

**FOUR-YEAR PLAN
OF THE
ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES
AREA AGENCY ON AGING**

**FOR THE PERIOD
July 1, 2012 through JUNE 30, 2016**



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AREA PLAN--PART A

I. EXECUTIVE SUMMARY

Introduction. The Area Agency on Aging (DHS/AAA), a program office of the Allegheny County Department of Human Services (DHS), serves some 41,000 older adults, 60 years of age and over, annually according to provisions of a comprehensive, state-approved four-year plan. The DHS/AAA provides services through internally administered programs, and contracts and agreements with about 100 community-based providers. Programs range from those for largely independent older adults to those for frail, vulnerable populations.

Community Needs Assessment. The DHS/AAA's conducted a multi-phased community needs assessment employing the following: Six participant focus groups; an on-line public survey; stakeholder interviews and a public meeting; and analyses of service usage trends, program surveys and demographic trends.

Community Needs. Based on the findings of its community needs assessment, the DHS/AAA identified five priority needs to be addressed in its four-year plan.

- Addressing the information and assistance needs of older adults.
- Helping older adults to live independently and delay the need for long-term care.
- Tailoring services to meet the individual needs of its service population.
- Supporting and balancing the respective needs of caregivers and care receivers.
- Re-engineering DHS/AAA staff, services and resources to maximize and measure their outcomes and benefits to participants, and better inform decision and policy making.

Strategies. Based on these needs, the DHS/AAA developed five strategies, with accompanying implementation steps and performance measures. The five strategies have also been correlated to the five policy themes stated in the area plan aging program directive (APD #12-01-01).

- **Strategy 1—Provide Accessible Expertise:** Change how the community thinks of, accesses and utilized the DHS/AAA.

(Corresponds to State Policy Theme: Effective and Responsive Management)

Performance Measures:

- By 2016, participants obtaining Information and Assistance services rate the benefit and value as good to excellent at least 90% of the time.
- By 2016, at least 50,000 county residents obtain information or services through the DHS/AAA annually.

- **Strategy 2—Extend Independent Living:** Enhance information, assistance and prevention programs to extend independent living and delay the need for more intensive services.

(Corresponds to State Policy Themes: Promote Health and Well-being; Communities to Age and Live Well)

Performance Measures:

- By 2016, the number of older adults actively participating in AAA-sponsored, evidence-based health and wellness programs increases by 50%.
- **Strategy 3—Customize Care:** Offer individualized Care Management that can be easily obtained by older adults with a wide range of needs.
(Corresponds to State Policy Themes: Revitalize/Re-architect Services; Innovation Incubator for Services)

Performance Measures:

- By 2016, older adults or their caregivers who seek services gain access to a care manager in less than half of the time that it takes in 2011.
 - By 2016, at least two programs in care-managed services will be implemented to sustain or improve quality of life by improving care connections with systems and families.
- **Strategy 4—Partner with Caregivers:** Consider—and balance—the needs of participants and caregivers to optimize their quality of life.
(Corresponds to State Policy Themes: Communities to Age and Live Well; Promote Health and Well-being)

Performance Measure:

- By 2016, major DHS/AAA programs specifically identify and address the needs of caregivers.
- **Strategy 5—Continuous Improvement and Community Impact:** Transform planning, research, training, evaluation and quality improvement functions to better serve participants, and inform decision and policy making.
(Corresponds to State Policy Themes: Revitalize and Re-architect Services; Effective and Responsive Management)

Performance Measures:

- By 2016, quality improvement measurements include tracking real-life benefits to participants in DHS/AAA programs.
- By 2016, competency-based assessment and training is established in DHS/AAA programs; 15% of staff demonstrate advanced competency in an area of specialization.

II. OVERVIEW

Allegheny County Department of Human Services Area Agency on Aging (DHS/AAA)

DHS Vision Statement. *“To create an accessible, culturally competent, integrated and comprehensive human services system that ensures individually tailored, seamless and holistic services to Allegheny County residents, in particular the county’s vulnerable populations.”*

Organization. “Area Agency on Aging is a designation of the U.S. Administration on Aging (AoA) and Commonwealth of Pennsylvania’s Department of Aging (PDA) to indicate one of the 52 organizations that provide services for older adults (60 years of age and older) in designated county or multi-county areas of Pennsylvania. AAAs are responsible for administering comprehensive, state-approved multi-year plans to meet the needs of their service populations. The Allegheny County AAA has fulfilled this role since its formal designation in 1973, and previously, as the Adult Services Area Agency on Aging since the mid-1960s.

Governance. Newly elected (2011-2015) first-term Allegheny County Executive Rich Fitzgerald and a 15-member County Council, elected by district, constitute the executive and legislative arms of county government, respectively. County departments are organized to provide specific services, including DHS, which includes the AAA as one five program offices.

The AAA’s Advisory Council, a voluntary body of local citizens, provides ongoing input on the development and implementation of the four-year plan and annual area plans, which are presented for public comment at annual public hearings.

AAA operations are directed by the Administrator, who also holds the rank of a Deputy Director in DHS. AAA staff carry out agency policies and programmatic guidelines in administering contracts and assuring quality service delivery. Staff have professional training in their fields, including ongoing professional development opportunities, and are hired through the Pennsylvania State Civil Service Commission.

DHS Statement of Principles. *“All services will be:*

- *High quality—Reflecting best practices in case management, counseling and treatment.*
- *Readily Accessible—In natural, least-restrictive settings, often community-based.*
- *Strengths-based—Focusing on the capabilities of individuals and families, not their deficits.*
- *Culturally Competent—Demonstrating respect for individuals, their goals and preferences.*
- *Individually Tailored and Empowering—By building confidence and shared decision making as routes to independence, rather than dependency.”*

Programs. The AAA provides a full range and continuum of services administered internally or through contracts and agreements with about 100 community-based providers. In 2010-2011, the AAA served more than 41,000 unduplicated participants in the following programs:

- Information and Assistance
- Senior Community Centers
- Nutrition
- Shared-ride Transportation
- Health Insurance Counseling
- Legal Counseling
- Health Counseling and Prevention for Public Housing Residents
- Assessments and Level of Care Determinations
- Care Management
- In-Home Services
- Senior Companions
- Adult Foster Care (Domiciliary Care)
- Caregiver Support
- Long-term Living Counseling
- Nursing Home Transition
- Advocacy for Long-term Care Consumers (Ombudsman)
- Protective Services
- Legal Guardianship
- Better Choices, Better Health—Chronic Disease Self-management (grant funded)
- Healthy Steps for Older Adults (grant funded)
- Carrier Alert Program
- Money Management Program

In addition to direct personal contact and services, the AAA also annually processes more than 100,000 phone calls, scheduled and walk-in appointments, and written and electronic for information and assistance through its extensive Information and Assistance resources at its main office and network of community-based providers.

See **Appendix A** for a grid of the plan's strategies, implementation steps, performance measures and outcomes.

See **Appendix B** for a complete listing of DHS/AAA Collaborations and Community Partnerships, and Program Innovations and Initiatives.

See **Appendix C** for organizational charts for the Department of Human Services (DHS) and the Area Agency on Aging (DHS/AAA).

III. Community Needs Assessment

Organization and Methods. The DHS/AAA’s strategic planning process was led by the Administrator, two Deputy Administrators and five Bureau Chiefs, as well as a few knowledgeable, external consultants. The group took a holistic approach, identifying and addressing overarching issues that ran across bureaus and the provider network. For instance, accessible information for participants and caregiver needs across all programs arose as critical issues. Emerging from this approach was a coherent agenda of key strategic initiatives, implementation steps and measurable performance standards.

The DHS/AAA used several methods to conduct the community needs assessment.

Public and Participant Outreach

- A series of five focus groups involving 45 participants representing a cross-section of Allegheny County older adults and DHS/AAA consumers
- A sixth focus group conducted with members of the DHS/AAA Advisory Council.
- An on-line survey on information, independent living and caregiver issues that was posted on Survey Monkey and attracted 300 responses from participants, community partners and general public.

Stakeholder Input

- Interviews of seven community partners or stakeholders with practical knowledge of aging services in our community.
- A community stakeholder gathering with 40 participants who discussed aging services issues in small groups and an open forum.

Service Usage Trends: Analysis of 4-year service trends in key program areas.

Participant Surveys: Analysis of participant satisfaction surveys in key program areas.

Demographic Trends: Analysis of current demographic trends affecting older adults (outlined in Section IV. of the plan).

Summary of Public, Participant and Stakeholder Results

<i>Community Assessment Needs</i>	<i>Participant Focus Groups</i>	<i>On-line Public Survey</i>	<i>Stakeholder Interviews</i>	<i>Stakeholder Public Meeting</i>
<u>Barriers to Independent Living:</u>				
• Home Upkeep	X	X		X
• Health Status and Care	X	X		
• Home-related Expenses (taxes, utilities, etc.)	X	X		
• Mobility Needs (transportation)	X	X	X	X

Allegheny County Department of Human Services
 AREA AGENCY on AGING
 Four-year Plan: July 1, 2012-June 30, 2016

<u>Community Assessment Needs</u>	<u>Focus Groups</u>	<u>Public Survey</u>	<u>Stakeholder Interv.</u>	<u>Stakeholder Mtg.</u>
<ul style="list-style-type: none"> • Home Safety, Convenience and Safety Modifications) • Risks of Living Alone (falls, etc.) • Food Preparation • Respite for Caregivers • Help with Caregiver Tasks • Caregiver Information Sources 	X X X	X X X X	 X X	X X
<u>Service Information/Resources Used Regularly:</u>				
<ul style="list-style-type: none"> • Senior Centers • Community Bulletin Boards • Printed/Mailed Materials • <i>Allegheny County Senior Resource Guide</i> (DHS/AAA) • DHS/AAA senior Line/call center • On-line Resources • Human Services/Health Care Facilities • Word of Mouth 	X X X X X X X X	 X X X X X X		 X X X
<u>Service Information/Preferred Resources:</u>				
<ul style="list-style-type: none"> • Telephone with Extended Hours Access • Senior Centers • In-person Contacts with Resource Staff • E-mail and On-line Resources • Community Events and Sites (churches, doctor's offices, etc.) • Printed/Mailed Materials 	X X X X X X	 X X		 X X X
<u>Service Information/Barriers:</u>				
<ul style="list-style-type: none"> • Recorded phone "menus" • Groups offering information to "sell something" • Not knowing where/who to call /questions to ask (unfamiliarity with aging services/procedures) • Long wait times on the phone 	X X X	X X X	 X	 X X

<u>Community Assessment Needs</u>	<u>Focus Groups</u>	<u>On-line Survey</u>	<u>Stakeholder Interv.</u>	<u>Stakeholder Mtg.</u>
<ul style="list-style-type: none"> • Easy Access to Information • Communicating with immigrant or Non-English speaking groups 			X	X X
<u>Service Information/Needs:</u> <ul style="list-style-type: none"> • Reliable, personal, accessible, easy to understand sources • Resources and computer training appropriate to older adults • Help for older adults to understand information presented in unfamiliar, confusing ways • Reliable, widely recognized, easy to use one-stop source of information 	X X			X X X
<u>Health Activities/Participation:</u> <ul style="list-style-type: none"> • Exercise (physical and mental) • Volunteerism • Socializing • Hobbies • Good Nutrition • Learning Experiences • Doctor's Visits 	X X X X X X X	X X X X		
<u>Healthy Activities/Barriers:</u> <ul style="list-style-type: none"> • Isolation • Depression • Access to facilities • Getting Others to Participate 	X X X X			X X
<u>Life Planning Needs/Top Priorities:</u> <ul style="list-style-type: none"> • Long-term Health Insurance • Funeral Arrangements • Retirement Planning • Financial and Personal Affairs 	X X X X		X	
<u>Life Planning Needs/Barriers:</u> <ul style="list-style-type: none"> • Access to knowledgeable, reliable professionals 	X			

<u>Community Assessment Need</u>	<u>Focus Groups</u>	<u>On-line Survey</u>	<u>Stakeholder Interv.</u>	<u>Stakeholder Mtg.</u>
<ul style="list-style-type: none"> • Not knowing the right questions • Paperwork • Less help/ fewer resources for the “middle class” and “near poor” 	X X X	X	X	X X X
<u>DHS/AAA --Public Image Issues:</u>				
<ul style="list-style-type: none"> • Positive Image among Partners • Low Visibility/General Public • DHS/AAA Serve Only the Poor • DHS/AAA/Not a Crisis Center 			X X X	X X
<u>DHS/AAA-- Recommendations:</u>				
<ul style="list-style-type: none"> • Better, Targeted Community Outreach to Institutions • Broader Awareness and Support of Caregivers • Increase General Community Awareness of the DHS/AAA • Update Community Partners on Referral Outcomes • More Regular Meetings with Community Partners • More awareness/coordination with mental health, behavioral and cognitive health Issues • Greater advocacy for aging needs in the public agenda • Better marketing/accessibility of high-quality, in-demand aging services 			X X X X X	X X X X X X X

DHS/AAA Four-year Service Trends

The DHS/AAA also tracked service usage patterns to assess the changing needs of participants within and across programs. Over the course of the current four-year plan (2008-2012), the following patterns in major service groupings are the most prominent.

- **The demand for Care Management and emergency care interventions has grown rapidly.**
 - Options Care Management
 - Despite the imposition of a wait list in December, 2008, participants grew from 4,024 in July, 2008 to 4,728 as of December, 2011, an 18% increase.
 - Participants increased in the 2011 calendar year from 3,974 to 4,728, a one-year increase of 19%.
 - The average number of participants per month increased from 4,057 in 2008-2009 to 4,676 in the 2011-2012, to date, a 15% increase.
 - Aging Waiver
 - Despite changes and delays in the approval process, participants grew from 1,024 in July, 2008 to 1,617 in February, 2012, a 58% increase.
 - The average number of consumers per month increased from 1,070 in 2008-2009 to 1,514 in 2011-2012, to date, a 41% increase.
 - Nursing Home Transition
 - Nursing home transitions have climbed annually from 93 in 2008-2009 to a projected total of 207 in 2011-2012, a 123% projected increase.
 - The conversion rate for NHT referrals has grown from about 30% to 34% over the past four years.
 - Emergency Care Interventions
 - Reports of Need monthly totals have grown overall from 102 in July, 2008 to 131 in March, 2012, a 28% increase. Significantly, the totals have held in the 130-150 range virtually every month in the past two years.
 - Active Guardianships have increased, with minor fluctuations, from 220 in July, 2008 to 244 in December, 2011, a 28% increase.

- **The need for Information and Assistance and Assessments of Need has remained at a steady, high level.**
 - Contacts to the Information and Referral unit have averaged between 4,000 and 4,500 per month for the past four years.
 - Clinical determinations of participant need have risen from 8,924 in 2008-2009 to a projected total of about 10,622 for the current year. The total for the most recent complete year (2010-2011) was 10,278.

- **Senior Center visits, congregate meal services and home delivered meals have declined over the past four years, while health and wellness activity units have grown.**
 - The monthly average for visit and meal service units has declined from 58,258 in 2008-2009 to 55,026 in 2011-12, to date, a decline of 6%.
 - Home delivered meals have declined by 21% over the past four years, from 48,071 in 2008-2009 to 38,032 in 2011-2012, despite expanded capacity and area coverage during this period. Tightened eligibility criteria have likely contributed to the decline.
 - The monthly average for health and wellness activity service units increased from 29,782 in 2008-2009 to 30,397 in 2011-2012, to date, a 2% increase.

Participant Surveys, Individual DHS/AAA Services

As part of its commitment to continuous quality improvement, the DHS/AAA conducts regular surveys of participants in its programs to determine satisfaction levels and identify areas for improvement. In the past two years, the AAA has completed surveys in the following programs:

- **Options Adult Day Services (ADS).** The survey was completed by 31 out of a sample of 50 caregivers of ADS participants. Enrollment has declined in the past four years due to the care plan cap. Overall conclusions, based on results, include the following.
 - Over 75% expressed were satisfied with quality of the services and staff.
 - While attendance did not always improve chronic or progressive conditions, the data suggested that ADS may be a positive resource in coping with or stabilizing some of these conditions.
 - It is reasonable to say that, in some instances, ADS attendance may provide a vital support to independent living by delaying or avoiding institutionalization.

- **Family Caregiver Support Program (FCSP).** The survey was completed by 134 of 370 caregivers in FCSP. The overall conclusions, based on the results, include the following.
 - 70% of caregivers were 60 or over; another 27% were between 40 and 59.
 - 69% indicated that their only household income came from retirement sources.
 - The three greatest caregiver needs--financial support, respite and more help, in that order--rose progressively during the time spent as a caregiver.
 - 77% had been caregivers for a period of four to ten years.

- **In-home Services (IHS).** The IHS survey used telephone and personal interviews of Options Care Management and Aging Waiver participants. The phone survey reached 1,554, or 37% of participants, while personal interviews were conducted with 106 participants.
 - 94% was the average satisfaction score of the 48 providers whose participants were surveyed.
 - Satisfaction scores for worker performance averaged in the mid-90% range.

- **Senior Community Centers.** A Senior Community Center survey of 2,674 participants was conducted to assess participant satisfaction with various aspects of programming.
 - Satisfaction was very high for senior center programming (91%) and staff (94%).
 - Respondents were less satisfied with aspects such as program variety (72%), outlets for ideas and talents (79%), and programs appropriate to their needs or interest (81%).
 - Although congregate meal satisfaction was at 88%, fewer were satisfied with the quality (71%) and variety (66%) of meals. The respondents rated enjoying meals with friends the highest (92%). It is the DHS/AAA's intention to study lower meal utilization in relation to community need factors.
 - Transportation service received a 78% satisfaction rating, due mainly to the perception of poor on-time performance (69%). Satisfaction with drivers and service was at 85%.

- **Home Delivered Meals (HDM).** As part of the Senior Community Center survey, the HDM survey attracted 2,674 responses to five questions related to service features and quality.
 - 83% indicated that delivery persons are friendly, helpful and courteous; delivery is reliable; and they are satisfied with the service.
 - The lowest rating was 68% for good meal variety.
 - 78% have been receiving HDMs for less than five years.

- **Information and Assistance (I&A).** The DHS/AAA studied subject matter patterns of phone inquiries processed by the I&A unit during two three-month periods in 2010 and 2011.
 - The top three subject areas for both periods were the same: In-home Services (17% and 19%), Transportation (14% and 14%) and Public Benefits (9% and 14%). Taken together, the areas accounted for over a third of all calls in the two periods (40% and 47%).

- **Chronic Disease Self-Management Program.** The DHS/AAA evaluated the Chronic Disease Self-Management Program, one of four such grant-funded programs at AAAs in the state. Although funding has just ended, the learning derived from it has informed our approach to evidenced-based programming. The evaluation measured participants' attitudes about their health before and six months after completing the workshops. On average,
 - Respondents reduced how often they feel discouraged, fearful, worried or frustrated with their health condition by 52%.
 - They reduced how often they experienced fatigue, shortness of breath and pain by 43%.
 - They increased their level of confidence about managing their health conditions and keeping them from interfering with their daily lives by 15%.

IV. Demographic Trends

Population

The table below shows that while the overall and older adult population declined, significant growth occurred in three age groups, the 60-64 and 85-over among older adults, and the extraordinarily large 50-59 group that will enter their sixties within the current decade.

<i>Source: U.S. Census</i>	50-59	60-64	65-74	75-84	85-over	Total 60-above (% of Total)	Total Allegheny Co.
1970						255,354 (15.9%)	1,605,016
1980						285,391 (19.7%)	1,450,085
1990						308,874 (23.1%)	1,336,449
2000	146,770	54,278	112,549	87,724	28,143	282,694 (22.1%)	1,281,666
2010	188,166	72,838	95,684	74,259	35,116	277,897 (22.7%)	1,223,348
% Change 2000-2010	+28.2%	+34.2%	-15.0%	-15.3%	+24.8%	-1.7%	-4.6%

Population Growth—Conclusions

- The 25% growth in the 85-over is the second sizeable increase in this group in the last two censuses; the 85-over increased 36% in the 2000 census.
- The 28% growth in the 50-59 group is even more striking because of its size. The total of 188,166 represents more than two-thirds (68%) of the entire 60 and over population.
- The 50-59 and 60-64, the two “baby boomer” age groups, together, total 261,004, nearly as large as the entire 60 and over population.
- The median age for Allegheny County rose 1.7 years from 39.6 in 2000 to 41.3 in 2010, a significant jump indicating that the overall population is growing older. The median age for males is 39.3 and 43.3 for females.

Population Growth and Care-managed Services. The growth and changes within the older adult population pose significant challenges for the DHS/AAA and its community partners. On the one hand, the continued growth in the 85-over group will fuel the demand for care-managed services that is already apparent in recent DHS/AAA service usage patterns. The time, labor and cost of providing intensive services will not only drive up the expense of doing business at a time of flat budget growth. It will also require that services be tailored more than even before to meet the individual needs and circumstances of participants. In addition to more traditional medical conditions, the rising incidence and acuity of mental health, behavioral and cognitive disabilities now emerging in this population are likely to increase as older adults live longer. Finally, the prevalence of more complex living arrangements (e.g., living alone, non-traditional families, etc.) will affect the delivery of services.

Population Growth, Prevention and Healthy Living. On the other hand, the sheer size of the 60-64 group and emerging 50-59 group means that aging services will need to meet the demands of a large generation that is different in many ways from those preceding it. In general, these groups tend to be better educated, more sophisticated and assertive of their rights as service consumers, and more resourceful and tech savvy in how they pursue information and help. Fortunately, they also tend to be more aware of and committed to health and wellness issues. It will be the great challenge of aging services in the years ahead to use the strengths of these groups to support them in staying healthy and living independently for as long as possible so that they do not overstrain the system with their sheer numbers.

Income and Poverty

Poverty. The growth of elder poverty has been a troubling trend in recent years. The 2008-2012 DHS/AAA plan reported poverty at 7.5% for those 65-over, according to the 2000 census, and 9%, based on the 2006 American Community Survey (ACS). The 2009 ACS puts the figure at 9.9%; the overall rate is 13.3%. The tables below show some defining features of elder poverty:

- Poverty increases with age for older adults from age 65 onward.
- Median household income for older adults declines with age.
- Women are more affected than men.
- African-Americans are more affected than Caucasians.

Poverty Rates	Males	% Males	Females	% Females	Total	% Total
55-64	5,006	7.6%	8,773	12.3%	13,779	10.0%
65-74	1,750	4.5%	4,767	13.9%	6,517	8.8%
75-over	2,966	6.2%	8,099	14.3%	11,065	10.6%
65-over	4,716	5.5%	12,866	13.9%	17,582	9.9%

Age Group	Median Household Income
Overall Population	\$38,329
55-64	\$44,403
65-74	\$28,746
75-over	\$20,787

Older Adults in Poverty 65 Years of Age and Over	65-74	75-over	Total in Poverty	Percentage of 65-over Population in Poverty
Caucasian Males	1,313	2,407	3,720	5.2%
Caucasian Females	3,243	6,978	10,221	9.8%
Total Caucasian	4,566	9,385	13,941	7.9%
African-American Males	437	537	974	16.0%
African-American Females	1,524	1,012	2,536	22.8%
Total African-American	1,961	1,549	3,510	20.4%

Income. Other data show that older adults in Allegheny County fare better than the overall population. For instance, the overall estimated poverty rate for the county, according to the 2009 ACS, is 13.3%, 3.4% higher than for those 65-over. The University of Pittsburgh/University Center for Social and Urban Research (UCSUR) and the 2009 ACS provide other positive indicators of income status for older adults 65-over in the county.

- 72% of older adult homeowners have no home mortgage. (UCSUR)
- Older adults own 57% of all non-mortgaged homes in the county, and just 13% of homeowners in this age group have a mortgage (UCSUR)
- 78% have private health coverage; only 18% have only one type of health of coverage. (2009 ACS)
- While 10% of the all households in the county receive food stamps, only 6.6% of households with at least one person over 60 years of age do. (2009 ACS)
- While older adults account for 22% of the total population of the county, only 9.4% are enrolled in the Low-income Heating and Energy Assistance (LIHEAP). (DHS data)
- The cost of living is about 9% lower and housing costs are about 25% lower than the national averages, based on a recent census estimate. (UCSUR)
- Many current retirees enjoy generous pension and health benefits from the time when Pittsburgh was a major corporate and industrial center. Not as many future retirees are likely to enjoy these advantages.

- The so-called “Reverse Snowbird” effect, documented by UCSUR, shows that many older adults who moved to Florida in their 60s return later because of better health care.

Living Alone

A key demographic in Allegheny County is the high number of older adults living alone. The 2010 census showed that the proportion of older adults 65-over living alone increased to 34%, from 31.3% in 2000. The 2009 ACS reported that people living alone comprised 37% of the households in the county, only 5% fewer than married-couple households.

The table below indicates how the living alone dynamic is heavily influenced by marital status and variation in life expectancy by gender. In the United Nations list of average current life expectancy at birth by country, the United States ranked 38th out of 194 nations, with an average life expectancy of 78.2 years. However, the variation between men (75.6 years) and women (80.8 years) is more than five years.

<i>2009 ACS</i>	<i>Single/Never Married</i>	<i>Married/ Spouse Absent</i>	<i>Widowed</i>	<i>Divorced</i>	<i>Totals</i>	<i>Married/ Spouse Present</i>
60-64	M- 3,200 F- 3,854	M- 1,041 F- 1,106	M- 1,236 F- 4,458	M- 5,118 F- 7,360	M-10,595 F- 16,778	M- 22,204 F- 21,044
65-74	M- 2,115 F- 3,160	M- 1,029 F- 1,071	M- 3,543 F- 12,821	M- 4,690 F- 8,663	M- 11,377 F- 25,715	M- 29,331 F- 27,055
75-84	M- 2,093 F- 2,826	M- 791 F- 858	M- 6,850 F- 25,270	M- 1,837 F- 2,694	M- 11,571 F- 31,648	M- 17,832 F- 13,158
85-	M- 826 F- 2,076	M- 662 F- 400	M- 4,132 F- 20,046	M- 552 F- 929	M- 6,172 F- 23,451	M- 4,870 F- 2,850
Totals	M- 8,234 <u>F- 11,916</u> T- 20,150	M- 3,533 <u>F- 3,435</u> T- 6,968	M-15,761 F- 62,595 T- 78,356	M-12,197 <u>F- 19,646</u> T- 31,843	M- 39,725 <u>F- 97,592</u> T-137,317	M- 74,237 <u>F- 64,107</u> T- 138,344

Living Alone—Conclusions. The data show clearly that women, with greater life expectancy, live alone far more than men, especially in their later years. Although many older adults living alone maintain regular community engagement or have family and friends to look after them, many others lead solitary lives. Not only are they isolated from human contact, but from the means of learning about and being connected to the information and assistance that they need to continue living independently. The DHS/AAA has a special concern for those living alone with few supports or little social contact, especially those in isolated locations where it is difficult to know of the circumstances of their existence.

Other Aging Issues

Transportation. Allegheny County has one of the finest transportation systems in the country. County residents 65-over ride fixed-route transit free of charge anywhere, anytime. State Department of Transportation data (2007-2008) show that older adults took 6,012 one-way

trips valued at \$11,878,000. They also enjoy low-cost shared-ride public paratransit services, including one sponsored by the DHS/AAA, and publicly and privately owned services in local communities that often fill gaps in the county transit system in resourceful, inexpensive ways.

However, two issues need to be addressed if the transportation system is to continue serving older adults as well.

- As older adults age in place, fixed route and paratransit need to adapt so that they remain a viable, accessible resource in support of independent living. For instance, many frail older adults require door-to-door and hand-over-hand assistance to use paratransit safely. Without this assistance and other innovations, access into the outside community will be limited for them.
- The local transit system is threatened with service cutbacks, route eliminations, and fare increases due to the lack of a dedicated state funding stream. More than any other service, older adults use the free fare program to ride public transit. With reduced service, older adults will be forced to turn to more limited and expensive transportation options. Moreover, fewer fixed route options will shift the cost burden onto paratransit systems that may not be able to fill the gap, both in terms of service and costs.

Housing. The housing stock in Allegheny County presents special challenges for older adult because of its age and the local terrain. The 2009 ACS indicates that of the 589,218 housing units in the county, 60% were built before 1960. Many were built in the post-World War II era to ease the housing shortage and were designed for young families. Today, these homes are over 50 years old, require significant and costly upkeep, and may be difficult or impossible to adapt to the safety and convenience needs of older adults. Many homes are even older; 42% of homes in the county were built before 1950, including 180,000 (30%) before 1940.

Pittsburgh's steep terrain and often severe winters also pose a challenge for many older adult home owners. Although the number of senior communities has increased in recent years, a large proportion of older adults continue to live, often alone, in aging, free-standing, single-family houses that may be located in isolated or hilly areas with difficult access.

Moreover, the terrain reduces the amount of land suitable for home construction so that the prospects for new, affordable housing for older adults in areas where they now live are limited. The county faces a shortage of readily accessible homes for those in mid- and lower-income ranges, which includes many older adults. The combination of these factors poses a formidable challenge for maintaining or relocating older adults into safe, affordable housing in the county.

V. AGING SERVICE VISIONS: PAST, PRESENT AND FUTURE

The DHS/AAA strategic planning process was guided by a long-range perspective of how services have evolved over time and need to be consciously re-engineered to address the changing environment in which we work. The following three vision schematics depict the conceptual and functional progression of services at the DHS/AAA over time.

Care Management

Ten Years Ago	Large caseloads mean care managers provide only basic services to relatively few participants.
Today	Reduced caseloads enable care managers to provide quality services to more participants.
By 2016	Care Management services are customized to individual participant needs.
By 2020	Older adults, caregivers and providers collaborate with the DHS/AAA to create an aging services network known for innovation and quality of care .

Senior Community Centers

Ten Years Ago	Senior community centers typically offer group meals and activities; programming varies widely in quality and consistency.
Today	A wider array of programming to address varied and changing interests is offered. Quality standards are in place.
By 2016	High-quality programming incorporates preventive health strategies and serves a wide range of participants in variety of community settings.
By 2020	Older adults are engaged and connected in greater numbers and more meaningful ways in their communities throughout their lives.

Participant and Caregiver Needs

Ten Years Ago	Long wait times for some DHS/AAA Senior Line callers have been remedied.
Today	The Senior Line responds promptly and provides callers with appropriate assistance or referral for any need. Caregiver needs receive greater attention.
By 2016	Information and Assistance is easily accessible 24/7 . Caregiver needs are addressed consistently over DHS/AAA programs and provider network.
By 2020	Older adults, caregivers and providers interact collaboratively in an aging services network known for innovation and quality care .

VI. STRATEGIES AND PERFORMANCE MEASURES

Introduction. The community needs assessment brought into clear perspective the areas of concern on which the DHS/AAA will focus substantial attention and resources in the next four years. While many challenges stand in the way, the issues identified in the community needs assessment are as clear as they are pressing.

- How can information and services be made more accessible and understandable for older adults so that they encounter fewer obstacles, including the introduction of new technologies to support participant needs and the work of aging services professionals?

- What can be done to support independent living, particularly for the younger generation of older adults as a means of fostering preventive health strategies and thereby delay or eliminate the need for more acute and costly long-term care?
- How can services be customized to meet the wide range of individual needs presented by the current and future generations of older adults, including the higher incidence of cognitive, behavioral and mental health issues?
- How can caregivers be supported so that they are able to sustain the health and well-being of their loved ones, as well as themselves?
- How can the DHS/AAA service support functions be organized and improved to produce the maximum, measurable impact on its participants and community?

Strategy 1—Provide Accessible Expertise	
Change how the community thinks of, accesses and utilizes the DHS/AAA	
<i>(Corresponds to State Policy Theme: Effective and Responsive Management)</i>	
Implementation Steps:	<ul style="list-style-type: none"> • Improve participant access and service quality through expanded Senior Line and Information and Assistance hours, community outreach and more consumer-friendly information. • Enhance consumer independence and agency effectiveness by implementing promising new technologies (video, mobile outreach). • Provide outreach and services to emerging and underserved target populations (baby boomers, LGBT, and immigrants and refugee groups) and tiered services for age groups in the 50-75 range.)
Performance Measures:	<ul style="list-style-type: none"> • By 2016, participants obtaining Information and Assistance services rate the benefit and value as good to excellent at least 90% of the time. • By 2016, at least 50,000 county residents obtain information or services through the DHS/AAA annually.

Strategy 2—Extend Independent Living	
Enhance information, assistance and prevention programs to extend independent living and delay the need for more intensive services.	
<i>(Corresponds to State Policy Themes: Promote Health and Well-being; Communities to Age and Live Well)</i>	
Implementation Steps:	<ul style="list-style-type: none"> • Enhance service delivery with a more efficient system of community-based service sites and partnerships. • Advance participants’ well-being with a significant expansion of evidence-based healthy aging programs.
Performance Measure:	<ul style="list-style-type: none"> • By 2016, the number of older adults actively participating in AAA-sponsored, evidence-based health and wellness programs increases by 50%.

Strategy 3—Customize Care	
Offer individualized Care Management that can be easily obtained by older adults with a wide range of needs.	
<i>(Corresponds to State Policy Theme: Revitalize/Re-architect Services; Innovation Incubator for Services)</i>	
Implementation Steps:	<ul style="list-style-type: none"> • Raise the quality of contracted care-managed programs through implementation of new performance standards, training and oversight.
	<ul style="list-style-type: none"> • Research, pilot and implement innovative programs to improve community-based living and customize service to meet the intensity of needs or specialized needs.
	<ul style="list-style-type: none"> • Research, pilot and adopt new approaches to family engagement in services.
Performance Measure:	<ul style="list-style-type: none"> • By 2016, older adults or their caregivers who seek services gain access to a care manager in less than half of the time that it takes in 2011.
	<ul style="list-style-type: none"> • By 2016, implement at least two programs in Care Management to support quality of life by improving care connections with systems and families.

Strategy 4—Partner with Caregivers	
Consider—and balance—the needs of participants and caregivers to optimize their quality of life.	
<i>(Corresponds to State Policy Themes: Communities to Age and Live Well; Promote Health and Well-being)</i>	
Implementation Steps:	<ul style="list-style-type: none"> • Plan and implement increased recognition and support for caregivers across agency programs.
	<ul style="list-style-type: none"> • Build partnerships to expand access to support for caregivers in the broader community.
Performance Measure:	<ul style="list-style-type: none"> • By 2016, major DHS/AAA programs specifically identify and address the needs of caregivers.

Strategy 5—Continuous Improvement and Community Impact	
Transform planning, research, training, evaluation and quality improvement functions to better serve participants, and inform decision and policy making.	
<i>(Corresponds to State Policy Themes: Revitalize and Re-architect Services; Effective and Responsive Management)</i>	
Implementation Steps:	<ul style="list-style-type: none"> • Attract and nurture high-performing providers through RFP selection, performance-based contracting, integrated monitoring and quality monitoring systems.
	<ul style="list-style-type: none"> • Deliver effective, high-quality service agency-wide through evaluation, data management and quality management.
	<ul style="list-style-type: none"> • Improve staff proficiencies by developing and offering competency-based

	training curricula based on individual job families.
Performance Measures:	<ul style="list-style-type: none"> • By 2016, quality improvement measurements include tracking real-life benefits to participants in DHS/AAA programs.
	<ul style="list-style-type: none"> • By 2016, competency-based assessment and training is established in DHS/AAA programs; 15% of staff demonstrate advanced competency in an area of specialization.

Continuing Commitment to Existing Services. The preceding presentation on new strategies reflects the DHS/AAA’s best thinking and approaches to emerging needs in its service population. What should not be overlooked, however, is that we will also continue to deliver a large volume and range of vital home and community-based services to one of the largest concentrations of older adults in the nation. At the same time that we are emphasizing service innovations, we will also continue to provide senior center meals and programming, transportation for medical and health-related purposes, care management services for participants with varying levels of need, safeguards for vulnerable older adults through the most active Protective Services unit in the state and many other services that enable older adults to live independently to the extent that they are able and choose to do so.

Aging Waiver/Program Issue. As we prepare this plan, the DHS/AAA has serious concerns about the separation of enrollment and service coordination in Aging Waiver. As we have not yet received definitive information about how these activities will be reorganized and the final payment structure, we are uncertain if we will be able to continue delivering these services, even if we can still provide the base services. Moreover, some of our well-performing direct care agencies are considering a cessation of service to Aging Waiver because the proposed payment rates are insufficient for delivery of services in a stable manner without incurring financial losses. We are hopeful that these issues can be resolved in a manner that is timely and favorable for AAAs, service providers and participants alike.

VII. U.S. Administration on Aging--Areas of Emphasis

1. **Individuals with Greatest Economic or Social Need.** Current (May 8) SAMS data show that the DHS/AAA serves the following participants with the greatest economic or social need.
 - 5,614 participants living below the federal poverty threshold
 - 5,138 with a disability
 - 4,619 homebound elderly
 - 8,400 85-over, or about 24% of this critical age group

2. **Individuals at Risk for Institutional Placement.** The DHS/AAA addresses the needs of individuals at risk for institutional placement through the following programs.
 - Aging Waiver has more than 1,600 NFCE participants enrolled; of Options Care Management’s more than 4,000 participants, 11% are NFCE.

- Consumer Choice enables the DHS/AAA to expedite Aging Waiver enrollment for participants at imminent risk for institutionalization.
 - Nursing Home Transition projects the return of over 207 nursing home participants back into the community during the current fiscal year.
 - In addition, the DHS/AAA is committed to a proactive, long-range approach to delaying or eliminating the need of participants for long-term care through increased focus on health, wellness and prevention programs for participants of all ages, as articulated in Strategy 2 of the four-year plan.
- 3. Low-income and Minority Individuals.** SAMS data show that the DHS/AAA serves the following low-income and minority participants.
- 5,614 participants living under the federal poverty threshold
 - 6,581 African-Americans
 - 435 Asians/Pacific Islanders
 - 58 Native Americans.
- 4. Individuals with Limited English Proficiency.** The DHS/AAA serves an area with a long immigration history and many ethnic communities, including newly resettled groups who are often unfamiliar with the social services and may be difficult to reach due to language and cultural barriers. To address these and other issues, the DHS/AAA employs the following strategies:
- Use of a service to translate printed material into foreign languages spoken by some participants, including Chinese and Russian.
 - Programming for a nearby Chinese community that patronizes a DHS/AAA-affiliated senior community center.
 - Bi-lingual care managers to work with foreign-language speakers, such as those in the growing Russian Jewish population that has emerged in the area.
 - Outreach to new immigrant groups with aging service needs is part of the DHS/AAA's broader initiative to reach underserved populations, as expressed in Strategy 1 of this plan. New, recently settled immigrant groups in the area include Africans, Bosnians, Bhutanese and Nepalis, among others.
- 5. Individuals in Rural Areas.** DHS/AAA serves a largely urban and suburban industrialized county with only six small rural communities that have been so designated by the state.

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APPENDIX A

Strategy 1—PROVIDE ACCESSIBLE EXPERTISE

Change how the community thinks of, accesses and utilizes the DHS/AAA.

(Corresponds to State Policy Theme: Effective and Responsive Management)

Implementation Steps	Performance Measures	Outcomes	Progress Updates
<ul style="list-style-type: none"> • Improve participant access and service quality through expanded Senior Line and Information and Assistance hours, community outreach and more consumer-friendly changes. • Enhance consumer independence and agency effectiveness by implementing promising new technologies. (e.g., video, mobile outreach, etc.) • Provide outreach and expanded services to emerging and underserved target populations (baby boomers, LGBT, and immigrant and refugee groups), and tiered services for age groups in the 50-75 range. 	<ul style="list-style-type: none"> • Participant rating of the benefits and value of Information and Assistance services. • Number of county residents obtaining information or services through the DHS/AAA annually. 	<ul style="list-style-type: none"> • By 2016, participants obtaining Information and Assistance services rate the benefit and value as good to excellent at least 90% of the time. • By 2016, at least 50,000 county residents obtain information or services through the DHS/AAA annually. 	

Strategy 2—EXTEND INDEPENDENT LIVING

Enhance information, assistance and prevention programs to extend independent living and delay the need for more intensive services.

(Corresponds to State Policy Themes: Promote Health and Well-being; Communities to Age and Live Well)

Implementation Steps	Performance Measures	Outcomes	Progress Updates
<ul style="list-style-type: none"> • Enhance service delivery with a more efficient system of community-based service sites and partnerships. • Advance participants' well-being with a significant expansion of evidence-based healthy aging programs. 	<ul style="list-style-type: none"> • Number of older adults actively participating in AAA-sponsored, evidence-based health and wellness programs. 	<ul style="list-style-type: none"> • By 2016, the number of older adults actively participating in AAA-sponsored, evidence-based health and wellness programs increases by 50%. 	

Strategy 3—CUSTOMIZE CARE

Offer individualized Care Management that can be easily obtained by older adults with a wide range of needs.

(Corresponds to State Policy Themes: Revitalize/Re-architect Services; Innovation Incubator for Services)

Implementation Steps	Performance Measures	Outcomes	Progress Updates
<ul style="list-style-type: none"> • Raise the quality of contracted Care Management programs through implementation of new performance standards, training and oversight. • Research, pilot and implement innovative programs to improve community-based living, and customize service to meet the intensity of needs or specialized needs. • Research, pilot and adopt new approaches to family engagement in services. 	<ul style="list-style-type: none"> • Time to access to a care manager for older adults and caregivers seeking services. • Programs in care-managed services that sustain or improve quality of life by improving care connections with systems and families. 	<ul style="list-style-type: none"> • By 2016, older adults or their caregivers who seek services gain access to a care manager in less than half of the time that it takes in 2011. • By 2016, at least two programs in care-managed services will be implemented that sustain or improve quality of life by improving care connections with systems and families 	

Strategy 4—PARTNER WITH CAREGIVERS

Consider—and balance—the needs of participants and caregivers to optimize their quality of life.

(Corresponds to State Policy Themes: Communities to Age and Live Well; Promote Health and Well-being)

Implementation Steps	Performance Measures	Outcomes	Progress Updates
<ul style="list-style-type: none"> • Plan and implement increased recognition and support for caregivers across agency programs. • Build partnerships that expand access to support for caregivers in the broader community. 	<ul style="list-style-type: none"> • DHS/AAA programs that identify and address the needs of caregivers. 	<ul style="list-style-type: none"> • By 2016, major DHS/AAA programs specifically identify and address the needs of caregivers. 	

Strategy 5—CONTINUOUS IMPROVEMENT AND COMMUNITY IMPACT

Transform planning, research, training, evaluation and quality improvement functions to better serve participants, and inform decision and policy making.

(Corresponds to State Policy Themes: Revitalize and Re-architect Services; Effective and Responsive Management)

Implementation Steps	Performance Measures	Outcomes	Progress Updates
<ul style="list-style-type: none"> • Attract and nurture high-performing providers through RFP selection, performance-based contracting, integrated monitoring and quality monitoring systems. • Deliver effective, high-quality service agency-wide through evaluation, data management and quality management. • Improve staff proficiencies by developing and offering competency-based training curricula based on job families. 	<ul style="list-style-type: none"> • Quality improvement measurements that track real-life benefits to participants in DHS/AAA programs. • Competency-based assessment and training in DHS/AAA programs. • DHS/AAA staff demonstrating advanced competency in an area of specialization. 	<ul style="list-style-type: none"> • By 2016, quality improvement measurements include tracking real-life benefits to participants in all DHS/AAA programs. • By 2016, competency-based assessment and training is established in all DHS/AAA programs. • By 2016, 15% of staff demonstrate advanced competency in an area of specialization. 	

APPENDIX B

Collaborations and Community Partnerships

DHS Collaborations. The AAA has additional opportunities for consultation and collaboration with other DHS program offices and administrative units that expand and enrich AAA programmatic resources and capabilities.

The AAA collaborates fully with the Allegheny Link for Aging and Disability Resources, which is housed in the same building. The AAA also works regularly with the following DHS programs offices and units:

- Aging and Disability Resource Center (ARDC)
- Behavioral Health (OBH)
- Community Relations (OCR)
- Children, Youth and Families (CYF)
- Data Analysis, Research and Evaluation (DARE)
- Community Services (OCS).
- Integrated Services

Through its relationship with DHS, the AAA also enjoys greater access to other community services for vulnerable populations such as the Low-Income Home Energy Assistance Program, hunger and housing assistance, and drug and alcohol counseling and treatment, among others. Finally, the AAA heads a committee with representation from DHS units, as well as the Allegheny County Health Department and local office of the Department of Public Welfare, for monitoring risks to residents of Personal Care Homes and planning for potential closings.

Collaborations and Other Relationships with Community Partners. In an effort to pursue greater strategic opportunities, leverage additional resources and improve the local system, the AAA proactively seeks out and engages in external collaborations that enhance participant services and address barriers facing the older adult population. The AAA maintains collaborative relationships with the following community organizations:

- Allegheny County Library Association—Provide healthy aging and other educational programs and disseminate aging services information throughout the county library system, including programming for the Better Choices/Better Health (chronic disease self-management) and Safe Neighbors (older adult emergency preparedness) programs.
- American Association for Retired Persons—Collaborate, with a contracted provider, in providing money management and financial counseling services for older adults.
- American Red Cross and DHS/Office of Behavioral Health—Provide ongoing emergency readiness workshops and “Grab ‘n Go Kits” to older adults throughout Allegheny County (Safe Neighbors program) at various community sites.

- Board of Directors, Professional Advisory Committees and Special Projects Service —A partial list of governing boards or advisory councils on which AAA staff serve include the following: Southwestern Pennsylvania Partnership for Aging, Bethany Hospice, LIFE programs, Pennsylvania Adult Day Services Association, Behavioral Health Coalition, Community Bridge Building, Pittsburgh MOVE Project, Peer Support for Older Adults, Department of Public Welfare Personal Care Residence Advisory Committee, Allegheny County Aging and Disability Resource Connection, Social Security Administration Economic Advisory Committee, Mental Health and Aging Collaborative, United Way, University of Pittsburgh School of Social Work Advisory Committee, and various UPMC research and advisory councils.
- Carrier Alert Program—Work with the U.S. Postal Service to provide a warning system for notifying the AAA of possible serious illness or incapacity of older adults living alone.
- Chronic Disease Self-management Program Partners—Provide for promotion and hosting of trainings at various accessible community locations throughout the county, including libraries, churches, non-profit community service organizations, private senior communities and public housing authorities. The AAA established some 20 new working relationships with community partners through this program. (grant funded to 3/31/12)
- Community College of Allegheny County—Coordinate specialized training needs for senior community centers and Senior Companions.
- District Attorney, Allegheny County—Collaborate with D.A. legal staff in the prosecution of elder abuse cases.
- Economic Education Group—AAA staff task force worked with local providers and community partners (e.g., Neighborhood Legal Services, Consumer Credit Bureau) to provide economic education and personal assistance for older adults (ended).
- Housing Authority, City of Pittsburgh (HCP)—Provide service coordination, in conjunction with a contracted community provider, for older adults residing in HCP public housing communities (Senior Living Enhancement Program).
- Jewish Healthcare Foundation—Participate in the End of Life Planning project and the Caregiver Champions program.
- Local housing coalitions—Help to address housing issues affecting older adults with local housing assistance organizations such as Local Housing Options Team, Rebuilding Together Pittsburgh, Pennsylvania Housing Financing Agency and the Pittsburgh Project.

- Non-contracted Providers/Community Partners—Conduct regular meetings to share information, discuss issues and build network cooperation and coordination in the delivery of services.
- PERSAD—Provide workshops and information for the aging provider network to strengthen access to services and understanding of the local lesbian-gay-bisexual-transsexual (LGBT) population’s aging service needs.
- Quality of Life Technology Center--A joint project of the University of Pittsburgh and Carnegie Mellon University, and the Tele-rehabilitation Engineering Research Center at the University of Pittsburgh that advances research and development work leading to new applications of assistive and telecare devices for older adults. Two AAA provider agencies have been certified in this area.
- Southwestern Pennsylvania Partnership for Aging—Are active members in the local coalition of aging service providers.
- University of Pittsburgh School of Social Work—Provide opportunities through the Hartford Partnership for Aging Education for MSW and BASW student placements at the agency and opens a vital new means for the development and entry of well-qualified professionals into the aging services field; also piloting a care manager training program through the school.
- Other Universities—Provide student internship opportunities for students from Duquesne, Chatham and Carlow Universities.
- University of Pittsburgh Graduate School of Public Health—Collaborate in research and survey projects on aging-related issues.
- UPMC (University of Pittsburgh Medical Center) Health Plan--Collaborate on information sharing with consumers in their health plans to better integrate and coordinate care in the Aging Waiver; also serve as guest speakers on aging-related issues.

DHS/AAA Program Innovations and Initiatives

In its commitment to continuous quality improvement and community impact, the AAA has introduced a wide range of program innovations and initiatives to enhance existing services, introduce new service dimensions, and expand and improve the ways in which consumers are served. The entries below represent ways in which the AAA has exceeded mandated program requirements to introduce new thinking and approaches that provide added service value and quality for consumers, and more effective (and often cost-effective) service delivery within the AAA and the aging services network. Entries in this partial listing are grouped under headings

that correspond to the strategies of the four-year plan and relate directly to the PDA policy theme, “Innovation Incubator for Service.”

➤ **Continuous Improvement/Community Impact**

- **Emergency Planning Experience**—Documented our experiences and developed standard operational plans for emergency response to provide uninterrupted service for consumers and deployment of staff; based on recent experiences with the G-20 conference, a major snowstorm, storm-related flooding and temporary relocation of staff from our building.
- **Learning Circles**—Use this learning model for staff training and leadership development.
- **Learning Management System**—Established this computerized learning system to plan and manage staff training and development.
- **Monitoring and Validation Systems**—For in-home services and senior centers.
- **Performance-based Contracting** —Piloting with five selected senior center providers.
- **Program Impact and Outcomes Research**—Re-orienting of program evaluation from processes to end results and impacts on consumers.
- **Quality Standards and Improvement**—Quality standards teams, involvement of consumers in the process, consumer surveys and annual provider symposium.
- **Semi-Annual Provider Meetings**—Meetings with contracted and non-contracted providers of information and assistance programs throughout Allegheny County to provide information about AAA programs, benefit programs and basic need resources for older adults, and build networks and collaboration opportunities.
- **VOIP Phone System**—Projected installation of a web-based phone system to modernize and expand telecommunications capacity.
- **Webinars**—Use of webinars for provider meetings and trainings

➤ **Provide Accessible Expertise**

- **Access to Immigrant & Non-English Speaking Populations**--Use of computer software and a translation service for converting printed materials into foreign languages; Expansion of programming at a senior center to address the needs of a Chinese immigrant population in the area; Outreach to newly emerged immigrant populations (Russian Jewish, African, Chinese, Bosnian, Bhutanese, Nepali).

- **Access to Underserved Populations**—Study group to explore ways to provide services and information to underserved populations; first focus of the group is the lesbian, gay, bi-sexual and transsexual population.
- **Aging Discussion Groups**—Convening of professionals from the local aging services network to discuss and share experiences, expertise and ideas on aging-related issues.
- **AIRS Certification**—Piloting nationally recognized training program for call center staff with AAA and community provider Information and Assistance staff for possible implementation with all AAA and provider staff.
- **Care Mangers for Information & Assistance**—Use of staff at care manager level to provide Information and Assistance.
- **Conversion to Information and Assistance Services**—Advancement of services beyond referral to direct assistance to consumers.
- **Paperless Documentation**—Use of on-base scanning technology for conversion from paper to electronic documentation and communication.
- **Strategic Relocation of Staff**—Redeployment of staff to regional offices to address new geographic patterns of consumer service needs.

➤ **Extend Independent Living**

- **Chronic Disease Self-Management Program**—One of four AAAs in Pennsylvania providing workshops, in cooperation with community partners, to train consumers how to live with and manage chronic medical conditions (grant funded to 3/31/12).
- **Community Ombudsman**—Implementing the first Ombudsman program in Pennsylvania for consumers of community-based long-term care as a pilot for future implementation at other state AAAs.
- **Cultural Enrichment**—Partnering with the Pittsburgh Cultural Trust to provide a wide range of cultural enrichment opportunities for older adult.
- **Emergency Boxes**—Stocking of selected senior centers and Care Management providers with cold weather and hot weather emergency supply boxes, and shelf-stable meals for emergency response.

- **Financial Education**—Training for consumers in personal financial management through collaboration between senior centers, community organizations and selected community partners.
- **New Senior Center Models**—Introduction of new service and facility designs that expand and improve the service capacity and overall concept of senior community centers; opening of new comprehensive regional senior center in September, 2012.
- **Senior Center Program Extension**—Providing senior community center programming locations in the community that are accessible and heavily frequented by older adults.

➤ **Customize Care/Partner with Caregivers**

- **Assessment for Hearing Disabled**—Using voice amplifiers to conduct assessments of consumers with hearing disabilities.
- **Care Management Quality Standards**—Raising of quality standards for Care Management services through implementation of a Request for Proposals.
- **Care Managers/Protective Services**—Selection and training of care managers to screen after-hours Protective Services reports of need.
- **Care Transitions**—Partnering with five local hospital systems to coordinate care needs of older adult patients and reduce re-admissions within 30 days (grant funded).
- **Ex-offenders Support**—Provide personal support to older adult ex-offenders for their life transition after release from correctional facilities (ASOP program).
- **Family Teaming**—Introducing family group decision making models in planning for long-term care needs.
- **In-home Assessments of Vision Disabled**—Partnering with a vision services agency to assess the need for safety and convenience adaptations of consumers with visual disabilities.
- **Law School/Protective Services Collaboration**—Partnering with local law schools to provide pro bono representation for guardianship court cases involving indigent older adults.
- **Protective Services**—Engaging independent psychologists and financial consultants in the evaluation of specific cases.
- **Special Diet Home Delivered Meals**—Introduced a kosher home delivered meal option.

- **Veterans Administration/Case Management Services**—Working on a collaboration with the Veterans Administration to provide case management services to veterans.

ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES

June, 2012

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Allegheny County Executive

James M. Flynn, Jr.
County Manager

Marc Cherna
Executive Director

Randolph Brockington
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Allegheny County DHS/Area Agency on Aging Organizational Chart – 2012

