Maryland Department of Aging

2013-2016
State Plan on Aging

Martin O'Malley
Governor

Anthony G. Brown
Lt. Governor

Gloria Lawlah
Secretary

DEPARTMENT OF HEALTH & HUMAN SERVICES
Administration for Community Living
Washington, D.C. 20201

October 4, 2012

Honorable Martin O'Malley
Governor of Maryland
100 State Circle
Annapolis, Maryland 21401-1925

Dear Governor O'Malley:

I am pleased to inform you that the Maryland State Plan on Aging under the Older Americans Act for October 1, 2012 through September 30, 2016, has been approved. Your activities to reform the long term care system as evidence by developing a comprehensive Maryland Access Point marketing plan to increase referrals to local sites by 20 percent, the State Health Insurance Program to assist Medicare beneficiaries and caregivers including one on one counseling, working to improve the oral health of older Americans by developing education information for 750 older adults, oral health screenings and dental services for 500 older adults in Maryland, and the other goals and objectives outlined in your State Plan will serve as a guide for action in the next four years. As a result, the State Plan reflects a proactive strategy to deliver high quality comprehensive services to meet the needs of older persons and their caregivers.

The Regional Office staff of the U.S. Administration for Community Living in New York looks forward to working with you in the implementation of the State Plan. If you have questions or concerns, please do not hesitate to contact Kathleen Otte, Region III Administrator, at (212) 264-5767. I appreciate your dedication and commitment toward improving the lives of older persons in Maryland.

Sincerely,

Kathy Greenlee
Administrator/Assistant Secretary for Aging

Martin J. O'Malley
Governor

Anthony G. Brown
Lt. Governor

MARYLAND
DEPARTMENT OF AGING
Choice, Independence and Dignity

Gloria G. Lawlah
Secretary

VERIFICATION OF INTENT

The State Plan on Aging is hereby submitted for the State of Maryland for the period October 1, 2012 through September 30, 2016, by the Maryland Department of Aging under provisions of the Older Americans Act of 1965, as amended. The State agency identified above has been given the authority to develop and administer the State Plan on Aging in accordance with the requirements of the Older Americans Act, and is primarily responsible for the coordination of all State activities related to the Act, and serves as the effective and visible advocate for the elderly in the State of Maryland.

This Plan is hereby approved by the Governor and constitutes authorization to proceed with activities under the Plan, upon approval by the Assistant Secretary of Aging.

The State Plan on Aging for Federal Fiscal Years 2013 through 2016 hereby submitted has been developed in accordance with all federal statutory and regulatory requirements.

July 27, 2012
(Date)

Gloria Lawlah, Secretary
Maryland Department of Aging

I hereby approve this State Plan on Aging and submit it to the United States Assistant Secretary on Aging for approval.

_____
(Date)

Martin O'Malley, Governor
State of Maryland

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A MESSAGE FROM THE SECRETARY

Dear Fellow Marylanders:

On behalf of Governor Martin O'Malley, I am pleased to present the Maryland State Plan on Aging, 2013-2016.

As you know, we face a major demographic challenge in the years ahead. Today, there are a little over one million older adults. By 2030, the number is projected to increase to about 1.7 million older adults. Fortunately, not all 1.7 million older adults will be looking to the State for assistance. Many will be healthy, independent, and financially secure. However, as the population increases, so will the actual number of persons who will require some assistance. That assistance may take the form of subsidies to help pay for community-based long-term services and supports in order to avoid less desirable and more costly nursing home care, protection for people who reside in nursing homes and assisted living facilities, and the provision of programs and services that will keep people healthy and engaged in community life. Others may find themselves involuntarily separated from the workforce and in need of training in order to bring their skills up to date with the demands of available job opportunities. These themes are visible throughout the Maryland State Plan on Aging, 2013-2016.

In addition to our traditional emphasis on older adults, the Department has taken on the responsibility of being the State's Single Entry Point for all people seeking information, counseling and assistance in finding long term services and supports. This new responsibility parallels national initiatives and changes among other State Units on Aging that have become Aging and Disability Resource Centers (ADRC) under federal initiatives from the Administration on Aging and the Center for Medicare and Medicaid Services. The expansion of the responsibilities of the aging network is built upon the strength and competency of Information and Referral/Assistance programs operated nationally by Area Agencies on Aging and it requires partnering with other state and local agencies to ensure seamless and high quality information and counseling.

As Secretary, I have been privileged to meet thousands of individuals who have confirmed what I long suspected to be true: older adults and younger adults with disabilities want to remain in their homes and remain active and connected to their communities. This requires continuing effort to improve the way people access information and services and the development of readily accessible community-based alternatives to institutional care. Not only is this what people want and need, it can save the State and federal governments tens of millions of dollars in long-term institutional care. The bottom line is that many of our programs and services that help Maryland's most vulnerable residents access trusted and competent long term care information, counseling, and direct services are good for all Marylanders and good for Maryland taxpayers.

The Maryland State Plan on Aging, 2013-2016 lays the foundation for MDoA, the aging network and many of Maryland's executive departments to work collaboratively to design and implement a plan that will improve the overall quality of life for our older adults and for all citizens in Maryland.

I hope that you will find this Plan informative, and that you will join with Governor O'Malley and the Maryland Department of Aging team in working to create a State where our older adults can realize their dream of aging in place among family and friends, with easy access to information, continued opportunities for social engagement, quality healthcare, and, when needed, appropriate long-term support.

Gloria Lawlah

EXECUTIVE SUMMARY

Under the requirements of the Older Americans Act of 1965, as amended, every four years the Maryland Department of Aging (MDoA) is required to submit a *State Plan on Aging* to the U.S. Department of Health and Human Services, Administration for Community Living (ACL). The State Plan on Aging, 2013-2016 details the efforts of MDoA and the local Area Agencies on Aging (AAA) to meet the needs of older adults. The State Plan gives MDoA the opportunity to review and evaluate its past performance and to look to the future to find creative ways to continue to meet the changing needs of older adults.

In developing services and programs under the State Plan, MDoA takes into account the needs of older adults as expressed through hearings, evaluation tools and waiting lists, as well as State and federal mandates. The needs of older adults are also represented through the Area Agencies on Aging in the development of Area Plans and in formal and informal discussions held with members of the aging network. Views of advisory councils, commissions on aging and senior groups are reflected in the development of the State Plan on Aging.

Maryland's 2013-2016 State Plan reflects MDoA's efforts to successfully build upon our work at the state and county levels to expand home and community-based services and improve the way older adults and persons with disabilities access Long-Term Services and Supports (LTSS) information and services. We are integrating this work with the state and national rebalancing efforts.

MDoA began developing Maryland's Aging and Disability Resource Center (ADRC) known as Maryland Access Point (MAP) in 2003. Beginning with two local MAP sites in 2004, the program now provides statewide accessibility through 20 local sites. Nationally, ADRCs are a collaborative effort of ACL and the Centers for Medicare & Medicaid Services (CMS), designed to streamline access to long-term care. The ADRC program provides states with an opportunity to effectively integrate the full range of long-term supports and services into a single, coordinated system across programs and service providers. By simplifying access to long-term care systems, ADRCs and other single point of entry (SEP) systems are serving as the cornerstone for long-term care reform in many states and local communities. As a result of the success of the Maryland Access Point infrastructure, Maryland has been able to respond swiftly to significant changes in the state's LTSS systems including successful participation in the Money Follows the Person (MFP) Demonstration and a successful application to participate in the Balancing Incentive Program (BIP). These are two national programs that provide federal incentives for increasing the proportion of home and community-based Medicaid spending. This ADRC/MAP infrastructure has positioned the MDoA as an integral partner with the Department of Health and Mental Hygiene (DHMH) in state and national rebalancing efforts. The MAP program also provides options counseling to individuals requesting assistance to transition from nursing homes to the community and MAP sites have facilitated these transitions through the Medicaid Home and Community-Based Services Waiver for Older Adults.. In 2012 Maryland became the second state to receive approval of its application for the Balancing Incentive Program from the Centers for Medicare and Medicaid Services. Maryland Access Point sites will constitute one of three core infrastructure requirements of the BIP, the Single Entry Point No Wrong Door (SEP/NWD) requirement and MAP sites will administer the screening instrument associated with the single state assessment instrument, another requirement under BIP. The MAP statewide public website provides information on LTSS agencies and providers. The MAP website and a state 1-800 number will be the entry point for contacting MAP options counseling services.

The emergence of the ADRC/MAP infrastructure within the Maryland Department of Aging has expanded the mission of the Department as well as its responsibilities and partnerships. ADRC/MAP services extend to all individuals with disabilities as well as older adults. The expansion of this service is

accomplished through a No Wrong Door approach that involves formal working relationships with other agencies and organizations supporting the diverse constituents served by MAP. The MAP program is administered by the Department in close partnership and collaboration with Maryland's Medicaid agency Department of Health and Mental Hygiene(DHMH), the Maryland Department of Disabilities, the Maryland Department of Human Resources, Area Agencies on Aging, local Health Departments, local Departments of Social Services, regional Centers for Independent Living, state and federal Veterans Administration, advocacy groups and organizations serving older adults and people with disabilities and service providers. Partnerships continue to expand to include other constituencies, e.g. behavioral health, traumatic brain injury, developmental disabilities. The national and state ADRC program initiative has leveraged the strength of the traditional aging Information and Assistance program to provide outreach, information and assistance, and options counseling and support planning to all individuals with disabilities. This transition has emerged out of partnerships and working arrangements that build on the strengths of the full aging and disability networks.

The vision of the Maryland Access Point has grown to encompass piloting and implementing new programs that divert or transition people from long term care institutions and offer person-centered counseling and self-directed services. These programs include: Nursing Home Diversion Community Living Program formerly known as Nursing Home Diversion); Veteran Directed Home and Community-Based Services Program; Person Centered Hospital Discharge; Evidence-Based Care Transitions; and Options Counseling.

Despite these accomplishments, there is much to be done. Maryland, like many other states, is facing challenging demographics. In some Maryland counties, adults over 60 outnumber schoolchildren. Flexibility and innovation are essential if we are to maintain the programs and services needed by older adults.

To ensure that older Marylanders have choice, independence and dignity, MDoA's goals reflected in this plan follow the set of principles put forth in the Older Americans Act and the following goals identified in the Administration on Aging's Strategic Action Plan 2007-2012:

Goal 1	Empower older people, their families, and other consumers to make informed decisions about, and to be able to easily access, existing health and long-term care options
Goal 2	Enable older adults to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers
Goal 3	Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare
Goal 4	Ensure the rights of older people and prevent their abuse, neglect and exploitation

The Maryland State Plan on Aging 2013-2016 presents the goals, objectives and strategies to improve the lives of older Marylanders, their families, and caregivers. This Plan builds on Maryland's capacity to provide comprehensive services for older adults and to use allocated resources in the most effective ways to meet the goals, objectives, and strategies that have been set forth.

While this Plan does not address all of the programs and activities of MDoA, it positions the State to meet the needs of a growing older population by providing a roadmap for how those needs will be met over the next four years and specific performance measures against which MDoA's performance may be gauged.

Organization

Mission and Values

The Maryland Department of Aging envisions Maryland as a state where all older adults are able to age with dignity, opportunity, choice and independence. To accomplish that vision, we have adopted the following mission:

The Maryland Department of Aging (MDoA), partnering with the Area Agencies on Aging and other organizations, provides leadership, advocacy and access to information and services for Maryland older adults, their families and caregivers.

Structure of the Aging Network

The Older Americans Act (OAA) authorizes grants to States for community planning programs, as well as for research, demonstration, and training projects in the field of aging. The U.S. Administration for Community Living (ACL) funds States for nutrition, supportive home and community based services, family caregiver and elder rights programs. This funding flows to the local, community based networks of Area Agencies on Aging and Tribal organizations. Additionally, ACL awards competitive grants in a number of substantive areas for developing comprehensive and integrated systems for long-term services and supports (e.g. Aging and Disability Resource Centers and evidence based disease prevention and health promotion services.

History

- In 1959, MDoA originated as the ***State Coordinating Commission on the Problems of the Aging*** (Chapter 1, Acts of 1959).
- It was renamed the ***Commission on the Aging*** in 1971 (Chapter 595, Acts of 1971).
- The ***Governor's Coordinating Office on Problems of the Aging*** was established by the Governor in 1974.
- In 1975, the ***Commission on the Aging*** and the ***Governor's Coordinating Office on Problems of the Aging*** merged to form the ***Office on Aging***, a cabinet-level independent agency (Chapter 261, Acts of 1975).
- In July 1998, the Office was restructured as the ***Department of Aging***, a principal executive department (Chapter 573, Acts of 1998).

Statutory Base

Two statutes serve as the primary base for MDoA operations: Human Services Article, Title 10, Annotated Code of Maryland and the federal Older Americans Act of 1965, as amended. The major duties assigned to MDoA under these statutes are:

- Administer programs mandated by the federal government;
- Establish priorities for meeting the needs of Maryland's senior citizens;
- Evaluate the service needs of Maryland's senior citizens and determine whether or not programs meet these needs;
- Serve as an advocate for older adults at all levels of government; and
- Review and formulate policy recommendations to the Governor for programs that have an impact on senior citizens.

In addition, four statutory committees serve in an advisory capacity to MDoA:

Commission on Aging – This Committee is charged with reviewing and making recommendations to the Secretary of MDoA with respect to ongoing statewide programs and activities. The Commission membership includes a State Senator and State Delegate appointed by their respective chamber leadership, and eleven citizens, including the Chairman, appointed by the Governor. At least seven members must be age 55 or older and membership should reflect geographic representation. Terms are for four years and rotate on a revolving four year cycle, with approximately four new appointments/reappointments annually. Members may serve two consecutive terms.

Financial Review Committee – This Committee is mandated by statute (Human Services Article, Title 10, Subtitle VII, 10-463-464) to review any applications or potential financial issues referred by MDoA concerning Continuing Care Retirement Communities. The Committee recommends specific actions to MDoA. The seven member Committee is appointed by the Secretary of Aging, chooses its own Chairman, and is made up of two Certified Public Accountants (CPAs), two consumer representatives, two members knowledgeable in the field of Continuing Care and one member from the financial community. Terms of office are three years and members may serve consecutive terms.

Interagency Committee on Aging Services –This Committee is charged with planning and coordinating the delivery of services to Maryland's elderly population and is comprised of the Secretaries of the Maryland Departments of Aging; Disabilities; Health and Mental Hygiene; Housing and Community Development; Human Resources; Labor, Licensing, and Regulation; and Transportation; a representative of the Area Agencies on Aging; and, a consumer member.

Oversight Committee on Quality of Care in Nursing Homes and Assisted Living Facilities –This Committee evaluates progress in improving the quality of nursing home and assisted-living facility care statewide. From the Department of Health and Mental Hygiene (DHMH), the Deputy Secretary of Health Care Financing reports annually to the Committee on the status of the Medicaid Nursing Home Reimbursement System. Annually, the Office of Health Care Quality at DHMH also reports to the Committee on implementation of the recommendations of the Task Force on Quality of Care in Nursing Facilities, and the status of quality of care in nursing homes. In the process of reviewing these reports, the Committee develops further proposals on how to improve nursing home care. Specific charges to the Committee include the mandate to evaluate the need for hospice care, mental health services and need for specialized services for persons suffering from dementia. The Committee is chaired by the Secretary of Aging and is composed of twenty-three members from across the spectrum of long-term services and supports and consumer/advocacy communities.

Responsibilities/Role

MDoA receives State general funds as approved by the General Assembly and federal funds through the Older Americans Act, Medicaid, and other sources to carry out its mission.

The partnership between MDoA and the 19 local Area Agencies on Aging (AAAs) provides programs and services for older adults statewide. AAAs are local government or non-profit organizations designated by MDoA under federal statutory authority to provide for a range of services to meet the needs of older Marylanders. Each AAA is required to submit a plan for the delivery of services. Approval from MDoA is based on AAAs having met State and federal statutory and regulatory requirements. State and federal funds are allocated to AAAs based on formulas developed by MDoA in cooperation with the AAAs.

AAAs receive additional funds through county and municipal support and other public/private contributions. AAAs provide services to older adults either directly or through contracts with other public or private organizations. While programs such as information and assistance and nutrition are available to

all older adults, the increase in the numbers of older adults and limited public funds necessitate that services be directed first to those older adults in greatest social and economic need and those who may be at risk of institutionalization.

An organization chart of MDoA is provided in Appendix A. Maryland's AAAs, their Planning and Service Area designations, locations, and profiles can be found in Appendices B and C.

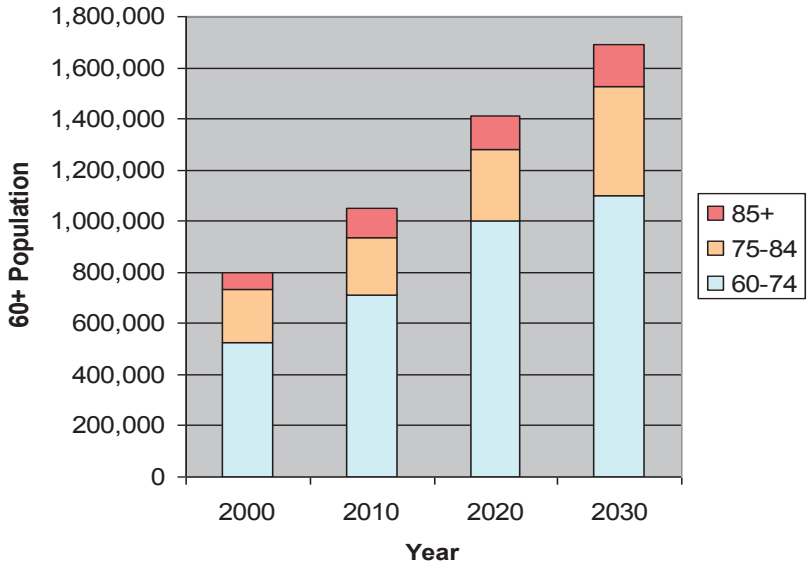
Demographics

The aging of Maryland will place an unprecedented demand on health, social services, the workforce, and housing accommodations. In the year 2000, the number of older adults in Maryland was just over 800,000. Today, there are a little over 1,025,000 and in ten years there are projected to be about 1.4 million older adults in Maryland. By 2030, the number is projected to increase to about 1.7 million older adults. Fortunately, not all 1.7 million older adults will be looking to the State for assistance. Many will be healthy, independent, and financially secure. However, as the population increases, so too will the actual number of persons who will require some assistance. Assistance may take the form of: subsidies to help pay for community-based long-term services and supports so that individuals can avoid less desirable and more costly nursing home care; mobility options for persons who cannot drive; protection of people who are wards of the State; protection and care of people who reside in nursing homes; and, programs to keep people healthy, employed, and engaged in community life. Several demographic trends shape MDoA's goals and priorities for service to older adults:

- **Maryland ranks 20th in the nation for individuals over the age of 65 according to estimates by the U.S. Census Bureau.** See Appendix F for 2010 Percent of Population Ages 65 and Over in Maryland's jurisdictions.

- **Individuals over the age of 85 are the fastest growing segment of the population.** This cohort will grow in number, statewide, from 98,126 in 2010 to 165,293 by the year 2030.

Elderly Population in Maryland by Age Group, Age 60+, 2000-2030



	2000	2010	2020	2030
60-74	523,014	713,873	998,658	1,099,935
75-84	211,120	223,743	279,967	425,993
85+	66,902	112,392	133,180	165,293
Total	**801,036**	**1,050,008**	**1,411,805**	**1,691,221**

- **The number of older Marylanders is increasing.** Of the nearly 5.7 million people in Maryland in 2010, 17.8% (1,025,421) were over the age of 60. The percentage is expected to increase to 25.1% of Maryland's projected population of 6.7 million by the year 2030.

- The largest absolute and percentage increase during the 2000 to 2010 period occurred in the 55-64 age cohorts (225,392), or 47.9 percent. This group was the leading edge of the baby boomers, born between 1946 and 1955, which has so profoundly affected all demographic-sensitive issues.

- The second largest percentage increase in population belonged to those ages 85and over (46.7%). As a share of total population, however, this cohort comprised only 1.7 percent of the 2010 population of Maryland, up from 1.3 percent in 2000. It is this population that most often requires a disproportionate share of medical services.

- **The geographic distribution of Maryland's senior population will shift as the overall population distribution changes over the next 30 years.** In 2010, 64.4% of Maryland's older adults resided in Baltimore City and in Anne Arundel, Baltimore, Montgomery and Prince George's counties. In 2030, these will remain the jurisdictions with the largest number of individuals over 60; however, the fastest growing older populations will be in Southern Maryland, where Calvert, Charles and St. Mary's counties are each projected to increase their 60+ populations by over 230%. In addition, Howard, Frederick, Carroll, Cecil and Queen Anne's Counties' over 60 populations are projected to increase by more than 150%.

- In the United States, minorities (including African Americans, Hispanics, Asian or Pacific Islanders, and American Indians or Alaskan Natives) represent 21.1% of persons 60 and over in 2010. **In Maryland, 30.5% of persons 60 and older are minorities. Half of State's minority older adults live in Prince George's County or Baltimore City according to estimates by the U.S. Census Bureau.** In 2010, 21.5% of 60+ minority individuals lived in Baltimore City and 29% of 60+ minority individuals lived in Prince George's County.

- **Low-income older individuals are concentrated in the Baltimore Metropolitan Area**. A smaller number of poorer individuals aged 60 and over reside in Western Maryland and on the Eastern Shore. In 2010, 74,527 older Marylanders lived in poverty as defined by the federal poverty guidelines.

- **Between 2005 and 2015, Maryland's workforce ages 55 and older is expected to grow by 48 percent.** Statewide, 14.6 percent of workers were 55 and older according to a 2004 report from the U.S. Census Bureau. By 2020, one in four Maryland workers will be 55 or older.

These demographic issues span all of MDoA's programs and efforts, and their potential impact on services is incorporated into all planning discussions. Because of these trends, coupled with an increasing demand for services and funding challenges within the State, MDoA is developing ways to use existing resources more efficiently and to assure that our outreach efforts are aggressive enough to reach our minority, low-income, and other underserved populations. Strategies, objectives, and performance measures for addressing the needs of both our current and future populations are described in this Plan.

Appendix G shows Maryland Adults with Disabilities 18 and over.

Sources: U. S. Census Bureau, Census 2010; MD Department of Planning Population Projections, Revised August, 2007; Maryland Department of Planning 2011 Maryland Statistical Handbook.

Critical Issues & Trends

Civic Engagement

Maryland has a strong tradition in leading the nation on civic engagement through the implementation of State and federal legislation and pioneering ways to create more effective pathways for older adults to serve. In 2007, the General Assembly passed the Maryland Baby Boomer Initiative Act, which established a Baby Boomer Initiative Council whose objectives include developing recommendations to address the needs of the baby boomer population and opportunities to capitalize on their potential for social capital. Maryland is also the home of one of the largest Experience Corps sites, with about 275 volunteers serving over 6,000 Baltimore City elementary school children since 1998. This innovative, high-impact program utilizes the time, skills, and experience of adults 55 years and older to benefit not only their own health and well-being but also to help improve educational outcomes for elementary school-aged children. The program serves students in grades Pre-K to 5. Each extensively-trained Experience Corps member commits a minimum of 15 hours per week for the entire school year and works at the direction of the teacher to support students in the areas of reading, writing, language and math. Maryland is also home to one of the newest ReServe sites. ReServe Maryland connects the state's nonprofits and public institutions to experienced professionals aged 55+ (ReServists) who want to give back. Launched in February 2012, ReServe Maryland is operated by the University of Maryland, School of Social Work. The Department of Aging is a member of the ReServe Advisory Board and is actively helping to promote the program to its partners and retired professionals.

Communities for a Lifetime

Research has long indicated that older adults prefer to "age in place," growing old in their own homes and communities rather than institutional facilities. In addition to the quality of life benefits, aging in place represents an important strategy for containing costs as Maryland's population ages because it helps older adults with disabilities remain in the community and avoid expensive institutionalization. Further, by helping people maintain their homes in good condition and remain as active consumers of and contributors to the economic, civic, and social environment, aging in place initiatives help communities remain desirable places for everyone to live. Many communities in Maryland have instituted exemplary aging in place programs for their residents that can serve as best practices for other communities. These programs promote creative strategies to overcome barriers in housing, transportation, health care, social and civic engagement, employment, and leadership.

Emergency Preparedness

Maryland has a strong emergency planning and preparedness structure that flows from the Federal Emergency Management Agency (FEMA) to the Maryland Emergency Management Agency (MEMA) to twenty-four local county Emergency Management Agencies. MDoA is intricately involved in the structure as are a number of the local AAAs. MDoA participates in "incident exercises" through the MEMA command center and encourages AAAs to participate in those exercises through their local Emergency Management Agencies. Emergency preparedness includes plans for natural disasters, aggressive actions, pandemic flu, and other events that affect significant numbers of people and require a coordinated response for assistance, evacuation, and sheltering in place.

MEMA operations have identified the location and size of all nursing homes and assisted living facilities in the State. The Maryland Department of Health and Mental Hygiene, together with police and fire rescue units at the State and county level are responsible for ensuring that institutions have developed appropriate evacuation plans in the event of an emergency. The challenge for MDoA is to be able to identify those vulnerable older adults living in the community in order to provide the assistance needed in

the event of an emergency. While MDoA participates in the State level emergency planning, preparedness, and exercises, it is not a front line responder like the AAAs. MDoA encourages and supports the full involvement of all the local AAAs with their local Emergency Management Agencies in an effort to:

- Assure that the needs of older adults are addressed in planning;
- Identify the location of vulnerable older adults in the community;
- Provide outreach and education to assist older adults to be prepared for emergencies; and,
- Provide front line assistance in an emergency and during recovery.

Strategies to Address Chronic Disease

Maryland is seeing a significant increase in the numbers of people with chronic conditions such as diabetes, hypertension and mental illness. Eighty percent of seniors report having one chronic condition, and 50% have more than one condition.

Chronic diseases, including heart disease, stroke, and diabetes, are among the leading causes of death in Maryland and currently account for 75 percent of health care costs. Fortunately, those living with chronic conditions have enormous potential to improve their quality of life and reduce debilitating complications associated with chronic disease through nutrition, exercise, proper health care and self-care habits. Disparities in health outcomes are a significant challenge in Maryland. According to indicators published by the Department of Health and Mental Hygiene, African Americans and Whites in Maryland are far more likely than Asians and Hispanics to go to the emergency room for complications related to diabetes, hypertension and behavioral health. Wide variations in access to health care services between rural, suburban and urban populations are another source of disparities.

Health care costs are rising, especially in the area of chronic diseases. While nearly all seniors have access to health care through Medicaid, Medicare or other means, regular doctor visits and medication are not sufficient to enable people to live as healthfully as possible with their chronic conditions. Recent research shows that the hospital readmission rate following a hospital stay for a chronic condition such as congestive heart failure or diabetes can be substantially higher for patients 65 and older than for acute conditions. Finding ways to reduce health care costs for seniors with chronic conditions is critical to reducing overall health care costs in Maryland.

Housing

Surveys consistently confirm that the goal of more than 90% of persons age 65 and over is to remain in their homes for as long as possible. Housing plays an increasingly important role in the continuum of care as Maryland works to shift the focus of long-term services and supports towards home and community-based settings. The need for affordable housing is significant, as evidenced by the 2004 report of the Governors Housing Policy Commission that projected a need for 25,000 units of affordable housing for older adults in Maryland. Much of the State's existing affordable housing inventory and housing voucher programs have lengthy waiting lists. The U. S. Department of Housing and Urban Development estimates that nationally 1.4 million very low-income elderly people pay more than 50% of their income for housing or live in substandard housing. For the 77% of Maryland older adults who own their own homes, routine repair and maintenance, rising property taxes, and the lack of accessible design features represent the greatest threats to their ability to remain in their home. The lack of affordable, accessible housing is also a major barrier to the State's efforts to transition persons in institutions to community care. Housing solutions must also address services needed to assure quality of life and support continued community residency. The integration of accessible and affordable housing with support services can play a critical role in diverting persons from institutional care, facilitating efforts to transition persons back to community care, and decreasing future acute and long-term services and supports expenditures.

Information Services

One of the primary roles of MDoA and the AAAs is to provide information to older adults, their families and caregivers on how to access services, resources, and information about aging issues. MDoA's key program in this area is the Senior Information and Assistance (Senior I&A) program. Senior I&A provides a central point in all twenty-four local jurisdictions in Maryland that seniors can access by phone or in person to obtain information, or as needed, hands-on assistance obtaining services and benefits. The program promotes awareness of services for the elderly through outreach and public education, and provides information about health care, Medicare/Medicaid/private health insurance, in-home services, transportation, housing, legal services, senior centers, retirement communities, prescription drugs and more. There are approximately 120 Senior I&A sites in Maryland. With the creation of the Aging and Disability Resource Centers, known in Maryland as Maryland Access Point (MAP), the Senior I&A system has been streamlined to provide a single point of entry to access long-term support resources for adults with disabilities as well as older adults. MAP will also provide individuals with a web-based tool for locating and selecting resource providers in their local area for services.

For FY 2011, over 537,300 inquiries were received in Maryland for information and assistance, with the majority of those requesting some form of financial assistance. The top five most requested services were (1) financial resources, (2) health care/dental care, (3) affordable housing, (4 assistance help for paying utility bills, and (5) transportation.

Long-Term Services and Supports

There is no greater fear among older adults than the fear that they may have to spend the rest of their life in a nursing home if they are unable to care for themselves. There is also no greater desire than the desire to age in place. Maryland spends almost 86 percent of its Medicaid long-term services and supports (LTSS) dollars in institutional settings and only 14 percent in community settings. Nationally, states spend an average of 33.4 percent of LTSS dollars on home and community-based care.[1]

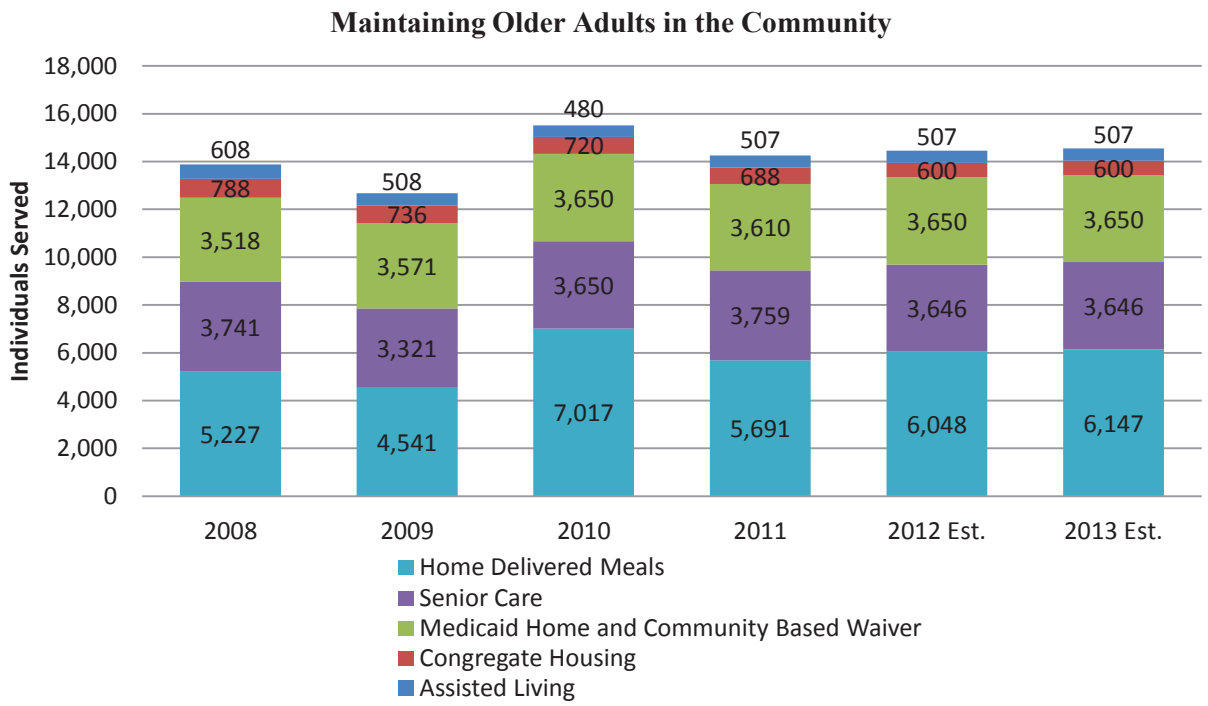
MDoA has a long history of providing community-based LTSS programs for frail and chronically ill older adults. MDoA administers the Medicaid Waiver for Older Adults and a number of State-funded home and community-based LTSS programs, including Senior Care, the Congregate Housing Services Program, and assisted living subsidies. Unfortunately, the need is greater than current resources can support, frequently leaving nursing home placement as the only available option. The challenge is to expand resources for community-based programs and use current resources more efficiently to divert frail older adults from institutional care.

MDoA, in partnership with the Maryland Department of Health and Mental Hygiene (the State's Medicaid Agency) and the Maryland Department of Disabilities**,** is committed to shifting the focus of Medicaid and State LTSS dollars toward community-based settings. MDoA and the AAAs are central partners in all of Maryland's efforts to transition and divert both Medicaid and non-Medicaid individuals from long-term care institutions. The ADRC/MAP model is the centerpiece of a broader delivery system reform effort that includes Money Follows the Person, Community Living Initiative, Person-Centered Hospital Discharge, Evidence-Based Care Transitions, Options Counseling, and the Veteran-Directed Home and Community-Based Services.. These initiatives demonstrate the growing collaboration among different state and local agencies and point the way toward rebalancing Maryland's LTSS system toward community-based services and toward putting the consumer and their caregiver in the driver's seat. The ADRC/MAP model provides a trusted and visible place from which people of all ages and incomes may seek information and services for long term supports. In this regard, the Department of Aging in tandem

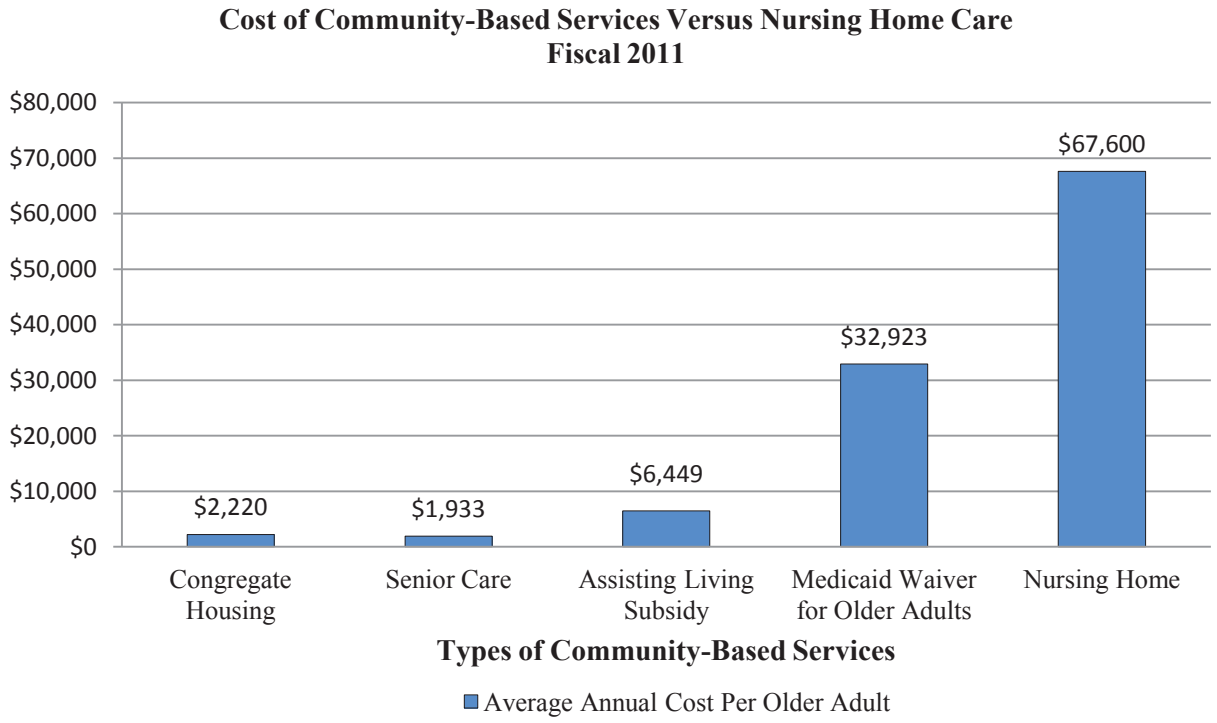
[1] National and State Long-Term Services and Supports Spending for Adults Ages 65 and over and Persons with Physical Disabilities. 2011. Analysis of Thompson Reuter's data by The Hilltop Institute.

with all State Units on Aging has assumed responsibility for access to information and counseling for people who traditionally would not be considered constituents of the aging network. This expansion is done through a "No Wrong Door" approach that includes partnerships among state and local agencies serving a diversity of constituents and building together a seamless and consistently high quality of information and assistance through joint databases, cross training, joint standards and certifications and the creation of formal agreements for cross referral and joint support. This No Wrong Door system allows people to "enter" the long term services and supports arena through those portals they know and trust, but then ensures that will receive a consistently high quality of information and assistance. This shift is a national shift building on the historical strength and competency of the aging network Information and Referral/Assistance programs.

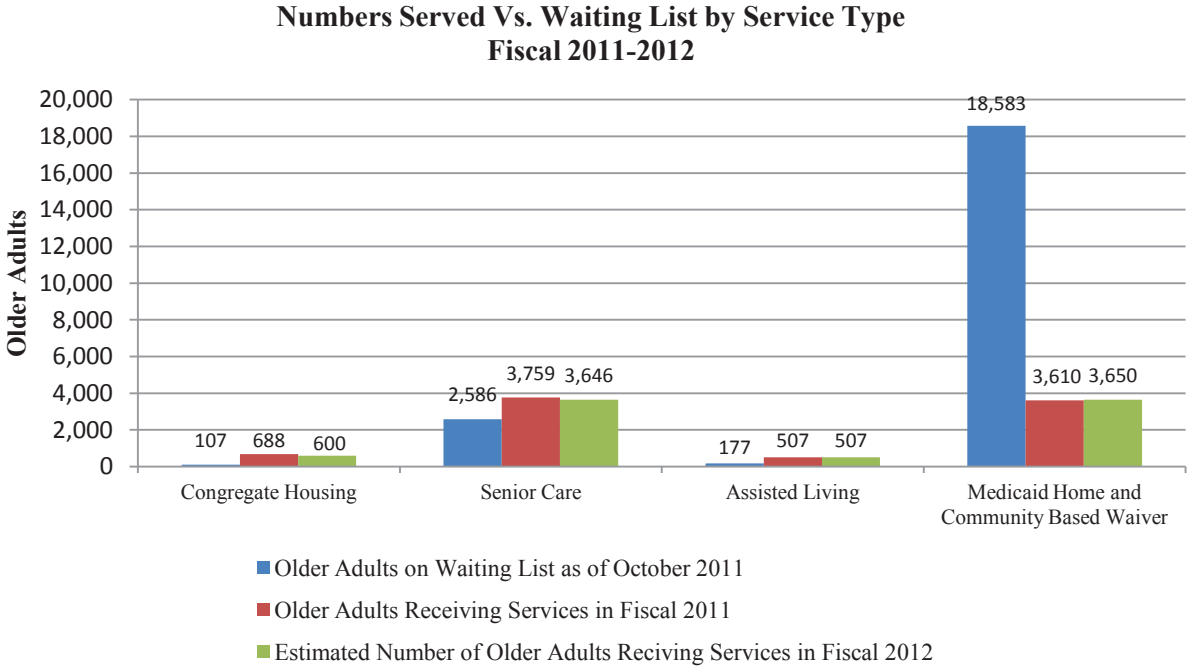
The chart on the next page illustrates the total number of older adults receiving community-based support services through MDoA programs. Most of the growth occurred in the Medicaid Home and Community-Based Services Waiver and Senior Care populations. From fiscal 2008 to 2009, a decrease in the number of older adults served is anticipated in the Senior Care and Congregate Housing programs. The decrease in Congregate Housing is attributed to conversion of some standard congregate housing sites to individualized congregate models that have a higher subsidy and per capita cost, which decreases the number of participants that may be served. The decrease in number of individuals served through the Senior Care program can be attributed to an increased need for case management and to an increase in services needed to maintain older adults already using the program. The 22% increase in older adults served in 2010 was due primarily to federal stimulus spending for Home Delivered Meals. The number of older adults served in fiscal 2011 decreased by 7.8% but is projected to increase slightly in both fiscal years 2012 and 2013.



Community-based services are considered to be a cost-effective investment for Maryland because many of the people who receive community-based services would require nursing home services if the community-based services were not available. As shown in the chart below, the cost for nursing home care is more than double the cost of the Medicaid Home and Community-Based Waiver for Older Adults.



The following chart illustrates the number of individuals being served by Congregate Housing, Senior Care, Assisted Living and Medicaid Home and Community-Based Waiver programs compared with the number on the waiting lists.



Maryland's long term supports and services (LTSS) are on the verge of a major systems transformation that is capitalizing on a multitude of federal initiatives. Maryland has or is in the process of implementing

a number of initiatives, including Money Follows the Person, Statewide Aging and Disability Resource Center Program, Community Living Program, Veterans-Directed HCBS Program, Options Counseling, the Balancing Incentive Program, and the Community First Choice Option. Implementing these options has required close cooperation among several State agencies and stakeholders. The goal of these initiatives is to transform Maryland's LTSS system from one dominated by nursing facility-based care to a person-centered home and community-based service system.

Under the Balancing Incentive Program, the State will implement a new standardized assessment. This assessment will be used to screen individuals who are on the registry for the Waiver for Older Adults.

Mental Health

While most older adults cope well with changes that occur as they age, approximately 20% of older adults living in the community, 42% residing in assisted living environments and nearly 70% of nursing home residents suffer from mental disorders that are frequently undiagnosed and untreated. Medications, illness, disability, substance abuse, and isolation are among the many possible causes of late life mental health problems. Additionally, individuals with mental health disorders are living longer, presenting challenges in traditional long-term services and supports settings as well as psychiatric and residential rehabilitation programs. Older adults with mental illness consume more health care, medication, and outpatient services and experience longer hospital stays. Of particular concern is the high rate of suicide among the older adult population, which is double the national average, with white males over the age of 80 committing suicide at a rate of more than six times the national average. Substance abuse is also rising among older adults and is expected to increase further as the baby boom population ages.

There are many barriers to the delivery of quality and appropriate mental health services for older Marylanders, including inadequate outreach, screening, assessment and treatment services, unequal insurance coverage for mental health services, and continuing stigmas about mental health that hinder referrals to qualified health professionals. The majority of older people who are treated for mental health and substance abuse problems are treated by their primary care physician, and data reveals that geriatric mental health and substance abuse problems are under-identified and under-treated. A number of initiatives in Maryland are in progress to "transform" systems, bridge gaps, streamline processes and develop an infrastructure to better support older adults and their mental health needs.

Oral Health

An individual's oral health often is a reflection of their general health. Diseases occurring elsewhere in the body, such as infections, nutritional deficiencies, immune disorders, and cancers often exhibit oral signs and symptoms. Furthermore, evidence is growing that impairments to oral health do not only reflect general health, but may also exacerbate existing medical problems. As an example, periodontal disease may be associated with respiratory disease, cardiovascular disease, coronary heart disease, and diabetes. Older adults often experience chronic diseases that may exacerbate oral health problems. The magnitude of oral health problems generally experienced by the elderly is well documented; however, specific data pertaining to the oral health status of older adults is not available.

Oral health problems are particularly problematical for older adults who may already be suffering from cognitive and functional limitations as well as serious medical conditions which may interfere with their ability to seek dental care. Furthermore, public funding for needed oral health services is lacking in that Medicare and Medicaid, with rare exceptions, do not cover dental services, and few older adults have private dental insurance. Further complicating the problem, low-income and minority individuals experience greater frequency and severity of oral disease than do other segments of the population.

Persons with Dementia

Over 86,000 people living in Maryland have Alzheimer's disease or some related type of dementia and 14% of these people live alone with increased risk of malnutrition, falls, unattended wandering and accidental deaths. MDoA realizes that this population will increase by nearly 20% by 2025, impacting every aspect of services delivery for older adults necessitating greatly increased family/caregiver support. MDoA is actively involved in the Maryland Alzheimer's Disease and Related Disorders Commission established by the Governor in 2012 to develop a statewide evaluation and plan. This enables MDoA to coordinate its efforts with public and private sector strategies and to advocate for increased resources and research. In addition, MDoA is reviewing each of its programs to ensure that the needs of those with Alzheimer's disease are being addressed.

Protection of Vulnerable Adults

A growing number of older adults with Alzheimer's disease or other cognitive impairments are vulnerable to abuse or neglect due to their increasing difficulty managing finances and making important life decisions. Without the support of caring family members, they may inadvertently ruin their credit, lose their homes, suffer from self-neglect, or become a victim of consumer fraud. In Maryland, the Public Guardianship Program serves adults 65 years and older who have been deemed by a court of law to lack the capacity to make or communicate responsible decisions concerning their daily living needs. The law requires that the MDoA Secretary or a Director of an AAA be appointed by the court as a guardian of that person when there is no other person or organization willing and appropriate to be named. The goal of the program is to provide protection and advocacy on behalf of the disabled older adult.

As MDoA seeks to return long term care residents to the community, it simultaneously works to improve quality of care and quality of life to those 47,000 persons who live in nursing homes and assisted living. In addition to addressing individual complaints, the Ombudsman Program is involved in collaborative strategies to promote residents rights and quality of life through the national Advancing Excellence in America's Nursing Homes (AE) initiative, the FY13 CMS and State of Maryland initiative to reduce antipsychotic medication use, and the implementation of the Quality Assurance and Performance Initiative (QUAPI). MDoA also addresses quality issues in the implementation of person directed care in its Assisted Living Waiver Program.

While there are several outstanding examples of culture change in nursing homes, the culture change movement has not been embraced by many long term care facilities. MDoA will actively promote the development of a statewide culture change initiative as a collaborative effort of providers, consumers, advocates and aging agencies. In addition, MDoA will work with the Green House and other small home movements so that those who must live in facility based care have a full array of options available. MDoA will continue its efforts to strengthen the Long Term Care Ombudsman Program so that all residents have timely access to effective ombudsman services throughout the state by developing an official designation process, updating its policies and procedures, and strengthening its volunteer program.

Transportation

The ability to get around is critical to quality of life. Easy-to-use, affordable mobility options are essential to accessing health care and other services, as well as maintaining independence. Unfortunately, because of where they live and the lack of transportation options, many older adults are at risk of becoming isolated and immobile. Many older adults rely on their car as their primary mode of transportation. In Maryland, as in the rest of the United States, an increase in car use is accompanied by a decline in the use of public transit. Planning means considering both an increase in older drivers and an increase in older non-drivers. Half of the expected growth in vehicle miles travelled between now and the year 2030, will be drivers 65 years old and over. Maryland has 608,072 licensed drivers ages 65 and over

as of February 2012. This is 15% of the total number of drivers licensed in Maryland. The National Household Travel survey showed that in the year 2000, the number of non-drivers in Maryland aged 65 and older was 170,000. If the same ratio persists, the number of Maryland non-drivers over the age of 65 in the year 2030 will be 225,533, or 17 percent.

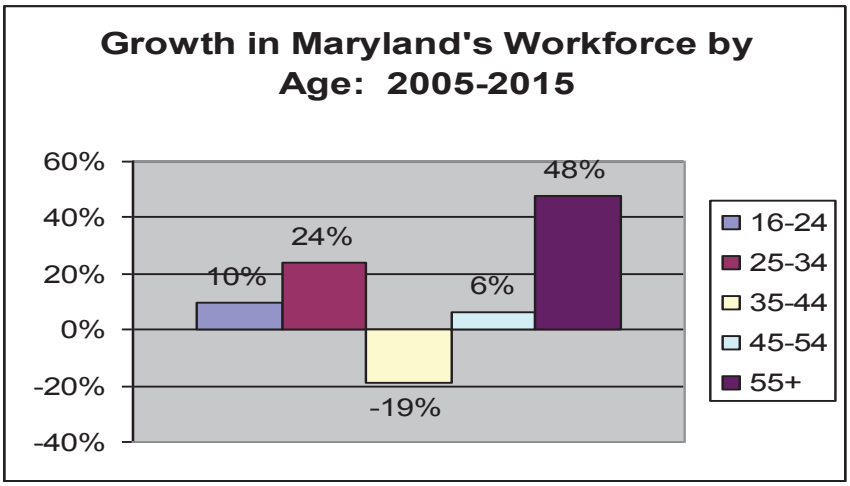
The Maryland Department of Transportation's Maryland Transit Administration (MTA) is leading the State of Maryland's Coordinated Transportation Plan efforts. The MTA is working in conjunction with the Maryland Coordinating Committee for Human Services Transportation, metropolitan planning organizations, regional coordinating bodies, and, the KFH Group to develop regional coordinated public transit-human services transportation plans. These regional coordination plans are being developed to meet new federal planning requirements for the Federal Transit Administration's (FTA) 5310 (Elderly Individuals and Individuals with Disabilities), Section 5316 (Job Access and Reverse Commute – JARC) and Section 5317 (New Freedom) Programs.

Maryland's Department of Transportation is sensitive to the importance of addressing the increasing number of older drivers and has initiated a voluntary screening test for older drivers, training for law enforcement, and continues its efforts to better coordinate human services transportation service. The Department of Aging is an integral partner in addressing Older Maryland drivers and those reliant on other transportation services.

The Maryland Coordinated Transportation Plans are accessible through the following website: www.kfhgroup.com/MDCoordinationPlans .

Workforce Development

Aging in Maryland presents two unique workforce challenges. The first challenge is fueled by the growth of the State's older population and the projected demand for workers in the health and long-term service and supports industries. Many Marylanders are unable to obtain quality affordable health and long-term services and supports because their communities lack the sufficient numbers of providers. The second challenge comes from the aging of the workforce itself. Beginning in 2011, the first of Maryland's 1.55 million baby-boomers reached traditional retirement age of 65 years. A growing number of older workers are choosing to remain in the work force for personal fulfillment and financial reasons, including the need for employment-based health insurance and the increased age eligibility for Social Security. If properly engaged, older workers have the potential to provide significant contributions to a shrinking workforce and cost savings to employers. The following chart illustrates how Maryland's workforce is projected to grow by age cohort:



The national economic downturn continues to have a significant impact on Maryland's older adult population. Many older workers found themselves downsized out of jobs long before they were ready to retire. While older workers may be less likely to be laid off, those who do lose their jobs are likely to be unemployed for a longer period of time than younger workers and they are unlikely to replace their former salary. Older workers are also more likely to be laid off from industries that have restructured or reduced their domestic presence, and may not have the skills that readily translate to currently available jobs.

Goals◆Objectives/Strategies◆Performance Measures

To establish goals to support its mission, MDoA considered the strategic goals identified in the Administration on Aging's Strategic Action Plan for 2013-2016 and the key strategic principles and objectives of Choices for Independence.

Goal 1 **Empower older Marylanders, their families, and other consumers to make informed decisions about, and to be able to easily access, existing health and long-term care options**

Objectives/Strategies:

- Provide streamlined access to nutrition and evidence based health promotion activities through Maryland Access Point, the Public Health network, and community and healthcare partners.
- Maryland Access Point website referrals to applicable health promotion programs will effectively refer potential participants to their local provider and will reflect current information.
- Integrate referral processes for health promotion and nutrition programs into Options Counseling standards.
- To identify and document the oral health needs of older Marylanders with a specific focus on dually eligible, low-income and minority elderly residents of senior housing facilities across the state.
- To work with the DHMH Office of Oral Health and the University of Maryland's School of Nursing and Dentistry and other statewide partners to develop an oral health plan for seniors to increase access to information and oral health services.
- Promote person directed care, consistent assignment and quality of life in statewide long term care initiatives including culture change, Advancing Excellence, QAPI and other CMS/ACL initiatives as well as in the Assisted Living Waiver Program.
- Provide consumers with concrete detailed information on long term care choices utilizing the MDoA website and MAP.
- Strengthen the Long Term Care Ombudsman Program by implementing relevant recommendations of the 2009 study to ensure compliance with federal and state law.
- Increase outreach and education efforts to empower older Maryland residents and their caregivers including those with Alzheimer's disease and related dementias to make informed decisions about their care options.
- Work collaboratively with the State Alzheimer's Disease and Related Disorders Commission to promote increased resources and research, effective outreach through Maryland Access Points (MAP), and a comprehensive service delivery system.

Performance Measure	Target Date
Provide evidence based health promotion and disease prevention workshop registration access via Maryland Access Point website.	2014
Partner with the State Health Improvement Process, Institute for a Healthiest Maryland and other state Public Health offices and their partners, resulting in 100 new referrals into evidence based health promotion and disease prevention programs.	2013
Conduct a survey of 300 older adults statewide of different socioeconomic background and geographical area to determine oral health needs.	2013

Develop senior center-based oral health initiatives in five senior centers that will provide educational information to 750 older adults and oral health screenings and/or dental services to 500 older adults	2014
Develop and announce statewide Culture Change Coalition; introduce Nursing Home/Assisted Living Oversight Committee to culture change movement.	December 2012
State and local ombudsmen actively participate and promote quality initiatives including Advancing Excellence, Reduction in Antipsychotic Initiative, and QAPI.	Quarterly
Equip 50 Assisted Living Waiver providers to provide person directed care in annual training events.	May 2013, 2014, 2015
Update Department website to include concrete consumer tools to participate in person directed care.	April 2013
Develop Statewide Plan with partners in ADRD Commission.	December 2012 Plan Finalized Ongoing - Implementation
Evaluate MAP services to ensure effective outreach to those with ADRD and their caregivers.	April 2012 Ongoing - implementation
Develop a comprehensive MAP marketing plan that will increase referrals to local MAP sites by 20 percent	2015
See attached MAP Strategic Plan	

Goal 2 **Enable older Marylanders to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers**

Objectives/Strategies:

- Maintain the total number of congregate and home-delivered meals provided to maintain current funding levels and serve unmet need.
- Provide technical assistance and share best practices for Title IIIC programs to increase cost efficiencies to reduce the cost per meal or improve resource management, in order to maintain the number of meals provided.
- Promote state-of-the-art management practices for Title IIIC programs, including the use of performance-based standards and outcomes.
- Identify concrete strategies in each program at MDoA that can more effectively serve those with Alzheimer's disease and Related Disorders to enable them to stay in their own homes and communities.
- Advocate for the transportation needs of older adults by participating on the Maryland Transit Administration's Interagency Committee on Specialized Transportation and the Maryland Coordinating Committee for Human Service Transportation.
- Review the National Family Caregiver Support Program to identify those services that maximize caregivers' ability to manage their caregiving responsibilities and assure that resources are targeted to those services in greatest demand by caregivers.

Performance Measure	Target Date
Evaluate each program at MDoA and implement strategies to provide support to older adults to remain in the community.	April 2013 Ongoing - implementation

Provide training opportunities at least annually for Title IIIC providers in order to promote: increased cost efficiency, sharing of best practices and creation of innovative solutions to limited funding resources.	October 2012-ongoing implementation
Increase public awareness and visibility of the NFCS Program by developing brochures, conducting training and community education sessions, and enhancing the MDoA website section for the program.	2013
Creation of a MDoA/AAA work group to review and strengthen various components of the NFCSP (i.e., funding priorities, data collection, policies and procedures, etc.)	December 2013
Promote or enhance the establishment of Caregiver Support Groups at the local level by working with the local AAAs to provide technical assistance and support.	2014
To identify mechanisms through which the NFCSP can develop a cost-sharing component to increase resources for the program to expand services.	2014
See attached MAP Strategic Plan	
Develop and implement cost-sharing policies for Title IIIB services to generate program income which may be used to expand services.	June 2013
Collect and make available best practices on policies to encourage aging in place.	December 2013
Convene the Communities for a Lifetime Commission to develop recommended criteria that local jurisdictions may use to certify Communities for a Lifetime	December 2014
Convene a regional professional conference and consumer expo to promote Innovations in Aging to 300 professionals and 3000 consumers.	2014

Goal 3 **Empower older Marylanders to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare**

Objectives/Strategies:

- Provide resources for evidence-based programming only for Title IIID programs.
- Provide technical assistance, sharing of best practices and pursue funding options to increase the number of moderate and highest tier evidence based programs across the State.
- Develop new partnerships to promote health and prevention benefits
- Develop new initiatives to promote older worker employment opportunities
- Expand the number of volunteers supporting department programs
- Promote civic engagement opportunities for older adults

Performance Measure	Target Date
Develop a plan to ensure the sustainability of the Chronic Disease Self Management Program by: providing ongoing technical assistance related to financial sustainability to Area Agencies on Aging; coordinating quarterly, regional meetings and other relevant training programs, and actively fostering partnerships with insurance and Medicaid/Medicare for the purpose of facilitating third-party payors.	September 2012-March 2014
Conduct two annual live televised phone-a-thons in the Baltimore and Washington television markets to increase awareness of SHIP and Medicare Part D Open Enrollment.	Annually
Develop an expanded network of at least 20 new public and private partners through which information on the availability of Medicare preventive health benefits, health promotion, and fitness programs may be disseminated.	2014
Increase by 10 percent the number of Senior Community Service Employment Program (SCSEP) participants who are transitioned into unsubsidized employment	2016

Convene a meeting of workforce development stakeholders to identify strategies to improve older worker skill sets in order to improve opportunities for employment	2013
Promote the availability of workforce resources including career one-stops through improved website content, through a network of public and private partners, and the use of social media	2013

Goal 4 **Ensure the rights of older Marylanders and prevent their abuse, neglect and exploitation**

Objectives/Strategies:

- Increase awareness of Legal Assistance Program and strive to reach potential clients earlier.
- Increase funding for the Legal Assistance Program.
- Seek grant opportunities to lend support to the Legal Assistance program. Explore the feasibility of increasing the Title IIIB priority funding percentage requirement for Legal Services.
- Identify opportunities to reduce administrative costs to the Legal Services Program and increasing program efficiency by reviewing contracts and the monitoring process.
- Advocate for the rights of the most vulnerable seniors in the State against abuse, exploitation, and consumer fraud by partnering with other organizations and agencies.
- Protect and advocate for the rights of older adults for whom the State or AAAs serve as public guardian.
- Convene the Maryland Stakeholder's Workgroup for the Prevention of Elder Abuse consisting of approximately 22 professionals from a cross-section of stakeholder groups to plan and implement initiatives to address elder abuse.
- To educate the public and financial professionals, including law enforcement, about how to avoid financial exploitation of older adults and how to refer suspected cases.
- To provide educational presentations on mental health services, programs and current issues through the Maryland Coalition on Mental Health and Aging.
- To advocate for older adults on the Joint Council, or the Maryland Advisory council on Mental Hygiene/Planning Council.
- To implement statewide initiatives that improve Medicare beneficiary awareness about healthcare fraud, waste and abuse, by eliciting the help from the faith based community.
- To engage the faith-based community in combating health care fraud
- To increase Senior Medicare Patrol outreach and education.

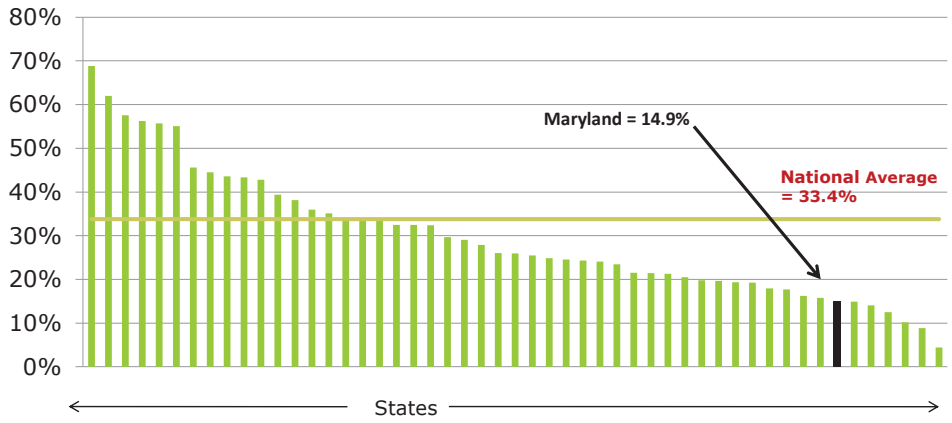
Performance Measure	Target Date
Work with Stakeholders quarterly to strengthen Ombudsman Program through implementing relevant recommendations of 2009 report including designation process for all ombudsmen.	April 2013
Develop a statewide Legal Assistance brochure. Use Facebook and MDoA website to provide program information and provide outreach in nontraditional settings.	2014
Develop Internet based training sessions on elder abuse.	2014
Organize a World Elder Abuse Awareness Day annually to heighten public awareness of elder abuse.	Annually
In partnership with the Maryland's Suicide Prevention Commission, develop a strategic plan on suicide prevention and intervention for older adults, and post-suicide services for families.	2015

Develop a model of care to meet the needs of consumers, including older adults, with behavioral health and substance abuse issues in partnership with Maryland's Department of Health and Mental Hygiene's Behavioral Health Integration initiative.	2014
Implement Volunteer Risk and Program Management Program statewide for Senior Medicare Patrol.	June 2013
Provide 4000 one-on-one counseling sessions and sponsor 450 community outreach events for Senior Medicare Patrol.	June 2013
Increase Senior Medicare Patrol volunteer workforce to 140	September 2013
The Department and and Area Agency on Aging Directors will participate in an emergency preparedness exercise in partnership with the Department of Health and Mental Hygiene.	September 2012

Focus Areas

Nationally, rebalancing efforts have reduced the proportion of Medicaid LTSS spending on nursing facilities from 73.4% to 66.6% between 2004 and 2009. Maryland has lagged behind in these national trends and in 2009, ranked among the poorest in home and community-based services (HCBS) financing. The percentage of Medicaid LTSS spending for Home and community-based services (HCBS) for older persons and persons with physical disabilities in 2009 was at 14%, compared to the nation's average of 33.4% (see graph 1). *These figures exclude the Developmental Disabilities programs which are primarily HCBS.

Percentage of Medicaid Long-Term Services and Supports Spending for HCBS: Older Adults and Persons with Physical Disabilities 2009



Source: National and State Long-Term Services and Supports Spending for Adults Ages 65 and over and Persons with Physical Disabilities. 2011. Analysis of Thompson Reuters data by The Hilltop Institute.

In the last three years, Maryland has moved swiftly to prepare for significant changes in the state's Long Term Services and Supports (LTSS) systems including successful participation in the Money Follows the Person (MFP) Demonstration and a successful application to participate in the Balance Incentive Program (BIP), two national programs that provide federal incentives for increasing the proportion of home and community-based Medicaid spending. Building on these successes, Maryland plans to submit an application to implement a Community First Choice (CFC) program in 2013. On a parallel, but coordinated path, the Maryland Aging and Disability Resource Center (ADRC) program known as Maryland Access Point, or MAP in Maryland, has grown from two pilot sites in 2004 to twenty sites providing access statewide in 2012. The confluence of these three programs (MFP, BIP and MAP) and the philosophical, financial and programmatic changes associated with them have positioned Maryland to move swiftly and decisively toward LTSS reform by 2015.

The Maryland Department of Aging (MDoA) administers the MAP program and the Medicaid Waiver for Older Adults, two programs that are integral to the MFP and BIP initiatives. In brief, the MFP program is built upon Home and Community -Based Service (HCBS) Waivers, one of which is the Medicaid Waiver for Older Adults with over 3,000 participants. The MFP program involves reaching out to Medicaid eligible individuals in institutional settings and assisting them to transition to community-based settings as part of a waiver. Under the MFP program, the Maryland Area Agencies on Aging (AAA), all of which

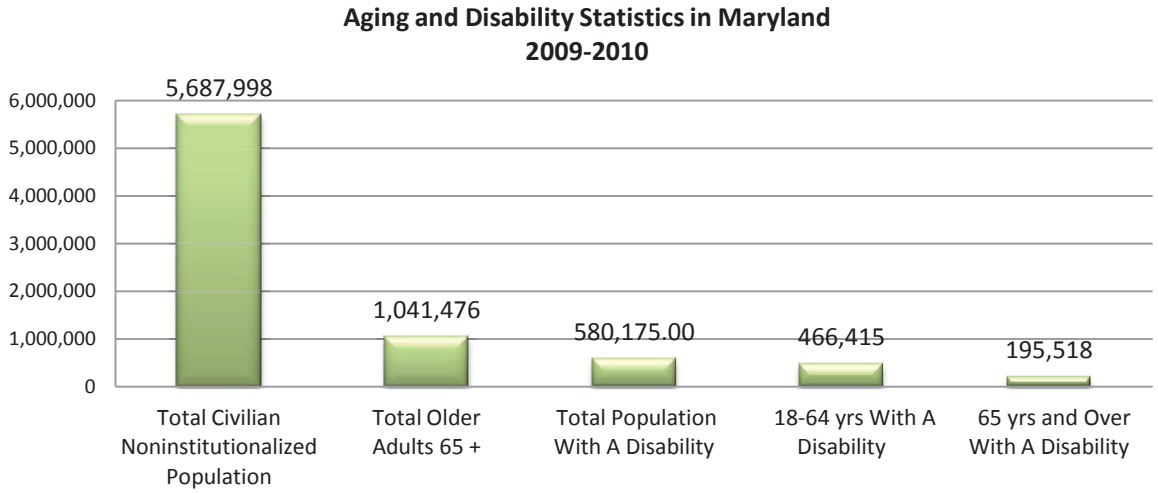
are MAP sites, have been responsible for providing options counseling to all individuals in nursing homes wishing to transition and for transitional and on-going case management for individuals transitioning into the Older Adult Waiver. Funding derived through the successful MFP program has been used to expand and stabilize the MAP program. The options counseling provided through MFP also laid the groundwork for options counseling for individuals identifying on the Minimum Data Set (MDS-3) a desire to move back to the community from a nursing home admission. Local MAP staff are the designated contact for requests generated by the MDS-3 and responsible for coordinating all options counseling in response to those requests. The BIP program requires three structural elements: 1) a statewide Single Entry Point (SEP) for LTSS; (2) a statewide single assessment instrument for LTSS; and (3) conflict free case management. The statewide ADRC/MAP program built upon the AAA Information and Assistance Program and the Older Adult Waiver is integral to each of these structural elements. An interdepartmental work group involving MDoA and Medicaid staff meets at least twice a month to coordinate MAP responsibilities under BIP.

MDoA Aging and Disability Resource Center Development

The Maryland Department of Aging (MDoA) began to work on LTSS reform in 2003 when the Administration of Community Living (ACL) (then known as the Administration on Aging) entered into a collaborative agreement with the Centers for Medicare and Medicaid Services (CMS) to assist states in the development of Aging and Disability Resource Centers (ADRC). Maryland was one of 12 states to receive the first ADRC grants. The ADRC program builds on the strengths of the aging and disability networks of service providers and advocates; it promotes streamlined access to information and services; it promotes person-centered counseling and self-direction in the way services are delivered; and it promotes community-based living and engagement rather than institutional long term care.
Partnerships developed as a result of the ADRC grant include Maryland's Medicaid agency, the Department of Health and Mental Hygiene (DHMH), Maryland Department of Disabilities, Maryland Department of Human Resources, Area Agencies on Aging, local Health Departments, local Departments of Social Services, Centers for Independent Living, state and federal Veterans Administration, advocacy groups and organizations serving older adults and people with disabilities and service providers. New formal partnerships are being forged with behavioral health and developmental disabilities agencies and advocates.
The ADRC sites in Maryland are known as "Maryland Access Point," or MAPS. Beginning with two local sites in 2004, the program has grown to twenty sites, providing information and referral, Options Counseling and services statewide. MAP sites, primarily located within the 19 Area Agencies on Aging, use a statewide web-based searchable database www.marylandaccesspoint.info with over 10,000 listings and resources for consumers, caregivers and professionals seeking LTSS information and services. The MAP sites have been designated point of contact for the Medicaid single assessment instrument being implemented under the BIP program. Individuals seeking information on LTSS will be able to contact MAP options counselors via a 1-800 statewide phone number or via the MAP website. All MAP sites have participated in a detailed assessment process to determine their "readiness" to reach a fully functioning ADRC status and to fully participate in the MFP and BIP programs. A state action plan is being developed to provide the necessary state support to fully achieve this status by 2015 and financial and technical assistance is being provided through the MFP and BIP programs. MDoA received an Options Counseling grant in 2010 and has developed standards and procedures that will be rolled out statewide in 2013 in conjunction with the roll out of the statewide single assessment instrument.

Partnerships and Expansion of Service Population

The ADRC has expanded the constituent base of the State Unit on Aging. Prior to 2003, the constituent base was older adults, age 50 and over. Over the period in which the ADRC/MAP program has developed, the constituent base expanded first to include individuals with disabilities age 18 and older and has now expanded to include individuals of all ages seeking information and assistance for LTSS (see graph below).



The MAP program serves this diverse constituency through a No Wrong Door approach that incorporates partnerships with those organizations and agencies through which people from different constituent groups traditionally seek information and assistance, e.g. specific disability organizations like Centers for Independent Living, regional Developmental Disabilities agencies, regional Core Service Agencies, disability specific associations, etc. The No Wrong Door approach has resulted in the creation of formal partnerships among organizations representing and serving different constituents. Options counselors designated by a MAP site may be from the AAA Information and Assistance staff or they may be from the partner Center for Independent Living Information and Referral staff. Regardless of the home agency, options counselors must meet statewide criteria that include: (1) on-going training and education requirements, (2) knowledge of and relationship with staff and services of different agencies servicing different constituents allowing "warm hand-offs" and follow-up, (3) person-centered options counseling, (4) support planning, and (5) short term case management.

ADRC Diversion Initiative Pilots

The ADRC/MAP program is a conduit for new state and federal funding sources to test new programs that can assist older adults and persons with disabilities to remain in their own homes and communities rather than transition to long term institutional settings. ADRC related federal grants and funding secured by the Maryland Department of Aging include: Empowering Individuals to Navigate Their Health and Long Term Support Options, Money Follows the Person, Person Centered Hospital Discharge, Evidence Based Care Transitions, Options Counseling, the Community Living Program and the Veteran Directed Home and Community- Based Services.

Empowering Individuals to Navigate Their Health and Long Term Services and Supports Options: the goal of this grant is to strengthen the existing ADRC/MAP sites and expand to add new ADRC/MAP sites. This grant provided the opportunity to advance the mission of the Maryland Department of Aging statewide and to develop infrastructure and outreach.

Money Follows the Person: The Maryland Department of Aging is working in partnership with the state's Medicaid Agency –Department of Health and Mental Hygiene –to implement a federal incentive program to identify individuals in nursing homes who wish to transition back into the community. Eligible individuals can transition into a Medicaid Home and Community-Based Services Waivers and/or receive state-funded programs. Since 2008, 548 people have transitioned to the Waiver for Older Adults under the MFP initiative. An additional 642 people have transitioned from nursing home under the Money Follows the Individual statute enacted in 2004. The MFP outreach and transition work has grown

to include the provision of options counseling for individuals requesting assistance to transition back to the community under the Minimum Data Set (MDS-3) a federally required nursing home assessment. A 2010 Memorandum of Understanding between the Maryland Department of Health and Mental Hygiene and the Maryland Department of Aging provided $3 million to fund the Money Follows the Person Demonstration and supporting MAP functions. Memorandums with similar funding have been executed annually through 2013. This funding is allocated to the Department to support the MFP program through local Area Agencies on Aging and to expand the MAP program and website.

Options Counseling Grant: will strengthen Maryland Access Point sites by building their capacity to provide options counseling to individuals seeking information and assistance on long term supports and services. Options counseling programs help people understand, evaluate, and manage the full range of long term services and supports available in their community. Under this grant, the MAP in Howard County is working to develop and test standards and to develop a method for incorporating these standards in all long term supports and services programs including the Money Follows the Person Demonstration. Please see the section below called "MDoA's Role in BIP" for additional information on the Options Counseling Program. The MDoA Options Counseling pilot in Howard County MAP is coordinating with the pilot of the Level 1 screening tool that will refer people to the core standardized assessment. These screening and assessment instruments are developed from the Inter RAI instrument and will replace current assessment instruments statewide.

Evidence Based Care Transition: will help older persons with multiple complex chronic medical conditions to avoid acute episodes and remain stable in the community. This program supports frail adults in the community by providing a Guided Care (an evidenced-based model) nurse that works with the individual upon hospital discharge to assist the individual to remain stable in the community. The Guided Care program has demonstrated savings and improved quality of life as a result of reductions in hospital admissions and readmissions and other acute episodes. The program is a collaboration between the Maryland Department of Aging, the Baltimore City MAP and the Johns Hopkins Community Physicians Practice.

Person-Centered Hospital Discharge Program: a 39-month grant from the Centers for Medicare and Medicaid Services to develop pilot programs to target hospital patients at high risk of being discharged to a long term nursing home placement and to provide those patients expanded counseling and services; there are currently six pilot sites in Maryland. The program is being evaluated by the School of Nursing at the University of Maryland. A MAP nurse liaison works with hospital admission and discharge staff to identify high risk patients and to offer them services upon discharge to support medication education, identification of support services, transportation to medical appointments and other services that prevent discharges to nursing homes or readmission to the hospital.

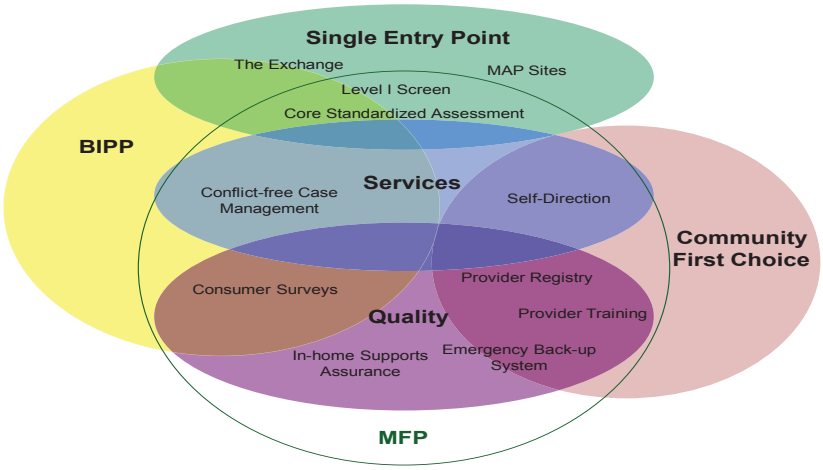
Chronic Disease Self Management Program(CDSMP): Since 2006, with the support of grants from the Administration on Aging and the Harry & Jeanette Weinberg Foundation, MDoA has created a substantial statewide infrastructure to deliver evidence-based health promotion programs primarily via our Area Agencies on Aging. Our "flagship" program is *Living Well* which implements the Stanford CDSMP model; our programs have served over 3,500 persons with chronic disease statewide. MDoA plans to continue building the program's infrastructure, with special focus on providing this service in areas of high need (i.e., elevated rates of chronic disease) and where health disparities exist. We will continue to promote the program through our MAP referral and outreach efforts and will encourage partnerships with the medical community and potential payers such as insurance companies, Medicaid, and others in order to build a sustainable funding and delivery system.

Nursing Home Diversion Grant/Community Living Program: has enabled the Maryland Department of Aging, in partnership with five Area on Agencies and other state stakeholders, to develop a tool to identify individuals at risk of Medicaid spend down and nursing home placement and provide them a flexible self-directed benefit program. In 2010, a Fiscal Intermediary was retained to provide personnel payroll and vendor purchases for individuals participating in the Community Living and Veterans Programs. First enrollments were initiated in 2012.

Veteran Directed Home and Community-Based Services Program: has been made possible via the above Nursing Home Diversion Grant/Community Living Initiative. The MDoA in partnership with five Area Agencies on Aging and the federal Veterans Administration have developed this program. The program will provide a flexible benefit to veterans who have disabilities and are living in the community. The goal is to assist the veteran to remain in the community and prevent an institutional placement. The veterans in this program have choice, flexibility, control and responsibility due to the self-direction framework. A Fiscal Intermediary has been retained to provide personnel payroll and vendor purchases for veterans in this program. Five veterans enrolled in 2012. Plans are underway to enroll up to 70 or more veterans in this program by the end of 2013. This program involves three Veteran Administration Medical Centers covering the full state. It is executed with a provider agreement between the VAMC and the Department with program services administered through five MAP sites.

MDoA's Role in Balancing Incentive Program (BIP)

Maryland was the second state in the nation to successfully apply for the Balance Incentive Program (BIP) authorized under the Affordable Care Act. The BIP offers an enhanced federal Medicaid matching percentage for all home and community-based covered services during the balancing incentive period through September 30, 2015. The projected $106 million dollars in additional revenue is to fund new and expanded Medicaid community-based LTSS. The Maryland Access Point (MAP) program has been designated the statewide single entry point (SEP) required by BIP and MAP sites will administer the Level One screen for the single statewide assessment instrument required by BIP. The MAP sites will be the Single Entry Point (SEP) through which individuals are screened for the standard assessment. BIP will use a 1-800 statewide phone number or a MAP website portal that will connect a consumer directly to their designated MAP. The MAP SEPs are built upon a No Wrong Door philosophy including other partners like regional Centers for Independent Living which provide options. All options counselors must meet specific criteria being developed by the state in conjunction with national standards and criteria. The following diagram depicts the programmatic and service components of Maryland's strategy to: shift the costs of long term services to community settings; streamline access to information and service; increase self-direction options for program participants; and implement strong quality assurance and control.



APPENDICES

Appendix A – Maryland Department of Aging Organization Chart

Appendix B – Maryland Planning & Service Areas Map

Appendix C – Maryland Area Agencies on Aging (PSA) Profiles

Appendix D – Public Input

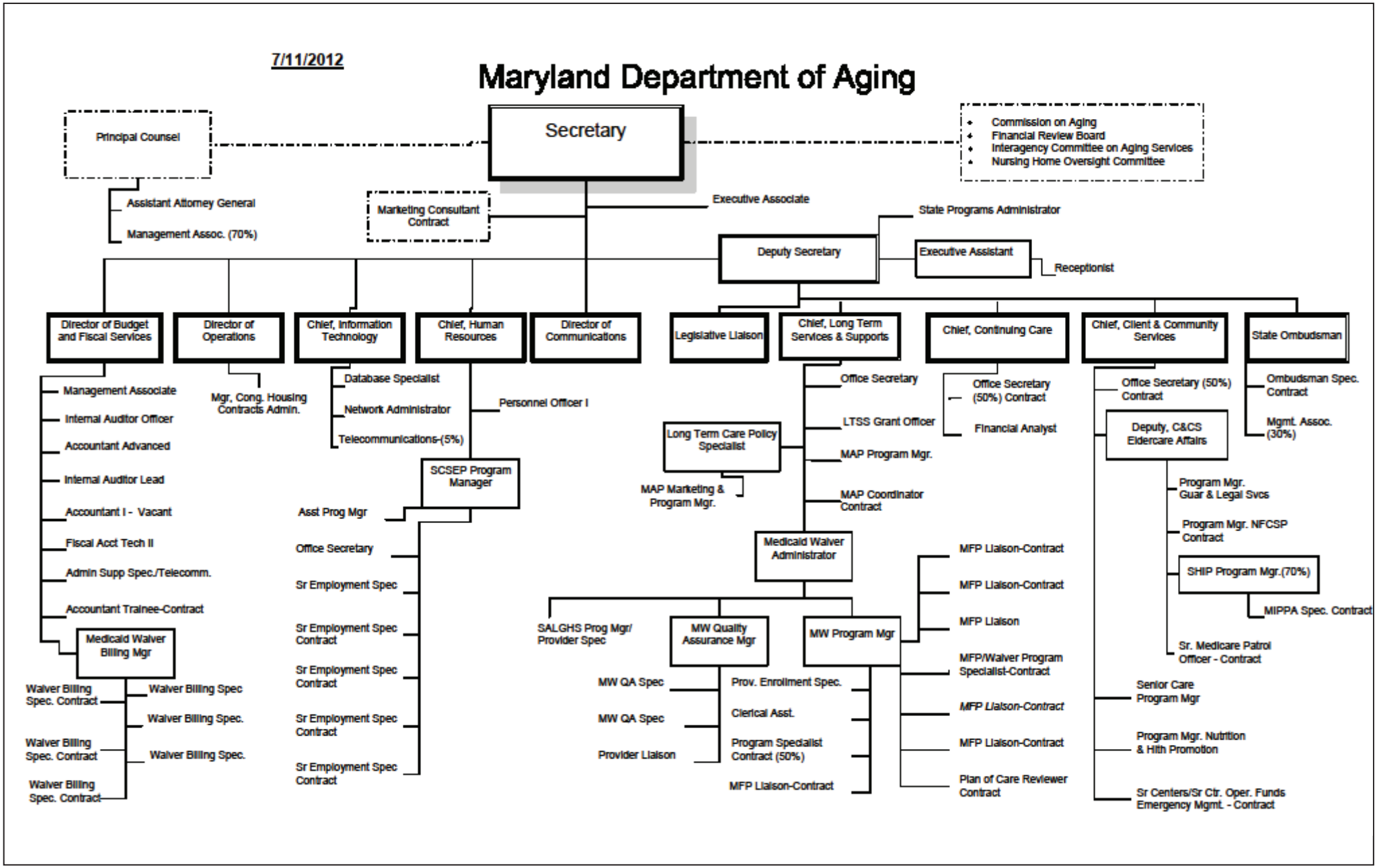
Appendix E – Intrastate Funding Formula (IFF) and Allocation Tables

Appendix F – 2010 Percent of Population Ages 65+ for Maryland's Jurisdictions

Appendix G – Maryland Adults with Disabilities – Aged 18+ by Jurisdiction (2010)

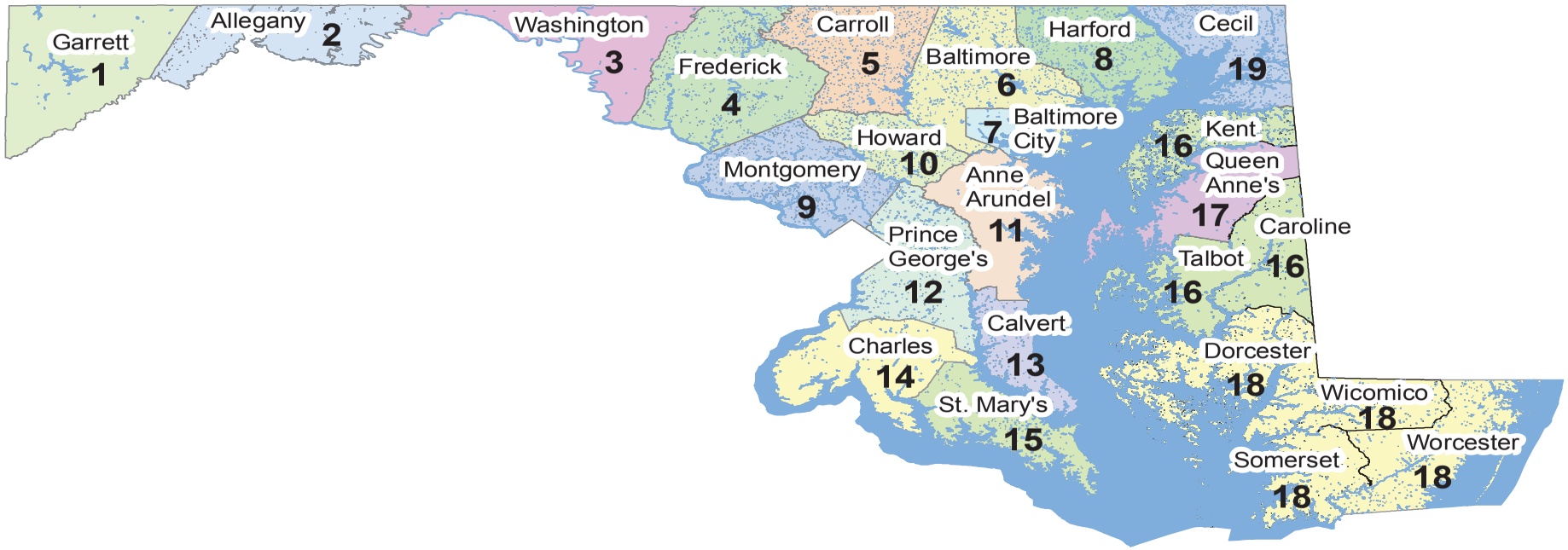
Appendix H – MAP Five Year Strategic Plan

Appendix I – State Plan Assurances, Provisions and Information Requirements


7/11/2012
Maryland Department of Aging
Principal Counsel
Assistant Attorney General
Management Assoc. (70%)
Secretary
Commission on Aging
Financial Review Board
Interagency Committee on Aging Services
Nursing Home Oversight Committee
Marketing Consultant Contract
Executive Associate
State Programs Administrator
Deputy Secretary
Executive Assistant
Receptionist
Director of Budget and Fiscal Services
Director of Operations
Chief, Information Technology
Chief, Human Resources
Director of Communications
Legislative Liaison
Chief, Long Term Services & Supports
Chief, Continuing Care
Chief, Client & Community Services
State Ombudsman
Management Associate
Internal Auditor Officer
Accountant Advanced
Internal Auditor Lead
Accountant I - Vacant
Fiscal Acct Tech II
Admin Supp Spec./Telecomm.
Accountant Trainee-Contract
Medicaid Waiver Billing Mgr
Waiver Billing Spec. Contract
Waiver Billing Spec
Waiver Billing Spec.
Waiver Billing Spec. Contract
Waiver Billing Spec.
Waiver Billing Spec. Contract
Mgr, Cong. Housing Contracts Admin.
Database Specialist
Network Administrator
Telecommunications-(5%)
Personnel Officer I
SCSEP Program Manager
Asst Prog Mgr
Office Secretary
Sr Employment Spec
Sr Employment Spec Contract
Sr Employment Spec Contract
Sr Employment Spec Contract
Sr Employment Spec Contract
Office Secretary
LTSS Grant Officer
Long Term Care Policy Specialist
MAP Program Mgr.
MAP Marketing & Program Mgr.
MAP Coordinator Contract
Medicaid Waiver Administrator
SALGHS Prog Mgr/ Provider Spec
MW Quality Assurance Mgr
MW Program Mgr
MW QA Spec
MW QA Spec
Provider Liaison
Prov. Enrollment Spec.
Clerical Asst.
Program Specialist Contract (50%)
MFP Liaison-Contract
MFP Liaison-Contract
MFP Liaison
MFP/Waiver Program Specialist-Contract
MFP Liaison-Contract
MFP Liaison-Contract
Plan of Care Reviewer Contract
Office Secretary (50%) Contract
Financial Analyst
Office Secretary (50%) Contract
Deputy, C&CS Eldercare Affairs
Program Mgr. Guar & Legal Svcs
Program Mgr. NFCSP Contract
SHIP Program Mgr.(70%)
MIPPA Spec. Contract
Sr. Medicare Patrol Officer - Contract
Senior Care Program Mgr
Program Mgr. Nutrition & Hlth Promotion
Sr Centers/Sr Ctr. Oper. Funds Emergency Mgmt. - Contract
Ombudsman Spec. Contract
Mgmt. Assoc. (30%)

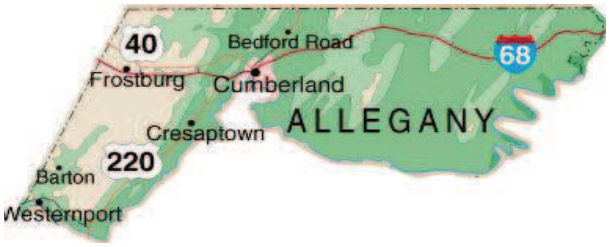
Appendix A

Maryland Planning & Service Areas

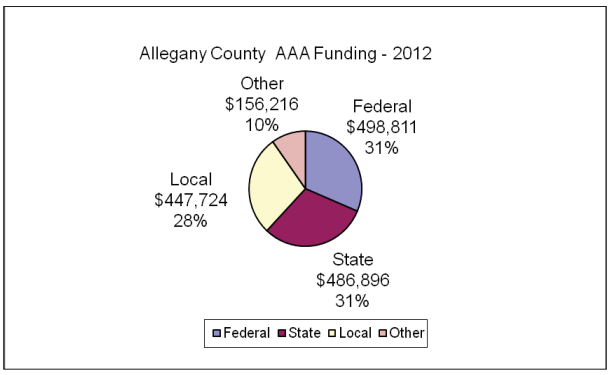


Source: Maryland Department of Aging

Appendix B



PSA #2



History
Formed in 1789 from Washington County
County Seat: Cumberland, MD 21502
Form of Government: Code Home Rule since 1974

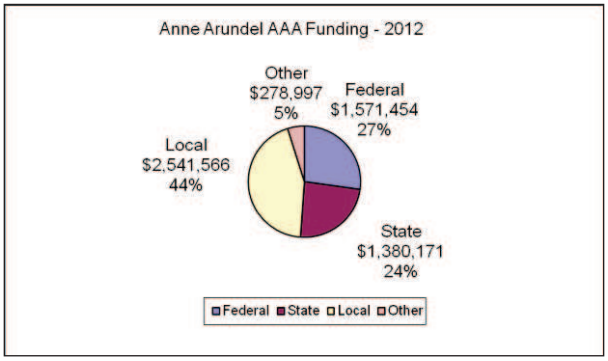
Square Miles- 425

AAA – Non-Profit
Renee Kniseley, Director
Allegany County Human Resources Development Commission, Inc. (HRDC)
125 Virginia Avenue
Cumberland, MD 21502
301-777-5970, x120
rkniseley@allconet.org

Population
75,087 (2010 Census)
17.8% over 65
White (not Hispanic) – 89.2%
Black – 8.0%
Hispanic or Latino – 1.4%
Asian – .8%
American Indian and Alaska Native - .1%

Community
Senior Centers – 4 (Cumberland, Frostburg, Lonaconing, Westernport)
Senior Assisted Living Group Homes - 4
Congregate Housing Services Programs - 2
CCRCs - 0
Nursing Homes - 8

PSA #11



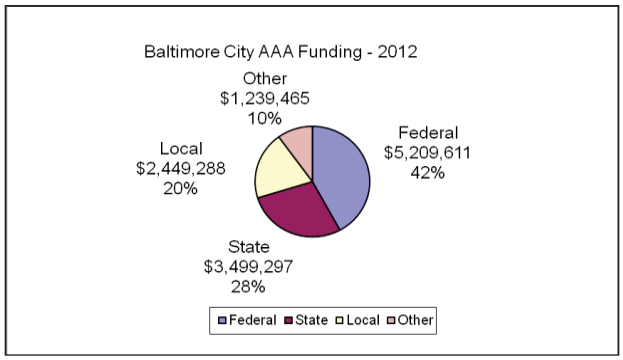
Square Miles – 416

AAA
Pamela Jordan, Director
Anne Arundel County Department of Aging
2666 Riva Road - Suite 400
Annapolis, MD 21401
410-222-4464
exjord00@aacounty.org

Population
537,656 (2010 Census)
11.8% over 65
White (not Hispanic) – 75.4%
Black – 15.5%
Hispanic or Latino – 6.1%
Asian – 3.4%
American Indian and Alaska Native - .4%

Community
Senior Centers – 7 (Annapolis, Pasadena, Arnold, Brooklyn Park, Odenton, Glen Burnie, Edgewater)
Senior Assisted Living Group Homes - 101
Congregate Housing Services Programs- 6
CCRCs - 2
Nursing Homes- 15

PSA #7



History
Baltimore City was incorporated in 1796
As a governmental unit, the City separated from Baltimore County in 1851

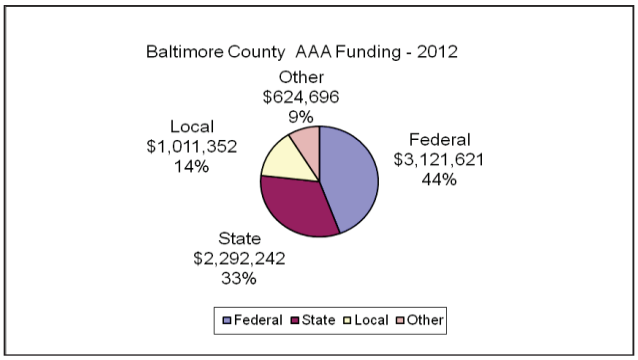
Square Miles- 81

AAA
Arnold Eppel, Director
CARE Services Baltimore City Health Department
1001 E. Fayette Street
Baltimore, MD 21202
410-396-4932
arnold.eppel@baltimorecity.gov

Population
620,961 (2010 Census)
11.7% over 65 (2010)
White (not Hispanic) – 29.6%
Black – 63.7%
Asian – 2.3%
Hispanic or Latino – 4.2%
American Indian and Alaska Native - .4%

Community
Senior Centers - 14
Senior Assisted Living Group Homes - 6
Congregate Housing Services Programs - 8
CCRCs - 2
Nursing Homes - 32

PSA #6



History
Form of Government: Charter since 1956

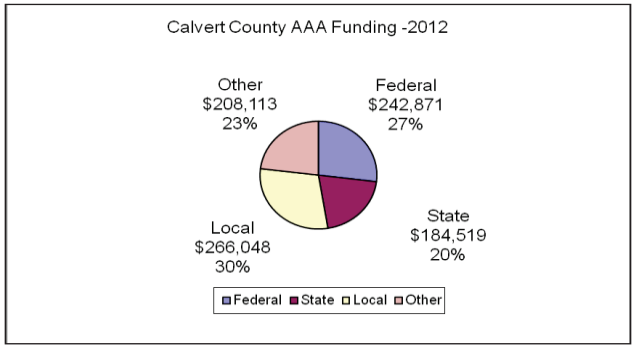
Square Miles- 599

AAA
Joanne Williams, Director
Baltimore County Department of Aging
611 Central Avenue
Towson, MD 21204
410-887-2108
410-887-2159- FAX
jwilliams@baltimorecountymd.gov

Population
805,029 (2010 Census)
14.6% over 65 (2010)
White (not Hispanic) – 64.6%
Black – 26.1%
Asian – 5.0%
Hispanic or Latino – 4.2%
American Indian and Alaska Native - .3%

Community
Senior Centers - 20
Senior Assisted Living Group Homes - 23
Congregate Housing Services Programs – 3
CCRCs - 12
Nursing Homes - 47

PSA #13



History
Formed in 1654
Original County; County seat: Prince Frederick
Form of Government: County Commissioners

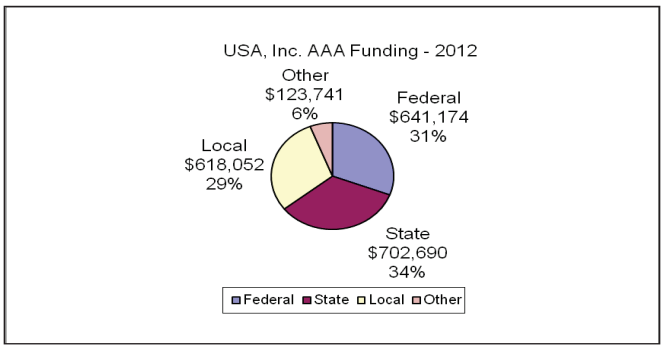
Square Miles - 215

AAA
Susan Justice, Chief
Calvert County Office on Aging
450 West Dares Beach Road
Prince Frederick, MD 20678
410-535-4606
justicsa@co.cal.md.us

Population
88,737 (2010 Census)
10.9% over 65
White (not Hispanic) – 81.4%
Black – 13.4%
Asian – 1.4%
Hispanic or Latino – 2.7%
American Indian and Alaska Native - .4%

Community
Senior Centers – 3 (Prince Frederick, North Beach, Lusby)
Senior Assisted Living Group Homes - 7
Congregate Housing Services Programs - 0
CCRCs - 1
Nursing Homes - 4

PSA #16



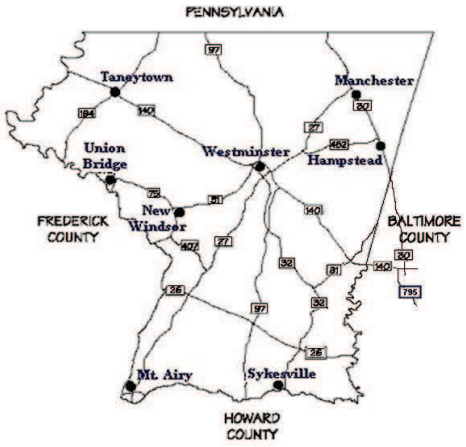
History
Caroline County was created in 1773 from Dorchester and Queen Anne's counties
Form of Government: Code Home Rule

Square Miles - 320

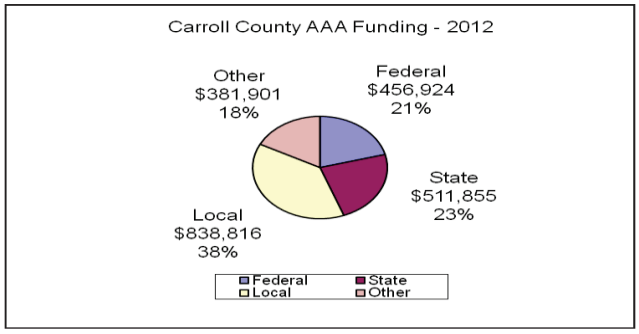
AAA
Gary Gunther, Executive Director
Upper Shore Aging, Inc
100 Schauber Road
Chestertown MD 21620
410-778-6000
ggunther@uppershoreaging.org

Population
33,066 (2010 Census)
13.3% - 65 and older
White (not Hispanic) – 79.8%
Black – 13.9%
Asian - .6%
Hispanic or Latino – 5.5%
American Indian and Alaska Native - .4%

Community
Senior Centers – 2 (Denton, Federalsburg)
Senior Assisted Living Group Homes - 0
Congregate Housing Services Programs - 0
CCRCs - 0
Nursing Homes - 2



PSA #5



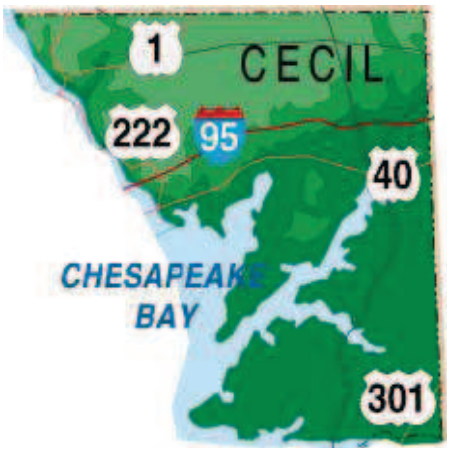
History
Carroll County was formed in 1837 from
Baltimore and Frederick Counties
Form of Government: County Commissioners

Square Miles – 449

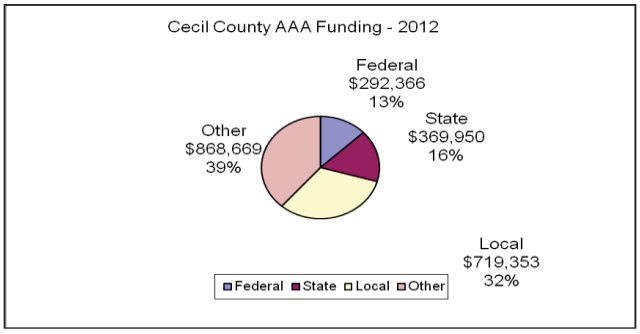
AAA
Jolene Sullivan, Director
Carroll County Bureau of Aging
125 Stoner Avenue
Westminster, MD 21157
410-386-3803
jsullivan@ccg.carr.org

Population
167,134 (2010 Census)
13% over 65
White (not Hispanic) – 92.9%
Black – 3.2%
Hispanic or Latino – 2.6%
Asian – 1.4%
American Indian and Alaska Native - .2%

Community
Senior Centers – 5 (Mt. Airy, Taneytown, Hampstead, Westminster, Taneytown)
Senior Assisted Living Group Homes - 17
Congregate Housing Services Programs - 0
CCRCs - 2
Nursing Homes - 10



PSA #18



History
Formed in 1674
Erected from Baltimore and Kent counties
County seat: Elkton
Form of Government: County Commissioners

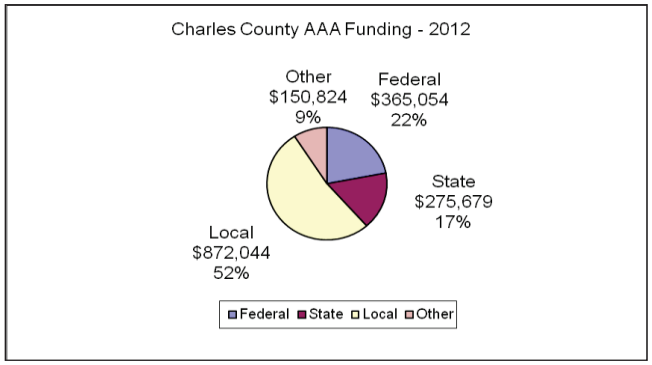
Square Miles – 348

AAA
David Trolio, Director
Senior Services & Community Transit of Cecil County
200 Chesapeake Blvd, Suite 2550
Elkton MD 21921
410-885-7435
dtrolio@ccgov.org

Population
101,108 (2010 Census)
11.7% over 65
White (not Hispanic) – 89.2%
Black – 6.2%
Hispanic or Latino – 3.4%
Asian – 1.1%
American Indian and Alaska Native - .3%

Community
Senior Centers - 1 (Elkton)
Senior Assisted Living Group Homes - 21
Congregate Housing Services Programs - 0
CCRCs - 0
Nursing Homes - 3

PSA #14



History
Created in 1658 by an Order in Council
County Seat: La Plata, MD 20646
Form of Government: Code Home Rule since 2002

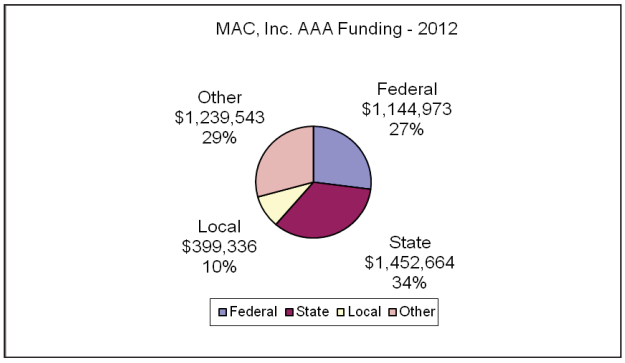
Square Miles - 461

AAA
Dina Barclay, Chief
Charles County Aging & Community Services Division
8190 Port Tobacco Rd·
Port Tobacco, MD 20677
301-934-0109
301-934-5624 (FAX)
barclayd@charlescounty.org

Population
146,551 (2010 Census)
9.5% over 65
White (not Hispanic) – 50.3%
Black – 41%
Hispanic or Latino – 4.3%
Asian – 3.0%
American Indian and Alaska Native - .7%

Community
Senior Centers – 4 (La Plata, Waldorf, Indian Head, Nanjemoy)
Senior Assisted Living Group Homes - 9
Congregate Housing Services Programs - 0
CCRCs- 0
Nursing Homes - 3

PSA #18



History
The exact date and legal origin of Dorchester County are unknown, but it was in existence by February 16, 1668/69.
County Seat: Cambridge, MD 21613
Form of Government: Charter, effective Dec. 5, 2002

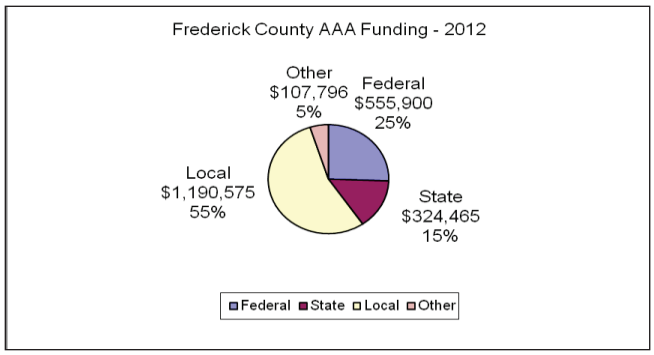
Square Miles – 558

AAA
Peggy Bradford, Executive Director
MAC, Inc.
909 Progress Circle, Suite 100
Salisbury, MD 21804
410-742-0505
410-742-0525 - FAX
mab@macinc.org

Population
32,618 (2010 Census)
9.5% over 65
White (not Hispanic) – 67.6%
Black – 27.7%
Hispanic or Latino – 3.5%
Asian – .9%
American Indian and Alaska Native - .3%

Community
Senior Centers – 2 (Cambridge, Hurlock)
Senior Assisted Living Group Homes – 12 (MAC, Inc.)
Congregate Housing Services Programs - 0
CCRCs - 0
Nursing Homes - 2

PSA #4



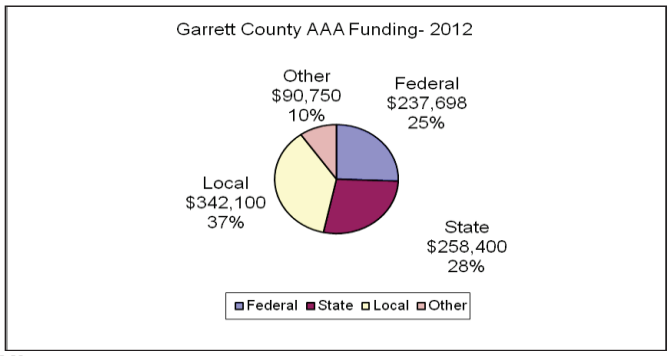
Square Miles - 663

AAA
Carolyn True, Director
Frederick County Department of Aging
1440 Taney Avenue
Frederick MD 21702
301-600-3521 (Director)
301-600-1605
ctrue@frederickcountymd.gov

Population
233,385 (2010 Census)
11.1% over 65
White (not Hispanic) – 81.5%
Black – 8.6%
Asian – 3.8%
Hispanic or Latino – 7.3%
American Indian and Alaska Native - .3%

Community
Senior Centers-4 (Brunswick, Emmitsburg, Frederick-2)
Senior Assisted Living Group Homes - 19
Congregate Housing Services Program - 0
CCRCs - 2
Nursing Homes-9

PSA #1



History
Created from Allegany County in 1872
County Seat: Oakland, MD
Form of Government: County Commissioners

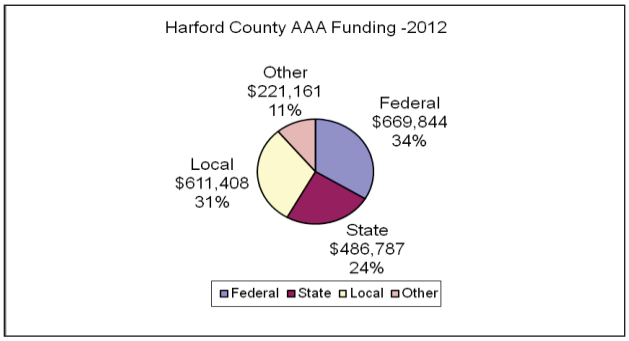
Square Miles - 648

AAA – Non-Profit
Ms. Adina Brode, Director
Garrett County Area Agency on Aging
104 E. Center Street
Oakland, MD 21550
301-334-9431, x 138
abrode@garrettcac.org

Population
30,097 (2010 Census)
17.4% over 65
White (not Hispanic) – 97.9%
Black – 1%
Hispanic or Latino – .7%
Asian – .3%
American Indian and Alaska Native - .1%

Community
Senior Centers – 3 (Accident, Grantsville, Oakland)
Senior Assisted Living Group Homes - 1
Congregate Housing Services Programs - 0
CCRCs - 1
Nursing Homes - 4

PSA #8



History
Created from Baltimore County in 1773
County Seat: Bel Air, MD '

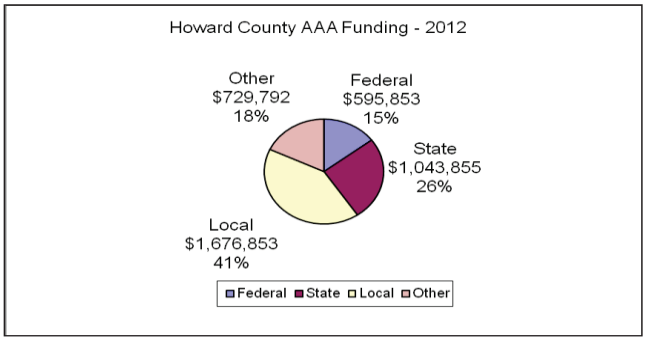
Square Miles- 440

AAA
Karen Winkowski, Director
Harford County Office on Aging
145 N. Hickory Avenue
Bel Air, MD 21014
410-638-3025
410-879-2000 ext. 3331
kawinkowski@harfordcountymd.gov

Population
244,826 (2010 Census)
12.5% over 65
White (not Hispanic) – 81.2%
Black – 12.7%
Hispanic or Latino – 3.5%
Asian – 2.4%
American Indian and Alaska Native - .4%

Community
Senior Centers – 6 (Aberdeen, Edgewood, Street, Bel Air, Havre de Grace, Fallston)
Senior Assisted Living Group Homes - 2
Congregate Housing Services Programs - 0
CCRCs - 0
Nursing Homes - 5

PSA #10



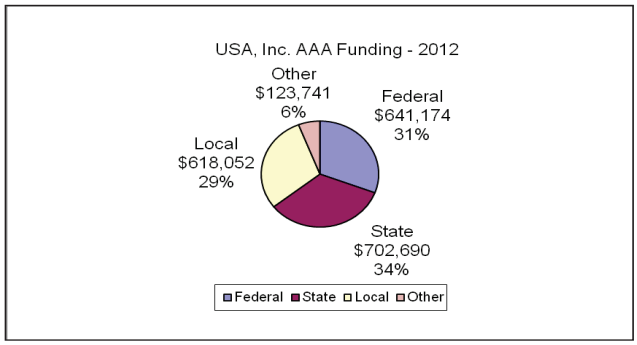
Square Miles – 252

AAA
Dayna Brown, Administrator
Howard County Office of Aging
6751 Columbia Gate way Dr. 2nd Floor
Columbia MD. 21046
(410)-313-6535
dmbrown@howardcountymd.gov

Population
287,085 (2010 Census)
10.1% over 65
White (not Hispanic) – 62.2%
Black – 17.5%
Asian – 14.4%
Hispanic or Latino – 5.8%
American Indian and Alaska Native - .3%

Community
Senior Centers - 6 (Columbia-2, Elkridge, Ellicott City, Cooksville, Laurel)
Senior Assisted Living Group Homes – 30
Congregate Housing Services Programs - 0
CCRCs - 1 (+1 pending)
Nursing Homes – 4

PSA #16



History
Kent County was first mentioned as a county in 1642
County Seat: Chestertown, MD 21620
Form of Government: Code Home Rule since 1970

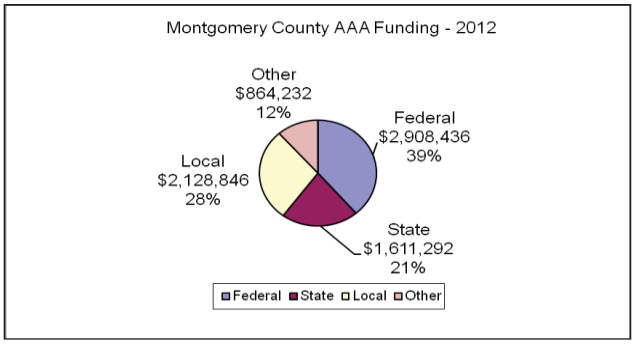
Square Miles – 279

AAA
Gary Gunther, Executive Director
Upper Shore Aging, Inc
100 Schauber Road
Chestertown MD 21620
410-778-6000
410-778-3562 – FAX
ggunther@uppershoreaging.org

Population
20,197 (2010 Census)
21.8% over 65
White (not Hispanic) –80.1%
Black –15.1%
Hispanic or Latino –4.5%
Asian –.8%
American Indian and Alaska Native - .2%

Community
Senior Centers – 1 (Chestertown)
Senior Assisted Living Group Homes - 0
Congregate Housing Services Programs - 0
CCRCs - 1
Nursing Homes - 3

PSA #9

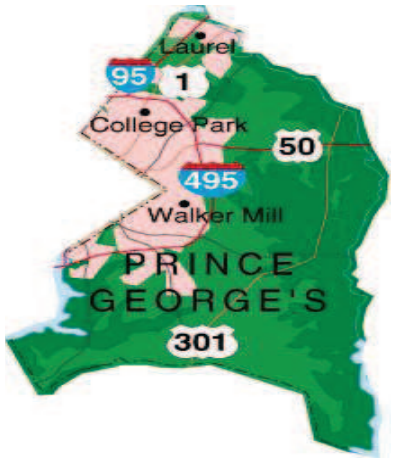


Square Miles - 496

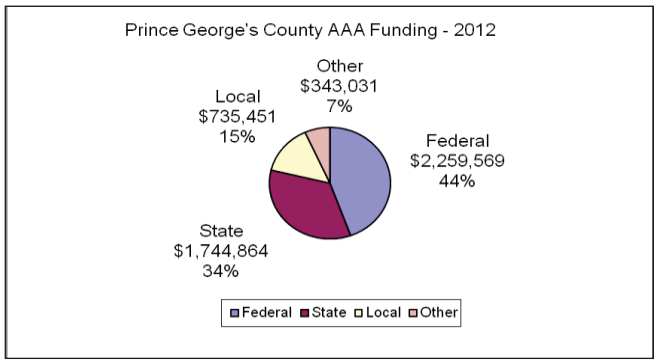
AAA
Dr. Odile Brunetto, Director
Montgomery County Area Agency on Aging
Division of Aging and Disability Services
401 Hungerford Drive, 4th Floor
Rockville, Maryland 20850
240-777-3000 (General)
odile.brunetto@montgomerycountymd.gov

Population
971,777 (2010 Census)
12.3% over 65
White (not Hispanic) – 57.5%
Black – 17.2%
Hispanic or Latino – 17%
Asian – 13.9%
American Indian and Alaska Native - .5%

Community
Senior Centers – 6 (Damascus, Gaithersburg, Rockville, Silver Spring-2, Wheaton)
Senior Assisted Living Group Homes – 58
Congregate Housing Services Programs – 2
CCRCs – 7
Nursing Homes – 34



PSA #12



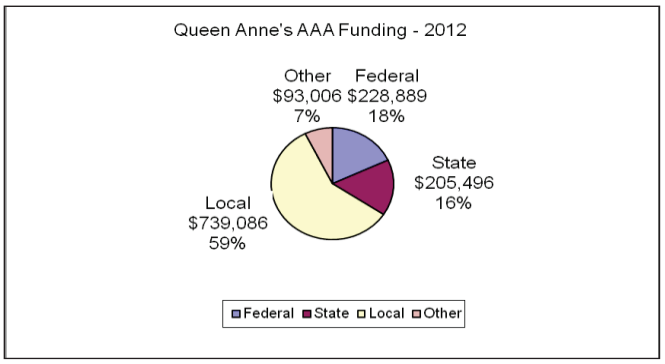
Square Miles – 485

AAA
Theresa Grant, Director
Prince George's County Department of Family Services
Aging Services Division
6420 Allentown Road
Camp Springs, MD 20748
301-265-8450
tmgrant@co.pg.md.us

Population
863,420 (2010 Census)
9.4% over 65
White (not Hispanic) – 19.2%
Black – 64.5%
Hispanic or Latino – 14.9%
Asian – 4.1%
American Indian and Alaska Native - .6%

Community
Senior Centers - 8 (Greenbelt, Bowie, Hyattsville, Laurel, North Brentwood, Seat Pleasant, Camp Springs, Capitol Heights)
Senior Assisted Living Group Homes - 61
Congregate Housing Services Program - 0
CCRCs - 2
Nursing Homes - 20

PSA #17



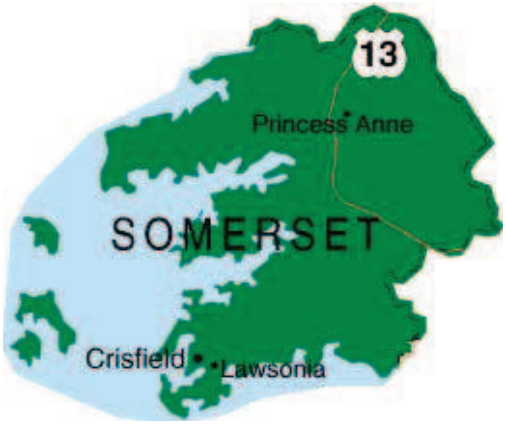
History
County Seat: Centreville, MD
Form of Government*:* Code Home Rule since 1990

Square Miles = 372

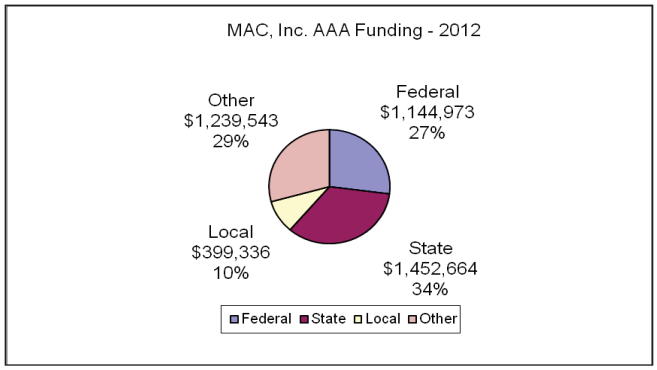
AAA
Catherine Willis, Director
Queen Anne's County Area Agency on Aging
Department of Community Services
104 Powell Street
Centreville, MD 21617
410-758-0848
cwillis@qac.org

Population
47,798 (2010 Census)
14.9% over 65
White (not Hispanic) – 88.7%
Black – 6.9%
Hispanic or Latino – 3%
Asian – 1%
American Indian and Alaska Native - .3%

Community
Senior Centers – 3 (Sudlersville, Grasonville, Stevensville)
Senior Assisted Living Group Homes-- 3
Congregate Housing Services Program- 0
CCRC - 0
Nursing Homes- 1



PSA #18



History
Created by an Order in Council in 1666
County Seat: Princess Anne, MD 21853
Form of Government: County Commissioners

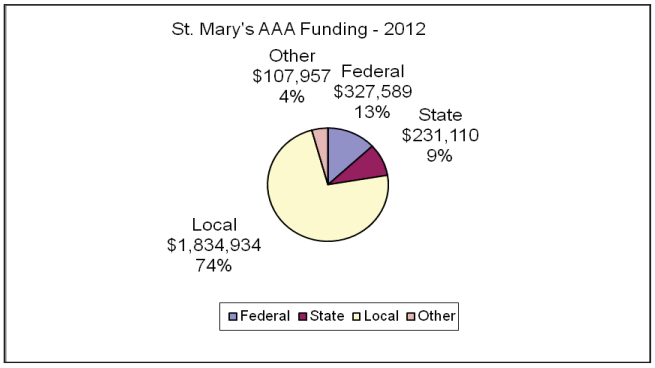
Square Miles – 327

AAA
Peggy Bradford, Executive Director
MAC, Inc.
909 Progress Circle, Suite 100
Salisbury, MD 21804
410-742-0505
410-742-0525 - FAX
mab@macinc.org

Population
26,470 (2010 Census)
13.8% over 65
White (not Hispanic) –53.5%
Black – 42.3%
Hispanic or Latino – 3.3%
Asian – .7%
American Indian and Alaska Native - .3%

Community
Senior Centers – 1 (Princess Anne)
Senior Assisted Living Group Homes – 12 (MAC, Inc.)
Congregate Housing Services Programs - 0
CCRCs - 0
Nursing Homes - 2

PSA #15



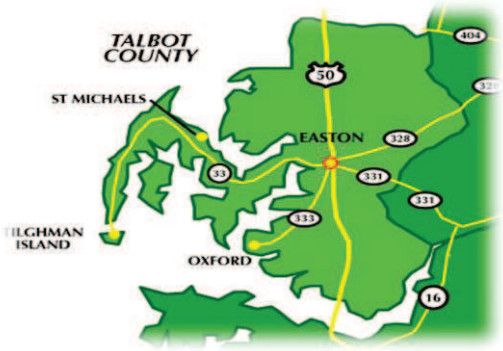
History
St. Mary's, the first Maryland county, was established in 1637
County Seat: Leonardtown, MD 20650
Form of Government: County Commissioners

Square Miles – 361

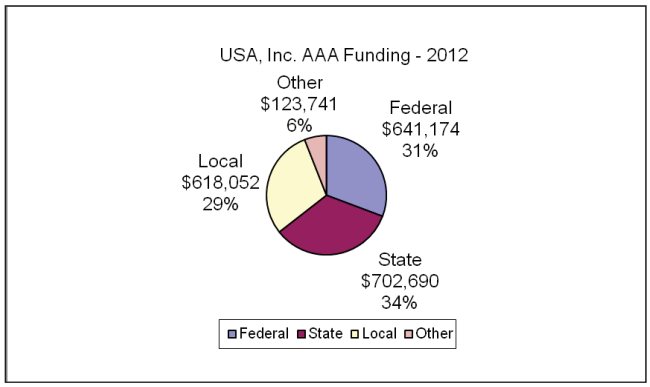
AAA
Lori Jennings-Harris, Director
St. Mary's County Department of Aging
41780 Baldridge St.
Leonardtown, MD 20650
301-475-4200, x1070
lori.harris@stmarymd.com

Population
105,151 (2010 Census)
10.3% over 65
White (not Hispanic) – 78.6%
Black – 14.3%
Asian – 2.5%
Hispanic or Latino – 3.8%
American Indian and Alaska Native - .5%

Community
Senior Centers – 3 (Leonardtown-3)
Senior Assisted Living Group Homes - 0
Congregate Housing Services Programs - 1
CCRCs - 0
Nursing Homes - 3



PSA #16



History
Talbot County was in existence by 1661/ 62
County Seat: Easton, MD 21601
Form of Government: Charter since 1973

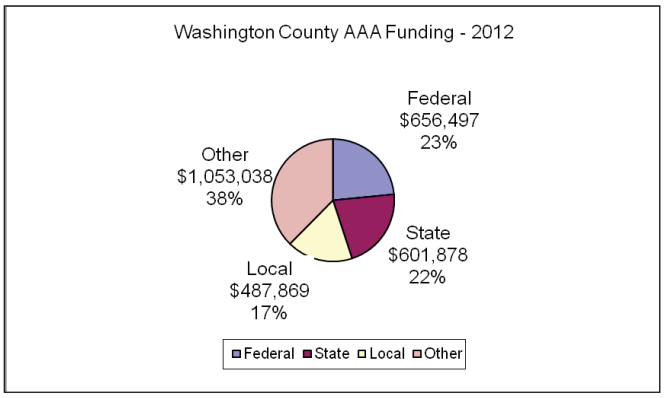
Square Miles – 269

AAA
Gary Gunther, Executive Director
Upper Shore Aging, Inc
100 Schauber Road
Chestertown MD 21620
410-778-6000
410-778-3562 – FAX
ggunther@uppershoreaging.org

Population
37,782 (2010 Census)
23.7% over 65
White (not Hispanic) – 81.4%
Black – 12.8%
Hispanic or Latino – 5.5%
Asian - 1.2%
American Indian and Alaska Native - .3%

Community
Senior Centers – 1 (Easton)
Senior Assisted Living Group Homes - 0
Congregate Housing Services Programs - 0
CCRCs - 1
Nursing Homes - 2

PSA #3



History
County Seat: Hagerstown, MD 21740
Form of Government: County Commissioners

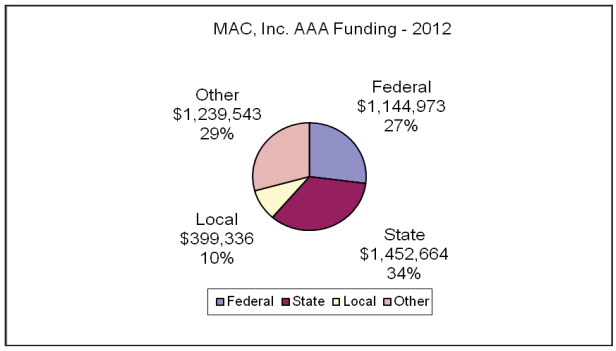
Square Miles - 458

AAA – Non-Profit
Susan MacDonald, Executive Director
The Washington Co. Commission on Aging, Inc./Area Agency on Aging
140 West Franklin St., 4th Floor
Hagerstown, MD 21740
301-790-0275 ext. 203
sjm@wccoaging.org

Population
147,430 (2010 Census)
14.3% over 65
White (not Hispanic) –85.1%
Black – 9.6%
Hispanic or Latino – 3.5%
Asian – 1.4%
American Indian and Alaska Native - .2%

Community
Senior Centers – 1 temporary (Hagerstown)
Senior Assisted Living Group Homes - 4
Congregate Housing Services Programs - 0
CCRCs - 3
Nursing Homes – 10

PSA #18



History
Wicomico County was created from Somerset and Worcester counties in 1867
County Seat: Salisbury, MD 21801
Form of Government: Charter since 1964

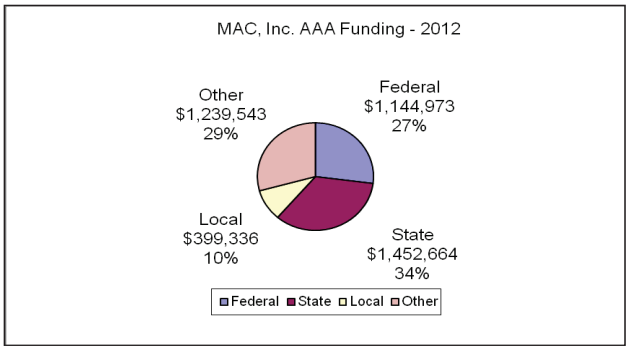
Square Miles – 377

AAA
Peggy Bradford, Executive Director
MAC, Inc.
909 Progress Circle, Suite 100
Salisbury, MD 21804
410-742-0505
410-742-0525 - FAX
mab@macinc.org

Population
98,733 (2010 Census)
13.0% over 65
White (not Hispanic) –68.7%
Black – 24.2%
Hispanic or Latino – 4.5%
Asian – 1.9%
American Indian and Alaska Native - .2%

Community
Senior Centers – 1 (Salisbury)
Senior Assisted Living Group Homes – 12 (All MAC, Inc. counties)
Congregate Housing Services Programs - 0
CCRCs - 0
Nursing Homes - 5

PSA #18



History
Created from Somerset County in 1742
County Seat: Snow Hill, MD 21863
Form of Government: Code Home Rule since 1976

Square Miles – 473

AAA
Peggy Bradford, Executive Director
MAC, Inc.
909 Progress Circle, Suite 100
Salisbury, MD 21804
410-742-0505
410-742-0525 - FAX
mab@macinc.org

Population
51,454 (2010 Census)
23.2% over 65
White (not Hispanic) – 82%
Black – 13.6%
Hispanic or Latino – 3.2%
Asian – 1.1%
American Indian and Alaska Native - .3%

Community
Senior Centers – 4 (Berlin, Pocomoke, Ocean City, Snow Hill)
Senior Assisted Living Group Homes – 12 (All MAC, Inc. counties)
Congregate Housing Services Programs - 0
CCRCs - 0
Nursing Homes - 3

PUBLIC INPUT

The Maryland Department of Aging serves as the State Agency with the authority to develop and administer the State Plan on Aging in accordance with all requirements of the Older Americans Act. The Maryland Department of Aging is primarily responsible for the coordination of all State coordinated systems for the delivery of supportive services, including multipurpose senior centers and nutrition services. In addition, the Maryland Department of Aging serves as the effective and visible advocate for the elderly in the State.

In carrying out these activities, the state agency solicits comments from the public on activities carried out under its State Plan and the needs of older persons and their caregivers within the State. Public input for the Plan came from hearings held across the State, attracting almost 150 individuals who spoke of their desire to remain independent for as long as possible and of their need for the programs and services that the local Area Agencies on Aging provide. Comments were also received by email and by letters.

Public Hearings

The Maryland Department of Aging held five public regional hearings throughout the State as noted below:
Southern (Anne Arundel, Calvert, Charles, Montgomery, **Prince George's**, St. Mary's counties) – May 29, 2012
Central (Baltimore City, **Baltimore,** Carroll, Harford, Howard counties) – May 24, 2012
Lower Eastern Shore (Dorchester, Somerset, **Wicomico**, Worcester counties) – May 22, 2012
Upper Eastern Shore (Caroline, Cecil, Kent, **Queen Anne's**, Talbot counties) – May 15, 2012
Western Region (Allegany, Frederick, Garrett and **Washington** counties) – May 31, 2012
Bold indicates actual county location of hearing.

Announcements of Public Hearings

The times, dates and places of the State public hearings were advertised in through press releases that were published in newspapers throughout the State. In addition to the newspaper announcements, information about the hearings was sent to AAAs, Senior Centers, nutrition sites, Continuing Care Retirement Communities and Congregate Housing Service apartment buildings. Managers of Senior Care programs and associations for older adults also received information. Local and State legislators, advocates, and other interested parties were notified via email. In addition, notices of the hearings were published in the May 4 and May 18 issues of the Maryland Register.

Comments and Issues

In addition to older adults and caregivers, Area Agency on Aging Directors, members of State and Local Commissions on Aging, the press, members of senior advocate groups, and other interested parties attended the hearings.

<u>Senior Input</u>
Generally, issues that were raised centered on the need for senior centers to remain open and able to offer the range of services that older adults have come to depend on including fitness programs, meals, socialization, and access to other needed services. They are concerned about funding cuts to senior centers and losing the services when the need for these services has increased. They believe tax money should be spent to keep the senior centers open and the services in place or expanded to meet the growing demand. In all locations, older adults spoke about the benefits they derive from being members of senior centers and participating in activities. A number of senior center participants explained the importance of the centers to their lives, as an escape from isolation and in keeping them healthy. Older adults noted that they needed more community-based services to allow them to "age in place." Also, they discussed ways

they could contribute to senior centers by becoming volunteers and advocating for funding with their local elected officials.

Caregiver Input

Caregivers' comments focused on the problem that there is not enough money spent to help the caregivers and those providing care to Alzheimer's patients. They noted that they are spending their own money sometimes to take care of their patients. Respite services are also needed because caregivers are sometimes providing 24 hours of care and they need a break.

Area Agencies on Aging

Area Agency Directors and their staff presented testimony at three of the public hearings.

- MDoA should take geographic area into account when allocating funds to priority service areas as larger, multi-county jurisdictions face challenges that county-based Area Agencies on Aging do not have. Also, this should also be taken into account when setting minimum funding levels. MDoA should also continue to fund pilot-projects.
- There is a need for transportation for rural areas especially assisted transportation to take older adults to doctor's appointments. Rural counties with a limited transportation system are not able to meet the door to door service needs of older adults for medical appointments, shopping, and pharmacy visits. Also, increased medication management is needed to assist those at home to take their medications properly and to place reorders. Additionally, dental grants for oral care for older adults are needed for dentures, exams, and routine care and cleanings as oral health problems can affect older adults 'overall health. More affordable and accessible senior housing with subsidy money and gap-filling funds like Senior Care are needed to keep older adults in the community, and emergency funds to help older adults pay their bills or other emergency need.
- Budget reductions have lead to reorganization at the local level in Queen Anne's County. Many agencies have consolidated under one roof to create efficiencies. They recognize the advantage and flexibility of joint partnerships and are fortunate to have many programs that they had but the funding continues to decrease while the demand goes up. MDoA should continue to provide State funds and access to federal funds.
- The biggest need in Washington County is a permanent senior center. They hope to begin construction in the summer on the new center thanks to the leadership and advocacy at MDoA.
- In the rural jurisdictions, Area agency staff spoke of the challenges of providing services for clients, noting that it can take an hour to just reach them. Services to these clients are also being impacted by rising fuel costs, cuts in local funds, and cost of employees. Area agency staff also discussed partnerships to meet the needs of the aging population and the disability community as their needs are parallel.
- For Aging in Place, more Senior Assisted Living Group Home Subsidy money is needed so people can live in Assisted Living. There are many people on the waiting list for services. Also, more money is needed to advertise for prevention programs like the Chronic Disease Self-Management Program and the Living Well program.
- There is a certain population that need nursing homes and assisted living, and the Ombudsman monitors all of these to advocate for residents. There is one Ombudsman for 36 facilities and she is on the road all of the time due to the geographic nature of the counties. One ombudsman is not enough for all of the facilities. There is training for volunteers to help.

Advocate Input

State Commission on Aging

Local representatives' comments from the State Commission on Aging focused on the following areas of concern:

- The State allocation is not keeping up with demand for services. The State must invest in Home and Community-Based Services now to save money in the future. Public services to older adults are not adequately funded to keep up with the increased demand.
- There is a need for older adults who live alone for assisted transportation and affordable and accessible housing so they can stay in their communities.
- There is a need for socialization and leisure programs that support vital living of older adults by providing opportunities for social interaction.
- There is a need for public health and prevention programs that promote health for older adults.
- There is need for effective communication that provides understandable, timely and accessible information on public resources for older adults, employment and training programs, and security and safety programs.
- The State Plan on Aging should address: the waiting list for the Older Adult Waiver program, respite care for caregivers and reimbursement rates, increasing the hourly rate for Case Management as a Service or allow Counties to outsource this service, develop assisted living facilities that can serve older adults with both physical needs and mental illness, and engaging public/private partnerships.
- Need for strong advocacy on behalf of older adults
- Need to collaborate with other State Departments to plan for the impact of the increasing older more diverse population.
- Need for employment retooling and job training

Congregate Housing Services Program
Advocates comments for this program focused on the need for additional subsidy money for this program as it saves Maryland taxpayers money by keeping older adults out of nursing homes and in the community at a much lower cost. This program lends itself well to Maryland's current efforts to rebalance the state's Medicaid dollars towards community-based alternatives to nursing home care.

Legal Services Advocates
Advocates comments for this program focused on the following areas of concern:

- Funding for legal services is important but it only fills a fraction of the need. Many legal issues critical and older adults can't afford private attorneys because of high hourly rate. Many critical issues:
    - Consumer issues concerning debts are the number one issue because they can't pay usually because of medical debt.
    - Denial of long term services and supports coverage under Medicaid because an agency denies level of care. Need care because of medical condition.
    - Housing an issue because of foreclosures, reverse mortgages and an increased need for counseling and advice.
    - Fraud cases involving financial exploitation often by caregivers.
    - Medical decision making, living wills, advance directives

- The Title IIIB grant hasn't changed in over ten years. The amount is not adequate to address the needs of older adults in such a large county with the many range of issues that they must deal with including consumer issues, bankruptcy because of creditors, housing issues and foreclosures.
- The Social Security Administration is targeting overpayment cases and they are going back 10 years or longer and the older adults don't have the records to defend themselves. They live on fixed incomes so they are not able to afford to pay this money back.
- Increased need for legal services for older adults for planning for disabilities, those facing guardianship, assisted living facilities and nursing homes require a power of attorney in place related to finances, defense against predatory lending.

- Increased need to educate older adults about the dangers of cosigning for others. In danger of having their social security garnished for cosigning and they are paying other creditors before they are taking care of themselves.
- Older adults living at home need services if they are going to be "aging in place". HCBS services are important but should have access to legal protection.
- Foreclosure scams and fraud are taking advantage of the most vulnerable citizens. Legal Services are a fundamental need for older adults. If you don't have legal services you can't get to the rest of the needed services.
- There is not enough affordable, accessible housing. Not enough subsidized low-income housing that people can access, which is a barrier to home and community-based services.
- Need to increase funding for Ombudsman to be able to protect older adults in nursing homes and assisted living facilities.
- Maryland needs to open up the 7,500 slots for Older Adult Waiver program. Additional, services for developmentally disabled needed as there is such a long waiting list. There are many older adults caring for disabled children and they need services.

Other Advocates comments:

- Access to services is the biggest problem because older adults are not able to easily navigate to find and receive services. It is daunting for older adults to navigate systems to get services unless they have a personal advocate. Some of the information is too wordy and not written for older adults. As services are created, older adults should be kept in mind as we try to promote services.
- Older adults face institutionalization if they can't receive services in their communities.
- Older adults need to think of innovative ways to make programs work locally because Federal and State government cannot do it all. Talk to your County government regarding programs and make yourself visible to them. Churches and local organizations can come up with new ideas in the communities.

Evaluations

The Maryland Department of Aging regularly evaluates its programs and services. Evaluations conducted in local jurisdictions are summarized in Area Plans. Results of surveys and customer satisfaction forms are submitted to program managers at the State level.

In addition to evaluations from older adults receiving services, the State Commission on Aging meets monthly to raise and evaluate various aging issues. The State Commission acts in an advisory capacity to the MDoA. The State Commission and the Secretary and Deputy Secretary of Aging also attend Commission on Aging meetings that are held on the regional levels. Topics for the agendas of these meetings include such issues as the need for transportation and affordable housing with senior services.

The MDoA works in collaboration with the United Older adults of Maryland, a coalition of local, State, and national senior citizen organizations such as AARP, Retired Teachers Association and National Association of Retired Federal Employees. This group advocates on senior issues at the State and national level.

The Department serves as a resource to the Maryland Senior Citizen Action Network. This is a coalition of provider organizations primarily from the faith communities advocating on behalf of senior services.

<u>Summary</u>

The Maryland Department of Aging reviews and uses all input to set the State's priority services. The State will continue to evaluate its programs and seek public comment to ensure that all Marylanders are able to age with dignity, opportunity, choice and independence.

INTRASTATE FUNDING FORMULA (IFF)

Requirement:
OAA, Sec. 305(a)(2)
"*States shall,*
(C) in consultation with area agencies, in accordance with guidelines issued by the Assistant Secretary, and using the best available data, develop and publish for review and comment a formula for distribution within the State of funds received under this title that takes into account--
(i) the geographical distribution of older individuals in the State; and
(ii) the distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals."

Following the guidelines of the Older Americans Act, as amended, the Maryland Department of Aging's formula is based on the AAAs population of low income and minority older adults. The formula is applied using the most recent census data from 2010 and the 2005-2009 American Community Survey Special Tabulation on Aging.

In allocating Older Americans Act funds to the State's 19 AAAs, the Maryland Department of Aging will use the 45-45-10 funding formula weights as follows:

- 45 percent weight to a jurisdiction's relative share of the State's total elderly population;
- 45 percent weight to a jurisdiction's relative share of the State's total low-income elderly population;
- 10 percent weight to a jurisdiction's relative share of the State's total low-income, minority population;

A base of $125,000 is used for allocating Title III funds and a base of $9,000 is used in allocating Title IIID funds. These bases act as an equalizer for rural jurisdictions with low populations.

This funding formula appears in previous State Plans and was approved by the Assistant Secretary of Aging.

In allocating Title VII Older Americans Act funds to the State's 19 AAAs, the Maryland Department of Aging will use the funding formula weights as follows:

- 20 percent weight to a jurisdiction's relative share of the State's total number of nursing homes
- 70 percent weight to a jurisdiction's relative share of the State's total number of long term care beds
- 10 percent weight to a jurisdiction's relative share of the State's total square miles of the planning and service area

Hold Harmless Funding

Hold harmless funding amounts were revised for the 2013 budget to offset federal fund losses due to the 2010 Census figures.

FY 2013
Older Americans Act funds – Allocations to AAAs

AAA	Funding Ratio (2000 Census)	IIIB	IIIC1	IIIC2	IIID	IIIE	VII	Total
Allegany	1.747%	$99,761	$122,262	$61,427	$9,000	$41,755	$11,470	$345,674
Anne Arundel	7.216%	$412,139	$505,097	$253,774	$21,530	$172,500	$34,867	$1,399,906
Baltimore City	20.044%	$1,144,890	$1,403,120	$704,963	$43,808	$479,190	$57,552	$3,833,524
Baltimore Co	14.627%	$835,448	$1,023,883	$514,425	$34,400	$349,674	$91,102	$2,848,932
Calvert	1.115%	$63,675	$78,037	$39,208	$9,000	$26,651	$4,504	$221,075
Carroll	2.526%	$144,292	$176,837	$88,847	$13,387	$60,393	$18,130	$501,886
Cecil	1.501%	$85,747	$105,087	$52,798	$9,000	$35,889	$7,352	$295,873
Charles	1.664%	$95,034	$116,469	$58,517	$9,000	$39,776	$7,559	$326,356
Frederick	2.843%	$162,408	$199,039	$100,002	$13,938	$67,975	$18,469	$561,830
Garrett	0.843%	$48,165	$59,029	$29,658	$9,000	$20,159	$4,738	$170,749
Harford	3.458%	$197,515	$242,065	$121,619	$15,005	$82,669	$14,705	$673,579
Howard	3.617%	$206,618	$253,220	$127,224	$15,282	$86,479	$20,551	$709,375
MAC	5.094%	$290,939	$356,560	$179,145	$36,000	$120,453	$21,062	$1,004,159
Montgomery	14.207%	$811,460	$994,484	$499,654	$33,671	$339,634	$76,650	$2,755,554
Prince George's	11.668%	$666,435	$816,750	$410,356	$29,262	$278,935	$51,462	$2,253,199
Queen Anne's	0.864%	$49,356	$60,488	$30,391	$9,000	$20,658	$2,355	$172,248
St. Mary's	1.554%	$88,745	$108,762	$54,645	$9,000	$37,144	$8,751	$307,047
USA	2.449%	$139,876	$171,425	$86,128	$27,000	$50,922	$12,332	$487,684
Washington	2.964%	$169,272	$207,451	$104,229	$14,146	$70,848	$19,240	$585,187
Total	**100.000%**	**$5,711,775**	**$7,000,065**	**$3,517,012**	**$360,430**	**$2,381,706**	**$482,850**	**$19,453,839**
MAC	**5.094%**	**$290,939**	**$356,560**	**$179,145**	**$36,000**	**$120,453**	**$21,062**	**$1,004,159**
Dorchester	0.936%	$53,438	$65,491	$32,904	$9,000	$22,366	$3,500	$186,698
Somerset	0.770%	$43,994	$53,917	$27,089	$9,000	$17,095	$2,892	$153,987
Wicomico	1.880%	$107,364	$131,580	$66,109	$9,000	$44,937	$9,964	$368,955
Worcester	1.508%	$86,143	$105,573	$53,043	$9,000	$36,055	$4,706	$294,519
USA	**2.449%**	**$139,876**	**$171,425**	**$86,128**	**$27,000**	**$50,922**	**$12,332**	**$487,684**
Caroline	0.770%	$43,994	$53,917	$27,089	$9,000	$16,458	$3,578	$154,035
Kent	0.770%	$43,994	$53,917	$27,089	$9,000	$12,746	$3,700	$150,446
Talbot	0.908%	$51,889	$63,592	$31,950	$9,000	$21,718	$5,054	$183,203

FY 2013
State Grants – Allocations to AAAs

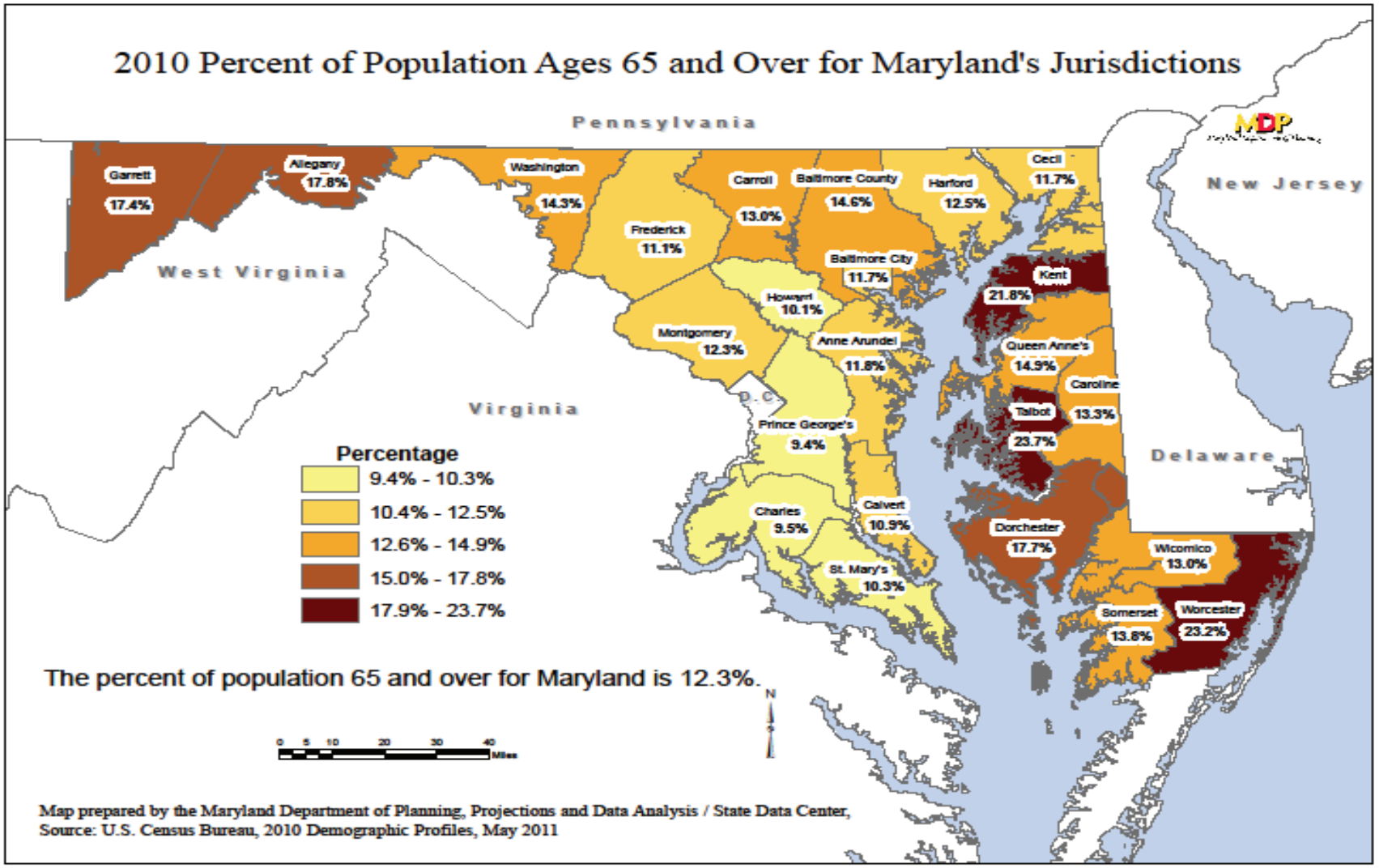
AAA	State Nutrition	Senior I&A	Guardian -ship	Senior Care	SALGHS	State Ombuds- man	VEPI	Supp. To MAC	Total State Funds
Allegany	56,985	20,738	28,907	120,285	17,447	26,648	8,393	0	277,559
Anne Arundel	103,716	46,138	9,064	496,929	453,622	81,006	34,675	0	1,217,532
Baltimore City	600,090	193,920	307,070	1,380,431	191,917	133,710	96,324	0	2,882,298
Baltimore Co.	126,659	105,829	82,337	1,007,327	357,664	211,656	70,289	0	1,946,317
Calvert	14,606	3,935	7,500	100,000	0	10,465	5,357	0	140,686
Carroll	39,588	14,845	29,044	173,977	87,235	42,122	12,140	0	396,284
Cecil	30,039	8,762	1,691	103,388	174,470	17,080	7,214	0	341,059
Charles	4,885	10,991	10,000	114,586	34,894	17,561	7,996	0	199,156
Frederick	51,095	18,582	6,707	195,820	0	42,909	13,664	0	325,775
Garrett	60,325	6,028	8,295	100,000	0	11,008	4,052	0	188,817
Harford	54,727	15,120	0	238,150	8,724	34,164	16,618	0	363,852
Howard	3,939	15,000	5,196	249,126	532,134	47,746	17,383	0	866,705
MAC, Inc.	210,328	46,600	15,912	433,318	165,747	48,933	24,213	131,800	1,071,530
Montgomery	123,954	75,807	43,902	978,403	209,364	178,081	68,271	0	1,662,782
Prince George's	144,808	51,096	50,670	803,543	645,539	119,562	56,069	0	1,858,967
Queen Anne's	23,476	7,613	4,136	100,000	26,171	5,471	4,153	0	170,107
St. Mary's	48,387	9,680	6,600	107,003	0	20,331	7,466	0	197,827
USA, Inc.	75,880	21,030	10,975	300,000	17,447	28,650	10,236	0	461,969
Washington	75,637	20,899	14,686	204,097	61,065	44,700	14,241	0	432,196
TOTAL	**1,849,126**	**692,613**	**642,692**	**7,206,384**	**2,983,438**	**1,121,801**	**478,756**	**131,800**	**15,001,417**

FY 2013
Hold Harmless Allocations

AAA	TOTAL	IIIB	IIIC1	IIIC2	IIIE
Allegany	$70,059	$23,119	$25,221	$13,311	$8,407
Anne Arundel	0	0	0	0	0
Baltimore City	145,788	48,110	52,484	27,700	17,495
Baltimore Co	0	0	0	0	0
Calvert	0	0	0	0	0
Carroll	0	0	0	0	0
Cecil	0	0	0	0	0
Charles	0	0	0	0	0
Frederick	0	0	0	0	0
Garrett	6,551	2,162	2,358	1,245	786
Harford	0	0	0	0	0
Howard	0	0	0	0	0
MAC	148,666	49,060	53,520	28,247	17,840
Montgomery	0	0	0	0	0
Prince George's	0	0	0	0	0
Queen Anne's	5,032	1,661	1,812	956	604
St. Mary's	0	0	0	0	0
USA	63,632	20,999	22,908	12,090	7,636
Washington	2,482	819	894	472	298
TOTAL	**$442,210**	**$145,929**	**$159,196**	**$84,020**	**$53,065**

MAC	**$148,666**	**$49,060**	**$53,520**	**$28,247**	**$17,840**
Dorchester	39,738	13,113	14,306	7,550	4,769
Somerset	19,923	6,575	7,172	3,785	2,391
Wicomico	65,116	21,488	23,442	12,372	7,814
Worcester	23,889	7,883	8,600	4,539	2,867

USA	**$63,632**	**$20,998**	**$22,908**	**$12,090**	**$7,637**
Caroline	19,962	6,587	7,186	3,793	2,395
Kent	19,962	6,587	7,186	3,793	2,395
Talbot	23,708	7,825	8,535	4,505	2,845


2010 Percent of Population Ages 65 and Over for Maryland's Jurisdictions
Pennsylvania
West Virginia
Virginia
D.C.
Delaware
New Jersey
Garrett 17.4%
Allegany 17.8%
Washington 14.3%
Frederick 11.1%
Carroll 13.0%
Baltimore County 14.6%
Harford 12.5%
Cecil 11.7%
Baltimore City 11.7%
Howard 10.1%
Montgomery 12.3%
Anne Arundel 11.8%
Prince George's 9.4%
Charles 9.5%
Calvert 10.9%
St. Mary's 10.3%
Kent 21.8%
Queen Anne's 14.9%
Caroline 13.3%
Talbot 23.7%
Dorchester 17.7%
Wicomico 13.0%
Somerset 13.8%
Worcester 23.2%
Percentage
9.4% - 10.3%
10.4% - 12.5%
12.6% - 14.9%
15.0% - 17.8%
17.9% - 23.7%
The percent of population 65 and over for Maryland is 12.3%.
0 5 10 20 30 40
Miles
N
Map prepared by the Maryland Department of Planning, Projections and Data Analysis / State Data Center,
Source: U.S. Census Bureau, 2010 Demographic Profiles, May 2011

Appendix G

Maryland Adults with Disabilities - Aged 18+
Projections by Jurisdictions (2010)

	Total 18+ Population	18+ With Disabilities	% of 18+ Population	% of State's 18+With Disabilities
Allegany	61,568	11,341	18.4%	2.2%
Anne Arundel	412,595	46,946	11.4%	9.0%
Baltimore Co.	628,279	79,274	12.6%	15.2%
Calvert County	65,506	8,038	12.3%	1.5%
Caroline County	24,719	3,826	15.5%	0.7%
Carroll County	125,897	13,105	10.4%	2.5%
Cecil County	75,753	11,926	15.7%	2.3%
Charles County	107,667	12,415	11.5%	2.4%
Dorchester County	25,550	4,512	17.7%	0.9%
Frederick County	174,341	18,918	10.9%	3.6%
Garrett County	23,437	3,924	16.7%	0.8%
Harford County	184,416	22,653	12.3%	4.4%
Howard County	212,421	16,769	7.9%	3.2%
Kent County	16,649	3,246	19.5%	0.6%
Montgomery County	738,247	62,405	8.5%	12.0%
Prince George's Co.	657,421	59,603	9.1%	11.4%
Queen Anne's County	36,424	4,243	11.6%	0.8%
St. Mary's County	77,565	10,917	14.1%	2.1%
Somerset County	22,005	3,319	15.1%	0.6%
Talbot County	30,407	3,974	13.1%	0.8%
Washington County	113,651	19,226	16.9%	3.7%
Wicomico County	76,638	10,090	13.2%	1.9%
Worcester County	42,031	6,490	15.4%	1.2%
Baltimore City	487,401	83,452	17.1%	16.0%
Total	4,420,588	520,612	11.8%	100.0%

Source: U.S. Census Bureau, Census 2010; American Community Survey 2008-2010
Percentages of 18+ population are based on the non-institutionalized universe.
Rounding may affect totals.

MARYLAND's FIVE YEAR STRATEGIC PLAN for MARYLAND ACCESS POINT (MAP)

2012 through 2016

Submitted by Maryland Department of Aging
July 2011

Maryland Five Year Aging and Disability Resource Center Strategic Plan 2012 through 2016

MARYLAND ACCESS POINT FIVE YEAR/AGING AND DISABILITY RESOURCE CENTER STRATEGIC PLAN 2012 through 2016

Executive Summary

The Aging and Disability Resource Center program is a national initiative of the Administration on Aging, the Centers for Medicare and Medicaid Services, the Department of Health and Human Services and the Office of Disabilities and the Veterans Administration. The initial national vision was to establish visible and trusted entities where consumers may seek streamlined access to long term services information and supports. The vision has grown to encompass piloting and implementing new programs that divert or transition people from long term care institutions and offer person-centered counseling and self-directed services. In October 2003, Maryland and eleven other states were the first to be awarded the federal grants to pilot Aging and Disability Resource Centers (ADRC). The Maryland Department of Aging (MDoA), in partnership with the Maryland Department of Health and Mental Hygiene (DHMH), Department of Human Resources (DHR), and the Department of Disabilities (DOD) used the funds to establish two ADRC's – one in Howard County - an urban/suburban county located between Baltimore and Washington, D.C., and the other in Worcester County, a rural Eastern Shore location. The initial work of developing the ADRC in Maryland was overseen by a State Advisory Board which continues to have statewide representation and input.

Fast-forward eight years later and we are continuing to successfully build upon our work at the state and county levels to expand home and community- based services and improve the way older adults and persons with disabilities access information, services and supports. Between 2003 and 2006, Maryland received additional grants to help foster the growth and development of the ADRC's, including the ADRC continuation grant, Nursing Home Diversion (aka Community Living Program); the Empowering Individuals to Navigate Health and Long Term Care Support Options, the ADRC Expansion and Person Centered Hospital Discharge grant; the Evidence Based Care Transitions grant; Medicare Improvements for Patients and Providers Act grants, and the Options Counseling grant. There are now ten ADRC sites (Anne Arundel, Baltimore County, Carroll, Howard, Montgomery, Washington, Worcester, Wicomico, Somerset and Prince Georges Counties and Baltimore City). The Maryland ADRC initiative is called Maryland Access Point or MAP and includes a public web-based searchable data base of long term services and support. http://www.marylandaccesspoint.info/

Our work includes continually improving and updating the MAP searchable database; increasing the number of ADRC sites to twenty by June of 2012; growing the number of our partnerships; clarifying and strengthening the infrastructure; conducting outcomes-based evaluation and research and continuing to integrate our work with the state and national rebalancing efforts.

A draft of the five year strategic plan was developed by the State Unit on Aging and reviewed in meetings and by email by all the agencies, groups and organizations listed below. Comments were taken and have been incorporated into the plan.
The plan describes seven goals, approaches and timelines for achieving those goals. All seven goals are subject to three overarching principles: the purpose of each goal is to: 1) improve and streamline individuals' access to long term services and information; 2) expand the options available for long term support to include self-direction, and 3) increase Maryland's capacity to identify individuals at high risk of institutionalization and Medicaid spend-down in order to divert these consequences whenever possible. These principles have guided the development of this plan and will continue to measure the plan's goals and MAP's performance against these principles.

Following is a list of the primary goals of the five-year strategic plan:

Goal 1: Expand ADRC coverage statewide from ten to twenty local MAPs by June 30, 2012.

Goal 2: Establish an ADRC infrastructure that includes consistent standards, training and evaluation and quality assurance capacity across MAP's/ADRC's and MAP/ADRC partners, including data collection on consumer use and satisfaction, and desired outcomes.

Goal 3: Expand the MAP/ADRC program to serve adults with disabilities of all incomes and adults seeking information and assistance with long term services and supports.

Goal 4: Maintain, improve and expand a statewide public web-based searchable database and work with sister agencies and partnering organizations to develop streamlined and integrated electronic application, assessment and client tracking systems.

Goal 5: Integrate the MAP/ADRC program with on-going state rebalancing efforts and use the MAP/ADRC statewide system to implement, test and adopt evidence-based practices and best practices among MAP/ADRC partners that divert or transition people from long term care institutional settings and acute care settings and promote best practices in person-centered counseling and self-direction.

Goal 6: Sustainability: develop on-going funding support for needed staffing to implement new rebalancing operations and maintain MAP/ADRC functions at the local and state level and develop flexibility to respond to new advancements in long term services and supports and incorporate them into the overall long term care system.

Goal 7: Develop, maintain and implement a strategic marketing plan for MAP/ADRC program.

Contact Information

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Participants in 5 Year Plan Development

Name	*Organization*
Secretary Gloria Lawlah	Maryland Department of Aging
Secretary Cathy Raggio	Maryland Department of Disabilities
Deputy Secretary Chuck Milligan	Maryland Department of Health and Mental Hygiene
Lorraine Narwara	Deputy Director for Community Integration, Department of Health and Mental Hygiene
Devon Snider	Interim Director, Money Follows the Person, Department of Health and Mental Hygiene
Tonya Gilchrist	Administrative Officer, Statewide Independent Living Council
April Seitz	Director, Adult Services, Maryland Department of Human Resources
Money Follows the Person Stakeholder Group	

Maryland Access Point Advisory Board	
Maryland Commission on Disabilities	
Maryland Commission on Aging	
MAP Directors	
Maryland Department of Developmental Disabilities	
Association of Centers for Independent Living	

Project Goal #1

Goal

Expand Aging and Disability Resource Center (ADRC) coverage statewide from ten to twenty local Maryland Access Points (MAP's) by June 30, 2012.

Description of Approach

Approach:

1. Establish application criteria using the "fully functioning Aging and Disability Resource Centers" (ADRC) elements as goals toward which the site must work.
2. Invite and review applications from every state Area Agency on Aging to become locally designated Maryland Access Point (MAP)/ADRC sites:
   - Provide start-up funding to successful applicants through Maryland Money Follows the Person (MFP) Demonstration Project and federal grant and program funding.
   - Provide sustaining funding to existing MAP/ADRC sites to support their continued development.
   - Provide state level staff support and assistance to existing and newly developing sites.
3. Conduct individual site visits to assess the status of each existing and proposed site to determine areas of strength and areas for improvement at the local and state level (conducted by MAP/MFP Liaison contractor).
4. Meet regionally with Centers for Independent Living (CIL'S) and MAP/ADRC sites or MAP/ADRC site candidates to develop relationships between CILs and MAP/ADRC sites or potential MAP/ADRC sites.

5. Establish an on-going method of joint training, collaboration and networking among MAP/ADRC sites.
6. Encourage and support ADRC training (in-house, webinar and conference) for all MAP/ADRC sites and CIL partners.
7. Strengthen an existing "peer mentoring" protocol in which more mature MAP/ADRC sites assist newer sites in development, as well as review other states' best practices protocols.
8. Assure the continued review and dissemination of ADRC best practices in Maryland and other states.

How will you measure progress toward your goal?

- Establish new sites by 6/30/2012
- Promote continued growth in existing sites toward fully functioning ADRC elements and required guidelines
- An analysis of all existing and proposed sites conducted by the MFP/MAP/ADRC Liaison
- Develop action plans for local sites and state programs building on the results of the MAP/MFP/ADRC Liaison analysis
- Formalized grant agreements with twenty MAP/ADRC sites by 6/30/2012
- Convene two annual MAP meetings per year of MAP/ADRC sites and CILs and other partners
- Conduct site visits to support each MAP/ADRC in achieving fully functioning goals at least one time per year
- Engage all sites in semi-annual report function
- Adoption of standards for options counseling, peer support and training
- Engage all sites in appropriate statewide rebalancing efforts

What are your anticipated barriers? How will you address these challenges?

- Local governmental review of new program establishment and grant applications will require support from the State MAP /ADRC program to educate county fiscal, political and executive officers to assure them of the value and importance of becoming a MAP/ADRC site.
- The use of more mature MAP/ADRC site staff to assist as mentors for newly developed MAP sites may overtax the more mature MAP sites without appropriate orchestration and support from the state.
- AAA concerns about developing formal partnerships with regional Centers for Independent Living (CILS) will require dialogue and meetings to understand what each party brings to the table and support in developing formal contracts.
- Creating formal Memorandum of Understanding among local agencies like the Health Department and the Department of Social Services which play significant roles in long term services and supports in terms of eligibility determinations and support programs will require assistance from more mature MAP/ADRC sites that have successfully established these agreements as well as assistance at the state level to provide model agreements and facilitate their adoption at the local level.

- Facility and financial limitations for creating physical co-location of major partners will require planning and the use of new building or physical arrangement opportunities to create space for co-location and will require agreements among the co-locating agencies for use of staff and space. More mature MAP/ADRC sites have been able to establish co-location and can be of assistance to newer sites. In cases where co-location is not feasible, due to space limitations or staffing issues, standards for virtual co-location will be established.
- Working with new MAP/ADRC sites to assist their staff to build on and integrate existing AAA programs like Information and Assistance and the Senior Health Insurance Program and to expand the breath of services to new populations and new concepts of person centered options counseling and service will require on-going site support and will involve regular meetings and trainings to encourage and facilitate the adoption of the ADRC concepts into existing programs.

Who are the key players and responsible parties?

Key players include executive leadership and staff from: the Maryland Department of Aging (MDoA); Area Agencies on Aging (AAA); Maryland Access Point (MAP); Regional Centers for Independent Living (CILs); the Maryland Department of Disabilities (MDoD); the Maryland Department of Human Resources (DHR); and the Maryland Medicaid Agency, the Department of Health and Mental Hygiene(DHMH). Other stakeholders include hospital associations, advocacy and protection agencies and organizations, consumer representation through advisory boards and work groups, health and support service providers, universities and community services, such as libraries.

What are your overall timeline and key dates?

- Twenty local MAP/ADRC sites by June 30, 2012.
- Twenty MAP/ADRC sites that have achieved 80% or more of the elements of fully functioning ADRCs by June 30, 2013.

The table below shows key dates and activities by Fiscal Quarter beginning July 1, 2012 through June 30, 2016. The Maryland Fiscal Year is July 1 through Jun 30th.

Activity	6/30/12				6/30/13				6/30/14				6/3015				6/30/16			
Establishment/Funding of Sites	Q 1	Q 2	Q3	Q 4	Q1	Q 2	Q 3	Q4	Q1	Q 2	Q3	Q 4	Q 1	Q 2	Q3	Q4	Q 1	Q 2	Q 3	Q 4
• Six new sites under contract	x																			
• Four more new sites	x																			
Establish and Update Criteria New MAP/ADRC Sites	x																			
Facilitate Regional Meetings of MAP/ADRC and potential MAP/ADRC sites with CILs.	x	x	x	x																
Complete MAP/ADRC/MFP Liaison review of all existing and potential sites for fully functioning ADRCs	x																			
Complete local and state action plans	x	x																		
Annual State Meetings and Webinars				x		x		x		x		x		x		x		x		x
• Incorporate local MAP partners	x	x																		
Incorporate MAP Strategic Plan into State Aging Plan		x																		
Conduct Annual MAP Site Reviews				x	x	x	x													
Provide On-going support	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Funding to Existing Sites to extent funds is available through state, MFP or federal grants.	x				x				x				x				x			
Strengthen Site to Site Peer Mentoring Process	x					x			x				x				x			

What resources do you need to meet this goal? What existing funds/programs will be used? What are the added costs to the State? What are the projected cost savings for the State?

The major resources needed to accomplish this goal are staff resources and start-up funding to jump start new sites and to assure appropriate level staff dedicated to the development of the local site. New sites are funded through MFP resources as reimbursable grants and through new federal grant sources on a project by project basis. Existing sites will be funded through MFP resources. The MAP/MFP Liaison is funded through MFP. Cost savings will be estimated through evaluations of grant programs such as the Person Centered Hospital Discharge Project. Efforts will be made to explore with state Universities the possibility of establishing outcome measurements that can be translated into savings and costs. There are no new costs to the State from general funds.

Project Goal Checklist	Yes	No
Is the goal reflected in the State Plan on Aging? *	x	
Does the goal require changes that must be proposed through the current budget cycle?		X
Does implementing this goal require regulatory, legislative, or statutory changes?		X
Does your plan seek private funding to augment public resources to support sustainability?	x	
Have the necessary stakeholders been identified and contacted?	x	
Are your data systems prepared to track progress towards the goal?		X

*Maryland's State Plan is due in 2012. All MAP/ADRC goals are expected to be reflected in that plan.

Project Goal #2

Goal

Establish an ADRC infrastructure that encourages consistent standards, training and evaluation and quality assurance capacity across MAP's/ADRC and MAP/ADRC partners, including data collection on consumer use and satisfaction, and desired outcomes.

Description of Approach

1. A number of initiatives will be undertaken to establish guidelines and standards for core ADRC functions in MAP/ADRC sites and in their primary partners' sites. These core functions will include: options counseling; peer support services; information and assistance standards that cut across populations, programs and organizations; development of outcome measures and quality assurance.
2. Each set of standards will be developed through MAP/ADRC work groups and then vetted among all MAP/ADRC stakeholders and partners prior to finalization.
3. Individual MAP/ADRC site staff functions will participate in operational reviews to determine unique functions to local sites as well as statewide functions in order to produce planning and action plans to strengthen and integrate core ADRC functions on an on-going basis.
4. Annual reviews will be conducted and MAP/ADRC sites and state partners will be encouraged to develop action plans for strengthening core functions across the state.
5. Currently, work groups are developing options counseling standards and peer support standards as part of new grants received in 2010. Annual state review meetings will be held with each local site and their partners to review progress, identify challenges and provide technical assistance.

How will you measure progress toward your goal?

Progress will be measured based on the development of written standards, implemented reviews of individual sites, documentation of the actions plan and incorporation of standards into each MAP/ADRC site, and annual reviews.

What are your anticipated barriers? How will you address these challenges?

- The work and time required to develop standards and to review and finalize them requires the involvement of MAP/ADRC and MAP/ADRC partners' staff and is difficult to focus on without financial incentives connected with grant opportunities. We will seek funding to support this work and integrate it whenever possible into other initiatives in the state like MFP.
- Local governments and MAP/ADRC sites have unique challenges in terms of establishing staff standards and integrating programs and service partners. The incorporation and measurement of standards on a statewide basis may meet resistance if individual MAP jurisdictions are not involved in establishing standards and flexibility in the standards and do not perceive added value in their operations. We will develop these standards with expertise and consensus seeking methods to obtain buy-in and work to continue to provide supplemental funding to MAP/ADRC sites to off-set their costs for participation.

- On-going assistance, monitoring, training, evaluation and quality assurance requires staff both at the state and the local level which in turn requires funding resources. It also requires expertise. We hope to develop working relationships with our state universities to assist in this work and we hope to build state level staff to assist with this work. We also will continue to take advantage of grant opportunities and the work of other organizations.
- Any system of standards is outdated as soon as it is established, so maintaining currency in standards and operations as the long term services and supports systems change will require thinking out of the box and constant exposure to new best practices in Maryland and other states. We will encourage and support the involvement of MAP/ADRC staff in national conferences, statewide training opportunities and individual webinar trainings with certifications.

Who are the key players and responsible parties?

Key players include executive leadership and staff from: the Maryland Department of Aging (MDoA); Area Agencies on Aging (AAA); Maryland Access Point (MAP); regional Centers for Independent Living (CILs); the Maryland Department of Disabilities (MDoD); the Maryland Department of Human Resources, the Maryland Medicaid Agency and consultants in funded projects and state universities.

What is your overall timeline and key dates?

Activity	*6/30/12*				*6/30/13*				*6/3/14*				*6/30/15*				*6/30/16*			
	Q1	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*
Develop, vet and establish standards																				
• Options Counseling and Information and Assistance				x																
• Peer Supports					x															
• Organizational Integration, e.g. SHIP, Information and Assistance								x												
• Partnership Development and Formalizations					x															
• Establish method for continuous quality					x															

Activity	*6/30/12*				*6/30/13*				*6/3/14*				*6/30/15*				*6/30/16*			
improvement in standards																				
Development of Outcomes Evaluation																				
• Identify outcomes				x																
• Seek expert assistance				x																
• Establish relationships with state universities to provide expertise				x	x	x	x													
• Coordinate and integrate individual outcomes studies of different initiatives like care transitions, targeting and diversion					x		x	x	x	x	x	x	x	x	x	x	x	x	x	x
• Implement outcomes evaluation in specific systems					x				x				x				x			
Establish Schedule and Methodology to Review Each Site Annually and Initiate Reviews and Action Plans				x	x	x	x				x				x				x	
Work with National Agencies to Develop Outcomes Reporting				x				X				x				x				x

What resources do you need to meet this goal? What existing funds/programs will be used? What are the added costs to the State? What are the projected cost savings for the State?

Resources needed include expertise, funding and staffing to design and implement outcomes evaluations. Some of these resources are included in federal grants. Additional funding is needed for robust systems.

Project Goal Checklist	Yes	No
Is the goal reflected in the State Plan on Aging?	x	
Does the goal require changes that must be proposed through the current budget cycle?		X
Does implementing this goal require regulatory, legislative, or statutory changes?		X
Does your plan seek private funding to augment public resources to support sustainability?	x	
Have the necessary stakeholders been identified and contacted?	x	
Are your data systems prepared to track progress towards the goal?		X

Project Goal #3

Goal

Expand the MAP/ADRC program to serve adults with disabilities of all incomes and adults seeking information and assistance with long term services and supports and work towards incorporating information and referral services for families and children.

Description of Approach

1. The MAP/ADRC program has been gradually expanding the populations that it serves in terms of type of disability, age and financial capacity. This expansion is built upon outreach to different policy groups, conferences and staff trainings and openness to adding data and services to the MAP/ADRC statewide searchable database for different groups, e.g. autism, Alzheimer's disease, behavioral health and Intellectual challenges. Web-based outreach efforts will continue.
2. Another approach is identifying opportunities to dialogue and work together on common issues.
3. Local and state policy bodies will strive to include representatives from different populations.
4. Private pay options will be included in the searchable database and in options counseling, e.g. reverse mortgages and the Maryland Long Term Insurance Private Public Partnership.

How will you measure progress toward your goal?

- The searchable database will continue to expand the information it provides for different populations.
- Policy bodies will include staff and consumer representatives from different populations.
- Training of MAP/ADRC staff and partners in services and support systems for different populations will be documented.

What are your anticipated barriers? How will you address these challenges?

- The current long term care system has been built upon separate programs and advocacy groups for populations with different disabilities. We will work to familiarize all MAP/ADRC staff and partners to understand the various service systems and specialized agencies and support groups for different populations.
- Different groups perceive that resources are scarce and therefore there is a competitive element in interactions. We need to protect current resources and provide opportunities for the various groups to work together to obtain new resources and efficiencies.
- Language and culture differ among populations. We will provide education on the different perspectives, language and its affect on different populations.
- Different groups have not been exposed to each other; they are often "the other". We will work to provide opportunities for diversity in policy bodies, work groups and trainings.
- Challenges still remain in understanding the culture and the differences in approach to services between aging and disability communities. Work will be ongoing to continue to support open dialogue and discussion about the issues on the state and local levels.
- Information technology does not support the study of populations across services and agencies even though individuals may require assistance from more than one agency. We will work within our Information Technology goal framework in addressing this concern.
- Private pay populations often do not plan ahead for the financial support they may need in long term services. We will provide educational outreach and information on the possibility of requiring long term services and ways to plan for such services (e.g. reverse mortgages, long term care insurance).

Who are the key players and responsible parties?

Key players include executive leadership and staff from : the Maryland Department of Aging (MDoA); Area Agencies on Aging (AAA); Maryland Access Point (MAP); regional Centers for Independent Living (CILs); the Maryland Department of Disabilities (MDoD); the Maryland Department of Human Resources (DHR); and the Maryland Medicaid Agency, Department of Health and Mental Hygiene (DHMH), advocates and consumers from different populations and agency and provider staff serving different populations.

What is your overall timeline and key dates?

Activity	*6/30/12*				*6/30/13*				*6/30/14*				*6/30/15*				*6/30/16*			
	Q1	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*
Inclusion of Representatives from Different Populations in Program Policy Bodies and Work Groups.																				
• Establish guidelines for representation on local and state policy bodies and workgroups.				x																
• Monitor inclusion efforts and results					x	X	x	x	x	x	x	x	x	x	x	x	x	x	x	x
• Understand challenges to recruiting representatives from different groups, e.g. mobility, service to family members, etc.	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x	X
• Develop supports to allow participation of consumers from different groups.				x	x															
Inclusion of Services and Agency and Advocates in Searchable Database		x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x	X
Conduct dialogue with family and children and agencies to determine feasibility of including information and					x	x	x													

Activity	*6/30/12*				*6/30/13*				*6/30/14*				*6/30/15*				*6/30/16*			
referral for families and children																				
Inclusion in Client Tracking to Be Developed in Conjunction with Medicaid and Other Agencies						x	x	x	x	x										
Outreach and Training																				
• Conduct joint trainings				x				x				x				x				X
• Provide presentations to different policy bodies and service providers and agency staff		x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Develop Systematic Approach to Private Pay Options					x															
Develop outreach and options counseling standards for private pay.				x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x	X

What resources do you need to meet this goal? What existing funds/programs will be used? What are the added costs to the State? What are the projected cost savings for the State?

Building relationships requires a commitment of time on the part of representatives of different populations and on the part of staff to schedule and facilitate meetings and opportunities for dialogue. Other resources include costs for trainings and, meeting space, travel, webinars and teleconferences. The costs are covered through operating budgets in grants and administration. The human resource factor requires the commitment of dedicated new staff or existing staff and representatives who can act as respected liaisons with their constituent groups And agency decision makers. In some cases, this requires funding to support new staff and is

part of the funding scheme for the development of the MAP/ADRC program building on MFP rebalancing funding and ADRC related federal and private grant opportunities.

Project Goal #4

Goal

Maintain, improve and expand a statewide public web-based searchable database and work with sister agencies and partnering organizations to develop streamlined and integrated applications, assessments and client tracking systems.

Description of Approach

1. Establish a strategic plan to maintain and update the statewide public searchable database www.marylandaccesspoint.info and to monitor utilization at the local and state level.
2. Add new functions to the public searchable database to make it more accessible and user friendly.
3. Conduct outreach and education to consumers, agencies and providers to encourage use of and feedback on the searchable database.
4. Add new resources as the number of populations is expanded.
5. Work with sister agencies to review and implement (1) technology that can be developed or purchased to facilitate client tracking upon referrals and across programs, (2) a single assessment instrument for long term services and supports, and (3) a common intake instrument for consumers seeking long term services and supports from MAP/ADRC partners.
6. Participate in the Maryland Health and Human Service Referral Board to develop a statewide 211 system and develop working relationships with sponsors of related searchable databases.

How will you measure progress toward your goal?

- Measure progress with the implementation of a strategic plan that focuses on maintaining and updating the statewide searchable database, also, monitor its use by local MAP/ADRC sites, partners and consumers, and encourage feedback on new and/or improved functions.
- Implement a plan to conduct outreach and education to agencies, providers and consumers to promote use of the statewide searchable database and to obtain feedback for improvements.
- Expand the collection of data to include new population groups, i.e. special diseases and conditions, younger populations.
- Implement a common “case management” function that allows client tracking across programs and agencies.

- Implement an electronic single assessment instrument and an electronic single intake instrument for all MAP/ADRC agencies and partners.

What are your anticipated barriers? How will you address these challenges?

- State and local agencies currently use different IT systems for client intake and tracking and most programs have different assessment instruments. One assessment instrument is currently imbedded widely in the current long term care system, but it requires a qualitative analysis of information and does not incorporate acuity algorithms and electronic referrals.
- Resistance to change will cut across agencies and programs and will require financial and training resources to encourage adoption of new complementary case management and client tracking systems. MFP will be explored as a possible funding mechanism for this change.
- Different agencies have worked independently to fill the void of searchable data bases that consumers and agencies can use and to develop "hotlines" for different issues resulting in a plethora of "entry points". The Maryland health and Human Service Referral Board is focused primarily on the Maryland 211 system, but is also working to develop an inventory of existing call centers and searchable data bases and to develop collaboration toward seamless access.

Who are the key players and responsible parties?

Key players include executive leadership and other staff from the Maryland Department of Aging (MDoA); Area Agencies on Aging (AAA); Maryland Access Point (MAP); Regional Centers For Independent Living (CIL); the Maryland Department of Disabilities (MDoD); The Maryland Department of Human Resources and the Maryland Medicaid Agency (Department of Health and Mental Hygiene, DHMH). Other parties are the state and local aging and human service networks.

What is your overall timeline and key dates?

Activity	*6/30/12*				*6/30/13*				*6/30/14*				*6/15*				*6/30/16*			
	Q1	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*
Establish a strategic plan to maintain and update the statewide public searchable database and monitor utilization.																				

Activity	*6/30/12*				*6/30/13*				*6/30/14*				*6/15*				*6/30/16*			
• Draft and review plan among stakeholders			x	x	x															
• Implement Plan					x				x				x				x			
• Add new functions and data based on consumer and user input		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	X	x	X
Expand data to include new population groups, i.e. special diseases and conditions, younger populations.																				
• Develop relationship with representatives of new populations		x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	X	x	X
• Identify data and develop inclusion and maintenance methodology for new data		x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	X	x	X
• Add data		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	X	x	X
Implement a plan to conduct outreach to agencies, providers and consumers to promote use of the statewide searchable database.																				
• Obtain consultant to design plan and develop materials		x	x	x																
• Implement Plan					x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Work with sister agencies to review and implement (1) technology that can be																				

Activity	6/30/12				6/30/13				6/30/14				6/15				6/30/16			
developed or purchased to facilitate client tracking upon referrals and across programs, (2) a single assessment instrument for long term services and supports, and (3) a common intake instrument for consumers seeking long term services and supports from MAP/ADRC partners.																				
• Facilitate and support a cross- agency work group to explore electronic options				x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
• Facilitate and support adoption of common electronic assessment, intake and case management systems									x	x	x	x	x	x	x	x	x	x	x	x
Participate on state board to develop a statewide 211 system and develop working relationships with sponsors of related searchable data bases.																				
• Develop formal relationship with 211					x	x	x	x												
• Maintain knowledge	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	X

Activity	6/30/12				6/30/13				6/30/14				6/15				6/30/16			
of all related searchable data bases and assure links																				

What resources do you need to meet this goal? What existing funds/programs will be used? What are the added costs to the State? What are the projected cost savings for the State?

The public statewide searchable database requires staff and technology expertise. The on-going technical maintenance of the public searchable database costs approximately $50,000 for hosting using a commercial off the shelve system customized to the MAP. This cost includes reasonable revisions and additions to functions and data. Currently, this cost is funded through state general funds and MFP funds as is the staffing. Staffing requires a management level person with expertise in information and assistance services and the ability to work with technical support. The development of a single assessment instrument and client tracking systems will cost in the millions. The MFP savings may be used to facilitate this development.

Project Goal Checklist	Yes	No
Is the goal reflected in the State Plan on Aging?	x	
Does the goal require changes that must be proposed through the current budget cycle?	x	
Does implementing this goal require regulatory, legislative, or statutory changes?		X
Does your plan seek private funding to augment public resources to support sustainability?		X
Have the necessary stakeholders been identified and contacted?		X
Are your data systems prepared to track progress towards the goal?		X

Project Goal #5

Goal

Integrate the MAP/ADRC program with on-going state rebalancing efforts and use the MAP/ADRC statewide system to implement, test and adopt evidence-based practices and other best practices among MAP partners that either divert or transition people from long term care institutional settings and promote best practices in person-centered counseling and self-direction.

Description of Approach

1. Implement and evaluate: the Person Centered Hospital Discharge project; the Real Choice Systems Change hospital discharge programs; the Evidence Based Care Transitions project; the Community Living Program and Veteran Directed Home and Community Based Service Program.
2. Provide options counseling and transition case management for individuals transitioning from institutional settings into home and community-based waivers and settings.
3. Explore a self-directed flexible benefit package option for Medicaid long term supports and services.
4. Provide on-going training in transition case management, person centered counseling and self-direction.

How will you measure progress toward your goal?

- Monitor the implementation of the pilot projects and enrollment in them.
- Perform an evaluation of the hospital and care transition pilot projects.
- Introduce best practices into the on-going functions of MAP and MAP partners.
- Monitor training opportunities and participation by MAP/ADRC staff and partners.

What are your anticipated barriers? How will you address these challenges?

Implementation and evaluation of the pilot projects requires staffing to facilitate the process and to retain and supervise consultant services to evaluate the projects and develop functional and financial strategies to introduce the new practices into the full system of long term services and supports. At this time, funding is available for these functions, but hiring freezes have made it difficult to provide adequate staffing to oversee the pilot projects and to develop procurements for consultants. New positions, regular state and contracts will be identified and we will explore grant funding and the possibility of MFP funding for program evaluation.

Who are the key players and responsible parties?

Key players include executive leadership and other staff from: the Maryland Department of Aging (MDoA); Area Agencies on Aging (AAA); Maryland Access Point (MAP); regional Centers for Independent Living (CILs); the Maryland Department of Disabilities (MDoD); the Maryland Department of Human Resources; and the Maryland Medicaid Agency.

What is your overall timeline and key dates?

Activity	*6/30/12*				*6/30/13*				*6/30/14*				*6/15*				*6/30/16*			
	Q1	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*
Implement and Evaluate Community Living Program	x	x	x	x	x	x	x													
Implement and Evaluate	x	x	x	x																
• Test program post grant period and funding				x	x	x	x													
• Determine feasibility of continuing and expanding the program using state funds					x	x	x													
Implement and Evaluate Veteran Directed HCBS Program	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Implement and evaluate *PCHD, *RCSC and *EBCT programs	x	x	x	x	x	x	x	x												
Continued implementation of MFP Program	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

***PCHD –Person Center Hospital Discharge; RCSC- Real Choice Systems Grant; EBCT-Evidence Based Community Transitions**

What resources do you need to meet this goal? What existing funds/programs will be used? What are the added costs to the State? What are the projected cost savings for the State?

Staffing resources are required and are funded through federal grants.

Project Goal #6

Goal

Sustainability: develop on-going funding support for needed staffing to implement new rebalancing operations and to maintain MAP/ADRC functions at the local and state level and develop flexibility to respond to new advancements in long term services and supports and incorporate them into the overall long term care system.

Description of Approach

1. Seek new grant funding that is relevant and integral to the overall Maryland rebalancing plan.
2. Maintain and increase state funding for core MAP/ADRC functions.
3. Develop new revenue producing arrangements like MFP through collaborative efforts with sister agencies, state universities and private foundations.
4. Build upon existing core aging network functions like Information and Assistance, State Health Insurance Program, (SHIP), Ombudsman and waiver case management and build on disability network core functions like Independent Living Specialists and Peer Mentoring, so as to modernize, coordinate and integrate these functions into the MAP network.
5. Encourage the development of more independent living options in the community that are available for individuals not wishing to reside in assisted living or smaller congregate settings.
6. Provide education and briefings on the MAP program to state executives, legislators and their staff.

How will you measure progress toward your goal?

- Gain additional grant funding.
- Develop new revenue producing arrangements like the MFP demonstration in Maryland and new arrangements with state universities and private foundations.

- Modernize, coordinate and integrate aging and disability network functions demonstrated through cross-training, co-location, and formal partnerships.

What are your anticipated barriers? How will you address these challenges?

- Federal grant funds are program specific and may distract from the specific goals of the MAP program and its sustainability. We will review grant opportunities for their relevancy to our goals and the state's rebalancing goals and if appropriate, apply for those funds - always being mindful of how to integrate new initiatives into the rebalancing efforts of the state and MAP/ADRC's.
- The current economy has reduced State revenues and without some recovery, expansion of State funding for new programs is limited. We will provide information and briefings to legislators and the state executive and budget staff.
- Reorganization and change are difficult within the aging and disability networks, especially those changes that require collaboration and coordination. We will work with our state and local aging programs to assure the coordination among programs and collaboration with MAP/ADRC partners.

Who are the key players and responsible parties?

Key players include executive leadership and staff from : the legislature, state executive and budget staff, the Maryland Department of Aging (MDoA); Area Agencies on Aging (AAA); Maryland Access Point (MAP); regional Centers for Independent Living (CILs); the Maryland Department of Disabilities (MDoD); the Maryland Department of Human Resources; and the Maryland Medicaid Agency, advocates and consumers from different populations and agency and provider staff serving diverse populations.

What are your overall timeline and key dates?

Activity	*6/30/12*				*6/30/13*				*6/30/14*				*6/15*				*6/30/16*			
	Q1	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*
Seek new grant funding that is relevant and integral to the overall Maryland rebalancing plan.																				
• Monitor all new relevant grant	x	x	x	x	x	x	x	x	x	x	x	x	x	x	X	x	x	x		

Activity	*6/30/12*				*6/30/13*				*6/30/14*				*6/15*				*6/30/16*			
opportunities																				
• Develop criteria for application to grants	x	x																		
• Develop and increase grant writing skills with MAP/ADRC staff				x				x				x				x				x
Maintain and increase state funding for core MAP/ADRC functions.																				
• Develop information and briefings for state legislators and executive and budget officers		x	x	x		x	x	x		x	x	x		x	x	x		x	x	x
• Develop strategic plan to engage legislators and state executive staff in briefings, site visits		x	x	x																
• Define the savings and quality of life benefits that flow from the MAP/ADRC program					x	x	x	x												
Develop new revenue producing arrangements like MFP through collaborative efforts with sister agencies and state universities and private foundations.																				

Activity	*6/30/12*				*6/30/13*				*6/30/14*				*6/15*				*6/30/16*			
• Explore opportunities with other state agencies, universities and private partners.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
• Develop criteria and operational protocols for collaboration			x	x	x			x	x	x	x									
• Engage in collaborative efforts as they arise.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Build upon existing core aging network functions like Information and Assistance, State Health, Insurance Program (SHIP), Ombudsman and waiver case management and build on disability network core functions like Independent Living Specialists and Peer Counselors, so as to modernize, coordinate and integrate these functions into the MAP network.																				
• Understand the functions of each of these operations within the context of long term care rebalancing and MAP		x	x	x	x															
• Identify areas of				x	x															

Activity	6/30/12				6/30/13				6/30/14				6/15				6/30/16			
overlap and collaboration																				
• Provide guidance regarding collaboration and integration					x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
• Monitor MAP/ADRC sites for integration of functions					x				x				x				x			

What resources do you need to meet this goal? What existing funds/programs will be used? What are the added costs to the State? What are the projected cost savings for the State?

Human resources are needed to identify funding opportunities and develop grants and contracts, as well as to provide guidance and assistance to local and state MAP/ADRC programs and partners in integrating operations.

Project Goal #7

Goal

Develop, maintain and implement a strategic marketing plan for the MAP/ADRC program.

Description of Approach

1. Retain consultant to develop strategic plan in collaboration with MAP/ADRC and MAP/ADRC partners and consumers.
2. Retain consultant to develop materials and marketing tools.
3. Develop financially sustainable marketing materials and activities.
4. Develop and implement consistent standards for marketing materials and activities among local MAP sites and partners.
5. Conduct outreach activities.
6. Measure outreach results.

How will you measure progress toward your goal?

- Monitor the increased utilization of MAP/ADRC statewide public searchable data base.
- Monitor the increased calls to MAP/ADRC sites and partners from consumers, providers and agencies.

What are your anticipated barriers? How will you address these challenges?

Increasing the use of the MAP/ADRC sites will place additional stress on their telephone and staff systems. We will work with the sites to develop strategies to support this increase financially and functionally.

Who are the key players and responsible parties?

Key players include executive leadership and staff from: the Maryland Department of Aging (MDoA); Area Agencies on Aging (AAA); Maryland Access Point (MAP); regional Centers for Independent Living (CILs); the Maryland Department of Disabilities (MDoD); the Maryland Department of Human Resources and the Maryland Medicaid Agency, advocates, consumers from different populations and agency and provider staff serving different populations and marketing consultants.

What are your overall timeline and key dates?

Activity	***6/30/12***				***6/30/13***				***6/30/14***				***6/30/15***				***6/30/16***			
	Q1	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q2*	*Q3*	*Q4*	*Q1*	*Q1*	*Q3*	*Q4*
Retain consultant to develop strategic plan in collaboration with MAP/ADRC and MAP/ADRC partners and consumers.	x	x																		
Retain consultant to develop materials and marketing tools.		*x*	*x*	*x*																

Develop financially sustainable marketing materials and activities.		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Develop and implement consistent standards for marketing materials and activities among local MAP/ADRC sites and partners.			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		
Conduct outreach activities.			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		
Measure outreach results.					x			x				x				x				x

What resources do you need to meet this goal? What existing funds/programs will be used? What are the added costs to the State? What are the projected cost savings for the State?

Funding is required to retain the consultant s and to prepare materials. At this time, appropriate funding is included in federal grants. On-going funding will be required for materials and updates. Efforts are being made to keep the materials clear and simple in order to absorb the costs in operations budgets for MAP's/ADRC's.

Consolidated Timeline

Goal/Activity	6/30/12				6/30/13				6/30/14				6/30/15				6/30/16			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Goal/Activity	6/30/12				6/30/13				6/30/14				6/30/15				6/30/16			
GOAL 1: Expand ADRC coverage statewide from ten to twenty local MAPs by June 30, 2012.																				
Establishment/Funding of Sites																				
• Six new sites under contract	x																			
• Four more new sites	x																			
Establish and Update Criteria New MAP/ADRC sites	x	x																		
Facilitate Regional Meetings of MAP/ADRC and potential MAP sites with CILs.	x	x	x	x																
Complete MAP/MFP Liaison review of all existing and potential sites for fully functioning ADRCs				x																
Complete local and state action plans	x	x																		
Annual State Meetings				x		x		x		x		x		x		x		x		x
• Incorporate local MAP partners	x	x																		
Incorporate MAP Strategic Plan into State Aging Plan		x																		
Conduct Annual MAP site Reviews				x	x	x	x													
• On-going teleconferences and webinars			x				x				x				x				x	
• On-going support	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Goal/Activity	6/30/12				6/30/13				6/30/14				6/30/15				6/30/16			
Funding to Existing Sites to extent funds is available through state, MFP or federal grants.	x				x				x				x				x			
Strengthen Site to Site Peer Mentoring Process	x					x			x					x			x			
GOAL 2: Establish an ADRC infrastructure that encourages consistent standards, training and evaluation and quality assurance capacity across MAP's/ADRC's and MAP/ADRC's partners, including data collection on consumer use and satisfaction, and desired outcomes.																				
Develop, vet and establish standards																				
• Options Counseling and Information and Assistance							x													
• Peer Supports					x															
• Organizational Integration, e.g. SHIP, Information and Assistance							x													
• Partnership Development and Formalizations					x															
• Establish method for continuous quality improvement in standards					x															
Development of Outcomes Evaluation																				
• Identify outcomes				x																
• Seek expert assistance				x																
• Establish relationships with state universities to provide expertise				x	x	x	x													

Goal/Activity	6/30/12				6/30/13				6/30/14				6/30/15				6/30/16			
• Coordinate and integrate individual outcomes studies of different initiatives like care transitions, targeting and diversion					x		x	x	x	x	x	X	x	x	x	X	X	x		
• Implement outcomes evaluation in specific systems					x				x				x				x			
Establish Schedule and Methodology to Review Each Site Annually and Initiate Reviews and Action Plans				x	x	x	x				x				x				x	
Work with National Agencies to Develop Outcomes Reporting				x				x				x				x				x
GOAL 3: Expand the MAP/ADRC program to serve adults with disabilities who are seeking information and assistance with long term services and supports.																				
Inclusion of Representatives from Different Populations in Program Policy Bodies and Work Groups.																				
• Establish guidelines for representation on local and state policy bodies and workgroups.				x																
• Monitor inclusion efforts and results				X	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Goal/Activity	6/30/12				6/30/13				6/30/14				6/30/15				6/30/16			
• Understand challenges to recruiting representatives from different groups, e.g. mobility, service to family members, etc.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
• Develop supports to allow participation of consumers from different groups.				x	x															
Inclusion of Services and Agency and Advocates in Searchable Database		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Conduct dialogue with family and children and agencies to determine feasibility of including information and referral for children and families					x	x	x													
Inclusion in Client Tracking to Be Developed in Conjunction with Medicaid and Other Agencies						x	x	x	x	x	x	x	x	x	X					
Outreach and Training																				
• Conduct joint trainings				x				x				x				x				x
• Provide presentations to different policy bodies and service providers and agency staff		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Develop Systematic Approach to Private Pay Options					x															

Goal/Activity	6/30/12				6/30/13				6/30/14				6/30/15				6/30/16			
Develop outreach and options counseling standards for private pay				x	x	x	x	x	x	x	x	x	x	x	x	X	x	x	x	X
GOAL 4: Maintain, improve and expand a statewide public web-based searchable database and work with sister agencies and partnering organizations to develop streamlined and integrated applications, assessments and client tracking systems.																				
Establish a strategic plan to maintain and update the statewide public searchable database and monitor utilization.																				
• Draft and review plan among stakeholders			X	x	x															
• Implement Plan					x				x				x				x			
• Add new functions and data based on consumer and user input		x	X	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Expand data to include new population groups, i.e. special diseases and conditions, younger populations.																				
• Develop relationship with representatives of new populations		x	X	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
• Identify data and develop inclusion and maintenance methodology for new data		x	X	x	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x

Goal/Activity	6/30/12				6/30/13				6/30/14				6/30/15				6/30/16			
• Add data		x	X	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Implement a plan to conduct outreach to agencies, providers and consumers to promote use of the statewide searchable database.																				
• Obtain consultant to design plan and develop materials		x	X	x																
• Implement Plan					x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Work with sister agencies to review and implement (1) technology that can be developed or purchased to facilitate client tracking upon referrals and across programs, (2) a single assessment instrument for long term services and supports, and (3) a common intake instrument for consumers seeking long term services and supports from MAP partners.																				
• Facilitate and support a cross- agency work group to explore electronic options									x	x	x	x	x	x	x	X	x	x	x	X
• Facilitate and support adoption of common electronic assessment, intake and case management systems									x	x	x	x	x	x	x	X	x	x	x	X

Goal/Activity	6/30/12				6/30/13				6/30/14				6/30/15				6/30/16			
Participate on state board to develop a statewide 211 system and develop working relationships with sponsors of related searchable databases.	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	X	x	x	x	X
• Develop formal relationship with 211					x	x	x	x												
• Maintain knowledge of all related searchable databases and assure links	x	x	X	x	x	x	x	x	x	x	x	x	x	x	X	X	x	x	x	X
GOAL 5: Integrate the MAP/ADRC program with on-going state rebalancing efforts and use the MAP/ADRC statewide system to implement, test and adopt evidence-based practices that either divert or transition people from long term care institutional settings and promote best practices in person-centered counseling and self-direction.																				
Implement and Evaluate Community Living Program			x	x	x	x	x													
• Test program post grant period and funding							x	x	x	x										
• Determine feasibility of continuing and expanding the program using state funds										x	x	x	x	x						
Implement and Evaluate Veteran Directed HCBS Program				x	x	x	x	x	x	x	x	x	x	x	X	X	x	x	x	X
Implement and evaluate PCHD, RCSC and EBCT programs	*x*	*x*	*x*	x	x	x	x	x												
Implement MFP Program	x	x	x	x	x	x	x	x	x	x	x	x	x	x	X	X	x	x	x	X

Goal/Activity	6/30/12				6/30/13				6/30/14				6/30/15				6/30/16			
Goal 6: Sustainability: develop on-going funding support for needed staffing to implement new rebalancing operations and to maintain MAP/ADRC functions at the local and state level and develop flexibility to respond to new advancements in long term services and supports and incorporate them into the overall long term care system.																				
Seek new grant funding that is relevant and integral to the overall Maryland rebalancing plan.																				
• Monitor all new relevant grant opportunities	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	X	x	x		
• Develop criteria for application to grants				x	x	x														
• Develop and increase grant writing skills with MAP staff				x				X				x				X				
Maintain and increase state funding for core MAP/ADRC functions.																				
• Develop information and briefings for state legislators and executive and budget officers				x																
• Develop strategic plan to engage legislators and state executive staff in briefings, site visits				x																

Goal/Activity	6/30/12				6/30/13				6/30/14				6/30/15				6/30/16			
• Define the savings and quality of life benefits that flow from the MAP program				x	x	x														
Develop new revenue producing arrangements like MFP through collaborative efforts with sister agencies and state universities and private foundations.																				
• Explore opportunities with other state agencies, universities and private partners.					x	x	x	x	x	x	x	x	x	x	X	X	x	x		
• Develop criteria and operational protocols for collaboration								x	x	x	x									
• Engage in collaborative efforts as they arise.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	X	X	x	x	x	X
Build upon existing core aging network functions like Information and Assistance, SHIP, Ombudsman and waiver case management and build on disability network core functions like Independent Living Specialists, so as to modernize, coordinate and integrate these functions into the MAP/ADRC network.																				

Goal/Activity	6/30/12				6/30/13				6/30/14				6/30/15				6/30/16			
• Understand the functions of each operations within the context of long term care rebalancing				x	x															
• Identify areas of overlap and collaboration				x	x															
• Provide guidance regarding collaboration and integration				x	x	x														
• Monitor MAP/ADRC sites for integration of functions					x				x				x				x			
GOAL 7: Develop, maintain and implement a strategic marketing plan for MAP/ADRC program.																				
Retain consultant to develop materials and marketing tools.			x	x																
Develop financially sustainable marketing materials and activities.				x	x	x														

Goal/Activity	6/30/12				6/30/13				6/30/14				6/30/15				6/30/16			
Develop and implement consistent standards for marketing materials and activities among local MAP/ADRC sites and partners.				x	x	x														
Conduct outreach activities.					x	x	x	x	x	x	x	x	x	x	x	X	x	x	x	X
Measure outreach results.					x	x	x	x	x	x	x	x	x	x	x	X	x	x	x	X

FY 2013
State Plan Guidance

STATE PLAN ASSURANCES, REQUIRED ACTIVITIES AND INFORMATION REQUIREMENTS
Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances, required activities and information requirements as stipulated in the Older Americans Act, as amended in 2006.

ASSURANCES

Sec. 305(a)- (c), ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging

will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-
(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);
(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) legal assistance;
and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will-
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);
(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will-
(1) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--
(!) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--
(1) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:
in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-
(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and
(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the pla1ming and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--
(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(ll)(A) The plan shall provide assurances that area agencies on aging will--
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--
(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared-
(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and
(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area-

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and
(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will-
(A) identify individuals eligible for assistance under this Act, with special emphasis on-
(i) older individuals residing in rural areas;
(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iv) older individuals with severe disabilities;
(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall
(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made--
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or

terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3–

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--

(i) public education to identify and prevent elder abuse;

(ii) receipt of rep01is of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order

REQUIREDACTIVITIES

Sec.307(a) STATE PLANS

(1)(A)The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306;and

(B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:

(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(ll), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

(5) The State agency:

(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--
(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or
(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

INFORMATION REQUIREMENTS

Section 102(19)(G)-(required only if the State funds in-home services not already defined in Sec. 102(19))
The term "in-home services" includes other in-home services as defined by the State agency in the State plan submitted in accordance with Sec. 307.

Section 305(a)(2)(E)
provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

Section 306(a)(17)
Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Section 307(a)

(2) The plan shall provide that the State agency will:
(C) Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) *(Note: those categories are access, in-home, and legal assistance).*

Section (307(a)(3)

The plan shall:

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning distribution of funds); *(Note: the "statement and demonstration" are the numerical statement of the intrastate funding formula, and a demonstration of the allocation of funds to each planning and service area)*

(B) with respect to services for older individuals residing in rural areas:

(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

Section 307(a)(8)) (Include in plan if applicable)

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

Section 307(a)(10)

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

Section 307(a)(21)

The plan shall:

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title *(title III),* if applicable, and specify the ways in which the State agency intends to implement the activities .

Section 307(a)(28)
(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.
(B) Such assessment may include-
(i) the projected change in the number of older individuals in the State;
(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;
(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and
(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

Section 307(a)(29)
The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

Section 307(a)(30)
The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

Section 705(a)(7)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6). *(Note: Paragraphs (1) of through (6) of this section are listed below)*

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(I) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3--

(A) in car1ying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

Signature and Title of Authorized Official

7/27/12

Date

Department of Aging

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