AREA IX AGENCY ON AGING

AREA PLAN

For the Period

OCTOBER 1, 2019 through SEPTEMBER 30, 2022

TABLE OF CONTENTS

SECTION	SUBJECT	PAGE
I	**EXECUTIVE SUMMARY and NARRATIVE**	3-8
II	**PUBLIC AND STAKEHOLDER INPUT**	9-25
III	**VOLUNTEERS**	24-25
IV	**FOCUS AREAS**	25-36
	A. Older Americans Act Core Programs ▪ Access Services ▪ In-Home and Community Services ▪ Nutrition	25-32
	B. Specific Programs ▪ Aging and Disability Resource Centers (ADRC) ▪ Evidenced-based Disease Prevention Programs ▪ Senior Medicare Patrol (SMP) and State Health Insurance Program (SHIP)	32-33
	C. Participant-Directed/Person-Centered Planning/Programs ▪ Options Counseling ▪ Veteran-Directed Home and Community-Based Services	33-34
	D. Elder Justice ▪ Long Term Care Ombudsman ▪ Legal Assistance and Adult Protective Service	34-36
V	**DEMOGRAPHICS**	36-39
VI	**TITLE III/VI COORDINATION**	39
VII	**OUTCOMES, STRATEGIES and PERFORMANCE INDICATORS**	39-46
VIII	**FORMS**	46
	▪ Attachment A: Direct Service Waiver Request	47-48
	▪ Attachment B: Community Focal Points and Senior Centers	49
	▪ Attachment C: Advisory Council Members	50
	▪ Attachment D: Statement of Intent/Signature Page	51
IX	**AREA PLAN IMPLEMENTATION**	52-53
X	**AREA PLAN CHECKLIST**	54

SECTION I: EXECUTIVE SUMMARY AND NARRATIVE

"We live in a world never to be young again." (Dr. Marvin Kaiser) The aging population is exploding nationally, across Montana and in Flathead County, and people are living longer than ever before. This trend is part of an unprecedented global demographic shift that will require sustained innovation and investment at all levels to ensure quality of life, health and well-being for all.

Although many older adults, especially those in the younger age groups, do not need assistance, others have challenges that make life difficult to manage without help. The likelihood of needing assistance increases as people age with those 75 and older being most at risk.

Older adults are aware of their growing numbers and are very concerned about access to and affordability of services now and in the future, but relatively few have an explicit plan for their older years. They vary in their understanding of the systemic issues that determine the help available to them. Regardless of planning or awareness, most older adults will depend at some point on safety net programs like Social Security, Medicare, Medicaid and Older Americans Act Programs.

Area Agencies on Aging are a primary source of information and support for older adults and their family caregivers. We are also one of the very few sources of non-Medicaid services and as such play a pivotal role in preventing or delaying entry into the Medicaid long-term care system and particularly into costly facility-based care.

Area Agencies on Aging, including ours, are experiencing a substantial increase in the demand for our services due to the changing demographics. However, government funding at the national and state levels, which provides the foundation for our services and others that support older adults, has not kept pace with the demand. While we are committed to exploring and pursuing other sources of revenue, stable and adequate public funding must form the secure base upon which we can add non-governmental funding and private pay service models to build a robust system. More state and regional collaboration could also lead to creative problem-solving and solution building.

Although aging services are critical to the health and well-being of older adults, aging itself is not a healthcare or social service problem looking for a healthcare or social service solution. It is a universal and complex experience that brings challenges and opportunities and requires local community engagement. How we think about and talk about aging matters. Aging brings with it unique concerns, but older adults are also vital and valuable assets.

Findings

In considering area demographics, reviewing our own client and performance data, consulting other community information and needs assessments and gathering public and stakeholder input, the following themes emerged to guide our objectives and strategies in this plan period:

1. **The number and percentage of older adults in our community continues to rise significantly.** U.S. Census Bureau 2017 estimates show 27.9% of Flathead County residents are now age 60 or older (a 6.7% increase from 2010) and 18.5% are age 65 or older. Almost 48% of households in Flathead County include a person 60 or older. 37% of those 65 or older report having a disability, as do 62% of those 75 and older. (See SECTION V.)

2. **We primarily serve an older, vulnerable population who have very limited incomes and are at a high risk of costly institutionalization and/or negative outcomes related to their health and well-being.** (See SECTION V.)
    a. The average age of those we serve is 76. People older than 75 report 3 times the rate of disability and functional limitations than those between ages 65 and 74.
    b. 90% of our in-home/community services clients present a moderate to high risk of institutionalization or negative outcomes in one functional area. Almost two-thirds have an overall moderate to high risk.
    c. 96% of the people we serve live at or below 200% of the federal poverty level; 61% live at or below 150%, and 33% live at or below 100% (compared to only 8% of older adults in Flathead County as a whole).
    d. There is a large percentage of veterans in Flathead County and one-quarter of them are older adults, underscoring the need for services like the Veteran Directed Home and Community-based Program.

3. **Demand for aging services, our and others, exceeds current resources.** (See SECTION IV)
    a. Despite recent increases in federal funding, Area Agencies on Aging have been historically underfunded. At the state level, in the last legislative session Area Agencies received a 2.5% budget cut and many other entities that serve older adults and people with disabilities received much more substantial cuts, shifting service demand to us.
    b. Our agency is functioning at maximum capacity and cannot do more without additional resources, nor can we fill in the gaps created when other entities lose funding. Our ability to maintain even our current level of service delivery is hampered by the rising costs of doing business.
    c. Although all our programs are underfunded, the Ombudsman Program is in crisis and is unsustainable at both a state and local level.
    d. Community mental health services are inadequate and difficult to access; our staff is not equipped or funded to address this growing need.
    e. Over the last four years, our agency has enhanced and improved every aspect of service delivery despite these challenges. Our staff are skilled, committed, caring and professional. They have stepped up to meet the needs, and along with our volunteers, have enriched the lives of older adults in Flathead County. To continue to do our best work, however, we need resources to support hiring of additional staff, increased compensation and more and better training.
    f. We've been pleased by the success of our recent collaborative efforts with the state and other regional Area Agencies on Benefits Enrollment Center

grants and the Veteran-Directed Home and Community-Based Services program. We hope to continue these efforts and pursue new opportunities during this plan period.

4. **People who provided input on the Area Plan are concerned about many aspects of aging, but there are three main categories** (see SECTION II)**:**
    a. Loss of health or functioning that leads to loss of independence and loss of quality of life
    b. Being unable to afford basic necessities (including housing and transportation), medical care and supportive services (both in-home and facility-based)
    c. Loss of interpersonal and social connectedness

5. **People who provided input on the Area Plan want to see public funding and support related to the things that concern them. Their top three priorities are** (see SECTION II)**:**
    a. Funding for safety net programs (including Social Security, Medicare, Medicaid and Older Americans Act programs)
    b. Affordable housing, transportation, health care and supportive services
    c. Financial assistance for basic needs

6. **People who provided input on the Area Plan worry about older adults who are vulnerable, especially those who are isolated in their homes**. This is reflected in the degree to which public and stakeholder feedback noted addressing social isolation and providing home-delivered meals and in-home care as priority services. Additionally, people are aware of and specifically mentioned their concern about the prevalence of exploitation (especially financial exploitation), neglect and abuse. For example, 19% of respondents to our community survey chose this as one of the top five concerns for older adults in our area. Many observed that this population does not have a "voice" and did not want them to be forgotten in the development of this plan.

7. **We offer programs and services that help people with many of the things that most concern them about aging, and clients and stakeholders see us as a valuable resource.** (See SECTION IV)
    a. People overwhelmingly want to age in their homes and communities, and our agency helps them do that through provision of core programs like in-home/community services, home-delivered meals, information and assistance and transportation (especially Eagle Transit).
    b. Respite and other supportive services help family caregivers keep their loved ones at home and out of costly institutions. Outreach to caregivers is critical as many don't know help is available or may be too overwhelmed to seek assistance on their own; Almost half of the public survey respondents reported having been a family caregiver of an older adult; almost three-quarters of our staff said the same.
    c. We help people access benefits that stretch their resources and reduce financial insecurity through SHIP counseling and BenefitsCheckUP

screenings and by offering our services by donation or on a suggested sliding fee scale.

d. We offer opportunities for social connectedness through our social dining program (congregate meals), financial and technical assistance support to local senior centers, volunteer opportunities and annual events.
e. Public and stakeholder input indicate people think we provide essential, high quality services.

8. **The service system as a whole is inadequate, fragmented and difficult to navigate**
    a. The people we serve frequently express frustration over the degree to which information is difficult to find and confusing to understand and the web of agencies and providers is complicated and frustrating to try to navigate. Our staff characterize the system the same way.
    b. The demand for our Information and Assistance services has increased 11% over the last two years and is on track to increase almost 30% this year, partly due to demographics but also because of our enhanced outreach efforts. We are experiencing a similar increase in demand for SHIP/benefits counseling.
    c. 38% of the public surveyed think Information and Assistance is a critical service and 29% noted benefits counseling as such; the AOA Advisory Council members also discussed the need for more of these services.

9. **A person-centered approach is key.**
    a. People define quality of life differently. They want and need services that support them to do what's important to them, be included in and valued by their community and have meaning and purpose.
    b. Over the last few years, we have expressly shifted our approach to all of our services from a "menu" or service array model to a person-centered model to help us improve our programs but also to help the people we serve think differently about their own lives and care choices.
    c. People need encouragement and help to plan for their aging years to increase the likelihood they will be able to live the lives of their choosing.

10. **Aging brings benefits and opportunities, and older adults are an asset to our agency and our community.**
    a. The people who provided input into the Pan report they appreciate the freedom that comes with retirement to focus on themselves and their families/friends and to do what they like to do when they like to do it. They also think of themselves as wiser, more knowledgeable and more experienced, with talents and expertise to share with younger people and their communities. Many also report having a "mellower" perspective on life and a more secure sense of self.
    b. Our agency, like many in the Flathead, depends heavily on older adult volunteers. Almost all of our approximately 130 volunteers are older adults themselves and they bring a depth of skill and commitment without which

we couldn't operate. In FY 2018, AOA volunteers gave 14,488 hours of their time at a value of $324,821. (See SECTION III)

11. Aging is not a "problem" but rather a universal experience requiring community engagement and investment.

a. In many ways, those who provided input on the Plan feel the Flathead is a good place to live and age. It's the "right size," safe with a small-town atmosphere, friendly and caring people and plenty of things to do. Older adults for the most part feel supported and included. They think the health care and social services available are of good quality.
b. People who participated/responded also feel the community as a whole needs to do more to support older adults to stay in their homes, with top needs being more affordable/accessible housing, transportation and supportive services. A frequently mentioned unmet need is affordable home maintenance/repair and accessibility modification, as well as help with yard work/snow shoveling.
c. They also expressed overall community accessibility and inclusiveness could be improved.
d. They are concerned that some older adults lack basic access to services, ours and others, especially people living in outlying/rural areas.
e. Our agency provides important even critical services to older adults and their family caregivers, but we don't and can't do everything
    i. There are many providers in the area that are key players in the aging services system; we need to figure out how to overcome very real barriers and constraints to achieve better coordination and collaboration.
    ii. We need planning and financial partnerships that extend outside the health and social service provider network to city governments and the business community.
    iii. Models that support friends and neighbors to help each other, like Village-to-Village and co-operative communities are essential and welcome additions to our system.

12. We need to change the conversation about aging

How we think about and talk about aging matters. Ageism and bias affect how we view ourselves and others as we age. We risk restricting the opportunities we are willing to embrace for ourselves or extend to others and foregoing the benefit of our/their experience and expertise. The cost to our individual health and well-being as well as that of our communities is unacceptably high.

As an Area Agency on Aging we have an obligation to lead a change in the conversation. We have begun this process by redesigning and incorporating new language into our outreach and materials, consciously thinking about and talking about ourselves and the people we serve from an asset perspective and participating in community efforts that focus on inclusivity and grass roots engagement.

Summary of Outcomes
(See SECTION VII for details on strategies and performance measures)

Information and Assistance: Older adults and their family caregivers access comprehensive, accurate information about and assistance to apply for services and supports that meet their individual needs

Transportation: Older adults access public and assisted transportation options that support independence and opportunities for community engagement

Senior Centers: Older adults access useful information and enjoy a wide variety of activities at area senior centers that promote health, well-being and social connectedness

In-Home and Community Services: Older adults and their family caregivers access in-home and community services to support independence, health and well-being and prevent or delay costly institutionalization

Nutrition: Older adults access nutrition services to support independence, improve health and enjoy opportunities for socialization

Aging and Disability Resource Center (ADRC): Older adults and adults with disabilities more easily navigate the community services and long-term care system through streamlined access to information and supports

Evidence-based Disease Prevention Programs: Older adults participate in Evidence-based Disease Prevention Programs to improve health

SHIP/SMP: Older adults engage in informed decision-making regarding benefits/services to enhance financial security and are supported to apply for those that meet their individual needs

Options Counseling: People are supported to plan for their aging years according to their personal circumstances and preferences

Veteran Directed Home and Community-Based Services (VDHCBS): Eligible Flathead County veterans access the VDHCBS program to maintain their independence and support their health and well-being

Long Term Care Ombudsman: Residents of long-term care facilities access ombudsmen to advocate for their rights and help resolve their issues and concerns

Legal Assistance/APS/Guardianship: Older adults have access to protection, legal assistance and advocacy

Funding/Policies for Aging Services: There is stable, adequate, flexible public funding for aging services along with person-centered policies that recognize both the challenges and opportunities that come with aging

Supplemental Revenue: Public/private partnerships, sponsorships, grants, private-pay options, etc. support and supplement base funding to create a robust system of support for older adults and their family caregivers

Best Practices and Innovation: Best practices, creative/innovative models, a person-centered approach and inclusive philosophy inform agency operations to achieve desired outcomes

Changing the Conversation: Aging is celebrated and older adults are seen as valued assets

SECTION II: Public and Stakeholder Input

We highly value client, stakeholder and community input and consider it the foundation of our Plan. We employed multiple methods to gather input from older adults, caregivers, service providers and the community-at-large, including public meetings and surveys, targeted focus groups, client surveys and review of community needs assessments and planning documents.

In addition to soliciting public input, we actively sought staff feedback. Agency staff represent decades of experience serving older adults, their families and caregivers. Their observations and ideas are invaluable.

Below is a summary of our efforts.

A. Public Meetings

Public Meeting on Aging and Aging Services
Date: 1:00-3:00 pm, January 22, 2019
Location: Flathead County South Campus, 40 11th St. West, Kalispell
Minutes attached

Thirty-seven (37) people attended the meeting to provide input on issues, challenges and opportunities related to aging and aging services. Three questions were asked to guide the discussion:

1. What are 3 things that most concern you about aging?
2. What are 3 things you enjoy or value about growing older?
3. How can our agency best support older adults as they age?

Summary of the discussion:

Concerns people have about aging:

- People are concerned they won't be able to afford the services and supports they will need to stay in their homes and live independently.
    - Transportation is of particular concern.
- People are concerned they won't be able to afford assisted living or nursing facility care.
    - They are also concerned about the quality of these services.
- People find it difficult to find and understand information about available services and they need help to navigate the system.
- People are worried about what will happen to them if they develop dementia or are otherwise unable to make decisions for themselves.
    - End-of-life decisions and care are important topics personally and at a policy level.
- Support isn't always about physical needs; people need emotional and mental health support around issues like loss of loved ones, caregiving for loved ones, institutionalization of loved ones (especially a spouse), transitioning roles and identities in different life stages (especially from paid work to retirement), declining abilities, etc.
- People wish families and other informal supports were available to meet their needs, but they know that isn't always the case and they want and appreciate agencies, programs and services that can help them.

What people enjoy or value about aging:

- People feel mature and knowledgeable (but not old!) and believe they have wisdom to share.
    - One 82 year-old participant told a story about how he recently taught a 20 year-old on Big Mountain how to snow board, saying "There's a lot of talk about what we (older adults) need, why aren't we developing programs where we present to school kids to let them know we can help them."
- People want to contribute; meaning and purpose are important, but it can be challenging to figure out what that looks like.
    - Volunteering is seen as a benefit to both the giver and the receiver.
- People appreciate the freedom that comes in retirement and after children are raised.
- Being engaged and involved with others of all ages and with one's community is desirable and critical to dispelling myths about aging.
- There are lots of opportunities for older adults to be engaged in the Flathead, but people are worried that many older adults are isolated.

How we can help as an agency:

- More than anything we can continue to help people figure out what assistance is available and help them to get it.
    - People want us to do more to get the word out about our services.
- We can offer services, like Meals on Wheels and transportation, that help people stay in their homes and communities.

- Home repair is an unmet need.

The meeting was promoted as follows:

Fliers were placed in the Flathead County South Campus Lobby and Flathead City-County Health Clinic, distributed with Meals on Wheels home delivered meals and delivered to community organizations including: Shepherd's Hand, Salvation Army, Samaritan House, Ray of Hope, Gateway Community Center and Hungry Horse Medical Clinic. They were also displayed in prominent locations throughout the county such as libraries, grocery stores, pharmacies and Kalispell Regional Healthcare. Email invitation/fliers sent to local churches and committees/workgroups including the AOA Advisory Council and the Care Transitions Coalition. Additionally, the meeting was mentioned and fliers were distributed as part of outreach events in the preceding weeks to the Columbia Falls Lions' Club and the National Association of Retired Federal Employees. Information was posted on the AOA website and on the Flathead County events site.

The planning process was also promoted/covered by local media:
1/7/2019: monthly interview with AOA Director on KGEZ radio
1/16/2019: Daily Inter Lake, "Agency on Aging updates plan" in Local Roundup section
1/18-22/2019: posting of meeting time/purpose in Daily Inter Lake "Daybook"
1/22/2019 (day of): Daily Inter Lake article, "AOA meeting to shape new area plan"
1/24/2019: Daily Inter Lake, front page "Seniors voice concerns about aging"
1/27/2019: Daily Inter Lake, editorial "AOA helps ease the stress of aging"
1/30/2019: Flathead Beacon, article "County Begins Work on New Aging Plan"

Public Meeting on Transportation
Date: 4:00-6:00 pm, December 13, 2018
Location: Flathead County South Campus, 40 11th St. West, Kalispell
Minutes attached

Twenty-one (21) people attended the meeting to provide input on the annual Transportation Coordination Plan, which in turn informs the development of our Area Plan. Discussion was guided by the following questions:

- What role do you see for public transit in this area now and as Flathead County grows?
- What do you think about the range, quality and availability of the services that Eagle Transit provides now?
- What changes, if any, would you like to see made to existing Eagle Transit routes or services?
- If funds are available, what services would you like to see added or expanded? For example, longer hours of service, weekend service, more in-city routes, expanded service areas, etc.
- How might we improve customer service?

- Do you use Eagle Transit now? Why or why not? If not, what would need to change to make riding an option for you?
- What could we do better to get the word out about our services?

Participants asked questions about funding, specific service/routes and operations. They offered suggestions for new stops, routes, and potential community partnerships. There were numerous questions/comments related to service in the Two Mile area, which includes popular destinations for older adults and people with disabilities like the Office of Public Assistance, the Social Security Office and Gateway Community Center which is operated by United Way and houses the food bank and many other local nonprofits and serves as our primary transfer point for Kalispell city routes. Two Mile is also home to a number of existing apartment complexes, some of which are subsidized and/or designated for older adults, as well as planned new multi-family development. We also discussed the possibility of implementing a volunteer driver program to serve Dial-A-Ride eligible passengers in Evergreen and outlying areas where paratransit service is not available.

The meeting was promoted through free and paid local media, including radio, TV and newspapers; on the Flathead County calendar of events and the Area IX and Eagle Transit web pages; targeted invitations to all private transportation providers, management and planning staff of all three incorporated cities in Flathead County and AOA Advisory Council members; distribution of flyers on buses, at senior and community centers, at local businesses and included with annual "destination survey" mailing.

Note: In addition to the public meeting held on December 13th, Eagle Transit conducted two public meetings regarding major changes to the Kalispell-Evergreen city route and paratransit services on June 12 and June 20, 2018 as part of the 5-Year Transportation Development Plan process.

Presentation of Area Plan to County Commissioners
Dates: 04/15/2019 and 4/22/2019
Location: Flathead County Courthouse, 800 South Main, Kalispell
Minutes can be found at https://flathead.mt.gov/commissioner/current_minutes.php

On 4/15/2019 AOA Director Lisa Sheppard presented the draft Area Plan to the Flathead County Commissioners in a public meeting which was posted on the Commissioners' web page and as part of the Flathead County calendar. Commissioners requested some revisions to the draft and voted on the final version on 4/22/2019.

B. Surveys

Community Questionnaire on Aging
A copy of the survey and full results are attached

The survey was distributed in late December 2018 and collected through late February

2019. Surveys and collection boxes were placed at each of the area senior center locations (and participation was promoted by center staff), the AOA ding room and waiting areas, the South Campus lobby reception desk, the City-County Health Clinic in Kalispell and the library in Lakeside. The survey was delivered to Meals on Wheels clients. The survey was also posted on the AOA website, emailed to stakeholders and promoted on KGEZ radio

Survey design: The survey included a mix of open-ended questions (questions 1, 2, 4 and 6) plus two "multiple choice" lists (questions 3 and 5) as well as demographic information about respondents. The open-ended questions were intended to capture broader and more nuanced results than the questions with prescribed answers from which to choose.

Responses: We received **170** responses. Although not all respondents answered each question, percentages are based on the total number of surveys received.

Survey results:

1. ***What are 3 things that most concern you personally about aging?***
   - Those who responded to the survey are most concerned about the loss of abilities/functioning (78%) with 54% fearing the loss of their independence and/or inability to stay in their own home. 20% are specifically concerned about not being able to drive and not having access to transportation.
   - 54% are also concerned about financial insecurity, not having enough money for living expenses and/or to pay for the supports they will need as they age.
   - Another 42% are worried they won't be able to afford their health care (including medications, mental and dental health).
   - 17% are concerned about being alone, lonely or socially isolated. Some specifically mentioned being away from or the loss of spouses, family members, friends.
   - 7% expressed concern about end-of-life care, decision-making.
   - 4% reported feelings of vulnerability, loss of self/identity, uselessness.

2. ***What are 3 things you most enjoy or value about growing older?***
   - All respondents reported appreciating the freedom older adults have to do what is important to them on their own schedule. 41% noted the ability to spend time with family and friends and enjoying social activities; many mentioned grandchildren. 12% spoke of the opportunity to volunteer, teach and mentor. 11% specifically addressed the reduced stress and ability to focus on oneself in retirement from paid work.
   - 42% of respondents cited greater wisdom and changed perspective as advantages of getting older. They indicated they felt wiser, more experienced, more knowledgeable (18%). They described themselves as more relaxed mellower, more at peace, more patient, more appreciative of what they have and

of the other people in their lives (12%). They also talked about being more comfortable with themselves, not feeling like they have to prove themselves or care what others think, being able to freely express themselves.

- Almost 14% said they felt they were aging with good health, financial security, and/or supports they need.
- 6% said they couldn't think of anything good about aging. Some said they were waiting for death.

3. ***What are the top five (5) concerns for older adults in the Flathead?***

- Funding for safety net programs like Social Security, Medicare, Medicaid, Older Americans Act programs (68%)
- Affordable and accessible housing (54%)
- Available and accessible transportation (51%)
- Financial assistance for basic needs (housing, food, transportation, insurance/health care/prescriptions) (49%)
- Access to and affordability of supportive services in the home to prevent or delay institutional care (53%)
- Support for family caregivers of older adults (27%)
- Access to health care, including preventive care and mental health services (38%)
- Social isolation and loneliness – need for planned and supported opportunities for engagement (37%)
- Individual planning for aging years (15%)
- Employment opportunities for older adults (17%)
- Home maintenance, repair and modifications for accessibility (32%)
- Elder abuse, neglect and/or exploitation (19%)

4. ***What makes this a good community for older adults?***

- 52% of respondents reported the community has good services for older adults, and most mentioned specific services they were appreciative of (health, housing, social/aging services, transportation, emergency response, etc.).
    - 22% specifically noted AOA/Eagle Transit services.
- 38% think the Flathead has a lot of fun, interesting, meaningful things for older adults to do; many mentioned specific activities.
    - 12% specifically noted the area senior centers as good places for older adults to gather and participate in activities.
- 24% mentioned appreciating the small-town atmosphere, the convenience/proximity of services and activities due to the community's size, the sense of safety and of being "close-knit."
- 22% spoke of the quality of the people, describing them as caring, helpful, friendly and accepting/inclusive of older adults.

5. ***What do you think are the 3 most important services AOA provides?***

- Meals on Wheels (home-delivered meals) (74%)
- Social dining sites (AOA dining room and area senior centers) (32%)
    - Note: We call our congregate meal program "social dining"

- Information about and help to access community services (38%)
- Medicare and benefits counseling (29%)
- In-home services like housekeeping and personal care (34%)
- Respite for caregivers (11%)
- Transportation (Eagle Transit and assisted transportation) (38%)
- Ombudsman (advocacy for nursing home and assisted living residents) (8%)
- Support for senior centers (17%)
- Mobile home repair (4%)

6. ***Beyond the services we provide, what could our community as a whole do better to help older adults remain independent?***
   - 38% think there is a need for the community to offer more financial assistance and/or affordable supportive services/help for people to stay in their homes (including transportation).
     - 13% specifically mentioned more/expanded public transportation options as a need.
   - 9% spoke about the need for better overall community accessibility and inclusion of older adults.
   - 7% would like to see more public outreach about aging issues and services.
   - 6% want more affordable and accessible housing options.
   - 5% pointed to the need for more outreach to older adults who are socially isolated and/or vulnerable.
   - 4% feel the community needs more activities, things to do for older adults.

Demographic information about respondents:

Characteristic	Percentage
Age	
Under 30	2%
30-44	6%
45-59	7%
60-69	25%
70-79	35%
80 or older	19%
Sex	
Male	29%
Female	65%
Area live closest to	
Kalispell/Evergreen	45%
Whitefish	8%
Columbia Falls	7%
Bigfork	24%
Lakeside	8%
Respondent or loved one ever used AOA services*	
Yes	57%
No	37%

Respondent ever been a family caregiver of an older adult	
Yes	49%
No	41%
Respondent is a health, social service or transit professional	
Yes	10%
No	81%

* Note: Many people who eat at a social dining (congregate) meal site do not think of themselves as using an AOA service; some because they eat at a senior center and don't associate it with our agency, and some because they don't think of the meal itself as a service. A number of respondents who completed the survey at a senior center or the AOA dining room responded "no" to this question.

Annual Nutrition Survey

Every spring we conduct a survey of both congregate and home-delivered meal clients. The results of the last survey are as follows:

Social Dining (congregate meals): 132 responses

- Quality of food: 56% very satisfied, 42% satisfied, 2% not satisfied
- Taste of food: 50% very satisfied, 47% satisfied, 3% not satisfied
- Site Manager friendly and helpful: 97% yes, 2 % no, 2% sometimes
- Rate volunteers: 85% very friendly, 15% friendly, none said not friendly
- Meals improve respondent's opportunities for socialization: 94% yes, 6% no
- Respondent's dining site: 67% AOA, 12% Whitefish, 8% Columbia Falls, 8% Lakeside, 5% Bigfork
- 40 comments:
    - 47% expressed thanks for/enjoyment of the service.
    - 42% expressed a like or dislike for a particular food or food prep.
    - "This place has become very special to me."
    - "I love coming to the senior center. It gets me out of the house and I get to see all my friends."
    - "This is really great food/nice friendly people. Thanks. God bless always."
    - "More dining music and dancing girls."

Home-delivered meals: 103 responses

- Number of meals received a week: 31% every day, 55% 4-5 a week, 14% 3 or fewer
- Quality of food: 37% very satisfied, 61% satisfied, 2 % not satisfied
- Service helps client stay at home: 93% yes, 7% no
- Taste of food: 36% very satisfied, 59% satisfied, 5% not satisfied
- Volunteer driver only visitor in a day: 14% yes, 49% sometimes, 37% no
- How long getting service: 29% 1-6 months, 20% 6 months-year, 22% 1-2 years, 28% 2 plus
- Recommend to a friend: 98% yes, 2% no
- Rate volunteer drivers: 81% very friendly, 19% friendly, none said not friendly
- 48 comments received

- 60% expressed gratitude for service
- 29% expressed a like or dislike for a particular food or food prep
- "So blessed to have the meals. Some days that is all I have. Bless the cooks and the drivers. Nice to see a friendly face."
- "On low sodium diet and no transportation. Sometimes this is the only decent meal we get for the day. Thank you, we appreciate it!"
- "Drivers always have a few minutes to visit me and are friendly and happy."
- "Thank you for making life a little easier. We are in our 80s and really appreciate it."

Annual In-Home and Community Services Survey

Every spring we conduct a survey of our In-Home and Community Services clients. The purpose of the survey is to gather information to inform management decisions and improve service delivery as well as aide in the development of the Area Plan. Questions focus on customer service, the quality and quantity of services provided, and identification of unmet needs. Questions are asked regarding clients' experience with both AOA and home care agency staff as services are delivered via purchased service agreements (See SECTION IV for more detail.)

Most recent survey results: 31 responses

- On first contact, staff respectful and professional: 100% yes
- On first contact, staff arranged home visit within 2 weeks: 100% yes
- At home visit, staff respectful and professional: 100% yes
- At home visit, staff provided service information: 100% yes
- At home visit, staff explained next steps: 100% yes
- Service began within 2 weeks of home visit: 90% yes, 10% no
- Service is reliable: 90% yes, 7% no, 3% somewhat
- Satisfied with quality of service: 93% yes, 7% somewhat
- Enough service to meet needs: 78% yes, 22% somewhat
- Service helps to stay in home: 86% yes, 10% no, 3% somewhat
- Aware monthly contribution helps fund service: 97% yes, 3%no
- Overall satisfied with service: 90% yes, 3% no, 6% somewhat
- 15 comments:
    - 53% expressed thanks/praise for service
    - 40% expressed a specific concern
    - "When I had to give up my car I would have been stranded without the service."
    - "Thank you for all the care. It makes me feel most of the time life's worth living. My caregivers are angels. Thank you. You are all just good people."
    - "I am very impressed with the help you provide. There is no question that it would be hard for me to stay home without it."
    - "I have terminated my service because they would schedule for a day and time and no one would show up. That happened 3 months in a row."

Although clients are very pleased with Agency services overall, when services aren't

available or provided as expected, or when the amount provided is too infrequent or too limited, it is at best a cause of frustration and more often a true hardship that can result in the loss of independence.

Annual Eagle Transit "Destination" Survey

We sent a survey to 124 businesses and organizations where Eagle Transit transports passengers to gather information and feedback about community transit needs. Recipients included area hospitals and medical practices, senior and community centers, senior and other apartments, assisted living and other residential services, public assistance and social services organizations, retail stores, etc. Flyers promoting the December 13, 2018 public meeting were also included in the mailing.

The survey was comprised of three sections: 1) transportation services provided to or used by the respondent's clients or customers, 2) unmet transit needs, and 3) space for narrative comment. We received 47 responses (37% response rate). Of those received, 33 were from Kalispell, 6 from Whitefish and 7 from Columbia Falls.

Only six of the respondents indicated they provide any transportation themselves, and only one said they provide all needed transportation to their customers or clients. Seventy-seven percent (77%) of respondents said their customers or clients make their own arrangements to use Eagle Transit services, while 34% said they assist individuals to do so. Forty-three percent (43%) indicated their business is on or near an Eagle Transit fixed bus stop.

The most often cited unmet needs were additional hours of service, new/expanded routes and weekend service. Other respondents would like to see express routes to popular destinations.

Lack of general service and limited paratransit service in Evergreen were noted as concerns in the comments section.

Eagle Transit Onboard Survey

An onboard survey was conducted by Eagle Transit staff in November and December 2018 on the Kalispell City Bus (Green Line), the Columbia Falls City Bus (fixed deviated), the Whitefish City Bus (fixed-deviated), the Evergreen Commuter and the Tri-City Commuter. The questions covered the reasons people ride the bus, when they typically ride, time spent on the bus, perceptions of safety and comfort, whether a lack of public transportation had ever affected access to employment, medical care or basic necessities and some demographic information.

Response highlights:

- Riders on all routes said they feel safe and comfortable all or most of the time when riding the bus.

- Very few riders (5%) reported employment difficulties related to a lack of public transportation, but some (18%) had been unable to access needed health care and 36% had been unable to get basic necessities.
- Approximately three-quarters of riders self-report as older adults or people with disabilities.

C. Focus Group *(questions attached)*

Agency on Aging Advisory Council
Date: November 8, 2018
Location: Flathead City-County Health Department, 1035 1st Ave. West, Kalispell
Minutes attached

The current Advisory Council is made up of 15 diverse representatives of the community appointed by the Flathead County Commissioners. Members include a Flathead County Commissioner, aging services providers, other service providers, area senior center members, volunteers and the community at large. All meetings are open to the public, posted on the County website and promoted through local media.

Nine (9) members and one guest participated in the focus group.

Summary of discussion:

- Concerns about aging include inadequate finances to cover both basic needs and supportive services, especially if you live a long life past retirement; the need for life planning and how to deal with the element of uncertainty given that you don't know how long you will live or what condition you will be in; lack of affordable and senior housing as well as concern about people living in independent senior housing who actually need assisted living or in-home care but can't afford it and/or won't seek it out; the number of older adults who don't know what resources are available to them, or how to access them, or where to get help with information and who may be reluctant to use services even if they know about them for a variety of reasons; social isolation among older adults but also resistance among some to get engaged; elder abuse and the need for legal assistance and guardianship/assisted decision-making for some older adults; the need for money-management assistance and representative payees for some; the need for more individualized transportation, like "Lyft for Seniors"; the need for medication management; lack of gerontologists; and the frustration of managing everyday life as we grow older.
    - Member discussed AOA programs and potential programs relative to these concerns, including Meals on Wheels, Telephone Reassurance and Options Counseling.
- Things that make the Flathead a good place to age include the size of the community; the degree to which people know and look out for each other; strong family networks; a warm-hearted, caring, compassionate culture; personal values that emphasize resilience and self-support; and the availability of paratransit/Dial-A-Ride services.

- Members noted the downside of older adults having an independent mindset is that they sometimes won't ask for help when they need it or accept help from anyone except perhaps immediate family, which can lead to crises and/or premature institutionalization.

- Participants ranked the top five (5) concerns for older adults in the Flathead:
  1. Affordable and accessible housing
  2. Funding for safety net programs like Social Security, Medicare, Medicaid and Older Americans Act programs
  3. Access to and affordability of supportive services in the home to prevent or delay institutionalization
  4. Available and accessible transportation
  5. Social isolation and loneliness – need for planned and supported opportunities for engagement
- Note: Two members who were unable to attend sent written comments.

D. Community Needs Assessments and Planning Documents

Internal Documents

Fiscal Year 2020 Transportation Coordination Plan (TCP)

The Area IX Agency on Aging is also the 5311 public transportation provider for Flathead County under the name Eagle Transit. Annually, the Agency must update its Transportation Coordination Plan (TCP) as part of its application for federal transportation funding. The planning process includes input from:

- The Transportation Advisory Committee (TAC), which is comprised of members representing community businesses, service providers, senior centers and riders
  - The TAC met in a public meeting from 8:30-10:30 am on January 3, 2019, at the Flathead County South Campus building to give input on and set priorities for the TCP. Members approved the Plan on February 7, 2019.
- The general public, through open meetings and a community "destination" survey
- Riders, through an onboard survey
- Other public or private transportation providers
- Area county/city planners (and growth policies as they may relate to public transit)

The Plan for FY 2020 identifies the aging of the population as the single largest factor in planning for the future of transit services in the Flathead. Currently, older adults account for approximately half of all paratransit riders, 40% of fixed route riders and 30% of city-to-city commuter riders. State general funds are used as match to support rides for older adults.

The Plan identifies the following needs, all of which impact older adults:

additional fixed and paratransit service in the three incorporated cities; alternative service models to cover outlying areas; a community-wide response to the increasing demand for medical rides; and better coordinated county/city/stakeholder planning and funding.

View the Plan at https://flathead.mt.gov/eagle/ .

Five Year Transportation Development Plan *(in process)*

Every 5 years the Agency completes a development plan that speaks to current and future transportation needs and the cost/feasibility of potential solutions. The current plan is in process and will be completed by December 2019. In the first phase of planning, the Planning Committee concentrated on two main issues: 1) reversing the downward trend in ridership on the Kalispell city fixed route and 2) boosting paratransit capacity in the Kalispell area to meet increasing demand for service and ensure regulatory compliance. Recommendations to reconfigure the Kalispell fixed and paratransit routes, as well as commuter service between the three incorporated cities in Flathead County, were implemented in July 2018 with great success. Remaining priorities include developing an alternative model for the Evergreen area, consideration of reconfiguration/expansion of service in Whitefish and Columbia Falls, better coordination of transit planning with area stakeholders and development of public/private partnerships and other funding options.

The last competed Plan can be viewed at the following link: http://flathead.mt.gov/eagle/documents/FlatheadCountyE.T.5YearPlan_Updated11_2013.pdf

External Documents

Community Health Needs Assessment

AOA staff participated in the current Community Health Needs Assessment process, a joint project of Kalispell Regional HealthCare, North Valley Hospital and the Flathead City-County Health Department. AOA Director Lisa Sheppard participated in an invited focus group meeting in October 2018. A draft of the plan is not yet available.

Staff also provided input on the last Community Health Needs Assessment and Plan effective 2016-2019. The report identified access to general, behavioral and oral health services as primary components in promoting healthy communities in the Valley. The report noted the critical role public transit plays in access to care. View the report at http://flatheadhealth.org/wp-content/uploads/2015/01/CHIP-2017-final.pdf

CAPNM 2017 Community Needs Assessment – covering Flathead, Lake, Lincoln and Sanders Counties

Community Action Partnership of Northwest Montana completed a community needs survey with 768 respondents as well as conducted six focus groups with 96 participants representing 61 organizations.

Some data to note about those respondents 65 and older:

- They reported their top five greatest needs as 1) assistance with home heating, 2) dental services, 3) home maintenance assistance, 4) vision assistance and 5) home weatherization.
- They identified a need for immediate help with 1) vision/dental care, 2) housing repairs, 3) energy assistance, 4) medical prescriptions and 5) food.
- Most were already enrolled in Medicare and/or Medicaid (71%) and LIEAP (69%). Many were enrolled in SNAP (40%) and were utilizing food banks/commodities programs (38%).

View the assessment at https://docs.wixstatic.com/ugd/e99820_dc48b5dd96c84691b2f62cf54b1c7ba8.pdf

E. Staff Input

Staff completed a questionnaire similar to the community questionnaire with additional space for narrative comments. The management team also participated in a focus group on 11/27/2018.

Staff survey

Full survey results attached

The survey was distributed to all AOA/Eagle Transit staff. Response was voluntary; 14 of 30 staff responded.

Results

- Staff were most concerned about poor health/loss of functioning (93%) and financial insecurity (93%) as they age, followed by loss of independence (64%).
- They most look forward to having the freedom and time to do what's important to them (93%). More than half (57%) feel they have or will have more wisdom, experience and maturity along with a more relaxed perspective.
- Of the top 5 concerns for older adults in the Flathead, 79% selected funding for safety net programs, 71% noted affordable and accessible housing and 64% included transportation and financial assistance for basic needs.
- 79% think our community has good services and supports for older adults with 29% mentioning AOA/Eagle services specifically. 43% noted the benefits of small-town living and 38% mentioned the kindness and caring of the people who live here. 29% mentioned the number of fun and interesting things to do and 21% mentioned senior centers specifically.

- On the importance of the services we provide as an agency, 86%noted the home-delivered meals, 71% selected transportation and 43% noted Medicare and benefits counseling followed by information and assistance at 36% and social dining (congregate meals) at 29%.
- Regarding what the community as a whole could do better to support older adults, 71% detailed more financial assistance and affordable supportive services to help people stay in their homes (38% specifically mentioned more transportation options).
- Most staff who responded are between the ages of 30 and 69 and almost evenly split between men and women. Almost all live in the Kalispell area. More than half have used or a loved one has used AOA services and 71% have at some time been a family caregiver of an older adult.
- Staff made many suggestions for ways we could improve our services and/or better support them to do their jobs.

Management Team Focus Group

The AOA Director, Assistant Director, I&A Program Manager, Nutrition Manager and Eagle Transit Manager, participated in a focus group using the same guiding questions as the AOA Advisory Council focus group.

Summary of Discussion

- Concerns about aging included loss of independence/having to depend on others to care for you/fear of going into a facility, loss of control over decision-making/no self-determination (including end-of-life decisions), loss of physical abilities, diminished cognitive functioning/dementia, losing sensory function (vision, hearing, sense of taste), lack of transportation when can no longer drive, financial insecurity, loss of identity/lack of purpose, inability to be involved in community life/to contribute, not feeling included/wanted in community life, being alone/isolated, loss of family or friends or physically or emotionally distant family, being limited by aging stereotypes and bias/being seen as "less than" and living too long without quality of life (e.g. undesirability of focusing on maintaining physical health when someone has advanced dementia or restricting food choices and other things people find pleasurable in the name of "health")
    - The team talked at length about concerns about poor quality of life in institutional settings and possible solutions.
    - Some quotes:
        - "I don't want to be put in a "box."
        - "I don't want to be 'cute' or 'adorable'; I don't want to be thought of as two-dimensional."
        - "I don't want to live to the point I can't decide what happened to me."
        - "We invented all that stuff you have, now what are you going to do?"
        - Don't keep me healthy until I die!"
- Enjoyment and anticipation of aging included being wiser and more

knowledgeable, knowing how to interact with people better, not caring what people think about you or whether they like you, not letting things bother you, "getting away with things" you can't get away with as a younger person (people extend you more grace), having stories (and recipes) to share/being the historian and mentor and knowing things the kids don't know or know how to do (i.e. things specific to your generation, like not being as technology dependent), getting to choose how you spend your time and energy and new ways to age/hopeful models like Village-to-Village and intergenerational communities

- Some quotes:
  - "I can choose to "hear" or not.
  - "I can eat chocolate all day if I want."
  - "If I reach 95 and am killed by a jealous husband, I will have had a life well-lived."

SECTION III: VOLUNTEERS

We are fortunate to have many dedicated, committed and caring volunteers without whom we would not be able to fulfill our mission:

- Between 110-120 volunteers annually support our nutrition program as Meals on Wheels drivers, kitchen and dining room assistants and greeters.
- Approximately 6 volunteers support our office, some of whom also completed initial I&A certification. They greet clients, staff the waiting room, help answer the phone, give out information and materials, assist with mailings, do data entry and provide other general office support.
- We typically have one, sometimes two volunteers who provide SHIP/SMP counseling.
- We have 1-2 volunteers who provide Telephone Reassurance.
- We have 8-12 volunteers who help with special events like our annual Older Americans Picnic in June.

In addition, we have two advisory committees whose volunteer members are appointed by the County Commissioners:

- Agency on Aging Advisory Council – 15 members currently
- Transportation Advisory Committee – 14 members currently

In FY 2018, AOA volunteers provided 14,488 hours of service at a value of $324,821. We hold an annual volunteer appreciation event, typically in the spring.

All volunteers (with the exception of advisory committee members and some event volunteers) complete a volunteer application that includes a criminal background check. We are in the process of exploring the following:

- Establishing a volunteer coordinator (hired or volunteer) to grow and manage our volunteer program, especially in relation to our I&A /SHIP services
- Developing a volunteer driver program through Eagle Transit to supplement our assisted transportation and public paratransit services
- Creating a "Transit Ambassador" program to educate people about public transit

services and advocate for local support of transit initiatives

SECTION IV: FOCUS AREAS

Below is a description of the core services we offer as well as some of the service delivery challenges we face and our efforts to address them. Overall, we provide a solid foundation of services to older adults and their family caregivers in our area, including I&A/SHIP, Nutrition and In-Home Services. Our Transportation program is particularly strong as we have the benefit of also being the 5311 transit provider for our area. Like all Area Agencies, we are one of the very few sources of non-Medicaid support for older adults and as such play a pivotal role in preventing or delaying entry into the Medicaid long-term care system. However, **we are at maximum capacity without additional resources**. Even our ability to maintain current level of service delivery is hampered by the rising costs of doing business, including health insurance costs for employees. There is unmet need currently, which will only continue to grow as the older population grows. While government funding is not the only solution, it has not kept pace nationally (even with recent increases) or at the state level (with recent cuts) with the rapid aging of the population, especially in a state like Montana with a much higher than average number of older adults per capita. Adequate, stable public funding is an imperative to form the secure base upon which we can add non-governmental funding and private pay service models to build a robust system.

Locally, we are expanding existing partnerships and looking to form new ones with city governments and the business community. We are engaging in efforts to build local solutions and encourage systemic change. We will also explore private pay services to expand community-based supports in this plan period.

A. Older Americans Act Core Programs

1. Access Services

a. Information and Assistance/Outreach

We offer this service countywide. In our previous Area Plan, one of our goals was to become the "go to" in our community for information and assistance related to aging issues and services. Due to concerted outreach efforts (including in the more rural areas of our county), service improvements and heightened visibility in our new location on the county campus in downtown Kalispell, we've raised community awareness about what our agency has to offer as well as the services and supports available to older adults and their family caregivers. Combined with the growing number of older adults in our area, the result has been an 11% increase in information and assistance/outreach contacts over a two-year period. In FY 2018, we made 19,429 contacts, compared to 17,523 in FY 2017. We are estimating a 30% increase this fiscal year. Contacts include phone calls, walk-ins, in-office appointments, home visits, presentations,

workshops, outreach events, materials distribution, etc. We also engaged in 116 specific outreach and education efforts. We are on track to exceed these numbers in FY 2019.

We offer I&A/Outreach services to all residents of Flathead County, but it is becoming increasingly difficult for staff to answer all requests and meet needs in a timely way. We currently have four staff and one Program Manager who perform information/assistance and outreach tasks. However, these same four staff also implement our SHIP/SMP programs. Two of the staff are further responsible for managing intakes and providing basic case management services to clients who receive in-home services, and the Program Manager is our senior Ombudsman. With the recent increase in federal funding, we are hoping to add 1 FTE by the end of this fiscal year to address the increase in demand for service. Additionally, we hope to build on our Volunteer Program (see SECTION III) and support and encourage senior center staff/volunteers to grow their knowledge and expertise as a way to expand our capacity in this area. However, even with the addition of 1 FTE, we will still be understaffed to meet current demand.

We are in the process of updating our website to provide greater depth and breadth of information and to invite more client, public and stakeholder participation and partnership. We also plan to participate in Flathead Forward (flatheadforward.com), a new web-based initiative of the Flathead County Health Department to connect community groups, activities, forums and data.

b. Transportation

More flexible, affordable, accessible transportation is always cited as one of the top needs in our community in our assessment and planning efforts as well as those of other entities, including the Community Health Needs Assessment. From an aging perspective, many older adults, especially those in the older age groups, no longer drive or are limited in their driving. Lack of adequate transportation alternatives limits individuals' access to services as well as opportunities for socialization and community engagement.

AOA is fortunate to be the 5311 public transit provider for Flathead County under the name Eagle Transit, offering fixed city routes for the general public in Kalispell, Whitefish and Columbia Falls and door-to-door paratransit service ¾ of a mile around these fixed routes for people who have conditions that make it difficult for them to typically use the city buses. We also offer commuter service between the three incorporated cities, a seasonal commuter to Glacier National Park and Premium Dial-A-Ride service (based on availability of buses/drivers) to residents in West Kalispell and Evergreen who meet the same functional need criteria as

paratransit passengers. Service is provided M-F; times vary depending on the route. Most fares are $1. All Eagle Transit vehicles are ADA compliant.

In FY 2018, Eagle Transit provided 99,115 rides, and we anticipate exceeding 100,000 rides in FY 2019. Currently, older adults account for approximately half of all paratransit riders, 40% of fixed route riders and 30% of city-to-city commuter riders. State general funds are used as match to support rides for older adults.

Due to funding constraints, we are unable to provide service at this time to other areas of Flathead County, which means about half of the county's population lives in an unserved area, including a portion of older adults and people with disabilities who need assistance. In addition, some older adults and people with disabilities within the service area who qualify for paratransit/Dial-A-Ride may find the rules difficult to follow or that the service is not available at times that meet their needs.

In addition to public transportation, AOA offers assisted transportation for those who need an individualized option due to their own needs and/or the unavailability or unsuitability of public transportation. In FY 2018, we provided 2,314 hours of escorted transportation service (a 133% increase over FY 2017). We offer this service county-wide via purchased service agreements with area home care agencies that employ attendants to drive clients where they need to go. It can be difficult for the home care agencies to find attendants willing to serve clients in some of the more rural areas of the county. Additionally, as attendants (or clients) don't typically have accessible vehicles, it is not a viable option for many people who use wheelchairs. Finally, because of funding limitations, we often prioritize rides for dialysis and other medical treatments. Sometimes we have a waiting list for this service.

Despite the significant amount of public and individualized transportation we provide in our area, more is needed. Our annual Transportation Coordination Plan and 5-Year Transportation Plan set priorities and strategies for increasing transportation services generally and specific to the aging population and people with disabilities. (See SECTION I for more details.)

c. Senior Centers

We help support four area senior centers: Kalispell Senior Center, Bigfork Community Center, North Valley Senior Center (Columbia Falls) and Whitefish Community Center. All but Kalispell are meal sites, and we provide funding to help all centers offer a wide range of activities. We also provide limited support to the Lakeside Gathering Place, which is not a senior center but is part of the Lakeside Chapel. It serves as a meal site and offers periodic activities.

The centers vary in terms of the scope of the programs and activities they offer. Only one, the Kalispell Senior Center, meets the definition of a community focal point as it is housed in the county campus building that includes our Agency and is connected to the City-County Health Department and dental clinic. The rest are stand-alone centers.

We see the centers as vital pieces of the aging services puzzle as they are "on the ground" in their communities and are well-positioned to identify unmet needs, develop locally-driven solutions, build personal relationships with older adults and stakeholders, reach some of the more rural residents in our county and add to the overall capacity of our network to assist older adults and their families and caregivers in the Flathead.

However, the centers struggle to varying degrees with organizational management, facility upkeep, fundraising, outreach and member recruitment/engagement/retention. Some are more successful than others in meeting these challenges.

To support the centers, the AOA and the County have undertaken the following efforts in addition to annual funding:

- Flathead County owns the buildings that house the Whitefish, North Valley and Bigfork centers. The centers rent the buildings for $1 a year. The County also allows the centers to rent out the facilities to other groups for additional revenue.
- The County recently sponsored and completed a $564,000 project, using CDBG funds and county match, to upgrade the Whitefish and North Valley centers to make them ADA compliant, bring them up to current building codes and improve their functionality.
- The County is working with the Bigfork Community Center to identify and pursue options for a new facility or a remodel of the current building, including possibly securing a CDBG grant.
- In 2016, the County offered the Kalispell Senior Center the opportunity to co-locate with our agency in a new facility on the county campus in downtown Kalispell. The center has dedicated activity space, an office suite and a dedicated art room as well as use of our dining room, which seats 120, a lobby/lounge with conversational seating, a reception area and several conference rooms. The building is also a main bus stop for Eagle Transit. Co-locating in such a highly visible and inviting space has boosted membership more than three-fold and offered members/guests access to a wide variety of county services.
- In FY 2018, we began offering senior centers free training on board governance and nonprofit management. This fiscal year, we've contracted with a nonprofit consultant to provide two half-day onsite training sessions to each center, the first focused on the basic elements of governance and the second individualized according to

each center's needs.

- We offer annual scholarships to senior center members who wish to attend the Governor's Conference on Aging.
- We've offered stipends to centers to help us promote onsite BenefitsCheckUp events for their members.
- Centers can approach us at any time during the fiscal year for assistance if they have an unexpected need or a project they want to implement and we'll fund or help fund it if we can.

Area Senior Centers have been the focus of our Health Promotion efforts in the past, but if they are to continue as such they will need assistance to fully meet the evidence-based program requirements. Two of the centers currently offer approved programs.

Our goals relative to senior centers for the new Plan period will focus on helping them enhance board membership and capacity; build local stakeholder interest, participation and support; increase center staff/volunteer knowledge of available services; provide evidence-based health promotion activities; and continue to engage in outreach and offer educational opportunities to senior center membership.

2. In-home and Community Services

The agency provides the in-home and community services below through purchase service agreements with local home care agencies. However, our staff maintain the outreach, intake, assessment, service approval, monitoring and reporting functions.

a. Homemaker – We typically offer two homemaker visits per month. Last year we provided 2,005 hours of homemaker service, (a 157% increase over the pervious year).
b. Home Chore - This service is usually limited to our summer air conditioner loan program at this time (home install/uninstall and service of 20 units), but we are considering expansion due to the large number of older adults who are unable to manage many of the heavier household tasks beyond what homemaking attendants are allowed to do.
c. Respite -We offer a wide range of in-home and out-of-home supportive services for caregivers based on what they identify as being most helpful to them. Last year we provided 2,079 hours of respite (162% increase over the prior year).
d. Senior Companion -We primarily use this service to support older adults to participate in a local therapeutic farm program that provides companionship and support through authentic farm experiences. However, we have also used it to pay for attendants to assist socially isolated clients to re-engage with the community. Last year we provided 1,310 hours of senior companion service (a 24% increase over the prior year).
e. Personal Care - We offer this service on a very limited basis, primarily to

assist clients with bathing/showering. If clients need more extensive personal care, we help them access in-home Medicaid services if possible. Last year we provided 231 hours of personal care (a 35% decrease over the previous year).

f. Home Repair/Modification – We currently offer this service to those living in mobile homes who are not eligible for other local home repair programs. We use only private funding for this program. The program typically completes approximately 30 projects per year We are considering ways to expand service to other homeowners as this is a frequent request and often cited unmet need. Given the cost and scope of this type of service, we would need to develop community partnerships and secure additional funding.

Our staff use a person-centered approach to determine what services are most important to each person's well-being and quality of life. They meet with each client in their home and develop a written service plan (shared with the client) to connect them to the services and supports that will best fit their individual needs and priorities. Staff coordinate with home care agency staff and maintain monthly contact with clients.

Our staff also provide basic case management services to all clients receiving in-home community services, including:

- Assessing their risk for premature institutional placement or other negative outcomes
- Enrolling them in the in-home and community-based services we provide
- Performing a Benefits Check-Up screening to identify other public benefits and programs they might be eligible for, assisting them to apply for the ones they want and following-up to ensure they receive the services
- Helping them access other local community services and supports and connect to opportunities for social/community engagement
- Working with them to identify and engage informal support systems (family, friends, neighbors, etc.) to help meet their needs

We provide all services countywide, but it can be challenging to serve clients in the more rural settings due to lack of attendants available to work in outlying areas and the higher cost of service delivery (primarily due to covering attendant travel costs). Additionally, we are limited in the number of hours of service we can provide due to funding constraints, and sometimes we have waiting lists. To help generate revenue for the programs we use a suggested sliding fee scale. Recent increases in federal funding will likely allow us to expand these services going forward. However, we are still evaluating how to best allocate the new funding given the overall increase in demand for all services.

3. Nutrition

Food insecurity is an ongoing concern for older adults in the Flathead. In addition to the meals we serve, many older adults in our community depend on local food banks to stretch their food budgets. Additionally, almost 7,000 people in Flathead County (7%) of the population) live in "food deserts," low income areas with limited access to grocery stores.

AOA prepares all meals in a centralized, commercial kitchen located in the new Flathead County South Campus building in downtown Kalispell, which includes all AOA offices as well as the Kalispell Senior Center. The building also houses several county departments and is connected via a sky bridge to the City-County Health Department.

AOA nutrition and I&A staff make home visits to conduct intakes and assessments for home-delivered meal clients. We have not had a waiting list for home-delivered meals in many years.

Hot lunches, congregate and home-delivered, are offered two to five days a week depending on meal site days of operation. Home-delivered meals are managed by the site closest to where a client lives. Meals are provided countywide. However, frozen meals may be substituted for hot meals for those recipients who live in the most rural areas. Frozen meals are also available on a case-by-case basis to recipients who need food for evenings and weekends.

Meal sites and days of operation:
AOA Dining Room, M-F
North Valley Senior Center, M-F
Whitefish Community Center, M-F
Bigfork Community Center, M,W,F
Lakeside Gathering Place, T, TH

a. Social Dining (Congregate Meals)

For the last two years we have provided approximately 33,000 congregate meals to between 1400 and 1800 older adults (plus guests) at the meal sites listed above. The AOA dining room with seating for approximately 120 people accounts for approximately 70% of the total meals served annually.

We call our congregate meal program "social dining" to be more appealing to clients and to better convey the purpose of the service.

b. Home-delivered Meals

For the last two years we've provided between 47,000 and 50,000 home-delivered meals to between 370 and 470 older adults annually. Meals are

delivered by dedicated volunteers.

B. Specific Programs

1. Aging and Disability Resource Center (ADRC)

Our agency achieved ADRC status in the first half of the current plan period. We work closely with the Independent Living Center in our area and with other entities that serve older adults and people with disabilities to ensure our effectiveness as a "one-stop shop."

However, it has become increasingly challenging to meet the growing needs. The combination of the rising number of older adults and substantial cuts in state funding to the programs that serve older adults and people with disabilities, including AAAs, has put a tremendous strain on our capacity to provide people with the help they need. For example, the cuts made during the last state legislative session resulted in statewide office closings and staff reductions at the Office of Public Assistance. Individuals who would have appropriately been served by OPA now look to the Area Agencies on Aging for help despite the fact that we have been historically underfunded and experienced budget cuts as well. We don't have enough staff or resources to fill the gaps.

2. Evidence-based Disease Prevention Programs

There are multiple groups in our area offering evidence-based disease prevention programs. For example, Kalispell Regional HealthCare offers the Stepping On program and Buffalo Hill Terrace conducts Powerful Tools for Caregivers classes and hosts caregiver support groups. The City-County Health Department offers Diabetes Self-Management courses.

Area Senior Centers have been the focus of our Health Promotion efforts in the past, but they have struggled to offer approved programs. Two senior center volunteers (one in Bigfork and one in Kalispell) have become Diabetes Self-Management trainers and two of the centers offer Tai Chi. Because the centers are gathering places for older adults who may not have easy access to other venues, we plan to work with their boards and staff during this plan period to develop their capacity to offer evidence-based programs.

3. Senior Medicare Patrol (SMP) and State Health Insurance Program (SHIP)

SHIP

In addition to providing general information and assistance to the public as well as intake, monitoring and basic case management services to our in-home services clients, our I&A staff are also our SHIP counselors. Last fiscal year, we provided 502 hours of benefits counseling; in the first half of this year, we have provided 657 hours. Staff teach at least one Medicare 101 class per month and

offer one-on-one consultation all year long as well as during Open Enrollment.

Additionally, since 2015, we have received a Benefits Enrollment Center grant from the National Council on Aging (NCOA) in partnership with the Area VI Agency on Aging. Staff have engaged in enhanced outreach to Medicare beneficiaries as part of the grant. We promote the BenefitsCheckUp as a core service and include it as part of our intake process for our in-home services. We have begun to routinely track the savings we are able to help clients achieve.

Because a significant subset of the clients we see as part our SHIP efforts have other needs, we find our staff often spend more time with them one-on-one connecting them to our other services and/or community supports. This is a valuable service to them but one that requires additional resources to maintain.

SMP

Our I&A staff are also responsible for implementing SMP. We incorporate SMP information into our Medicare 101 classes, in all one-on-one client appointments and as part of each BenefitsCheckUp. We distribute SMP information at all of our outreach events and make it available in our offices/waiting areas. Staff participate in monthly SMP training calls with Missoula Aging Services.

We have had one or two invested volunteers in the past, but we do not have any currently. The training and service demands of the program make recruitment difficult in our area, but we continue to promote the opportunity and hope that our upcoming efforts to revitalize our volunteer program will result in new interest in SMP.

C. Participant-Directed/Person Centered Planning

Our overall approach to service delivery is person-centered. We have, for example, made substantive changes in our in-home services over the last few years to move from a "service menu" model to one that emphasizes putting our resources toward helping those we serve get more of what's important to them and their quality of life. We routinely ask for feedback from those we serve and use what we learn to adjust our programs or the way we deliver services. As an example, we recently overhauled our main public transportation routes in Kalispell based on rider input. We're also in the process of redesigning our website to reflect our commitment to person-centered partnerships with those we serve and collaborative solution building with the larger community.

1. Options Counseling

Our staff routinely assist clients with their life planning efforts, particularly as they relate to accessing public benefits and community services, housing and transportation and making the transition into Medicaid long term care. However, we do not yet do formal Options Counseling or promote it as a service. Several

of our staff have received training but none of them feel it was comprehensive enough for them to feel competent to offer it. Additionally, we do not have enough staff/time to engage in Options Counseling. The staff we are planning to add will relieve some of the pressure on existing staff but will not be sufficient in number to allow us to add new tasks. We do not believe we can generate enough revenue in our area through Options Counseling to cover the costs. For example, we ask $10 per person for our Medicare 101 classes and have found that is the maximum we can charge before attendance drops off significantly or participants request a waiver of the fee. We would consider offering Options Counseling in the future if we had enough adequately trained staff to provide it for a reasonable fee on top of our core services.

2. Veteran-Directed Home and Community Based Services program (VDHCBS)

The VDHCBS service has been available since 2018 to eligible Flathead County veterans, first through a Memorandum of Agreement with the Area VI Agency on Aging and now directly through our agency. There are currently approximately 25 veterans enrolled in the program.

D. Elder Justice

1. Long Term Care Ombudsman

The Ombudsman Program is a critical tool in advocating for the rights and best interests of long-term care facility residents in Flathead County. However, the program is in crisis at the state level given extremely low funding levels combined with the challenges of serving rural/frontier areas. Additionally, the current structure of the program is in flux and it is unclear what model would best serve our state given its size and demographics. At both the state and local levels we must reallocate funds from other equally important services in order for the program to function. Although adequate funding is our most pressing concern, there are other issues that ultimately impact the success of the program:

1. The problems and needs that ombudsmen are called upon to address are increasingly complex and often difficult to resolve. The complicated nature of the work involves greater staff time and requires staff to have high-level, professional problem-solving, system navigation, negotiating and interpersonal skills. The need for more and more highly skilled staff further complicates the funding dilemma.
    i. Retirements and turnover in the program statewide mean there are few experienced ombudsmen at a time when the complexity of cases is escalating.
2. Local ombudsmen are being asked to review, follow-up on and document their efforts regarding all facility incident reports. This is a new requirement that is not resident-driven and that stretches staff who are already at the limit of their capacity.
3. Facilities in our area are looking to our experienced ombudsman for

management level advice and problem-solving. While this kind of technical assistance can potentially head off crises, it is more than we are equipped or paid to do.

4. One of the most difficult issues encountered by ombudsmen is the growing number of facility residents with mental health conditions and/or challenging behavior. Facility staff are ill-equipped to meet their needs and adequately address resulting safety concerns. Local facilities are seeking help from the Ombudsman Program, but mental health resources and alternative placement options are slim or non-existent.
5. Ombudsmen staff need more robust training/preparation for the intense interpersonal interactions that are an essential function of the job. Some helpful topics would include interviewing, mediation and conflict resolution Our staff would also benefit from national level, best practices training, but there is no funding to support it.

Regarding community education, our general outreach efforts and materials always include information about the ombudsman program. Our ombudsmen also engage in education efforts as time permits, but it is very challenging given the demands of the job. Some examples include presentations to local workgroups and coalitions, community college classes on aging and CNA certification classes. The ombudsmen are also in each facility on a monthly basis to meet residents and educate them about the program. We will continue these efforts during this plan period.

2. Legal Assistance Services and Adult Protective Service

Legal Assistance Services

Legal assistance continues to be a growing need in our area given the rise in the older adult population and the number of people we serve with very limited incomes. As part of a Montana Area Agencies on Aging Association (M4A) subcommittee, we are working with DPHHS to assess and improve the Legal Services Developer program.

Locally, legal document clinics while infrequent (two in the last five years) have been well-received. However, it may be that clinics are not the best option to fill the ongoing need for legal document assistance as they are sporadic and people who need help are not always able to take advantage of a clinic at the time it is offered. We'd like to work with the state and on a regional/local level to explore alternatives.

We get frequent requests for legal advocacy and assistance, which we refer to the Legal Services Developer. Our staff report the most frequent requests are landlord/tenant issues and a variety of domestic disputes. Other requests include assistance with wills, POAs and other documents; disability/benefits determinations and appeals; guardianship etc. We also partner with 2-3 local attorneys who provide free consultations to individuals we refer and will often

offer pro bono or reduced cost service beyond the initial consultation. However, they are unwilling to address landlord/tenant issues or anything which involves a dispute between parties.

Adult Protection Services (APS) and Guardianship

APS is a key partner. Our staff work very closely with local APS staff on a wide variety of issues including exploitation, abuse/neglect, lack of resources for self-care, care complications due to unmet mental health needs, client resistance to care, hoarding, etc. However, APS appears to have limited authority/ability to resolve many of the situations they/we encounter. Additionally, they face the same barriers our staff do in obtaining mental health services for clients, especially those who will not voluntarily seek assessment or treatment.

There is a critical need for guardianship options in our area, both temporary guardianship to obtain safe placement in an emergency situation and permanent solutions. APS used to fill the temporary role but no longer. We are aware of one Western Montana Chapter guardian serving our area, although there may be more. We are concerned by a general lack of a pool of qualified guardians and the degree to which available guardians understand their role in advocating for the best interests of the person. Conservator Corporation of Montana is a good model and a viable resource for those with substantial assets needing assistance because of exploitation or inability to manage financial matters. Western Montana Chapter is also available for those needing a payee, typically by court order.

AOA staff orientation and ongoing supervision emphasize mandatory reporting (for all except ombudsmen). Upon employment, all staff sign a confidentiality agreement which we will revise to include a statement about mandatory reporting responsibilities (excluding ombudsmen).

SECTION V: DEMOGRAPHICS

Census Estimates

The number and percentage of older adults in our community continues to rise dramatically. In 2010, the U.S Census showed 21.2% of Flathead County residents were age 60 or older (the eligibility age for Older Americans Act Services). Newer census statistics for 2017 estimate 27.9% of Flathead County residents are now age 60 or older (a 6.7% increase) and 18.5% are age 65 or older. 2017 data also shows:

- Almost 48% of households in Flathead County include a person 60 or older.
- Although there are almost equal numbers of men and women age 60 and older, the ratio changes dramatically in the older age groups with more than double the number of women than men who are 85 plus
- 37% of those 65 or older report having a disability, but the rate is significantly different depending on age:

    - 23% of those 65-74 report having a disability.
    - The number jumps to 62% for those 75 and older, of whom
        - 37% have difficulty hearing
        - 16% are experiencing cognitive decline
        - 29% have difficulty ambulating
- 8% of older adults live at or below the federal poverty level
- 13% of those 65 and older live alone
- 24% of Flathead County adults are veterans and approximately one-quarter of them are 65 or older

This local increase in the older adult population is part of an unprecedented national and global demographic shift that will require sustained innovation and investment at all levels to ensure quality of life, health and well-being for all.

AARP Data

Income and Social Security:
- Montana ranks 38th in income levels for older adults among states.
- One in five Montana residents receives Social Security, on average about $1,118/mo.
- Social Security is the only source of income for one in three older Montanans.
- 50% of older Montanans would live below the poverty level without it.
- Social Security pumps $4.5 billion into the Montana economy.

Caregivers (2015 survey):
- 118,000 Montanans are family caregivers, 48,000 of whom care for someone with Alzheimer's or dementia
- The average age of care recipients is 80
- Caregivers provide 10 million hours of care at a value of $1.4 billion; many do so while also working
- They want for themselves/their loved ones to age at home
- They are physically, emotionally and financially stressed by their caregiving responsibilities
- They need help with information, respite, transportation, meals, household tasks, connecting with other caregivers

AOA Client Data

Although many older adults, especially those in the younger age groups, do not need assistance, others have challenges that make life difficult to manage without help. The likelihood of needing assistance increases as people enter the older age groups.

We primarily serve a vulnerable population of older adults who have very limited incomes and are at a high risk of costly institutionalization and/or negative outcomes related to their health and well-being.

Below is a breakdown of client characteristics related to age, income and assessed risk for institutionalization and/or negative outcomes related to health or well-being.

A. Age

Of the 1,175 clients age 60 or older served meals or provided in-home services this fiscal year to date, the average age was 76. The range was 60 to 101. (Note: Those under 60 were excluded from the count as almost all of them were guests who ate congregate meals.) The percentage breakdown in age was as follows (data from MASTS):

- 46% age 60-74
- 81% of this age group were congregate meal clients
- 33% age 75-84
- 22% age 85 or older

Of the 414 I&A/SHIP clients entered into STARS this fiscal year to date for whom age data was collected:

- 32% age 64 or younger
- 40% age 65-74
- 18% age 75-84
- 9% age 85 or older

Data from the IRis database shows the following breakdown:

- 12% under 60
- 15% age 60-64
- 36% age 65-74
- 37% age 75 or older

B. Income (internal database)

Of the in-home and community service recipients who provided us with both household and income information:

- 33% are living at or below the federal poverty level
- 28% are living between 100% and 125% of poverty
- 19% are living between 125% and 150% of poverty
- 16% are living between 150% and 200% of poverty
- Only 4% have incomes above 200% of poverty

Comparatively, only 8% of older adults in Flathead County live at or below the federal poverty level.

C. Risk

One of the assessments we use is a "risk" matrix to help us determine the degree to which a client may be at risk of institutionalization or other negative outcomes. Of those older adults currently receiving in home and supportive services (homemaker, escorted transportation, personal care, respite, etc.) through the Agency, approximately 90% are assessed at a moderate to high risk in at least one major area based on presenting issues related to physical health, mental

health, cognitive functioning, nutritional needs, ability to complete ADLS or IADLS, mobility, communication, transportation, social connectivity, caregiver support and access to needed services. 62% have an overall score indicating moderate to high risk. 42% are assessed at the highest risk category in at least one category

- 81% need help with household and/or personal tasks
- 77% have physical health needs that limit their functioning
- 56% need assistance with transportation
- 22% report significant financial concerns
- 20% have limited social connections
- 15% have mental health needs
- 13% are experiencing cognitive decline

It is interesting to note that 13% of all older adults in Flathead County live alone, while 70% of our in-home assistance clients do; 37% of all residents 65 or older have a disabling condition, while 77% of our clients have physical or other conditions that potentially threaten their independence.

SECTION VI: TITLE III/VI COORDINATION

The Area IX/Flathead County Agency on Aging does not receive Title III urban Indian groups or Title VI funding.

SECTION VII: OUTCOMES, STRATEGIES and PERFORMANCE MEASUREMENT

Core program outcomes and performance indicators are as follows:

Note: In addition to reporting performance measures to DPHHS as part of this plan, we regularly report on performance to Flathead County Commissioners. Flathead County practices performance-based budgeting. The Agency annually develops performance measures to provide the foundation for our budget and to guide our work. The measures include both outcomes and output targets. Monthly, the Agency Director gathers and analyzes performance data and reports results to the Flathead County Commissioners, along with other information regarding Agency activities. Each report includes a table that compares current fiscal year data to both current targets and data from the two years prior, which allows for an ongoing review of trends. Reports and performance tables can be viewed on the Agency website at the following link: http://flathead.mt.gov/aging/Commisioner_Reports.php . Recorded minutes of monthly reports to the Commissioners can be accessed at https://flathead.mt.gov/commissioner/current_minutes.php .

Access Services

A. Information and Assistance

Outcome: Older adults and their family caregivers access comprehensive,

accurate information about and assistance to apply for services and supports that meet their individual needs

Strategies:

1. Create a continuous and ubiquitous information "loop" that is easily accessed by all county residents using multiple approaches, including in-person and phone contacts, home visits, updated AOA/Eagle Transit websites, distribution of brochures and other written materials, presentations, workshops, outreach events, media coverage, etc.
2. Engage Senior Centers, volunteers and other stakeholders as outreach and education partners
3. Develop and implement an annual outreach plan
4. Ensure I&A staff complete required training and certification and have access to additional training opportunities

Performance Indicators:

1. Number of information and assistance contacts
2. Number of outreach efforts/events
3. 90% of clients who provide feedback indicate information and assistance provided was helpful/useful

B. Transportation

Outcome: Older adults access public and assisted transportation options that support independence and opportunities for community engagement

Strategies:

1. Coordinate service delivery between Eagle Transit fixed/paratransit services and assisted transportation to increase transportation access and/or efficiency and to ensure transportation options are appropriate to meet individual needs
2. Create and implement fixed public transportation routes that are easier for older adults and people with disabilities to access to provide greater flexibility for riders and reduce the need for paratransit service
3. Explore the development of a volunteer driver program through Eagle Transit to serve Evergreen and outlying areas
4. Establish a local Transit Coalition to work collectively on expanding transportation options in the Flathead with a special emphasis on health care access
5. Engage cities and the business community in planning efforts and encourage financial partnerships to increase community-wide transportation

Performance Indicators:

1. Number of public transportation rides provided annually
2. Number of hours of assisted transportation provided
3. Number of paratransit applications processed

C. Senior Centers

Outcome: Older adults access useful information and enjoy a wide variety of activities at area senior centers that promote health, well-being and social connectedness

Strategies:

1. Provide training and technical assistance to senior centers related to good governance, program development/implementation and member/stakeholder relations
2. Assist with Flathead County's efforts to explore options for a new or remodeled center in Bigfork
3. Encourage and financially support centers to have staff/volunteers complete I&A/SHIP certification

Performance Indicators:

1. 90% of center board members participate in training opportunities offered
2. 100% of centers offer at least two activities (beyond meals)

In-Home and Community Services

Outcome: Older adults and their family caregivers access in-home and community services to support independence, health and well-being and prevent or delay costly institutionalization

Strategies:

1. Use a person-centered approach to connect older adults and their family caregivers to AOA services and other community services that will best meet their individual needs
2. Provide basic case management and benefits counseling to all in-home and community services clients
3. Prioritize creative respite alternatives that provide both a break for the caregiver and an enjoyable, meaningful experience for the person needing care
4. Explore community partnerships to develop home repair/maintenance and accessibility modification services

Performance Indicators:

1. Number of hours of homemaker services provided
2. Number of hours of respite/supportive services to caregivers provided
3. Number of hours of senior companion services provided
4. Number of hours of personal care provided
5. 90% of clients surveyed report the services help them remain in their homes and communities

Nutrition

Outcome: Older adults access nutrition services to support independence, improve

health and enjoy opportunities for socialization

Strategies:

1. Develop menus that meet nutritional guidelines and offer a variety of food options that are appealing to clients
2. Work with all sites to better promote social dining (congregate meals) and engage in targeted outreach to identify those who could benefit from home-delivered meals
3. Continue to provide frozen meals to clients who are at nutritional risk or who live in rural areas where hot meal delivery isn't an option

Performance Indicators:

1. Number of congregate meals served
2. Number of home-delivered meals provided
3. 90% of home-delivered meal clients report the service helps them remain in their homes and communities
4. 90% of congregate meal clients consider dining at a site a social experience

Specific Programs

A. Aging and Disability Resource Center (ADRC)

Outcome: Older adults and adults with disabilities more easily navigate the community services and long-term care system through streamlined access to information and supports

Strategies:

1. Identify and implement cross-training opportunities with our local Independent Living Center and other disability service providers/groups
2. Identify opportunities to collaborate with other providers on outreach, information sharing and service delivery

Performance Indicators:

1. Number of collaborative efforts
2. Number of clients reached through collaborative efforts

B. Evidence-based Disease Prevention Programs

Outcome: Older adults participate in Evidence-based Disease Prevention Programs to improve health

Strategies:

1. Help senior centers that wish to do so offer and promote Evidence-Based Disease Prevention programs
2. Identify and promote programs offered by other providers/groups in our community (i.e. link on our website, distribute brochures/fliers, etc.)

3. Consider providing scholarships to older adults to attend approved programs

Performance Indicators:

1. At least two senior centers offer Evidence-Based Disease Prevention programs
2. Number of older adults provided scholarships

C. SHIP/SMP

Outcome: Older adults engage in informed decision-making regarding benefits/services to enhance financial security and are supported to apply for those that meet their individual needs

Strategies:

1. Expand the number of Medicare 101 classes and offer them in additional locations, such as area senior centers, senior housing complexes, Gateway Community Center, etc.
2. Continue to offer and promote BenefitsCheckUps; target outreach to rural residents
3. Partner with the Office of Public Assistance and/or local service providers to offer workshops on Medicaid LTC and Medicaid waivers

Performance Indicators:

1. Number of hours of Medicare and benefits counseling provided
2. Number of Medicare 101 classes offered/number of participants
3. Amount of savings clients realize as a result of our efforts

D. Options Counseling

Outcome: People are supported to plan for their aging years according to their personal circumstances and preferences

Strategies: We will continue to

1. Consider offering Options Counseling as resources allow
2. Support staff to participate in additional training

Performance Indicators: None at this time

E. Veteran Directed Home and Community-Based Services (VDHCBS)

Outcome: Eligible Flathead County veterans access the VDHCBS program to maintain their independence and support their health and well-being

Strategies:

1. Complete the transition of the program from Area VI to our agency

2. Work with local veteran groups to promote and grow the program

Performance Indicators:

1. Transition is completed by July 1, 2019
2. Number of veterans enrolled

F. Long Term Care Ombudsman

Outcome: Residents of long-term care facilities access ombudsmen to advocate for their rights and help resolve their issues and concerns

Strategies:

1. Continue to allocate sufficient resources for the program to function locally
2. Work with the state to develop a plan for restructuring and adequately funding the program

Performance Indicators:

1. Number of cases/consults

G. Legal Assistance/APS/Guardianship

Outcome: Older adults have access to protection, legal assistance and advocacy.

Strategies:

1. Promote legal document clinics in our area when offered
2. Refer individuals to the Legal Developer's office for assistance and advocacy; link to information on our website
3. Work with the state to develop a plan for restructuring and adequately funding the program
4. Research the viability of expanding local attorney network willing to offer pro bono assistance to those referred by the Agency; explore model used by Missoula Aging Services
5. Continue to work with APS locally and at the state level to communicate and collaborate effectively
6. Advocate for and participate in the development of local guardianship options

Performance Indicators:

1. Number of referrals to Legal Services Developer or local attorneys

Other

The outcomes and strategies below are intended to address systemic, long-range issues related to funding for aging services and policies that support healthy aging, local participation in solution-building and changing perceptions and assumptions about aging and older adults. Performance indicators are not included, but reports to DPHHS

will include narrative updates.

A. **Outcome:** There is stable, adequate, flexible public funding for aging services along with person-centered policies that recognize both the challenges and opportunities that come with aging

   Strategies:
   1. Participate in state level workshops, coalitions, etc. to promote flexible, person-centered policies and programs
   2. Continue active participation in M4A; continue membership in n4a and participate in national training opportunities
   3. Continue to educate elected officials about issues and potential solutions; use monthly report to Flathead County Commissioners as a vehicle for providing impact information
   4. Continue to educate Agency advisory boards and other stakeholders about pertinent issues and encourage them to take action
   5. Conduct advocacy workshops to educate interested parties about the process
   6. Stay abreast of related research and disseminate through stakeholder network and via website
   7. Convene community forums to provide information and promote discussion of issues
   8. Participate in the city/community planning processes to ensure inclusion of an aging and disability perspective

B. **Outcome:** Public/private partnerships, sponsorships, grants, private-pay options, etc. support and supplement base funding to create a robust system of support for older adults and their family caregivers

   Strategies:
   1. Research successful efforts by other Area Agencies in Montana and other states
   2. Seek additional advice and assistance from the State Unit on Aging, n4a, NCOA, etc.
   3. Engage local stakeholders to explore partnerships/sponsorships and locally-driven solutions

C. **Outcome:** Best practices, creative/innovative models, a person-centered approach and inclusive philosophy inform agency operations to achieve desired outcomes

   Strategies:
   1. Research best practices and successful models of service delivery from other areas, states, countries
   2. Enlist partners to brainstorm and collaborate; work with subcontractors to identify and implement creative strategies for service delivery
   3. Consider experiments and pilot projects to try out new ideas

4. Participate in local workgroups and coalitions; initiate and lead new efforts as needed
5. Engage agency staff in continuous improvement efforts; create and support a culture of innovation

D. Outcome: Aging is celebrated and older adults are seen as valued assets

Strategies:

1. Redesign our approach and materials to reflect positive attitudes about aging, acknowledge the contributions and value of older adults and recognize and honor the partnership with have with the older adults we serve and those who serve us and our community by volunteering their time and talents
2. Support events/activities/media coverage etc. that showcase contributions and celebrations and/or illustrate the human complexity of aging rather than reinforcing stereotypes
3. Empower older adults to use their voices to dispel myths and advocate for what's important to them; create both in-person and online forums in which their voices are elevated
4. Support the development of intergenerational and integrated programs and activities
5. Continue to bring this message to local and state workgroups, coalitions, policy-makers, etc.

SECTION VIII: FORMS

See the following attachments:
Attachment A: Direct Service Waiver Request
Attachment B: Community Focal Points and Senior Centers
Attachment C: Area Agency on Aging Advisory Council Membership
Attachment D: Statement of Intent/Signature Page

ATTACHMENT A

DIRECT SERVICE WAIVER REQUEST

The following is a list of each service and funding source for which a waiver to provide direct services is being requested, the reason for requesting the waiver, and the time period to be covered by the waiver.

Nutrition Service:

Area IX Agency on Aging hereby requests a waiver for the delivery of nutrition service to older adults and eligible people with disabilities in Flathead County.

The request to directly provide nutrition service is based upon the following:

1. The service is cost-effective as evidenced by the cost per meal (currently about $6.60).
    a. As a single county area producing all meals in a centralized kitchen, the Agency realizes costs savings through economies of scale in the purchasing of food, supplies, equipment, etc.
    b. We have a state-of-the-art commercial kitchen (completed in 2016) that offers efficiencies that reduce personnel costs.

2. Preparing meals directly allows for greater oversight and quality control over the service.
    a. 98% of meal recipients are satisfied or very satisfied with the quality of the service.
    b. The Nutrition Manager is involved in and monitors food preparation and meal quality on a daily basis. The Agency Director is also onsite.

3. Many meal recipients know the kitchen staff and report how much they value the relationships they have developed with them (they feel like the people who cook for them care about them), as do the Meals on Wheels volunteers. These personal relationships encourage participation in the service and support long-term volunteer retention.

Transportation Service:

Area IX Agency on Aging hereby requests a waiver for the delivery of certain transportation services to older adults and people with disabilities in Flathead County.

The request to directly provide certain transportation services is based upon the following:

1. The Agency, under the name Eagle Transit, is the 5311 public transportation provider for Flathead County and as such receives federal transportation funds for both general and specialized transit services. We supplement the

transportation budget with state general funds to help support both fixed route transportation and door-to-door, appointment based, ADA compliant bus service for older adults and people with disabilities who have a functional need for the service to get to nutrition and a wide range of supportive services.

Note: The Agency contracts with area service providers for Escorted Transportation Services.

This request for waiver is for the period October 1, 2019 to September 30, 2022.

Lisa Sheppard — Date: 4/22/2019

Lisa Sheppard, Director Area IX Agency on Aging

Phil Mitchell — Date: 4-22-19

Phil Mitchell, Flathead County Commissioner

ATTACHMENT B

COMMUNITY FOCAL POINTS AND SENIOR CENTERS

Center Info	Facility Is:			Location Serves:	
	Focal Point	Senior Center	Funded Title IIIB	Low Income	Low Income, Minority
Bigfork Community Center 639 Commerce St. P.O. Box 2272 Bigfork, MT 59911 406-837-4157 Contact: Rocky Feckete		X	X		
Kalispell Senior Center 40 11th St. West Kalispell, MT 59901 406-257-1598 ksc@montanasky.net Contact: Cathy Herron	X	X	X		
North Valley Senior Center 205 Nucleus Ave. Columbia Falls, MT 59912 406-892-4087 nvsc205@gmail.com Contact: Roxy Larsen		X	X		
Whitefish Community Center 121 Second Street Whitefish, MT 59937 406-862-4923 Whitefishcommunitycenter1@gmail.com Contact: Kathy Cozad		X	X		

ATTACHMENT C

ADVISORY COUNCIL MEMBERSHIP

NAME	ORGANIZATION AFFILIATION
Dee Boyce	Community Member
Jim Driscoll	Community Member
Glenn Graham	Community Member
Stan Harper	Community Member
Pam Holmquist (non-voting)	County Commissioner
Linda Hunt	Community Member
Jenna Justice	Frontier Hospice
Lois Katz (Chair)	Community Member
Dale Lauman	Community Member
Marceen Liechti	Community Member
Mike Merchant	Community Member
Laurie Normandy	Immanuel Lutheran Communities
Diane Queen Miller	Community Member
Nola Rice	Community Member
Pat Sylvia	Community Member

Low-Income	Minority	60+
unknown	unknown	13

ATTACHMENT D

STATEMENT OF INTENT

The Area Plan
Is hereby submitted for

Area IX/Flathead County Agency on Aging

For the period October 1, 2019-September 30, 2022

This Area Plan includes all assurances plans under provisions of the Older Americans Act during the period identified. The Area Agency on Aging identified above shall assume full responsibility to develop and administer the Area Plan in accordance with the requirements of the Older Americans Act and related State regulations and policy. In accepting this authority, the Area Agency on Aging assumes responsibility to promote the development of a comprehensive and coordinated system of community services and to serve as the advocate and focal point for older persons in the planning and service area.

The three-year area plan has been developed in accordance with the rules and regulations specified under the Older American's Act, and is hereby submitted to the Montana Department of Public Health and Human Services, Senior and Long Term Care Division Aging Services Bureau for review and approval.

SIGNATURES:

Lisa Sheppard — 4/22/2019
Lisa Sheppard, Director, Area IX Agency on Aging — **Date**

Lois Katz — 4/11/2019
Lois Katz, Chair, Area IX Agency on Aging — **Date**

Philip Mitchell — 4-21-19
Philip Mitchell, Chair, Flathead County Commissioners — **Date**

This section needs to be completed based on the performance indicators included in the AAAs plan. The dates required are listed in the columns. The first column labeled 09/30/19 is the base year for incremental measurement over time. This document will be required to be submitted to the State Unit on Aging annually.

SUMMARY OF OUTCOMES PERFORMANCE INDICATORS

	9/30/19	9/30/20	9/30/21	9/30/22
OUTCOME:				
Number of information and assistance contacts				
Number of outreach efforts/events				
90% of clients who provide feedback indicate information and assistance provided was helpful/useful				
Number of public transportation rides provided annually				
Number of hours of assisted transportation provided				
Number of paratransit applications processed				
90% of center board members participate in training opportunities offered				
100% of centers offer at least two activities (beyond meals)				
Number of hours of homemaker services provided				
Number of hours of respite/supportive services to caregivers provided				
Number of hours of senior companion services provided				
Number of hours of personal care provided				
90% of clients surveyed report the services help them remain in their homes and communities				
Number of congregate meals served				
Number of home-delivered meals provided				
90% of home-delivered meal clients report the service helps them remain in their homes and communities				
90% of congregate meal clients consider dining at a site a social experience				
Number of collaborative efforts				
Number of clients reached through collaborative efforts				
At least two senior centers offer Evidence-Based Disease Prevention programs Number of older adults provided scholarships				

	9/30/19	9/30/20	9/30/21	9/30/22
Number of hours of Medicare and benefits counseling provided				
Number of Medicare 101 classes offered/number of participants				
Amount of savings clients realize as a result of our efforts				
Number of veterans enrolled in VDHCBS				
Number of ombudsman cases/consults				
Number of referrals to Legal Services Developer or local attorneys				

SECTION X: AREA PLAN CHECKLIST

Section	Section Contains Information and Approved	Y/N	Page #s Where Information is Located	Section to be Revised
Executive Summary	Incorporate essential points. Describe outcomes and strategies.			
Public Input	Describe number, dates, and locations of the Public Input Meetings. Discuss how public input informed Area Plan.			
Volunteers, Current/Future Programs/Focus Areas	List programs currently in place. List additional programs the AAA is considering implementing.			
Title III/VI Coordination	Regions that provide both Title III and Title VI nutrition programs shall describe the coordination of the programs.			
Forms	Attachment A? Only AAAs requesting waivers Attachment B? Attachment C? Attachment D?			
Area Plan Implementation	Implementation form properly filled out. (Please remember, implementation of the Area Plan will be reviewed during program evaluations by SUA staff.)			

Please submit one signed paper copy of the Area Plan to the State Unit on Aging by March 15, 2019 to Freddi Haab-Fiedler, SLTC, PO Box 4210, Helena, MT 59604. Should you have any questions regarding the Area Plan, please contact Freddi by phone at 406-444-1956 or email fhaab-fiedler@mt.gov or Kerrie at 406-444-7788 or email at kreidelbach@mt.gov.