2006-2007
UPDATED ELDER ANALYSIS FOR BROWARD COUNTY

FINAL REPORT, RECOMMENDATIONS, AND BUSINESS PLAN

Prepared for

Broward County
Human Services Department
Elderly and Veterans Services Division

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By

THE CENTER ON AGING

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Part I
EXECUTIVE SUMMARY

NEW IDEAS FOR OLD CHALLENGES

“Nonprofit agencies that provide services to older adults are increasingly challenged by unprecedented increases in demands for service at the same time that resources are shrinking. Contributing to this difficult climate are rising operating costs, staff shortages, governmental regulations, changing technology and increased competition.”

“To meet these challenges, creative nonprofits have diversified their funding bases by generating new funding streams that allow flexibility and innovation. They use earned income to make a profit and fold that profit back into their nonprofit mission. Some of these programs also reflect a trend to make programs more consumer-directed, where older people and their caregivers have a larger say in how, when, and where services are delivered as well as who provides them.”

From the publication *Consumer Directions*

BACKGROUND: In the spring 2001, the Broward County Elderly and Veterans Services Division initiated a contract with The Center on Aging of Florida International University to conduct an analysis of Broward County’s aging population and its current service system, to research best practices and innovative programming relevant to community-based aging populations, and to develop a plan for long-term care services for Broward County’s elders and their families. The four major findings from the 2001 study were: (1) available resources did not meet the needs of older adults; (2) available services needed to be reorganized to improve effectiveness; (3) consumers could not easily find and access the help they need; and (4) available services were not culturally responsive. These findings resulted in two recommendations. The first was to create a community alliance, comprised of aging network agencies as well as consumers, businesses, governments, housing and transportation agencies, resident associations, health and social service providers, and elected officials, that would work together to develop solutions to address the needs of older persons in Broward County. The second recommendation was to locate/relocate resources for older residents close to where they live in the community.

In 2006, as Broward County government and the Broward Aging Alliance (developed in response to the recommendation for such an alliance in the 2001 study) prepared to develop new strategies

for responding to older residents, they wanted to update data regarding elders in Broward County. Once again The Center on Aging was selected to conduct the evaluation and analysis. The most current available census and service data, updated scholarly and web-based literature on related topics, and input from consumers and key informants through surveys, interviews, and a one day summit were considered in the report, recommendations, and strategic business plan that have been produced as the final work product for the 2006 Elder Analysis Update. Information from this report will be made available for review on the County's website in spring 2007.

KEY DEMOGRAPHIC TRENDS IDENTIFIED:

- Dramatic increases in the number of Broward County residents who are age 60+ beginning in 2010, primarily as a result of aging baby boomers and also a result of increased longevity.
- While the number of White, non-Hispanic elders is steadily decreasing as a percent of the total elder population, the number of Black and Hispanic elders is increasing in relation to the total population, a trend that is expected to accelerate over the next twenty years.
- In the 2000 Census data for Broward County:
  - **32,166** residents age 65+ reported incomes below the federal poverty level;
  - **just one third** of all persons age 65+ had annual incomes at or above $30,000;
  - **37,313** residents age 65+ reported having two or more disabilities, including self-care;
  - **more than 53,000** residents age 65+ reported living alone;
  - **only 2%** of residents age 65+ were permanently residing in a skilled nursing facility.

CONSUMER AND PROVIDER SURVEYS MAJOR FINDINGS:

- Four-hundred five (405) consumers/caregivers and 40 providers responded to the 2006 survey. For both groups affordable senior housing, transportation, and healthcare services were identified as the three most important services for older persons living in the community.
- Affordable senior housing, prescription medication assistance, and financial assistance were the three most difficult services to arrange to receive in the provider sample; affordable senior housing, financial assistance, and home repairs/improvements were the three most difficult services to arrange to receive according to consumers.

- According to consumers, the biggest barrier to elders getting help they need is that they don't know what's available.

KEY INFORMANT INTERVIEWS: The project team conducted personal interviews with 18 key informants who were selected by the Broward Aging Alliance as representative of County and non-profit agencies with elder constituents or clients, which address a range of service needs, including substance abuse, mental health, HIV/AIDS, transportation, elder abuse, volunteerism, gay, lesbian, bi-sexual, and transgender elders, public and low-income housing, guardianship and the courts, homelessness, emergency management, Hispanic-serving, and persons with disabilities. The group was not intended to be inclusive of all providers, but rather to generate qualitative data based on opinions about priority issues effecting elders that should be addressed in Broward County. Respondents provided information regarding critical issues facing Broward elders that need to be addressed by the community, critical issues facing the elder service system/providers, aspects of current elder services that most need to be improved, geographic areas of the County that are difficult to serve, challenges and barriers to effectively serving ethnic and cultural elder sub-populations, cooperative initiatives and partnerships, unmet needs of special elder populations, and disaster preparedness. Responses, which are detailed in Attachment III.D, were generally consistent with data collected from consumers and providers on the survey, and with comments and recommendations made by summit participants.

ELDER SERVICES SUMMIT: A 2007 Elder Services Summit was conducted on January 31, 2007. More than 300 people participated in the day-long event organized by Broward County Vice-Mayor Lois Wexler in conjunction with the Broward Aging Alliance to discuss and reach consensus on issues facing Broward County's elder population. Participants, who represented a cross-section of county residents, as well as elected officials, service providers, and elder advocates, identified priorities and gaps in services provided for community dwelling elders living in Broward County.

The program included: (1) presentation of preliminary findings from the 2006 Updated Elder Analysis for Broward County with a follow-up question and answer session; (2) themed, facilitated breakout sessions on key issues that provided an opportunity for detailed discussion of basic needs, disaster planning, special needs populations, and advocacy, governance, and social marketing; and (3) a closing session where groups presented major recommendations. Each participant had the opportunity to attend

two breakout sessions, all of which were offered once in the morning and again after lunch. Participants in each session generated a list of action items for the County and then prioritized the list through a group consensus process.

Identified action item themes included:

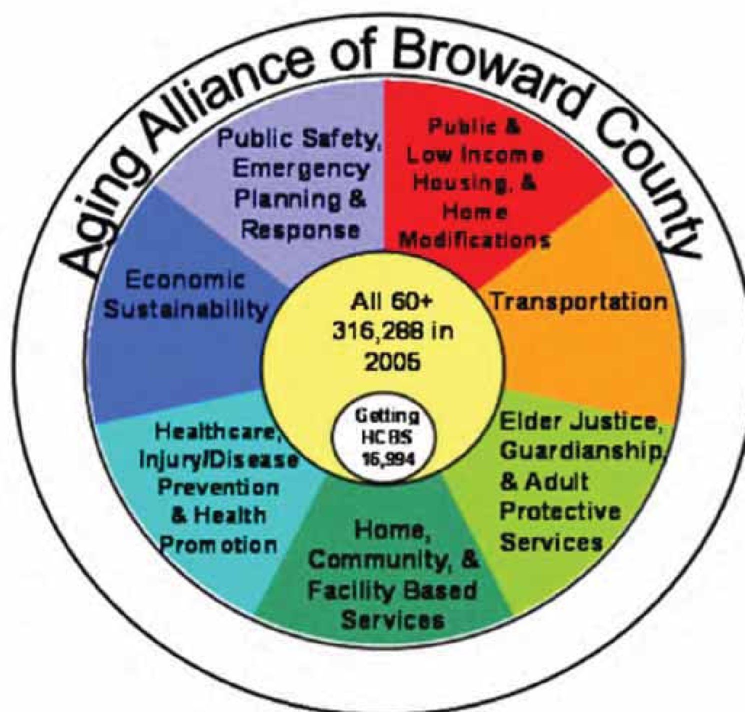
- Expand awareness about elder issues and elder services county-wide.
- Expand/increase programs and services.
- Increase affordable housing.
- Improve professionalism of direct service providers.
- Increase funding available for elder services, including special allocations from sales and/or casino taxes.
- Develop public/private partnerships.
- Develop one-stop centers.
- Make elder services more effective and efficient.
- Advocacy.
- Public Awareness of Elders.
- Volunteers.
- Redefine “aged” by function and need.
- Support caregivers.

ELDER COMMUNITY SERVICE WHEEL:

Since the inception of publicly-funded elder services, communities typically have addressed planning for the needs of older residents through a “traditional” elder services network, generally comprised of funders and providers of home and community-based services, assisted living facilities, and custodial nursing home care. Based on data from key informants and consumers, and supported in the literature and best-practice models we identified while working on this project, a broader view of community service response emerged. This view is illustrated by the Elder Community Service Wheel (the Wheel) shown here, a framework that is integrated into the Strategic Business Plan (the Plan).

Elders are placed at the center of the Wheel, reflecting the general consensus in research and practice that **any elder service system must be elder-centered** in its design in order to effectively meet constituents’ needs. The Wheel also shows that the number of people age 60 and older who currently get services through publicly-funded home and community-based programs (16,994) represent approximately 5% of Broward’s total elder population (316,288 in 2006). The need for the system to link

elders to support and services in the seven community sectors is shown by the intersection between the sectors and the center circle. Finally, the Wheel is surrounded by the Aging Alliance of Broward County to recognize the importance of this entity, or an entity like it, in existence to bring all sectors together to share challenges and ideas and to plan for a comprehensive community response to elders.



Key issues raised regarding each of the seven sectors on the Wheel are summarized below:

- Healthcare, Injury/Disease Prevention, and Health Promotion. Healthcare was the third highest "most important service" on the 2006 provider and consumer surveys. Major gaps and concerns identified in collected data include: coverage for mental health services are not adequate in many managed healthcare, long-term care, and home and community-based service plans; newer, more effective medications often are prohibitively expensive; preventive services are virtually non-existent; elder immigrants not eligible for Medicare or Medicaid lack access to even basic health services.

- Economic Sustainability. Data show that many elders work well into older age. More than 32,000 Broward residents age 65+ were employed in 2000. Interview, survey, and summit data indicated that some work by choice, but many work, often at low

wage jobs that are physically taxing, because they need income to meet basic living expenses. Long-term care planning is uncommon; this is particularly problematic for people with middle and low incomes who are "one crisis away" from abject poverty. Funding for the traditional public/community safety net has steadily declined leaving many of Broward's older residents living in very dire circumstances. Need to pursue alternative funding for public services through sales and/or casino taxes.

- Public Safety/Emergency Planning and Response. Interview, survey, and summit data indicated the need for comprehensive disaster planning among elder service agencies to address needs of all elder residents, including those not currently receiving services, and the need for well-coordinated community response, including the designation of one organization to take leadership in coordinating agencies serving elders, county, cities, and departments. Consumer surveys indicated that fear of not being able to get back home after a disaster and not having a place to go or transportation to get anywhere are the main reasons why elders are unwilling to leave, even in a mandated evacuation. There was great concern about post disaster home repairs with information that there were still some Broward County elders living in un-repaired homes, apartments, and condominiums going back to Hurricane Wilma 18 months earlier. Many, maybe most, elders do not have personal disaster plans.

- Housing. **Affordable housing was the number one concern on everyone's list in 2006**. We included both publicly-subsidized low-income housing through six housing authorities, and affordable housing offered through private and not-for-profit developers in our research and analysis and found that both areas were in crisis. Public housing has long waiting lists, and for some programs waiting lists are closed. Affordable housing stock is rapidly declining because of increased costs, taxes, insurance, fewer trailer parks, condo conversions, effects of recent hurricanes, and slow response of insurers and government agencies to fund repairs. Several interviewees believed that homelessness among elders in Broward is increasing, although we found no empirical data regarding this trend.

- Transportation. Capacity issues, particularly lack of drivers, result in wait lists for programs and unreliable or unacceptably lengthy special transportation service. Some municipalities offer very good public transportation options for elders, while others offer very little. Transportation for elders was identified as a major issue before, during, and after disasters.

- Elder Justice/Guardianship. Several key informants expressed

concern about elder offenders, elder victims, elders in the guardianship process, and elders experiencing discrimination. Legal policies and procedures, which often are determined by individual judges, are inconsistent and/or complex. There is a need for more programs and/or expansion of current programs that provide legal advice and representation to elder Broward residents regarding issues such as housing, health and public benefits, consumer protection, abuse and exploitation, and naturalization. Key informants perceived that many elders have unmet needs for these types of services, which they cannot afford to purchase.

- Home and Community-Based Services. Based on data from the Florida Department of Elder Affairs, 16,994 elder Broward residents received services under one or more federal and state-funded home and community-based service programs in state fiscal year 05-06. Total estimated 2006 expenditures under these programs were estimated at $19,573,794. As many as 48,511 residents age 65+ with at least two disabilities may have unmet needs. Estimated percentage of persons within this category who are getting no [DOEA-funded] services in the 53 Broward zip codes ranges from 80.3% to 98.8%, and averages 93.3% for the county overall. In addition to affordable senior housing and financial assistance, on the 2006 consumer survey consumers identified home repairs/safety modifications, counseling, and home delivered meals among the seven most difficult services for elders to arrange to receive.

SYSTEMIC GAPS/ CONCERNS IDENTIFIED:

Key informants and summit participants identified many systemic gaps and concerns that need to be addressed to improve the community's response to older residents. These concerns are listed below:

- Funding in all service sectors is inadequate to meet needs, particularly for middle and low-income elders. This results in long wait lists for many services, including transportation, public and low-income housing, and home and community-based services. Other elder service sectors affected by inadequate funding include mental illness and behavioral health, chronic diseases, including HIV/AIDS, developmental disabilities, physical disabilities requiring home modification or repair, court monitoring of wards, and staff in elder-serving agencies.
- Need to continue to improve/expand streamlined client intake system (ADRC/ARC) that maximizes resources and shares essential service need and service delivery information.

- Too many elders are uneducated about or unaware of available services and not enough community education and outreach is aimed at elders, their caregivers, and the broader community.
- There are several formal boards/organizations in Broward that focus on elder issues. While each has its own governance and has achieved some community networking, there is no overarching relationship among them all, although the Aging Alliance is a step in that direction.
- Funders in Broward County have a history of informal collaboration but do not pool funding when establishing priorities or allocating resources.
- Implementation of concepts like Communities for a Lifetime and Life: Act 2 throughout Broward County would be advantageous. Benefits would include encouragement for municipalities to expand support of home and community-based programs and expanded use of volunteers.

FINDINGS AND STRATEGIC GOALS:

Based on all collected data, The Center on Aging identified the following findings and strategic goals for Broward County.

Finding I: Available resources are not adequate to meet the needs of older adults, where resources are defined as infrastructure, including human capital, funding, and community commitment.

- *Strategic Goal I.A*: Improve utilization of existing housing, transportation, human capital, funding, and other infrastructure-related resources to better meet needs.
- *Strategic Goal I.B*: Increase levels from current funding sources and develop new funding sources.
- *Strategic Goal I.C*: Increase community commitment to meeting needs of elder residents.

Finding II: Available services need to be organized and interconnected to improve their effectiveness in meeting consumer needs, where effectiveness is defined as develop new linkages, reduce duplication, and encourage leveraging.

- *Strategic Goal II.A*: Create cooperative agreements with agencies in all seven sectors of the elder community service wheel (see Figure 1 below) – public safety, emergency planning and response; public and low-income housing, and home modifications; transportation, elder justice, guardianship, and adult protective services; home, community, and facility-based services; healthcare, injury/disease prevention, and health promotion; home and

community-based services; and economic sustainability.

- *Strategic Goal II.B*: Reduce duplication of services for elders across all seven sectors on the elder community service wheel. Eliminate duplication to the greatest degree possible.
- *Strategic Goal II.C*: Promote practice of pooling resources across funding programs, agencies, and sectors to maximize value of each funding dollar spent to provide services to elders and their caregivers.

Finding III: Consumers cannot easily access the help they need, where easy access is defined as consumer driven, single point of entry, and readily available information about options.

- *Strategic Goal III.A*: The Broward Aging Alliance and all constituents adopt "consumer driven" as an essential component of any service system or individual agency response plan.
- *Strategic Goal III.B*: The aging and disability resource center (ADRC) offers a mechanism for elders and their caregivers to access all needed services through a single point of entry.
- *Strategic Goal III.C*: Elders and their caregivers who require assistance can easily identify a source of information regarding available services.

Finding IV: Available resources are not sufficiently culturally responsive to the growing elder population in terms of generational characteristics, sexual preference, race, and ethnicity, where cultural responsiveness is defined as cultural knowledge, service flexibility, and cultural context.

- *Strategic Goal IV.A*: The Aging Alliance promotes cultural knowledge among member agencies and other community agencies that provide any services to elders and caregivers; cultural knowledge incorporates differences in race, ethnicity, economic status, sexual orientation, and age cohort.
- *Strategic Goal IV.B*: The service system for older persons in the community is designed to offer flexibility to elders and their caregivers based on preferences determined by race, ethnicity, economic status, sexual orientation, and age cohort within the constraint of maximizing resources.

Finding V: Elders in the community are not adequately prepared for disasters, and the community is not adequately prepared to provide appropriate and responsive assistance to elders before, during, and after a hazard event, where adequately prepared is

defined as engaged in ongoing all-hazard planning at the personal, Aging Alliance, and community levels.

- *Strategic Goal V.A*: Individual elders and caregivers are encouraged to increase personal knowledge about potential hazard scenarios and to develop personalized disaster plans.
- *Strategic Goal V.B*: All composite agencies in the Aging Alliance have developed Continuity of Operations Plans (COOPS) for all potential hazard scenarios, including plans to provide ongoing services to community elders and their caregivers, regardless of whether they currently receive formal services, before, during, and after a disaster.
- *Strategic Goal V.C*: The County and all municipalities have formalized agreements with the Aging Alliance to provide support and services to elder county residents and their caregivers before, during, and after disasters.

HOW TO USE THIS REPORT:

This final report document includes a **Strategic Business Plan** (the Plan) as well as detailed information/documentation produced by data collection activities conducted by The Center on Aging to inform our recommendations. The Plan (Part II, see page 18) is based on the five major findings from the analysis. Strategic goals, specific action items, and outcomes associated with each strategic goal reflect data collected through key informant interviews, consumer and provider surveys, the one-day summit, data provided by the Florida Department of Elder Affairs and the Broward County Aging and Disability Resource Center/Area Agency for Aging, the U.S. Census Bureau, and an extensive review of scholarly and internet literature and information.

The remainder of the final report document (Part III) is **a series of 13 Supporting Attachments** that offer details regarding collected data and intensive subject-specific investigation and analyses conducted by the project team as described below:

- III.A Demographics of Elders in Broward County 2006 and Beyond provides information regarding demographic patterns and predictions as well as zip code-specific tables with demographic data that may be used for targeted planning and programs (III.A begins on page 31).

- III.B Current Services for Elders Through Traditional Elder Services Network, Including Financial Resources reports data regarding service programs, units of each type of service provided under these service programs, waiting lists, and actual expenditures for elder services in Broward County for state fiscal year 05-06 (III.B begins on page 49).

- III.C Projections of Unmet Need for Broward County Elders 2006 and Beyond reports data and analysis regarding number of Broward County elders at risk for needing a broad spectrum of community services to continue independent living, including zip code-specific data on several key indicators, and estimates of current number of elders in these high risk categories who do not receive services through the elder service network (III.C begins on page 55).

- III.D Summary of Key Informant Interviews reports results of 18 personal interviews conducted by the project team using a prepared focused interview protocol (III.D begins on page 72).

- III. E Provider/Consumer Survey Results provides data from 2006 provider (n=40) and consumer (N=405) surveys and comparisons among and within respondent groups as well as with results from the 2001 consumer and provider surveys, which had like questions (III.E begins on page 84).

- III.F Summary of Summit Proceedings and Results includes a description of the January 31, 2007 Elder Summit and summarizes action items identified in morning and afternoon breakout groups and in two open microphone sessions (III.F begins on page 93).

- III.G Special Needs Populations: Descriptions and Resources includes general information regarding issues for elders in special needs populations, including community-specific data, where available, and resources for report readers who want additional information. Included populations/issues are: abuse, neglect, and exploitation; alcohol and illegal drug abuse; involvement in the criminal justice system; developmental disabilities; gay, lesbian, bisexual, and transgender; HIV/AIDS; homelessness; and behavioral health (III.G begins on page 96).

- III.H Leadership, Governance, and Innovative Community Service Models includes descriptions of the most current and promising approaches that the federal government, as well as states and local governments, are taking to improve community response to elder populations and their comprehensive service needs. Included are sections on inter-organizational leadership and governance models and descriptions of various types of integrated service models. Sections include: BOOMerang Project; Met Life Project; Life: Act2; Aging Resources Centers; Centralized Intake/Single Point of Entry; Centrally-Located Senior Services/All Service Needs Met in One Location; Consumer-Directed Care; Case-Managed Services; Innovative

Housing Models; Integrated Use of Funding for Healthcare and Social Services; Multi-agency Elder Service Networks (III.H begins on page 124).

- III.I Affordable Housing provides a basic primer on housing-related issues for elder residents of Broward County. Offers County-specific data and information regarding public and affordable housing for older Broward residents. Also included are descriptions of various public housing programs that currently exist or are potentially available for Broward County to offer low-income elders (III.I begins on page 142).

- III.J Disaster Preparation and Recovery describes results of consumer and provider survey and key informant interview items that addressed disaster planning specifically. Also included is a review of findings from previous research and discussion of recommendations for community-based elder-specific all hazards planning (III.J begins on page 150).

- III.K Social Marketing describes how this potentially powerful approach to changing attitudes regarding aging and older persons can be employed in Broward County (III.K begins on page 162).

- III. L Project Methodology and III.M References (III.L and III.M, respectively, beginning on page 168) describe the approach taken by the project team to collect and analyze data as well as all references cited throughout this report.

In the next section, Part II, we present the Strategic Business Plan (the Plan), which includes strategic goals, action items, and outcomes associated with each strategic goal along with an estimated planning time frame – short term is one year, medium term is three years, and long term is five years. Although it will not be possible for Broward County and the Broward Aging Alliance to embrace all goals and action items immediately, specific ideas identified in the Plan will facilitate the process of identifying what areas need the most attention now and what strategies may be employed to address the most immediate concerns.

Part II
STRATEGIC BUSINESS PLAN

***Finding I*: Available resources are not adequate to meet the needs of older adults, *where resources are defined as infrastructure, including human capital, funding, and community commitment*.**

STRATEGIC GOAL I.A: IMPROVE UTILIZATION OF EXISTING HOUSING, TRANSPORTATION, HUMAN CAPITAL, FUNDING, AND OTHER INFRASTRUCTURE-RELATED RESOURCES TO BETTER MEET NEEDS.			
Code	**Action Item(s)**	**Outcome(s)**	**Time**
I.A1	Increase support for informal caregivers.	◆ Tested, improved, and implemented model that case manages the caregiver AND care recipient dyad.	3 Years
I.A2	Increase number of screened and trained service providers.	◆ Incentives, including salaries and benefits, made more attractive – reduced turnover in HCBS, nursing home, and ALF workforce by 10%. ◆ Developed/implemented social marketing campaign to increase desire for careers in aging – increased number of people enrolled in any elder-specific certification course by 10% per year. ◆ Partner with local colleges, universities, and technical schools to improve visibility of careers in aging and increase stature by formalizing certification requirements for certain jobs. ◆ Increased trained workforce to elder ratio by 3% per year.	1 Year 3 Year 3 Years 5 Years
I.A3	Increase informal resources for elders and caregivers in the community.	◆ Organized and provided ongoing support for at least 20 neighborhood groups.	3 Years
I.A4	Improve flexibility, timeliness, reliability, and safety of community transportation system for elders.	◆ Added weather-protected bus stops in areas with high elder bus ridership. ◆ Identified unused capacity among all transportation service providers (e.g., health plans, aging services network, county paratransit, private transport services, municipalities) and developed interagency agreements to use all capacity.	1 Year 3 Years

STRATEGIC GOAL I.A: IMPROVE UTILIZATION OF EXISTING HOUSING, TRANSPORTATION, HUMAN CAPITAL, FUNDING, AND OTHER INFRASTRUCTURE-RELATED RESOURCES TO BETTER MEET NEEDS.

Code	Action Item(s)	Outcome(s)	Time
I.A5	Improve availability of low income and affordable housing.	◆ Reduced “disincentives” under local control, such as complex paperwork, for refurbishing older affordable housing and building new stock.	1 Year
		◆ Protected existing affordable housing stock by reducing financial attractiveness of condo conversions **OR** by increasing financial attractiveness of retaining low income stock – save at least 500 units.	3 Years
		◆ Improved financial incentives for developers to build new affordable housing or mixed rate housing projects – at least 1,000 units completed or under construction.	5 Years
I.A6	Reduce/eliminate duplication of services.	◆ Developed agreements that linked generic “help and/or crisis lines” with the ADRC to leverage funding for both – reduced wait time for elder-specific assistance and crisis counseling to one hour (24/7).	1 Year
		◆ Assured that elders and caregivers are directed to a centralized intake process regardless of which agency they contact for assistance; i.e. they don’t need to know a “right number” to call as all calls leads them to the same intake process.	1 Year
I.A7	Increase capacity by helping elders safely develop and coordinate shared housing, transportation, and personal assistance resources.	◆ Expanded ADRC concept to include a virtual resource center for elders to share information and resources with each other; provided access to the resource center through community sites, including focal points and libraries.	1 Year
		◆ Implemented broad public awareness campaign regarding how elders can avoid and protect themselves from abuse, neglect, and exploitation.	1 Year
I.A8	Commit ongoing, sustainable county funding to support and expand successful pilot	◆ County budget modified to include line item to support and expand successful service programs for elders.	3 Years
		◆ Broward Aging Alliance identified mechanisms for constituent agencies	1 Year

STRATEGIC GOAL I.A: IMPROVE UTILIZATION OF EXISTING HOUSING, TRANSPORTATION, HUMAN CAPITAL, FUNDING, AND OTHER INFRASTRUCTURE-RELATED RESOURCES TO BETTER MEET NEEDS.

Code	Action Item(s)	Outcome(s)	Time
	programs that otherwise cannot survive past pilot funding phase.	to maximize existing resources by sharing space, furniture, equipment, and software systems, including use of items placed in surplus by non-operational programs.	
I.A9	The Aging Alliance is formally recognized as the primary coalition for dealing with issues related to elders and their caregivers in the community.	◆ Formed a sustainable governance structure. ◆ A leadership/governance structure has been formalized. ◆ Recognized by Broward County as the primary coalition for addressing elder issues.	1 Year 1 Year 3 Years

STRATEGIC GOAL I.B: INCREASE LEVELS FROM CURRENT FUNDING SOURCES AND DEVELOP NEW FUNDING SOURCES.

Code	Action Item(s)	Outcome(s)	Time
I.B1	Increase non-state and non-federal elder services funding.	◆ Obtained at least one grant for at least $250,000 from private foundation or corporate sponsor to build local capacity, to include funding for infrastructure, training, and social marketing. ◆ Secured sustained annual funding of at least $250,000 from non-federal and non-state funding source to support local infrastructure, training, and social marketing. ◆ Increased County funding for home and community-based services to reduce all wait lists to a maximum of 2 months.	1 Year 3 Years 3 Year
I.B2	Increase infrastructure-building funding through federal, state, local, and foundation grants.	◆ The County and the Aging Alliance developed/submitted at least two collaborative funding proposals to test new (to Broward County) collaborative service models for elders and caregivers.	1 Year
I.B3	Integrate public and private service delivery for HCBS.	◆ Developed at least one formal agreement to co-fund service delivery between the county and private provider(s), including use of sliding fee system for all who receive services – increased revenues for subsidized services by 10%.	1 Year

STRATEGIC GOAL I.B: INCREASE LEVELS FROM CURRENT FUNDING SOURCES AND DEVELOP NEW FUNDING SOURCES.

Code	Action Item(s)	Outcome(s)	Time
		◆ Explored sliding fee structure for all HCBS programs funded through the DOEA and maximized all co-pay opportunities – increased annual revenues above public funding by 10%.	1 Year
I.B4	Explore options and identify strategies to increase funding for elder services through local property and/or sales tax set-asides.	◆ Mobilized to get state to allow vote and get BC voters to approve. ◆ Advocated for access to some or all of local casino tax revenues. ◆ Obtained sustained tax-based funding for elder services of at least $10,000,000 per year.	3 Years 3 Years 5 Years
I.B5	Increase older people's knowledge and skill in maximizing individual options.	◆ Provided neutral information about reverse mortgages, Florida Telecommunications Relay, Inc. (FTRI), Lifeline, and other cash program options elders have to maximize personal resources through broad public awareness campaign.	1 Year
I.B6	Develop/enhance programs and initiatives that help elders who need or want to work obtain appropriate, safe employment.	◆ Determined how existing programs could be expanded, and incorporated best and promising practices into these programs ◆ Leveraged current funding for this activity by pooling resources allocated by various federal, state, and local funders.	1 Year 3 Years

STRATEGIC GOAL I.C: INCREASE COMMUNITY COMMITMENT TO MEETING NEEDS OF ELDER RESIDENTS.

Code	Action Item(s)	Outcome(s)	Time
I.C1	Engage local leaders and policy-makers in dialogue regarding the importance of offering adequate services for residents of Broward County who are age 60+.	◆ County and all municipalities committed to the value of zero tolerance for any older person to live without basic needs for food, safe and clean shelter, healthcare, and human dignity being met. ◆ Designed and implemented social marketing program that enhances public perception of elders – if possible pre and post test public attitudes.	1 Year 5 Years
I.C2	Involve existing community volunteer organizations in elder	◆ Identified at least three existing volunteer programs and received formal commitments to elder-specific projects.	1 Year

STRATEGIC GOAL I.C: INCREASE COMMUNITY COMMITMENT TO MEETING NEEDS OF ELDER RESIDENTS.

Code	Action Item(s)	Outcome(s)	Time
	issues and services (e.g., school service clubs, Rotary and Lion's clubs, faith-based community volunteer groups).		
I.C3	Centralize recruitment, training and management of volunteers who are and/or want to be involved in providing assistance to elders.	◆ Identified a home agency and funded volunteer coordination infrastructure including staff, technology, and office/meeting space. ◆ Created standardized volunteer recruitment and training protocols that include background checking and supervision standards. ◆ Increased percent of county residents providing volunteers services for elders by 10%.	1 Year 1 Year 3 Years
I.C4	Adopt "Communities for a Lifetime" across all Broward municipalities and for the County as a whole.	◆ Increase visibility of Aging Alliance throughout the community. ◆ Implemented public relations program that included ads in multiple media and languages and outreach to local media reporters; employ existing state resources to promote concept.	1 Year 1 Year
IC.5	Ask local, state, and federal elected officials to take action to solve housing, healthcare, and transportation problems.	◆ Developed volunteer consumer advocacy initiative to spearhead efforts to contact and influence elected officials.	3 Years

Finding II: Available services need to be organized and interconnected to improve their effectiveness in meeting consumer needs, <u>where effectiveness is defined as develop new linkages, reduce duplication, and encourage leveraging</u>.

STRATEGIC GOAL II.A: CREATE COOPERATIVE AGREEMENTS WITH AGENCIES IN ALL SEVEN SECTORS ON THE ELDER COMMUNITY SERVICE WHEEL – PUBLIC SAFETY, EMERGENCY PLANNING & RESPONSE; PUBLIC & LOW-INCOME HOUSING & HOME MODIFICATIONS; TRANSPORTATION; ELDER JUSTICE, GUARDIANSHIP, & ADULT PROTECTIVE SERVICES; HOME, COMMUNITY, AND FACILITY-BASED SERVICES; HEALTHCARE, INJURY/DISEASE PREVENTION, AND HEALTH PROMOTION; ECONOMIC SUSTAINABILITY.			
Code	**Action Item(s)**	**Outcome(s)**	**Time**
II.A1	Formalize relationships between the Aging Alliance and non-Aging Alliance agencies around the seven critical functions on the Elder Community Service Wheel.	◆ Formally included representatives from all sectors as members of the Aging Alliance.	1 Year
II.A2	Develop community-wide protocol for discharging elders after an emergency department visit or overnight hospital stay.	◆ Created work group comprised of key stakeholders, to draft protocols. ◆ Funded, tested, and evaluated protocol in at least two community sites. ◆ Established formal agreements between all hospitals and relevant Aging Alliance agencies to implement county-wide protocol for discharging elders after an emergency department visit or overnight stay.	1 Year 3 Years 5 Years

STRATEGIC GOAL II.B: REDUCE DUPLICATION OF SERVICES FOR ELDERS ACROSS ALL SEVEN SECTORS ON THE ELDER COMMUNITY SERVICE WHEEL. ELIMINATE DUPLICATION TO THE GREATEST DEGREE POSSIBLE.			
Code	**Action Item(s)**	**Outcome(s)**	**Time**
II.B1	Identify opportunities to eliminate administrative duplication.	◆ Developed formalized agreements between agencies that provide the same or similar services for elders to implement mechanisms for sharing personnel, equipment, and information to reduce duplication (for example, multiple community switchboards might partner to reduce administration and other overhead costs while continuing to provide 24/7 access for people with a wide variety of concerns and needs).	3 Years

STRATEGIC GOAL II.C: PROMOTE PRACTICE OF POOLING RESOURCES ACROSS FUNDING PROGRAMS, AGENCIES, AND SECTORS TO MAXIMIZE THE VALUE OF EACH FUNDING DOLLAR SPENT TO PROVIDE SERVICES TO ELDERS AND THEIR CAREGIVERS.

Code	Action Item(s)	Outcome(s)	Time
II.C1	Create shared services model.	◆ Identified opportunities for use of shared services.	1 Year
		◆ Implemented at least one shared services program and evaluated effectiveness of outcomes, including satisfaction of elder service users, improved timeliness (i.e., less waiting time) and reduction in overall costs.	3 Years

Finding III: Consumers cannot easily access the help they need where easy access is defined as consumer driven, single point of entry, and readily available information about options.

STRATEGIC GOAL III.A: THE AGING ALLIANCE AND ALL CONSTIUENTS ADOPT "CONSUMER DRIVEN" AS AN ESSENTIAL COMPONENT OF ANY SERVICE SYSTEM OR INDIVIDUAL AGENCY RESPONSE PLAN.

Code	Action Item(s)	Outcome(s)	Time
III.A1	Provide elders with some level of system support in order to enhance their independence.	◆ Developed and implemented program where volunteers and became "experts" in the service system and assisted elders and caregivers to get the services they need.	1 Year
		◆ Developed and implemented program that enhanced the skills and confidence of older people to advocate on their own behalf.	1 Year
III.A3	Support "regionalized" service system that brings services into communities where elders live.	◆ Developed focal point satellite programs to bring important services in close proximity to where concentrations of elders live.	3 Years
		◆ Leveraged existing facilities such as school, churches, and non-elder specific community centers as locations for satellite programs.	1 Years

STRATEGIC GOAL III.B: THE AGING AND DISABILITY RESOURCE CENTER OFFERS A MECHANISM FOR ELDERS AND THEIR CAREGIVERS TO ACCESS ALL NEEDED SERVICES THROUGH A SINGLE POINT OF ENTRY.

Code	Action Item(s)	Outcome(s)	Time
III.B1	Assessment and Intake into service programs for elders and their caregivers, including waiting lists, are standardized in Broward County.	◆ Developed formal agreements to standardize assessment and intake procedures, including elimination of processes that were not tied to specific funding requirements or where funding requirements allowed for modification. ◆ All elders needing services through any agency reflected on the Elder Community Services Wheel have access to a single point of entry **OR** all points of entry have access to shared database.	3 Years 5 Years

STRATEGIC GOAL III.C: ELDERS AND THEIR CAREGIVERS WHO REQUIRE ASSISTANCE CAN EASILY IDENTIFY A SOURCE OF INFORMATION REGARDING AVAILABLE SERVICES.

Code	Action Item(s)	Outcome(s)	Time
III.C1	Catalogue and promote information about resources through multiple media, in multiple languages, targeting service providers, caregivers, and elders themselves.	◆ Developed and maintained an accurate and current list of available information and resources for elders and their caregivers; made list available on the internet, in print, and through a recorded message that can be accessed by telephone. ◆ Implemented ongoing outreach and training for service providers in fields likely to have contact with older people, e.g., financial institutions, physicians, clergy, social workers, judges, public guardians, etc. regarding long-term care services, including availability of such services for elders and their caregivers in Broward County. ◆ Increased accessibility to information about services through social marketing campaign that identified service options and encouraged older persons and their caregivers to use these services to improve the quality of their lives.	1 Year 1 Year 3 Years

Finding IV: Available resources are not sufficiently culturally responsive to the growing elder population in terms of generational characteristics, sexual preference, race, and ethnicity, where cultural responsiveness[1] is defined as cultural knowledge, service flexibility, and cultural context.

STRATEGIC GOAL IV.A: THE AGING ALLIANCE PROMOTES CULTURAL KNOWLEDGE AMONG MEMBER AGENCIES AND OTHER COMMUNITY AGENCIES THAT PROVIDE ANY SERVICES TO ELDERS AND CAREGIVERS; CULTURAL KNOWLEDGE INCORPORATES DIFFERENCES IN RACE, ETHNICITY, ECONOMIC STATUS, SEXUAL ORIENTATION, AND AGE COHORT.			
Code	**Action Item(s)**	**Outcome(s)**	**Time**
IV.A1	The Aging Alliance assures that there are elder-specific resources in the community to promote culturally-specific knowledge about elders and their caregivers.	◆ Developed, printed, and disseminated culturally-specific information about elders in Broward County. ◆ Developed, offered, and implemented community outreach programs that enhanced culturally-specific knowledge about elders.	1 Year 3 Years
IV.A2	The Aging Alliance is responsive to differences among elders based on race, ethnicity, income level, sexual orientation, and age.	◆ Implemented ongoing training for professionals and paraprofessionals working with older persons regarding differences among elders based on race, ethnicity, income level, sexual orientation, and age; training included positive strategies for accommodating cultural differences.	1 Year

STRATEGIC GOAL IV.B: THE SERVICE SYSTEM FOR OLDER PERSONS IN THE COMMUNITY IS DESIGNED TO OFFER FLEXIBILITY TO ELDERS AND THEIR CAREGIVERS BASED ON PREFERENCES DETERMINED BY RACE, ETHINICITY, ECONOMIC STATUS, SEXUAL ORIENTATION, AND AGE COHORT WITHIN CONSTRAINT OF MAXIMIZING RESOURCES.			
Code	**Action Item(s)**	**Outcome(s)**	**Time**
IVB.1	Focal points and other agencies offer activities and services for elders in multiple races, ethnicities, cultures, economic statuses, and age cohorts.	◆ Reviewed the BoomerANG project methodology and outcomes, and implemented recommendations from that project, as appropriate.	3 Years

[1]**Cultural Knowledge** developed through a formal process for obtaining, updating, disseminating; **Service Flexibility** that allows development of alternative strategies and methods to meet needs of culturally diverse elders; **Cultural Context** is applied in understanding elders' choices, actions, and decisions.

STRATEGIC GOAL IV.C: THE AGING ALLIANCE CONDUCTS/SUPPORTS CULTURAL CONTEXT TRAINING FOR FRONT LINE AIDES, DRIVERS, AND OTHER PERSONS WHO PROVIDE SERVICES TO OLDER PEOPLE AND THEIR CAREGIVERS IN BROWARD COUNTY.

Code	Action Item(s)	Outcome(s)	Time
IV.C1	Front line service providers for elders and their caregivers receive cultural context training to enhance their ability to effectively communicate with elders and caregivers.	◆ Implemented mandatory cultural context training for front line aides, drivers, and other persons who provide direct services to older people or their caregivers; included a component that facilitated identification and recognition of personal biases that may affect communication with older clients and their caregivers.	3 Years
IV.C2	Professionals and para-professionals who work with elders and their caregivers receive cultural context training to enhance their ability to effectively communicate with elders and caregivers.	◆ Implemented mandatory cultural context training for professionals and paraprofessionals who provide services to older people or their caregivers as a component of obtaining/maintaining licensure; included a component that facilitated identification and recognition of personal biases that may affect communication with older clients and their caregivers.	5 Years

Finding V: Elders in the community are not adequately prepared for disasters, and community is not adequately prepared to provide appropriate and responsive assistance to elders before, during, and after a hazard event, where adequately prepared is defined as engaged in ongoing all-hazards planning at the personal, Aging Alliance, and community levels.

STRATEGIC GOAL V.A: INDIVIDUAL ELDERS AND CAREGIVERS ARE ENCOURAGED TO INCREASE PERSONAL KNOWLEDGE ABOUT POTENTIAL HAZARD SCENARIOS AND TO DEVELOP PERSONALIZED DISASTER PLANS.

Code	Action Item(s)	Outcome(s)	Time
V.A1	The Broward Aging Alliance conducts ongoing outreach to increase awareness of elders and their caregivers regarding the importance of developing personalized disaster plans.	◆ Prepared and disseminated materials in multiple languages using varied formats and media approaches to reach the greatest number of elders and caregivers possible (at least 50% of community elders) regarding personal all hazards planning. ◆ Working with corporate partners, developed and distributed materials to assist with all hazards planning, including disaster preparedness kits; outreach and distribution of materials and supplies are ongoing. ◆ Made sure that each affiliated elder has a plan with a copy on file with their primary provider. ◆ Developed and implemented a program to help non-affiliated elders and their caregivers create personalized disaster plans **AND** to retain contact information for these elders.	1 Year 3 Years 3 Years 5 Years

STRATEGIC GOAL V.B: ALL COMPOSITE AGENCIES IN THE AGING ALLIANCE HAVE DEVELOPED CONTINUITY OF OPERATIONS PLANS FOR ALL POTENTIAL HAZARD SCENARIOS, INCLUDING PLANS TO PROVIDE ONGOING SERVICES TO COMMUNITY ELDERS AND THEIR CAREGIVERS, REGARDLESS OF WHETHER THEY CURRENTLY RECEIVE FORMAL SERVICES, BEFORE, DURING, AND AFTER A DISASTER.

Code	Action Item(s)	Outcome(s)	Time
V.B1	The Aging Alliance conducts ongoing all hazards planning as part of overall strategic planning and management activities.	◆ Developed an all hazards continuity of operations plan that supports and enhances individual member agency plans. ◆ Initiated formal agreements/memoranda of understanding with partners in other parts of the county/state to provide housing, transportation, trained staff and other resources in a hazard community event.	3 Years 3 Years

V.B2	Focal points and some satellite senior centers have been "hardened" to accommodate elders and their caregivers in sheltering and recovery period during and after a hazard event.	◆ Obtained funds from federal, state, county, and/or municipal governments to underwrite "hardening" of senior centers in order to provide safe and comfortable sheltering during and after a hazard event. ◆ Disaster "hardened" at least three senior centers in Broward County.	3 Years 5 Years

STRATEGIC GOAL V.C: THE COUNTY AND ALL MUNICIPALITIES HAVE FORMALIZED AGREEMENTS WITH THE AGING ALLIANCE TO PROVIDE SUPPORT AND SERVICES TO ELDER COUNTY RESIDENTS AND THEIR CAREGIVERS BEFORE, DURING, AND AFTER HAZARDOUS EVENTS.

Code	Action Item(s)	Outcome(s)	Time
V.C1	The Aging Alliance has a seat at the EOC.	◆ Obtained EOC approval for a designated representative to serve on the EOC.	1 Year
VC.2	The Aging Alliance is prepared to serve as a bridge between community agencies and elders/caregivers to ensure that all elders obtain disaster-related information and assistance.	◆ Developed a program and trained volunteers with high levels of knowledge regarding elders in disasters to be stationed at strategic evacuation, re-entry, distribution, and assistance sites. ◆ Developed training curriculum and provided training to individuals and agencies responsible for facilitating pre- and post-hazard community services. Continued to update training based on new information and promising practices.	3 Years 3 Years
VC.3	The Aging Alliance informs non-Alliance partners regarding roles, responsibilities, expertise, and capabilities of Aging Alliance agencies.	◆ Developed presentation and handout materials. ◆ Presented materials at least 10 times each year. Note: non-alliance partners include hospitals, housing, transportation, public safety.	1 Year 3 Years
VC.4	The Aging Alliance and composite agencies participate in disaster drills and include mock or actual elders in the exercises.	◆ Participated in two disaster drills over the previous 12 month period. ◆ Worked with the County OEM to integrate elders into drill scenarios.	1 Year 1 Year

Part III
SUPPORTING ATTACHMENTS

Attachment IIIA
DEMOGRAPHICS OF ELDERS IN BROWARD COUNTY 2006 AND BEYOND

Background

Attachment IIIA provides a profile of Broward County's current and future elder residents, including data regarding age, gender, ethnicity, race, language, education, income, and employment. In some cases these data will be shown at the zip code level. Otherwise data will be shown for the County as a whole.

Broward County is an urban county in southeast Florida with an estimated 2005 population of 1,757,590 (ACS 2005). The county, which included 31 municipalities in 2006, covers approximately 1,196 square miles, of which 787 square miles comprise conservation areas and 165 square miles comprise an Indian Reservation. The remaining 410 square miles, with its nine planning districts, is where the majority of the population resides (FY 2004-2005 Broward County Annual Report).

Prior to the 1960s population characteristics were similar to those of other southern United States cities (Croucher, 1997). However, that does not mean that Broward County was culturally homogeneous. Wingerd (1999) reported that of the 83,933 residents in 1950, 54,116 were foreign-born (either naturalized or not). The majority of immigrants came from European countries: Russia, Italy, and Poland (Wingerd, 1999). Beginning in the 1960s, Broward, like Miami-Dade County to the south, experienced a shift in immigration patterns with a dramatic increase in immigration from Latin America and the Caribbean in response to ongoing international political and economic events/crises throughout these regions.

Another group of migrants and immigrants that impacted the phenomenal growth of South Florida has been individuals from the northern United States and Canada. Generally, they came to South Florida as a temporary escape from the cold winters of the north (i.e., "snow-birds") or for retirement, especially after World War II (Croucher, 1997). For snow-birds, as time went on, usually their "temporary" stays became longer; until finally they were more permanently residing in South Florida. This migratory flow continues today.

Population growth from neighboring Miami-Dade County also began to dramatically increase in the 1990s, with residents looking for cheaper housing, less congestion, or indeed, any housing following Hurricane Andrew in 1992.

Geographic Distribution

Map IIIA.1, at the end of this Appendix, shows the distribution of individuals aged 60+ living in Broward County based on 2000 census data, by zip code. Notably, the western zip codes have relatively few elder residents. Seven zip codes have at least 11,382 and

nine zip codes have between 7,461 and 11,381 elder residents. Concentrations occur along the Broward – Dade County line west of the coastal area, in the middle of the county, and in the central northeast. The population age 85 and older appear in largest numbers in the same areas, but there are even fewer new west county zip codes with concentrations of the oldest old than there are for the larger 60+ population (see Map IIIA.2).

Age and Gender

In the 2000 census, 19.8 percent of Broward County's total population was age 60 years or older. Table IIIA.1 shows number of residents age 60+ and the percentage of the total Broward County population that is age 60+ years or older residing in Broward County since 1940, by decade.

Table IIIA.1. Elder Population Residing in Broward County, 1950-2000 (Number and Percentage of Total Population)

	1940	1950	1960	1970	1980	1990	2000
Number 60+	3,937	9,709	56,731	154,410	289,716	318,089	321,663
Total Population	39,794	83,933	333,946	620,102	1,018,257	1,261,972	1,623,018
% 60+	10.0%	11.6%	17.0%	24.9%	28.4%	25.3%	19.8%

Data Sources: U.S. Census (2001) for 2000; BEBR (2000) for 1990 elder population; U.S. Bureau of the Census (1995) for 1980 and 1970; --- (1963) for 1960; --- (1952) for 1950 and 1940 data.

It is interesting to note that between 1980 and 2000 the elder population grew at a lower rate than the total population. This trend also is evident in Table IIIA.2, which compares past and projected future population growth rates for the 60+ and the total populations. However, projections by the Bureau of Economic and Business Research (BEBR) show that between 2000 and 2005 and between 2005 and 2010 the 60+ population is expected to again grow at a faster annual rate than the overall population.

Table IIIA.2. Growth Rate of Elder Population and Total Population in Broward County between Censuses 1950-2000

	1940-50	1950-60	1960-70	1970-80	1980-90	1990-2000	2000-05	2005-10
60+ Population	9.0%	17.7%	10.0%	6.3%	0.9%	0.1%	3.1%	2.6%
Total Population	7.5%	13.8%	6.2%	5.0%	2.1%	2.6%	0.2%	1.4%

Data Source: U.S. Census Bureau (2001) for 2000 population; BEBR (1998) for 1990 elder population; and Longino & McNeal (1991) and U.S. Bureau of the Census (1995, 1963, 1952) for earlier periods.

Table IIIA.3 below shows changes in the number of persons in the elder (60+) and oldest old (85+) age groups between 2000 and 2005. Although we don't know the reasons for the apparent reduction of elders during this period, several key informants suggested the decline may at least partially be explained by the impact of the 2004 and 2005 hurricane seasons. Nevertheless, looking ahead to 2010 – a mere three years

away – and beyond, the numbers are expected to increase in all age groups as shown in the projections for 2010, 2020, and 2030. Additionally, note that the gender discrepancy is decreasing, a pattern that is predicted to continue as healthcare breakthroughs continue to lengthen the lifespan of men in relation to the lifespan of all elders.

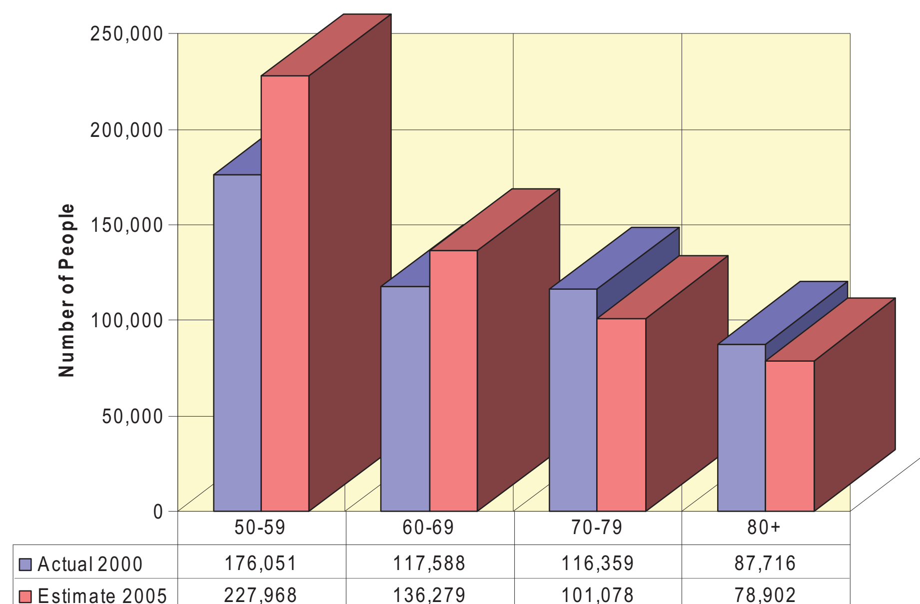
Table IIIA.3. Age and Gender Distribution of Elders in Broward County, 2000-2030

Age	Census	Estimated[2]	Projected		
	2000	2005	2010	2020	2030
60+	321,663	316,288	362,284	472,700	616,066
60+ as a % of Total Population	19.82%	18.00%	60+ as % of Total Population		
85+	42,199	36,354	18.54%	20.8%	24.2%
85+ as a % of 60+	13.1%	11.7%			
Female as a % of 60+	58.2%	56.9%			

Data Sources: Census 2000 SF1 Table P12 for 2000. US Census American Community Survey, Table B01001 for 2005 data. *Population Projections* (2002) for 2010, 2020, and 2030 projections.

The expected increase in the elder population from the aging-in of the Baby Boomers is dramatically evident in Figure IIIA.1, where the size of the population between 50 and 59, which increased by almost 30% between 2000 and 2005, appears as a veritable tsunami in comparison with the older age groups.

Figure IIIA.1 Broward County Aging Population by Age Groups, 2000 and 2005



Data Sources: Census 2000 SF1 Table P12 and US Census American Community Survey 2005 Table B01001

[2] Estimates for 2005, based on the Census Bureau American Community Survey 2005, Table B01001, have extremely large margins of error. Therefore, the 2005 numbers should not be considered accurate. Nevertheless, the margins of error are not large enough to explain the drop in the older cohorts. A more plausible cause may be the hurricane seasons for 2004 and 2005.

Ethnicity and Race

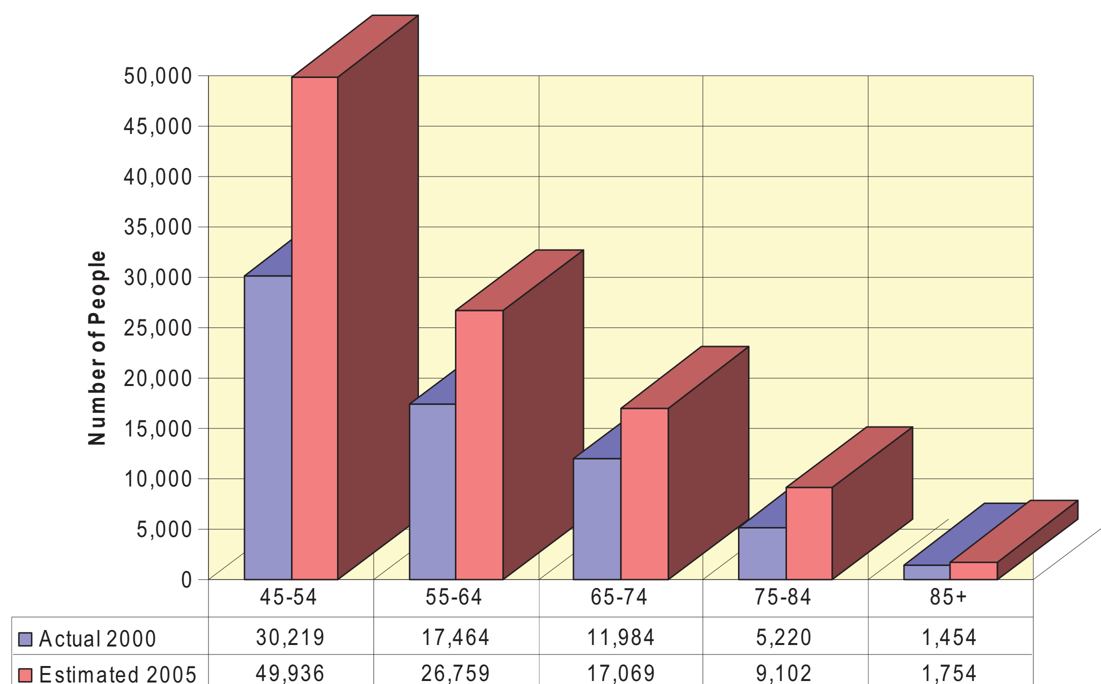
Not only will the elder population get larger over the next few decades, it also will become more diverse, as shown in Table IIIA.4. Figure IIIA.2 shows the dramatic 65% increase in the Hispanic population age 45-54 between 2000 and 2005, more than double the increase in the total population in this age group for the same period (see Figure IIIA.1). Figure IIIA.3 below shows a similar pattern for Broward County's Black/African American community, with the 45-54 age group increasing by 50%.

Table IIIA.4. Racial & Ethnic Characteristics of Broward County Elders, 1980-2004

Race/Ethnicity	% of 60+			% of 65+[3]
	1980	1990	2000	2005
White non-Hispanic	94.8%	91.5%	81.3%	77.4%
Black non-Hispanic	2.9%	5.0%	8.3%	10.0%
Hispanic	1.7%	3.2%	8.3%	10.7%
Other	0.6%	0.3%	2.1%	1.9%

Data Sources: Ruggles, Sobeck, et al (1997) for 1980 and 1990 figures. Census 2000 SF1 Table P12 for 2000. US Census American Community Survey, Tables B01001A-B01001I for 2005 data.

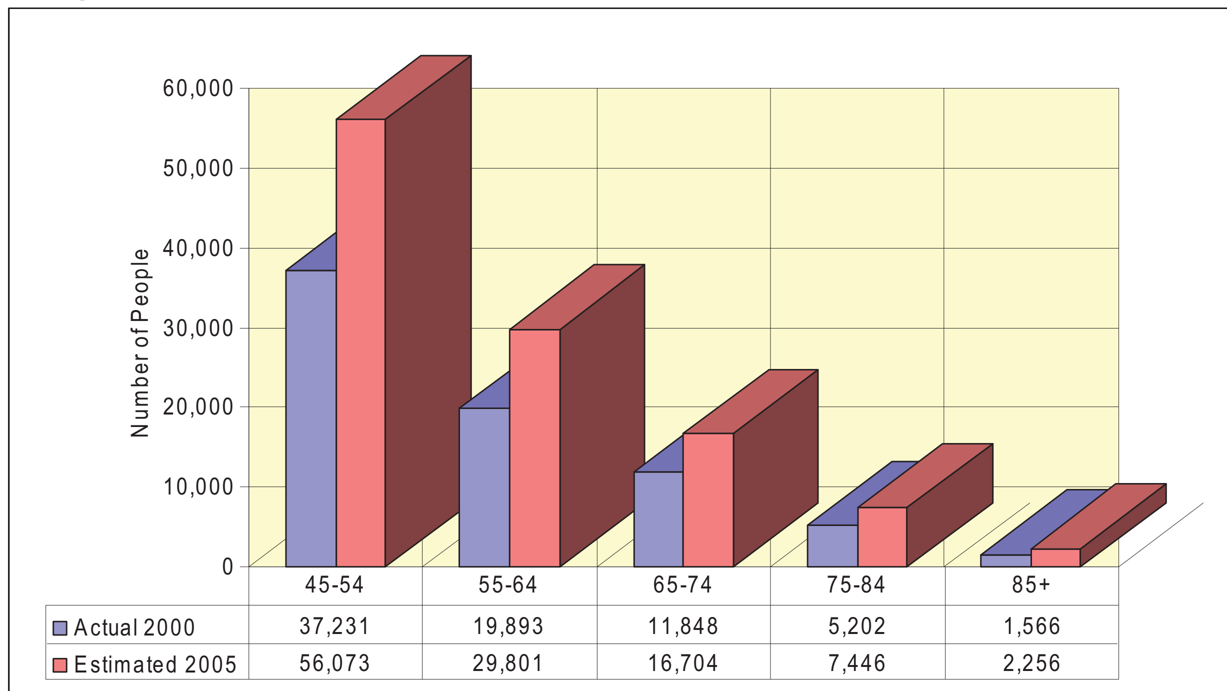
Figure IIIA.2. Broward County Aging Hispanic Population by Age Groups, 2000-2005



Data sources: Census 2000 SF1 Table PCT12 and US Census American Community Survey 2005 Table B01001I

[3] Some of the Census data is not available at the age 60+ cut-off.

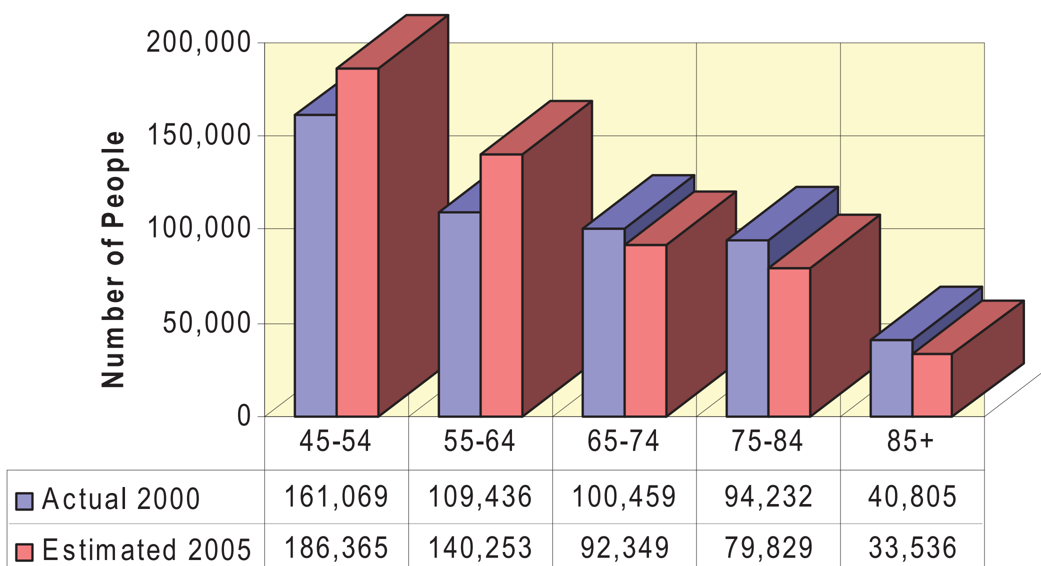
Figure IIIA.3. Broward County Aging Black/African American Population by Age Groups, 2000-2005



	45-54	55-64	65-74	75-84	85+
Actual 2000	37,231	19,893	11,848	5,202	1,566
Estimated 2005	56,073	29,801	16,704	7,446	2,256

Notably, as shown in Figure IIIA.4, unlike the pattern seen for Hispanics and Blacks, the estimated number of White elders in the three oldest groups declined between 2000 and 2005. Furthermore, while the size of the two youngest age groups did increase between 2000 and 2005, the rate of increase was quite modest.

Figure IIIA.4. Broward County Aging White Population by Age Groups, 2000-2005



	45-54	55-64	65-74	75-84	85+
Actual 2000	161,069	109,436	100,459	94,232	40,805
Estimated 2005	186,365	140,253	92,349	79,829	33,536

Details regarding ethnicity and race at the zip code level are shown in Table IIIA.5 below. This information is particularly useful for planners to identify where to target culturally and ethnically responsive service delivery information, social marketing, and disaster preparedness communications. Cells with darker blue shading indicate relatively large numbers of resident elders in the referenced ethnic/racial group for the particular zip code.

Table IIIA.5. Broward County Ethnicity and Race 75+ Census 2000, by Zip Code

Zip Code	City	# 60+	# 60+ Hispanic	# 60+ White	# 60+ Black/ African American	# 60+ Any Other Race	# 60+ More Than One Race
			Highest (1-10)		Highest (1-10)	Third Highest (21-30)	All Others
33004	Dania	3,409	213	3,366	613	35	28
33009	Hallandale	13,689	1,532	14,481	707	141	161
33019	Hollywood	6,957	723	8,019	24	58	49
33020	Hollywood	6,868	1,195	7,359	764	158	169
33021	Hollywood	12,630	1,540	14,546	334	214	143
33023	Hollywood	7,460	2,172	6589	1,951	306	198
33024	Hollywood	8,549	2,796	10,316	365	408	174
33025	Hollywood	5,546	1,377	4,987	1,227	236	162
33026	Hollywood	5,079	919	6,347	222	121	83
33027	Hollywood	10,574	1,624	10,984	288	140	111
33028	Pembroke Pines	1,418	833	1,727	162	120	42
33029	Hollywood	2,533	1,419	3,062	325	182	62
33060	Pompano Beach	5,810	274	5,392	1,258	64	120
33062	Pompano Beach	11,381	390	13,209	27	57	75
33063	Pompano Beach	13,650	1,212	15,771	328	188	166
33064	Pompano Beach	10,155	935	11,599	489	155	179
33065	Pompano Beach	6,007	971	7,679	321	226	82
33066	Pompano Beach	9,646	208	10,296	30	26	28
33067	Pompano Beach	1,510	211	2,529	87	51	22
33068	Pompano Beach	4,985	1,114	5,492	628	260	142
33069	Pompano Beach	7,947	402	7,913	829	38	44
33071	Pompano Beach	2,778	467	4,941	119	117	27
33073	Pompano Beach	2,359	328	3,092	92	84	36
33076	Pompano Beach	957	187	1,609	62	81	15
33301	Ft. Lauderdale	1,951	100	2,522	29	11	15
33304	Ft. Lauderdale	3,467	197	3,916	175	41	64
33305	Ft. Lauderdale	2,322	125	2,938	38	22	29
33306	Ft. Lauderdale	965	46	1,222	1	7	3
33308	Ft. Lauderdale	11,036	460	13,011	42	63	58
33309	Ft. Lauderdale	4,645	529	4,906	627	109	121
33311	Ft. Lauderdale	9,277	338	2,912	6,456	104	259
33312	Ft. Lauderdale	6,495	999	6,887	1,153	126	104
33313	Ft. Lauderdale	8,321	732	6,218	2,608	160	225
33314	Ft. Lauderdale	3,117	546	4,027	93	60	34
33315	Ft. Lauderdale	2,105	280	2,723	65	51	20
33316	Ft. Lauderdale	3,053	135	3,647	68	25	15

Zip Code	City	# 60+	# 60+ Hispanic	# 60+ White	# 60+ Black/ African American	# 60+ Any Other Race	# 60+ More Than One Race
33317	Ft. Lauderdale	5,974	926	6,844	651	155	100
33319	Ft. Lauderdale	14,694	927	14,558	1,290	205	239
33321	Ft. Lauderdale	17,039	1,017	18,637	286	129	118
33322	Ft. Lauderdale	14,819	1,112	16,013	445	188	109
33323	Ft. Lauderdale	1,461	451	1,918	173	79	38
33324	Ft. Lauderdale	8,490	905	10,834	174	116	69
33325	Ft. Lauderdale	2,717	568	3,976	70	91	31
33326	Weston	3,570	1,100	4,734	65	93	39
33327	Weston	806	348	1,218	36	40	13
33328	Ft. Lauderdale	2,620	414	3,851	31	61	20
33330	Ft. Lauderdale	1,105	277	1,589	42	44	3
33331	Ft. Lauderdale	1,547	566	2,306	86	94	22
33332	Ft. Lauderdale	303	98	500	13	9	0
33334	Ft. Lauderdale	4,520	866	5,500	140	111	86
33351	Ft. Lauderdale	3,807	747	4,417	337	167	65
33441	Deerfield Beach	5,946	389	5,974	870	60	55
33442	Deerfield Beach	13,594	408	14,765	69	75	84

Legend: Highest (1-10) | Highest (1-10) | Third Highest (21-30) | All Others

Additional zip-code specific race and ethnicity data is shown in Maps IIIA.3, IIIA.4, IIIA.5, IIIA.6, and IIIA.7.

Language

Learning a new language for an older person is extremely challenging. Although multi-lingual service providers are increasingly available, lack of proficiency in English may make it especially difficult to even understand how to access the service system. Of the 18,621 residents age 65+ who speak Spanish, 42% speak English either not well or not at all[4]. In addition, 12% of the population 65+ speak an Indo-European language other than Spanish and of these, 15.46% speak English either not well or not at all. The total number of Broward residents age 65+ who did not speak English well or at all was 13,611. These language barriers may be particularly “dangerous” in emergency situations, e.g., hurricanes, pandemics, where rapid communication and comprehension of information and instructions may be critical for survival. Maps IIIA.8 and IIIA.9 show the zip code distribution of Spanish speaking and Indo-European language speaking elders, respectively, who do not speak English well.

[4] Note that age 65+ is used, rather than 60+, because these census data are not available at the lower age cut-off. This also is true for data on education, income, employment, and living alone.

Income

Poverty makes aging without some assistance a great challenge. About 32,166 people age 65+ with incomes below the federal poverty level – $9,800 annually for a single person in 2006 – lived in Broward County when the last census was done in 2000. An additional 14,730 persons 65+ had annual incomes above the federal poverty level, but below $14,999, and **just under one third had annual incomes below $29,999** (Census 2000 SF3 Table P55) (see Maps IIIC.3 and IIIC.2 for distribution of elders 75+ with incomes below the federal poverty level, and elders 65+ with at least one disability and living below the federal poverty level, respectively, by zip code). Moreover, data show that, as people age (and therefore become more frail and in need of assistance) the poverty rates increase. Poverty rates among elders in all age groups are expected to increase over the next 20 to 30 years.

Employment

Data also show that many elders continue to work well into older age. More than 32,000 people age 65+ were employed as of the 2000 census. Of these 6,780 were 75+. An additional 2,024 people age 65+ were unemployed but looking for work. Some of these people continue to work by choice, but many work, often at low wage jobs that are physically taxing, because they need the income to meet their living expenses. In the future, more elders, particularly in the lower age groups, may need to work in order to expand an adult labor force that is expected to decrease.

Disability

Many older Broward County residents are disabled. In 2000 104,696 (41.1%) persons age 65+ had at least one disability; of these 12,358 had incomes below the federal poverty level (see MAP IIIC.2 for distribution by zip code). More than 11 percent (37,313) of persons age 65+ had two or more disabilities, including a self-care disability. Map IIIC.5 shows the zip code distribution of elders age 75+ who have a self-care disability.

Living Situation

At the last census (2000) there were 53,542 households with a householder age 75+ who lived alone (Census 2000, SF1 Table P24) (see Map IIIC.4 for distribution by zip code). Although it will not be true for all, many people in this age group need one or more types of assistance in order to age in place. Additionally, living alone puts elders at serious risk of financial exploitation and isolation that exacerbates functional, cognitive, and health deficits, in some cases causing rapid decline that may result in serious impairment or death if left unaddressed.

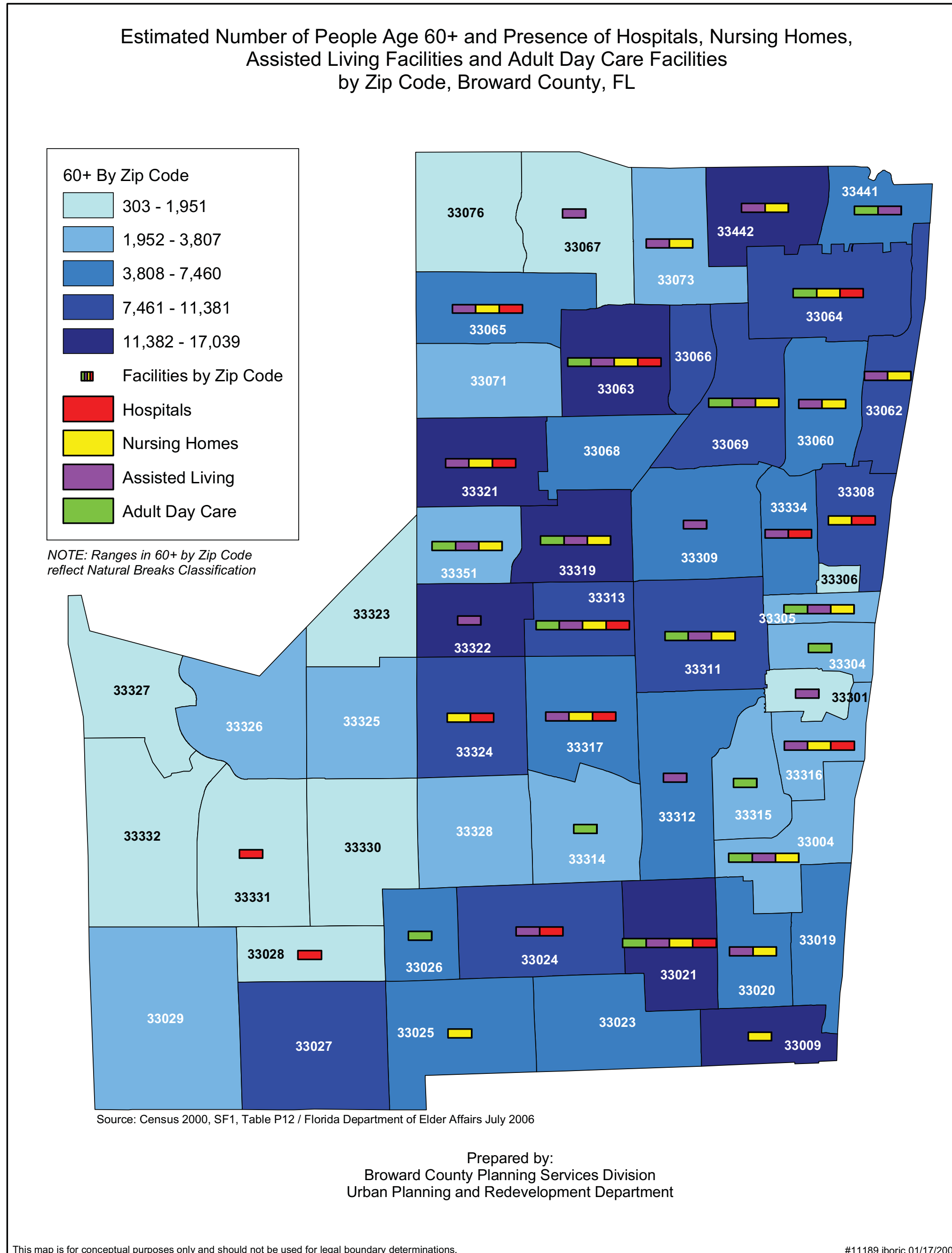
Finally, despite poverty, disability, and language barriers described above, all of which make it challenging for an older person to live independently, only 2% of the population 65+ resided in nursing homes in 2000. The great majority of older people and the family members who care for them see custodial institutional care as a very undesirable last

resort. Therefore, most elders with one or more risk factors for needing assistance still live independently in Broward County communities, but will increasingly need assistance in the coming years.

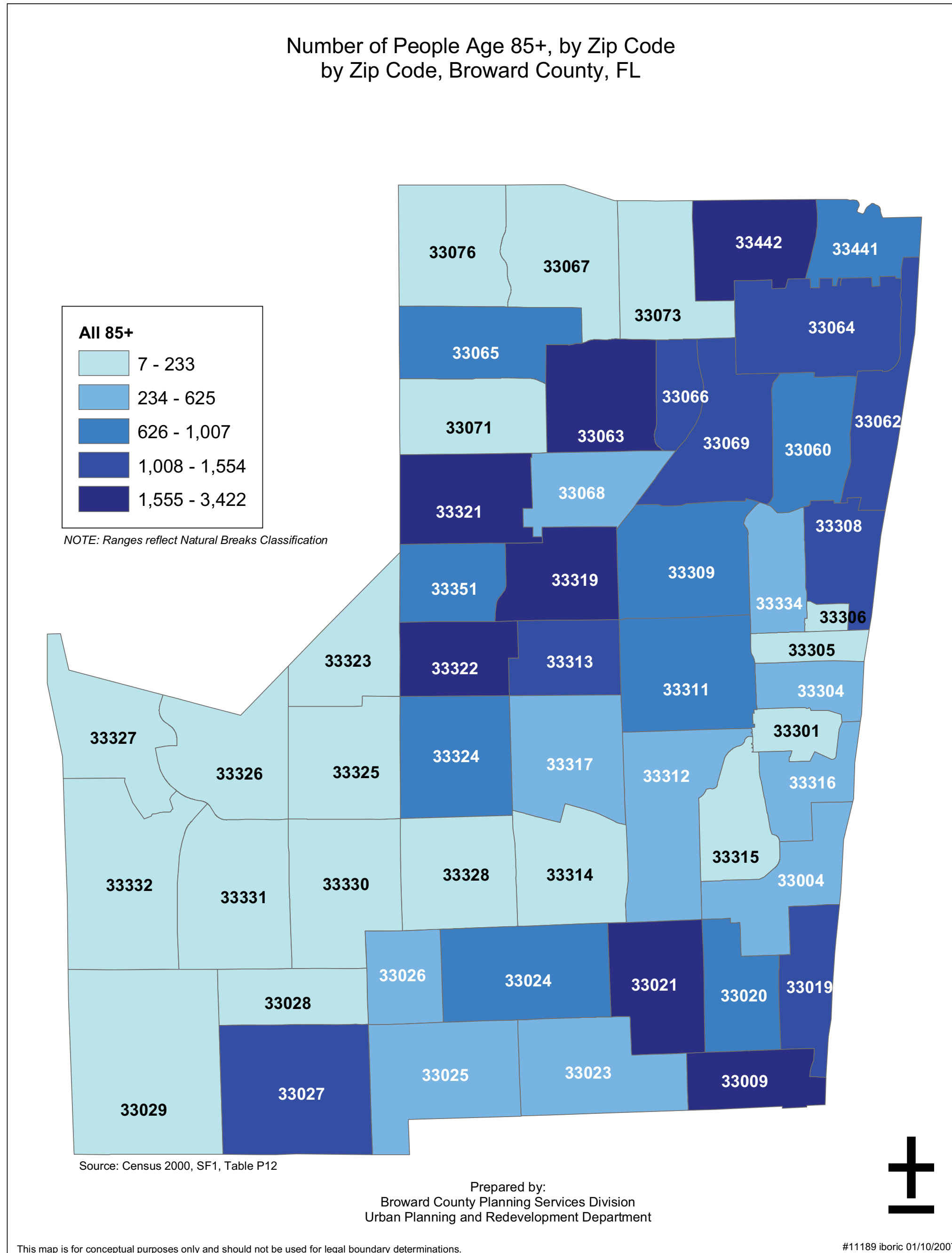
In summary, the elder population in Broward County is expected to increase dramatically for the next several decades, beginning in 2006, as the first of the large Baby Boom population begins to “age in”. Diversity within this population also will continue to increase along with the percentage of older persons who are unable to communicate in English. Only a small percentage of the elder population currently lives in a nursing home, and because of personal preferences as well as the high cost of institutional care, this fact is expected to continue. There is a fairly substantial labor force in the 65+ population, but the number drops sharply after age 75, which will become a critical concern as the Baby Boom generation ages and requires more personal assistance to live independently. Almost half of all elders 75+ live alone, creating a likelihood of at least some need for home- and community-based services to support continued independent living.

These data were used as background in design of the Plan that reflects the findings of the 2006 Analysis of Broward County Elders Project.

Map IIIA.1



Map IIIA.2



Map IIIA.3

Number of White People Age 75+
by Zip Code, Broward County, FL

White 75+

- 67 - 1,050
- 1,051 - 2,198
- 2,199 - 4,056
- 4,057 - 6,300
- 6,301 - 8,824

NOTE: Ranges reflect Natural Breaks Classification

33076 33067 33073 33442 33441
33065 33064
33066 33062
33071 33063 33069 33060
33321 33068 33308
33351 33319 33309 33334 33306
33323 33322 33313 33305
33311 33304
33327 33301
33326 33325 33324 33317 33312 33316
33332 33331 33330 33328 33314 33315 33004
33026 33024 33021 33020 33019
33028
33029 33027 33025 33023 33009

Source: Census 2000, SF3, P145

Prepared by:
Broward County Planning Services Division
Urban Planning and Redevelopment Department

This map is for conceptual purposes only and should not be used for legal boundary determinations.

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Map IIIA.4

Number of Black/African-American People Age 75+ by Zip Code, Broward County, FL

Black 75+
- 0 - 50
- 51 - 162
- 163 - 279
- 280 - 732
- 733 - 1,519

NOTE: Ranges reflect Natural Breaks Classification

33076 33067 33073 33442 33441 33064 33065 33066 33071 33063 33069 33060 33062 33321 33068 33308 33351 33319 33309 33334 33306 33323 33322 33313 33311 33305 33304 33327 33301 33326 33325 33324 33317 33312 33316 33315 33332 33331 33330 33328 33314 33004 33026 33024 33021 33020 33019 33028 33025 33023 33009 33027 33029

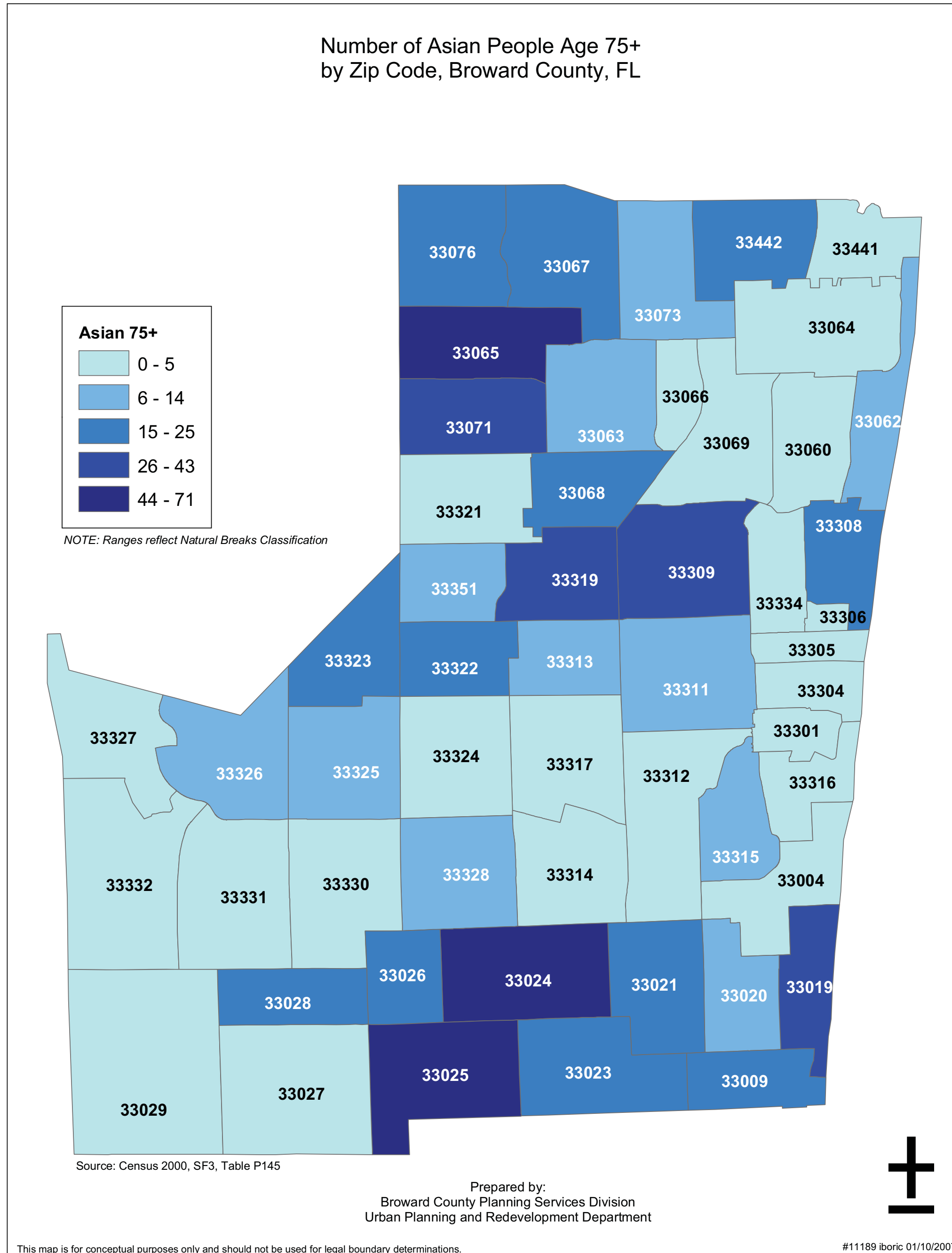
Source: Census 2000, SF3, Table P145

Prepared by:
Broward County Planning Services Division
Urban Planning and Redevelopment Department

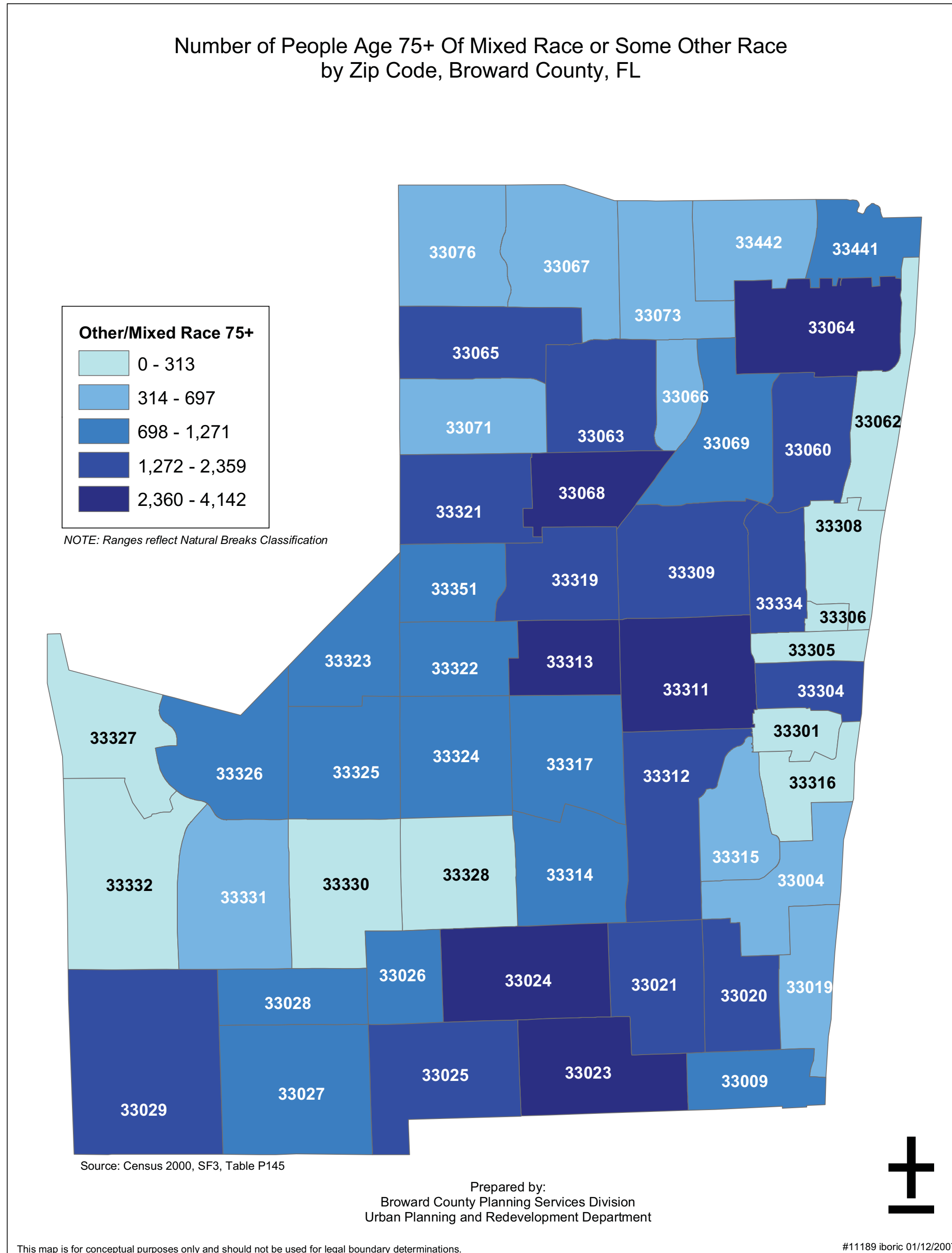
This map is for conceptual purposes only and should not be used for legal boundary determinations.

#11189 iboric 01/10/2007

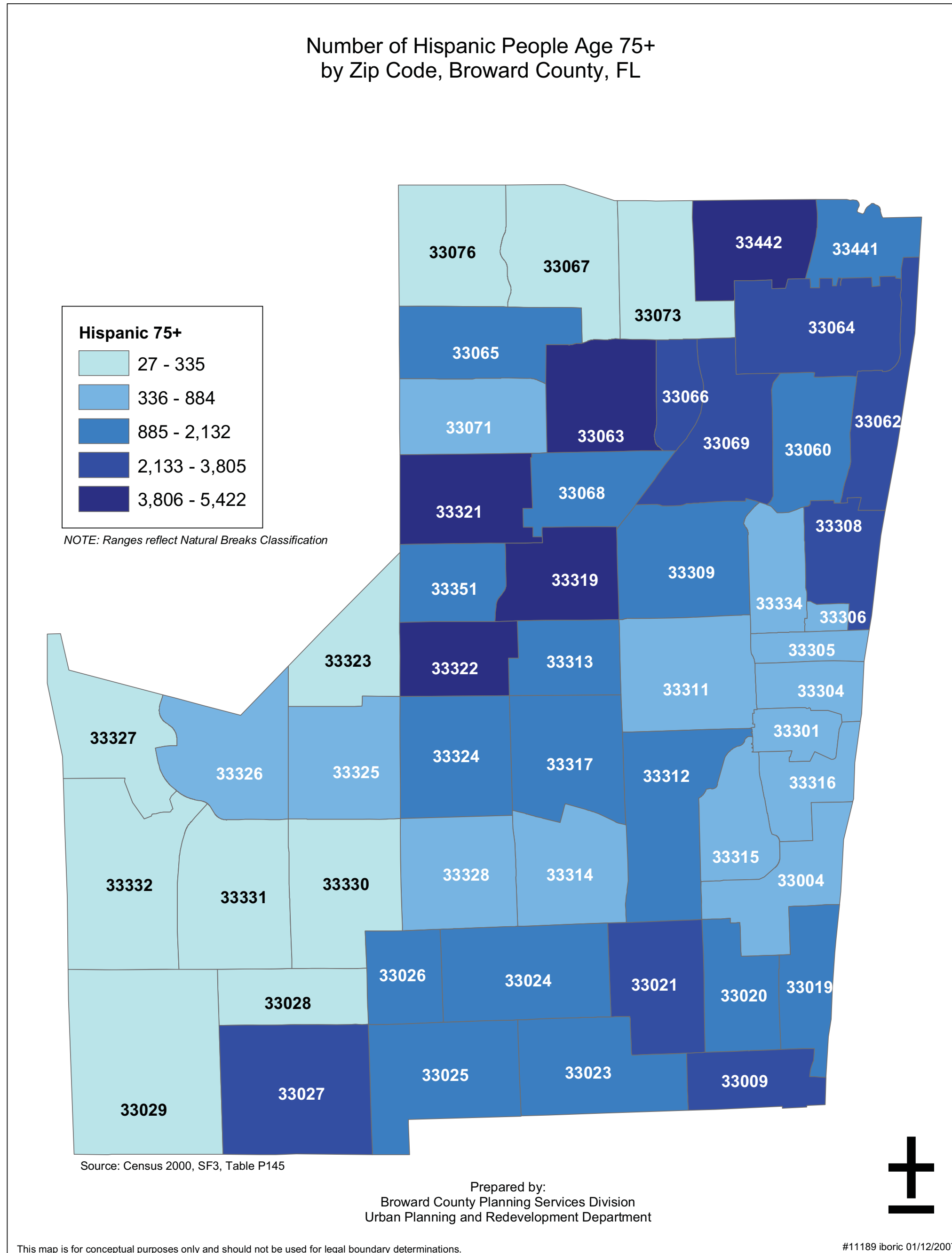
Map IIIA.5



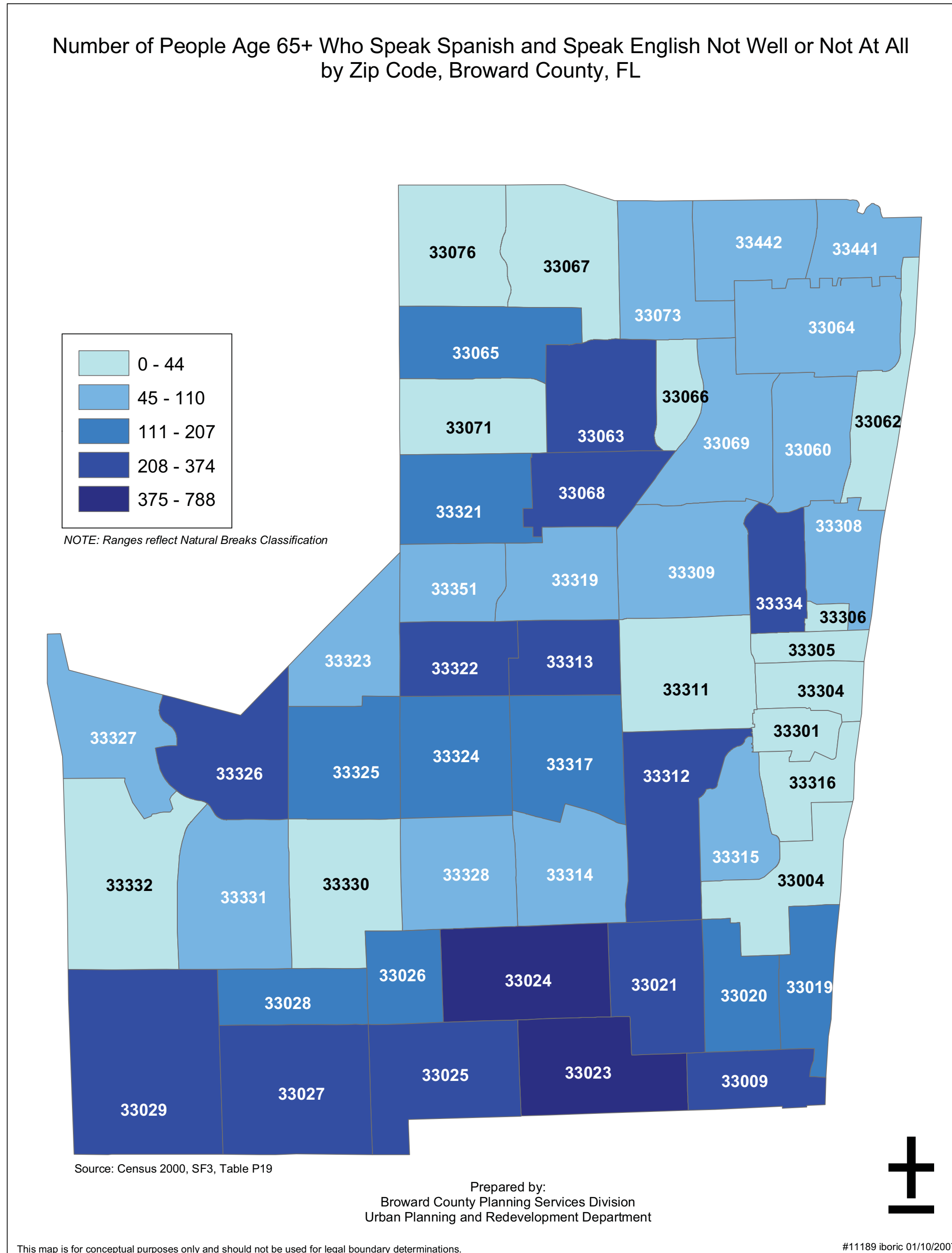
Map IIIA.6



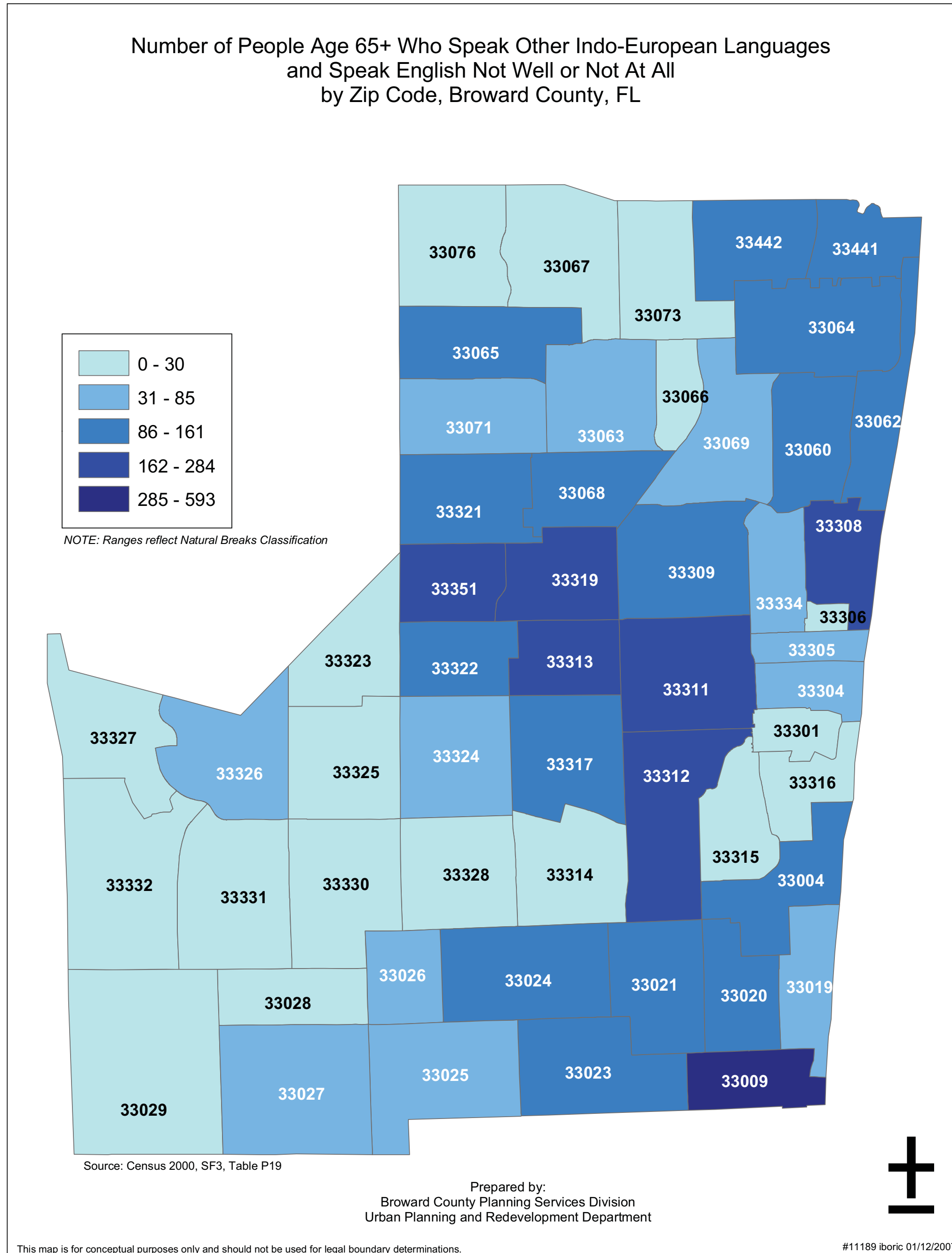
Map IIIA.7



Map IIIA.8



Map IIIA.9



Attachment IIIB

Current Services for Elders Through Traditional Elder Services Network, Including Waiting Lists and Public Funding Resources

Home and Community-Based Service Programs

By far the largest component of Broward County's elder services network is comprised of federal and state programs that are overseen by the Florida Department of Elder Affairs (DOEA). Based on service data provided by the DOEA, in state fiscal year 05-06 **16,994** elder Broward residents (17.2% of all residents age 65+) received services under one or more federal and state funded home and community-based service programs (HCBS). The number of elders enrolled and the average client age for each program are shown in Table IIIB.1.

Table IIIB.1. DOEA Program Participation and other Demographic Data for Broward County Elders Who Received Services in SFY 05-06

# Clients Served SFY 05-06	DOEA Program	Average Client Age
11,926	Older Americans Act Title IIIB (OA3B)	76.95
4,049	Local Service Program (LS)^	80.04
3,061	Older Americans Act Title IIIC1 (OA3C1)	78.24
2,962	Older Americans Act Title IIIC2 (OA3C2)	79.17
1,916	Community Care for the Elderly (CCE)^	80.53
867	Aged and Disabled Adult Medicaid Waiver (MW)	78.07
511	Home Care for the Elderly (HCE)^	79.81
490	Older Americans Act Title IIIE (OA3E)	78.15
400	Older Americans Act Title IIIF (OA3F)	90.17
365	Alzheimer's Disease Initiative (ADI)^	82.80
305	Assisted Living Medicaid Waiver (ALW)	82.77
268	Respite for Elders Living in Everyday Families (RELIEF)^	83.09
128	Older American Act Title IIID (OA3D)	80.67
49	Older Americans Act Title XII (OAA7)	86.12
8	Emergency Home Energy Assistance for the Elderly (EHEAP)^	69.38
27,556	**TOTAL SERVED**	

Source: Florida Department of Elder Affairs July 2006
^ Indicates programs funded through State of Florida general revenues

In Table IIIB.2 below we show the number of units delivered for each of the provided services and the programs that funded these services for the 2005 calendar year. The table is organized by most frequently used service. In most cases, a unit equals one hour of direct service. Exceptions include home delivered and congregate meals, (counted by the meal), transportation, emergency alert response, supplies and equipment, basic subsidy (monthly payment), housing improvement, and material aid.

Table IIIB.2. Types of Services Provided, by Program, for 2005 Calendar Year

SERVICE NAME	TOTAL UNITS	MW	ADI	CCE	HCE	LSP	NDP	O3C1	O3C2	OA3B	OA3E	RELF
Home Delivered Meals	888,842	X					X		X			
Personal Care	569,625	X		X	X					X		
Adult Day Health Care	550,693	X		X		X				X	X	
Recreation	478,771					X				X		
Congregate Meals	368,915					X		X				
Homemaker	291,218	X		X	X					X		
Respite	280,596	X	X	X	X					X		X
Transportation	183,393					X				X		
Facility Based Respite	161,162	X	X			X				X		
Emerg Alert Resp Maintenance	132,012	X		X								
Information	127,520									X		
Case Management NON Hrs	87,820	X	X	X	X							
Referral	14,207									X		
Health Support	10,203			X						X		
Med/Incontinent Supl	8,488	X		X								
Other Services	7,992					X						
Health Promotion Individual	7,604									X		
Legal Services	7,531									X		
Screening & Assessment	7,141								X			
Case Aide	4,949	X										
Geriatric Counseling Individual	4,767		X				X			X	X	
Basic Subsidy	4,358				X							
Chore	3,743	X		X						X		
Housing Improvement	3,581			X						X	X	
Sped Med Equip & Supplies	3,548	X	X	X								
Caregiver Trng/Supp Indiv & Grp	1,718	X	X							X	X	
Supplies/Serv Medical	1,444			X	X							
Nutrition Counseling	1,116							X	X			
Material Aid	487			X		X						

Source: Florida Department of Elder Affairs July 2006

It is important to note that community elders receive services from many sources other than federal and state funded HCBS programs. Many elders are able to purchase these services or their families are able to purchase the services on their behalf. In some cases family members provide extensive unpaid assistance even to an elder not living with them. Additionally, many elders live with family who provide much of the HCBS without compensation.

Additional details regarding the funding programs and services listed above can be accessed on the DOEA web site under “DOEA Manual” at http://elderaffairs.state.fl.us/. Map IIIB.1 shows the distribution of elders receiving services under these programs, by zip code.

While waiting lists are not indicative of the total need for services, the DOEA's Assessed Priority Consumer List (APCL) does suggest the number of people who have formally requested publicly-funded services and are waiting because funding is not sufficient even to meet this known need. The size of this list is in constant flux, as new clients requesting services are screened and other clients are removed from the list, either because they no longer need/want services or because their case is opened in at least one of the programs. The APCL as of July 2006 is shown in Table IIIB.2 below:

Table IIIB.3. Assessed Priority Consumer List at July 2006

Program	Number of Clients Currently on APCL
ADI	4
CCE	965
HCE	30
LSP	38
OA3B	134

Most federal and state-funded HCBS services for elders are provided through the DOEA programs listed above. However, there are a few other programs. One of these is the Broward County Consumer Directed Care Program, established and funded by Broward County based on recommendations in the 2001 Broward County Elder Analysis. This program offers case managers working with frail elder and/or caregiver clients to determine the types of services that are needed and to offer assistance with finding service providers. The county also contributes a monthly stipend of $200 toward the cost of needed services and supplies. The most recent full-year of data on the program is from Broward County fiscal year 04-05 during which **186 unduplicated clients** received services, with the County spending an average of $1,943.97 per consumer per year (36.8% of the total cost of services for these 186 clients). This is much lower than annual costs for CCE and Medicaid Waiver care plans (range between $9,000 and $14,700). Estimated cost for the program in BCFY 04-05 was $361,578 in stipends and $115,320 for case management, for a total of $476,898.

Another option is the Frail Elder Program Medicaid HMO (FEP, brand name Evercare At Home™) operated by United HealthCare, under contract to the Florida Agency for Health Care Administration, in Miami-Dade and Broward Counties. This program offers coordinated care management service for community-based elders and chronically ill adults who are at risk of nursing home placement to optimize their health and well being, allowing them to continue to live in the community for as long as possible. Services provided include case management, physician/hospital services, home health aide visits, respite, adult day care, housekeeping and chore services, escort to medical appointments, prescription drugs from contracted pharmacies, and medical supplies and equipment. In a 2004 study of this program, The Center on Aging determined that the program was similar in many respects to the Aged and Disabled Medicaid Waiver and care plan costs and consumer satisfaction were similar, although the FEP funding structure offers some aggregate cost savings for the State. As of November 2006, Broward County enrollment in Evercare At Home ranged between 204 and 225 enrollees per month during the most recent 12 month period. Elders who receive

services under this program are not eligible for the other publicly funded HCBS programs described above.

Finally, many of the municipalities in Broward County offer at least one special program for elder community residents. Some of these activities are free (e.g., many of the exercise classes are offered at no cost), some offer a senior discount, and some are "fee for service". Many of the programs are joint ventures between the municipalities and the Area Agency on Aging, with primary program funding coming from the DOEA programs described above. These jointly funded, community-based responses to the needs of community elders offer a model of funding leveraging and inter-agency cooperation that should be greatly expanded.

Financial Resources Allocated for Elder HCBS in SFY 2005-2006

Data collected for this project did not come from a consistently defined fiscal year. Therefore, all amounts must be considered to be estimates. That being said, an estimated **$19,573,794** was expended for DOEA programs over various 12 month periods in 2005 and 2006. Data were provided by the Area Agency on Aging, Inc. and are shown below in Table IIIB.3. Total estimated costs for the Broward County Consumer Directed Care Program in BCFY 04-05 was $476,898. In all approximately $20,000,000 in public money was expended on home and community-based elder services during 2005-2006.

Table IIIB.4. DOEA Program Expenditures for Broward County in SFY 05-06

DOEA Program	Expenditure*,**
Older Americans Act Title IIIB	1,194,172*
Local Services Program	915,818
Older American's Act Title CI	422,574*
Older American's Act Title C2	662,158*
Community Care for the Elderly	6,207,640
Home and Community-based Services Medicaid Waiver	5,448,828*
Home Care for the Elderly	707,564
Older American's Act Title IIIE	360,862*
Alzheimer's Disease Initiative	919,533
Medicaid Assisted Living Waiver	1,887,908
Respite for Elders Living in Everyday Families	168,968
Older American's Act Title IIID	71,765*
Older American's Act Title VII	11,550*
Emergency Home Energy Assistance for the Elderly	108,789
USDA Congregate Meals**	147,277
USDA Home Delivered Meals**	338,388
Total Estimated Expenditures	19,573,794

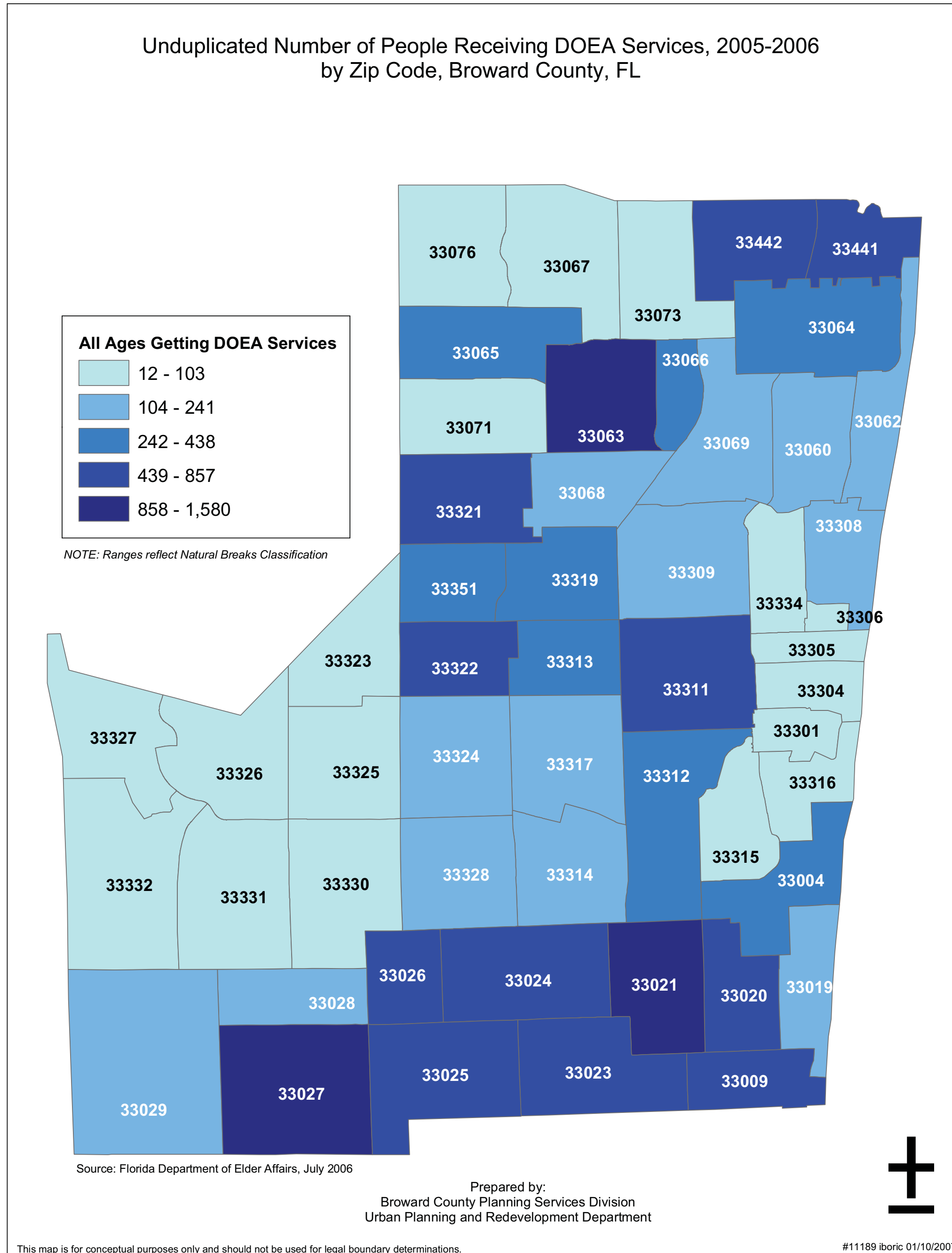
Source: Broward County Area Agency on Aging, Inc. March 2006
* Estimated due to inconsistent fiscal year periods
** Slightly different fiscal year than stated for Table 4

To understand the inadequacy of this amount in terms of meeting critical needs it must be put in context. For example, at this funding level, each of the 14,596 elders age 75+ living below the federal poverty level in 2006 would receive annual services costing $1,370, almost $600 less than the County provides for the Consumer Directed Care Program that serves elders with relatively few deficits and an active caregiver. Moreover, the average annual cost of HCBS in the CCE and Medicaid Waiver programs ranges from $9,000 to $14,700[5], with recognition that many frail elders are underserved at these funding levels.

These data are considered and reflected in the Plan.

[5] Estimates provided by HCBS lead agency in Miami-Dade County, August 2006.

Map IIIB.1



Attachment IIIC

PROJECTION OF UNMET SERVICE NEED FOR BROWARD COUNTY ELDERS 2006 AND BEYOND

Background

"Unmet service need", as applied in this section, describes the number of elders who need and qualify for community assistance with housing, transportation, home and community-based services, legal counseling, healthcare, and/or disaster planning and recovery, and who, in fact, do not receive any services or who receive less assistance than is required to meet their basic needs. It is important to remember, however, that not all elders who need and qualify will actually want services, even if those services are available, accessible, and affordable. The challenge, then, is to:

1. Identify the potential magnitude of need;
2. Estimate how much of the need is met through existing services;
3. Estimate the gap between available elder services and needed services for currently un-served or under-served[6] elders; and
4. Fill the estimated elder service gaps, to the extent possible, through community alliances while reaching out to community elders to make sure (a) they know what services are available, (b) that services are offered that elder residents will find useful and be willing to use, and (c) that services are accessible.

In this section, we estimate the potential number of Broward County elders who may require assistance in meeting one or more basic needs, including housing, transportation, home and community-based services, legal counseling, healthcare, and disaster planning and recovery assistance, and who may be receiving no assistance or less assistance than required. These estimates focus on elders with certain demographic characteristics that combine poverty, disability, living alone, and much older age, and which, according to both the literature on long-term care (Anderson, 1995; Miller & Weissert, 2000; Weissert & Matthews-Cready, 1989) and interviews with key informants regarding elders in Broward County, increase elders' risks for morbidity, mortality, or untimely custodial institutional placement. The US Census Bureau provides data on individuals or households with these characteristics, enabling us to conduct a focused analysis at the zip code level. These four indicators are:

- persons age 65+ with two disabilities
- persons age 65+ with incomes below the federal poverty level and at least one disability
- persons age 75+ with incomes below the federal poverty level
- persons age 75+ and living alone

[6] Identifying an elder person as un- or under-served implies the individual is aware of service options and able to access services they need **and** want.

County-wide data on these four major risk categories is provided in Table IIIC.1:

Table IIIC.1: Profile of Elders in Broward County Likely to Need Assistance with Housing, Transportation, Home and Community-Based Services, Legal Counseling, Healthcare, and/or Disaster Planning and Recovery

Characteristic	#	%
Age 60+^	316,288	16.1%*
Age 65+ AND ≥ 2 Disabilities^^	51,975	16.4%**
Age 65+ AND Below Poverty AND ≥ 1 Disability^^^	12,358	3.9%**
Age 75+ AND Below Poverty^^^^	14,598	4.6%**
Age 75+ AND Living Alone[x]	53,542	16.9%**

** Percent of total population in Broward County. Source: 2000 Census, SF1 Table P12.
** Percent of population age 65+ In Broward County (denominator taken from 2000 Census, SF1 Table P12).
^ Source: 2000 Census, SF1 Table P12.
^^ Source: 2000 Census, SF3 Table PCT 26.
^^^ Source: 2000 Census, SF3 Table PCT 34.
^^^^ Source: 2000 Census, SF3 Table PCT 49
x Source: 2000 Census, SF1 Table P24.

In addition to the four major risk categories above, there are other characteristics that may, in combination, intensify an older person's need for assistance. County-wide data on elders with these characteristics is shown in Table IIIC.2:

Table IIIC.2: Number of Elders with Other Risk Characteristics

Characteristic	#	%*	Source
Age 85+	36,354	11.5%	2000 Census SF1 P12
People 65+ who do not speak English well or at all	13,611	4.3%	2000 Census SF3 P19
People 65+ with no high school diploma or equivalent	73,704	23.3%	2000 Census SF3 PCT25
Households where householder is 65+ where there is no telephone service (includes owner-occupied and rental households)	1,127	***	2000 Census SF3 H43
Households where householder is 75+ where there is no private vehicle available for transportation (includes owner-occupied and rental households)	26,729	8.4%	2000 Census SF3 H45
Households where householder is 75+ and housing was built before 1970 (includes owner-occupied and rental households)	28,318	8.9%	2000 Census SF3 HCT5

*People with the characteristic as a percentage of all people age 60+
*** Less than one percent

Estimates of County-wide Unmet HCBS Need

In order to calculate estimates regarding the number of elder residents in the four risk categories identified for our analysis who may have unmet service needs, we combined DOEA service program and census data. Specifically we looked at the difference between number of elders with the characteristic and number of elders any age

receiving services under one or more DOEA programs. This analysis produced the following estimates of unmet need for the four high risk indicators:

- As many as **48,511** persons age 65+ with at least two disabilities may have unmet needs. Estimated percentage of persons with this risk factor who are getting no services in the 53 Broward County zip codes ranges from 80.3% to 98.8%, and is 93.3% for the County overall (see Map IIIC.1).
- As many as **11,759** persons age 65+ with at least one disability and living below the federal poverty level may have unmet needs. Estimated percentage of persons with this risk factor in the 53 Broward County zip codes who are getting no services ranges from 86.2% to 99.2%, and is 95.2% for the County overall (see Map IIIC.2).
- As many as **13,065** persons age 75+ and living below the federal poverty level may have unmet needs. Estimated percentage of persons with this risk factor in the 53 Broward County zip codes who are getting no services ranges from 52.7% to 93.3%, and is 61.5% for the County overall (see Map IIIC.3).
- As many as **32,920** persons age 75+ who live alone may have unmet needs. Estimated percentage of persons with this risk factor in the 53 Broward County zip codes who are getting no services ranges from 74.5% to 98.2%, and is 89.5% for the County overall (see Map IIIC.4).
- **Elders age 75+ who live alone are significantly more likely to be receiving DOEA services than those in the other three risk categories** – 61.5% of elders age 75+ who live alone are not getting services compared to 93.3%, 95.2%, and 89.5% of persons 65+ with two disabilities, 65+ with at least one disability and living below the federal poverty level, and 75+ and living below the federal poverty level, respectively. However, in some zip codes, particularly those with relatively small number of elders, being age 75+ and living alone did not seem to reduce the percentage of people in the risk category not receiving services.

Notably elder service data regarding public housing, special transportation services, and enrollment in entitlement programs such as Medicaid, were not included in this analysis. Therefore we cannot rule out that some of the elders not receiving HCBS funded by the Florida DOEA are not, in fact, benefiting from services under one or more of these other programs.

Although there is no way to accurately estimate the cost of meeting existing unmet or under-met needs, the following example provides some insight. If 20% of persons age 65+ with at least one disability and living below the federal poverty level (the high risk factor showing the lowest number of persons who may have unmet needs) were to receive services based on a $2,000 per person annual care plan, the added cost over the current $2 million in public funding would be $4,703,600. Based on the other information presented in this section, there is certainly reason to believe that many more elders require services and the costs for those additional services would be substantial.

Zip Code Specific Data

Table IIIC.3 shows occurrence of risk characteristics, by zip code[7], ordered according to number of elders receiving DOEA services, in descending order. Cells shaded in the darkest blue mark the 10 zip codes with the highest number of elders or households with the specified characteristic (1st – 10th). Zip codes marked by medium blue and light blue shading identify those with the 11th – 20th highest number of people/households and 21st – 30th highest number of people/households, respectively.

Table IIIC.3 offers a visual tool that will help the Broward County Aging Alliance with their strategic planning agenda. Aging Alliance members are encouraged to examine the following:

- Zip codes with elevated occurrence of high risk characteristics along with characteristics that, in combination with others, create or increase risk for needing services from multiple community sectors. Most of the zip codes in the first quarter of the table meet these criteria, with the possible exception of 33025 and 33026.
- Zip codes that would require special attention in all hazard planning and recovery as indicated by presence of relatively large number of elders/elder households with one or more of the following characteristics: living below the federal poverty level, without vehicles or telephones, in older housing, 85+, with no English or poor English language skills (see Maps IIIC.3, IIIC.6, IIIC.7, IIIC.8, IIIA.2, IIIA.8, IIIA.9).
- Zip codes with large numbers of elders age 60+ who do not have characteristics of high risk of needing services, but may need outreach with a heavy focus on healthy aging strategies.
- Zip codes that may currently require little special emphasis on current services, but that should be monitored over time to detect changes in the elder population that may indicate a need for increased attention and services in the future.

[7] Fifty-three zip codes are included. Two additional Broward County zip codes had no elder residents.

Table IIIC.3. Number of Elders or Elder Households with Risk Characteristics Indicating Relatively High Need for HCBS, by Zip Code

	City	# All Ages Getting DOEA Services	#60+	Elder Characteristics With Known High Risk for Needing Services				Elder Characteristics That, In Combination With Others, Create or Increase Risk for Needing Services						
				# 75+ Living Below FPL	# 75+ Living Alone	# 65+ ≥ 1 Disability, Living Below FPL	# 65+ ≥ 2 Disabilities	# 85+	#65+ With No Telephone	# 65+ With ≤ High School Diploma or Equivalent	# 75+ With Self-Care Disability	# Householder 75+ in Housing Built Before 1970	# 65+ Speak English Poorly or Not At All	# Households 75+ No Vehicle available
33027	Hollywood	1,580	10,574	582	2,437	399	1,884	1,161	8	2,601	659	48	422	1,468
33021	Hollywood	1,069	12,630	611	2,308	588	2,413	2,074	22	2,818	983	1,532	483	1,077
33063	Pompano Beach	1,040	13,650	786	2,933	650	2,513	2,317	19	3,437	897	512	318	1,377
33024	Hollywood	857	8,549	375	936	382	1,688	744	19	2,829	442	893	926	471
33311	Ft. Lauderdale	842	9,277	561	880	779	1,815	854	165	3,737	487	1,146	293	718
33442	Deerfield Beach	795	13,594	830	3,787	541	2,621	3,422	62	2,715	1,003	399	175	2,463
33026	Hollywood	793	5,079	115	741	79	719	418	0	904	265	58	172	297
33025	Hollywood	666	5,546	309	715	219	766	625	5	1,380	254	88	356	253
33023	Hollywood	658	7,460	353	640	398	1,401	567	80	2,322	468	1,252	628	539
33322	Ft. Lauderdale	623	14,819	827	3,608	527	2,895	2,541	0	3,173	1,096	319	456	2,029
33020	Hollywood	589	6,868	439	1,141	419	1,293	950	160	2,106	457	1,363	335	762
33009	Hallandale	558	13,689	830	2,892	752	2,038	2,136	76	4,135	688	2,245	937	1,784
33321	Ft. Lauderdale	546	17,039	523	3,098	277	2,131	2,156	20	2,981	727	359	250	1,223

Legend: Highest (1-10); Next Highest (11-20); Third Highest (21-30); All Others

Legend: Highest (1-10) | Next Highest (11-20) | Third Highest (21-30) | All Others

	City	# All Ages Getting DOEA Services	#60+	Elder Characteristics With Known High Risk for Needing Services				Elder Characteristics That, In Combination With Others, Create or Increase Risk for Needing Services						
				# 75+ Living Below FPL	# 75+ Living Alone	# 65+ ≥ 1 Disability, Living Below FPL	# 65+ ≥ 2 Disabilities	# 85+	#65+ With No Telephone	# 65+ With ≤ High School Diploma or Equivalent	# 75+ With Self-Care Disability	# Householder 75+ in Housing Built Before 1970	# 65+ Speak English Poorly or Not At All	# Households 75+ No Vehicle available
33441	Deerfield Beach	523	5,946	273	999	323	874	708	56	1,615	247	856	177	376
33319	Ft. Lauderdale	438	14,694	851	3,167	609	2,487	2,757	19	3,189	789	945	283	1,619
33313	Ft. Lauderdale	430	8,321	526	1,544	497	1,427	1,506	38	2,839	383	747	525	900
33064	Pompano Beach	371	10,155	472	1,583	370	1,345	1,143	32	2,480	477	1,658	250	582
33312	Ft. Lauderdale	339	6,495	344	631	329	1,107	427	36	2,031	380	987	544	344
33065	Pompano Beach	304	6,007	282	1,023	252	1,296	989	16	1,386	426	161	308	727
33351	Ft. Lauderdale	271	3,807	319	402	328	636	782	0	933	269	64	282	321
33004	Dania	268	9,646	216	446	147	544	373	28	1,073	201	266	113	198
33066	Pompano Beach	268	3,409	221	2,430	120	1,158	1,554	17	1,630	444	179	51	734
33068	Pompano Beach	241	4,985	193	616	209	1,157	554	0	1,694	387	271	395	264
33060	Pompano Beach	237	5,810	294	1,000	352	1,046	1,007	8	1,585	277	895	200	506
33314	Ft. Lauderdale	192	3,117	110	342	106	473	233	3	793	78	147	104	170
33328	Ft. Lauderdale	187	2,620	50	224	69	354	177	8	538	55	130	96	107

				Elder Characteristics With Known High Risk for Needing Services				Elder Characteristics That, In Combination With Others, Create or Increase Risk for Needing Services						
	City	# All Ages Getting DOEA Services	#60+	# 75+ Living Below FPL	# 75+ Living Alone	# 65+ ≥ 1 Disability, Living Below FPL	# 65+ ≥ 2 Disabilities	# 85+	#65+ With No Telephone	# 65+ With ≤ High School Diploma or Equivalent	# 75+ With Self-Care Disability	# Householder 75+ in Housing Built Before 1970	# 65+ Speak English Poorly or Not At All	# Households 75+ No Vehicle available
33029	Hollywood	183	2,533	16	37	42	296	108	0	461	63	0	277	20
33324	Ft. Lauderdale	180	8,490	155	1,114	140	1,231	849	22	1,312	306	271	232	407
33019	Hollywood	165	6,957	289	1,492	191	1,282	1,246	21	1,305	611	1,114	199	835
33028	Pembroke Pines	152	11,381	40	21	6	143	58	0	276	48	0	205	0
33062	Pompano Beach	152	7,947	500	1,919	316	1,577	1,540	21	1,636	548	1,766	147	711
33069	Pompano Beach	152	1,418	223	1,618	220	1,149	1,329	34	1,326	455	416	146	731
33309	Ft. Lauderdale	136	5,974	327	674	293	896	743	10	1,152	362	462	207	347
33317	Ft. Lauderdale	136	4,645	258	569	189	723	529	17	1,080	268	630	259	206
33308	Ft. Lauderdale	113	11,036	392	1,971	269	1,438	1,420	8	1,617	459	2,292	276	743
33334	Ft. Lauderdale	103	4,520	216	504	133	721	501	9	1,135	292	734	309	175
33304	Ft. Lauderdale	95	3,467	174	648	196	603	429	22	505	179	855	94	403
33315	Ft. Lauderdale	91	2,105	84	355	89	303	182	0	518	97	453	90	173
33073	Pompano Beach	88	2,717	94	164	77	274	129	11	566	67	0	75	28
33325	Ft. Lauderdale	88	2,359	66	169	61	388	120	16	622	83	8	144	64

Legend: Highest (1-10); Next Highest (11-20); Third Highest (21-30); All Others

	City	# All Ages Getting DOEA Services	#60+	Elder Characteristics With Known High Risk for Needing Services				Elder Characteristics That, In Combination With Others, Create or Increase Risk for Needing Services						
				# 75+ Living Below FPL	# 75+ Living Alone	# 65+ ≥ 1 Disability, Living Below FPL	# 65+ ≥ 2 Disabilities	# 85+	#65+ With No Telephone	# 65+ With ≤ High School Diploma or Equivalent	# 75+ With Self-Care Disability	# Householder 75+ in Housing Built Before 1970	# 65+ Speak English Poorly or Not At All	# Households 75+ No Vehicle available
33071	Pompano Beach	77	2,778	63	147	41	364	207	0	362	148	0	94	56
33326	Weston	76	3,570	57	245	65	320	171	0	602	107	35	269	77
33331	Ft. Lauderdale	47	1,547	15	31	33	176	80	0	264	60	0	106	13
33330	Ft. Lauderdale	46	1,105	5	36	6	134	57	0	175	44	0	32	27
33305	Ft. Lauderdale	37	2,322	77	338	82	380	221	21	300	90	337	58	57
33316	Ft. Lauderdale	35	3,053	82	470	50	430	402	9	281	110	658	10	123
33067	Pompano Beach	30	1,510	0	48	0	203	94	0	282	107	9	74	17
33301	Ft. Lauderdale	26	1,951	36	268	35	211	201	9	183	60	483	22	101
33332	Ft. Lauderdale	24	303	0	1	0	45	7	0	44	7	0	17	0
33327	Weston	23	806	0	10	0	40	18	0	115	14	0	89	8
33323	Ft. Lauderdale	22	1,461	43	32	23	195	72	0	351	106	0	102	30
33076	Pompano Beach	21	957	30	13	13	91	38	0	137	34	0	13	0
33306	Ft. Lauderdale	12	965	64	125	67	281	125	0	173	90	275	39	68

Legend: Highest (1-10); Next Highest (11-20); Third Highest (21-30); All Others

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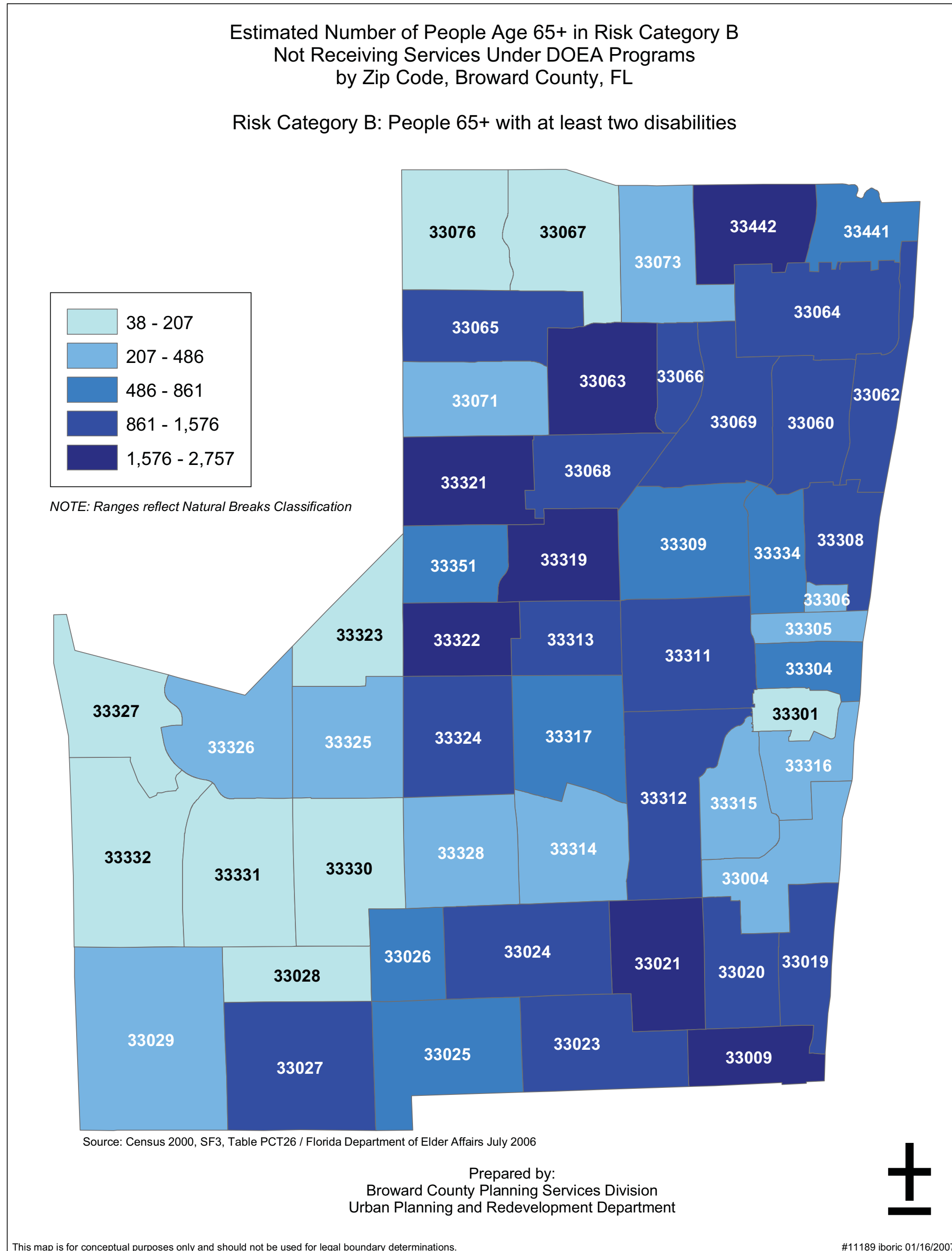
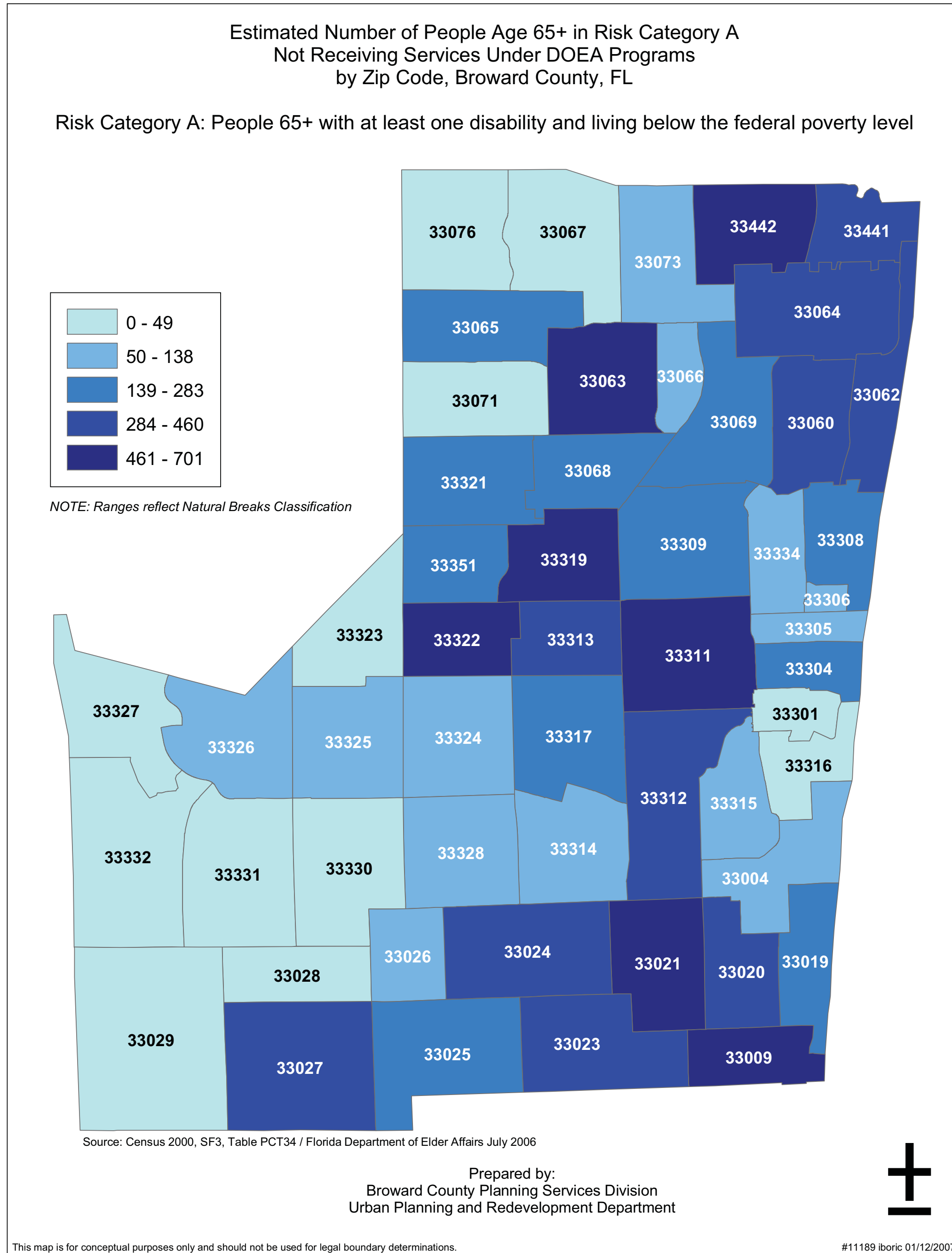
Weissert, W.G. & Mathews-Cready, C. (1989). Toward a Model for Improved Targeting of Aged at Risk of Institutionalization. *Health Services Research,* 24(4), 485-509.

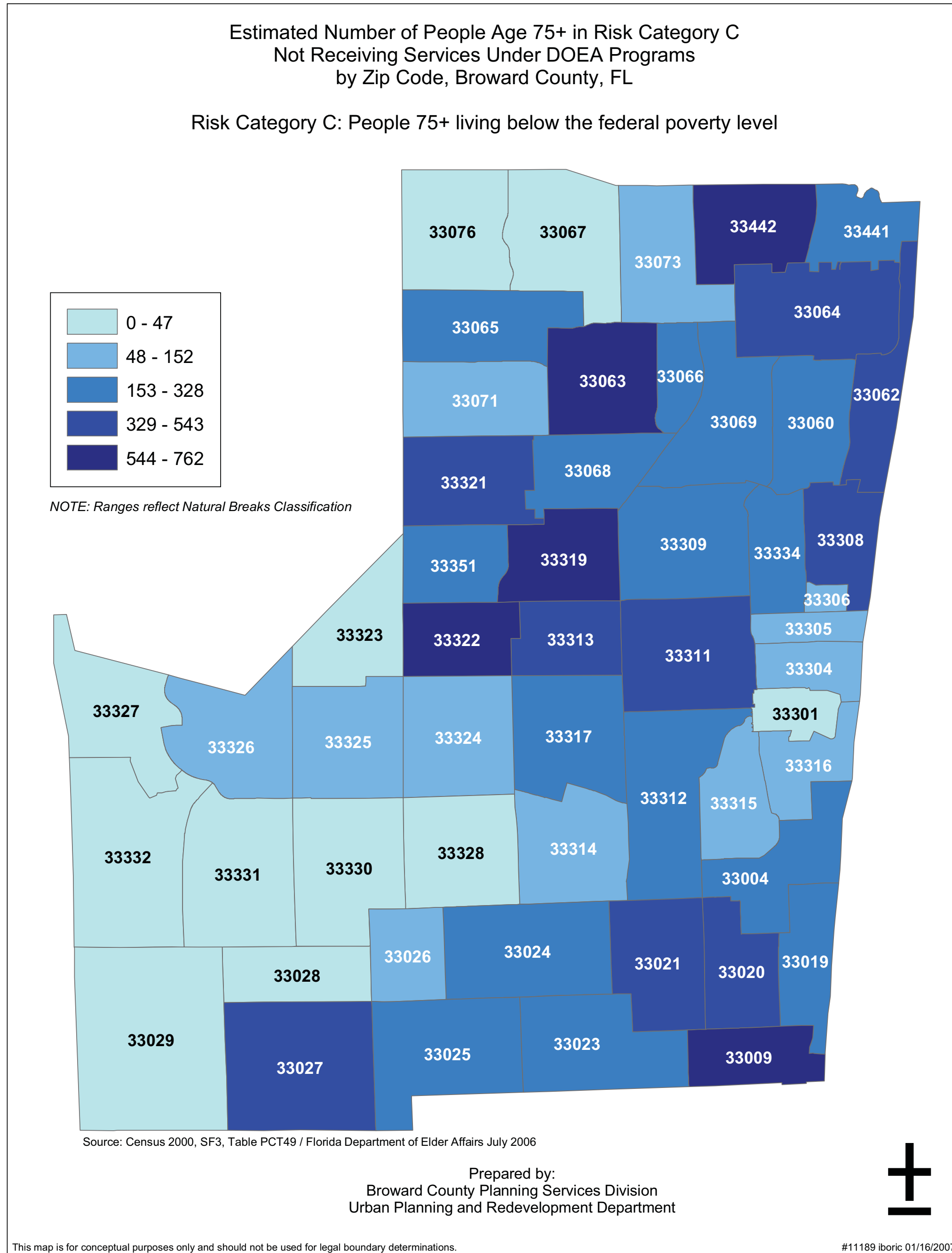
Map IIIC.1



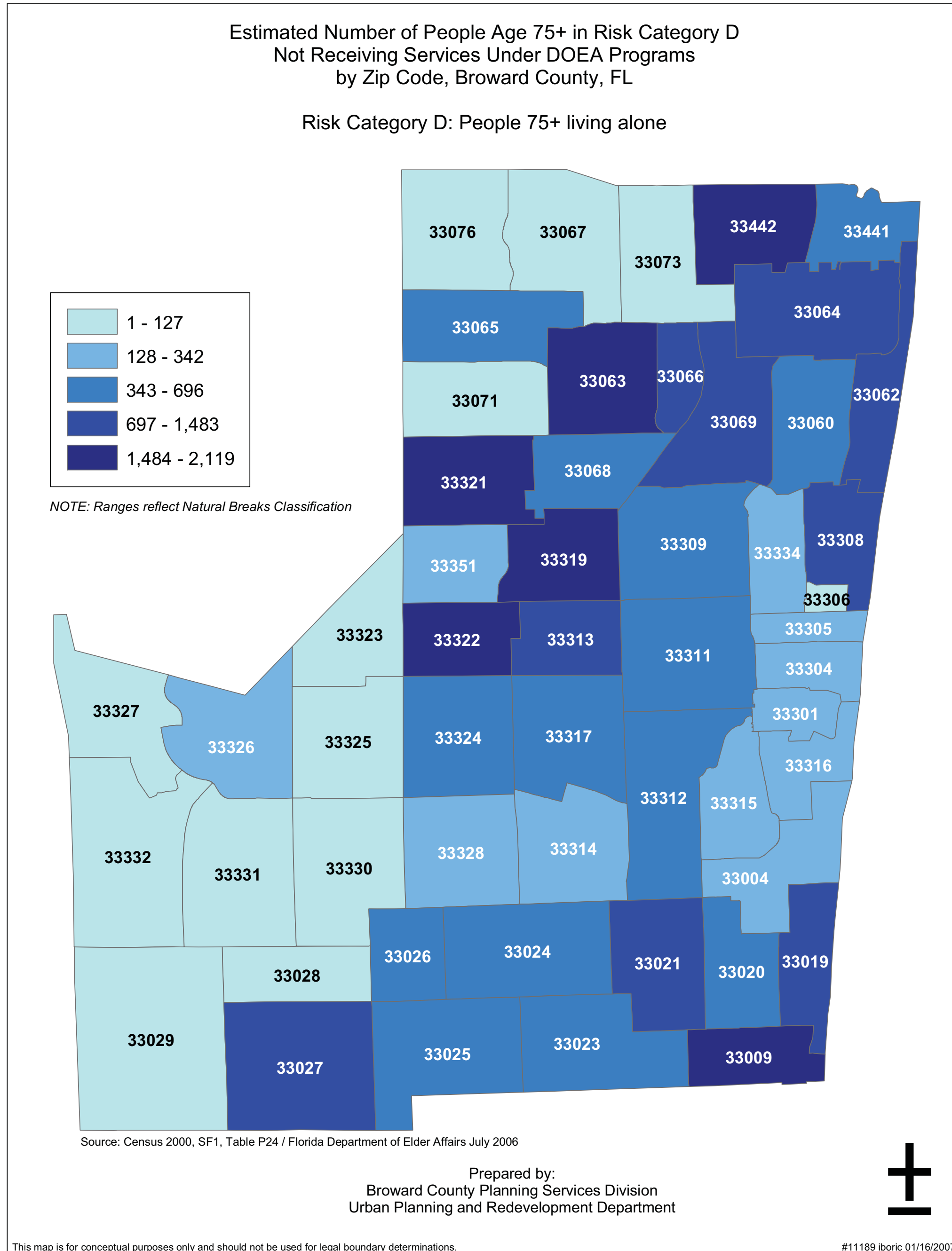
Map IIIC.2



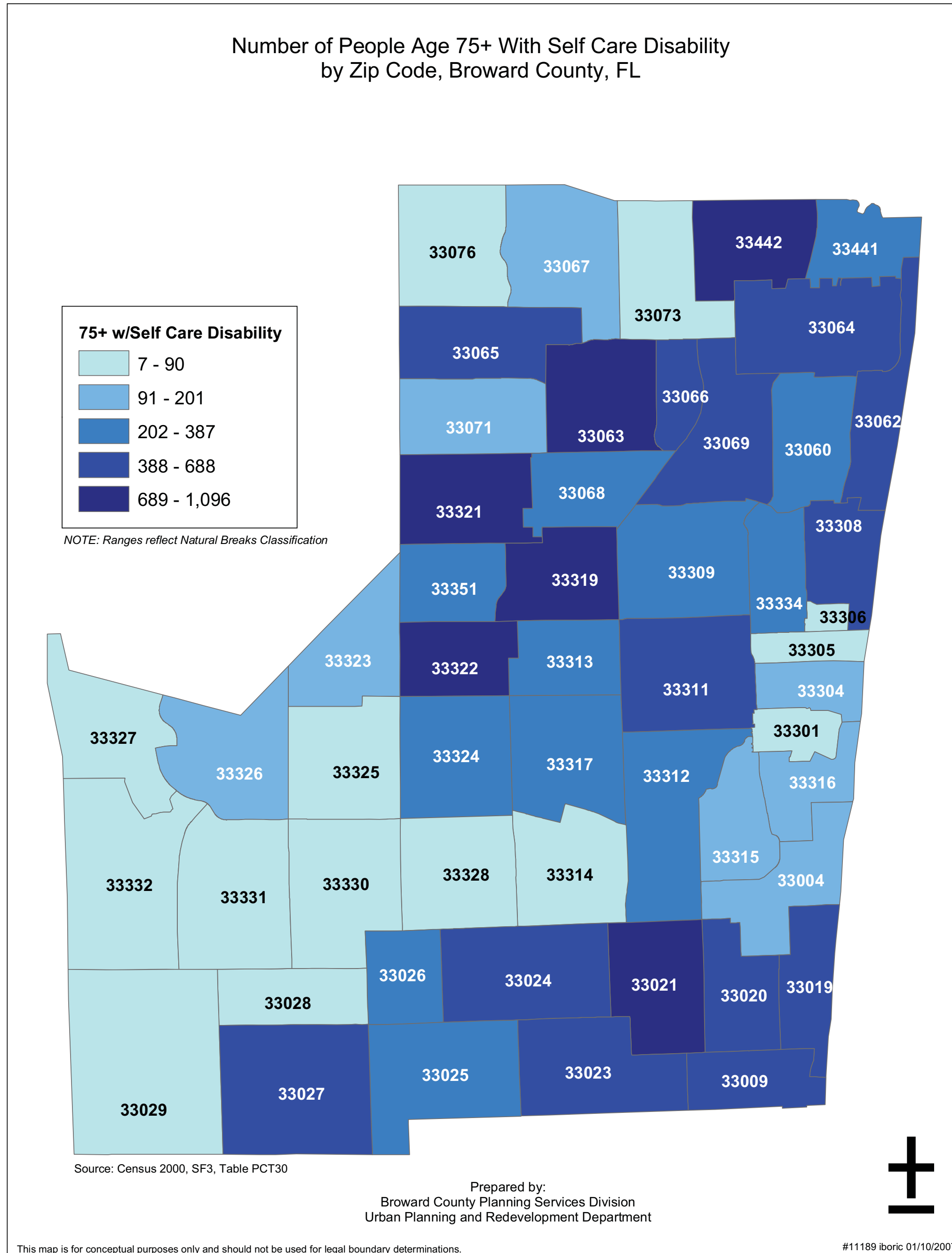
Map IIIC.3



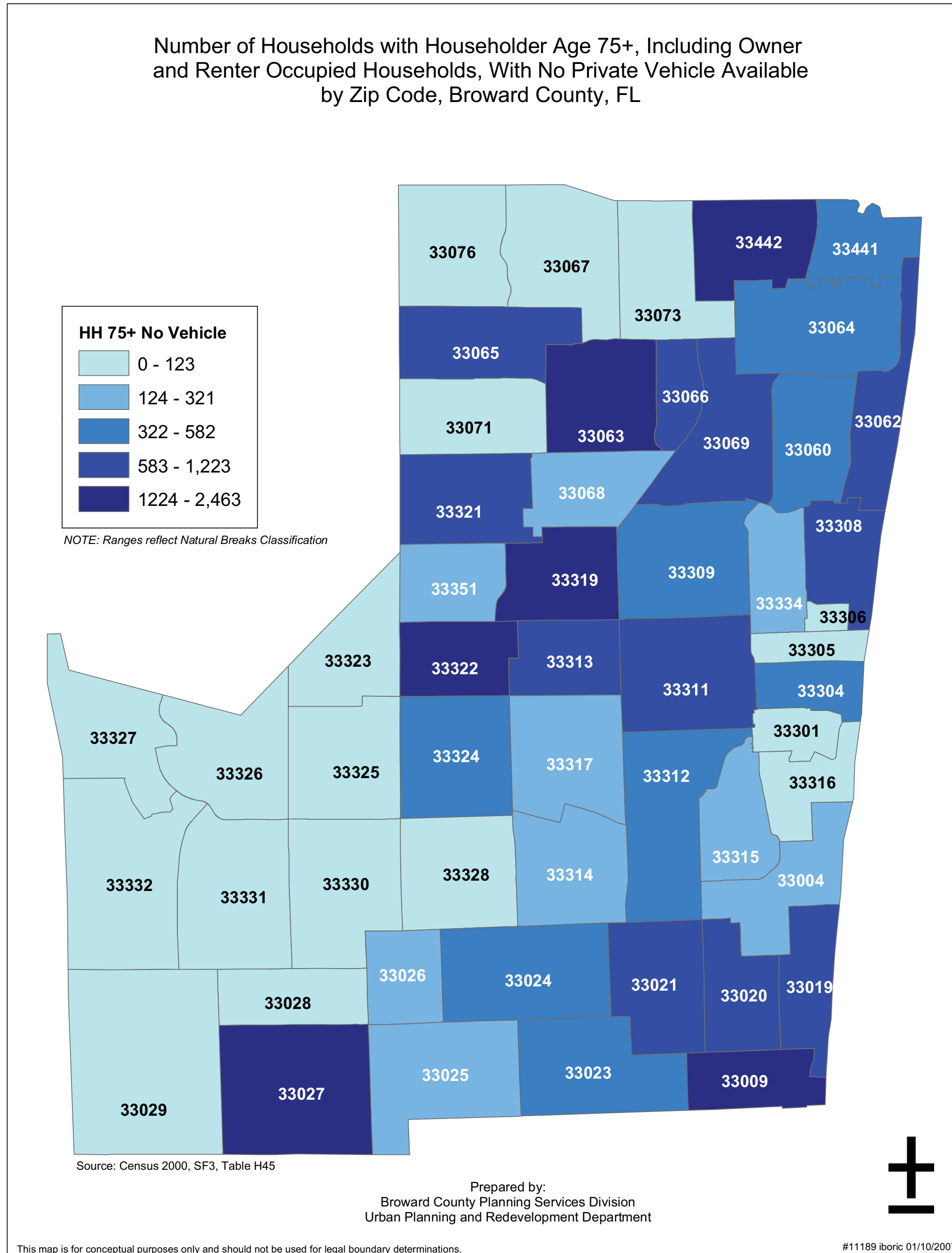
Map IIIC.4



Map IIIC.5



Map IIIC.6



Map IIIC.7

Number of People Age 65+ With No Telephone Service by Zip Code, Broward County, FL

65+ and No Telephone

- 0 - 5
- 6 - 17
- 18 - 38
- 39 - 80
- 81 - 165

NOTE: Ranges reflect Natural Breaks Classification

33076
33067
33073
33442
33441
33064
33065
33066
33062
33071
33063
33069
33060
33068
33321
33308
33309
33351
33319
33334
33306
33323
33322
33313
33305
33311
33304
33327
33301
33326
33325
33324
33317
33312
33316
33315
33332
33331
33330
33328
33314
33004
33026
33024
33021
33020
33019
33028
33025
33023
33009
33027
33029

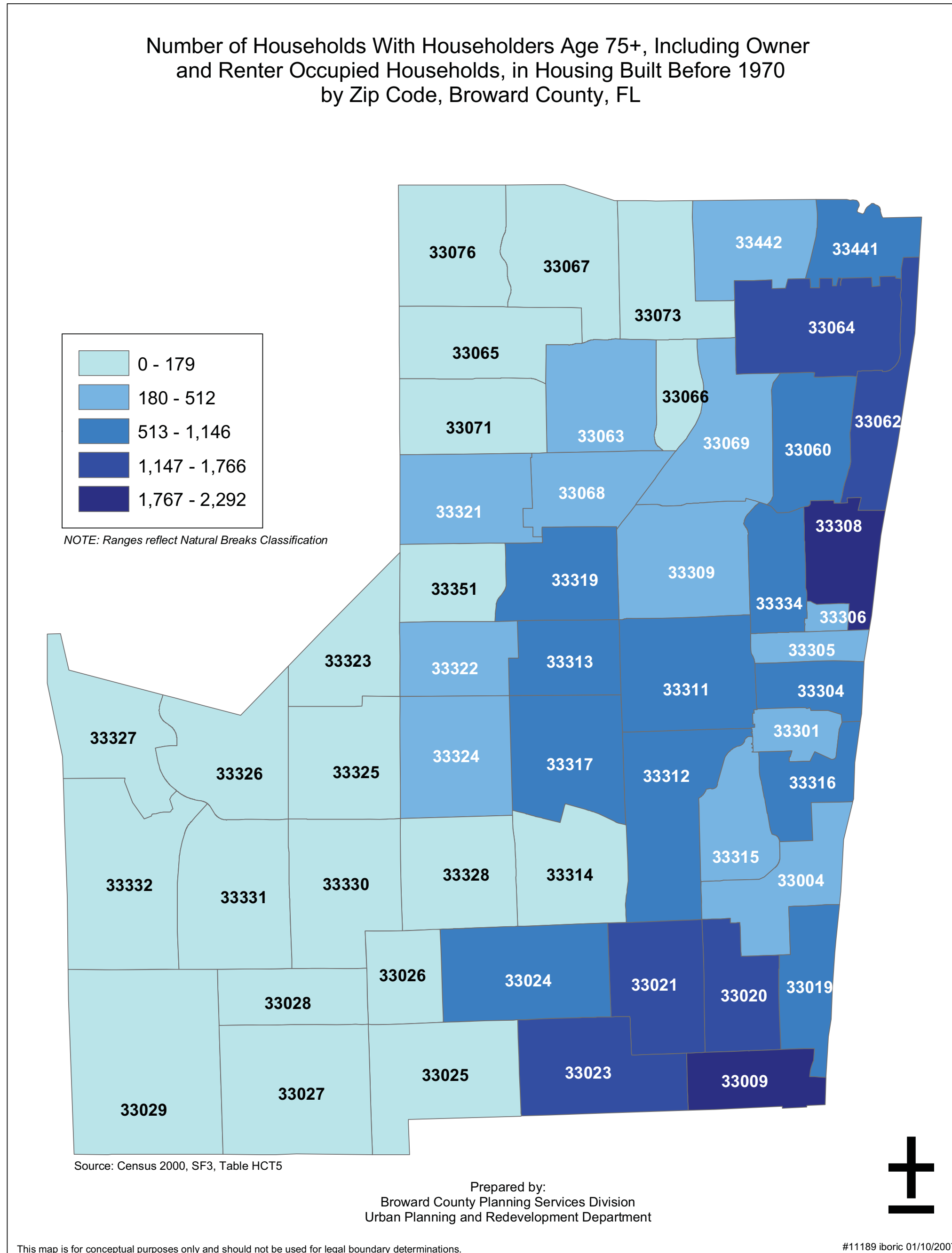
Source: Census 2000, SF3, Table H43

Prepared by:
Broward County Planning Services Division
Urban Planning and Redevelopment Department

This map is for conceptual purposes only and should not be used for legal boundary determinations.

#11189 iboric 01/12/2007

Map IIIC.8



Attachment III.D
SUMMARY OF KEY INFORMANT INTERVIEWS

The project team conducted personal interviews with 18 key informants who were selected by the Elderly and Veterans Services Division as representative of County and non-profit agencies with elder constituents or clients, which address a range of service needs, including substance abuse, mental health, HIV/AIDS, transportation, elder abuse, volunteerism, gay, lesbian, bi-sexual, and transgender elders, public and low-income housing, guardianship and the courts, homelessness, emergency management, Hispanic-serving, and persons with disabilities. The group was not intended to be inclusive of all providers, but rather it was intended to generate qualitative data based on opinions about priority issue areas effecting elders that should be addressed in Broward County. Together with other data obtained in this elder analysis update, including the elder and caregiver survey, the provider survey, the demographic and utilization analysis, literature review and senior summit feedback, conclusions from these data are used to help identify problems and issues for further analysis, strategy development, and action by the community.

Interviews were conducted based on a structured protocol. The following is a summary of the responses, by question.

1. **What are the critical issues facing older persons living in Broward County in 2006 that need to be addressed by the community? (listed in order of frequency)**

    1. Affordable Housing: Rapidly worsening because of increased costs, taxes, insurance, fewer trailer parks, condo conversions, the effects of recent hurricanes and slow response of insurers and government agencies to funding repairs. Increase in homelessness among those 50 and above reported.

    2. Transportation: Capacity issues, particularly lack of drivers, result in wait lists for programs, and reliable or unacceptably lengthy special transportation services. Particularly affects elders with accessibility impairment and those living alone.

    3. Mental Health and Substance Abuse: Elders experiencing depression, isolation, and confusion, alcohol and prescription drug abuse, cognitive impairment and dementia, and abuse, neglect, or exploitation. Preventive services are virtually non-existent. Services for acute and, particularly, chronic sufferers are inadequate and, in some cases, not reflective of state-of-the-art treatment. Many newer medications found to be effective are prohibitively expensive.

    4. Access to Healthcare: Issue raised in connection with elders with or at risk of contracting HIV/AIDS, including denial of the problem by consumers, education

of all service providers, and resolution of Medicare issues that impact service delivery.

5. Communication with elders about the availability of services and how to access the services system, including improvements in Information and Referral.

6. Insufficient funding for elder services, including HCBS, housing, transportation, healthcare, injury/disease prevention and health promotion, and elder justice. Many respondents talked about importance of establishment of an independent taxing district to help address funding shortfall.

7. Insufficient funding for public guardians and a need for more professional guardians.

8. Strategy to encourage elders to develop personal disaster plans.

9. Workforce issues, including numbers of workers available, training, and retention. Also both employment and volunteer opportunities for elders need to be increased.

10. Language and cultural barriers, particularly affecting Hispanics and Haitians. Many agencies now have bi-lingual staff. Also, elders who only speak English sometimes have difficulty understanding English-speaking Hispanics and Haitians because of pronounced accents.

2. What are the critical issues facing the service delivery system(s) that provides support and services to older persons in Broward County? (listed in order of frequency)

1. Funding in all service sectors inadequate to meet needs, particularly for middle- and low-income elders. Results in long wait lists for many services, including transportation, public and low-income housing, and home and community-based services. Other elder service sectors affected by inadequate funding include the mentally ill, those with multiple chronic diseases, the developmentally disabled, those with HIV/AIDS, those with physical disabilities requiring home modification or repair, court monitoring of wards, and staffing in all elder-serving agencies.

2. Lack of a streamlined client intake system that maximizes resources and shares essential service need and service delivery information. Too many elders uneducated about or unaware of services and not enough community education and outreach aimed at elders and at the broader community.

3. Need for more comprehensive disaster planning among agencies serving elders and all elders, even those not receiving services. Need for

implementation of best practices to address this issue, e.g., decentralizing planning to the neighborhood or condo level.

4. Coverage for mental and behavioral health services not adequate in many managed healthcare, long-term care, and home and community-based services plans. Additionally, many elders continue to be resistant to this type of assistance.

5. Greater understanding of the specialized needs of older persons and their caregivers, especially regarding mental health and substance abuse, disaster planning and recovery, and long-term care planning, by persons in all agencies that include elder clients.

6. Staffing issues, including a severe driver shortage for paratransit.

7. Improvements to the Guardianship Examining Committee and more extensive monitoring of wards needed.

3. Which aspects of the current array of services available to older adults in Broward County most need to be improved? Address both funding and operational issues.

1. Public and affordable housing, including expansion of home repair and modification programs.

2. Home-delivered services.

3. Expansion of Med Waiver to include more intensive services to older persons with developmental disabilities who are living longer.

4. Guardianship issues, including more education of professionals about appropriate referrals, more public guardians, and increased funding for appropriate placements in the community for wards.

5. Mental health services, including case management.

6. Day-time drop-in centers.

7. Services for persons 50 and over with HIV/AIDS.

8. More public busses, together with covered bus stops and benches.

9. Comprehensive assessments at the front end to better link providers and coordinate care.

10. Health services for immigrants without Medicare, e.g., flu shots.

11. Outreach to increase personal disaster plans.

12. Expansion of special transportation to include taking nursing home residents to the doctor.

4. Are you aware of any geographic areas in the County that are difficult to serve and/or where unmet service needs of older persons are particularly problematic?

1. West Broward - services traditionally have been located in the older, poor areas to the East.

2. Suburban areas where there is little or no public transportation, and where lower- to middle-income persons, above Medicaid eligibility levels, reside.

3. Hispanics in southwest Broward - Miramar, Pembroke Pines, Hollywood, and Tamarac were identified by key informants as having substantial numbers of older Hispanics.

4. Extreme north and south areas with substantial minority elder populations.

5. Central Broward with larger numbers of elder African-Americans and Haitians.

6. Communities should adopt the investment policies of communities like Pembroke Pines and Lauderdale Lakes by funding services and activities for older persons.

5. Within the Broward County elder service system, what are the challenges and barriers to effectively serving ethnic and cultural elder sub-populations?

1. Although cultural competency has been improving, all agencies need to communicate effectively with each cultural group in the community, including Whites.

2. Hispanics and African-Americans tend to be underserved; for example, it has been difficult to reach either group with behavioral health services.

3. A substantial challenge exists in reaching out to Haitian elders.

4. Guardianship is very low for Hispanics, high for African-Americans.

5. There are few Hispanics served in the homeless shelter.

6. Most healthcare providers are not Spanish-speaking. Also, Hispanics have difficulty paying for services (immigration issues tend to keep Hispanic elders

silent about healthcare needs and they use the emergency room only when seriously ill).

6. **Within the past two years, what initiatives has your agency undertaken to directly address consumer choice, consumer-centered service systems, one stop, and/or centralized resource centers to help older persons in Broward County? Are you aware of any such initiatives by other agencies or county-based consortiums?**

    1. The county administers a consumer-directed care plan.

    2. The Aging and Disabled Resource Center (ADRC) is a centralized service for elders and those with mental health problems, providing more consumer choice.

    3. Mental health services are more centralized and consumer-driven with the goal of empowering consumers.

    4. Developmental Services providers are serving more elders along a continuum of services with a goal of greater empowerment.

7. **In the next series of questions we want to learn about any formal or informal coalitions or partnerships that jointly address the needs of older adults: (a) Are you aware of any such coalitions/partnerships? Please describe. (b) Does your agency participate in any of these groups? (c) What service needs of older adults are being addressed by formal or informal partnerships at this time? Are any new partnerships planned within the next two years? (d) Do you believe participants in this coalition(s) have a good understanding of how their services interrelated in affecting older persons who receive services from more than one service agency or provider (e.g., multiple case managers)? (e) Among participants in these formal/informal partnerships, are unmet needs or waiting lists specifically addressed? Is there a written action plan? (f) Do any of these partnerships/coalitions rely on joint funding? (g) Are you aware of any providers/funders that offer services or funding resources that are important to older adults, which don't participate in any local partnerships or coalitions?**

    1. The Area Agency for Aging/Aging and Disabilities Resource Center contracts with many local providers to deliver home and community-based services funded by federal and local programs.

    2. The Aging Alliance is well-recognized and is helping to bring organizations together to network and to address common issues in the community but needs to become more formalized, including development of a plan of action with designated goals, objectives, and measurable outcomes. It should aspire to become similar to the Children's Services Council, with its own tax base

and staff, and the ability to address a broad range of community issues, including funding of services, affecting elders.

3. The Broward Coalition for Optimal Mental Health and Aging has 35 members and is well-established.

4. United Way's Long-term Recovery Coalition for disaster management includes one task force on elders.

5. The Broward Coalition on Aging and the Elder Services Resource Network consist primarily of for-profit organizations.

6. The Guardianship Association.

7. TRIAD is a partnership between the Broward Sheriff's Office, the Broward County Chiefs of Police and the Association for the Advancement of Retired Persons (AARP) and older/retired leadership in the area. This partnership works together to reduce the criminal victimization of senior citizens and enhances the delivery of law enforcement services to Broward County's elderly population. TRIAD provides the opportunity for the exchange of information between law enforcement and senior citizens.

8. Although each group or coalition has its own membership and has achieved a level of community networking, there is no overarching relationship among them. There is no community plan related to serving multiple-service clients or to addressing priority funding issues.

8. The next series of questions addresses the network of providers that serve older adults in Broward County: (a) Is there any effective formal or informal problem-solving mechanism in place to resolve conflicts that arise between providers, funders, and/or policy-makers? How are such conflicts likely to be addressed? (b) Generally, do you find that individual providers or funders consider the impact of their actions on other providers/service resources when they are addressing their own agency's needs and/or plan for the future of their programs? Can you think of any individual providers or funders you would consider exemplary in this regard? Please explain. (c) Where or how to you get useful information about new service options and promising practices for older adult services? Describe sources for local information, and any other sources.

1. In general, most problems and coordination of services are resolved informally between providers or in community meetings of organizations referenced above. Agencies have good working relationships on a day-by-day basis but the Aging Alliance offers the greatest potential for a more formal approach to planning and allocation of all available resources from a variety of service sectors.

2. Likewise, funders in Broward County have a history of informal collaboration but do not pool funding when establishing priorities or allocating resources.

3. Agencies obtain community and best practice information through participation in community meetings and through internet-based listserves.

9. Are any of the following issues of particular concern to you? If yes, please describe that concern:

1. Workforce issues: low wages and staffing at nursing homes, turnover and training in service provider agencies, bias against older worker and the need for computer training, lack of courteous behavior by paratransit employees, low wages for home health aides, and better physical space for workers to deliver services.

2. Affordable housing: lack of an adequate supply because of market forces, taxes, insurance, expensive rentals, long waiting lists of two years for Section 8 housing and nine months for public housing, increased costs of assisted living facilities, lack of knowledge by elders of community alternatives, lack of support systems for those with mental health and substance abuse problems (the hardest to place are those 55-62 who are not working), and absence of cities' involvement in responding to issues.

3. Cost-effectiveness of service options: Alliance needs to develop a strategic plan with goals, objectives, and measurable outcomes to demonstrate accountability and cost effectiveness of programs, develop a strategy to address Medicaid reform and the expansion of managed care options for elders, and educate providers about DOEA outcome measures.

4. Aging in place and consumer choice: educate the community about the effectiveness of CCE (Community Care for the Elderly) and the Medicaid Waiver in helping maintain elders in their own homes, implement Communities for a Lifetime as widely as possible throughout Broward County, encourage municipalities to expand their support of home- and community-based programs, develop a transportation strategy, and expand the use of volunteers.

5. Forecasting Service Needs: use data and findings from The Center on Aging Elder Analysis Update to develop community priorities and strategy, particularly for special populations who otherwise are not the focus of community planning, and encourage the court system to improve capability for electronic filing and data collection.

10. Identify resources that your organization has brought into the service system for older persons. (a) What new resources or funding sources to you plan to

acquire in the next few years? (b) What are the barriers to leveraging new funding for your organization?

1. New resources: Support legal authority to develop a council with taxing authority similar to the Children's Services Council, fully utilize the Department of Human Resources grants team, and continue to encourage individual and collaborative applications for new resources to identify community priorities.

2. Barriers: there was only one response to this issue which addressed the limited dollars available in the current environment to expand services and the competitive nature of obtaining more funding.

11. How would you go about making older adults in Broward County aware of the services that are available to them? In your experience, where are they most likely to turn for information?

1. Develop a strong social marketing campaign.

2. Expand the use of radio (especially for Hispanics) and TV (in all appropriate languages).

3. Expand community meetings and Health Fairs to disseminate information.

4. Involve cities to help inform about services in the same way they are involved in the County's efforts to expand disaster planning.

5. Distribute available national information about programs available in the county.

6. Use in-service training to ensure all workers are aware of and know how to access available services and other resources.

12. Can you share information with me about available services and unmet needs for older adults in any one or more of the following special populations?

1. Homeless. There is a Homeless Coalition and three homeless assistance centers but no firm data about prevalence, an increasing perception based on anecdotal information that the number of homeless elders is increasing, concern that this group is in and out of the criminal justice system, and uncertainty about the extent to which this issue is a mental health/substance abuse issue, and requires a special effort to tailor shelter space and services to addressing it.

2. Alcohol/substance abuse. This is a growing problem associated with depression, elder abuse, gambling, and suicide, not always self-identified or

acknowledged, and often addressed more within the healthcare system than by the aging network. Broward County's Elderly and Veterans Services Division administers the BRITE Project (Brief Intervention and Treatment for Elders) program funded by the Department of Children and Families, a demonstration program based on best practices that targets at risk elders.

3. Psychiatrically disabled/mentally ill. This is a major issue described above that is complicated because of housing, transportation, and service system issues already described, is often a taboo issue for elders and not self-identified, and often manifests itself upon hospital discharge. There are no reliable data on the prevalence of this issue in Broward County but it is projected to increase because of the baby boom generation now reaching retirement age. The Elderly and Veterans Services Division also is a major provider of services to this population.

4. Incarcerated or at-risk for criminal behavior. This population is also often tied to issues of mental health, domestic violence and battery, and homelessness, there is a need for an elder pre-trial assessment capability, and more treatment options like the jail release linkage program which is well regarded.

5. HIV/AIDS. The SHIP program under the Health Department is the primary program for educating elders about prevention of HIV/AIDS which otherwise is often difficult for elders to discuss, but services typically are obtained through the traditional healthcare system rather than the aging network.

13. What are your biggest concerns regarding disaster response to older adults in Broward County as it was implemented in the 2004 and 2005 hurricane seasons? What do you think worked particularly well in terms of response?

1. Concerns included the fact that too many older adults did not have personal disaster plans, particularly those in trailer parks and condos, those with special medical needs such as prescription medications or dialysis, those who are wards of the court pursuant to guardianship proceedings, and those with HIV/AIDS. Too many elders were stranded in their homes without power or support.

2. Opinion was mixed concerning the community's ability to track elders who were not on the special needs registry and in a special needs shelter.

3. Opinion was mixed concerning how well the community response was coordinated among the various entities responsible for education of elders, mobilization before and after the event, and delivery of services. Some emphasized the magnitude of issues because of the special needs of so many elders and the complexity of responding effectively, while others cited the dedication of staffs of many organizations in providing immediate

responses to needs for food, emergency funds, case management, and mental health services.

4. There is concern that there was not sufficient capability in special needs shelters to respond effectively to the disorientation and complex needs of large numbers of older persons.

5. There is no organization in charge of home repairs for those either able to remain in their own homes or those displaced.

6. Crisis counseling under Project Hope worked well.

7. Broward County was very responsive in terms of funds for emergency housing and food.

8. There were significant improvements in 2006 in preparation for disasters as a result of experiences in 2005-2006, particularly in terms of overall coordination.

14. What are your biggest concerns regarding Broward County's approach to planning for future natural or other types of disasters in terms of meeting the needs of older Broward County residents before, during, and after such events? Are you aware of any past or current planning that produced good or improved outcomes for older adults here?

1. The biggest concern is the need for aggressive outreach through a well-coordinated community response on behalf of all older persons, with particular emphasis on elders with special needs. This includes designation of one organization to coordinate agencies serving elders and to take leadership in coordination with the county, cities, and other organizations, such as the Health Department, whose responsibilities include serving all residents of Broward County.

2. There is a need to engage all Broward municipalities in planning collaboratively on behalf of older persons. State agencies and non-profit organizations all have individual disaster plans but there is still little sharing of plans and coordination of effort.

3. There is no long-range community plan for shelters and longer-range housing needs of elders.

4. Planning for individual elders should occur at the block level, supported by municipalities, to ensure that every elder has an individual plan. The County Office of Emergency Management is coordinating creation of a database of vulnerable persons that will be able to produce maps for first responders.

5. Staffs of all organizations should receive disaster preparedness training.

6. Other issues include specific preparation for other types of disasters, including pandemic flu and bioterrorism, and the need to accommodate federal and state responders, including the military, as necessary.

7. Special efforts need to be targeted to the most vulnerable, including wards of the court, homeless, those in nursing homes and assisted living facilities, older women living alone in trailer parks, those with language and cultural difficulties, those with pets, and those with other special needs.

Table IIID.1 Key Informant Interviewees:

Focus Area	Agency	Name
AIDS/HIV	Director, Senior HIV Intervention Project	Jolene Mullins
Aging/Local Service System	Director, Area Agency on Aging and Aging and Disabilities Resource Center	Edith Lederberg
Aging/Local Service System	Director, Broward Elderly and Veterans Services Division	Stephen Ferrante
Aging/Local Service System	Director, DCF Adult Protective Services	Emilio Macias
Behavioral Health	Director, DCF Substance Abuse and Mental Health Program Office	Patricia Kramer
Developmental Disabilities	Director of Habilitation Services, ARC Broward	Jody Ellis
Disability Community	Center for Independent Living	Karen Dickerhoof
Emergency Management	Director, Office of Emergency Management	Tony Carper
Emergency Management	Emergency Management Coordinator, Field Services Division, Broward County Emergency Management Operations Center	David Sandau
Employment/Volunteerism	Director, Senior Volunteers, Inc.	John Gargotta
Gay, Lesbian, Bisexual, Transgender	President, Senior Action in a Gay Environment (SAGE)	Jean Johnson
Guardianship	Director, Office of Public Guardian	Eloisa Ramos
Home Delivered and Congregate Meals	Director, Broward Meals on Wheels	Peggy Miller
Homeless	Broward Partnership for the Homeless/Inverrary Station	Lorraine Wilby
Housing	President, Elder Housing Development and Operations Corporation	Steve Protulis
Legal System	17th Judicial Circuit Court	Alexandra Rieman

Focus Area	Agency	Name
Local Government	Commissioner and Vice Mayor	Lois Wexler
Transportation	Director, Broward County Mass Transit/Paratransit	Andrea Buscada

Attachment III.E
PROVIDER/CONSUMER SURVEY RESULTS

A survey was distributed in 2006 to consumers and providers. This survey closely resembled the survey that was used for consumers in the 2001 Broward County Elder Services Analysis to enable us to compare results between respondents to the 2001 and 2006 administrations.

In 2006, the surveys were distributed in three ways. Surveys were available on-line on the Broward County website for consumers to download, complete, and mail in to the Elderly and Veterans Services Division. Additionally, printed copies of the survey were distributed to Broward Aging Alliance members who completed surveys and distributed additional copies to County aging and human services providers. These providers were encouraged to complete the survey and also to further disseminate copies to their elder and caregiver clients. Finally, when Elderly and Veterans Service Division staff made home and community visits, they offered the survey to elders and caregivers for completion.

In this section we present analysis of survey findings, by question, including comparisons of: (a) 2006 providers and consumers; (b) 2006 caregivers and consumers; and (c) 2001 and 2006 consumers,

Characteristics of the Samples

Table IIIE.1 below shows characteristics of consumer and provider respondents to the 2006 survey, including sample size.

Table IIIE.1. Characteristics of 2006 Provider and Consumer Survey Respondents

Characteristic	Providers (N=40)		Consumers (N=405)	
	n	(%)	n	(%)
Age 60 or older	9	(22.50)	320	(79.01)
Unpaid caregiver for a person age 60 or older	5	(12.50)	38	(9.38)
Service Provider/Stakeholder	28	(70.00)	0	(0)
Paid caregiver for a person age 60 or older	2	(5.00)	2	(0.49)
Currently receive at least one service or participate in at least one program for older adults	2	(5.00)	203	(50.12)

Table IIIE.2 shows characteristics of consumers, by caregiver status. Thirty nine (of the 405 consumer respondents in 2006) identified themselves as caregivers for a person

who is 60 years of age or older. The majority of the caregivers (38/39) were not paid, a third were 60 years of age or older, and a third were receiving services. Of the 366 who were not identified as caregivers 307 (84%) were elders 60+. About 16% non-caregivers are *not* elders (or did not check off 'age 60 or older'). About one half currently receive services.

Table IIIE.2. Consumer Respondents, by Caregiver Status

Characteristic	Non-Caregivers (N=366)		Caregivers (N=39)	
	n	%	n	%
Age 60 or older	307	83.88	13	33.33
Unpaid caregiver for a person age 60 or older	N/A		38	97.44
Currently receive at least one service or participate in at least one program for older adults	191	52.19	12	30.77

Table IIIE.3 below compares consumer respondent characteristics from the 2001 survey with characteristics of the 2006 sample. Note the differences in the two samples in each characteristic. In particular, almost one third of the 2001 survey respondents were caregivers (29.9%) while less than 10 percent were caregivers in 2006. Likewise, a much larger percentage of the 2006 sample (79.01%) was age 60 and older compared with the 2001 sample (64.9%). Finally, more respondents in the 2001 sample than the 2006 sample were receiving services, 57.6% and 50.12%, respectively. There differences likely contribute to some of the differences in survey responses between the two samples, as shown in Figures IIIE.1, IIIE.2, and IIIE.3.

Table IIIE.3. Characteristics of Survey Respondents, 2001 and 2006 Surveys Compared

Characteristic	Consumers 2006 (N=405)	Consumers 2001 (N=231)
Age 60 or older	79.01%	64.9%
Unpaid caregiver for a person age 60 or older	9.38%	29.9% *
Paid caregiver for a person age 60 or older	0.49%	
Currently receive at least one service or participate in at least one program for older adults	50.12%	57.6%

*The 2001 survey did not differentiate between paid and unpaid caregivers.

Survey Question 1

Survey respondents were asked: "From the following list, please check the four types of services you think are the most important for help older adults live where they choose

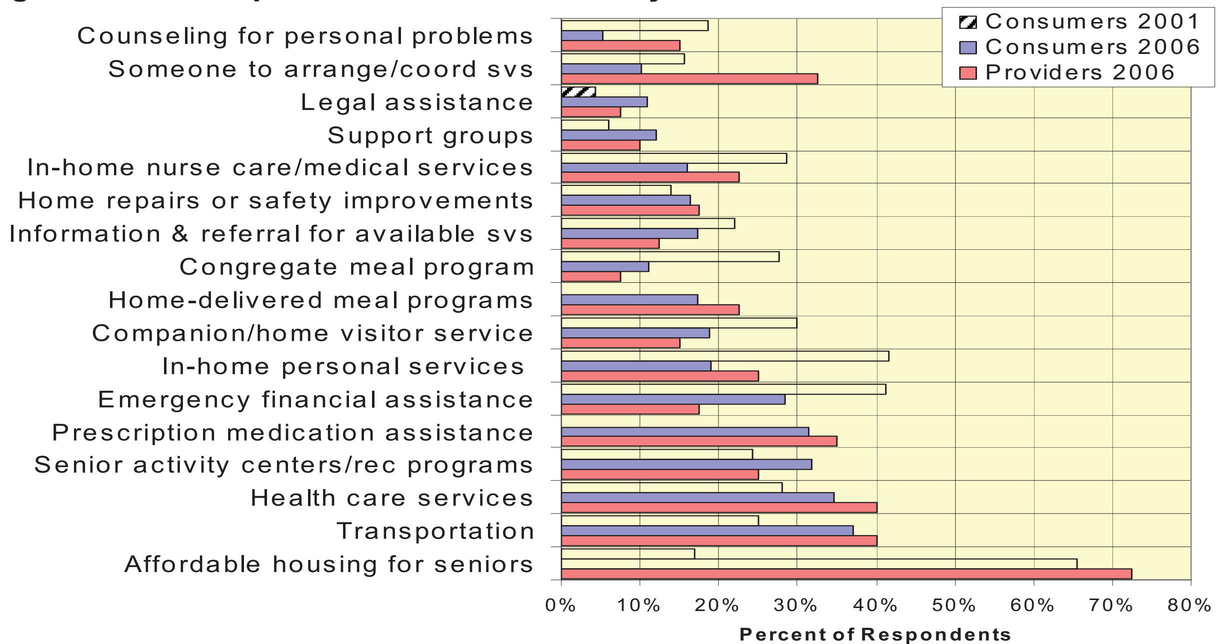
for as long as possible". Table IIIE.4 below summarizes the 10 most frequently identified services on the 2006 survey for providers and consumers. Notably the top three selections were the same for both respondent groups. The only major difference was that providers ranked case management fifth while case management was not in consumer's top 10.

Table IIIE.4. 2006 Survey Results to Question 1 Most Important Services

Response Frequency, Highest at Top	2006 Providers	2006 Consumers
1 = most	Affordable senior housing	Affordable senior housing
2	Transportation	Transportation
3	Healthcare services	Healthcare services
4	Prescription meds assist	Senior activity/rec centers
5	Person to arrange/coord svs	Prescription meds assist
6	Senior activity/rec centers	Financial assistance
7	In-home personal services	In-home personal services
8	Home-delivered meals	Companion/home visitor
9	In-home nurse/medical care	Home-delivered meals
10	Home repairs/improvements	Info/referral for available svs
	Financial assistance	

Figure IIIE.1 below shows comparative results for consumer respondents in 2001 and 2006 and for provider respondents in 2006. Notice that in contrast to 2006 results, 2001 consumers did not indicate that housing and transportation were major concerns.

Figure IIIE.1. Comparative Results for Survey Question 1, 2001 and 2006



Finally, Table IIIE.5 compares responses to question 1 between caregivers and all other consumer respondents in 2006. Highlighted are those services that were selected by 30% or more respondents in either group. Overall, the most important services for helping older adults live where they choose for as long as possible are affordable housing for seniors, transportation, health care services, prescription medication assistance, and senior centers. The difference in responses between caregivers and non-caregivers is statistically significant in the following cases:

- 39.6% non-caregivers and only 12.8 caregivers include ‘transportation’ among four most important services, this finding is statistically significant.
- non-caregivers are more likely thank caregivers to list affordable housing, emergency help necklace, and prescription medication among most important services.
- a higher proportion of caregivers (38.46%) included ‘In-home personal services (homemaker, personal care)’ among most important services, compared to non-caregivers (only 16.9%)

The following choices are not included in the table because less than 20% of both non-caregivers and caregivers selected them as most important: counseling for personal problems, congregate meal program, disaster planning and recovery, legal assistance, self-care training, someone to arrange and coordinate services; substance abuse/ misuse services; support groups; work/volunteering; and wellness, learning, and life enrichment.

Table IIIE.5. 2006 Survey Results to Question 1 Most Important Services by Caregiver Status

Service	Non-Caregivers (N=366)		Caregivers (N=39)	
	n	(%)	n	(%)
Affordable housing for seniors	248	67.76	17	43.59
Companion/home visitor service	66	18.03	10	25.64
Emergency help necklace or wristband system	77	21.04	0	0.00
Emergency financial assistance	108	29.51	7	17.95
Financial / Insurance counseling	51	13.93	12	30.77
Health care services	131	35.79	9	23.08
Home-delivered meal programs	62	16.94	8	20.51
Home repairs or safety improvements	58	15.85	8	20.51
Information and referral for available services	61	16.67	9	23.08
In-home nurse care and medical services	52	14.21	13	33.33
In-home personal services (homemaker, personal care)	62	16.94	15	38.46
Prescription medication assistance	121	33.06	6	15.38
Senior activity centers and recreation programs	109	29.78	20	51.28
Transportation	145	39.62	5	12.82

Survey Question 2

The second survey question was similar to the first, but focused on services that were most difficult to arrange to receive. Again, general there was general agreement between providers and consumers, with case management as the exception, as shown in Table IIIE.6 below. Figure IIIE.2 shows comparative results for consumer respondents in 2001 and 2006 and for provider respondents in 2006.

Table IIIE.6. 2006 Survey Results to Question 2 Most Difficult Services to Arrange

Response Frequency, Highest at Top	Providers 2006	Consumers 2006
1 = most	Affordable senior housing	Affordable senior housing
2	Prescription meds assist	Financial assistance
3	Financial assistance	Home repairs/improvements
4	Transportation	Transportation
5	Person to arrange/coord svs	Prescription meds assist
6	In-home personal services	Counseling for persnl problems
7	Healthcare services	Home-delivered meals
8	Home repairs/improvements	
9	In-home nurse/medical care	

Figure IIIE.2. Comparative Results for Survey Question 2, 2001 and 2006

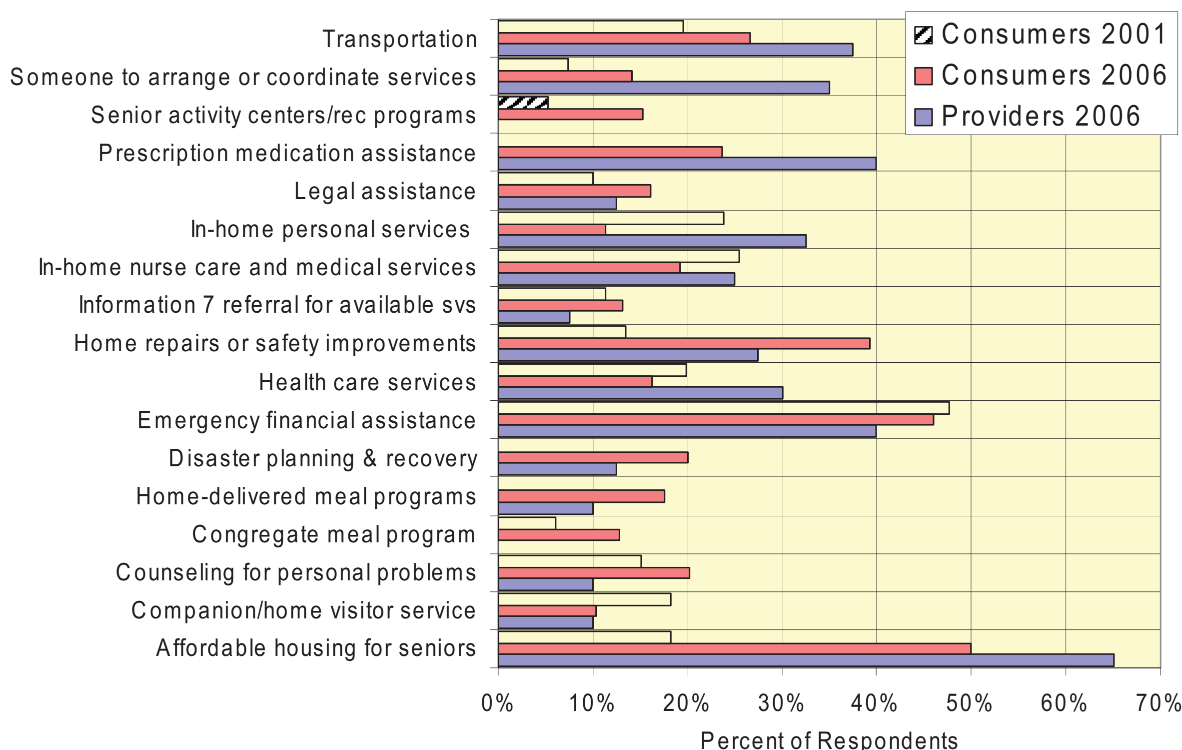


Table IIIE.7 shows services or programs most difficult for older adults in Broward County to get when they need help, by caregiver. Highlighted are services that over 30% in either group checked off. Overall, affordable housing, emergency financial assistance, and home repairs are most difficult services to get. Caregivers and non-caregivers significantly differed on some perceptions regarding the difficulty of obtaining services in the following ways:

- caregivers were more likely than non-caregivers to include 'information and referrals' among services most difficult to get.
- compared to caregivers, non-caregivers were more likely to include 'affordable housing', 'congregate meal programs', and 'legal assistance' services as most difficult to get.

The following choices are not included in the table because less than 20% of both non-caregivers and caregivers selected them as most important: companion/home visitor service; congregate meal program; emergency help necklace or wristband system; financial/insurance counseling; legal assistance; self-care training; senior activity centers and recreation programs; someone to arrange or coordinate services; substance abuse/misuse services; support groups; work/volunteering; wellness/ learning and life enrichment.

Table IIIE.7. 2006 Survey Results to Question 2 Most Difficult Services to Get by Caregiver Status

Service	Non-Caregivers (N=366)		Caregivers (N=39)	
	n	(%)	n	(%)
Affordable housing for seniors	189	51.64	13	33.33
Counseling for personal problems	72	19.67	10	25.64
Disaster planning & recovery	76	20.77	5	12.82
Emergency financial assistance	171	46.72	15	38.46
Health care services	56	15.30	10	25.64
Home-delivered meal programs	61	16.67	10	25.64
Home repairs or safety improvements	148	40.44	11	28.21
Information and referral for available services	41	11.20	12	30.77
In-home nurse care and medical services	68	18.58	10	25.64
In-home personal services (homemaker, personal care)	38	10.38	8	20.51
Prescription medication assistance	88	24.04	8	20.5
Transportation	99	27.05	9	23.08

Survey Question 3

A third survey question focused on barriers most likely to keep older adults and caregivers in Broward County from getting help they need. Table IIIE.8 compares 2006 results between consumers and providers. Overall, lack of knowledge about services and inability to pay are the most important barriers to getting help when it is needed. A significantly larger proportion of providers perceive inability to pay as a barrier,

compared to consumers (60% vs. 39.5%). Figure IIIE.3 compares results between consumer respondents in 2001 and 2006.

Table IIIE.8. 2006 Survey Barriers Most Likely to Keep Older Adults/Caregivers from Getting Help

Barrier	Providers (N=40) n (%)	Consumers (N=405) n (%)
Don't know what's available	25 (62.50)	242 (59.75)
Don't want help from strangers	1 (2.50)	53 (13.09)
Information is confusing	9 (22.50)	139 (34.32)
No Transportation	13 (32.50)	99 (24.44)
Can't pay for services	24 (60.00)	160 (39.51)
Don't trust people they don't know	9 (22.50)	117 (28.89)

Figure IIIE.3. Barriers Most Likely to Keep Older Adults/Caregivers from Getting Help, 2001 and 2006 Surveys Compared

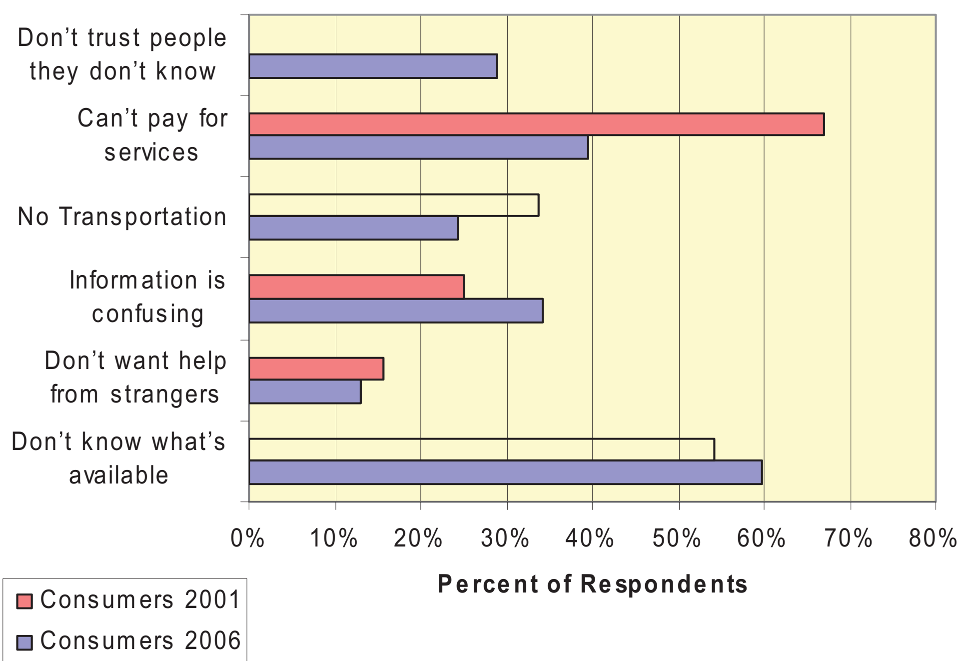


Table IIIE.9 describes 2006 consumer results, by caregiver. Highlighted are barriers that over 30% in either group checked off. Overall, lack of knowledge about services, confusing information, and inability to pay are the most important barriers to getting help when it is needed. A statistically significant larger proportion of caregivers perceive inability to pay as a barrier, compared to non-caregivers (56.4% vs. 37.7%, respectively).

Table IIIE.9. 2006 Survey Barriers Most Likely to Keep Older Adults/Caregivers from Getting Help by Caregiver Status

Barrier	Non-Caregivers (N=366)		Caregivers (N=39)	
	n	(%)	n	(%)
Don't know what's available	220	60.11	22	56.41
Don't want help from strangers	52	14.21	1	2.56
Information is confusing	122	33.33	17	43.59
No Transportation	90	24.59	9	23.08
Can't pay for services	138	37.70	22	56.41
Don't trust people they don't know	106	28.96	11	28.21

Survey Question 4

Results of the fourth question regarding disaster preparedness are reported in Attachment III.J.

Survey Question 5

The last survey question asks about sources of information that older adults and their caregivers most often use to learn about new services or community programs. Table IIIE.10 compares 2006 results for providers and consumers. Word-of-mouth, newspapers, and TV are most common sources of information about new services or community programs for older adults/caregivers. There were no significant differences between providers and consumers regarding information sources. Results were similar when we compared 2006 responses from caregivers and non-caregivers, as shown in Table IIIE.11. Notably, compared to caregivers, non-caregivers are significantly more likely to rely on TV and word of mouth as information sources.

Table IIIE.10. 2006 Survey Sources of Information that Older Adults/ Caregivers Most Often Use to Learn About New Services or Community Programs

Source	Providers (N=40)	Consumers (N=405)
	n (%)	n (%)
Ads on buses	2 (5.00)	14 (3.46)
Ads or stories on television	15 (37.50)	130 (32.10)
Ads or stories in the newspaper	12 (30.00)	158 (39.01)
Ads or stories on the radio	2 (5.00)	39 (9.63)
Call 211	3 (7.50)	14 (3.46)
Clergy	1 (2.50)	16 (3.95)
Doctor or nurse	5 (12.50)	98 (24.02)
First Call for Help	3 (7.50)	37 (9.14)
Word-of-mouth	25 (62.50)	246 (60.74)
Yellow Pages/Phone Book	0 (0)	21 (5.19)

Table IIIE.11. 2006 Survey Sources of Information that Older Adults/ Caregivers Most Often Use to Learn About New Services or Community Programs by Caregiver Status

Source	Non-Caregivers (N=366)		Caregivers (N=39)	
	n	(%)	n	(%)
Ads on buses	14	3.83	0	0.00
Ads or stories on television	128	34.97	2	5.13
Ads or stories in the newspaper	141	38.52	17	43.59
Ads or stories on the radio	38	10.38	1	2.56
Call 211	11	3.01	3	7.69
Clergy	16	4.37	0	0.00
Doctor or nurse	88	24.04	10	25.64
First Call for Help	37	10.11	0	0.00
Word-of-mouth	214	58.47	32	82.05
Yellow Pages/Phone Book	15	4.10	6	15.38

Attachment III.F
SUMMARY OF SUMMIT PROCEEDINGS AND RESULTS

The 2007 Elder Services Summit, organized by Broward County Vice-Mayor Lois Wexler in conjunction with the Broward Aging Alliance, took place on January 31, 2007 at the Signature Grand in Davie. More than 300 people participated in the day-long Summit to discuss and reach consensus on the many issues facing Broward County's elder population. Participants, who represented a cross-section of county residents, identified priorities and gaps in the services provided for elders living in Broward County.

The program included: (1) a presentation of preliminary findings from the 2006 Updated Elder Analysis for Broward County with a follow-up question and answer session; (2) themed, facilitated breakout sessions on key elder issues that provided an opportunity for detailed discussion of basic needs, disaster planning, special needs populations, and advocacy, governance, and social marketing; and (3) a closing session where groups presented major recommendations. Each participant had the opportunity to attend two breakout sessions, all of which were offered once in the morning and again after lunch. Participants in each session generated a list of action items for the County and then prioritized the list through a group consensus process.

Many action items were identified in multiple groups. Below is a list of items grouped by common themes and presented in priority order, as reflected by participant input.

- Expand awareness about elder issues and elder services county-wide. Action items in this category included: create resource list that includes public and private resources for elders and link to 211; market availability of programs and services more effectively in newspapers, radio, TV, posters, events, health fairs, and utility/tax bill inserts; take information about services and the services themselves to elders in the communities where they live.
- Expand/increase programs and services. Action items in this category included: expand services for homebound elders; expand pilots/programs that have proven to be successful; eradicate hunger.
- Increase affordable housing. Action items in this category included: government should require large buildings to set aside an established percentage of low-rent units; provide incentives for developers to refurbish or develop new affordable housing, including streamlining the process for developers to initiate such projects; create a partnership between affordable housing developers and the County/municipalities.
- Improve professionalism of direct service providers. Action items in this category included: develop/delivery training programs in basic competencies for all types of basic service providers; create strategies for professionalizing service providers; train and sensitize direct service providers to elder issues, including physicians, law

enforcement, and emergency responders; improve culturally sensitive recruitment and training of workers.

- Increase funding available for elder services. Action items in this category included: using County funding to address service gaps from federal and state funding to eliminate waiting lists; collaborate for additional funding; investigate/support more sliding-fee programs; evaluate systems/programs to better use funds and make use of partnerships to provide access to services; budget/prioritize by tiered needs; and legislate percent of casino profits for senior and disabled adult services.
- Develop public/private partnerships. Action items in this category included: bring for-profit/not-for-profit organizations together into a single referral network so that elders who have means also have access to service information; develop/market services to those who can pay and use profits to provide services for those who can't pay; and develop public/private partnerships to address need for more transportation.
- Develop one-stop centers. Action items in this category included: develop single point of entry for services; expand ADRC services with federal and state lobbying efforts/dollars; develop one-stop and centralized information; and identify initial point of contact (ADRC).
- Make elder services more effective and efficient. Action items in this category included: adopt evidence-based models like communities for a lifetime and Life: Act 2; streamline and create shared services model; and improve cooperation between aging and other services systems.
- Advocacy. Action items in this category included: teach older adults to advocate on their own behalf, including grass roots tactics; ask politicians to take action to solve housing, healthcare, and transportation problems; and create Broward aging advocacy/watchdog group; promote empowerment groups.
- Public Awareness of Elders. Action items in this category included: develop a public awareness campaign to make the community more aware of elder residents and their benefits to the community; one participant suggested a "hear me, see me" theme; and increase general knowledge about elders and decrease stigma.
- Volunteers. Action items in this category included: designate elders/guides who walk older adults through "the system"; create more effective community social support through faith-based community, adopt a grandparent program, neighborhood networks; and create volunteer corps to retrofit and repair homes with community/business sponsorships.
- Redefine "aged" by function and need. Differentiate needs across the aging population by asking people of different ages what they want and need, developing and marketing needed services.
- Support caregivers. Action items in this category included: develop policies/advocate to include caregivers as service recipients; extend community support to caregivers even after caregiving stops; conduct a stakeholder forum on caregiving; and develop outreach and support for family caregivers, including focus groups.

Additional action items, which were supported by only a few participants, but which nevertheless may be good items for the County to follow-up on include: advocate for human and civil rights for elders in condos and rentals; ensure that elders can keep pets in condos; create a safe peer network for seniors looking for housing; adopt a "home share" model; help older adults who want or need to work find jobs; provide all information in multiple languages; require all services and programs to conduct ongoing quality improvement programs; create a blog to facilitate provider communication with the Aging Alliance; provide humans to answer phones; protect rights of senior in nursing homes; and implement a program to re-involve estranged family members in senior care.

Most of these action items are reflected in The Plan. Action items related to disaster planning that were identified at the summit are described in Attachment III.J.

Attachment III.G
SPECIAL NEEDS POPULATIONS: DESCRIPTION AND RESOURCES

This Appendix provides general information regarding elders' issues in the following special needs populations:

1. Abuse, Neglect, and Exploitation
2. Alcohol and Illegal Drug Abuse
3. Involvement in the Criminal Justice System
4. Developmental Disabilities
5. Gay, Lesbian, Bisexual, Transgender
6. HIV/AIDS
7. Homelessness
8. Behavioral Health

We included as much Broward County-specific information as was available, along with national trends regarding related issues and effective community response or best practices. At the end of each of the Sections 1-8 we offer a few resources that we found helpful and that may be helpful to community planners and service providers as they become more involved in targeting services to these populations. All of the information in this Appendix was used as background in design of the Strategic Business Plan that reflects the findings of the 2006 Analysis of Broward County Elders Project.

IIIG.1. Abuse, Neglect, and Exploitation

The most recent family violence issue to gain the attention of the public and medical community is elder abuse. The American Medical Association defines elder abuse as "an act **OR** omission which results in harm or threatened harm to the health or welfare of an elderly person" (Stiles et al., 2000, pp.8). Currently in the United States elder abuse receives less attention than domestic violence or child abuse, although it is estimated 2.5-3 million senior citizens are elder abuse victims (Hall et al., 2005). All 50 states have enacted elder abuse statutes. However, each state has its own system of addressing elder abuse, resulting in many inconsistencies pertaining to reporting and responding to domestic and institutional elder abuse, neglect, and exploitation. Forty-two states, including Florida, mandate reporting of suspected elder abuse by health care professionals (Hall et al., 2005).

The National Center on Elder Abuse (NCEA) has identified the following seven categories of elder abuse: (1) physical abuse, (2) emotional abuse, (3) financial abuse, (4) sexual abuse, (5) neglect, (6) self-neglect, and (7) miscellaneous (Kleinschmidt, 1997). Hitting, grabbing, slapping, pushing, or causing bodily injury are considered forms of physical abuse. Emotional or psychological abuse is characterized by verbal or nonverbal insults, humiliation, infantilization, or threats. Theft, misappropriation of funds, and coercion are forms of financial or material abuse. Sexual abuse involves

nonconsensual intimate contact (Kleinschmidt, 1997), and occurs within families as well as in institutional settings. Neglect is the failure of a caregiver to provide basic care to a patient, such as assisting with activities of daily living (ADLs), and may be “active” or “passive”. Active neglect, which includes abandonment, is the willful failure to provide care, whereas, passive neglect describes non-willful failure due to a caregiver’s ignorance or lack of skills. Self-neglect is present when an individual’s conduct threatens his/her safety. Violation of rights, medical abuse, and abandonment fall into the category of miscellaneous elder abuse.

Exploitation of elders occurs when a perpetrator misappropriates the elder’s assets for his/her own benefit through theft, coercion (undue influence), or misappropriation. In Florida statues, the value of the assets, funds, or property involved in the exploitation determines the degree of the felony: first degree felony if funds, assets, or property involved are valued at $100,000 or more; second degree felony if value is between $20,000 and $100,000, and third degree felony if the value is less than $20,000 (Hall et al., 2005).

Perpetrators of elder abuse include family, friends, and paid caregivers. For elders living in institutional settings, abusers also may include other facility residents or institutional staff. Many studies have documented that family, including spouses and adult children, are by far the most frequent abusers of elders living in non-custodial settings. Risk factors for elder abuse include “a cycle of violence”, advanced age, increased dependency, social isolation, dementia, and behavior issues (Stiles et al., 2000). In addition, literature pertaining to elder abuse indicates elders living with someone are at greater risk of verbal and physical violence, whereas, financial exploitation is more likely to occur in elders who live alone. Elder abuse has not been correlated with religion, economic background, education, or alcohol use. Although it varies by type of abuse, approximately 25 to 30 percent of victims are males.

Between July 1, 2005 and April 30, 2006 3,186 adult abuse investigations were conducted in Broward County and, of these, 1,185 received protective supervision. Research suggests that this grossly under-states the actual number of victims. Many elders who experience abuse do not file any report and are isolated from others who might file such reports on their behalf. Additionally, many victims who could request help choose not to do so for many reasons (Beaulaurier et al., 2005; Beaulaurier et al., in press). Finally, much of the community’s response to elder abuse focuses on a “protective” response by the Department of Children and Families. Any reported elder deemed to have capacity to make [good or bad] decisions on their own behalf are able to refuse DCF services and may not be referred to other community resources that may be more in tune with their needs.

Emergency department physicians have the greatest opportunity to identify victims of elder abuse. Jones et al. (1997) surveyed a random sample of 3,000 American College of Emergency Physicians members to determine the perceived magnitude of elder mistreatment, physician awareness of applicable state laws, and the barriers to reporting suspected cases. Respondents had evaluated an average of four suspected

cases of elder mistreatment, of which only 50% were reported (Jones et al., 1997). In addition, only 31% of the emergency physicians reported having a written protocol for reporting elder mistreatment, and generally the physicians were not aware of or familiar with the application of their state's elder abuse laws.

Several studies recommend encouraging both emergency and primary care physicians to learn the signs of elder abuse because they can play an integral role in the prevention, identification, assessment, and management of elder abuse. Physical signs of elder abuse include weight loss, dehydration, poor hygiene, traumatic Alopecia, poor oral hygiene, absent devices such as hearing aids, dentures, or eyeglasses, hematomas, welts, bites, bruises, burns, pressure sores, inguinal rash, and fecal impaction. Stiles et al. (2000) provided physicians with guidelines for routine screening questions, including:

- Are you afraid of anyone at home?
- Are you alone a lot?
- Has anyone at home ever hurt you?

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Resources

- Florida Mandatory Reporting Statute: http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=Ch0415/titl0415.htm&StatuteYear=2006&Title=%2D%3E2006%2D%3EChapter%20415
- National Center on Elder Abuse: www.nationalabusecenter.org
- American Psychological Association: http://www.apa.org/pi/aging/eldabuse.html
- National Committee for the Prevention of Elder Abuse: http://www.preventelderabuse.org

- Clearinghouse on Abuse and Neglect of the Elderly: http://www.elderabusecenter.org/default.cfm?p=cane.cfm

IIIG.2. Alcohol and Illegal Drug Abuse

The prevalence of heavy drinking (12 to 21 drinks per week) in older adults is estimated at three to nine percent and abuse and dependence are four times more common in men than in women age 65 and older (USDHHS, 1999). In terms of substance abuse, although there is little research, misuse of prescription and over-the-counter medications is more common among older adults than abuse of illegal drugs. Elders use prescription drugs about three times as frequently as the general population and use over-the-counter medication even more commonly. Women are at greater risk of misuse than men (USDHHS, 1999). Illicit drug abuse is expected to become a more significant problem with the aging of Vietnam War era veterans and the baby boom generation. Notably, substance abuse issues cross lines with several other special concerns of older adults, including mental health and homelessness.

In Johnson's (2000) review of epidemiological research of alcohol problems in old age the reported prevalence of alcohol problems in earlier studies ranged between 1 and 22% in population-based surveys (i.e., community samples) and 29% of nursing home residents had a lifetime diagnosis of alcohol abuse. In addition, alcohol problems were common among older patients in medical settings. According to Friedmann et al., (1999) active problem drinking is present in 4% to 15% of elders using hospital outpatient services, 14% of older emergency department patients, and 5% to 20% of geriatric inpatients. In comparison to younger populations with alcohol problems, older persons may have fewer traumatic fatalities. However, alcohol abuse may exacerbate coexisting illnesses. For example, heavy drinking in older patients may complicate health conditions through adverse alcohol-drug interactions, dietary or medication noncompliance, inducement or exacerbation of cognitive impairment or psychiatric illness, or other mechanisms such as hypertension or gastric bleeding, which may increase morbidity and mortality among older patients in medical settings (Friedmann et al., 1999).

Schultz et al. (2003) compared substance abuse treatment facilities with and without services designed for older adults and explored the location of these services relative to the regional distribution of older adults across the United States. Survey results revealed that of the 13,749 responding facilities only 17.7% had programs for older adults. The majority of the older adult programs were associated with hospitals, primarily those with a psychiatric inpatient service. "Importantly, the number of facilities with special programs for older adults did not correlate with the size of older populations in each state" (Scultz et al., 2003). Thus, despite the increasing need for substance abuse programs geared towards older adults, it appears there are currently few programs available to this age group.

Schonfeld and his colleagues (2000) found that older adults in Florida are underserved by the substance abuse treatment system in proportion to their population or to experts'

estimates of the problem. According to data from Florida DCF, only 676 (2.2%) of 30,097 adults (age 18+) who were admitted to substance abuse treatment programs in FY 1998-1999 were age 60+. Schonfeld extrapolates from prevalence estimates for alcohol abuse and population estimates to conclude, "more than 99% of elders in need of treatment do not receive it." [p.29]

In 2001, The Center on Aging reported on a survey of providers in Broward County. Twenty-seven of the 64 surveyed providers said they serve elder alcohol and substance abusers (note, this does not necessarily mean they specifically target or reach out to this population) and 31 of 64 were able to name one or more local agencies that provide specialized treatment services. Estimates of the elder alcohol and substance abuser population in Broward ranged from 1,000 to 30,000.
Other findings from the provider survey:

- Greatest needs are substance/alcohol abuse services (16), counseling for elders (15), mental health services (12), and healthcare services (8).
- Of the 31 providers identified by respondents, the ones most frequently cited were Broward County Substance Abuse and Health Care Services (19) and Henderson Mental Health Center Inc. (9).

Schonfeld and Dupree (1997) reported that published research literature on substance abuse in older adults includes at least six specific recommendations for effective treatment for older problem drinkers. These include:

- Emphases on age-specific group treatment with approaches that provide support and avoid confrontation.
- Attention to negative emotional states such as depression, loneliness, or overcoming losses (e.g., death of a loved one, retirement).
- Teaching skills to rebuild a social support network.
- Employing staff that are experienced in and committed to working with older adults specifically.
- Developing linkages with aging services, medical services, and institutional settings for referral into and out of treatment as well as case management.
- Slowing the pace and modifying the content of treatment to be more appropriate for older people.

Elder-specific illicit substance abuse treatment programs are even rarer. Without citing specific program examples, however, the TIP protocol identifies five specific objectives for treatment and general approaches that may be effective in reaching each objective. The five treatment objectives are:

- Eliminate or reduce substance abuse.
- Safely manage intoxication episodes during treatment.
- Enhance relationships of substance abuser (family, friends, etc.).

- Promote health (i.e., improve sleep habits and nutrition, increase exercise, reduce tobacco use and stress).
- Stabilize and resolve medical, psychiatric, and sensory deficit co-morbidities.

Screening for drug misuse, as well as alcohol and drug abuse, should be included in assessment tools for community providers who come in frequent contact with older adults.

Gerontology Alcohol Project. The Florida Mental Health Institute established the Gerontology Alcohol Project (GAP) in 1979 as a demonstration day treatment model for clients age 55+ with late onset alcohol abuse problems. A modified version, the Substance Abuse Program for the Elderly (SAPE) was implemented in 1986 for all older adults with alcohol or medication misuse, regardless of age of onset. Although neither of these programs currently operates, manuals and assessments developed to document and structure the specific treatment model used in those programs are still available and have been used most recently in Los Angeles and Michigan. This approach also influenced the Treatment Improvement Protocol (TIP) on Substance Abuse among Older Adults produced by SAMHSA in 1998.

The BRENDA Model. The BRENDA model was proposed in response to a Johns Hopkins study of patients admitted to general medical services, which found that only 37% of elder patients with alcoholism were identified, and intervention was only initiated for 16% (Kaempf et al., 1999). The BRENDA method is carried out by nurse practitioners. The steps of the BRENDA method include: (1) conduct a bio-psychosocial assessment (B), (2) report assessment findings to the patient (R), (3) use empathic approach in discussions with the patient (E), (4) discuss patient needs identified during the assessment (N), (5) offer direct advice (based on patient's needs) (D), and (6) conduct assessment of direct advice (A). Preliminary data analysis of the BRENDA model demonstrated a greater compliance with treatment visits among older alcoholics compared to results in a more traditional addiction treatment setting that used aged-specific alcohol counseling (Kaempf, 1999).

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Resources

- National Institute on Alcohol Abuse and Alcoholism:
  http://pubs.niaaa.nih.gov/publications/aa40.htm
  http://pubs.niaaa.nih.gov/publications/arh26-4/308-315.htm
- AARP: http://www.aarp.org/bulletin/yourhealth/calling_quits.html
- Treatment Improvement Protocol (TIP) on Substance Abuse Among Older Adults:
  http://ncadi.samhsa.gov/govpubs/BKD250

IIIG.3. Involvement in the Criminal Justice System

According to FBI Uniform Crime Report data, 119,513 people age 60 and over were arrested in the United States in 2003 (FBI, 2003). Of these, the most frequent offenses charged were: driving under the influence (25,594); other assaults (11,118); larceny-theft (9,221); drug abuse violations (5,466); aggravated assault (4,652); and 32,712 people age 60 and over were arrested for "all other offense, except traffic" (FBI, 2003).

In 1998 there were 83,667 inmates age 50 and older in United States federal and state prisons (Camp and Camp, 1998). This did not include older inmates in local jails, reported at 1.5% of the total U.S. jail population[8] (Harlow, 1998) or offenders under pre- or post-incarceration community supervision, for which age-specific data are not available. A little closer to home, Florida has one of the largest concentrations of older offenders and inmates in the country. As of October 2006, Florida prisons housed 11,669 inmates age 50 or older (Trends in Florida Prisons, 2006), accounting for 13% of all inmates. Closer still, Florida's Department of Corrections reported in September 2006 that there were 540 persons age 60 and older who were under active or active-suspense community supervision in the 17th Judicial Circuit (Ft. Lauderdale).

Based on historical patterns, as the number of older Americans increase in proportion to the total population, the number of older offenders and prisoners will grow proportionately as well, meaning that with the aging of the baby boom generation older offenders and prisoners will become an increasing burden on the criminal justice system. For Broward County, which had the 15th largest local jail jurisdiction in the US in 1998 (USDOJ, 1998), these numbers are likely to be quite large.

[8] 567,079 x 1.5% = 8,506

In 2001, The Center on Aging conducted a survey of elder service providers in Broward County. Only 13 of 64 responding providers said they serve elders in jail, on probation or at risk for criminal activity (note, this does not necessarily mean they specifically target or reach out to this population). This subpopulation is, by far, the least understood and apparently the most underserved of the special populations examined in the study. Provider estimates of the number of older adults in Broward County who fall in this category ranged from 1,000 to 2,000. Greatest needs were identified as legal assistance (9), mental health services (8), counseling for elders (7), financial assistance (6), substance or alcohol abuse services (6), and support groups (6).

Several key informants in the current project expressed concern about this population. A respondent who works for DCF Adult Services commented that this subpopulation represents some of the most complex and difficult to resolve cases they see, noting that many elders who are arrested face crimes related to homelessness, such as loitering and vagrancy. Some judges refer these cases to the DCF Adult Services office, although this is done entirely at the discretion of each individual judge. Another DCF respondent discussed the problem of elders with mental health issues who end up in the criminal justice system, most often due to misdemeanor infractions such as intoxication and disorderly conduct. These cases may be ordered to treatment instead of jail time but, again, this is entirely at each individual judge's discretion. Comprehensive case management is needed, but not sufficiently available. The DCF Substance Abuse and Mental Health Program Office provides post-release services to ex-offenders with substance abuse and mental health problems. Another respondent mentioned post-release notification to SHIP, which provides services to elders with HIV/AIDS. One respondent talked about problems with elders who perpetrate domestic violence or battery and emphasized the importance of pre-trial assessment to determine the needs of these elder offenders. Finally, one respondent discussed the importance of the healthcare system in working with this population.

Although home and community-based services might appear to have little to offer incarcerated elders, it seems likely that these kinds of services can play an important role in prevention, diversion, and reintegration programs. In addition, it may be prudent for agencies that provide elder home- and community-based services to be involved with older prisoners prior to their release back into the community so that supports are in place to assure a smooth transition back to community life. Successful early release and parole of aging inmates may depend on the ability of the aging, criminal justice, and healthcare service systems to work together to proactively assist these individuals.

The best-known reintegration program for older prisoners is the Project for Older Prisoners (POPS), a law-school based service model originally implemented in 1989. POPS uses a four-step protocol to facilitate reintegration: (a) identify low risk/high cost inmates; (b) assign older prisoners to law student volunteers who conduct extensive risk assessments; (c) develop residential, employment and financial plans; and (d) prepare reports for parole/pardon board reviews. This model may be adapted in other academic disciplines (e.g., social work) or may be established on an inter-disciplinary basis.

The Elder Justice Center currently operating in Palm Beach County is another program providing services to elder offenders. It began as an Elderly at Risk Project that advocated for improved services to older adults in the judicial system. Innovations in Palm Beach County include: (1) alternatives to incarceration are presented to the Duty Judge at the first appearance. An attorney from the Elder Justice Center consults with all defendants over the age of 60 (who are not represented by counsel) to evaluate and to make recommendations to the Court regarding possible alternatives to incarceration; and (2) an emphasis on detection, assessment and intervention in elder abuse cases including custody issues, guardianship and assistance to the elder accused of, or victim of, domestic abuse (see *Consultation with the 15th Judicial Circuit on the Elder Justice Center,* http://www.fiu.edu/~coa/research/elder_justice.htm).

Kerbs (2000) noted that African Americans were the most over-represented group of older prisoners in state and federal prisons. This group was particularly difficult to effectively serve because most of them had no financial resources and little or no intact community-based support systems. Specialized programs that focus on realistic plans for financial stabilization and skills training in developing and maintaining a community-based support system were especially important in the consideration of decarceration for older prisoners. Supportive services that have been identified as important include senior housing, community counseling, employment services, in-home services, nutritional services, meal services, and senior centers.

Although not conclusive, research indicates that there may be significant links between older adult criminal behavior and mental disorders, substance abuse, and alcohol abuse, further highlighting the importance of implementing effective and coordinated strategies for addressing older adult subpopulations with special needs in Broward County.

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Resources

- Pennsylvania Report of the Advisory Committee on Geriatric and Seriously Ill Inmates, June 2005***:*** http://jsg.legis.state.pa.us/Inmates%20Report.html
- Incarcerating Elderly And Aging Inmates: Medical And Mental Health Implications (Florida Department of Health): http://www.doh.state.fl.us/cma/reports/agingreport.pdf
- Aging and Prison Bibliography (National Association of Social Workers) http://www.nwsa.org/agingbib.htm
- The Center on Aging Website, Elder Justice Section: http://www.fiu.edu/~coa/research/elder_justice.htm
- Managing Aging and Terminally Ill Inmates (National Institute of Corrections): http://www.nicic.org/Resources/supplemental/PubDetails.aspx?recordID=219
- Project for Older Prisoners (POPS)
  George Washington University Law School
  http://www.gwu.edu/~ccommit/law.htm
  University of Michigan Law School
  http://www.law.umich.edu/JournalsandOrgs/pops.htm
  Tulane University Law School
  http://www.law.tulane.edu/tuexp/studentorg/studenttemplate.cfm?orgID=11&act
- California Prison Reform Autumn 2005-2006: http://www.law.stanford.edu/program/centers/scjc/workingpapers/TGubler_06.pdf

IIIG.4. Developmental Disabilities

Developmental disabilities (DD) are conditions with onset before age 22 that cause significant life-long functional impairments in areas such as independent living, self-care, receptive and expressive language, learning, and economic self-sufficiency (Griswold & Goldstein, 1999) resulting from a variety of conditions, including cerebral palsy, mental retardation, learning disorders, autism, epilepsy, learning disabilities, and attention deficit disorders. Persons with DD are a heterogeneous population with vastly differing physical and cognitive abilities. As with the general population, this heterogeneity increases as the population ages.

The elder population with DD is increasing at a rate similar to that of the general elder population. The deinstitutionalization policies implemented in the 1970s have resulted in an increasing community responsibility to meet the health care and social service needs of all individuals with DD. The increasing life expectancy of persons with DD also is presenting new challenges. “At the beginning of the 20th century, mean life expectancy for those with Down’s syndrome was less than 10 years, whereas it is now nearer 50 years (Holland, 2000).” Ageing of developmentally disabled individuals is not only

associated with biological changes, but there are also social and economic changes. Informal caregivers, who are themselves aging into a need for caregiving, are particularly burdened by caring for their aging developmentally disabled children and express grave concerns regarding how these "children" will be cared for when they, the parents, are no longer able to do it.

Overeynder and Bishop (2002) offered the following recommendations regarding community health and social services and programs for older persons with DD:

Health

- Older persons with developmental disabilities should be screened for health risks on a routine basis.
- Special attention should be paid to age-related diseases that may present atypically in persons with significant communication problems.
- Physical environmental assessments need to be done to prevent injuries and accidents and enhance quality of life.
- Older persons with developmental disabilities should be educated in health and wellness activities.
- Caregivers need to be trained in observation of symptoms and in interacting with health care providers. They need to differentiate between disability and age-related changes and diseases.

Programs and Services

- Data needs to be collected on the numbers and functional status of older persons with developmental disabilities. Outreach efforts need to be made in order to identify older adults who are not known to the service system, but who may need care when their families can no longer do so.
- Programs and services need to become more flexible to fulfill the spirit of .person-centered planning. There needs to be better coordination between residential and day services in order to ensure flexibility as consumers age.
- The use of resources beyond those offered by the traditional aging and developmental disabilities service systems must be encouraged.

Evenuis et al. (2001) recommended that health and social services providers caring for people with intellectual disabilities of all ages adopt a *life-span approach* that recognizes the progression or consequences of specific diseases and proactively identifies interventions and case management strategies that will result in better outcomes for older persons with DD as well as their caregivers.

In 1999 the Broward Center for Independent Living sponsored a community town hall meeting for residents with developmental disabilities, their families, and service providers. A needs assessment conducted with the 140 attendees identified residential placement as the number one future service need. This is because a significant number

of people with developmental disabilities who are aging themselves are often living with very elderly parents who are their caregivers. The second highest priority identified was respite care or drop off centers where the disabled person can be supervised and participate in appropriate activities while an aging caregiver is temporarily relieved of care responsibilities. The planning process that followed identified a need to develop better data about the extent of the anticipated future need for services by aging developmentally disabled persons currently residing with families.

Notably, the Florida Department of Children and Families has received funding increases over the past few years to expand home- and community-based services to hundreds of developmentally disabled individuals on waiting lists in Broward County in response to class action litigation. The major areas of need identified were:

- Family and consumer support, including guardianship, transportation, job training, financial planning, and training for support services workforce.
- Health and medical services, including therapies, dental, durable medical equipment, home care, and primary care that is knowledgeable about both aging and the disability.
- Residential services, including a range of housing options from “own home” to supported living to group homes to residential facilities, and the role of the housing authority, CDBG, HUD, financial institutions, community development programs in developing and maintaining such housing.
- The aging services network needs to tap into this relatively new resource to assure that service agendas recognize the needs of developmentally disabled aging persons.

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Resources

- Florida Developmental Disabilities Council: http://fddc.org/HOME/index.asp
- Association of University Centers on Developmental Disabilities: http://www.aucd.org
- Interdisciplinary Training Center on Gerontology and Developmental Disabilities: http://www.ihd.umkc.edu/ITC/default.htm

IIIG.5. Gay, Lesbian, Bisexual, Transgender (GLBT)

The following section is adapted from: *Outing Age: Public Policy Issues Affecting Gay, Lesbian, Bisexual, and Transgender Elders* by Sean Cahill, Ken South, and Jane Spade (2000). The Policy Institute of the National Gay and Lesbian Task Force Foundation. Available on-line at: http://www.thetaskforce.org/downloads/outingage.pdf.

There is a growing wave of GLBT people aging and entering the social service systems and community institutions that care for and advocate for elders, while government funding for social service needs for all elders has been reduced. To date, aging service providers are not ready for the new wave of GLBT elders, policy makers are running away from it, and until very recently, the GLBT community has not faced this wave either. Nevertheless, GLBT elders are among the most invisible of all Americans. Little is known about GLBT elders because of the widespread failure of governmental and academic researchers to include questions about sexual orientation or gender identity in studies of the aged. Legal and policy frameworks, which have traditionally excluded GLBT people, engender social and economic consequences that deny GLBT elders access to financial resources and community support networks.

It is estimated that one to three million Americans over age 65 are gay, lesbian, bisexual, or transgender, based on a range of 3-8% of the population. The number and proportion of GLBT elders will increase significantly over the next few decades, along with the overall elder population. By 2030, one in five Americans will be 65 or older. Roughly four million of these will be gay, lesbian, bisexual, or transgender.

GLBT elders face a number of particular concerns as they age. Several studies have documented widespread homophobia among professionals entrusted with the care of America’s seniors. Most GLBT elders do not avail themselves of services on which other seniors thrive. Many retreat back into the closet, reinforcing isolation. They often do not access adequate health care, affordable housing, and other social services that they need, due to institutionalized heterosexism.

Federal programs designed to assist elder Americans can be ineffective or even irrelevant for GLBT elders. Several federal programs and laws blatantly treat same-sex couples differently from married heterosexual couples. For example:

- Social Security pays survivor benefits to widows and widowers, but not to the surviving same-sex life partner of someone who dies. This may cost GLBT elders $124 million a year in un-accessed benefits.
- Married spouses are eligible for Social Security spousal benefits, which can allow them to earn half their spouse’s Social Security benefit if it is larger than their own Social Security benefit. Unmarried partners in life-long relationships are not eligible for spousal benefits.

- Medicaid regulations protect the assets and homes of married spouses when the other spouse enters a nursing home or long-term care facility; no such protections are offered to same-sex partners.
- Tax laws and other regulations of 401(k)s and pensions discriminate against same sex partners, costing the surviving partner in a same-sex relationship tens of thousands of dollars a year, and possibly over $1 million during the course of a lifetime.
- And even the most basic rights such as hospital visitation or the right to die in the same nursing home as one's partner are regularly denied same-sex partners.

Many GLBT elders experience social isolation and ageism within the GLBT community itself. These issues, often compounded by racism and other kinds of discrimination, demand the attention of policy makers, service providers, and activists working on behalf of, and with, older persons. As GLBT people grow older, they enter a world of services that may not be familiar with GLBT issues. Some activists have created GLBT-specific service organizations for the aged, such as Senior Action in a Gay Environment (SAGE), Gay & Lesbian Outreach to Elders (GLOE), Pride Senior Network, and a few others. These types of programs are not available in all parts of the country and cannot provide all the services needed. This is particularly true in rural areas.

A number of the problems faced by GLBT elders also stem from the fact that often they do not have the same family of origin support systems as heterosexual people. This is compounded by the failure of the state to recognize their same-sex families. Many gay men and lesbians already have experience providing care. Since a disproportionate number of GLBT elders live alone, innovative support networks are critical.

The need to make broad assumptions about the size of the GLBT elder population underscores one of the major problems in understanding the needs of this population. GLBT elders are not only underserved, they are also understudied. There is an overall lack of empirical demographic data on gay, lesbian, bisexual or transgender persons of any age, but data on GLBT seniors are particularly limited. Very little literature examines the lives of older GLBT people, and that which exists has many limitations. Most samples heavily over-represent white gay men from urban areas with middle or upper incomes, and under-represent women, people of color, low-income people, or residents of suburban and rural regions. In addition to a policy agenda, a research agenda is urgently needed.

There may be some health risks which are particularly pronounced among GLBT populations, including GLBT elders. A number of studies indicate that certain risk factors associated with breast cancer occur at higher levels among lesbians than among heterosexual women. These risk factors include nulliparity (never having given birth), differential rates of exposure to hormones due to less use of oral contraceptives, obesity, alcohol consumption, smoking, poor diet, and lower rates of breast cancer screening. Yet the Institute of Medicine's 1999 *Lesbian Health* study cautioned that, to

date, there are “no epidemiological studies supporting a conclusion that lesbians are at increased risk for breast or other cancers”. The *Lesbian Health* study also reported possible higher risk factors for cervical cancer for lesbians: lesbians were less likely than women in general to get a Pap test done at least once a year, and at one community health center, lesbians went 21 months between Pap smears versus an average of 8 months for heterosexual women of the same age.

As of yet there is no epidemiological research which definitively proves higher risk for any form of cancer among lesbians. Other health concerns of older lesbians include Alzheimer’s Disease, fibromyalgia, arthritis, heart disease, and hypertension. Lesbians and bisexual women who have sex with women with HIV clearly face some risk of transmission of HIV and other sexually transmitted diseases. Consequently, safer sex guidelines tailored to this population are limited.

In the US, gay and bisexual men who do not practice safe sex remain at elevated risk for the transmission of HIV and other sexually transmitted diseases like hepatitis. Hepatitis can be severely debilitating and even fatal; while vaccines are available for hepatitis A and B, vaccination remains rare. A 1996 CDC analysis of a San Francisco study of 385 young men who have sex with men found that only 3% were vaccinated against hepatitis B. Yet 20% showed evidence of current or previous hepatitis B infection. Sell and Bradford also report that “[c]ommunity-based clinics reported epidemic rates of HAV (hepatitis A virus) in 1998 and 1999 among gay men in New York, Boston, Atlanta, and various cities outside the US. There is increasing evidence that gay men who engage in unprotected anal sex are at higher risk for anal cancer.

There are two issues which make HIV/AIDS a particular concern for GLBT elders: the continued transmission of HIV among older populations, especially of men who have sex with men, and the increased lifespan of people with HIV and AIDS due to the new medications which offer the promise, as yet unrealized, of transforming HIV/AIDS into a chronic condition rather than a terminal disease.

A number of studies indicate that prevention messages are not working with older men who have sex with men and that older men may be at higher risk for HIV transmission. A 1994 study of 432 self-identified gay men in Chicago compared men 60 and older and younger men in the study. It found that 44% of the older men reported multiple partners, and fewer of the older men were in a primary relationship with another man. Kooperman’s 1993 study of 191 American and Canadian gay and bisexual men over 50 found that 9% of those reporting sexual activity within the past month (13 of 139) had engaged in anal intercourse without a condom. When asked why they hadn’t used a condom, 59% said, “My partner and I are not at risk”, and 32% said, “Sex is less enjoyable with condoms”. Linsk reported that older gay men appear to have more difficulty negotiating the change to safer sex practices. During their adolescence and early and middle adulthood, this generation of men had little to fear from unprotected sex other than hepatitis and relatively easily treatable sexually transmitted disease. Many are finding it difficult to incorporate safer sexual practices into their sexual repertoire. Although older gay men may be quite knowledgeable about HIV

transmission, many express the sentiments of a 67-year-old client who said, “Our people don’t use condoms”.

Of more than 700,000 Americans diagnosed with AIDS through 1999, 10-11% of them were age 50 or older at the time of their diagnosis. The Centers for Disease Control and Prevention reported that from 1991 to 1996, people age 50 and older experienced a sharp increase in the incidence of HIV-related illnesses (up 22%), while the 13-49 year old age group experienced only a 9% increase. Based on CDC data, Linsk predicted in 1997 that by the year 2000, there would be about a quarter of a million HIV-positive people age 50 and older in the US and 100,000 to 120,000 people with HIV age 60 years or older. The success of new drug regimens will also contribute to an increase in the number of old people living with HIV in the future.

While there is no conclusive evidence that alcohol abuse is more prevalent among gay men and lesbians, numerous studies document much higher smoking rates among both gay men and lesbians than among heterosexual men and women. One study of gay and lesbian youth in the southern United States found higher rates of smoking among young lesbians than among young gay men.

Community initiative-relevant recommendations from the *Outing Age: Public Policy Issues Affecting Gay, Lesbian, Bisexual, and Transgender Elders* Report include:

- Maintain the inclusive definition of caregiver contained in the Older Americans Act reauthorization legislation.
- Hospitals and nursing homes should adopt policies treating the families of GLBT people the same as they treat family members of heterosexual patients and residents. Such policies should be integrated into staff training.
- Home care agencies should be trained to be culturally sensitive and respectful of GLBT old people, and they should not tolerate abuse and neglect motivated by homophobia, transphobia, or any other form of prejudice.
- Appropriate social service agencies should provide GLBT-sensitive support for informal family caregivers, including same-sex partners and close friends.
- Nursing homes, assisted living centers, congregate housing, and home health care services need to take proactive steps to minimize the incidence of discrimination, abuse, and neglect of GLBT elders. All providers of caregiving services and housing to elders should be trained to be competent in issues of sexuality and gender.
- Nursing home staff must be fully trained to understand and better serve the needs of GLBT clients.
- Diversity training is critical given documented examples of bias among health care providers.
- Nursing homes should include detailed sexuality policies within residents’ rights policies, and accommodate the appropriate, private expression of the sexual needs of residents, be they homosexual, bisexual, or heterosexual. The right to privacy is

already included in most nursing home regulations, but is not always protected for GLBT seniors.

- Public education campaigns should be undertaken by appropriate local, state and federal governmental agencies to identify, prevent, stop, and punish abuse and neglect of GLBT elders.
- More research on abuse and neglect of GLBT seniors should be done by agencies responsible for monitoring such abuse.
- Target prevention messages to GLBT people, particularly on issues that may disproportionately affect GLBT people, such as breast and cervical cancer, HIV/AIDS, other sexually transmitted diseases, tobacco and substance abuse, hate violence, and domestic violence.
- Conduct public education outreach campaigns to end homophobia, transphobia, and the presumption of heterosexuality in health care, including mental health care services, and encourage GLBT people to be out to health care professionals.
- Fund age-appropriate programs at all educational levels that teach tolerance, understanding, and respect, regardless of race, religion, ethnicity, age, national origin, sexual orientation, disability, gender, or gender identity.

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Resources

- Family Caregiver Alliance: http://www.caregiver.org/caregiver/jsp/print_friendly.jsp?nodeid=409
- National Gay and Lesbian Task Force Aging Initiative: http://www.thetaskforce.org/theissues/issue.cfm?issueID=24
- American Society on Aging Lesbian and Gay Aging Issues Network: http://www.asaging.org/lgain
- Gay, Lesbian & Bisexual Veterans of America, P.O. Box 29317, Chicago, IL 60629. www.glbva.org
- Gay & Lesbian Association of Retired Persons, PO Box 30808, Los Angeles, CA 90024. www.gaylesbianretiring.org

IIIG.6. HIV/AIDS

Society has largely neglected the need for research and services regarding elders with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Recently, however, more information about risks, prevalence, and experiences of elders with HIV/AIDS has been made available. Generally, a common theme pertains to society's denial of the behaviors which increase the risk of elder populations for contracting HIV/AIDS. The literature discusses the older adult's lack of knowledge of the modes of HIV/AIDS contraction, and the lack of use of condoms during sexual intercourse as factors contributing to the increase rates of HIV/AIDS in the elderly population. In the majority of the literature elder adults are considered aged fifty years or older. However, the United States Department of Census defines older adults as a "those aged 55 and older" (Department of Health [DOH], 2003).

According to the Administration on Aging (AOA), the number of older people with HIV/AIDS is on the rise. It is estimated about 10% (75,000 individuals) of people diagnosed with AIDS in the U.S. are aged 50 and older (Inelmen et al., 2005). HIV/AIDS disproportionately affects minority elders and, increasingly, women. Nationally, 52% of people age 50+ with HIV/AIDS are African American or Hispanic (49% average for men age 50+ and 70% average for women age 50+). In the last five years the number of new AIDS cases in women over age 50 rose by 40% (Richerson, 2001). In South Florida, 15% of new AIDS diagnoses are in the 50+ population. Furthermore, as treatments for HIV and related conditions become more effective, the survival of infected individuals first diagnosed in their 30s and 40s will result in increasing numbers of older adults who live (and age) with the disease as a chronic illness. Notably, it is difficult to determine the HIV infection rates among older adults because few adults over the age of 50 at risk for HIV get tested routinely.

The HIV/AIDS clinical manifestations in elders are similar to those in younger patients. However, studies have shown that, prior to the era of antiretroviral therapy, older individuals had a more severe course of the disease and shorter survival rate (Inelmen et al., 2005). HIV/AIDS symptoms are often mistaken for other diseases common in older adults such as weight loss, fatigue, declining physical and mental activity,

Parkison's Disease, Alzheimer's, and respiratory diseases, resulting in delay of appropriate diagnostic evaluation (Inelmen et al., 2005).

HIV/AIDS is transmitted the same way among persons of all ages. However, a study by Ketiz et al., demonstrated older patients were less likely to acquire HIV from intravenous use, making sexual contact the primary mode of transmission (Inelmen et al., 2005). This is important because research has revealed there is a high percentage (81.5%) of older adults who are sexually active. The main risk behavior associated with HIV infection among older adult Americans is male-to-male unprotected sex with an infected partner. However, there are many other contributing factors. For example, studies have revealed that many subjects over the age of 50 were involved in more than one sexual relationship, including unprotected sex with prostitutes. The use of clinically effective oral medications for erectile dysfunction has led to an increased level of sexual activity in the older population, which has also facilitated the spread of HIV. Finally, older women are at greater risk for HIV infection during intercourse than younger women due to the loss of estrogen and the deterioration of the immune system, which results in reductions in vaginal lubrication and thinning of the vaginal walls. Thus, the vaginal mucosa is more likely to sustain micro-tearing during intercourse, which provides HIV easier access. Unfortunately, individuals diagnosed with HIV after age 60 have been shown to have a poorer survival prognosis than their younger counterparts (Richerson, 2001).

Today, older adults are thought to be at increased risk of infection with HIV/AIDS and other sexually transmitted diseases because many have never thought about HIV/AIDS in terms of personal risk. Persons older than 65, and even some of the early "baby boomers", still associate condoms use with a need for birth control, which is no longer a relevant concern. The newer meanings of "safe sex" may be totally unfamiliar. Inelmen et al. (2005) suggest that primary care physicians discuss sexual activities with their older patients who are at high risk, such as those who are lesbian, gay, bisexual, or transgender. A review of the literature has revealed that the majority of people aged 50 and older with AIDS did not receive much or any information regarding HIV/AIDS. However, the information they received was provided by the media, such as magazines and television. Overall, HIV/AIDS information and prevention among elders is needed to reduce the prevalence of the disease.

In 2001, The Center on Aging conducted a survey of elder service providers in Broward County. Twenty-six of 64 responding providers said they serve elders with HIV/AIDS (note, this does not necessarily mean they specifically target or reach out to this population) and 32 of 64 were able to name one or more local agencies that provide services. Estimates of the elder HIV/AIDS population in Broward County ranged from 400 to 25,000. Respondents identified the following greatest needs are healthcare services (16), counseling for the elder (12), senior housing (9), support groups (9) and in-home nursing and medical services (6). Of the 32 providers identified by respondents, the ones most frequently cited were Center One, Inc. (18), Broward County Health Department (11), Broward House, Inc. (10), and the Senior HIV Intervention Project (9). Several key informants in the current project expressed concern

about this population, commenting in particular on the way that shame prevents elders from discussing sexual issues or seeking medical help for sexually-related issues.

Research does suggest that older age impacts HIV health care needs and use patterns. Domains in which such differences are likely to be important include social and economic characteristics, medical co-morbidity, psychiatric co-morbidity, delays in diagnosis (related to such factors as lowered index of suspicion, rates of disease progression and survival), access to medical care, and patterns of inpatient services use (Crystal and Sambamoorthi, 1998).

A number of model programs currently exist, particularly in relation to HIV/AIDS prevention among older adults. One such model, the Senior HIV Intervention Project (SHIP), already operates in Broward County. SHIP is a collaborative effort sponsored by the State of Florida Department of Elder Affairs and Department of Health in cooperation with local Area Agencies on Aging in Palm Beach, Broward, and Miami-Dade Counties. The program is designed to increase public awareness of, involvement in, and support for HIV/AIDS prevention for seniors. Services include education, prevention, and HIV testing for older adults. SHIP recruits and trains volunteers to bring awareness of HIV/AIDS to seniors through educational seminars, workshops, and health fairs. SHIP also now targets health care professionals that provide services to older clients in terms of identifying early symptoms. An alliance with the corporate business world as well as community-based organizations has helped SHIP achieve relatively rapid success.

The Brookdale Gerontology Center and the School of Social Work at Hunter College created a task force consisting of a network of HIV and aging-service providers to exchange information, conduct needs assessments, and present conferences to stimulate educational, programmatic and policy initiatives in the fields of HIV and aging. In Massachusetts, a network of AIDS advocates, caregivers, researchers, and health practitioners created the Massachusetts HIV/AIDS and Aging Planning Committee with a goal to train community trainers by developing a training curriculum for conferences and other venues that offer opportunities to train aging network and HIV service providers. This same group is working with a Massachusetts university to develop an AIDS awareness campaign for the older population. Yet another program, Senior Action in a Gay Environment (SAGE), based in New York City, developed a support program primarily for older HIV-infected gay males. SAGE has also developed an outreach program for service providers in aging organizations about issues related to gay and lesbian gerontology and about intervention strategies for gay men with HIV/AIDS (Strombeck and Levy, 1998).

The National Association on HIV Over Fifty recommends the following actions (NAHOF, 2001):

- Implement specific programs for older adults who need to be informed about the transmission and prevention of HIV.

- Develop outreach programs devoted to basic HIV/AIDS information, "safe" sexual and drug-using practices, testing, negotiation skills in relation to aging and the particular perspective of older adults.
- Educate healthcare and service providers about HIV risk behaviors in older adults and symptoms of HIV infection, misdiagnoses, testing technologies, treatments, support groups, case management and the importance of being actively involved in the health and well-being of their older clients/patients.
- Routinely conduct risk assessment for older clients/patients.
- Raise awareness of HIV/AIDS in older people and reinforce the need for educational programs, while promoting respect and validation for elders as a group through successful media and social marketing initiatives.

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Richerson, C (2001). AIDS and HIV in Seniors and the Elderly. Obtained on-line: www.drkoop.com/dyncon/article.asp?ptp=trueandid=9707andat (article no longer available).

Resources

- National Association of HIV over 50. http://hivoverfifty.org
- Research Network on HIV/AIDS and the Elderly. http://agingaidsnet.psc.isr.umich.edu

IIIG.7. Homelessness

The hallmark of a homeless person is “extreme disaffiliation and disconnection from supportive relationships and traditional systems designed to help” (Stergiopoulos & Herrmann, 2003, pp. 374). In the mid-1980s awareness of homelessness was heightened in the United States by the media, public, and government entities. As a result, the U.S. and many city governments implemented services and policies to prevent and decrease homelessness. However, little is known about homeless elders.

Based on the Aging Health Policy reports from eight cities, it is estimated that between 14.5% and 28% of homeless persons are age 50 years or older (Stergiopoulos & Herrmann, 2003). Additionally, according to Hecht and Coyle (2001), the number of older persons who are homeless is likely to increase as the baby boomer generation ages, particularly because low-cost housing is expected to remain in short supply.

Explanations for homelessness among elders focus on both structural causes beyond the individual’s control and behavior choices which hinder the ability to maintain a stable life. Structural factors include fewer employment opportunities for unskilled workers, decrease in affordable housing, erosion of the welfare system, and the increase of deinstitutionalized individuals (Hecht & Coyle, 2001). Other risk factors include eviction, death of spouse, relative, or significant other, loss of income, domestic problems, alcohol and substance abuse, and physical and mental health problems.

“Being homeless has been associated with greater incidence of morbidity and a lifestyle that negates the pursuit of disease-prevention practices and interferes with attempts to treat health problems (Stergiopoulos & Herrmann, 2003, pp. 376).” Clearly the conditions in which homeless people live magnify health conditions, including dental problems, arthritis, hypertension, circulatory problems, lung disease, sensory impairment, stomach ailments, asthma, glaucoma, and diabetes. Other physical conditions resulting from being elderly homeless include consequences of trauma or criminal assault, infestation with lice and/or scabies, peripheral vascular disease, leg ulcers and cellulites, frostbite, and communicable disease (e.g. HIV, tuberculosis).

Additionally, it is estimated approximately one-third of single homeless adults suffer from severe mental illness, and homeless single women have a greater prevalence of mental illness when compared to single homeless men (Stergiopoulos & Herrmann, 2003). Although research on the mental health of the elder homeless people is limited, studies have demonstrated a significant psychiatric morbidity in this population.

Unfortunately, older homeless persons are vulnerable to victimization in shelter and on the street, particularly because poor mental or physical health contributes to their frailty. In addition, a reluctance of some aging service providers to include homeless elders in their programs increases their vulnerability (Rosenhech et al., no date).

In the 2001 Broward County provider survey, 20 of 64 responding providers said they serve homeless elders (note, this does not necessarily mean they specifically target or

reach out to this population) and 32 of 64 were able to name one or more local agencies that provide services to this population. Estimates of the size of the elder homeless population in Broward from the surveyed providers ranged from 150-60,000, indicating a lack of reliable information. Other findings from the provider survey were that the greatest needs of homeless elders were senior housing, healthcare services, mental health services, and financial assistance. Of the 25 Broward County agencies providing services to home elders identified by respondents, the ones most frequently cited were Broward Coalition for the Homeless (11), Salvation Army (6), Broward Outreach Center (6), and the Homeless Assistance Center (5).

In the current project, a number of key informant interview respondents discussed the needs of homeless elders in Broward County. Housing was one of the most frequently mentioned concerns. Both subsidized public housing and affordable community housing are in extremely short supply, and the shortage is expected to increase dramatically. In addition to economic trends that reduce incentives to build public or affordable housing, the recent onslaught of hurricanes in Broward County also has reduced the housing stock for low-income elders. Other housing-related problems that were mentioned include rising insurance rates and property taxes. A related issue discussed by key informants was the difficulty of keeping homeless elders in health care and other support service systems they need in order to regain any kind of permanent housing. Some homeless persons, we were told, do not want to be cared for by “government”. This creates a “rotating door” scenario, which increases the sense of hopelessness of homeless elders while unfortunately suggesting to service providers that intervention efforts are pointless. Finally, one respondent connected elder homelessness to increases in incarceration for substance abuse, trespassing, disorderly conduct, loitering, and other misdemeanors.

There are some programs that specifically target older homeless people in select communities across the country. The following elements were identified as critical to the success of these programs:

- Use a lower age threshold criteria (generally seems to be age 50) for service programs targeting older homeless persons.
- Homeless elders come from a variety of backgrounds and with many reasons for their current situation. Make sure programs are flexible and adaptable in order to meet the varied and unique needs of homeless older adults.
- Programs should include both (a) day services for elders who cannot or will not move into stable housing but who nevertheless need a sanctuary when they are ill, injured, cold, dirty, or hungry; and (b) transitional housing and training services for those elders who, with such assistance, are capable of managing a stable housing situation.
- As much as possible, bring special services into the program facility rather than requiring the elder homeless to go from one public building to another, often not in close proximity, in order to obtain benefits and put appropriate and needed supports in place.

- Use the shelters, both day and transitional, to implement routine medical and psychiatric screening for all clients.
- Obtaining medication, challenging for all older adults, is even more difficult for homeless older adults, many of whom suffer from chronic health and/or emotional illnesses. Access to medication and supervision in using the medication often makes the difference between chronic homelessness and persons' abilities to move into and maintain themselves in stable housing.

Hoch & Huth recommended a three-tier residential approach which ties together short-term and long-term solutions (Heicht & Coyle, 2005, pp. 67). Solutions include emergency shelter, transitional shelter with supportive services, and permanent low-cost housing.

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Resources

- Helping Elders At Risk Through Homes (HEARTH). http://www.hearth-home.org/
- National Resource Center on Homelessness and Mental Illness. Homeless and Mental Health Among Older American, 2004. http://www.nrchmi.samhsa.gov/pdfs/bibliographies/OlderAmericans.pdf

IIIG.8. Behavioral and Mental Health

Mental illness is an important contributing factor to the disease burdens of elders. It is estimated that 18 to 25 percent of elders experience mental disorders that are not part of normal aging. The most common, in order of prevalence are: anxiety, severe cognitive impairment, and mood disorders (primarily depression); other conditions include psychosomatic disorders, adjustment to aging, and schizophrenia. However, few elders with mental illness receive proper care and treatment for these conditions. It is estimated that only half of elders who acknowledge mental health problems receive

treatment from any health care provider, and half of those receive that help from a primary care physician. Only 3% receive specialty mental health services, a lower utilization rate than for any other adult age group (AAGP, 2001; Persky, 2001). In fact, elders account for only seven percent of all inpatient psychiatric services, six percent of community mental health services, and nine percent of private psychiatric care. Less than three percent of all Medicare reimbursement is for the psychiatric treatment of older patients.

Notably, the high prevalence of depressive symptoms in older adults results in a large economic toll. For all age groups, depression is one of the most costly disorders in the United States with direct and indirect costs of $43 billion each year (US Department of Health and Human Services, 1999).

The mental health concerns of the elders include dementia, delirium, psychosis, anxiety, and mood disorders (primarily depression). The Epidemiologic Catchment Area (ECA) Survey, conducted between 1980 and 1985 found that, for adults 65 years or older, the prevalence of anxiety disorders was 5.5%, phobic disorders was 4.8%, panic disorders was 10.1%, obsessive-compulsive disorders was 10.8%, severe cognitive impairment was 4.9%, affective disorders was 2.5%, dysthymia (most common mood disorder) was 1.8%, Alzheimer’s disease was between 3.3% and 10.3%, and schizophrenia was 4% to 10%. Only 3% of patients with schizophrenia, mostly women, experience their first symptoms in their sixties or after (Estronaut, 1999). Notably, older patients are sensitive to anesthesia, drug toxicity, and infections. Commonly, symptoms for delirium, described as “a mental disorder of acute onset with a fluctuating course, characterized by disturbances in consciousness, orientation, memory, thought, perception, and behavior” (Voyer et al., 2006) are misdiagnosed as relating to other conditions.

About 2 million out of 35 million Americans aged 65 years and older demonstrate depression symptoms. Depression is an under-recognized and under-treated mental illness (Djernes, 2006). In older adults, depression often co-occurs with other illnesses such as heart disease, diabetes, cancer, stroke, and Parkinson’s disease, but may also occur in the absence of any acute or chronic illness. Cases presenting with clinically relevant depressive symptom vary between 7.2% and 49% (Djernes, 2006). The main predictors of depression in elders are female gender, somatic illness, cognitive impairment, functional impairment, lack or loss of close social contacts, and a history of depression (Djernes, 2006). Symptoms of depression include sleep disturbances; low levels of self-esteem, libido, appetite, interest, energy, concentration, memory, and movement; feelings of guilt; suicidal thoughts, plans, or attempts; and pain (Estronaut, 1999).

Studies have shown that many older adults who die from suicide (up to 75%) have visited their primary care physician within a month of suicide. Thus, there is a need to improve the detection and treatment of depression in order to reduce the risk of suicide among adults. In 2000, individuals aged 65 and older comprised 13 percent of the United States population and accounted for 18 percent of all suicides (NIH, 2006). Additionally, white men aged 85 years and older accounted for the highest rates of

suicide (59 deaths per 100,000 persons, which was 5 times the national rate of 10.6 per 100,000) in 2000.

Elders take more medications than younger adults. Some of these medications, known to be associated with depression, include anticancer drugs, anti-inflammatory drugs, and progesterone. Depression is commonly treated with a combination of anti-depressants and psychotherapy. The anit-depressants commonly used are tricyclics (i.e., imipramine, desipramine, amitryptyline, and nortriptyline), heterocyclics, selective serotonin reuptake inhibitors (SSRIs, e.g., Prozac), and monoamine oxicase inhibitors (MAOIs). Older adults are more susceptible to the side effects of taking these medications, which include blurred vision, dry mouth, urinary retention, confusion, constipation, drowsiness, insomnia, cardiac arrhythmia, hypotension, gastrointestinal distress, weight fluctuations, and sexual dysfunction to name a few.

In the 2001 Broward County provider survey, 36 of 64 responding providers said they serve psychiatrically disabled elders (note, this does not necessarily mean they specifically target or reach out to this population) and 40 of 64 were able to name one or more local agencies that provide services. Respondent estimates of the psychiatrically disabled elder population in Broward ranged from 1,500 to 120,000, perhaps indicating a lack of data regarding the actual size of this group. Greatest needs identified were: counseling (14), healthcare services (12), mental health services (11), case management (9), senior housing (9), and transportation (8). Of the 40 providers identified by respondents, the ones most frequently cited were Henderson Mental Health Center (26), Nova Southeastern University Geriatric Institute (16) and Broward County Elderly and Veterans Services (7).

In the current project, a number of key informant interview respondents discussed the needs of psychiatrically disabled elders in Broward County. Many of the needs described, i.e., housing, transportation, lack of services also were discussed in connection with other special needs populations. One respondent estimated that only about 50% of the needs of this elder population are met with appropriate services. Moreover, many elders refuse services, even when available, because of their desire to keep mental health issues “private”. The result of insufficient services, as was the case with many of the other special populations discussed, include increased risk for arrest, incarceration, referral to adult protective services, and possible loss of the right to make decisions on their own behalf.

Services developed in the 1990s by the Broward County Elderly and Veterans Services Division in partnership with the Florida Department of Children and Families, Alcohol, Drug Abuse and Mental Health Services Program (ADM), is a model program that places the community in an excellent position to expand services that are working well. Broward is the only community in Florida with such a state-county partnership offering specialized mental health and substance abuse services to older adults. The Mental Health Section of the Broward Elderly and Veterans Services Division provides ongoing support to Broward County residents over the age of 55 that have a serious and persistent mental illness and/or substance disorder. The services include case

management, supported housing, substance abuse prevention, and intervention. The staff of this program includes social workers, psychiatric nurses, and paraprofessionals with personal experience with mental illness.

The Mental Health Section coordinates closely with the court system to assess and develop alternative community-based housing and other services for any older adult recommended for involuntary commitment before that decision is made by the Court. The success of the Broward Elderly and Veterans Services Division program and statewide advocacy by the aging network led to passage of legislation in 2000 requiring the Florida Department of Children and Families to identify older persons with mental illness and/or substance abuse disorders as specific populations for state funding. A statewide task force was formed to define target populations and establish performance indicators for each.

The Older Adult Work Group for the Florida Commission on Mental Health and Substance Abuse developed recommendations to the Governor and State Legislature related to prevention, outreach, identification, access, quality care, outcome evaluation, staff training, and funding, including that a public health approach be utilized in serving these populations, that staff have cross-training in aging, mental health and substance abuse, that the Florida Department of Elder Affairs and the Florida Department of Children and Families form a collaborative effort to develop a system of care and collaborative outreach, and that physicians be trained to screen older adults for mental illness and substance abuse. These ideas were supported by several key informants and a few summit participants.

Persky (2001) identified innovative elements of model programs that have achieved some success in bringing psychiatric and/or mental health services to older adults. These include:

- Outreach to locate and identify older person who are depressed and provide care relevant to their needs.
- Mobile programs with staff that treat consumers in their own homes. Treatment in familiar surroundings reduces fear of stigma.
- Effective treatment of depression in elders. Treating elders has been found to be just as effective as treating young adults and middle-aged people; supportive therapy and drug treatment can be safely administered with beneficial results.
- Coalitions of staff members, statewide and local, associated with mental health and aging networks.
- Meetings with state mental health departments to ask that older people be officially designated as a special population with unique needs.
- Meetings with state legislators or their aides to brief them about the unmet mental health needs of their constituencies.

- Cross training between staffs of aging and mental health agencies to enhance common understanding of services and limitations of organizations service elders in need of mental health services.

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- Mental Health and Aging. http://www.mhaging.org/
- British Columbia Ministry of Health Services. Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities. http://www.healthservices.gov.bc.ca/mhd/pdf/elderly_mh_care.pdf

Attachment III.H
Leadership, Governance, and Innovative Community Service Models

In this section we summarize findings from a literature review regarding a number of community approaches to improving overall response to the needs of elder community residents, including coordinated community service models, other promising practice services models, and alternative finance models. These approaches may be used separately or in combination, and some (e.g., consumer-directed care) already are in place in Broward County. Specific strategies that incorporate many of these concepts are included in the business plan.

The following approaches are reviewed:

- The BoomerANG Project
- The Met Life Project
- Life: Act 2
- Aging and Disability Resource Centers
- Centralized Intake/Single Point of Entry
- Centrally Located Senior Services/All Service Needs Met in One Location
- Consumer-Directed Care
- Case-Managed Services
- Innovative Housing Models
- Integrated Use of Funding for Healthcare and Social Services
- Multi-agency Elder Service Networks

The BoomerANG Project

The BoomerANG Project focused specifically on what needed to change in traditional elder service systems to meet the needs of the very large number of “younger” older people who began “aging in” in 2006. Many of the ideas and recommendations are relevant to all cultural issues and the report provided useful information about coordinated community response, as well. The project began with an assessment of senior centers but grew to include broader community-based human services agencies, providers of services for the aging, the business community, and a wide spectrum of community services providers.

Transportation, housing, and health and wellness emerged as major issues among baby boomers as we know they also are issues for all elders and those who provide services to them in Broward County. The elder services network was identified as a key and essential resource for maintaining senior services, with its most critical roles including major funding source, legislative liaison at the state level, central network resource. The report recommends that, using its funding capacity, the elder services

network begin identifying where and how it can provide incentives for the necessary evolution of elder services and disincentives for providers whose capacity or objectives predominantly involve maintenance of the status quo.

The researchers struggled with the governance issue, asking (1) do a large number of separate boards and organizations make the most sense from both a programmatic and financial perspective, or would other alternative approaches such as partnerships with multi-generational non-profits, continuing care retirement communities, township programs, religious organizations, senior living communities, etc have more opportunities for success and longer-term viability?; and (2) would a single "senior-life-mega-board" offer a more promising organizational structure?

Researchers concluded that the most productive long-term framework for senior services is to adopt a market-driven approach to their response to the community, rather than a service-provision or needs-based approach. Although the latter have been the traditional foundation for the elder service network's identity and context, those agencies that adopt a more competitive and market-responsive framework will successfully evolve to take advantage of future opportunities for their own benefits as well as those of the community. This new approach must include a consumer-drive and market-oriented strategy for programming and the identification and development of relationships with nontraditional partners such as businesses, faith-based organizations and agencies, and organizations focused on health and wellness. The new approach also incorporates an asset-based model for community response, which articulates and identifies resources already existing in the community that can be applied at a local level to address issues and implement solutions.

A copy of the BoomerANG Project Final Report (January 2006) is available on-line at: http://www.npchf.org/boomerang/BoomerANG_Report_sunflowers.pdf .

The Met Life Project

Known as *The Maturing of America – Getting Communities on Track for an Aging Population*, the project was led by the National Association of Area Agencies on Aging, in partnership with the International City/County Management Association, National Association of Counties, National League of Cities, and Partners for Livable Communities (funded by MetLife). Researchers surveyed 10,000 local governments about response to community elders in the following areas: health; nutrition; exercise; transportation; public safety/emergency services; housing; taxation and finance; workforce development; civil engagement/volunteer opportunities; aging/human services; and policies/guidelines.

Results showed that the needs of older adults are often interrelated. For example, providing housing is not sufficient if residents lack transportation to get to basic services such as medical offices, the pharmacy, or grocery store. These interdependent needs may require a completely new comprehensive, holistic approach to service delivery organization and management. Moreover, while local governments offer older adults

basic services such as health and nutrition programs, they are less likely to provide or tailor programs that affect quality of life and the ability of older adults to live independently and contribute to their communities such as housing, transportation, and workforce development.

The top three challenges in meeting the needs of or planning for older adults (based on frequency of repetition) all related to housing: accessibility, availability, and affordability. Other frequently noted concerns included financial issues, health issues, transportation, needs of healthy and engaged baby boomers, and rural service challenges.

Recommendations:

- Communities should create and expand opportunities for the effective and purposeful participation of older citizens on community boards and commissions as well as to create and expand meaningful volunteer opportunities in local government and non-profit organizations.
- Communities should develop or partner with others who offer job training and retraining programs and lifelong learning opportunities that assist older adults to remain in the workforce. Additionally, communities should promote employment options, including part- and flex-time work options, to attract and retain an aging workforce.
- Communities can help older citizens by providing tax assistance and relief to those most in financial need. Additionally, communities should provide education and training for older adults about how to protect themselves against financial fraud and predatory lending.

The Maturing of America: Getting Communities on Track for an Aging Population Final Report is available on-line at: http://www.n4a.org/pdf/MOAFinalReport.pdf.

Life: Act 2

Life: Act 2 is a proactive response to the opportunities and challenges an exploding senior population in Jacksonville, Florida. In 1999, when the United Way of Northeast Florida Board of Trustees authorized the Resource Management Cabinet to begin a formal exploration of a Targeted Community Intervention, they formed an Assessment Task Force, comprised of United Way high-level volunteers, who researched 45 community issues and 18 target populations, with the help of the Jacksonville Community Council, Inc. The team concluded that the community was receptive to United Way developing a long-term focus on “Senior Independent Living and Quality of Life”.

To stimulate awareness about and collaboration on preparing for issues related to increasing numbers of elders in the community before they become critical, United Way proposed, and currently leads, the Northeast Florida Life: Act 2 Partnership Council. This council is comprised of public, private, and corporate funders of senior services.

The work that these collaborative partners are leading will positively change the community landscape for seniors across the First Coast region and our community's perspective on aging. Life: Act 2 has three goals: 1) to elicit a culture shift in the way the Northeast Florida community views and values seniors; 2) to integrate medical admission and discharge processes with our community's social service system; and 3) to strengthen the continuum of services available to our community's seniors.

In it's early stages of implementation Life: Act 2 has already accomplished the following:

- A partnership with the area's three primary hospitals (Mayo Clinic, St. Vincent's Medical Center and Baptist Health) has been formed to identify strategies to integrate the hospital admission/discharge processes with the community's social service system for seniors
- A partnership with the collegiate, early literacy and children's books sectors has been formed to develop and distribute children's books containing positive senior/multi-generational themes in order to promote a positive view of seniors and aging
- The number of frail seniors on a waiting list for home delivered meals has been cut in half
- Over $1 million new dollars have been leveraged to invest in senior services
- Over $200,000 have been invested in community intergenerational activities
- Over $50,000 have been invested to create or expand 10 neighborhood projects designed to engage seniors in meaningful community activities

Information regarding Life: Act 2 is available on-line at:
https://www.uwnefl.org/partner_LA2.asp.

Aging [and Disability] Resource Centers

The 2004 Florida Legislature created the Aging Resource Center (ARC) initiative to reduce fragmentation in the elder services delivery system through a locally-focused, coordinated approach that integrates information and referral for all available services. The legislation requires each of the 11 area agencies in Florida to transition to ARCs by assuming additional responsibilities, while maintaining an identity as the local area agency on aging. The following eight primary functions are mandated:

- Increase access to elder services.
- Provide more centralized and uniform information and referral.
- Increase screening of elders for services.
- Improve triaging and prioritizing of elders for services.
- Streamline Medicaid eligibility determination.
- Improve long-term care options counseling.
- Enhance fiscal control and management of programs.

- Increase quality assurance.

A three-year $800,000 grant from the U.S. Administration on Aging served as the primary source of funding this initiative. The Aging and Disability Resource Center (ADRC) Grant Program, a cooperative effort of the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS), was developed to assist states in their efforts to create a single, coordinated system of information and access for all persons seeking long term support to minimize confusion, enhance individual choice, and support informed decision-making as part of the President's New Freedom Initiative. Since 2003, 43 states have received over $40 million in ADRC initiative grant funding. Recently Health and Human Services announced nearly $6 million in additional funding to 22 states to expand their efforts to establish single entry points to long-term care for families who are trying to learn about and access services in their communities.

Three Florida pilot sites were selected, including Broward County. In 2006 the Administration on Aging awarded Florida an additional $85,000 in supplemental funds, which was split between two of the three pilot sites. In addition to the federal funds, each of the three pilot sites received state general revenue funding of $100,000 in fiscal year 2004-05, $20,000 in fiscal year 2005-06, and $300,000 in fiscal year 06-07.

In a September 2006 report, OPPAGA indicated that two of the three pilot sites (including Broward County) were doing well, while the third was having difficulty implementing the initiative. This report further indicated that the Department of Elder Affairs wanted to undertake a detailed study of the pilot sites before moving forward with state-wide implementation of the 2004 legislated ARCs. However, after a year delay, the Department of Elder Affairs resumed ARC transition activities late in 2006.

The fiscal year 2006-2007 budget appropriates $3.3 million in general revenue funds for statewide implementation of the ARC initiative. Unfortunately, at the current time only $300,000 of this allocation is recurring although the Department of Elder Affairs has requested that the entire amount be designated as recurring. The framework for a revised transition process has been introduced, although at the time of this report the Department was still developing details regarding how it will monitor and evaluate the transition and had not released a full set of guidance documents.

According to OPPAGA Report No. 06-62 (September 2006), in June 2006, the Department of Elder Affairs conducted an on-site operational review of this center and concluded that it is addressing seven of the eight functions to the extent possible. The center made several changes to implement the Aging Resource Center initiative, and is making progress in addressing the eighth function, eligibility determination. These improvements include those described below.

- The center hired seven staff and assumed additional responsibilities for screening and waitlist management. Five of the seven staff are multilingual and can communicate in Spanish or Haitian Creole in addition to English. Center staff reports that this has enhanced the center's ability to provide services to diverse populations.

- The center added a bilingual benefits counselor who helps clients apply for public and private benefits for which they are eligible.
- The center enhanced its screening process by adding a triage specialist. 13 The center separated this position from all client contact in order to maintain objectivity in placement decisions and promote a more equitable process for distributing services to clients.
- Center managers report increasing the number of entities with which they coordinate services for the elderly, including for-profit and not-for-profit organizations. Managers also report developing more effective relationships with other governmental entities such as the Department of Children and Families and the county health department.

The department concluded that although the Broward ADRC is planning changes to improve timeliness of the Medicaid eligibility determination process, it needs to make more progress in this area. ADRC managers plan to co-locate with Department of Children and Families' Economic Self-Sufficiency staff in a new building scheduled for occupancy by January 2007. Center managers also plan to implement a virtual co-location structure, as authorized by statute, with the local DOEA CARES unit.[9] Although CARES staff will be located in a separate building, center staff plans to work closely with CARES and Economic Self-Sufficiency staff to improve the timeliness of the Medicaid eligibility determination process. However, DOEA officials concluded that the center needs to more clearly specify how this process will streamline Medicaid eligibility determination. The department has asked the center to begin tracking this data and measure whether changes result in improving timeliness in eligibility determination.

Key informants and participants in the summit were very positive about the ADRC/ARC concept, viewing this as progress made towards streamlining access to services for older persons. However, in general many people seemed unaware of the ADRC and/or failed to associate it with the Area Agency on Aging.

Centralized Intake/Single Point of Entry

Background: The concept of single point of entry incorporates one or more functions including referral, screening, client information system, waiting list and access point (i.e., telephone number) as well as meeting comprehensive service needs, including both health and long-term care.

Many elders and their families are besieged by multiple problems and needs. Rather than providing a system of coordinated care, however, service providers often operate independently of one another and lack knowledge about the involvement of their clients

[9] Virtual co-location means the performance of center functions by the area agency, CARES, and Economic Self-Sufficiency staff operating from more than one location in the planning and service area. The performance of center functions in this organizational structure is facilitated through the use of technology, such as shared computer access, facsimile machines and teleconferencing, as well as frequent face-to-face contact.

and their clients' families with other services. Elders often enter the same system repeatedly, but through different doors (e.g., healthcare, managed care, government programs, community-specific programs). For these elders and their families, accessing appropriate services requires navigating a maze of caseworkers, intake workers, physicians and other medical personnel.

An SEP can be viewed in several ways. Basically, it is a "one-stop shop" process providing people with access to long-term care services. However, the concept of "access" can be extended beyond merely how one enters the system to how one actually receives services and follow-up monitoring. **Consequently, an SEP – as a process – can operate independently of the actual type of services provided**. That is, an SEP is the funneling process through which potential clients of long-term care services can be screened, assessed, advised, and directed to appropriate services, whatever those services are.

An SEP can also be thought of as either horizontally or vertically integrated, or both. Horizontal integration results from a single access to long-term care services across various service departments or agencies. In some cases, these may include a state department of aging, department of health, department of human services, other governmental bodies, and perhaps private organizations.

A horizontally integrated SEP would attempt to either consolidate or coordinate access to diver services across authorizing agencies and providers…Vertical integration of the entry process links all services from all sources from the time a consumer becomes aware of available services up to the provision and monitoring of those services. This is a more extended view of the entry process than the mere making of initial contact and taking the first step to obtain services.

Conceptual elements of a single point of entry may include some or all of the following:

- Single point of entry and assessment.
- Sharing information across disciplines and providers.
- Comprehensive case management across disciplines and providers.
- Broadening definition of "client" to include family or others involved in caregiving and decision-making.
- Regarding confidentiality (often used as a barrier to sharing information resources) – develop intergovernmental and interagency agreements to specify what can be shared.

Reachable goals for single point of entry models include:

- Reducing front-end costs
- Reducing burden on elders and caregivers to navigate complex systems
- Reducing paperwork and record-keeping across the board
- Accelerating access to treatment and other services

- Pooling resources of multiple agencies and organizations
- Facilitating cooperation and communication among agencies
- Creating consistent policies, procedures and outcome targets across agencies
- Streamlining current fragmented service delivery system

It is important to note that discussion of fragmentation normally refers to the entire long-term care system. An SEP is only one component of that system. The concept of an SEP implies some degree of integration of the overall system. However, the existence or the establishment of an SEP neither implies nor guarantees an integrated long-term care system in its entirety.

Best Practice Ideas:

1. The Access Unit of North West Hospital. The Access Unit was established in 1995 to provide a single point of entry to programs provided by North West Hospital in Victoria. Health care professionals who are able to provide an immediate clinical response do not answer all telephone inquiries. Each referral is triaged to an appropriate service, whether provided by North West Hospital or elsewhere. The establishment of the Access Unit has not only improved clinical management; it has identified a number of deficiencies in the hospital's protocols, which have now been address. Following the successful implementation of this model in the subacute sector, the Western Healthcare Network is investigating the feasibility of expanding it to the acute hospital sector.
2. Bill 1: Concerning a Reorganization of Service Delivery for Persons in Need of Long-Term Care through a Single Entry Point System, and, in Connection Therewith, Adopting a Uniform Assessment Instrument. Presently Colorado does not have a single coordinated system for providing long-term care services. Individuals and families needing long-term care services often have difficulty accessing and using the current system. The intent of Bill 1 is to better organize client entry, assessment, and service delivery for long-term health care by providing for a single entry point. A single entry point is an agency in a local community that all elderly and disabled clients must use to obtain needed publicly funded long-term care services. The Department of Social Services will be required to develop and implement a long-term care uniform client assessment instrument, in order to determine appropriate services and levels of care to meting the needs of the client…. This concept will better organize client entry, and assessment and service delivery by providing clients access to the full continuum of care services…establishment of a single entry point in local areas for long-term health care…includes the implementation of a standardized client assessment procedure and an instrument to more appropriately and consistently target services to persons most in need. These changes would replace multiple forms and criteria now being utilized…Providing a continuum of care allows individuals to remain in their homes and communities, maximizing their independence and quality of life. By accessing the system and receiving services through a single entry point and based on a common assessment tool, individuals can: (1) move from one level of care to another in the continuum of care as their

needs change over time with less chance of encountering gaps or barriers, and (2) receive more precisely only those services that they need and no more, resulting in cost savings.

3. The Hamilton Health Sciences Corporation. At the time of referral, it is not always clear which patients are best served by a medical approach and which ones require psychiatric input. When patients are referred to the less appropriate service, diagnosis and treatment may be delayed to the detriment of the patient. A wide spectrum of specialized services for the elderly is offered at the Hamilton Health Sciences Corporation, a four-site teaching hospital in Ontario. The authors describe the development of a common intake process which provides rapid triage to the most appropriate services, and facilitates a combined medical and psychiatric approach where indicated. The end result is a single entry point for referrals, more efficient triage and a net reduction in the number of staff needed to accept and process referrals.

Centrally Located Senior Services/All Services Needs Met in One Location

Background. The concept of centrally located services refers to the co-location of multiple services within a single building, shopping plaza or neighborhood to include health care, personal care needs (e.g., barber/beauty, podiatry, pharmacy, dentist), grocer and sundry vendors, congregate meal sites, entertainment and recreation, as well as critical elements of the service system that might include representatives from Medicare, Medicaid, Information and Referral and the Lead Agency.

Best Practice Idea: The Full Service School. The primary responsibility of schools is to provide students with the essential skills that are necessary for full participation in society. Teachers and administrators know children's basic health and social services needs must be adequately resolved before the learning needs of high-risk children can be successfully addressed. Consequently, in addition to educating children, many schools today also provide breakfast and lunch and include information in the curriculum related to prevention of teen pregnancy, AIDS, substance abuse and violence. Since schools cannot be expected to solve every student need by themselves, school officials need to reach out to other agencies that serve children and actively seek ways to collaborate and share resources.

A full-service school can be defined as "a school center in which health, mental health, social, and/or family services may be co-located, depending on the needs of the particular school and community. The vision of the full-service school puts the best of school reform together with all other services that children, youth, and their families need. The full-service school model envisions that a sustained web of interventions is much more likely to result in measurable changes in at-risk children's lives, rather than fragmented and disconnected support mechanisms.

In the full-service school model, instead of assuming primary responsibility for addressing students' and families' multiple needs, school officials act as equal partners with other community agencies. Services are not limited only to students and their

families, but are open to all community residents. The result is a seamless institution that is accessible to the general public and responsive to the needs of the community. An additional benefit is that community residents of all ages once again begin to recognize the school as the hub around which the community revolves, and they reestablish positive connections with the school system.

Consumer-Directed Care

Background. Consumer direction includes a continuum that ranges from consumers having a role in developing their plan of care to having complete control over services, choice of providers and payment for services. The fundamental underpinnings of consumer direction include the ability of people with long-term care needs to assume a proactive role in their choice of service modalities as well as in the delivery of that care. Important characteristics include privacy, autonomy and the right to "manage one's own risk". Consumer direction in long-term care is seen as a way of leveling the playing field between institutional and home and community-based care. It is also viewed by a growing number of policymakers as a potential mechanism for cost savings through gaining efficiencies in both the allocation of resources and in care delivery.

Policy options span the continuum from consumer involvement in care planning and decision-making to the ultimate in consumer direction—providing cash benefits to beneficiaries and allowing them to purchase their own services.

With the exception of one program administered by the Department of Veteran's Affairs, most of the activity in the area of consumer direction has occurred at the state level through Medicaid home and community-based waiver and state-funded personal assistance services programs.

The concept of direct cash payments for long-term care services, including payments to caregivers, has been much more controversial in the U.S. than other countries. Germany's 1994 Dependency Insurance Act, for example, provides universal coverage of long-term care for disabled people of all ages with the options of cash, vendor payments or a combination of in-kind and cash benefits. Statistics for the first year of operation indicate that 80% of care recipients with the lowest level of impairment and nearly two-thirds of the severely disabled opted for cash benefits. Since the value of the program's cash payments is considerably lower than the money-value of vendor payments, the overwhelming use of the cash option helped Germany's care funds to keep their budgets within prescribed limits.

The Medicaid program precludes direct cash payments to care recipients. However, through a joint planning and evaluation grant from the Department of Health and Human Services and the Robert Wood Johnson Foundation, three states (New Jersey, Arkansas, and Florida) have received Medicaid waivers to experiment with "cashing out" the home and community-based care benefit.

Steps to developing a consumer-directed program include:

- Establishing cash payment rates
- Developing a marketing strategy for enrollment
- Developing a counseling program to help cash recipients to make choices
- Creating a quality monitoring system to balance consumer autonomy with safety and potential fraud and abuse concerns.

Notably, following recommendations in the 2001 Broward County Elder Services Analysis report, Broward County has implemented a consumer-directed program.

Best Practice Ideas.

1. Studies of Cash Disability Allowances for Long-Term Care (1998), funded by the Robert Wood Johnson Foundation, reported that 93 countries and several US states were already using or experimenting with cash and counseling programs. Austria undertook a federal long-term care program in 1993 that is based entirely on cash benefits or care allowances. The Dutch government recently began to allow insurance funds throughout the country to provide disabled and elderly persons with cash benefits called "care budgets." Researchers also found that the only cash-and-counseling program in the United States at the federal level (due to Medicaid restrictions) was in the Department of Veteran's Affairs. In 1995 approximately 220,000 veterans and surviving spouses were receiving cash benefits in the place of formally provided homemaker or personal care services. These unrestricted cash grants are included in monthly VA pension checks. Several U.S. private insurance cash benefit programs were also reported.

2. The Cash and Counseling Demonstration and Evaluation is a policy-driven study of a consumer-directed approach to personal assistance services (PAS) for elders and younger adults with disabilities. Funded by the U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation, this rigorous social experiment tests the use of a cash benefit to enhance Medicaid consumers' ability to design PAS services that best meet their needs (while maintaining overall program budget neutrality). Using their cash benefit, consumers choose who provides these very personal and essential services as well as when and how they are provided. Consumers are also able to use their benefit to buy other services that may increase their independence. Counseling and bookkeeping are offered to help consumers manage their services. Arkansas, Florida, and New Jersey are demonstration sites. Arkansas came on line first (December 1998), then New Jersey (November 1999) with Florida starting last in May 2000. Each state will have open enrollment for at least one year and consumers will be followed for one year with a promise of two years of cash.

   Cash and Counseling is expected to affect consumers' use of, unmet need for, and satisfaction with PAS. As a result it may also affect their health and functioning. Because consumers purchase PAS on their own, rather than relying solely on agencies, they are likely to have more control over who provides their PAS and how

and when these services are delivered. Consumers may use different amounts or mixes of services than they would have received under traditional Medicaid PAS. They may also use their funds to buy equipment or devices to increase their independence. The greater flexibility afforded by the cash allowance should reduce unmet need and improve satisfaction with PAS. If the quality of the PAS improves, it may also improve independence and disability-related health. Potential negative outcomes will also be monitored. If consumers can not manager their cash allowances, if the allowances are not sufficient to purchase needed care, or if consumers either hire people who provide poor care or cannot find workers to hire, unmet need will increase and satisfaction will decline. Consumers could also be abused or neglected, and health and functioning may suffer.

For a comparison of the three demonstration programs please go to:
www.inform.umd.edu/EdRes/Colleges/HLHP/AGING/CCDemo/ataglance.html
www.inform.umd.edu/EdRes/Colleges/HLHP/AGING/CCDemo/secondglance.html
Items on these two tables include: implementation date, populations service, departments involved, territory covered, enrollment targets, current caseload at 8/31/2001, outreach approach, counseling approach, payment for Fiscal Intermediary services, quality monitoring.

3. Missouri's initiative is a 1915c Medicaid waiver program that includes a consumer-directed option. The program is a partnership between Missouri Medicaid, the Department of Vocational Rehabilitation, and Centers for Independent Living. Program participants are limited to individuals between the ages of 18 and 64 who have physical and cognitive disabilities and who are eligible to receive Medicaid personal assistance services. The department contracts with the privately run centers to recruit attendants and to provide optional consumer and attendant training and ongoing follow-up as requested by the consumer. Consumers select, train, and schedule for their personal care assistants. An independent fiscal agent performs the tax and payroll functions.

4. The Minnesota initiative focuses on a counseling component for the state's Consumer Support Grant program. People enrolled in the CSG program, established in 1995, receive a cash grant instead of the services they previously had received through enrollment in state-funded long-term care programs for older people and for families having a child with developmental disabilities. Working with an approved budget, a consumer or authorized representative and a county case manager develop a service plan to guide expenditure of the cash grant. The consumers may use the grant for services and other costs that related to their disability and ability to live independently. They can purchase services directly from providers they choose, who may include family members, neighbors, or friends. The state requires only that counties obtain a signed statement from the consumer or authorized representative at the end of each year stating that all purchases fall within the categories in that year's service plan. The counseling component helps CSG enrollees develop the skills and confidence they need to hire and direct their own personal assistance, homemakers, or other supports and fulfill other responsibilities associated with

participation in the CSG program. The curriculum links training with a needs assessment so that enrollees, in collaboration with a trainer, can determine gaps in their knowledge and the skills needed to function successfully in the CSG program. The project also provided support and training to county staff working with enrollees.

5. Similar programs in various stages of implementation are in use in Oregon, Ohio, Maine, Maryland, Massachusetts, New Hampshire, North Dakota, Pennsylvania, Rhode Island, and Wisconsin.

6. The National Association of State Units on Aging (NASUA) has an independent choices project called "Promoting State Policy Reform to Enhance Consumer Direction". This project focuses specifically on assisting the aging network to look broadly at the entire spectrum of home- and community-based services to identify opportunities for increasing consumer choice and control for older consumers. The project includes development of a self-assessment tool and demonstration of the tool's usefulness in helping states identify opportunities for consumer direction in their home- and community-based services. The tool is organized into six broad categories of consumer direction benchmarks that address all aspects of home-and community-based services:
   - Administration and program design
   - Information and outreach
   - Eligibility and service authorization
   - Service planning and case management
   - Services, providers, and service delivery
   - Service quality

Case-Managed Services

Background. When services are case-managed it generally means that assessment of client needs, development of care plan, selection of providers and supervision of service delivery agencies are handled by a case manager, frequently under the auspices of a "lead agency." There are also private case management agencies that provide the same kinds of services for more affluent clients who can afford to purchase them independently.

Case management may be thought of as a set of logical steps and processes of interaction within a service network that assure that an individual receives needed services in a supportive, efficient, and cost-effective manner. Case managers can influence the kinds and amounts of services provided, the order in which they are rendered to achieve optimal efficiency, and the quality of patient care. The growth of managed care systems, such as health maintenance organizations, preferred provider organizations, and independent practice associations, makes case management even more critical as a means of delivering more personalized, effective, and efficient care.

Case management takes place at several different levels. At the institutional or community level, it involves conducting needs assessments, evaluating community support, and determining agency responsibilities and program policies. The inter-organizational level encompasses the network of public and private services, linking the formal to the informal or natural helping networks. Finally, the intrapersonal level of case management deals with personal biological/physical and psychosocial factors.

The major functions of case management include:

- Prescreening to respond to those who most need and can benefit most from the service
- Intake to engage the client in a dignified way
- Assessment to understand the client as a whole person and be aware of all aspects of the client's situation that threaten functional well-being
- Goal setting to develop clear expectations about what is to be achieved through the service
- Care planning to arrange an individualized package of services
- Capacity building to maximize the potential of the client and of the support network
- Care-plan implementation to assure that high-quality services are found and delivered
- Reassessment to keep current regarding client status and the suitability of the service plan
- Termination to phase out the case management service when it is no longer necessary
- Maintaining relationships to remain accessible

Innovative Housing Models

Background: Service-enriched housing refers to models where housing, home care services, health care services and transportation are managed through the same housing agency or cooperatively through a consortium. Vertically-integrated housing refers to models where multiple levels of care are provided within a single housing facility or housing complex, enabling elders to age within a single environment as they become increasingly frail and in need of additional ADL, IADL and medical support services.

Best Practice Ideas:

In his report The Casera Project: Creating Affordable and Support Elder Renter Accommodations, Stephen Golant (University of Florida) describes five models that currently are in use in at least one facility. Each model has advantages and disadvantage and determining an appropriate model will be specific to the community, the elders in that community, the service provider and healthcare agency networks, and

the opportunities presented in local housing. New models may be developed by mixing concepts from two or more of these service models.

The Basic Service Coordination Model is distinguished by the role of the service coordinator, a full- or part-time employee in each housing facility who coordinates the work of case managers and volunteer coordinators, and creates partnerships with other local entities in order to facilitate residents' access to a broad base of community services. The function of the service coordinator is to identify the resident's needs and support them to age in place; to identify and secure funds to benefit the residents; and to coordinate the delivery of services. Key components of this model include:

- Skilled and competent service coordinator
- Focus on empowering consumers
- Collaboration with home- and community-based service providers

The Partnership Model is designed to establish interagency collaboration that results in effective coordination of services. Key components include:

- Interagency collaboration for effective service delivery
- Written agreements among participating partners
- Maximizes resources through partnerships

The Congregate Housing and Capitation Model fosters residents' independence through a one-stop shopping service package. In this model, all services are provided on-site, including congregate dining, health services, transportation, homemaker, personal care, and an array of group activities, such as adult day care. The organizational structure of this model includes a full-time service coordinator who assigns and manages specific service providers on-site. Key components of this model include:

- One stop shopping for services
- Services provided on site
- Cost of services determined through a capitated system

The Multi-Tiered Assisted Living Program Model is designed to provide two or more levels of social and supportive services within the same facility, providing a continuum of care for residents. Specifically, there would be designated areas or apartments within each facility for each level of care with a differentiated menu of services. Key components of this model include:

- Two or more levels of services within a facility
- Defined set of services to be provided for each level
- Service coordination with home- and community-based services

The Home Modification Program Model is designed to act as a catalyst for organizations to make a long-term commitment to home modifications as a priority issue at the

national, state and community levels, and to promote effective public and private collaborations between national, state and community stakeholders. The home modification model includes several components: leadership and coalition building, research, education, funding, and service delivery. Key components of this model include:

- Emphasizes leadership and coalition building
- Assesses needs and identifies strategies of effective home modifications
- Educates providers, health care professions, policymakers and consumers

Helen Sawyer Plaza ALF (HSP) is a fully renovated public housing building that offers multi-level assisted living for elders in public housing. Helen Sawyer Plaza ALF represents a successful public-private partnership between the Miami Dade Housing Agency (MDHA) and MIA Consulting Group, Inc (MIA). It combines aspects of several of the models identified by Golant and has been operating successfully since January 1999.

In 1996, responding to national and local concerns, MDHA asked MIA to assess the functional needs of low-income elders living in public housing to determine the degree to which there was a need for housing options offering a higher level of care than traditional independent living with supplemental services. The MIA study documented significant demand for affordable, high-quality assisted living facility and extended congregate care options for elders residing in public housing to enable them to defer and/or avoid nursing home placement. Armed with these findings, in 1998 the MDHA successfully petitioned the Sate of Florida for $1.2 million to transform and operate HSP, an underutilized public housing facility for elders, into a multi-service residential facility. The MDHA contracted with MIA to develop and plan for offering an assisted living facility option to public housing residents within the structure of the MDHA. The consultants created a concept call the Total Housing Enterprise Model, based on vertical integration of service-enriched housing facilities for elders. A key feature of this model is the elimination of fragmentation in coordination and delivery of the full range of ALF services. Eventually MDHA contracted with MIA to implement the model, which includes adult day care and extended congregate care in addition to the assisted living facility. The model also provides a unique funding component that combines basic SSI/OSS resident income sources with the Medicaid ALF-Waiver subsidy (for eligible residents) as well as the HUD Federal housing subsidy.

Integrated Utilization of Funding for Healthcare and Social Service Programs

Background: This section deals with long-term care delivery and financing that comprehensively addresses health and social services for older adults through pooled funding sources.

Over the past ten to twenty years, a number of initiatives at the federal, state, and provider levels have focused on the management of acute and long-term care services through a range of integrated approaches. Although definitions of integration differ, most

would agree that the following elements are critical to achieving the goal of integration of services:

- Broad and flexible benefits, including primary, acute and long-term care
- Far-reaching delivery systems that have the capacity and experience to go beyond traditional hospital, physician and post-acute services to community-based long-term care, case management and specialty providers
- Adoption of mechanisms for actually integrating care (e.g., care management and care planning protocols, interdisciplinary care teams, centralized records and integrated information systems)
- Overarching quality systems with a single point of accountability
- Flexible funding with incentives to align payers and minimize cost shifting

Best Practice Ideas:

1. Federal demonstration projects have included:
    - Social HMOs (SHMO – ongoing since 1985; adds community care services and short-term nursing home care to a Medicare-HMOs acute care plan; focusing on providing a broad cross-section of the Medicare eligible population with acute care had limited community-based long-term care coverage.
    - The Program of All Inclusive Care for the Elderly (PACE) represents a public approach to providing long-term care to frail elders who are Medicaid eligible and nursing home certifiable. Distinguishing features of PACE include: integrated funding and providers financial risk through capitated Medicare and Medicaid reimbursements, integrate service delivery with adult day care as the focal point, case management through interdisciplinary care teams (from physician to van driver), and an aggressive attempt to keep individuals out of nursing homes using community care alternatives.

2. State initiatives have included:
    - Arizona's long-term care system is part of a mandatory Medicaid managed care program that has been in existence since the late 1980s. Medicaid acute, long-term care and behavioral health services are included in the service package, but Medicare funding is not explicitly integrated into the program. The program implicitly achieves a degree of integration at the contractor level because Medicare services are usually delivered through the organization that provides the capitated long-term care services – Medicare reimburses the contractor on a fee-for-service basis.
    - Minnesota was the first state to receive Medicare and Medicaid waivers to explicitly integrate acute and long-term care for the dually eligible elderly (in seven counties). The Minnesota Senior Health Options offers an integrated package of acute and long-term care services through a choice of three managed care plans with voluntary enrollment. Plans are at risk for the first 180 days of nursing home costs and then are reimbursed on a fee-for-service basis

with the plan continuing to provide all services. MSHO has multiple rate cells to create incentives for plans to use home and community-based services in lieu of institutional services.

3. A number of providers are attempting to create integrated service systems. There are strong marked incentives to develop such systems…hospitals trying to fill beds and skilled nursing facilities looking to expand their business beyond traditional long-term care. Hospitals are vertically integrating-buying up nursing homes, rehab centers and home health agencies-in an effort to become an all-purpose provider in the community. Skilled nursing facilities and, to a lesser extent, home health agencies, are more likely to be integrating horizontally – building alliances with hospitals, physician groups, assisted living developers and other community-based providers.

4. The National Chronic Care Consortium (NCCC), a strategic alliance of 31 nonprofit health systems in the United States and Canada, used a grant from the Hartford Foundation to develop the Self-Assessment for Systems Integration (SASI) tool, a set of guidebooks and training materials. The main part of the tool identifies nine key objectives essential for chronic care integration and addresses these objectives through four goal-setting, planning, self-measurement, and resource sections. No evaluation of the tool has been published. It is available from NCCC for $500.

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Attachment III.I
AFFORDABLE HOUSING

Affordable housing was the most frequently discussed concern expressed by consumers, providers, and key informants in the 2006 Broward Elder Services Analysis. Moreover, this topic had almost no presence in the previous elder services analysis (completed in 2001), possibly indicating a dramatic increase in the problem over a relatively short period of time (5 years). It is difficult to even imagine how much unmet need for affordable and subsidized housing actually exists, but the data described below paints a grim picture regarding public and affordable housing for Broward County's elder population.

In this report, we use the term "affordable housing" to cover both subsidized and non-subsidized residences. In their report on the Broward Affordable Housing Needs Assessment (2006), the FIU Metropolitan Center reported that "the median housing price-to-income ratio – a key economic indicator in assessing local market trends and vitality – tripled during the three-year boom period, outpacing other high-priced metropolitan markets. This means the majority of individuals and most two-income families in Broward County are priced out of the market" (media release by Broward Housing Partnership, March 1, 2006).

Although age was not measured and reported as a variable in the report, overall findings indicated that there was an affordability gap of more than $100,000 between median sales price of a single family home and the family median income required to purchase a home in 22 Broward municipalities. Condominiums often are assumed to be a more affordable alternative; however, they require an annual household income of $50,000 for a median priced condo of $193,000 and 44% of households in Broward County have annual incomes lower than $41,300. Rental housing is similarly "unaffordable" at an average market rate of $1,122 per month; the median income of renters is only $31,898 per month meaning that rents at the market rate are often more than 30% of a household's income.

These numbers are particularly alarming when considering the impact on older community residents, where just under one third age 65+ (approximately 78,000 people) had annual incomes below $29,999, and 14,598 people age 75+ had annual incomes below the federal poverty level (see section III.C). As stated earlier, data show that, as people age (and therefore become more frail and in need of assistance) poverty rates increase, and that poverty rates among elders in all age groups are expected to increase over the next 20 to 30 years (see Section III.A). Therefore, it is likely that the oldest old may face the greatest price barriers to owning or renting homes or apartments in the community.

Subsidized "public housing" also is inadequate to meet current needs. Table III.I1 below shows the number of elders living in different public housing programs – a total of 1,444.

Table IIII.1. Persons Age 62+ in Public Housing, by Type of Program and Housing Authority, as of 11/30/06

Housing Authority	Public Housing	in Voucher-Funded Assist Units	in Section 8 Mod Rehab Units
Broward County	176	604	30
Dania	0	0	
Deerfield Beach	70	35	
Ft. Lauderdale	279	176	
Hollywood	0	0	
Pompano Beach	8	66	
Total	533	881	30

2006 Broward Elder Analysis Housing Findings

The following summary of the findings regarding gaps and concerns from interviews and surveys was presented at the Elder Summit in January 2007.

- Affordable housing was the number one concern on everyone's list in 2006
- There was an increasing perception among a number of providers, based on anecdotal information that the number of homeless elders is increasing.
- Affordable housing for elders is rapidly worsening because of increased costs, taxes, insurance, fewer trailer parks, condo conversions, effects of recent hurricanes, and slow response of insurers and government agencies to fund post-hurricane repairs.
- Public Housing is fragmented (6 housing authorities in Broward), complicated for elders to negotiate, and available stock is inadequate, based on reports of long waiting lists (9 months for public housing; 2 years for Section 8). Public housing and voucher programs are very difficult to understand in terms of what is available, how to qualify, which program is best. For an example, see Table III.I2.
- There are an overwhelming number of potential programs, each with a somewhat unique set of requirements and application process, although each public housing agency may only be managing one or more of these programs at any time.
- Affordable housing initiatives face barriers/disincentives, including the inflated cost of land available for housing development.
- Elders lack knowledge about public and affordable housing alternatives.
- Elders with mental health and substance abuse problems who require assistance with housing face even greater barriers and challenges and there is no specific support system to assist them with housing issues.
- Cities' involvement in responding to issues related to the affordable housing crisis was reported to be inconsistent across municipalities. Many are not addressing the

need in any way. Several key informants suggested looking for opportunities improve coordination between Broward's 6 housing authorities

- Need centralized resource for affordable housing. Likewise need centralized access to all available subsidized housing programs county-wide.

Key action items from the 2007 Elder Summit:

- Tiered housing communities (includes service-enriched housing)
- Increase resources for modifications and repairs to make current housing safe
- Protect elders from forced evictions
- Create incentives for developers to refurbish existing buildings and build new
- Centralized access to housing assistance
- Increase safety of public housing

Table III.I2 is a reproduction of an on-line resource listing of multifamily inventory units for elders and persons with disabilities. This inventory is designed to assist prospective applicants with locating units in HUD insured and HUD subsidized multifamily properties that serve the elderly and/or persons with disabilities. If you are searching for all HUD subsidized properties, please go to HUD's Subsidized Apartment Search. The data displayed on this site is current as of 3/31/03. HUD is in the process of gathering current data from owners/agents of multifamily housing properties and its internal systems. As current data is received, the data will be updated. HUD will update this site in fiscal year 2006. This site does not provide eligibility and waiting list information, unit availability, tenant selection preferences, or types of accessible features for these properties. Therefore people who use the site are directed to contact the Property Manager/Management Agent for additional information. This information was deleted here for brevity but is included on the web site. This provides an excellent indication of how challenging it is for elders to find such housing. Information regarding number of units was obtained from *The Seniors Resource Guide for Broward County and the Surrounding Areas*, Spring-Summer 2006.

Table IIII.2. Section 8 Multifamily Units for Elders and Persons with Disabilities

Contact	Property	# Units	Type	Bedrooms	
				1	2
Catholic Housing Management	St. Andrew Towers Coral Springs, FL 33065-4837	432	Elderly	X	
Sharkey and Associates, Inc.	Federation of Gardens of Davie DAVIE, FL 33328-6021	Unknown	Elderly	X	
SPM, Inc.	B'nai B'rith Apartments Deerfield Beach, FL 33441-3353	Unknown	Elderly	X	
SPM, Inc.	B'nai B'rith Apartments II Deerfield Beach, FL 33441-3355	Unknown	Elderly	X	
Housing Authority City of Ft. Laud.	Alan Apartments Fort Lauderdale, FL 33311	72	Elderly	X	

Contact	Property	# Units	Type	Bedrooms	
				1	2
Westminster Retirement Communities	Gateway Terrace Apartments Fort Lauderdale, FL 33304-3855	Unknown	Elderly	x	x
Sharkey and Associates, Inc.	Hillmont Gardens Fort Lauderdale, FL 33311-4052	123	Elderly	x	
Catholic Housing Management	Hurley Hall Hallandale, FL 33009-4142	120	Elderly	x	
Sharkey and Associates, Inc.	Federation Plaza Hollywood, FL 33021-4461	123	Elderly	x	
Gene B. Glick Company, Inc.	Sunbelt Manor Hollywood, FL 33024-5774	Unknown	Elderly	x	
Catholic Housing Management	St. Joseph Towers Lauderdale Lakes, FL 33311-1889	107	Elderly	x	
Unknown	DGN Towers Pembroke Pines, FL 33025	Unknown	Elderly	x	
Arbor Properties, Inc	Pembroke Towers Pembroke Pines, FL 33024-3600	100	Elderly	x	
Catholic Housing Management	St. Boniface Gardens Pembroke Pines, FL 33024-6602	Unknown	Elderly	x	
Catholic Housing Management	St. Elizabeth Gardens Pompano Beach, FL 33064-5255	150	Elderly	x	
Sharkey and Associates, Inc.	Federation Gardens Sunrise, FL 33351-4770	Unknown	Elderly	x	
Sharkey and Associates, Inc.	Federation Landings Sunrise, FL 33351-4700	Unknown	Elderly	x	

Types of Public Housing Assistance

Low rent apartments: the government gives funds directly to apartment owners, who lower the rents they charge low-income tenants. You can find low-rent apartments for senior citizens and people with disabilities, as well as for families and individuals.

Housing choice vouchers: Housing choice vouchers allow very low-income families to choose and lease or purchase safe, decent, and affordable privately-owned rental housing. Below is a list of various types of vouchers, for more information click on the subject you want:

- Conversion vouchers assist PHAs with relocation or replacement housing needs that result from the demolition, disposition, or mandatory conversion of public housing units. Also conversion vouchers include providing assistance to families living in section 8 projects for which the owner is opting out of the HAP contract, HUD is taking enforcement action against owners with project-based assistance, and projects for which the owner is prepaying the mortgage. Families that are

affected by the conversion action will automatically receive a voucher if the family meets all other program requirements.

- Family unification vouchers are made available to families for whom the lack of adequate housing is a primary factor in the separation, or threat of imminent separation, of children from their families or in the prevention of reunifying the children with their families. Family unification vouchers enable these families to lease or purchase decent, safe and sanitary housing that is affordable in the private housing market.

- Homeownership vouchers help qualified individuals meet a monthly mortgage payment and other home ownership expenses for a first home.

- The housing choice voucher program is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. Since housing assistance is provided on behalf of the family or individual, participants are able to find their own housing, including single-family homes, townhouses, and apartments. Participants are free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects. This program is administered locally by public housing agencies (PHAs). The PHAs receive federal funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher program. Family that have a housing voucher are responsible for finding a suitable housing unit of the family's choice where the owner agrees to rent under the program. A housing subsidy is paid to the landlord directly by the PHA on behalf of the participating family. The family then pays the difference between the actual rent charged by the landlord and the amount subsidized by the program. Under certain circumstances, if authorized by the PHA, a family may use its voucher to purchase a modest home.

- Project-based vouchers are a component of a public housing agencies (PHAs) housing choice voucher program. A PHA can attach up to 20 percent of its voucher assistance to specific housing units if the owner agrees to either rehabilitate or construct the units, or the owner agrees to set-aside a portion of the units in an existing development. Rehabilitated units must require at least $1,000 of rehabilitation per unit to be subsidized, and all units must meet HUD housing quality standards. Any eligible family on a PHA's housing choice voucher waiting list that is interested in moving into the specific project. Owners select families for occupancy of a particular unit after screening each family. Under the project-based voucher program, a PHA enters into an assistance contract with the owner for specified units and for a specified term. The PHA refers families from its waiting list to the project owner to fill vacancies. Because the assistance is tied to the unit, a family who moves from the project-based unit does not have any right to continued housing assistance. However, they may be eligible for a tenant based voucher when one becomes available.

- Tenant-based vouchers increase affordable housing choices for very low-income families. Families with a tenant-based voucher choose and lease safe, decent, and affordable privately-owned rental housing. Under the tenant-based housing choice

voucher program, the PHA issues an eligible family a voucher and the family selects a unit of its choice. If the family moves out of the unit, the contract with the owner ends and the family can move with continued assistance to another unit.

- Mainstream vouchers for elders and non-elder families that have a person with disabilities.
- Designated housing vouchers for non-elderly families who would be eligible for public housing if occupancy were not restricted to elderly households. These vouchers also assist families affected by a PHA decision to designate their buildings as "mixed elderly and disabled buildings" but demonstrate a need for alternative resources for families with a disabled person.
- Certain development vouchers for non-elderly families with a disabled person, who do not currently receive housing assistance, in certain developments where owners establish preferences for, or restrict occupancy to, elderly families.
- Project access vouchers were issued in 2001 as part of a demonstration program between HUD and HHS. 400 vouchers were awarded to 11 lead PHAs to partner with Medicaid agencies in providing housing assistance to non-elder disabled persons transitioning from nursing homes into the community.

It is not difficult to see why a flexible voucher program and other forms were proposed as the State and Local Housing Flexibility Act of 2005. SLHFA provides local Housing Authorities the ability to fashion housing programs that best meet the needs of their local populations. However, PHAs can retain much of what they are doing now if they so choose. SLHFA changed the one-size-fits-all approach to assistance and offered PHAs the freedom to set reasonable subsidy standards based on local market conditions, and therefore serve as many families as possible within their grant amount. SLHFA provided an incentive program (MTW) that would provide even greater flexibility. Proponents of the bill argued this was necessary because:

- The assisted housing programs have become overly complex and burdensome to administer thus making it more difficult to serve families that need help.
- Unintended consequences have led to programs that disincentivize work and independence.
- Rising costs experienced by the Housing Choice Voucher program have led to the need to reexamine programs to ensure dollars allocated are spent in the most effective way.
- About 20 income exclusions and 18 mandated exclusions/deductions go into calculating rent and income.
- One study indicated that it would consume more than 6 hours of PHA staff time to correctly conduct the required tenant interview and income calculation process.
- While many families stay less than five years in assisted housing, even more stay 5 years and more. It is likely that those families that do stay at least five years will end up staying up to 10 years.

- In 1998, the Housing Choice Voucher program consumed 36 percent of the HUD budget. Today, it absorbs nearly 60 percent.

Senior Housing Information Center

The purpose of this Center is to provide program options and HUD sponsored technical assistance to public housing authorities (PHA's) or tribally designated housing entities (TDHE's) that may have an interest in modernizing or constructing elderly public housing. This mission will assist very-low income elderly public housing residents to age in place and avoid unnecessary institutionalization. The Senior Housing Information Center, a service of HUD's Public Housing Clearinghouse Center (see left margin), will answer inquiries from PHA's or TDHE's, and link them with the appropriate supportive services to sustain service-enriched elderly housing. www.hud.gov/pihforseniors also brings you to this page and is easier to remember.

Financial Tools to Modernize or Construct Elderly Public Housing

- Since 1993, HOPE VI has helped to revitalize a large portion of the Nation's most distressed public housing developments by providing grants and regulatory flexibility to address the housing and social service needs of PHA's poorest residents. There have been 193 HOPE VI Revitalization grants awarded to 114 housing authorities since 1993 - totaling $5 billion. Revitalization grant funds may be used for an array of activities, including: demolition of severely distressed public housing; acquisition of sites for off-site construction; capital costs of major rehabilitation, new construction and other physical improvements; and community and supportive service programs for residents, including those relocated as a result of revitalization efforts. HUD will pay relocation costs for residents whose apartments are being demolished. Relocated residents in good standing will be given an opportunity to move back to the newly constructed units at the site, or will be given Housing Choice Vouchers (Section 8) that will subsidize their rents in privately owned apartments if they choose not to return to public housing.

- The Resident Opportunities and Self Sufficiency (ROSS) Program links public housing residents with supportive services, resident empowerment activities, and assistance in becoming economically self-sufficient. This program is consistent with the Department's goal to more effectively focus resources on welfare-to-work and independent living for the elderly and persons with disabilities. ROSS grants may be made to four types of applicants: (1) Public Housing Agencies (PHAs) on behalf of public housing residents; (2) Site-based resident associations (RAs)--resident management corporations, resident councils, or resident organizations (including nonprofit entities supported by residents); (3) Intermediary Resident Organizations (IROs); and (4) Nonprofit entities operating as associations or networks that administer programs benefiting public and assisted housing resident organizations.

ROSS incorporates three basic funding categories: Technical Assistance/Training Support for Resident Organizations, Resident Service Delivery Models, and Service Coordinators. ROSS Resident Service Delivery Models for the Elderly and Persons with Disabilities is intended to provide supportive services for the elderly and persons with disabilities to help them maintain independent living. Eligible activities include, but are not limited to: (a) Providing personal assistance with daily activities; (b) Transporting residents to medical appointments, shopping, and other locations; (c) Helping residents maintain their health through nutritional meals, wellness programs, health education, and referrals to community resources; and (d) Providing congregate services.

- The supportive Housing for Persons with Disabilities Program (Section 811) provides financial assistance in the form of capital advances and project rental assistance to nonprofit sponsors to expand the supply of housing for very low income persons with disabilties. The provider must demonstrate that an applicant can live more independently if housed in Section 811 project. If a PHA creates a subsidiary with a 501(c)(3) classification, the subsidiary is still a public body, therefore, it cannot apply for the HUD 202 program, but it can for 811. However, if it is newly formed with no experience, it must submit an 811 application with a co-sponsor, otherwise it has little chance of being selected in the competitive process. For purposes of developing a mixed finance project with additional units over and above the 811 units, the owner can be a for-profit limited partnership with the nonprofit entity as the sole general partner.

Attachment III.J
DISASTER PREPARATION & RECOVERY

In this Attachment we discuss critical issues regarding disaster preparation and recovery for elders in Broward County. We will present some background information that helps answer questions providers may have regarding elder vulnerability in disaster scenarios, and then present results from the 2006 provider and consumer surveys, key informant interviews, and action items from the 2007 Elder Summit special sessions on disaster planning. Finally, we briefly describe a Model All Hazards Plan for Older Adults, which focuses on the role of the aging service network in the disaster planning and response process.

Background

Perhaps one of the most perplexing challenges in developing a community response to disaster planning and recovery for older persons is to understand their vulnerability. Obviously frail elders require extra care and concern and the nature of their vulnerability is relatively easy to identify. However, the majority of older persons are not frail, and yet we would argue that even those elders who are not frail require special consideration in disaster planning and recovery.

According to Oriol (1999) special concerns for older persons in an emergency may arise from (1) sensory deprivation, i.e., older persons' sense of smell, touch, vision, and hearing are likely to be less acute than that of the general population; and (2) delayed response as a result of age-related slowing of cognitive and motor activity, which means they generally cannot react as quickly as the general population.

Additionally, there are a number of issues regarding chronic illness and dietary considerations, again for older people who are relatively healthy and active. For example, arthritis is increasingly prevalent as people age and may prevent an older person from standing in line, walking even moderate distances, and getting up and down from a low cot or floor-level mattress. Well functioning elders taking new medications or dealing with temporary suspension of regular medication regimens may become temporarily confused and also may have increased susceptibility to dehydration, falling, and dangerous changes in blood pressure. Conditions of elders dependent on dialysis, oxygen, and other electricity-driven functions, may worsen if treatment is suspended, even for a short time.

Often older persons are careful about their diets. For example, low salt and low fat foods are often essential for maintaining an elder's good health. Emergency food rations, not specifically developed for older consumers, may be filled with ingredients that elders should not consume in great quantity. Older adults also are more dramatically [negatively] affected by extremes of heat or cold.

Finally, many elders are more vulnerable because they are reluctant to accept assistance from outside agencies. In some cases this is cause by welfare stigma and unfamiliarity with bureaucracy. Elders may not accept public assistance because of perceived stigma, and belief that if they accept help, someone else who may need it more will have to go without it. Additionally, many elders fear that any contact with government bureaucracy may place them at risk of involuntary nursing home placement. Additionally, older adults may be reluctant to ask for or accept very important mental health services for many reasons.

2006 Broward County Consumer Survey Results

On the 2006 consumer survey (see Attachment III.E) consumers were asked to identify barriers most likely to prevent them from evacuating from their homes even if a mandatory evacuation was announced. Table III.I1 below shows results for consumers, by caregiver status. The most frequently identified factors preventing evacuation included lack of transportation out of the area, no place to stay, not willing to stay in a shelter, and fear of not being able to return. Interestingly, pets were significantly more likely to be perceived as more of a problem by caregivers (51.3%) than by non-caregivers (9.8%). Likewise, no transportation out of the area was identified significantly more often by non-caregivers (34.15%) than by caregivers (10.26%).

Table IIIJ.1. 2006 Survey Barriers Most Likely to Prevent Older Adults from Leaving Home Even if a Mandated Evacuation is Announced by Caregiver Status

Barrier	Non-Caregivers (N=366)		Caregivers (N=39)	
	n	(%)	n	(%)
No transportation out of the area	125	34.15	4	10.26
No place to stay out of the area	138	37.70	17	43.59
Not willing to stay in a disaster shelter	114	31.15	17	43.59
Not willing to leave property	82	22.40	10	25.64
Won't leave family pet	36	9.84	20	51.28
Have to stay to protect property from looters	66	18.03	7	17.95
Fear that, after the disaster, won't be able to get back to where you lived before	157	42.90	10	25.64
Don't know evacuation is mandatory	68	18.58	5	12.82
Have to stay to protect property from disaster damage	56	15.30	7	17.95
Didn't know about disaster or emergency	55	15.03	6	15.38
Can't afford to leave	64	17.49	3	7.69

Table IIIJ.2 compares responses of consumers, including caregivers, and providers to the same 2006 survey question. Overall, the most important factors preventing evacuation were lack of transportation out of the area, no place to stay, and fear of not being able to return. Significantly more providers than consumers identified not willing to

leave property, and won't leave family pet differences as barriers. Significantly more consumers than providers identified need to stay to protect property from looters and don't know about disaster or emergency as reasons for not leaving.

Table IIIJ.2. 2006 Survey Barriers Most Likely to Prevent Older Adults from Leaving Home Even if a Mandated Evacuation is Announced by Respondent Type

Barrier	Providers (N=40) n (%)	Consumers (N=405) n (%)
No transportation out of the area	21 (52.50)	129 (31.85)
No place to stay out of the area	14 (35.00)	155 (32.35)
Not willing to stay in a disaster shelter	17 (42.50)	131 (22.72)
Not willing to leave property	15 (37.50)	92 (22.72)
Won't leave family pet	17 (42.50)	56 (13.83)
Have to stay to protect property from looters	1 (2.50)	73 (18.02)
Fear that, after the disaster, won't be able to get back to where you lived before	11 (27.50)	167 (41.23)
Don't know evacuation is mandatory	3 (7.50)	73 (18.02)
Have to stay to protect property from disaster damage	5 (12.5)	63 (15.56)
Didn't know about disaster or emergency	0 (0)	61 (15.06)
Can't afford to leave	9 (22.50)	67 (16.54)

2006 Key Informant Interviews

In key informant interviews for the 2006 Broward County Elder Services Analysis project (see Attachment III.D) respondents were asked to questions specifically related to disaster planning:

- What are your biggest concerns regarding disaster response to older adults in Broward County as it was implemented in the 2004 and 2005 hurricane seasons? What do you think worked particularly well in terms of response?
- What are your biggest concerns regarding Broward County's approach to planning for future natural or other types of disasters in terms of meeting the needs of older Broward County residents before, during, and after such events? Are you aware of any past or current planning that produced good or improved outcomes for older adults here?

In terms of what worked particularly well, respondents said the following:

- Dedication of staffs of many organizations in providing immediate responses to needs for food, emergency funds, case management, and mental health services.
- Crisis counseling under Project Hope worked well.
- Broward County was very responsive in terms of funds for emergency housing and food.

- There were significant improvements in 2006 in preparation for disasters as a result of experiences in 2005-2006, particularly in terms of overall coordination.

Interview respondents expressed the following concerns:

- There was no designated aging network organization to coordinate agencies serving elders and to take leadership in coordination with county, cities, and other organizations, such as Health Department, whose responsibilities include serving all residents of Broward County.
- State agencies and non-profit organizations all have individual disaster plans but there is still little sharing of plans and coordination of effort.
- Many elders did not have personal disaster plans, particularly those in trailer parks and condos, with special medical needs such as prescription medications or dialysis, wards of the court pursuant to guardianship proceedings, and those with HIV/AIDS.
- Many elders were stranded in their homes without power or support, in some cases for several weeks post-hurricane (Wilma, Katrina).
- There was no organization in charge of home repairs for those able to remain in their own homes or those displaced; key informants in the summer of 2006 reported that some elder renters and homeowners were still living in unrepaired housing.
- There was only immediate community planning for shelters and no longer-range solutions identified for elders who cannot shelter at home.
- The magnitude of issues because of the special needs of so many elders and the complexity of responding effectively remained a challenge in many areas.
- There was insufficient capability in special needs shelters to respond effectively to disorientation and complex needs of large numbers of older persons.

The following promising planning activities were identified:

- The county Office of Emergency Management is now coordinating creation of a database of vulnerable persons that will be able to produce maps for first responders.
- The county is now exploring vulnerability mapping to identify areas with at risk populations, including elders.

Additional concerns and recommendations regarding all-hazard planning:

- Planning for individual elders should occur at the block level, supported by municipalities, to ensure that every elder has an individual plan.
- There is a need for aggressive outreach regarding planning through well-coordinated community response on behalf of all older persons, with particular emphasis on elders with special needs, including wards of the court, homeless, nursing homes and assisted living facilities, older women living alone, elders in

trailer parks, those with language and cultural difficulties or who are non-English-speaking, those with pets, and those with other special needs.

- There is a need for aggressive outreach after disasters to identify all older persons in need of assistance.
- All Broward municipalities should be engaged in planning collaboratively on behalf of older persons.
- Staffs of all organizations should receive disaster preparedness training specific to older persons.
- The county should explore a call-down procedure, such as reverse 911 to assure that all elders are (1) called 24-48-72 hours prior to an event to advise them to prepare and ask about help needed, and (2) called again within 24 hours after an event to determine their status and need for recovery assistance.
- Other issues included specific preparation for other types of disasters, including pandemic flu and bioterrorism, and need to accommodate federal and state responders, including military, as necessary.

Summary of 2007 Elder Summit Proceedings and Results Re: Disaster Planning

The 2007 Elder Services Summit, organized by Broward County Vice-Mayor Lois Wexler in conjunction with the Broward County Elder and Veterans Services Division, took place on January 31, 2007 at the Signature Grand in Davie. More than 300 people participated in the day long Summit to discuss and reach consensus on the many issues facing Broward County's elder population. Participants, who represented a cross-section of county residents, identified priorities and gaps in the services provided for elders living in Broward County.

Below is a list of items generated in the two disaster planning breakout sessions grouped by common themes.

- The community must offer elders and their caregivers access to disaster preparation training, including information and assistance in developing personal disaster plans. Information must be available in multiple languages.
- Individual agencies and the Aging Alliance must develop multi-level plans that account for elder-specific needs and ensure the ability to quickly regroup and begin offering services immediately after a disaster.
- There were many ideas about access to reliable forms of communication, both for elders and caregivers, service providers, and the emergency operations center.
- Several action items were suggested having to do with way to identify elders needing help, including door hangers, coded arm bands, and medic alert bracelets/dog tags.
- Volunteers at the neighborhood level as well as at the community level need to be recruited and trained on an ongoing basis.

- Partnerships, particularly with faith-based organizations and universities, were recommended.
- Require Homeowner Associations to assume at least some responsibility for assisting elder residents.
- Develop and distribute information about best practices.
- Make sure transportation is available for elders, caregivers, and pets when there is a decision to evacuate.
- Need to modify permitting laws for repairs following a disaster in order to facilitate rapid (and safe) rebuilding.

In fact, action items suggested in the summit were consistent with survey and key informant information, as well as with The Center on Aging's findings in two previous projects on Disaster Planning. One of these was conducted in Palm Beach County for the Quantum Foundation. The second, funded by the U.S. Administration on Aging through the University of South Florida's Florida Policy Exchange Center, has a national focus. This previous work generated the following recommendations:

- Under disaster conditions community should respond to elders as a single unified network. Memoranda of understanding or other forms of formal inter-agency cooperative agreements should be executed prior to disasters to address such issues as evacuation, shelter, transportation, distribution of food and water, temporary and permanent relocation, provision of health and social services, and prioritizing and facilitating damage assessment and repairs.
- Negotiate with federal/state agencies to implement procedural changes that would make emergency funds available prior to or within 24 hours following emergency event to enable the ASN to assist elder <u>non-clients</u> who might otherwise have to take complex and exhausting actions to survive.
- Test a plan – perhaps apply for federal funding – to capitate payments for <u>currently un-served elders</u>, based on census data and an estimated average amount of incident-specific help needed per elder before, during, and after a disaster.
- Work with faith-based and civic organizations to develop creative, safe evacuation options for elders unable to evacuate independently; might include establishing host homes, host "transporters", or other alternatives created through collaboration with community organizations.
- Develop long-term plan that would enable elders to come into well-furnished shelters where they would be able to stay safely and comfortably during and after a disaster until either homes can be made livable or longer-term relocation plans can be made; will reduce "transfer trauma", which especially affects frail elders.
- Work with task force including representatives from County Health Department, Area Agency on Aging, County Community Affairs Department, insurance companies, pharmacies (including hospital pharmacies), and physicians to establish plan for wide distribution of prescription and over-the-counter drugs and medical supplies during and after emergencies.

- Develop and fund plan to train social service providers to assist clients with applications for assistance from public and private organizations and relief agencies, i.e., “disaster recovery case management”. Implementation of such a plan will ensure that persons who already are familiar with providing services to elders can “take the application process to the people.”
- Ensure appropriate and sufficient distribution of food, water, batteries, and ice to older adults, including those who cannot open containers or prepare food.
- Develop and implement a plan to stock special needs supplies like wheel-chairs, incontinence supplies, sunscreen, moisturizing lotion, bug repellant, and materials for wound care.
- Develop campaign to promote preparation, event, and recovery activities for elders in a variety of circumstances. Local businesses might be engaged in this initiative, which could include not only printed material and media outreach, but kits containing some of the necessary survival items, such as insect repellant, flashlights, batteries, transistor radios/TVs, instant hand sanitizer, plastic envelopes or zip lock bags for photocopies of important documents and contact numbers, toothbrush and toothpaste, pre-moisturized wipes, etc.
- Develop plan to provide specialized transportation to and from food, water, and ice distribution points, and FEMA offices, as well as the shelters for elders. Funding to reimburse for fuel and staff driving time must be included in the plan. Agreements for these specialized transportation services should be executed prior to community crisis and reviewed at least one time each year to make sure contracted provider capabilities are sufficient to meet needs as the elder population increases.
- Outfit some temporary housing stock with accommodations for elders and physically handicapped, e.g., grab-bars, wheelchair ramps, widened doorways, etc.
- Identify longer-term temporary housing options for elders whose residences are destroyed or require extensive repair.
- Develop plan to assess damage to elders’ homes and to organize needed repairs, including criteria for prioritizing.
- Speed up process of reviewing commercial repair contractor applications in recovery periods.
- Make the public aware that volunteers are needed for post disaster community service and that they must be trained in advance. Make sure pre-trained volunteers receive an ID badge and vest that will allow them to enter disaster areas to check on elders and deliver essentials.
- Prepare older persons to be volunteers during and after a disaster. Use a recruiting and implementation strategy that takes into account that many potential active older adult volunteers reside out-of-state during the hurricane season.
- Fund and implement campaign to make older persons aware of scams and fraudulent situations they may encounter in aftermath of disaster. Because it will

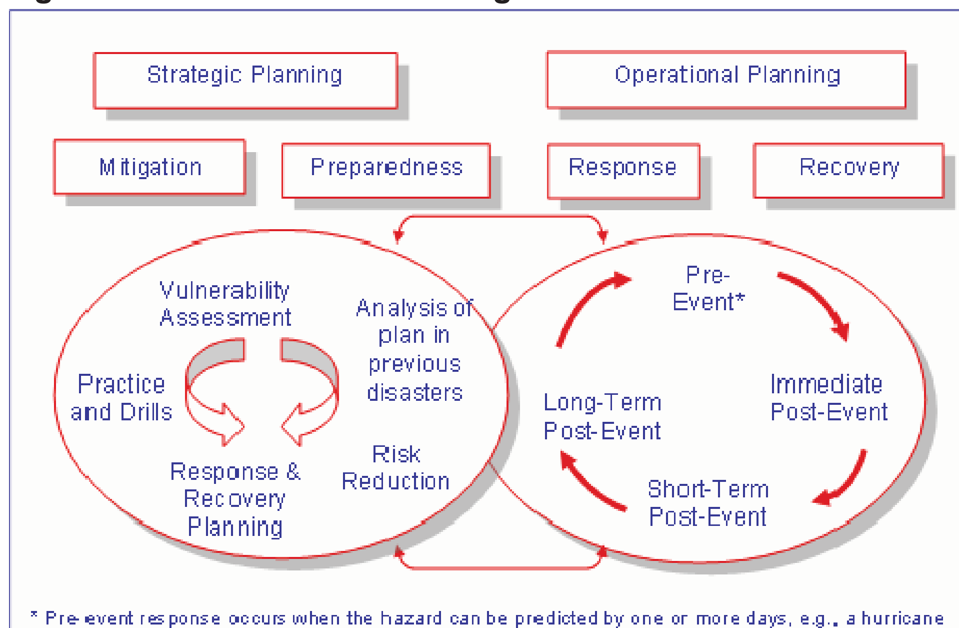
be important to inform older consumers while not alarming them so much that they refuse all assistance, this educational campaign must be skillfully and carefully planned and implemented.

- Develop training program aimed at providing "lay" and professional emergency response personnel with minimum skills to understand basic attributes of dementia (confusion, non-verbal, angry, etc.) and behaviors these attributes often cause, as well as good strategies for dealing with each of these attributes in a crisis situation.

An All-Hazard Preparation Framework:

Figure IIIJ.1 below represents the conceptual model on which a Model All-Hazards Plan for Older Adults (the Plan) is based. This plan was developed by The Center on Aging for the U.S. Administration on Aging. In the model, *Strategic Planning* is comprised of *mitigation* and *preparedness* activities that include vulnerability assessment, analysis of how plans worked in previous disasters, proactive risk reduction, training, and practice. Lindell & Prater (2003) defined *mitigation* as "pre-impact actions that protect passively against casualties and damage at the time of hazard impact". More specifically, hazard mitigation may be described as, "any action taken to lessen, eliminate, or reduce the devastating effects of a disaster on people, property, and the environment. Mitigation can also reduce the fear, panic, and inconvenience that surround a disaster". *Preparedness*, the type of disaster planning that many communities already are engaged in, involves development of pre-defined responses to disaster events. However, as previously noted, there are still frequent scenarios where preparedness is not addressed as a strategic activity, and instead is undertaken "on the fly" in the middle of or following a crisis.

Figure IIIJ.1 All-Hazards Planning for Older Adults Framework



Operational Planning is comprised of activities that focus on community preparation for CHE *response* and *recovery.* In Figure IIIJ.1, and throughout this report, *response* and *recovery* are discussed in the context of a four-stage timing sequence – pre-event, immediate post-event, short-term post-event, and long-term post-event – consistent with the reality of community mobilization when a disaster occurs. Of the four stages, pre-event response is the only one that does not always apply. Clearly in some scenarios, such as a terrorist attack, there is no pre-event warning. Response activities in these cases begin with the immediate post-event period.

There is general recognition that communities today must plan for types of hazards that were not planned for in the past. This means that, in addition to regionally-common natural disasters like floods, heat waves, hurricanes, earthquakes, and blizzards, it also is important to be ready for man-made disasters (acts of terrorism and bio-terrorism), pandemics, and even for natural disasters not common to the geographical area (e.g., earthquakes on the U.S. east coast). Therefore, the Plan incorporates an all-hazards planning perspective that is independent of local weather patterns.

The Plan was designed as a comprehensive tool that can easily be adapted and utilized in individual communities anywhere in the United States and, perhaps, in other countries as well. Based on interviews, literature review, and internet-based research, it identifies essential strategic and operational planning goals and objectives along with ideas for how community aging service networks can address them.

The Plan is organized around the 12 issues identified by interviews and a literature review conducted for the 2004-2005 Palm Beach County Disaster Planning for Elders project as particularly relevant to the unique needs of older adults in community emergencies. For ease of use, the 12 issues have been condensed into seven focus areas in the Plan. As shown in Table 1, below for each of the seven focus areas we will discuss mitigation, preparedness, response, and recovery.

Table IIIJ.3: Plan Structure

	Focus Area	Strategic Planning for Mitigation & Preparedness	Operational Planning for Response & Recovery
I.	Roles and Responsibilities	Includes Vulnerability Assessment, Review of Prior Events, Risk Reduction, Training, and Practice Activities	Includes Planning for all Emergency Phases, including Pre-event, Immediate Post-event, Short-term Post-event and Long-term Post-event
II.	Evacuation, Shelter, Relocation, and Housing		
III.	Social and Healthcare Issues, including Dementia and Mental Health		
IV.	Community Infrastructure, including Communication and Transportation		
V.	Volunteerism and Consumer Protection		
VI.	Special Considerations Regarding Ethnicity, Race, and Culture		
VII.	All-Hazards Considerations		

Strategic and Operational Goals by Focus Area. Listed below are the strategic and operations goals specific in the Plan. These goals offer individual communities great flexibility in terms of developing an approach that is feasible and appropriate to the needs of the area.

I. Allocation of Roles and Responsibilities Among Agencies and Organizations

Strategic Goal I.S1: The ASN *organizes itself* to maximize available expertise and resources in disaster mitigation, preparedness, response, and recovery planning and activities related to elders and their caregivers.

Strategic Goal I.S2: The ASN is the *definitive resource* for community-specific data, information, and training for disaster mitigation, preparedness, response, and recovery Planning and Activities related to older people and their caregivers.

Strategic Goal I.S3: The ASN's *strategic disaster planning cycle is ongoing* and independent of specific disasters.

Operational Goal I.O1: All composite agencies and organizations in the ASN have developed Continuity of Operations Plans *(COOPs)* to ensure the safety of and provide ongoing services to clients and staff during and after any disaster.

Operational Goal I.O2: The ASN *proactively seeks release* of pre- and post-disaster federal, state, and local *funding* for elder-related mitigation, preparedness, response, and recovery planning and activities.

II. Evacuation, Shelter, Relocation, and housing

Strategic Goal II.S1: The ASN provides the OEM with *current* census, service, geographic distribution, and capacity *data, expertise, and training resources* needed for disaster mitigation, preparedness, response, and recovery planning related to evacuation, shelter, relocation, and housing for older people.

Strategic Goal II.S2: The ASN conducts ongoing *outreach activities* to increase awareness of older people and their caregivers regarding evacuation, shelter, relocation, and housing issues that may arise during and after a disaster, and disseminates information about available resources for assistance with individual planning, including pre-registration for special services.

Operational Goal II.OP: The ASN is prepared to serve as a *bridge* between community agencies and elders/caregivers to ensure that all elders obtain disaster-related evacuation, sheltering, relocation, and housing information and assistance.

III. Social and Healthcare Issues

Strategic Goal III.S1: The ASN provides the OEM with *current* census, service, geographic distribution, and capacity *data, expertise, and training resources* needed for disaster mitigation, preparedness, response, and recovery planning related to social and healthcare issues for older people.

Strategic Goal III.S2: The ASN conducts ongoing *outreach activities* to increase awareness of older people and their caregivers regarding social and healthcare issues that may arise during and after a disaster, and disseminates information about available resources for assistance with individual planning, including pre-registration for special services.

Operational Goal III.OP: The ASN is prepared to serve as a *bridge* between community agencies and elders/caregivers to ensure that all elders obtain disaster-related social and healthcare service information and assistance.

IV. Community Infrastructure, including Communication and Transportation

Strategic Goal IV.S1: The ASN provides the OEM with *current* census, service, geographic distribution, and capacity *data, expertise, and training resources* needed for disaster mitigation, preparedness, response, and recovery planning related to community infrastructure issues for older people.

Strategic Goal IV.S2: The ASN conducts ongoing *outreach activities* to increase awareness of older people and their caregivers regarding community infrastructure failures that may occur during and after a disaster, and disseminates information about available resources for assistance with individual planning.

Operational Goal IV.OP: The ASN is prepared to serve as a *bridge* between community agencies and elders/caregivers to ensure that all elders obtain disaster-related information and assistance regarding community infrastructure.

V. Volunteerism & Consumer Protection

Strategic Goal V.S1: The ASN provides the OEM with *current* census, agency, geographic distribution, and capacity *data, expertise, and training* resources regarding disaster mitigation, preparedness, response, and recovery planning related to volunteerism, including elder volunteerism and general volunteerism to increase assistance for elders, and consumer protection issues for older people.

Strategic Goal V.S2: The ASN conducts ongoing *outreach activities* to increase awareness of older people and their caregivers regarding volunteerism and consumer protection issues that may arise during and after a disaster, and disseminates information about available resources for assistance with individual planning.

Operational Goal V.OP: The ASN is prepared to serve as a *bridge* between community agencies and elders/caregivers to ensure that all elders obtain disaster-related information and assistance with volunteerism and consumer protection issues.

VI. Special Considerations Regarding Ethnicity, Race, and Culture

Strategic Goal VI.S1: The ASN provides the OEM with *current* census, agency, geographic distribution, and capacity *data, expertise, and training resources* needed for disaster mitigation, preparedness, response, and recovery planning related to ethnic, racial, and cultural issues for older people.

Strategic Goal VI.S2: The ASN conducts ongoing *outreach activities* to increase awareness of older people of all races, ethnicities, and cultures and their caregivers

about how they can reduce vulnerability during and after a disaster, and disseminates information regarding available resources for assistance with individual planning.

Operational Goal VI.OP: The ASN is prepared to serve as a *bridge* between community agencies and elders/caregivers to ensure that all elders obtain disaster-related information and assistance that is ethnically, racially, and culturally sensitive and appropriate.

VII. All-Hazards Considerations

Strategic Goal VII.S1: The ASN provides the OEM with *current* census, agency, geographic distribution, and capacity *data, expertise, and training resources* needed for CHE mitigation, preparedness, response, and recovery planning related to issues that vary for older people based on the type of disaster that occurs.

Strategic Goal VII.S2: The ASN conducts ongoing *outreach activities* to increase awareness of older people and their caregivers regarding issues and vulnerability specific to different types of disasters, and disseminates information about available resources for assistance with individual planning.

Operational Goal VII.OP: The ASN is prepared to serve as a *bridge* between community agencies and elders in a disaster to ensure that all elders obtain information and assistance regarding any elder-related issues unique to the particular type of disaster that has occurred.

The Model All-Hazards Plan for Older Adults will be available on The Center on Aging Website in May 2007 (www.fiu/~coa.edu).

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Attachment III.K
SOCIAL MARKETING

<u>What is social marketing?</u> (excerpt from *Wikipedia* on-line)

Social marketing is the systematic application of marketing alongside other concepts and techniques **<u>to achieve specific behavioral goals for a social good</u>**. Social marketing began as a formal discipline in 1971, with the publication of the first edition of *Social Marketing* by marketing experts Philip Kotler and Eduardo L. Roberto. Speaking of what they termed "social change campaigns," Kotler and Roberto introduced the subject by writing, "A social change campaign is an organized effort conducted by one group (the change agent) which attempts to persuade others (the target adopters) to accept, modify, or abandon certain ideas, attitudes, practices or behavior."

Although social marketing is sometimes seen only as using standard commercial marketing practices to achieve non-commercial goals, this is not the case, and an over-simplification. The primary aim of social marketing is social good, while in commercial marketing the aim is financial gain. This does not mean that commercial marketers can not contribute to achievement of social good. However, it is important not to confuse social marketing with other types of commercial marketing where there is a contribution to a social good involved but not the primary aim. For example societal marketing, cause-related marketing or pro-social marketing are aspects of commercial marketing that can contribute in different ways to social good. The distinction between these activities and social marketing is that in their case social good is not the primary goal, but a related goal in order to support a company's commercial and financial aims.

Also, whereas commercial marketing often aims at a comparatively simple influence over its target market, social marketing goals can be far more subtle and complex. A commercial marketer selling a product may only seek to influence a buyer to make a product purchase. Social marketers, dealing with goals such as reducing cigarette smoking or encouraging condom usage, have more difficult goals: to make potentially difficult and long-term behavioral change in target populations.

While social marketing initially developed from a desire to capitalize on commercial marketing techniques, it has in the last decade matured into a much more integrative and inclusive discipline that draws on the full range of social sciences and social policy approaches as well as marketing. Increasingly social marketing is being described as having two parents - a social parent = social sciences and social policy, and a marketing parent = commercial and public sector marketing approaches.

<u>Basic Social Marketing Concepts</u>

- The ultimate objective of marketing is to influence action;
- Action is undertaken whenever target audiences believe that the benefits they

receive will be greater than the costs they incur;

- Programs to influence action will be more effective if they are based on an understanding of the target audience's own perceptions of the proposed exchange;
- Target audiences are seldom uniform in their perceptions and/or likely responses to marketing efforts and so should be partitioned into segments;
- Marketing efforts must incorporate all of the "4 Ps," i.e.:
    - Create an enticing *"Product"* (i.e., the package of benefits associated with the desired action);
    - Minimize the *"Price"* the target audience believes it must pay in the exchange;
    - Make the exchange and its opportunities available in *"Places"* that reach the audience and fit its lifestyles;
    - *Promote* the exchange opportunity with creativity and through channels and tactics that maximize desired responses;
- Recommended behaviors always have competition which must be understood and addressed;
- The marketplace is constantly changing and so program effects must be regularly monitored and management must be prepared to rapidly alter strategies and tactics.

SOCIAL MARKETING IS:

- A social or behavior change strategy
- Most effective when it activates people
- Targeted to those who have a reason to care and who are ready for change
- Strategic, and requires efficient use of resources
- Integrated, and works on the "installment plan"

SOCIAL MARKETING IS NOT**:**

- Just advertising
- A clever slogan or messaging strategy
- Reaching everyone through a media blitz
- An image campaign
- Done in a vacuum
- A quick process

Social Marketing for Behavior Change Toward and By Elders in Broward County

Based on the 2006 Broward County Elder Analysis results, there are a number of social marketing themes that could be pursued. These include:

1. Elder Registry – Encourage elder community residents and their caregivers to feel comfortable registering in a confidential registry that could be access under specified conditions, such as an individual crisis or a community hazard event.

2. Organized Neighborhood Groups – Mobilize the community to accept responsibility for elder neighbors in individual crisis or in related to a community hazard event. A more general approach would be to fold organized neighborhood groups into a more general campaign to interest the community in volunteering to help elders in a variety of capacities.

3. Health Promotion – Identify critical health promotion activities for elders to be able to live better and longer in independent community settings; convince community elders to embrace these activities.

4. Long Term Care Planning – Encourage middle aged and older community residents and caregivers in all income brackets to proactively plan for a time when they may need long-term care assistance. Make long term care planning as common an activity as traditional retirement, estate, or burial planning.

5. All Hazard Planning – Similar to long term care planning, encourage older community residents and their caregivers in all income brackets to proactively engage in planning and preparation for a variety of potential hazard scenarios.

6. Increase Desire for Careers in Aging (includes raising compensation) – This would be targeted toward the community at large, including students in middle-school and older to increase prestige and desirability of careers in aging.

7. Eliminate Ageism – Targeted to the entire community, including elders, service providers for elders, and the general population of all ages. Might include improving elder's positive perception regarding using available assistance when they need it.

NOTE: One or more of these ideas could be combined under the "Community for a Lifetime" umbrella.

DEVELOPING A SOCIAL MARKETING CAMPAIGN: SAMPLE OUTLINE

Because of the comprehensive nature of this type of campaign, using a professional social marketer to at least assist in developing a plan would probably generate best results. Although different social marketers may have different planning approaches, the following is an annotated outline that might be useful, even in preparing to meet with a social marketer.

Situational Analysis

- Introduction
- Background and Research: explanation of the issue you wish to address; background facts.
- Issue definition:
    - campaign focus - the behaviour change you wish to promote.
    - purpose of the campaign - the intended impact of a successful campaign.
- Environmental Scan: research on external factors that could affect your campaign
- SWOT Analysis
    - Strengths
    - Weaknesses
    - Opportunities
    - Threats

Market Segmentation

Involves division of the total market into relatively homogeneous, but distinct segments.

- Geographically
- Demographically
- Psycho graphically

Target Market Selection

Criteria	Description
Total number of people in the segment.	Segments encompassing larger groups of individuals are more attractive
At Risk	Segments at higher levels of risk should be given priority
Persuadability	A segment that is easily persuaded to change should be given higher priority, as it will take fewer resources to establish a behavior change
Accessibility	Target audiences that are easier to reach with messages are more attractive as less work and fewer resources will be needed to make an impact
Resources required	The fewer resources required, to meet the needs of the target market, the greater the expected return on investment
Equity	The need to target specific disadvantaged segments

Objectives

Behavior Objectives: actions
Knowledge Objectives: statistics or facts that could motivate the target audience
Belief Objectives: attitudes, opinions, feelings, or values held by the target audience
Specific Measurable Objectives

- Specific
- Measurable
- Achievable
- Relevant
- Time-based

Marketing Strategy

Product:

- Actual Product: specific behavior that is being promoted.
- Core Product: tangible objects and services offered to support behavior change.
- Augmented Product: benefits the target audience will experience when they perform the behavior

Price: cost (monetary or non-monetary) that individuals associate with adopting the new behavior

Place: where and when the target market will perform the desired behavior and access products and services

Promotion: messages and the tactics used to deliver the messages

Key Messages: brief statements highlighting the bottom-line message to a campaign.
Messaging approach
Promotional tactics

Evaluation Plan

- Evaluation and Tracking Plans: measuring the actual outcomes of the campaign and the tactics used to create the outcomes.
- Application of evaluation results

Budget

- Include costs of creating, producing, printing, and distributing campaign materials.

- Review specific objectives, identifying tasks associated with objectives and the expected costs of the tasks.

Implementation Plan

Task	Responsible Party	Completion Date	Expected Cost
what actions need to be performed	who will be responsible	when activities will be completed	costs for each activity.

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www.socialmarketing.org
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Attachment III.L
PROJECT METHODOLOGY

The Center on Aging employed a triangulated data collection approach that included: obtaining available census and Department of Elder Affairs/Area Agency for Aging service data; conducting an extensive literature and internet search on related topics; and obtaining input from consumers and key informants through surveys, interviews, and a one day community summit.

Census data were obtained on-line from the U.S. Census Bureau. Data from the 2000 Census is available down to the zip code level and can be downloaded for analysis. The American Community Survey, which offers updated annual estimates of key indicators, does not offer zip-code level data but does offer data by county that also can be downloaded for analysis. Both data sources were used.

Service units and client profile data were provided by The Department of Elder Affairs. DOEA also provided us with unduplicated client count data by program at the zip code level. The Aging and Disabilities Resource Center/Area Agency on Aging provided aggregate service and expenditure data, by program. Analysis of these data was designed to provide a current picture of services and the community elders who use those services, as well as to provide a basis for estimating the potential magnitude of unmet need for service among Broward's elder population.

The literature review from the 2001 Elder Analysis project was updated and expanded and included searching both academic and internet literature sources. Internet sources were particularly important in identifying promising practices recently or currently used in many communities throughout the United States.

Both providers (40) and consumers (405) were surveyed using an instrument that was similar to the 2001 survey to enable us to make comparisons. Additional provider information was obtained through 18 key informant interviews that included key functional areas outside of the traditional elder services network. Finally, we obtained comments and ideas for action items from more than 300 one-day elder summit attendees who included providers, consumers, and representatives from local government.

The outcome of this multi-source data collection process is a Strategic Business Plan that will help Broward County mobilize to improve community response to the needs of elders, a rapidly growing population.

Approach to Estimating Unmet Needs: We used four indicators as the basis for calculating needs, allowing us to project varying levels of needs without diluting the data through multiple assumptions. These indicators –

- persons age 65+ with two disabilities

- persons age 65+ living below the federal poverty level with at least one disability
- persons age 75+ and living alone
- persons age 75+ living below the federal poverty level

-- are strongly supported in the literature and, additionally, are available from the U.S. Census 2000 data by zip code. Although there are likely to be many persons who meet the criteria for two or more of the selected indicators, results are based on number of people who meet the specified criteria according to the U.S. Census 2000. However, while DOEA data were available as unduplicated counts by program and by zip code, these data could not be matched with the four indicators. Therefore, to estimate unmet need in each category we subtracted the total number of people getting services in the area from the total number of people who met the criteria according to 2000 Census data. By dividing the number getting any service by the total number for each criterion, we also were able to express the potential magnitude of unmet need as a percent.

Description data and simple comparisons were produced from the provider and consumer surveys. Qualitative data collected in the key informant interviews and elder summit were sorted by question (key informant interviews) and themes (both key informant interviews and summit data).

Attachment III.M
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