearing		21.05%	28
Housing		6.02%	8
Caregiving		21.5%	28
Access to mental health services		7.52%	10
Access to medical health care		9.02%	12
Other (please specify)		5.26%	7
Answered	133		
Skipped	363		

23. Does this person you know receive the assistance to meet their needs?

Answer Choices	Responses	
Yes, go to question 25	55.35%	8
No, go to question 24	44.65%	71
Answered		159
Skipped		337

24. If assistance is needed, and they are not receiving it, is it because: (Mark all that apply)

Answer Choices	Responses	
They do not know what is available in our community	38.75%	31
They do not have family, friends, neighbors, or church support available	12.50%	10
They do not want to ask for help	50.00%	40
They are afraid to ask for help because someone may say they need to be in a facility	18.75%	15
They do not have enough money to pay for help	37.50%	30
They do not want to pay for help	15.00%	12

The help they need is not available in our area	3.75%	3
Other	6.25%	5
Other (please specify)		7
Answered	80	
Skipped	416	

25. If the person that you know needs assistance, is there someone they could call for help in getting that assistance? (Check all that apply)

Answer Choices	Responses	
Yes, a family member	44.68%	84
Yes, a friend or neighbor	14.36%	27
Yes, other	3.72%	7
Yes, medical provider	0.53%	1
Yes, Area Agency on Aging	7.45%	14
Yes, Clergy or church member	11.70%	22
No	17.55%	33
	Answered	188
	Skipped	308

26. Do you provide unpaid care for one or more family members or friends on a regular basis?

Answer Choices	Responses	
Yes-Go to question 27	17.75%	82
No-Go to question 30	82.25%	380
	Answered	462
	Skipped	34

27. Whom do you provide care for?

Answer Choices	Responses	
Spouse (wife/husband)	35.29%	36
Significant Other	0.98%	1
Parent (mother/father)	21.57%	22
At least one child	12.75%	13
Child(ren) and his/her/their family	1.96%	2
Other Relatives	8.82%	9
Unrelated adults/friends	16.67%	17
Grandchildren/Great-grandchildren	17.65%	18
Other (please specify)	4.90%	5
	Answered	102
	Skipped	394

28. How many hours per week do you spend providing care for this person or persons?

Answer Choices	Responses	
1-5 hours	40.00%	38
6-10 hours	8.42%	8
11-15 hours	4.21%	4
16-20 hours	3.16%	3
21-25 hours	10.53%	10
26-30 hours	5.26%	5
31-35 hours	2.11%	2
36-40 hours	6.32%	6
More than 40 hours	20.00%	19
	Answered	95
	Skipped	401

29. What kinds of assistance could you use more help in within your caregiving role?
(Check all that apply)

Answer Choices	Responses	
Organized support group	17.65%	9
Formal advice or emotional support (from a therapist, counselor, psychologist, psychiatrist, or family care physician) on issues such as caring for grandchildren and other caregiving issues	19.61%	10
Services such as respite care (a temporary break from caregiving)	27.45%	14
Communication tips for people with reduced mental function (i.e., dementia or Alzheimer's)	25.49%	13
Physical care assistance (lifting, diapering, transporting, cleaning)	7.84%	4
Obtaining equipment (such as walker, wheelchair, cane, shower chair, other assistive devices, etc.)	25.49%	13
Home modifications for safety (wheelchair ramp, grab bars, railings, etc.)	27.45%	14
How to take better care of your own health and well-being (Powerful Tools for Caregivers class)	19.61%	10
Medication Management	3.92%	2
	Answered	51
		44
	Skipped	5

30. How do you find out about community activities, events, and resources? (Check all that apply)

Answer Choices	Responses	
TV News	41.46%	170
TV Advertisements	18.29%	75
Newspaper	40.49%	166
Radio	15.37%	63
Internet	34.39%	141
Senior Publications (including senior center newsletters and organizations/club newsletters)	26.34%	108
Family, Friends, Neighbors, Church	64.88%	266
Facebook pages	29.27%	120
Other (please specify)	3.17%	13
	Answered	410
	Skipped	86

31. For most of your trips, how do you travel? (Select One)

Answer Choices	Responses	
Drive myself	57.42%	263
Ride with a family member or friend	30.13%	138
Walk	0.22%	1
Bike	0.22%	1
Use a volunteer service	0.22%	1
Public Transportation (PRT-Pocatello Regional Transit)	10.48%	48
Public Transportation (Lyft, Uber)	0.22%	1
Taxi	0.22%	1
Non-Emergency Medical Transportation	0.66%	3
Not applicable-I never leave the house	0.22%	1
	Answered	458
	Skipped	38

32. Within the last twelve months, have you used the Pocatello Regional Transit bus system? (Select all that apply)

Answer Choices	Responses	
Fixed Route (Arrive at a bus stop at a specific time)	6.07%	27
Paratransit within Pocatello or Chubbuck (Door to Door Service)	7.87%	35

Paratransit outside of the Pocatello or Chubbuck area (Door to Door Service)	5.39%	24
		36
Have not used the Pocatello Regional Transit bus system	82.92%	9
		44
	Answered	5
	Skipped	51

33. How often has it been difficult for you to arrange transportation for each of the following activities?

	Frequently		Sometimes		Never		Total
Medical trips	4.70%	19	18.81%	76	76.49%	309	404
Shopping	5.51%	22	15.79%	63	78.70%	314	399
Personal errands	4.88%	19	17.74%	69	77.38%	301	389
Recreational or social trips	5.99%	23	13.02%	50	80.99%	311	384
					Answered		411
					Skipped		85

34. When you have trouble getting the transportation you need, what would you say are the reasons? (Check all that apply)

Answer Choices	Responses	
I have to rely on others	31.07%	110
Weather	21.19%	75
Not available when I need to go	9.04%	32
Car doesn't work/Problems with vehicle	6.78%	24
Transportation does not go where I need to go	3.11%	11
Can't afford it	5.93%	21
Don't know who to call	2.54%	9
Disability or health reasons	13.28%	47
Not available in my community	0.85%	3
Too far/Distance related	3.95%	14
Have trouble getting around without someone to help	9.04%	32
Sidewalks are in poor condition or missing	5.37%	19
Not Applicable	44.63%	158
Other (please specify)	1.98%	7
	Answered	354
	Skipped	142

35. Do you use a computer at home?

Answer Choices	Responses	
Yes	59.18%	261
No	40.82%	180
	Answered	441
	Skipped	55

36. Do you send and receive email?

Answer Choices	Responses	
Yes	63.47%	278
No	36.53%	160
	Answered	438
	Skipped	58

37. Do you search the internet for information?

Answer Choices	Responses	
Yes	59.60%	270
No	40.40%	183
	Answered	453
	Skipped	43

38. Within the last 12 months-Have you utilized assistance or support from one or more of the following services the Area Agency on Aging is able to offer? (Mark all that apply)

Answer Choices	Responses	
Information and Assistance	13.22%	46
Long Term Care Ombudsman	1.44%	5
Veteran Support	6.90%	24
Senior Medicare Patrol-Help with Medicare questions	1.15%	4
Homemaker	9.48%	33
Respite Care	4.60%	16
Caregiver Support Program (Powerful Tools for Caregivers)	6.61%	23
Home Delivered Meals	49.71%	173
Congregate Meals/Curb-Side Meals	39.66%	138
Assistive Technology (Lending Closet)	1.72%	6
Legal Assistance	0.57%	2
Adult Protective Services	1.72%	6
Chronic Disease Health Management	3.74%	13
	Answered	348

39. Have you EVER utilized assistance or support from one or more of the following services the Area Agency on Aging is able to offer? (Mark all that apply)

Answer Choices	Responses
Information and Assistance	14.04% 50
Long Term Care Ombudsman	2.25% 8
Veteran Support	9.55% 34
Senior Medicare Patrol-Help with Medicare questions	1.97% 7
Homemaker	10.67% 38
Respite Care	4.78% 17
Caregiver Support Program (Powerful Tools for Caregivers)	7.58% 27
Home Delivered Meals	51.12% 182
Congregate Meals	39.89% 142
Assistive Technology (Lending Closet)	1.97% 7
Legal Assistance	2.53% 9
Adult Protective Services	2.25% 8
Chronic Disease Health Man	3.93% 14
	Answered 356
	Skipped 140

40. Do you go to your local senior center for meals or activities?

Answer Choices	Responses
Yes, Go to Question 41	42.70% 196
No, Go to Question 44	57.30% 263
	Answered 459
	Skipped 37

41. Which nutrition provider/senior center do you attend or receive meals from?

Answer Choices	Responses
Aberdeen Senior Center	0.51% 1
Bear Lake County Senior Center	3.54% 7
Bingham County Senior Center (Blackfoot)	9.60% 19

Caribou County Senior Center	13.13%	26
Curlew Valley Senior Center	6.57%	13
Franklin County Senior Center	2.53%	5
Greater Pocatello Senior Activity Center	25.76%	51
Lava Hot Springs Senior Center	2.53%	5
Oneida County Senior Center	14.14%	28
Power County Senior Center	11.11%	22
Shelley Senior Center (The Elite Retreat)	8.08%	16
SEICAA/Meals on Wheels)	4.55%	9
	Answered	198
	Skipped	298

42. What do you like most about the senior center?

Responses	
Answered	128
Skipped	368

Answers available upon request

43. Would you recommend the meal program to a friend?

Answer Choices	Responses	
Yes	94.87%	185
No	2.05%	4
Not Sure	3.08%	6
	Answered	195
	Skipped	301

44. If you do not go the senior center for meals or activities, why not?

Responses	
Answered	212
Skipped	284

Answers available upon request

45. Please tell us how you would respond to an emergency, such as a wild, earthquake, severe weather, or flood:

Answer Choices	Responses
In case of an emergency or disaster, have talked with doctor about an emergency back-up plan for any needed medical treatments, such as oxygen, dialysis, or chemotherapy	Yes 18.43% (75) No 81.57% (332) Total (407)
If you have a pet, Grab and Go Bag includes food and water for your pet	Yes 29.31% (114) No 70.69% (275) Total (389)
Grab and Go Bag includes water, medications, food that won't spoil, can opener, utensils, plate and cup, underwear and socks, wipes, flashlight and a radio with batteries	Yes 38.81% (156) No 61.19% (246) Total (402)
Signed up to receive Reverse 911 calls or emergency text message alerts from county Sheriff's Office or local public safety office	Yes 34.07% (139) No 65.93% (269) Total (408)
Supplies in Grab and Go Bag would last for at least three days	Yes 35.28% (139) No 64.72% (255) Total (394)
Keep a Grab and Go Bag ready to take with you if you need to evacuate	Yes 39.05% (157) No 60.95% (245) Total (402)
Have spoken with friends, family and/or neighbors about the help you might need, including the evacuation plans, if a disaster occurs	Yes 29.14% (118) No 70.86% (287) Total (405)
Keep a list of medications, emergency contacts and physicians in Grab and Go Bag or Operation Red File Folder	Yes 36.88% (149) No 63.12% (255) Total (404)
If ordered to evacuate, could leave home and travel to a safe place without help	Yes 63.20% (261) No 36.8% (152) Total (413)
	Answered 420 Skipped 76

46. Which services do you use now, and which services do you think you'll need to start using in the next 12 months?

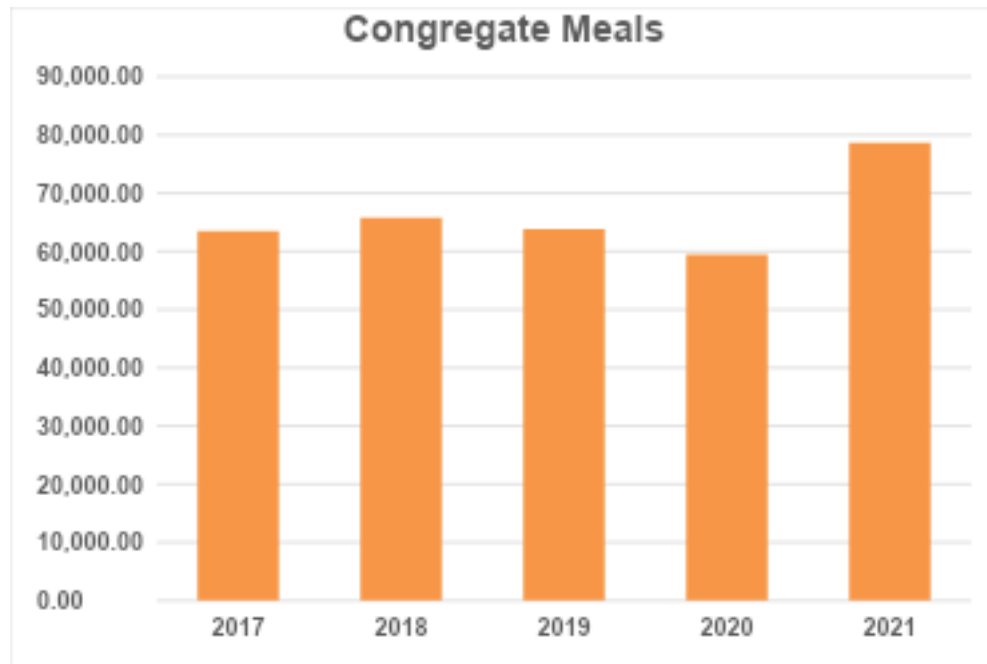
	<u>USE NOW</u>	<u>MAY START USING IN THE NEXT 12 MONTHS</u>	<u>MAY START USING IN THE NEXT 5 YEARS</u>	<u>TOTAL</u>
Meals delivered to my home	60.42% 174	9.03% 26	30.56% 88	288
A break from caregiving to take care of my own needs	34.09% 45	17.42% 23	48.48% 64	132
In-home care with personal care	38.95% 74	13.16% 25	47.89% 91	190
Help with Medicare options and issues	30.64% 53	23.12% 40	46.24% 80	173
Meals at a senior center	64.68% 163	12.70% 32	22.62% 57	252
In-home help with housekeeping	46.05% 99	25.12% 54	28.84% 62	215
Shuttle/bus to pick me up at home and take me to place I need to go	17.96% 30	27.54% 46	54.49% 91	167
Help with my caregiving role, i.e., counseling, caregiver training, support group	19.35% 24	15.32% 19	65.32% 81	124

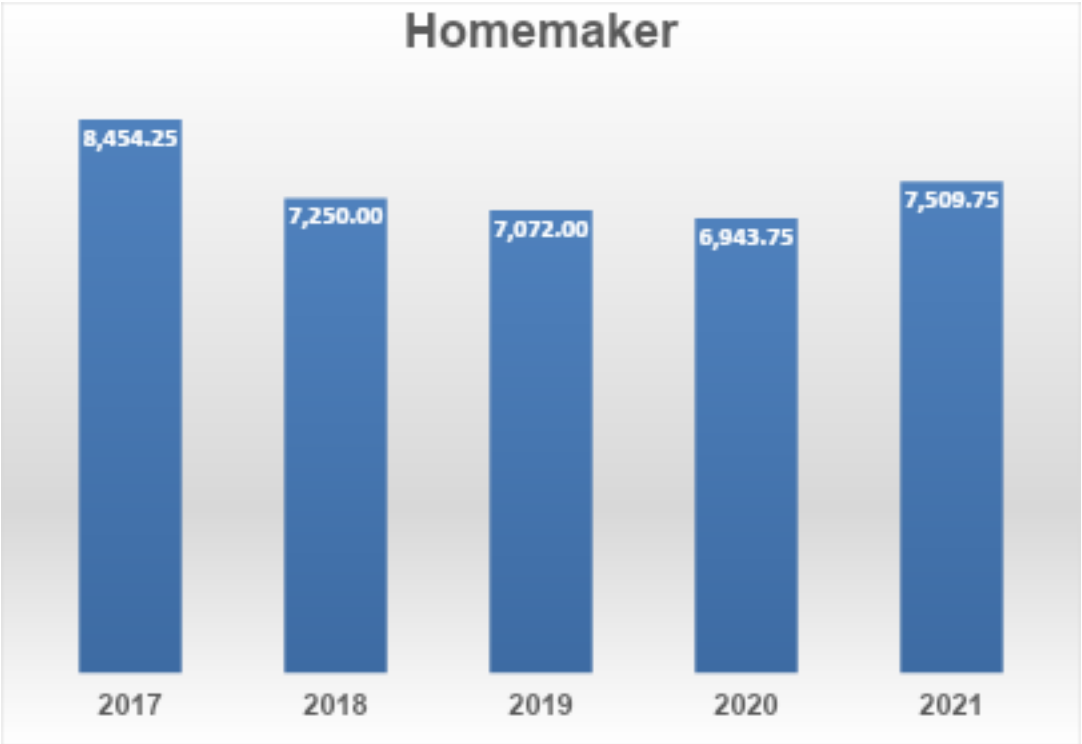
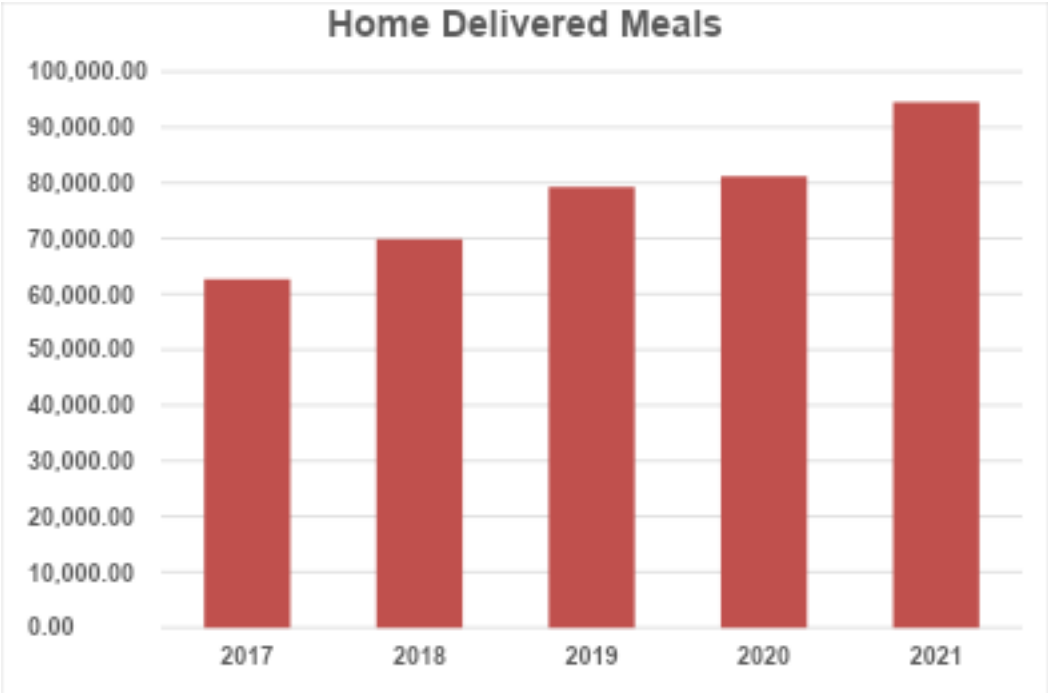
Answered
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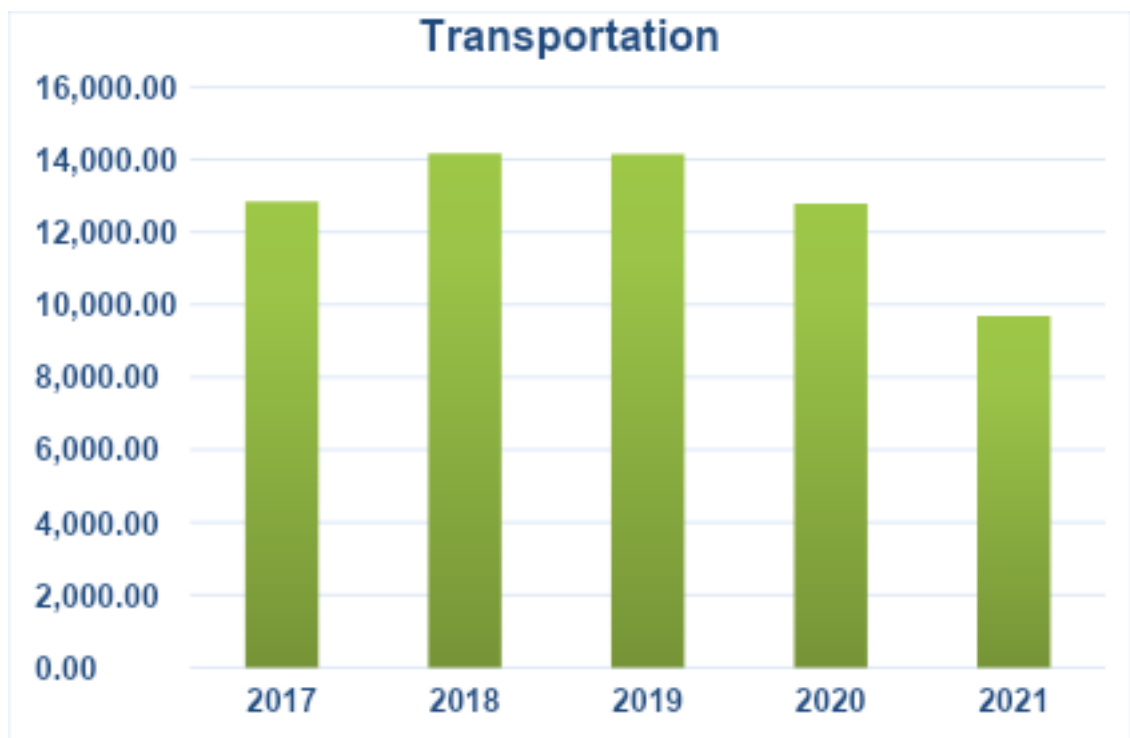
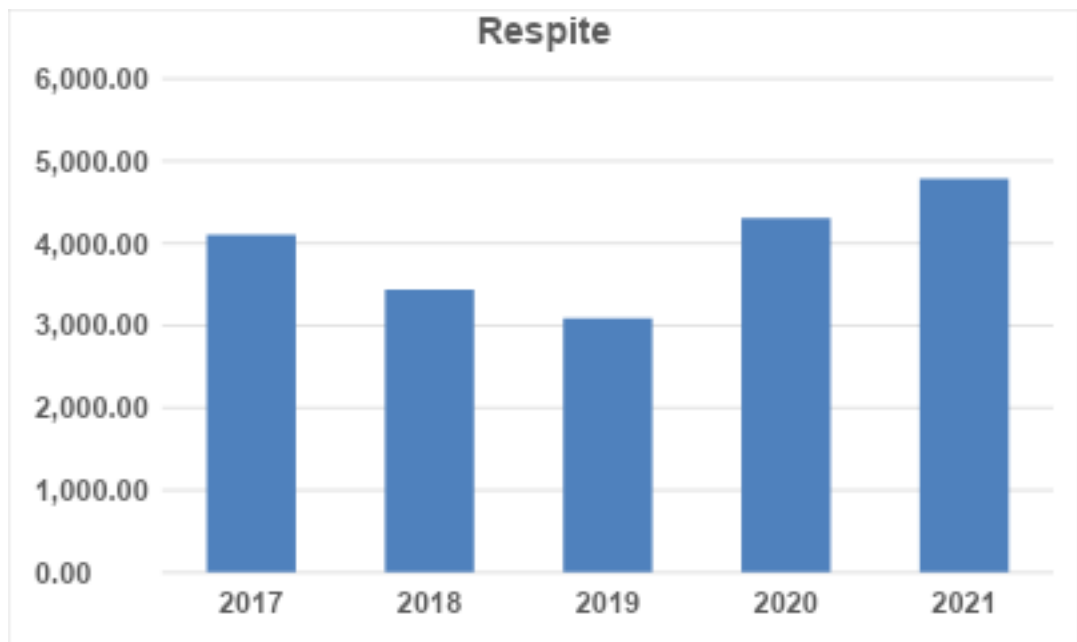
47. Other comments you would like to make?

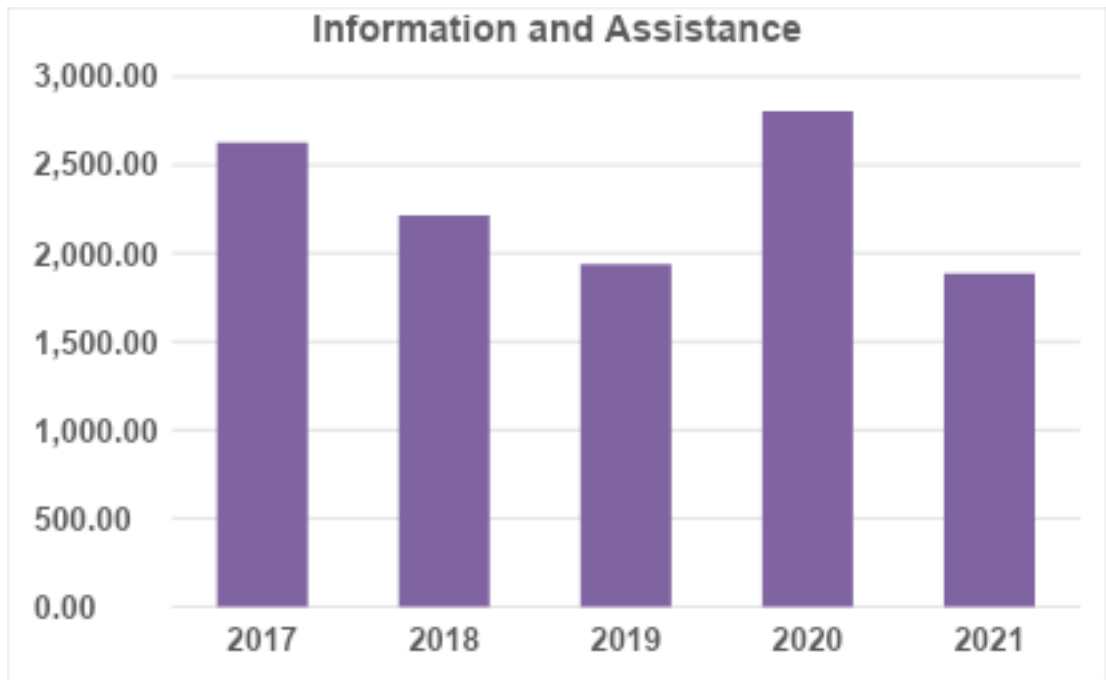
Answers available upon request

AAAV Service Unit History









Section 4 Strategic Plan

It is abundantly clear that as we have gone through this planning process that the opportunities for, building upon our current partnerships, forging new partnerships and cultivating our ability to collaborate with these partners will be key in meeting our goals. We see strengthening our current partnerships with some entities to foster new relationships. AAVV will continue to partner with the Southeast Idaho Public Health Department, United Way, findhelpidaho.org, justserve.org, the Shoshone Bannock Tribes, Health West, Community Family Clinic, Idaho State University, SHIBA and Life, Inc. AAVV also works collaboratively with the counties and cities located within our planning and service area as representatives from these areas make up the SICOG Board of Directors. This list is not a complete list of the partners we collaborate with but provides a firm base for us to strive to meet the needs of older adults in the Planning and Service Area of our region especially those who have greatest economic need. Many of these opportunities are identified in this section of the plan below.

Gap priorities: AAVV uncovered several gaps during the environmental scan of our region. To prioritize and address the gaps AAVV and our partners answered the following questions:

1. Does AAV have the capacity to address the identified gap?
2. Does the gap address a strategy focused on one or more of the most at-risk populations:
 - Older adults 65+ living in poverty
 - Older adults 65+ living alone
 - Aged 75+
 - Aged 85+
 - 60+ Racial Minority (Not Hispanic)
 - 60+ Hispanic
 - 60+ Living in a rural county
3. Does the gap align with AAV's mission, vision, and values?

AAA V Gaps identified:

- There is an increased demand in our region for Home Delivered Meals, Homemaker and Respite Care
- Social Isolation and loneliness are issues that need to be addressed
- There is a lack of volunteers to assist with and support the vision, mission and values of the services and programs of AAV
- AAV does not currently offer Chore, Home Modification or Case Management services
- Service Providers having a difficult time retaining staff in this job market thus not always able to take referrals from AAV
- From 2010 to 2019-the number of older adults in our PSA aged 65+ increased 32% from 19,968 top 26,346*
- From 2010 to 2019-the number of Hispanics in our PSA aged 60+ increased 61% from 2,281 to 3,665*
- From 2010 to 2019-the number of older adults 60+ that are considered a racial minority increased 32% from 2078 top 2739*
*Census data obtained from Idaho Department of Labor
- At-Risk Populations need to have focused outreach and messaging to increase their awareness and participation in services that are offered by the AAA and our providers
- Lack of knowledge about the services and programs offered by the AAA

Area Agency on Aging V's Mission, Vision, and Values

Mission: To provide a person-centered network of quality services and supports that empower, inspire, and educate older adults, persons with disabilities, vulnerable adults and family caregivers to maintain their independence, safety and quality of life in a setting of their choice.

Vision: To safeguard and support the independence of older adults, family caregivers and person with disabilities in Southeast Idaho.

Values:

Integrity: We build trust through transparent actions and honest relationships.

Respect: We value everyone and treat people with dignity and professionalism.

Accountability: Each of us is responsible for our words, our actions, and our results.

Teamwork: We achieve more when we collaborate and all work together as partners in the aging network.

Empathetic: We are kind and caring to everyone we encounter.

The strategies to address the prioritized gaps that were revealed during the AAA V planning process are listed below. This plan is ambitious and we appreciate the opportunity to use this plan to help ensure we are appropriating resources adequately and focusing on serving those at most need that reside in our planning and service area.

Universal Services

Goal: Investing in Healthy Aging

Objectives:

- To access reliable and trustworthy information, services and supports
- To stay active in the community
- To plan for our own independent living needs

1. Focus Area - Information and Assistance and Aging & Disability Resource Connection

General Eligibility:

- General public needing long-term care and/or caregiver information

Service Description:

- Provides individuals with Long-term Care information
- Prepares initial and annual eligibility assessments
- Links people to available services
- Ensures individuals receive services through follow up
- Manages registered clients

Universal Services Strategy 1.1 One outreach presentation and program sign up day at each of the designated focal points each year		
Prioritized Gap	Measurement	Time
<p>Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors; Increased need of knowledge of AAA and services/programs offered</p>	<p>Measurement Tool: Outreach Plan; GetCare report of registered consumers in rural areas</p> <p>Target: 11 Outreach sign-up days conducted annually; Increase rural seniors participating in Older Americans Act programs by 3% annually</p>	<p>Year 1: Establish Process and Schedule</p> <p>Year 2: 11 Focal Point visits conducted</p> <p>Year 3: 11 Focal Point visits conducted</p> <p>Year 4: 11 Focal Point visits conducted</p>

Universal Services Strategy 1.2 Provide targeted outreach to counties with the highest rate of individuals over the age of 75		
Prioritized Gap	Measurement	Time
<p>Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors; High risk for institutional placement</p>	<p>Measurement Tool: Census data; GetCare demographic report; outreach plan</p> <p>Target: Increase rural seniors aged 75+ participating in Older Americans Act programs by 3% annually</p>	<p>Year 1: Develop outreach plan and pilot new outreach materials</p> <p>Year 2: 2 focused outreach activities conducted in rural counties with highest percentage of older adults aged 75+</p> <p>Year 3: 3 focused outreach activities conducted in rural counties with highest percentage of older adults aged 75+</p> <p>Year 4: 4 focused outreach activities conducted in rural counties with highest percentage of older adults aged 75+</p>

2. Focus Area - Congregate Meals

General Eligibility

- Senior 60 years old and over and their spouses
- Adult with a disability under 60 living with an eligible person

Service Description:

- Prepare and serve meals in a congregate setting, which provide older persons with assistance in maintaining a well-balanced diet. The purpose is to reduce hunger and promote socialization.

Universal Services Strategy 2.1 Improve the overall quality of congregate meals to ensure satisfaction levels of participants remain high		
Prioritized Gap	Measurement	Time
Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors	Measurement Tool: Congregate participant satisfaction survey Target: Consumer satisfaction surveys will indicate at least a 90% positivity rate	Year 1: Establish quality assurance baselines Year 2: Implement and evaluate 2 nd satisfaction survey Year 3: Provide training to staff and site managers Year 4: Implement and evaluate 3 rd satisfaction survey

Universal Services Strategy 2.2 One outreach presentation and program sign up day at each of the designated focal points each year		
Prioritized Gap	Measurement	Time
Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors; Increased need of knowledge of AAA and services/programs offered	Measurement Tool: Outreach Plan; Target: 11 Outreach sign-up days conducted annually; Increase rural seniors participating in Older Americans Act programs by 3% annually	Year 1: Establish Process and Schedule Year 2: 11 Focal Point visits conducted Year 3: 11 Focal Point visits conducted Year 4: 11 Focal Point visits conducted

Universal Services Strategy 2.3 Develop materials focused on rural, minority, and culturally diverse populations for distribution to increase participation in congregate meals of consumers in our most at-risk populations		
Prioritized Gap	Measurement	Time

<p>Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors; Increase participation of 60+ racial minority</p>	<p>Measurement Tool: Census data; GetCare demographic report; outreach plan</p> <p>Target: Increase number of minority individuals participating in Older Americans Act programs by 3% annually</p>	<p>Year 1: Develop outreach plan and pilot new outreach materials</p> <p>Year 2: 1 focused outreach activities conducted in counties with the highest percentage of minority individuals</p> <p>Year 3: 2 focused outreach activities conducted in counties with the highest percentage of minority individuals</p> <p>Year 4: 3 focused outreach activities conducted in counties with the highest percentage of minority individuals</p>
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3. Focus Area - Disease Prevention and Health Promotions

General Eligibility:

- Senior 60 years old and over and their caregivers

Service Description:

- Workshops available that can provide us with the tools to:
 - o Establish our own support network
 - o Create our personalized action plan
 - o Learn relaxation and strategies to deal with pain, fatigue, and frustration
 - o Discover how nutrition can improve our health
 - o Develop an exercise program that works for us
 - o Understand new treatment choices
 - o Communicate effectively with our doctors and families about our health

Universal Services Strategy 3.1 Provide at least 1 CDSMP workshops at each of the AAV identified focal points over the 4-year plan time period

Prioritized Gap	Measurement	Time
<p>Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors; Increase participation of 60+ racial minority</p>	<p>Measurement Tool: Workshop Wizard</p> <p>Target: Number of workshops conducted annually</p>	<p>Year 1: Pilot 2 CDSMP workshops as identified AAV focal point expectations</p> <p>Year 2: Conduct 3 CDSMP workshops as identified AAV focal points expectations</p> <p>Year 3: Conduct 3 CDSMP workshops as identified AAV focal points expectations</p> <p>Year 4: Conduct 3 CDSMP workshops as identified AAV focal points expectations</p>

Universal Services Strategy 3.2 Promote and recruit lay leaders to teach CDSMP classes within our Planning and Service Area		
Prioritized Gap	Measurement	Time
<p>Gap: Lack of volunteers for programs/services offered by AAA V</p>	<p>Measurement Tool: Workshop Wizard</p> <p>Target: Number of lay leaders trained annually</p>	<p>Year 1: Promote and recruit lay leaders to teach the CDSMP classes in our region</p> <p>Year 2: Conduct Lay Leader training for CDSMP classes</p> <p>Year 3: Promote and recruit lay leaders to teach the CDSMP classes in our region</p> <p>Year 4: Conduct Lay Leader training for CDSMP classes</p>

Universal Services Strategy 3.3 One outreach presentation and program sign up day at each of the designated focal points each year		
Prioritized Gap	Measurement	Time
<p>Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors; Increased need of knowledge of AAA and services/programs offered</p>	<p>Measurement Tool: Outreach Plan;</p> <p>Target: 11 Outreach sign-up days conducted annually; Increase rural seniors participating in Older Americans Act programs by 3% annually</p>	<p>Year 1: Establish Process and Schedule</p> <p>Year 2: 11 Focal Point visits conducted</p> <p>Year 3: 11 Focal Point visits conducted</p> <p>Year 4: 11 Focal Point visits conducted</p>

4. Focus Area - Senior Medicare Patrol/MIPPA

SMP-General Eligibility:

- Medicare beneficiaries and their caregivers

Service Description:

- Education for Medicare and Medicaid beneficiaries to detect, report, and prevent health care fraud
- Train SMP staff and volunteers to conduct group education sessions, provide one-to-one counseling with Medicare beneficiaries, and hold regional Scam Jams

MIPPA-General Eligibility:

- Low-income Medicare beneficiaries

Service Description:

- Outreach in partnership with Idaho’s Department of Insurance State Health Insurance Benefit Advisors (SHIBA) to signup eligible beneficiaries for:
 - o Medicare Savings Programs (MSP)
 - o Low Income Subsidy (LIS)
 Medicare Part D and Prevention and Wellness benefits

Universal Services Strategy 4.1 One outreach presentation and program sign up day at each of the designated focal points each year		
Prioritized Gap	Measurement	Time
<p>Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors; Increased need of knowledge of AAA and services/programs offered</p>	<p>Measurement Tool: Outreach Plan;</p> <p>Target: 11 Outreach sign-up days conducted annually; Increase rural seniors participating in Older Americans Act programs by 3% annually</p>	<p>Year 1: Establish Process and Schedule</p> <p>Year 2: 11 Focal Point visits conducted</p> <p>Year 3: 11 Focal Point visits conducted</p> <p>Year 4: 11 Focal Point visits conducted</p>

Universal Services Strategy 4.2 Collaborate with Native American tribe located in our PSA region to promote MIPPA materials		
Prioritized Gap	Measurement	Time
<p>Gap: Native American</p>	<p>Measurement Tool: MIPPA Reporting Form</p> <p>Target: 2 outreach efforts with the Shoshone Bannock Tribes reported annually to grant</p>	<p>Year 1: 2 Native American MIPPA outreach events</p> <p>Year 2: 2 Native American MIPPA outreach events</p> <p>Year 3: 2 Native American MIPPA outreach events</p> <p>Year 4: 2 Native American MIPPA outreach events</p>

5. Focus Area – Loneliness Reduction/Multigenerational Socialization

Universal Services Strategy 5.1 Promote socialization activities offered at community focal points		
Prioritized Gap	Measurement	Time
<p>Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors; High risk for institutional placement</p>	<p>Measurement Tool: Facebook, Wordpress</p> <p>Target: Number of activities promoted via the AAA V Facebook page or the AAA V Website</p>	<p>Year 1: 1 activity a month promoted via AAA V Facebook page or AAA V website</p> <p>Year 2: 2 activities a month promoted via AAA V Facebook page or AAA V website</p> <p>Year 3: 2 activities a month promoted via AAA V Facebook page or AAA V website</p> <p>Year 4: 2 activities a month promoted via AAA V Facebook page or AAA V website</p>

Universal Services Strategy 5.2 Support the continued growth and expansion of PROAge connections including the friendly caller program		
Prioritized Gap	Measurement	Time

<p>Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors; High risk for institutional placement</p>	<p>Measurement Tool: GetCare report of friendly call tracking,</p> <p>Target: Number of consumers on the friendly caller list</p>	<p>Year 1: Addition of 10 older adults added to the PROAge Connection program and/or the AAA V friendly caller program</p> <p>Year 2: Addition of 12 older adults added to the PROAge Connection program and/or the AAA V friendly caller program</p> <p>Year 3: Addition of 15 older adults added to the PROAge Connection program and/or the AAA V friendly caller program</p> <p>Year 4: Addition of 20 older adults added to the PROAge Connection program and/or the AAA V friendly caller program</p>
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Universal Services Strategy 5.3 Promote and provide capacity building to all 11 focal points in our region in ensuring they offer at least 1 multigenerational activity to their consumers annually		
Prioritized Gap	Measurement	Time
<p>Gap: Combat social isolation Increased need of knowledge of AAA and services/programs offered</p>	<p>Measurement Tool: Focal Point reports to AAA</p> <p>Target: Number of multigenerational programs offered to consumers at one of the 11 focal points in our area</p>	<p>Year 1: 1 multigenerational programs initiated at each of the AAAV focal points</p> <p>Year 2: 1 multigenerational programs initiated at each of the AAAV focal points</p> <p>Year 3: 1 multigenerational programs initiated at each of the AAAV focal points</p> <p>Year 4: 1 multigenerational programs initiated at each of the AAAV focal points</p>

6. Focus Area - Outreach and Education

General Eligibility:

- General public needing supportive services and/or caregiver information

Service Description:

- Public Information
 - o Events, publications, campaigns, and other mass media activities targeting Supportive Services
- One-on-One Outreach
 - o Intervention with individuals initiated by an agency or organization for the purpose of identifying potential clients (or their caregivers)
- Caregiver Information Services
 - o Events, publications, campaigns and other mass media activities targeting Caregivers

Universal Services Strategy 6.1 Utilize social media to inform the community and aging network partners of upcoming events and campaigns that promote the activities of AAAV as well as ICOA		
Prioritized Gap	Measurement	Time
<p>Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors; Increased need of knowledge of AAA and services/programs offered</p>	<p>Measurement Tool: Facebook and Wordpress</p> <p>Target: Number of multigenerational programs offered to consumers at one of the 11 focal points in our area</p>	<p>Year 1: 1 activity a month promoted via AAA V Facebook page or AAA V website</p> <p>Year 2: 2 activities a month promoted via AAA V Facebook page or AAA V website</p> <p>Year 3: 2 activities a month promoted via AAA V Facebook page or AAA V website</p> <p>Year 4: 2 activities a month promoted via AAA V Facebook page or AAA V website</p>

Universal Services Strategy 6.2 One outreach presentation and program sign up day at each of the designated focal points each year		
Prioritized Gap	Measurement	Time
<p>Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors; Increased need of knowledge of AAA and services/programs offered</p>	<p>Measurement Tool: Outreach Plan</p> <p>Target: 11 Outreach sign-up days conducted annually; Increase rural seniors participating in Older Americans Act programs by 3% annually</p>	<p>Year 1: Establish Process and Schedule</p> <p>Year 2: 11 Focal Point visits conducted</p> <p>Year 3: 11 Focal Point visits conducted</p> <p>Year 4: 11 Focal Point visits conducted</p>

Targeted Services

Goal: Preventing Institutionalization

Objectives:

- To live as independently as possible
- To choose our own caregiver
- To provide caregiver training and resources

1. Focus Area - Family Caregivers/Respite/Grandparents raising grandchildren

General Eligibility:

- Caregivers and relatives as caregivers who are 55 or under 55 caregiving for an older person

Service Description:

- Support and train caregivers through the following activities:
 - o Information Services (Outreach & Education)
 - o Access assistance (Information & Assistance-telephone)
 - o Support Group/Training/Counseling
 - o Respite
 - o Supplemental Services (Limited basis)

Targeted Services Strategy 1.1 Increase Consumer Direct Respite participation in the rural areas of AAV		
Prioritized Gap	Measurement	Time
<p>Gap: Increase participation in rural area; Increased need of knowledge of AAA and services/programs offered; Caregiver Support</p>	<p>Measurement Tool: GetCare custom report; outreach plan</p> <p>Target: Number of consumer direct respite caregivers living in rural areas increases annually by 3% annually</p>	<p>Year 1: Increase of 3% annually the number of caregivers participating in the Consumer Direct Respite program</p> <p>Year 2: Increase of 3% annually the number of caregivers participating in the Consumer Direct Respite program</p> <p>Year 3: Increase of 3% annually the number of caregivers participating in the Consumer Direct Respite program</p> <p>Year 4: Increase of 3% annually the number of caregivers participating in the Consumer Direct Respite program</p>

Targeted Services Strategy 1.2 One outreach presentation and program sign up day at each of the designated focal points each year

Prioritized Gap	Measurement	Time
Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors	Measurement Tool: Outreach Plan Target: 11 Outreach sign-up days conducted annually; Increase rural seniors participating in Older Americans Act programs by 3% annually	Year 1: Establish Process and Schedule Year 2: 11 Focal Point visits conducted Year 3: 11 Focal Point visits conducted Year 4: 11 Focal Point visits conducted

Targeted Services Strategy 1.3 Partnering with the Shoshone Bannock Tribes to establish a grandparents raising grandchildren/kinship group

Prioritized Gap	Measurement	Time
Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors; Native Americans; Caregiver Support	Measurement Tool: Outreach Plan Target: A grandparents raising grandchildren/kinship group will be started	Year 1: Work with partners with the Shoshone Bannock Tribes to establish a grandparents raising grandchildren/kinship group committee to implement plan Year 2: Establish the grandparents raising grandchildren/kinship group with the Shoshone Bannock Tribes Year 3: Maintain and Sustain the grandparents raising grandchildren/kinship group Year 4: Maintain and Sustain the grandparents raising grandchildren/kinship group

Targeted Services Strategy 1.4 Promote and sustain Powerful tools for Caregivers classes in AAV region

Prioritized Gap	Measurement	Time
Gap: Combat social isolation; Increase participation in rural area; Increased need of knowledge of AAA and services/programs offered; Caregiver Support	Measurement Tool: Outreach plan Target: Number of workshops conducted annually	Year 1: Pilot 2 PTC classes as identified AAV focal points expectations Year 2: Conduct 3 PTC classes as identified AAV focal points expectations Year 3: Conduct 3 PTC classes as identified AAV focal points expectations Year 4: Conduct 3 PTC classes as identified AAV focal points expectations

2. Focus Area – Senior Transportation

General Eligibility:

- Seniors 60 years old and over who do not have personal transportation

Service Description:

- Service is in conjunction with local transportation providers
- Target: reduces isolation, and promotes independent living by providing transportation to:
 - o Medical and health care services
 - o Meal programs
 - o Employment locations
 - o Shopping and Community functions
 - o Adult Day Care facilities
 - o Social service agencies

Targeted Services Strategy 2.1 Promote transportation resources to seniors living alone, living in rural areas and seniors at risk for nursing home placement		
Prioritized Gap	Measurement	Time
<p>Gap: High risk for institutional placement; Increase participation in rural area; Combat social isolation</p>	<p>Measurement Tool: GetCare custom reports; outreach plan</p> <p>Target: Total number of boardings, Number of boardings in rural areas</p>	<p>Year 1: Develop marketing plan and materials for outreach</p> <p>Year 2: Implement marketing and outreach plan</p> <p>Year 3: Boardings of older adults utilizing PRT Door to Door service will increase 5% in rural areas of our planning and service area</p> <p>Year 4: Boardings of older adults utilizing PRT Door to Door service will increase 5% in rural areas of our planning and service area</p>

3. Focus Area - Home Delivered Meals/ Nutrition Services Incentive Program (NSIP)

HDM - General Eligibility:

- Assessment Required
 - o Senior 60 years and older
 - o Homebound
 - o Frail
 - o Unable to safely prepare a meal

Service Description:

- Provide a home delivered meal 5 or more days a week; may consist of hot, cold, frozen, dried, canned, fresh or supplemental foods

NSIP - General Eligibility:

- Participate in a Home Delivered/Congregate Meal Program
- Purchase domestically grown food
- Service Description:

This is an incentive program and funds are distributed based on the meals a site provided during the previous year

Targeted Services Strategy 3.1 Improve the overall quality of home delivered meals to ensure satisfaction levels of participants remain high		
Prioritized Gap	Measurement	Time
Gap: Combat social isolation; High risk for institutional placement; Increased demand for service	Measurement Tool: Home delivered meal participant survey Target: Consumer satisfaction surveys will indicate at least a 90% positivity rate	Year 1: Establish quality assurance baselines Year 2: Implement and evaluate 2 nd satisfaction survey Year 3: Provide training to staff and site managers Year 4: Implement and evaluate 3 rd satisfaction survey

Targeted Services Strategy 3.2 Develop materials focused on rural, minority, and culturally diverse populations for distribution to increase participation of consumers of home delivered meals in our most at-risk populations		
Prioritized Gap	Measurement	Time

<p>Gap: Combat social isolation; Increased demand for service; Increase participation in rural area; Increase participation of low-income seniors; Increase participation of 60+ racial minority; High risk for institutional placement</p>	<p>Measurement Tool: GetCare demographic reports; Outreach plan</p> <p>Target: Number of at-risk older adults participating in home delivered meals will increase 3% annually after the outreach plan is implemented</p>	<p>Year 1: Develop marketing materials and plan for dissemination</p> <p>Year 2: Distribute marketing materials focused on promoting the home delivered meal program among our most at risk populations</p> <p>Year 3: Number of low-income minority individuals, older adults in rural areas and older adults that live alone participating in the home delivered meal program will have a combined increase of at least 3% annually</p> <p>Year 4: Number of low-income minority individuals, older adults in rural areas and older adults that live alone participating in the home delivered meal program will have a combined increase of at least 3% annually</p>
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Targeted Services Strategy 3.3 Ensure program sustainability by initiating a prioritization process to ensure those at highest risk of facility placement will be eligible for the service, including low-income minorities, older adults in rural areas, and older adults that live alone		
Prioritized Gap	Measurement	Time
<p>Gap: Combat social isolation; Increased demand for service; Increase participation in rural area; Increase participation of low-income seniors; Increase participation of 60+ racial minority; High risk for institutional placement</p>	<p>Measurement Tool: GetCare demographic reports</p> <p>Target: Number of at-risk older adults receiving home delivered meals will increase 3% annually after prioritization tool is implemented</p>	<p>Year 1: Establish quality assurance baselines</p> <p>Year 2: w</p> <p>Year 3: Number of low-income minority individuals, older adults in rural areas and older adults that live alone participating in the home delivered meal program will have a combined increase of at least 3% annually</p> <p>Year 4: Number of low-income minority individuals, older adults in rural areas and older adults that live alone participating in the home delivered meal program will have a combined increase of at least 3% annually</p>

4. Focus Area - Commodity Supplement Food Program

General Eligibility:

- U.S. Department of Agriculture Grant

- o Individual 60 years of age or older
- o 130% of poverty
- o Resident of Idaho

Service Description:

In Partnership with The Idaho Foodbank

- To improve the health of seniors by supplementing their diets with a monthly nutritious food box that includes nutrition information and helpful recipes

Targeted Services Strategy 4.1 Coordinate an annual in-service for AAV staff and the AAV contracted nutrition providers with Idaho Food Bank on the CSFP		
Prioritized Gap	Measurement	Time
Gap: Increased need of knowledge of AAA and services/programs offered	Measurement Tool: Area Plan Quality Tool Target: Number of in-services/education opportunities	Year 1: 1 st in-service/education opportunity conducted Year 2: 2 nd in-service/education opportunity conducted Year 3: 3 rd in-service/education opportunity conducted Year 4: 4 th in-service/education opportunity conducted

Targeted Services Strategy 4.2 Share CSFP program information on the AAV website and Facebook page		
Prioritized Gap	Measurement	Time
Gap: Increased need of knowledge of AAA and services/programs offered	Measurement Tool: Facebook and Wordpress Target: Number of page views, clicked links; Number of social media posts will increase over baseline when set	Year 1: Develop website content and long-term plan of posts for Facebook Year 2: Set baselines for views and clicks of content Year 3: Increase in page views and clicks will increase at least 5% from baseline Year 4: Increase in page views and clicks will increase at least 10% from baseline

5. Focus Area - Homemaker

General Eligibility:

- Seniors 60 years and older that have physical barriers preventing them from maintaining a clean home environment
- Required Assessment:
 - o IADLs – Instruments of Activities of Daily Living; preparing a meal, able to drive, manage money, managing medication, shopping for food, doing laundry, housekeeping and using the telephone
 - o ADLs – Activities of Daily Living: help needed with eating, bathing, dressing, transferring, toileting, and walking or moving around

Targeted Services Strategy 5.1 Increase homemaker participation among seniors at risk for nursing home placement, including low-income minority individuals		
Prioritized Gap	Measurement	Time
Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors; Increased need of knowledge of AAA and services/programs offered	Measurement Tool: GetCare demographic reports; outreach plan Target: Number of at-risk seniors participating in the program will increase 5% annually	Year 1: Develop marketing plan & materials for focused outreach Year 2: Number of at-risk seniors participating in the program will increase 5% annually Year 3: Number of at-risk seniors participating in the program will increase 5% annually Year 4: Number of at-risk seniors participating in the program will increase 5% annually

Targeted Services Strategy 5.2 Incorporate consumer direct as a service model for homemaker service		
Prioritized Gap	Measurement	Time
Gap: Combat social isolation; Increase participation in rural area; Increase participation of low-income seniors	Measurement Tool: GetCare demographic reports; outreach plan Target: Number of consumers receiving consumer direct homemaker service	Year 1: Incorporate ICOA standards into AAV process and be prepared to implement service Year 2: Number of consumers receiving consumer direct homemaker service will increase 2% Year 3: Number of consumers receiving consumer direct homemaker service will increase 2% Year 4: Number of consumers receiving consumer direct homemaker service will increase 2%

6. Focus Area - Dementia Capable

General Eligibility:

- Competitive Three-year Grant: \$649,093
- Persons with Alzheimer’s disease and their caregivers

Service Description:

- Improving awareness, education, and direct services for people with dementia and their families

Targeted Services Strategy 6.1 Incorporate dementia training as a requirement for all AAA staff		
Prioritized Gap	Measurement	Time
<p>Gap: Increased need of knowledge of AAA and services/programs offered</p>	<p>Measurement Tool: AAA in-service record documentation</p> <p>Target: All AAA staff will be required to incorporate dementia training in their deliverables of their normal job duties</p>	<p>Year 1: Establish AAA V process of annual dementia training for all staff</p> <p>Year 2: All AAA staff will complete annual dementia training</p> <p>Year 3: All AAA staff will complete annual dementia training</p> <p>Year 4: All AAA staff will complete annual dementia training</p>

Targeted Services Strategy 6.2 Incorporate dementia training resources on the AAV website		
Prioritized Gap	Measurement	Time
<p>Gap: Increased need of knowledge of AAA and services/programs offered</p>	<p>Measurement Tool: Outreach plan</p> <p>Target: Dementia training available as a resource on the AAA V website</p>	<p>Year 1: Identify appropriate resources and links to be added to the AAV website</p> <p>Year 2: Dementia training and resources available on the AAV website</p> <p>Year 3: Dementia training and resources available on the AAV website</p> <p>Year 4: Dementia training and resources available on the AAV website</p>

Crisis Services

Goal: Preserving Rights & Safety

Objectives:

- To live without abuse, neglect and exploitation
- To live with dignity
- To make our own choices

1. Focus Area – Elder Rights and Legal Assistance

Adult Protective Services (APS)/Elder Rights - General Eligibility:

- Vulnerable adults age 18 and older (State Funded Program)

Service Description:

- Provide safety and protection to vulnerable adults
 - o Investigates allegations of abuse, neglect, exploitation
 - o Assists to reduce risk of harm
 - o Provide prevention education

Legal Assistance - General Eligibility:

- Low-income seniors 60 years old and over

Service Description:

- Legal assistance addresses issues related to:
 - o Income – Health care – Long-term care – Nutrition – Housing – Utilities – Protective services – Defense of guardianship – Abuse – Neglect – Age discrimination

Crisis Services Strategy 1.1 Promote legal risk detector tool on website and social media		
Prioritized Gap	Measurement	Time
Gap: Increased need of knowledge of AAA and services/programs offered	Measurement Tool: AAVV quality plan; GetCare referral report Target: Number of legal risk detector tool referrals in AAA V region will increase annually	Year 1: Set baseline numbers for referrals and ensure staff educated about documentation of referrals in GetCare Year 2: Number of legal risk detector tool referrals will increase 5% annually from baseline Year 3: Number of legal risk detector tool referrals will increase 5% annually from baseline Year 4: Number of legal risk detector tool referrals will increase 5% annually from baseline

Crisis Services Strategy 1.2 Expand the use of preventative programs. (Intervention Aid)		
Prioritized Gap	Measurement	Time

<p>Gap: High risk for institutional placement; Increased need of knowledge of AAA and services/programs offered</p>	<p>Measurement Tool: APS intervention aid semiannual reports</p> <p>Target: Number of individuals served under the APS Intervention Aid will increase annually</p>	<p>Year 1: Set baseline numbers for individuals served under the APS Intervention Aid program</p> <p>Year 2: Number of individuals served under the APS Intervention Aid will increase 5% annually from baseline</p> <p>Year 3: Number of individuals served under the APS Intervention Aid will increase 5% annually from baseline</p> <p>Year 4: Number of individuals served under the APS Intervention Aid will increase 5% annually from baseline</p>
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2. Focus Area - State and Local Ombudsmen

General Eligibility:

- Seniors 60 years old and older
- Resident in a facility

Service Description:

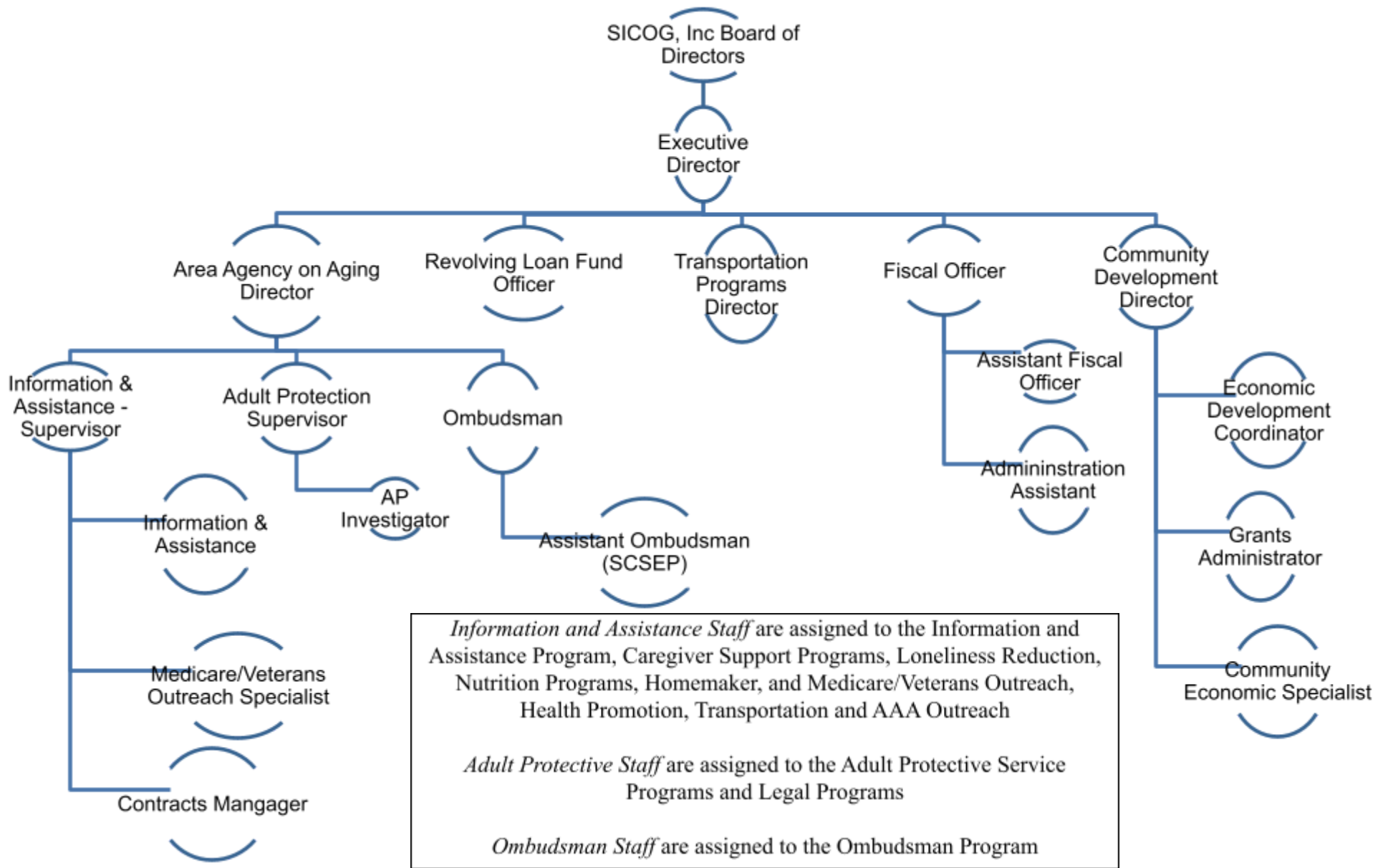
- Identify, investigate, and resolve complaints
- Protect resident health, safety, welfare, and rights
- Assist residents to obtain services
- Represent resident interests before agencies
- Provide technical assistance and monitor laws related to long term care
- Provide training

Crisis Services Strategy 2.1 Promote, Recruit and train volunteer Ombudsmen in AAA V region		
Prioritized Gap	Measurement	Time
<p>Gap: Lack of volunteers for programs/services offered by AAA V</p>	<p>Measurement Tool: Quarterly Ombudsman Report; AAA V quality plan</p> <p>Target: Number of Volunteer Ombudsman</p>	<p>Year 1: Develop plan to promote, recruit and train volunteer Ombudsmen in our region</p> <p>Year 2: Will have at least 2 volunteer ombudsmen trained in our region</p> <p>Year 3: Will increase the number of trained volunteer Ombudsmen in our region to 3</p> <p>Year 4: Will increase the number of trained volunteer Ombudsmen in our region to 4</p>

Crisis Services Strategy 2.2 Improve data tracking and documentation of complaints, quarterly facility visits and case documentation

Prioritized Gap	Measurement	Time
<p>Gap: Increased demand for service with population increase</p>	<p>Measurement Tool: Quarterly Ombudsman Report;</p> <p>Target: Tracking tool developed to assist with appropriate staffing model</p>	<p>Year 1: Get baseline information gathered as a pilot to determine appropriate staffing model</p> <p>Year 2: Use tool to determine staffing levels of program</p> <p>Year 3: Use tool to determine staffing levels of program</p> <p>Year 4: Use tool to determine staffing levels of program</p>

Section 5 Plan Execution



AAA V Area Plan Implementation Responsibility

Universal Services 1. Focus Area - Information and Assistance and Aging & Disability Resource Connection

Strategies	Measurement	Time	Responsible Party
<p>Universal Services Strategy 1.1 One outreach presentation and program sign up day at each of the designated focal points each year</p>	<p>Measurement Tool: Outreach Plan; GetCare report of registered consumers in rural areas</p> <p>Target: 11 Outreach sign-up days conducted annually; Increase rural seniors participating in Older Americans Act programs by 3% annually</p>	<p>Year 1: Establish Process and Schedule</p> <p>Year 2: 11 Focal Point visits conducted</p> <p>Year 3: 11 Focal Point visits conducted</p> <p>Year 4: 11 Focal Point visits conducted</p>	Information and Assistance Supervisor
<p>Universal Services Strategy 1.2 Provide targeted outreach to counties with the highest rate of individuals over the age of 75</p>	<p>Measurement Tool: Census data; GetCare demographic report; outreach plan</p> <p>Target: Increase rural seniors aged 75+ participating in Older Americans Act programs by 3% annually</p>	<p>Year 1: Develop outreach plan and pilot new outreach materials</p> <p>Year 2: 2 focused outreach activities conducted in rural counties with highest percentage of older adults aged 75+</p> <p>Year 3: 3 focused outreach activities conducted in rural counties with highest percentage of older adults aged 75+</p> <p>Year 4: 4 focused outreach activities conducted in rural counties with highest percentage of older adults aged 75+</p>	Information and Assistance Supervisor

Universal Services 2. Focus Area - Congregate Meals

Strategies	Measurement	Time	Responsible Party
<p>Universal Services Strategy 2.1 Improve the overall quality of congregate meals</p>	<p>Measurement Tool: Congregate participant satisfaction survey</p> <p>Target: Consumer satisfaction surveys will indicate at least a 90% positivity rate</p>	<p>Year 1: Establish quality assurance baselines</p> <p>Year 2: Implement and evaluate 2nd satisfaction survey</p> <p>Year 3: Provide training to staff and site managers</p> <p>Year 4: Implement and evaluate 3rd satisfaction survey</p>	<p>Contracts Manager</p>
<p>Universal Services Strategy 2.2 One outreach presentation and program sign up day at each of the designated focal points each year</p>	<p>Measurement Tool: Outreach Plan;</p> <p>Target: 11 Outreach sign-up days conducted annually; Increase rural seniors participating in Older Americans Act programs by 3% annually</p>	<p>Year 1: Establish Process and Schedule</p> <p>Year 2: 11 Focal Point visits conducted</p> <p>Year 3: 11 Focal Point visits conducted</p> <p>Year 4: 11 Focal Point visits conducted</p>	<p>Information and Assistance Supervisor</p>
<p>Universal Services Strategy 2.3 Develop materials focused on rural, minority, and culturally diverse populations for distribution to increase participation of consumers in our most at-risk populations</p>	<p>Measurement Tool: Census data; GetCare demographic report; outreach plan</p> <p>Target: Increase number of minority individuals participating in Older Americans Act programs by 3% annually</p>	<p>Year 1: Develop outreach plan and pilot new outreach materials</p> <p>Year 2: 1 focused outreach activities conducted in counties with the highest percentage of minority individuals</p> <p>Year 3: 2 focused outreach activities conducted in counties with the highest percentage of minority individuals</p> <p>Year 4: 3 focused outreach activities conducted in counties with the highest percentage of minority individuals</p>	<p>Contracts Manager</p>

Universal Services 3. Focus Area Disease Prevention and Health Promotions

Strategies	Measurement	Time	Responsible Party
<p>Universal Services Strategy 3.1 Provide at least 1 CDSMP workshops at the AAV identified focal points over the 4-year plan time period</p>	<p>Measurement Tool: Workshop Wizard</p> <p>Target: Number of workshops conducted annually</p>	<p>Year 1: Pilot 2 CDSMP workshops as identified AAV focal point expectations</p> <p>Year 2: Conduct 3 CDSMP workshops as identified AAV focal points expectations</p> <p>Year 3: Conduct 3 CDSMP workshops as identified AAV focal points expectations</p> <p>Year 4: Conduct 3 CDSMP workshops as identified AAV focal points expectations</p>	Information and Assistance Supervisor
<p>a. Recruit lay leaders to teach classes within our PSA</p>	<p>Measurement Tool: Workshop Wizard</p> <p>Target: Number of lay leaders trained annually</p>	<p>Year 1: Promote and recruit lay leaders to teach the CDSMP classes in our region</p> <p>Year 2: Conduct Lay Leader training for CDSMP classes</p> <p>Year 3: Promote and recruit lay leaders to teach the CDSMP classes in our region</p> <p>Year 4: Conduct Lay Leader training for CDSMP classes</p>	Information and Assistance Supervisor
<p>Universal Services Strategy 3.3 One outreach presentation and program sign up day at each of the designated focal points each year</p>	<p>Measurement Tool: Outreach Plan;</p> <p>Target: 11 Outreach sign-up days conducted annually; Increase rural seniors participating in Older Americans Act programs by 3% annually</p>	<p>Year 1: Establish Process and Schedule</p> <p>Year 2: 11 Focal Point visits conducted</p> <p>Year 3: 11 Focal Point visits conducted</p> <p>Year 4: 11 Focal Point visits conducted</p>	Information and Assistance Supervisor

Universal Services 4. Focus Area - Senior Medicare Patrol/MIPPA

Strategies	Measurement	Time	Responsible Party
Universal Services Strategy 4.1 One outreach presentation and program sign up day at each of the designated focal points each year	Measurement Tool: Outreach Plan; Target: 11 Outreach sign-up days conducted annually; Increase rural seniors participating in Older Americans Act programs by 3% annually	Year 1: Establish Process and Schedule Year 2: 11 Focal Point visits conducted Year 3: 11 Focal Point visits conducted Year 4: 11 Focal Point visits conducted	Medicare Outreach Specialist
Universal Services Strategy 4.2. Collaborate with Native American groups located in our PSA region to promote MIPPA materials	Measurement Tool: MIPPA Reporting Form Target: 2 outreach efforts with the Shoshone Bannock Tribes reported annually to grant	Year 1: 2 Native American MIPPA outreach events Year 2: 2 Native American MIPPA outreach events Year 3: 2 Native American MIPPA outreach events Year 4: 2 Native American MIPPA outreach events	Medicare Outreach Specialist

Universal Services 5. Focus Area – Loneliness Reduction/Multigenerational Socialization

Strategies	Measurement	Time	Responsible Party
Universal Services Strategy 5.1 Promote socialization activities offered at community focal points	Measurement Tool: Facebook, Wordpress Target: Number of activities promoted via the AAA V Facebook page or the AAA V Website	Year 1: 1 activity a month promoted via AAA V Facebook page or AAA V website Year 2: 2 activities a month promoted via AAA V Facebook page or AAA V website Year 3: 2 activities a month promoted via AAA V Facebook page or AAA V website Year 4: 2 activities a month promoted via AAA V Facebook page or AAA V website	Information and Assistance Supervisor

<p>Universal Services Strategy 5.2. Support the continued growth and expansion of PROAge connections</p>	<p>Measurement Tool: GetCare report of friendly call tracking,</p> <p>Target: Number of consumers on the friendly caller list</p>	<p>Year 1: Addition of 10 older adults added to the PROAge Connection program and/or the AAA V friendly caller program</p> <p>Year 2: Addition of 12 older adults added to the PROAge Connection program and/or the AAA V friendly caller program</p> <p>Year 3: Addition of 15 older adults added to the PROAge Connection program and/or the AAA V friendly caller program</p> <p>Year 4: Addition of 20 older adults added to the PROAge Connection program and/or the AAA V friendly caller program</p>	<p>Information and Assistance Supervisor</p>
<p>Universal Services Strategy 5.3 Promote and provide capacity building to all 11 focal points in our region in ensuring they offer at least 4 multigenerational activities to their consumers</p>	<p>Measurement Tool: Focal Point reports to AAA</p> <p>Target: Number of multigenerational programs offered to consumers at one of the 11 focal points in our area</p>	<p>Year 1: 1 multigenerational programs initiated at each of the AAAV focal points</p> <p>Year 2: 1 multigenerational programs initiated at each of the AAAV focal points</p> <p>Year 3: 1 multigenerational programs initiated at each of the AAAV focal points</p> <p>Year 4: 1 multigenerational programs initiated at each of the AAAV focal points</p>	<p>Information and Assistance Supervisor</p>

Universal Services 6. Focus Area - Outreach and Education

Strategies	Measurement	Time	Responsible Party
<p>Universal Services Strategy 6.1 Utilize social media to inform the community and aging network partners of upcoming events and campaigns that promote the activities of AAAV as well as ICOA</p>	<p>Measurement Tool: Facebook and Wordpress</p> <p>Target: Number of multigenerational programs offered to consumers at one of the 11 focal points in our area</p>	<p>Year 1: 1 activity a month promoted via AAA V Facebook page or AAA V website</p> <p>Year 2: 2 activities a month promoted via AAA V Facebook page or AAA V website</p> <p>Year 3: 2 activities a month promoted via AAA V Facebook page or AAA V website</p> <p>Year 4: 2 activities a month promoted via AAA V Facebook page or AAA V website</p>	Information and Assistance Supervisor
<p>Universal Services Strategy 6.2 One outreach presentation and program sign up day at each of the designated focal points each year</p>	<p>Measurement Tool: Outreach Plan</p> <p>Target: 11 Outreach sign-up days conducted annually; Increase rural seniors participating in Older Americans Act programs by 3% annually</p>	<p>Year 1: Establish Process and Schedule</p> <p>Year 2: 11 Focal Point visits conducted</p> <p>Year 3: 11 Focal Point visits conducted</p> <p>Year 4: 11 Focal Point visits conducted</p>	Information and Assistance Supervisor

Targeted Programs 1. Focus Area – Family Caregivers/Respite/Grandparents raising Grandchildren

Strategies	Measurement	Time	Responsible Party
<p>Targeted Services Strategy 1.1 Increase Consumer Direct Respite in the rural areas of AAV</p>	<p>Measurement Tool: GetCare custom report; outreach plan</p> <p>Target: Number of consumer direct respite caregivers living in rural areas increases annually by 3% annually</p>	<p>Year 1: Increase of 3% annually the number of caregivers participating in the Consumer Direct Respite program</p> <p>Year 2: Increase of 3% annually the number of caregivers participating in the Consumer Direct Respite program</p> <p>Year 3: Increase of 3% annually the number of caregivers participating in the Consumer Direct Respite program</p> <p>Year 4: Increase of 3% annually the number of caregivers participating in the Consumer Direct Respite program</p>	<p>Information and Assistance Supervisor</p>
<p>Targeted Services Strategy 1.2 One outreach presentation and program sign up day at each of the designated focal points each year</p>	<p>Measurement Tool: Outreach Plan</p> <p>Target: 11 Outreach sign-up days conducted annually; Increase rural seniors participating in Older Americans Act programs by 3% annually</p>	<p>Year 1: Establish Process and Schedule</p> <p>Year 2: 11 Focal Point visits conducted</p> <p>Year 3: 11 Focal Point visits conducted</p> <p>Year 4: 11 Focal Point visits conducted</p>	<p>Information and Assistance Supervisor</p>
<p>Targeted Services Strategy 1.3 Partnering with the Shoshone Bannock Tribes to establish a grandparents raising grandchildren-kinship group</p>	<p>Measurement Tool: Outreach Plan</p> <p>Target: A grandparents raising grandchildren/kinship group will be started</p>	<p>Year 1: Work with partners with the Shoshone Bannock Tribes to establish a grandparents raising grandchildren/kinship group committee to implement plan</p> <p>Year 2: Establish the grandparents raising grandchildren/kinship group with the Shoshone Bannock Tribes</p> <p>Year 3: Maintain and Sustain the grandparents raising grandchildren/kinship group</p> <p>Year 4: Maintain and Sustain the grandparents raising grandchildren/kinship group</p>	<p>Information and Assistance Supervisor and AAA Director</p>

<p>Targeted Services Strategy 1.4 Promote and sustain Powerful tools for Caregivers classes in AAV region</p>	<p>Measurement Tool: Outreach plan</p> <p>Target: Number of workshops conducted annually</p>	<p>Year 1: Pilot 2 PTC classes as identified AAV focal points expectations</p> <p>Year 2: Conduct 3 PTC classes as identified AAV focal points expectations</p> <p>Year 3: Conduct 3 PTC classes as identified AAV focal points expectations</p> <p>Year 4: Conduct 3 PTC classes as identified AAV focal points expectations</p>	<p>Information and Assistance Supervisor</p>
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Targeted Programs 2. Focus Area - Senior Transportation

Strategies	Measurement	Time	Responsible Party
<p>Targeted Services Strategy 2.1 Promote transportation resources to seniors living alone, living in rural areas and seniors at risk for nursing home placement</p>	<p>Measurement Tool: GetCare custom reports; outreach plan</p> <p>Target: Total number of boardings, Number of boardings in rural areas</p>	<p>Year 1: Develop marketing plan and materials for outreach</p> <p>Year 2: Implement marketing and outreach plan</p> <p>Year 3: Boardings of older adults utilizing PRT Door to Door service will increase 5% in rural areas of our planning and service area</p> <p>Year 4: Boardings of older adults utilizing PRT Door to Door service will increase 5% in rural areas of our planning and service area</p>	<p>Contracts Manager</p>

Targeted Programs 3. Focus Area - Home Delivered Meals/ Nutrition Services Incentive Program (NSIP)

Strategies	Measurement	Time	Responsible Party
<p>Targeted Services Strategy 3.1 Improve the overall quality of the meals served to consumers</p>	<p>Measurement Tool: Home delivered meal participant survey Target: Satisfaction surveys will indicate at least a 90% positivity rate</p>	<p>Year 1: Establish quality assurance baselines Year 2: Implement and evaluate 2nd satisfaction survey Year 3: Provide training to staff and site managers Year 4: Implement and evaluate 3rd satisfaction survey</p>	Contracts Manager
<p>Targeted Services Strategy 3.2 Develop materials focused on rural, minority, and culturally diverse populations for distribution to increase participation of consumers in our most at-risk populations</p>	<p>Measurement Tool: GetCare demographic reports Target: Number of at-risk older adults receiving home delivered meals will increase 3% annually after prioritization tool is implemented</p>	<p>Year 1: Establish quality assurance baselines Year 2: Number of low-income minority individuals, older adults in rural areas and older adults that live alone participating in the home delivered meal program will have a combined increase of at least 3% annually Year 3: Number of low-income minority individuals, older adults in rural areas and older adults that live alone participating in the home delivered meal program will have a combined increase of at least 3% annually Year 4: Number of low-income minority individuals, older adults in rural areas and older adults that live alone participating in the home delivered meal program will have a combined increase of at least 3% annually</p>	Contracts Manager
<p>Targeted Services Strategy 3.3 Ensure program sustainability by initiating a prioritization process to ensure those at highest risk of facility placement will be eligible for the</p>	<p>Measurement Tool: GetCare demographic reports; Outreach plan Target: Number of at-risk older</p>	<p>Year 1: Develop marketing materials and plan for dissemination Year 2: Distribute marketing materials focused on promoting the home delivered meal program among our most at risk populations Year 3: Number of low-income minority individuals, older adults in rural areas and</p>	Contracts Manager and AAA Director

service, including low income minorities, older adults in rural areas, and older adults that live alone	adults participating in home delivered meals will increase 3% annually after the outreach plan is implemented	older adults that live alone participating in the home delivered meal program will have a combined increase of at least 3% annually Year 4: Number of low-income minority individuals, older adults in rural areas and older adults that live alone participating in the home delivered meal program will have a combined increase of at least 3% annually	
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Targeted Programs 4. Focus Area - Commodity Supplement Food Program

Strategies	Measurement	Time	Responsible Party
Targeted Services Strategy 4.1 Coordinate an annual in-service for AAV staff and the AAV contracted nutrition providers with Idaho Food Bank on the CSFP	Measurement Tool: Area Plan Quality Tool Target: Number of in-services/education opportunities	Year 1: 1 st in-service/education opportunity conducted Year 2: 2 nd in-service/education opportunity conducted Year 3: 3 rd in-service/education opportunity conducted Year 4: 4 th in-service/education opportunity conducted	Contracts Manager
Targeted Services Strategy 4.2. Share CSFP program information on the AAV website and Facebook page	Measurement Tool: Facebook and Wordpress Target: Number of page views, clicked links; Number of social media posts will increase over baseline when set	Year 1: Develop website content and long-term plan of posts for Facebook Year 2: Set baselines for views and clicks of content Year 3: Increase in page views and clicks will increase at least 5% from baseline Year 4: Increase in page views and clicks will increase at least 10% from baseline	Contracts Manager

Targeted Programs 5. Focus Area - Homemaker

Strategies	Measurement	Time	Responsible Party
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<p>Targeted Services Strategy 5.1 Increase homemaker participation among seniors at risk for nursing home placement, including low-income minority individuals, older adults aged 75+, and older adults in rural areas of our PSA</p>	<p>Measurement Tool: GetCare demographic reports; outreach plan</p> <p>Target: Number of at-risk seniors participating in the program will increase 5% annually</p>	<p>Year 1: Develop marketing plan & materials for focused outreach</p> <p>Year 2: Number of at-risk seniors participating in the program will increase 5% annually</p> <p>Year 3: Number of at-risk seniors participating in the program will increase 5% annually</p> <p>Year 4: Number of at-risk seniors participating in the program will increase 5% annually</p>	<p>Information and Assistance Supervisor</p>
<p>Targeted Services Strategy 5.2 Incorporate consumer direct as a service model for homemaker service</p>	<p>Measurement Tool: GetCare demographic reports; outreach plan</p> <p>Target: Number of consumers receiving consumer direct homemaker service</p>	<p>Year 1: Incorporate ICOA standards into AAV process and be prepared to implement service</p> <p>Year 2: Number of consumers receiving consumer direct homemaker service will increase 2%</p> <p>Year 3: Number of consumers receiving consumer direct homemaker service will increase 2%</p> <p>Year 4: Number of consumers receiving consumer direct homemaker service will increase 2%</p>	<p>Information and Assistance Supervisor</p>

Targeted Programs 6. Focus Area - Dementia Capable

Strategies	Measurement	Time	Responsible Party
<p>Targeted Services Strategy 6.1 Incorporate dementia training as a requirement for all AAA staff</p>	<p>Measurement Tool: AAA in-service record documentation</p> <p>Target: All AAA staff will be required to incorporate dementia training in their deliverables of their normal job duties</p>	<p>Year 1: Establish AAA V process of annual dementia training for all staff</p> <p>Year 2: All AAA staff will complete annual dementia training</p> <p>Year 3: All AAA staff will complete annual dementia training</p> <p>Year 4: All AAA staff will complete annual dementia training</p>	<p>Information and Assistance Supervisor</p>

<p>Targeted Services Strategy 6.2 Incorporate dementia training resources on the AAV website</p>	<p>Measurement Tool: Outreach plan</p> <p>Target: Dementia training available as a resource on the AAA V website</p>	<p>Year 1: Identify appropriate resources and links to be added to the AAV website</p> <p>Year 2: Dementia training and resources available on the AAV website</p> <p>Year 3: Dementia training and resources available on the AAV website</p> <p>Year 4: Dementia training and resources available on the AAV website</p>	<p>Information and Assistance Supervisor</p>
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Crisis Services 1. Focus Area – Elder Rights and Legal Assistance

Strategies	Measurement	Time	Responsible party
<p>Crisis Services Strategy 1.1 Promote legal risk detector tool on website and social media</p>	<p>Measurement Tool: AAAV quality plan; GetCare referral report</p> <p>Target: Number of legal risk detector tool referrals in AAA V region will increase annually</p>	<p>Year 1: Set baseline numbers for referrals and ensure staff educated about documentation of referrals in GetCare</p> <p>Year 2: Number of legal risk detector tool referrals will increase 5% annually from baseline</p> <p>Year 3: Number of legal risk detector tool referrals will increase 5% annually from baseline</p> <p>Year 4: Number of legal risk detector tool referrals will increase 5% annually from baseline</p>	<p>Adult Protective Service Supervisor</p>
<p>Crisis Services Strategy 1.2 Expand the use of preventative programs. (Intervention Aid)</p>	<p>Measurement Tool: APS intervention aid semiannual reports</p> <p>Target: Number of individuals served under the APS Intervention Aid will increase annually</p>	<p>Year 1: Set baseline numbers for individuals served under the APS Intervention Aid program</p> <p>Year 2: Number of individuals served under the APS Intervention Aid will increase 5% annually from baseline</p>	<p>Adult Protective Service Supervisor</p>

		<p>Year 3: Number of individuals served under the APS Intervention Aid will increase 5% annually from baseline</p> <p>Year 4: Number of individuals served under the APS Intervention Aid will increase 5% annually from baseline</p>	
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Crisis Services 2. Focus Area - State and Local Ombudsmen

Strategies	Measurement	Time	Responsible party
<p>Crisis Services Strategy 2.1 Promote, Recruit and train volunteer Ombudsman in AAA V region</p>	<p>Measurement Tool: Quarterly Ombudsman Report; AAA V quality plan</p> <p>Target: Number of Volunteer Ombudsman</p>	<p>Year 1: Develop plan to promote, recruit and train volunteer Ombudsmen in our region</p> <p>Year 2: Will have at least 2 volunteer ombudsmen trained in our region</p> <p>Year 3: Will increase the number of trained volunteer Ombudsmen in our region to 3</p> <p>Year 4: Will increase the number of trained volunteer Ombudsmen in our region to 4</p>	Ombudsman
<p>Crisis Services Strategy 2.2 Improve data tracking and documentation of complaints, quarterly facility visits and case documentation</p>	<p>Measurement Tool: Quarterly Ombudsman Report;</p> <p>Target: Tracking tool developed to assist with appropriate staffing model</p>	<p>Year 1: Get baseline information gathered as a pilot to determine appropriate staffing model</p> <p>Year 2: Use tool to determine staffing levels of program</p> <p>Year 3: Use tool to determine staffing levels of program</p>	Ombudsman

		Year 4: Use tool to determine staffing levels of program	
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Section 6: Continuous Quality

AAAV strives to ensure that our 4-Year area plan is crafted to serve older individuals who have the greatest economic need including low-income minority older individuals, older individuals with limited English proficiency, and individuals residing in rural areas. Additionally, we aim to serve individuals who have great social need with particular attention to low-income older adults, including low-income minority older individuals, older individuals with limited English proficiency, and individuals residing in rural areas. Lastly we aim to serve older adults at risk for institutional placement. Section 4 of this area plan covers our strategies which promotes emphasis on serving the most at-risk populations in our region. Our data Integrity plan and quality assurance plan addresses how we will continually remain focused on ensuring our strategies are meeting their mark as a guide to serving the most at-risk populations of older adults in the planning and service area we cover.

Data Integrity Plan: AAAV has established a process to ensure data is being entered properly and consistently. Staff person responsible listed in the data integrity plan will pull reports in an appropriate time frame that is in accordance with the program deliverables. AAAV Director will review program reports at least quarterly as a quality assurance measure and will adjust plan when appropriate.

Continuous Quality-Data Integrity Plan:

Focus Area/Program	Source/Report	Name/Type of Report	Staff Person Responsible
Information and Assistance/ADRC	GetCare	Call Summary Report;	I & A Supervisor
Congregate Meals	GetCare, Survey Monkey	Number of consumers; Utilization of service; Target Population demographic information	Contracts Manager
Health Promotion	Workshop Wizard, GetCare	Number of classes; number of participants starting classes;	I & A Supervisor

		number of participants that finished classes	
MIPPA/SMP	SHIBA reports	Number of 1:1 contacts; number of education sessions; number of LIS applications assisted with	I & A Supervisor
Loneliness Reduction/ Multigenerational Socialization	GetCare, internal spreadsheets	Number of postcards delivered; number of electronic pets delivered; Number of friendly calls made	I & A Supervisor
Family Caregiver/Respite/ Grandparents raising grandchildren	GetCare, Internal spreadsheets	Number of consumers; Utilization of service; Target Population demographic information	Contracts Manager and I & A Supervisor
Transportation	GetCare	Number of trips recorded	Contracts Manager
Home Delivered Meals/NSIP	GetCare, Survey Monkey	Number of consumers; Utilization of service; Target Population demographic information	Contracts Manager
Commodity Supplemental Food Program		Number of older adults receiving food boxes	Contracts Manager
Homemaker	GetCare	Number of consumers; Utilization of service; Target Population demographic information	Contracts Manager
Dementia Capability			I & A Supervisor
Elder Rights and Legal Assistance	GetCare	Number of cases; number of reports vs number of investigations; number of Legal Risk Detector Referrals	APS Supervisor

Ombudsman	GetCare	Number of cases; number of consultations; number of quarterly facility visits completed	Ombudsman
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Continuous Quality-Quality Plan

AAA V will utilize the following indicators to monitor performance of the goals and strategies identified in the 4-year Area Plan. Progress will be determined by the measurement identified in the Area Plan Implementation Plan. Reports will include the following indicators on each strategy to track and monitor performance:

- Pending: Strategy not yet started, timeline to implement
- In Progress: Strategy started, report milestones and key dates
- Completed: Date strategy was completed, identify measurements.
- Barriers to implement: Report barriers, recommendations for improvements.

AAA V will utilize several different mechanisms to specify how Area Plan progress and success will be measured, and appropriate adjustments made. These mechanisms will be completed monthly, quarterly, semiannually, or annually as outlined below. This pattern will strategically provide for continual monitoring of the performance measures outlined in this plan

- **Manager Meetings:** AAA V will hold monthly manager meetings to have the program managers report on Area Plan strategy performance measurements. The program managers will be required to report progress made, barriers, and propose any improvements to Area Plan strategies. Annual employee performance reviews will include documenting their performance of the Area Plan deliverables they are assigned. **Report frequency: Monthly**
- **ICOA Commissioners Report:** Area Plan strategy progress and updates will be provided during ICOA Commissioners meetings. The AAA V Director will share a copy of the AAA V ICOA Commissioner report to the ICOA regional commissioner prior to the meeting for an opportunity to provide feedback and recommendations for improvements. **Report frequency: Quarterly**
- **Parent Organization Reports:** SICOG Executive Director will receive quarterly progress reports for quality that is then presented to the SICOG Board of Directors Administrative Committee for updates on the progress of each of the program deliverables. The AAA director will also provide an end of year report to the SICOG

board including: outcome of area plan goals, end of year budget/financial report, outcome of identified performance improvement projects, and a plan outlining new performance improvement projects and any changes to the current area plan. **Report frequency: Quarterly to SICOG ED and Annually to the SICOG Board of Directors**

- **AAAV Advisory Council Reports:** AAA V Director will provide the advisory council an Area Plan semiannual quality assurance report to be sure they are updated on the progress of each of the program deliverables. The advisory council will get the opportunity to provide feedback and any recommendations. Advisory council members will be utilized to approve annual updates and changes. **Report frequency: Semiannually**
- **Area Plan Updates:** A quality assurance report will be attached to Area Plan updates and submitted to ICOA for review. The report will include any proposed strategy changes, barriers identified and justification for unmet strategies. Area Plan updates will also include changes to staffing and strategy assignments. **Report frequency: Annually**

AREA AGENCY ON AGING V DISASTER AND EMERGENCY PREPAREDNESS PLAN

TO MEET THE NEEDS OF SENIORS IN THE EVENT OF NATURAL OR
MAN-MADE DISASTER OR OTHER WIDESPREAD EMERGENCY

National, State and Local Roles:

National Role: USAGing and the Administration for Community Living provide guidance to our Area Agency on Aging in how best we can support disaster and emergency efforts. The Area V Agency on Aging provides emergency preparedness materials at health fairs, via social media and at our office.

State Role: Idaho Area V Agency on Aging coordinates with the The Idaho Commission on Aging (ICOA) who is actively involved in the emergency management planning and operations of the State of Idaho as a supporting agency. The Administrator of ICOA has appointed a staff member as the Emergency Preparedness/Disaster Coordinator, and two other as the alternates. These individuals work with the Idaho Bureau of Homeland Security (BHS), state agencies and the regional Area Agencies on Aging (AAAs) to plan for and respond to the needs of seniors in an emergency event. The State of Idaho's Executive Order No. 2010-09 and the Idaho Emergency Operations Plan assign specific emergency support activities to the ICOA and the AAAs in assisting and in supporting local and state government prior to and during emergencies and disasters.

As the primary agency, BHS notifies the appropriate persons/agencies and activates the Idaho Emergency Operations Plan (IDEOP). The ICOA supports with following functions:

- Assessing the needs of the elderly and homebound elderly including older individuals with access and functional needs.
- Coordinating senior services through the AAAs during natural or man-made disasters.
- Providing information/assistance to their clientele and the public.
- Coordinating senior citizen centers for shelter, mass feeding, and rest centers.
- Identifying homebound/isolated elderly clients.

The Administration for Community Living (ACL) and the Aging Network composed of State and AAAs, Native American Tribal Organizations, service providers and educational institutions have

the legislative mandate to advocate on behalf of older persons and to work in cooperation with other federal and state programs to provide needed services. The authority and responsibility of ACL and the Aging Network to provide disaster services is found within the charge from the Older Americans Act to serve older persons in greatest need and from Title III, Sec. 310, and Disaster Relief Reimbursements, which provides for limited resources to fund disaster response services. Older adults and people with disabilities are frequently overlooked during the disaster planning, response, and recovery process. Emergency management planning integrates older adults and people with disabilities of all ages—and their caregivers—into community emergency planning, response, and recovery. ACL provides the following link http://www.acl.gov/Get_Help/Preparedness/Index.aspx with best practices to support the needs of older adults and people of all ages with disabilities during an emergency.

The Aging Network's has the ability to perform two basic types of disaster assistance service, which are:

- Advocacy and Outreach – assuring that older persons have access to and the assistance necessary to obtain needed services, including locating older persons; getting medical attention if needed, including medications and assistive devices; assisting in the completion and filing of applications for financial and other assistance; and follow-up monitoring to assure needs are met.
- Gap-filling – to assure that needed services and follow-up are provided beyond the timeframes and restrictions of other relief efforts if necessary. OAA funds can be used for chore, homemaker, transportation, nutrition, legal, and other temporary or one-time only expenses which help older persons retain maximum independent living.

Cooperation with emergency management entities may include; disaster planning and preparedness, sharing statistical and other data on elderly populations, establishment of disaster advocacy and outreach programs, and making congregate and home delivered meals programs available to the general public during a disaster.

To help meet these obligations, to ensure business continuity and to meet the needs of older citizens in an emergency, the Area Agency on Aging is required to develop an emergency disaster plan, that supports ICOA's emergency disaster plan.

Local Role: See below for the Area V Agency on Aging Area-Wide Disaster Plan.

Basic Components of an Area-Wide Disaster Plan:

1. Name and title AAA person responsible for implementation of area's Disaster Plan:

NAME	TITLE/POSITION
Mike Hirschi	AAA Director

2. Names and titles of other AAA staff:

NAME (AAA STAFF)	TITLE/POSITION
Gina Hubbard	Information and Assistance Supervisor
Susan Cronquist	Adult Protective Service Supervisor
Andrea DeMartinis	Ombudsman
Laurie Keyes	Information and Assistance
Angelyn Norgaard	Community Outreach Specialist
Therese Combs	Adult Protective Service Investigator
Matthew Harvey	Contracts Manager

3. Alternate AAA business location if primary office is inaccessible or uninhabitable:

LOCATION NAME AND ADDRESS	TELEPHONE / OTHER CONTACT NUMBERS
Bannock County Criminal Justice Center 5800 South 5th, Pocatello 83201	208-236-7104

4. Does the AAA have personal and community disaster preparedness information available for clients, services providers and the general public?

Yes, this information can be found on our website and in our office. AAA staff also provide personal and community disaster preparedness information over the phone, by email and my mail. The information provided to clients, service providers and the general public may come from a variety of sources including:

- The Federal Emergency Management Agency
- Centers for Disease Control and Prevention
- Red Cross
- ready.gov website
- Idaho Office of Emergency Management
- <https://acl.gov/emergencypreparedness>

5. Local Emergency coordinators and Red Cross coordinators in EACH county or city with whom the AAA coordinates emergency planning for the needs of older citizens, and will collaborate during an emergency or disaster situation:

AGENCY NAME AND ADDRESS	COUNTY/ OTHER JURISDICTION	CONTACT NAME	PHONE / E-MAIL
Bannock County 5500 South 5th Pocatello 83205	Bannock	Wes Jones Emergency Service Manager	(208) 236-7104 (208) 240-1798
Bear Lake County PO Box 151 Bloomington 83223	Bear Lake	Alan Eborn Emergency Service Coordinator	(208) 945-2212 (208) 251-9935
Bingham County 501 N. Maple, # 208 Blackfoot 83221	Bingham	Scott Reese Emergency Management Director	(208) 782-3190 (208) 243-8611
Caribou County Box 775 Soda Springs 83276	Caribou	Eric Hobson Director of EMS	(208) 547-2583 (208)221-7055
Franklin County 6869 N. Capital Hill Preston 83263	Franklin	Warren Wilde Director of EMS	(208) 852-1332 (208) 221-1408
Oneida County Sheriff's Dept. 10 Court Street Malad 83252	Oneida	Dan Williams Director of Disaster Services	(208) 221-9517
Power County 560 N. Oregon Trail Road American Falls 83211	Power	Di Jones Office of Emergency Management	(208) 226-2839 (208) 221-1129
Public Health Department 1901 Alvin Ricken Drive Pocatello 83201	Region 5	Paige Ellis	(208) 478-6315

		Program Manager-Public Health Preparedness	
The Shoshone-Bannock Tribes Emergency Operations Center	Shoshone-Ba nnock Tribes	William Trahant	(208) 339-8220

6. Included clauses in contracts, grants and agreements with service providers describing and assuring their response during a disaster or emergency.

<p>The Area Agency on Aging contracts with our service providers include the following clause:</p> <p><u>Emergencies/Disaster:</u> The Service Provider agrees that it shall, to the reasonable best of its ability, perform such activities and services, as requested, prior, during and after any declared emergency or disaster, with local, state and federal emergency response agencies, relief organizations, local, state and federal governments, and any other institutions (including local emergency preparedness committees and the AAA) that have responsibility for disaster relief service delivery.</p>

7. List service providers of major programs (transportation, nutrition, homemaker, etc.) with whom the AAA will coordinate emergency services.

SERVICE PROVIDER NAME AND ADDRESS	COUNTY/ OTHER JURISDICTION	CONTACT NAME	PHONE / E-MAIL
Pocatello Regional Transit 5815 South 5th Avenue Pocatello, Idaho 83204	Counties of Bannock, Bear Lake, Bingham, Caribou, Franklin, Oneida and Power	Skyler Beebe	(208)234-A-BUS (2287) Email: prt@pocatello.us
Senior Activity Center 427 N. 6 th Ave. Pocatello, ID 83201	Cities of Pocatello and Chubbuck	Anita Valladolid	(208)233-1212 Email: senioractivities@ida.net
Aberdeen Senior Center 42 W. Washington St. Aberdeen ID 83221	City of Aberdeen	Amy Sidell	(208)397-4349 Email: Aberdeenseniortitizen@hotmail.com
Bear Lake Senior Center 300 Hospital Plaza Montpelier, ID 83254	Bear Lake County	Connie Wright	(208)847-3141 Email: seniorcenterbearlake@gmail.com
Bingham County Senior Center 20 E. Pacific St. Blackfoot, ID 83221	Bingham County	Pam Beus	(208)785-4714 Email: pambeus@seniors4ever.com

Caribou County Senior Center 60 S. Main St. Soda Springs, ID 83276	Caribou County	ShaLayne Bartschi	(208)547-3007 Email: caribousenior@gmail.com
Curlew Valley Senior Center 10808 S. 2300 W. Stone ID 83280 25 E. 50 S. #A Malad, ID 83252	City of Stone, Idaho	Kelsie Hickman	(208)534-6080 Email: kelsie.hickman@malad.us
Franklin County Senior Center 64 W. 1 st S. Preston, ID 83263	Franklin County	Carol Parker	(208)852-2844 Email: communitycenter60@yahoo.com
Lava Hot Springs Senior Center 150 N. Center St. Lava Host Springs, ID 83246	City of Lava Hot Springs Area	Rosie Scott	(208)776-5569 Email: thelavaseniors@aol.com
Oneida County Senior Center 26 N. Main St. Malad, ID 83252	Oneida County	Laura Maxfield	(208)766-2250 Email: ocseniorcenter@outlook.com
Power County Senior Center 180 Idaho St. American Falls, ID 83211	Power County	Kathleen Ulrich	(208)226-2794 Email: seniorcenteraf@outlook.com
Shelley Senior Center 193 W. Pine St. Shelley, ID 83274	City of Shelley	Tuma Reams	(208)357-3621 Email: theeliteretreat@outlook.com
SEICAA/MOW 825 E. Bridger St. Pocatello, ID 83201	Cities of Pocatello and Chubbuck	Kathryn Dye	(208)232-1114 ex. 3 Email: mow@seicaa.org
Bear Lake Memorial Home Care 164 S. 5 th Montpelier, ID 83254	Counties of Bear Lake and Caribou	Shauna Dawes	(208)847-4454 Email: shauna.dawes@blmhospital.com
Care Connection of Idaho 215 N. 9 th St. Suite F Pocatello, ID 83201	Cities of Blackfoot and American Falls, Bannock County	Amber Davis	(208)240-5535 Email: CareConnectionofIdaho@gmail.com
Franklin County Medical Center Home Care 44 N. 100 E. Preston, ID 83263	Franklin County	Kaylene Owen	(208)852-1937 Email: klowen@fcmc.org

Friends and Family Home Care 4922 Yellowstone Suite B Chubbuck, ID 83202	Cities of Chubbuck, Inkom, Downey, Pocatello, Blackfoot, Shelley American Falls	LeeAnn Campbell	(208)244-4136 Email: friendsandfamily@cablone.net
PCS Helping Hands 2785 Bannock Hwy. Pocatello, ID 83204	Cities of Chubbuck, Pocatello, Blackfoot, Soda Springs and Preston	Denise Dustin	(208)232-2009 Email: pcs@hhofpoky.com
Quality Home Care 258 McKinley Pocatello, ID 83201	Cities of Chubbuck, Inkom, McCammon, Pocatello, Aberdeen, American Falls	Kita Maravilla	(208)235-4677 Email: qltyhmc@aol.com
Rockwell 28 S. 1100 E. Suite C American Fork, UT 84003	Counties of Bannock, Bear Lake, Bingham Cities of Grace, Soda Springs, Franklin, Preston, American Falls	Kim Robinson	(801)642-2665 1-888-571-6771 Email: kim@rockwell.com
Comfort Home Care 900 Pendlebury Ln Blackfoot, ID 83221	Cities of Pocatello, Chubbuck, Blackfoot and Firth	Care Fitzgerald	(208)681-5533 Email: Idahocomfortcare@gmail.com

8. Does the AAA have a process to identify homebound, frail, disabled, isolated and/or vulnerable clients who may need assistance in the event of a man-made or natural disaster:

Yes, this information is maintained on the statewide Management information system (MIS). All recipients of Home Delivered Meals, Homemaker, Chore, Respite and Case Management Services have addresses and/or directions to their home accessed through the statewide MIS database (GetCare). The database has client demographics and emergency contact information to determine the status of the individual that there may be a concern about.

Another resource our AAA has available to identify frail, disabled and/or vulnerable clients is the HHS emPOWER Map 2.0. This internet-based tool helps to further identify specifics about Medicare beneficiaries in our area. The HHS emPOWER Map 2.0 features the monthly total of Medicare beneficiaries with electricity-dependent equipment claims at the U.S. state, territory, county, and zip code level to identify the areas and populations that may be impacted and at risk

for prolonged power outages. The AAA will likely receive information from this internet-based tool from personnel of the local incident command system. AAA staff will then be able to provide further assistance to homebound, frail, disabled, isolated and/or vulnerable adults as directed by these local emergency officials.

9. Describe the AAA's process for intake and recording of information about the disaster related needs of older people, providing access to needed services, and follow-up during and beyond the recovery period.

The capability and extent of assistance the AAA's can provide, in case of a disaster or emergency are limited. Primary to the mission is disaster relief and assistance. The first 24 hours of a disaster or emergency are key to accessing relief and assistance.

In case of a disaster or emergency the following information should be recorded on any known victims:

- Name
- Home address
- Telephone number, if working
- Known health conditions
- Next of kind and telephone number
- Nature of need
- Location of individual if not at home

This information should be relayed to Idaho Office of Emergency Management (IOEM) if rescue is required. The AAA Director and ICOA should be made aware of all efforts accomplished by IOEM.

The AAA will be prepared to pass on information to the Idaho Commission on Aging about the approximate number of older persons that might be residing in a given area.

It is vitally important that any contracted nutrition providers who provide commodities or meals during a disaster or emergency, keep extensive and accurate records of what was provided to whom, when, and under what circumstances and at whose direction. These services are reimbursable by the federal government if properly authorized but require good records in order to make a claim.

10. Describe the AAA's process for staff and service providers to record employee's time and expenses associated with disaster related activities (see example below: necessary to apply for reimbursement in the event of a presidential disaster declaration):

AAA staff and service providers must maintain accurate records during an emergency event, including time worked, emergency purchases made, and personal miles driven for work purposes, as well as instructions and information that the individual engaged in. These documents will be required for monetary reimbursement and payroll. These records will be invaluable after the event to improve the AAA emergency preparedness plan.

AAA utilizes the example below for the documentation that is necessary to apply for reimbursement in the event of a presidential disaster declaration. Copies of this form

will be available at the front desk at the agency and an electronic copy will be available on the AAA shared drive.

AAA Employee Emergency/Disaster Record								
Authorized Person's Name:								
Date	Time Worked	Emergency Purchases Made	Purpose of Purchase	Costs of Emergency Purchase	Personnel Miles Driven	Store Purchase made and Location	Instructions & information	Instructions Came From

11. Describe activities the AAA will undertake during the contract period to expand emergency preparedness of the Aging Network within the PSA (i.e. attend LEPC meetings, work with local emergency management officials to advocate for inclusion of older citizens' needs in emergency planning, establish CERT Training in senior centers, make 72-hour kits available for homebound clients, establish "call-down" lists and procedures to be used during emergencies, include emergency preparedness activities in contracts with providers, etc.)

AAA staff will work with local emergency management officials, particularly the regional Idaho Healthcare Coalition and the Local Emergency Planning Committee's (LEPC) in our area, to advocate for inclusion of older citizens' needs in emergency planning. The AAA will cultivate strategic partnerships with entities that have expertise in service to aging and/or adult populations with disabilities. These partnerships might include local chapters of the Voluntary Organizations Active in Disasters (VOAD), the regional Idaho Healthcare Coalition and Local Emergency Planning Committee's (LEPC). The AAA service providers contracts or agreements will continue to include clauses that describe and assure their response during a disaster or emergency.

AREA AGENCY ON AGING RESPONSIBILITIES IN THE EVENT OF AN EMERGENCY OR DISASTER

Develop and maintain Continuity of Operations Plan (COOP) to (a) address how the agency will provide essential services to citizens during response and recovery, and (b) return the agency to normal operations.

Agencies will notify the IOEM of any significant event, incident, emergency, or disaster, impacting the ability of government to provide public services within the State of Idaho. Provide resource and logistical support (i.e. personnel, equipment, materials, supplies, etc.) to the IDEOC as requested, within the scope, laws, and policies that govern their organizations.

The primary goal of our agency during an emergency is to maintain a continuity of service at a minimum level for older adult and family caregivers in our area. Highest consideration will be placed on senior nutrition and information and assistance which are an essential part of response and recovery. Efforts will be made to identify and map vulnerable populations.

AAA V recognizes that the responsibility for coordinating emergency preparedness rests with the Idaho Office of Emergency Management (IOEM) through public health officials and local elected officials. As an Area Agency on Aging however, we are responsible to ensure the needs of older adults are considered and addressed in time of natural and man-made disasters. AAA V's first priority after a disaster is to ensure that services to our consumers and contract agencies continue or are restored as soon as possible. AAA V staff will assess the status of provider staff and clients, facilities and needs as soon as possible after a disaster to provide them with needed assistance to continue operations. After addressing the needs of AAA V consumers and programs, AAA V staff may assist local emergency operations with specific emphasis on older adults and family caregivers.

Evacuation/Non-Evacuation

Evacuation

There are many types of natural and human-caused emergencies that could occur while we are at work. When an emergency arises, we will be notified through official channels.

Evacuation of facility in the event of:

- Flood
- Fire
- Chemical Spills (inside the building)
- Earthquake (non-high rise building)
- Bomb (threat or explosion)
- Violence
- Bio-Terrorism

Evacuation Procedure:

- When time allows, shut your door, before you leave the building
- Exit the building in a calm manner through one of the main doors of the building (doors at the north or south side of the building)
- Staff must reassemble at the predetermined location (northwest end of parking lot) to verify everyone is safely out of the building

No Evacuation of facility in the event of:

- Weather
- Chemical Spills (outside)

- Civil Disorder

The Idaho Emergency Operations Plan indicates Area Agencies on Aging will assist during an emergency in the following ways:

Mass Care (Idaho Emergency Support Function)

- Inform local emergency officials and Idaho Commission on Aging of the needs of the elderly and homebound elderly
- Coordinate senior services with contracted providers
- Provide disaster related information /assistance to consumers
- Assist with coordination for the utilization of senior citizen centers for shelter, mass feeding, and rest centers

Pandemic Influenza

- Disseminate informational and action-required messages received by the, local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management.
- Provide assistance in coordinating with senior centers for mass vaccination operations (i.e., facilities, staffing) as listed under Mass Care.

Flooding

- Provide support as requested and coordinated by local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management. The level of involvement will vary based on the disaster.

Earthquake

- Provide support as requested and coordinated by local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management. The level of involvement will vary based on the disaster.

Severe Weather

- Provide support as requested and coordinated by local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management. The level of involvement will vary based on the disaster.

Nuclear/Radiological Incident

- Provide support as requested and coordinated by local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management. The level of involvement will vary based on the disaster.

Cybersecurity Incident

- Provide support as requested and coordinated by local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management. The level of involvement will vary based on the disaster.

Terrorism

- Provide support as requested and coordinated by local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management. The level of involvement will vary based on the disaster.

Should a disaster or state of emergency exist in our area, the following individuals will be responsible for actions indicated. The AAA Director has been assigned as the Emergency Coordinator. In his absence, Contracts Manager has been assigned alternate.

AREA AGENCY ON AGING FISCAL OPERATIONS:

Payments during emergencies will continue to providers for on-going distribution of services. AAA V will ensure funds are made available to contracted providers to support their ability to serve vulnerable seniors during emergencies. AAA V must be able to receive funding and make payments to the providers. Process for paying bills to providers in the event we lose access to network, internet is disabled or office closures:

- Back up internet MIFI's can be utilized to connect to the internet. (if the internet is disabled.)
- Fiscal Manager will have the ability to remote into the fiscal management system from home
- Fiscal management System data is backed up daily and offsite. IT will assist, staff to have access to data if staff lose the ability to have access locally.
- Payroll could be processed offsite utilizing the agency's contracted accountant.
- Fiscal team can access outlook emails offsite to accept and approve invoices.
- There are currently four signers assigned to sign checks if needed.
- ICOA payments are electronically deposited into the bank account.

RECORD KEEPING

AAA staff must maintain accurate records during an emergency event, including time worked, emergency purchases made, personal miles driven for work purposes, as well as noteworthy benchmark activities, instructions, and information. These documents will be required for monetary reimbursement and payroll and be invaluable after the event to improve emergency preparedness plans.

Vitals

The capability and extent of assistance the AAA's can provide, in case of a disaster or emergency are limited. Primary to the mission is disaster relief and assistance. The first 24 hours of a disaster or emergency are key to accessing relief and assistance. In case of a disaster or emergency the following information should be recorded on any known victims:

- Name
- Home address
- Telephone number, if working
- Known health conditions
- Next of kin and telephone number
- Nature of need
- Location of individual if not at home

Vital Records:

Vital Record	Storage Location	Maintenance Frequently	Current Location	Recommendations for Additional Protection
Contracts	Locked File Cabinet in Contract Manager Office	3 Years	Locked File Cabinet	Electronically stored on shared drive
Fiscal Records	Locked File Cabinet in Fiscal Office	3 Years	Locked File Cabinet	Electronically stored on shared drive
Human Resources	Locked File Cabinet in Fiscal Office	5 Years	Locked File Cabinet	Electronically stored on shared drive
LTC Ombudsman	Locked in File Cabinet in office	3 Years	Locked File Cabinet in office	Electronically stored on shared drive

This information should be relayed to IOEM if rescue is required. The AAA Director and Region X should be made aware of all efforts accomplished by the ICOA and IOEM. It is imperative any meal site who provides commodities or meals during a disaster or emergency, keep extensive and accurate records of what was provided to whom, when, and under what circumstances and at whose direction. These services are reimbursable by the federal government if properly authorized but require good records to make a claim.

The (AAA) must be able to indicate how many older persons might be residing in each area. This information is to be provided to ICOA by the AAA involved immediately after a disaster. Region X is required to contact the ICOA to obtain and forward this information to the federal government.

Alternate Business Office Location

Should a disaster or emergency occur that renders the (AAA) offices inaccessible or uninhabitable, business will be temporarily conducted from the facilities of the Bannock County Criminal Justice Center. Their location and contact are:

LOCATION NAME AND ADDRESS	TELEPHONE / OTHER CONTACT NUMBERS
Bannock County Criminal Justice Center 5800 South 5 th , Pocatello 83201	208-236-7104

Alternate work model

(AAA) staff may have the option of telecommuting, when appropriate and deemed necessary.